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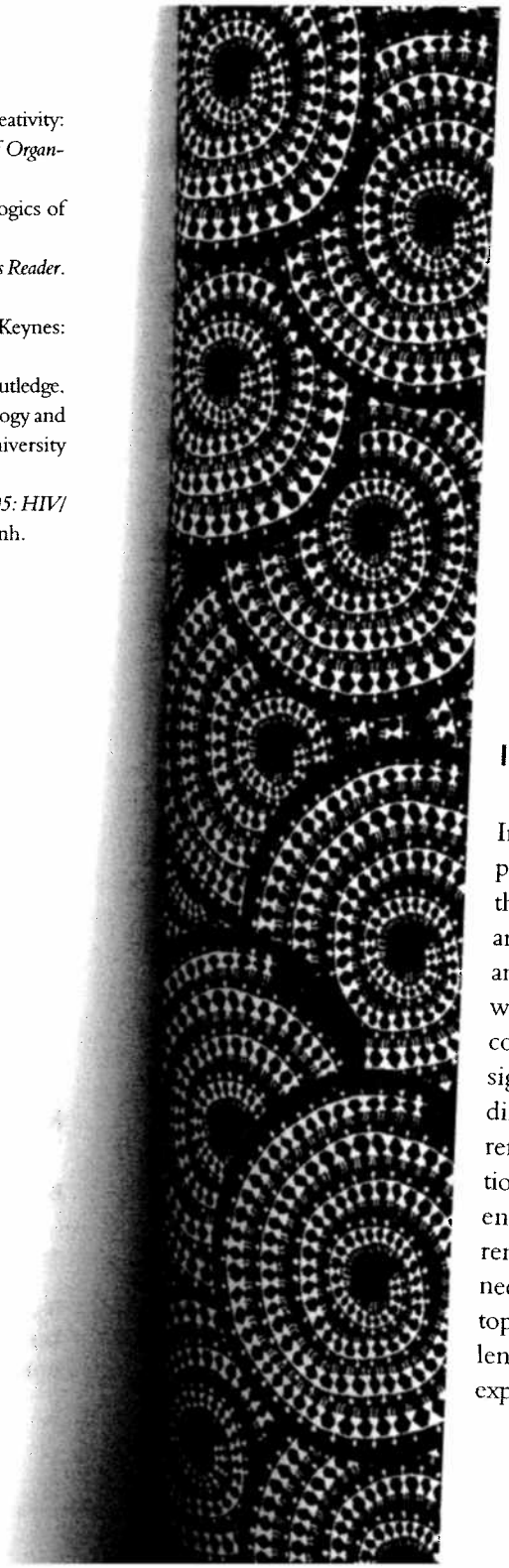

10

JASOOS VIJAY

SELF-EFFICACY, COLLECTIVE ACTION AND SOCIAL NORMS IN THE CONTEXT OF AN HIV AND AIDS TELEVISION DRAMA

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Introduction

In India, as many as 3.1 million adults are HIV positive, which places critical emphasis on the urgent need to enhance prevention efforts and address the associated deep levels of stigma and discrimination that exist. The mass media and wider communication (peer, interpersonal and counselling) response to HIV in India has been significant, yet taboos associated with openly discussing issues associated with sex remain, reflecting the negative social and moral connotations of the disease. In the context of HIV in India enormous health communication challenges remain. Many of these challenges centre on the need for cultural sensitivity in communicating topics such as HIV, while simultaneously challenging current cultural norms. This chapter explores such issues via the example of the BBC

World Service Trust (BBC WST) *Jasoos Vijay (Detective Vijay)* through which viewers of this serial drama were exposed to issues that affect people living with HIV or AIDS.

Prior quantitative research has already demonstrated that viewing this drama had direct impacts on HIV-related knowledge, attitudes, and behaviour (Chatterjee et al., 2009). Consequently, following an introduction to the *Jasoos Vijay* production, this chapter presents a theoretical and thematic assessment of qualitative (letters, focus groups and interviews) and quantitative survey data, in order to identify key elements of the narrative that resonated with viewers. More specifically, we apply a number of relevant theoretical frameworks, principally emerging from the fields of health communication and social psychology, to explicate the shifts in viewers' HIV-related knowledge, attitudes and actions.

Various communication theories discuss the role of cultural context or social norms and their impact on behaviour. However, many such theories neglect the broader social and cultural contexts or 'fields' in which action occurs. They do not recognise that, 'complex cultural patterns of behavior are, in large part, transmitted and regulated at a social-systems level' (Bandura, 1969: 255). As Dutta-Bergman (2005) points out, the theories most commonly used to understand and measure the impact of health campaigns—such as the theory of reasoned action, the theory of planned behaviour and the more recent integrated model of behavioural prediction—acknowledge the role of social and cultural normativity and the collective nature of community, but remain largely individualistic in scope.

This individualistic orientation can be problematic for mass-mediated drama interventions produced for audiences in the so-called 'developing world'. This is particularly true within more 'collectivist' cultures, such as India, because the 'meanings associated with the behavior and the behavioral outcome might very well be located in the social networks, the collective fabric of the community' (Dutta-Bergman, 2005: 106). This point is supported by Sinha and Kumar, who note that:

> Indians possess both an 'independent' as well as an 'interdependent self' [...] The 'independent self' is associated with a desire to pursue individualistic goals whereas the 'interdependent self' is always concerned with fulfilling the expectations of others. The 'other' is highly evident in the consciousness of the 'interdependent self' and this leads to a preoccupation with fulfilling the obligations of significant others [elders, husbands, caste groups, elites and so on].
>
> (2004: 100)

In calling for a more culture and context-centred approach, Dutta-Bergman (2005) argues that the inclusion of subjective norms within these theoretical models does not make such models sufficiently social. Rather, the norms that these models tend to measure are those internalised and understood by the individual, rather than the collective. For development practitioners, this has both theoretical and methodological implications. In assessing some of these implications, this chapter draws upon qualitative and quantitative data to examine and challenge notions of collectivity, normativity and group dynamics and show how these concepts are mobilised, rightly or wrongly, in current theoretical models in health communication.

Jasoos Vijay: Background and Impact

In response to the growing number of HIV and AIDS cases in India, the BBC WST developed a broad programme of E-E interventions funded by the UK Department for International Development (DFID). *Jasoos Vijay* was specifically designed to impact viewers' HIV-related knowledge, attitudes and practices (commonly referred to as the KAP model of health communication). Working with the National AIDS Control Organization (NACO) and the national television broadcaster, Doordarshan, *Jasoos Vijay* was the centrepiece of the campaign to promote HIV and AIDS awareness. The BBC WST staff believed that an entertainment-based intervention would be most effective in achieving the objectives of the wider campaign which were: (*a*) increasing knowledge of how HIV is transmitted; (*b*) encouraging people to get tested and learn their HIV status; (*c*) challenging the culture of discrimination towards people who are HIV positive and (*d*) promoting support and treatment for those living with HIV or AIDS.

In conceptualising *Jasoos Vijay*, the BBC WST research team was particularly sensitive to the stylistic and genre preferences of the intended audience. In 2001, during the development of the drama, Nielsen's Television Audience Monitoring (TAM) data revealed that action or thriller

genres were the second most popular type of content on general entertainment channels in India. Moreover, the creative team felt that the fast-paced action/thriller format and the constant stream of new cases for *Jasoos Vijay* to investigate and solve would allow them to easily weave key messages into the script without it appearing overly didactic. The series was shot with professional actors in various locations across India in order to forge a cultural and emotional connection to viewers from disparate parts of the country. Finally, *Jasoos Vijay* had all the ingredients of a *Bollywood*-style thriller—attractive heroes, evil villains, helicopters, car chases, suspense and, of course, lots of singing and dancing (see Dickey, 2007).

Jasoos Vijay was broadcast on the national television channel Doordarshan, the only freely available terrestrial channel in India, between 2002 and 2007. During that time, the BBC WST produced and broadcast 130 episodes of the drama. The key to the programme's longevity was its significant popularity. Television Audience Monitoring (TAM) data from Nielsen's audience panel showed that during its final phase, between October 2006 and September 2007, *Jasoos Vijay* reached a weekly audience of up to 15 million, and cumulatively it reached 70 million viewers over its last 52 episodes, making it one of the 10 most-watched programmes on Indian television.[1]

The drama's leading character was a male detective, Vijay, who was HIV positive. Vijay's HIV status was not revealed until the show had already become popular with the viewing public since the creative team did not want to risk rejection of the main character at the outset of broadcasting. Likewise, the way in which he became HIV positive was never disclosed. The fact that the central character was HIV positive allowed the programme to repeatedly address issues related to the care and treatment of those living with the virus, as well as the stigma and discrimination associated with HIV and AIDS. Here, Devika Bahl, the creative director for *Jasoos Vijay*, observes that:

> At the heart of the serial's success was our decision to portray the detective hero, Vijay, as HIV positive. Vijay's personal journey contributed greatly to dispelling myths and creating better awareness of HIV, its treatment and management [...] Vijay's first disclosure of his HIV status was to Gauri (his wife to be) after she professed her love for him. He maintained that an HIV positive person doesn't have to walk around with a sign around their neck saying that he/she is positive but that if there is a risk of transmitting infection, then it is their responsibility to inform their partner and take precautions.
>
> (Interview, 2009)

Jasoos Vijay was designed for mass audiences—cutting across caste, class and regions. For this reason, Detective Vijay was not given a surname, lest audiences perceive him to be upper or lower caste or from a particular locale or ethnicity. This purposeful ambiguity regarding Vijay's background was an attempt by producers to ensure that various audience segments would not feel alienated by a specific rendering of place, caste or ethnicity, allowing viewers more potential to project their own contexts and experiences onto the narrative. Though caste permeates all aspects of life in India, both the drama and its ensuing audience research efforts did not directly tackle the issue of caste. Instead, a deliberate strategy of being 'caste-vague' was employed, although it is possible that viewers may have made their own caste-related inferences with respect to Jasoos Vijay and his colleagues. Moreover, although Vijay and his team were shown to be from an urban background, they solved crime cases mostly in rural areas or villages, so as to further broaden the appeal of the programme and promote them to the status of 'visitors', freed from the specificities of context and therefore more able to intervene within that context in dramatic ways.

Jasoos Vijay managed to garner huge popularity in India. In evaluating the drama, the BBC WST conducted a quantitative baseline survey at the outset of the project that served as a benchmark of the public's HIV-related knowledge, attitudes and practices (KAP). After the campaign went off-air in 2007, an end-line survey was conducted using the same research methodology. This allowed for comparison of the baseline and end-line surveys, with potential respondents matched with respect to gender, age, education and location (specific town or village). The final baseline and end-line samples included 11,691 and 12,050 participants, respectively. Comparisons between the two surveys demonstrated that viewers did indeed change in terms of their HIV-related knowledge, attitudes and behaviours (Sood et al., 2006). More specifically, a higher percentage of those exposed to the *Jasoos Vijay* drama knew the different routes of HIV transmission and methods of preventing HIV

transmission (for a more detailed analysis focusing on this quantitative data, see Chatterjee et al., 2009).

Although this quantitative research provides strong evidence that *Jasoos Vijay* was successful in achieving its stated goals, it does not answer the question of 'why' it was successful, or how the behaviour of audiences change. As Papa et al. point out, 'most past studies of entertainment education programs, with a few exceptions [...] have not provided an adequate theoretical explanation of how audience members' change as a result of being exposed to ... programs' (2000: 33). Indeed, understanding and utilising the theoretical elements that make a narrative impactful constitute a core challenge for future drama for development initiatives. Moreover, the success of E-E formats has often been judged (as outlined above) using multi-phase KAP surveys, which assess shifts in knowledge, attitudes and practices over time. The present chapter goes beyond this somewhat narrow quantitative focus to consider other outcomes and intervening factors that may be just as significant, such as social norms. Below we present a qualitative analysis of viewers' comments as expressed in letters, focus groups and one-on-one interviews, in an attempt to answer the question of why *Jasoos Vijay* was successful, while pointing out some constraints on success.

The letters included in our qualitative analysis were a subset of the letters and e-mails from the final year of the programme and included viewers from the Hindi-speaking states of Uttar Pradesh, Uttaranchal, Rajasthan, Punjab, Haryana, Madhya Pradesh, Chattisgarh, Bihar and Maharashtra. In addition, after the programme ended, 12 focus group discussions and 36 one-on-one interviews were conducted (between February and March 2007) with the audiences of *Jasoos Vijay*. After considering the logistics of inviting participants from a wide catchment area and with the intent of keeping travel to a minimum, 100 male viewers were invited and came from their home states to participate in 12 focus groups conducted in the nearby cities of New Delhi, Jaipur, Nagpur and Patna. To capture the opinions of those unable to attend the focus groups, the BBC WST audience research team travelled to a number of villages to conduct one-on-one interviews (all interviews were conducted by an interviewer of the same sex). A total of 36 interviews (18 with females and 18 with males) were conducted in rural areas in the aforementioned states. These data are supplemented by listener's letters received en masse throughout the duration of the production.

Thematic and Theoretical Analysis of *Jasoos Vijay*

Jasoos Vijay received more than 1,500 audience letters per month, and over 23,000 in its last year, providing further evidence of its popularity. The vast majority of these letters reflected positively upon the drama's impact, as a rural viewer of *Jasoos Vijay* mentioned: 'Earlier, family members used to get up and walk away whenever HIV or AIDS messages appeared on TV [...] but not any more [...] [after we started watching *Jasoos Vijay*] we all sit and watch and listen'. Moreover, many viewers reported impacts at the community level: '[...] inspired by your serial we have set up a group in our village which disseminates information on HIV, AIDS, STIs [sexually transmitted infections] among the villagers'. Such quotes typify the bulk of letter-based response from the audience, and together with BBC WST survey data, suggests that *Jasoos Vijay* had the potential to influence not only individual attitudes, but also cultural norms and beliefs held at a societal level (Chatterjee et al., 2009; Sood et al., 2006). In the following sections, we articulate the theoretical importance of this leap from individual attitudes and behaviours to collective norms and the implications for long-term sustainable behaviour change.

Social Cognitive Theory, Identification and Self-Efficacy

With its origins in social learning theory (Bandura, 1969, 1977b), Bandura's social cognitive theory (SCT) began with research that included media influences on aggression. Based on his experiments with children and adults, Bandura determined that people can learn vicariously by watching mass-mediated role models. Further, if an individual identifies with a role model, he or she is particularly likely to imitate that role model's behaviour (Bandura, 1969). Individuals are even more likely to perform a modelled behaviour if the role model is shown to be rewarded for the behaviour (Bandura, 1969). In the focus groups, participants frequently referred to Vijay's lifestyle and work ethic when discussing how people

with HIV or AIDS should be treated: 'Jasoos Vijay is also suffering with this disease, and he is having and living a normal life' (male focus group participant, New Delhi). Similarly, another focus group participant observed that: 'even after getting HIV positive, Jasoos Vijay goes to villages and tells people about it' (male focus group participant, Uttar Pradesh). While fictional characters such as Vijay are often portrayed as free from the constraints of the socio-cultural context and the social mores and norms that define them, many audience members nevertheless make a connection between the characters' on-screen conduct, how people living with HIV/AIDS (PLWHA) should live and how they should be treated by the wider community. Numerous letters received by the BBC WST reinforce this fundamental position.

But not all role models are equally effective. Prior research suggests that health information delivered through engaging storytelling, involving characters the viewer already 'knows' and cares about is more likely to be attended to and modelled in behaviour (Murphy et al., forthcoming; Singhal et al., 2004; Singhal and Rogers, 1999). For example, an analysis of listeners of the radio drama *Tinka Tinka Sukh* (*Little Steps to a Better Life*) in a village in rural India revealed that audience members who felt as if they had a para-social relationship with the characters were more likely to both discuss the issue of dowry and to take action in opposing it. Even within a single narrative, viewers appear to learn more from models—in this case, fictional television characters—that they identify with, like, feel as if they know, or perceive to be similar to themselves (Bandura, 2002).

The Vijay character was deliberately crafted to evoke such sentiments. However, it was not only Vijay's own behaviour that can be influential, but also the modelling of how others on the show react to him, as a man in Nagpur noted: 'The main character, *Jasoos Vijay*, is shown as HIV positive, but people are shown to treat him nicely in the drama' (Male focus group participant, Nagpur). Viewers also pointed to Gauri, Vijay's wife, as a positive role model for female viewers with respect to ways in which to interact with people who are HIV positive. For example, 'The one who performed the character of Gauri was also very good. Women have understood Gauri's message better' (male focus group participant, Uttar Pradesh). Similarly, 'Gauri's role was good, and its story was also good. I liked that Gauri as a lady could fight for AIDS'

(male focus group participant, Maharashtra) or 'Gauri knew that Jasoos Vijay was HIV positive, and still she married him' (male focus group participant, Uttar Pradesh).

While much has been made of the role of central characters, it is crucial to keep in mind that supporting characters can likewise serve as significant role models. Indeed, Sabido (2004) highlights the use of supporting characters, particularly what he terms 'transitional characters', which begin as negative role models, but within the narrative, transition into positive role models. Sabido suggests such transitional characters can show audience members how to enact behaviour change through identification of first negative and then ultimately positive outcomes. However, within the *Jasoos Vijay* drama only a few main characters recurred throughout the series. Supporting characters only appeared in four-episode story arcs; thus, it is debatable whether viewers would have had sufficient time to clearly identify with such characters or for the story to show a believable transition from negative to positive role models. In turn, this suggests that the Bollywood-style of genre employed by the production may influence audiences in different ways, using different kinds of role models, than those typically employed in socially realist drama for development serials (see Chapter 8).

Nonetheless, for behaviour change to occur, individuals must not only know what to do, but must also believe that they are capable of performing that behaviour. Self-efficacy is the extent to which an individual feels able to perform a particular behaviour, which can be increased not only through personal experience and action, but also by the vicarious experience of observing others (Bandura, 1977a, 1982). An increase in self-efficacy resulting from engaging with the *Jasoos Vijay* drama was expressed in many viewers' comments. For example: 'I like the will power of *Jasoos Vijay* very much. The programme has taught me what we should do and at what time' (male letter writer, West Bengal). Similarly, and with regard to clear HIV-related messaging: 'So much change has come [as a result of watching the drama]. Now, when we go to doctors, we ask them to use a new syringe, when we go to the barbershop, we ask them to use a new blade' (male focus group participant, Patna). Other letter writers commented on the ambitions of spreading information about HIV and AIDS derived from *Jasoos Vijay* amongst their immediate peer groups. Such data reveal that viewers

think not just of themselves when talking of efficacy beliefs, they also think of others, their peers and friends. In turn, this suggests that collective forms of efficacy may also derive from engagement with drama and effect change on a broader societal level.

Collective Efficacy

In its more recent form, social cognition theories seek to go beyond an analysis of the influences of drama serials on individual behaviour to include the broader social context (Bandura, 1998, 2001, 2004a, 2004b). Bandura (2001) suggests that personal, behavioural and environmental determinants all interact in producing thought and behaviour. Bandura also notes:

> The further evolution of the ... [health communication] model treats personal changes as occurring within a network of social influences. It adds socially oriented interventions designed to provide social supports for personal change and to alter the practices of social systems that impair health and to foster those that enhance it.
>
> (1998: 633)

This position is supported by Law and Singhal (1999) who examined letters from listeners of the Indian radio drama *Tinka Tinka Sukh* and found considerable overlap between the concepts of self-efficacy and collective efficacy, as also suggested by Sinha and Kumar (2004) at the outset of this chapter. Likewise, the analysis of letters concerning *Jasoos Vijay* showed the importance of the related concepts of self and collective forms of efficacy and action. For example: 'Our villagers have become aware [of HIV and AIDS] mostly from your serial. My friends now use condoms to prevent themselves from [getting] AIDS. There are several slogans pasted on the walls of our village. We watch your serial to make ourselves aware of AIDS' (male letter writer, Rajasthan). Another letter writer draws a direct link between watching *Jasoos Vijay* and collective efficacy and action:

> It felt very good to watch your serial. It gives very useful information for illiterate rural people of India regarding HIV and AIDS and sexual diseases. Inspired by your serial, we organized an association, an AIDS Eradication Society. We are providing AIDS information to the villagers.
>
> (Male letter writer, Karnataka)

Interpersonal Discussion

Bandura theorised that media (and consequently campaigns that employ the media) can have 'dual paths of influence' (Bandura, 2001: 285). The first path is a direct pathway through which media influences behaviour change, and the second pathway is media that is effectively 'remediated' through people's interpersonal discussions (Bandura, 2001). Watching the drama helps people to talk to others about HIV and AIDS and watching often occurs in a group setting. Many of the focus group participants spontaneously mentioned co-viewing *Jasoos Vijay*. For example: 'All of the family watches the programme together, so we talk frankly about AIDS' (male focus group participant, Madhya Pradesh). While co-viewing is important, taboos on open discussion of sex-related issues still remain: 'We can't discuss. But *Jasoos Vijay* was so interesting that we could watch together at home' (Male focus group participant, Patna).

These quotes, and the many others like them, form a pattern. They suggest that although change is occurring, when it comes to discussions concerning sexuality and unsafe sex, many viewers (unsurprisingly and quite typically) are still constrained by socially held norms and taboos. These constraints remain so strong that many adolescents are not able to ask their parents questions relating to sexual matters (though discussion of sexual issues with peers would be more common). A recent study of Indian students reported (again, somewhat unsurprisingly) that most participants did not have open communication with their parents and other family members on sex-related matters (Selvan et al., 2005). By way of explanation, the study cited religious beliefs and the belief that sex is considered appropriate for discussion only after marriage and only with one's partner, as reasons for the poor communication between parents and adolescent children on sexual matters. In keeping with the work of Miller (1995) and Gillespie (1995), *Jasoos Vijay* appears to have provided a potentially safe impersonal outlet for engaging in discussions concerning

sex and HIV. For example, 'all family members watch television together and tell our young how HIV spreads' (male focus group participant, Delhi) and 'we watch *Jasoos Vijay* together at home and now we openly discuss AIDS at home' (male focus group participant, Jaipur).

Social Norms

This safe environment may provide the potential for social norms about sex and HIV/AIDS to change. According to Bandura, norms work both through internal and external constraints on behaviour. Citing a health-related example, he notes that:

> Norms influence behavior anticipatorily by the social consequences they provide. Behavior that fulfills social norms gains positive social reactions. Behavior that violates social norms brings social censure. In addition, social norms convey behavioral standards. Adoption of standards creates a self-regulatory system that operates through self-sanctions. In this process, people regulate their behavior by self-evaluative reactions.
>
> (Bandura, 1998: 628)

Participants of both focus groups and interviews recognised clear social taboos surrounding matters relating to sex. These cultural norms become particularly relevant in understanding the hesitancy of Indians to talk about HIV and AIDS or condom use. All of the focus groups discussed the societal strictures against talking about sex-related issues. In the Madhya Pradesh focus group, the following conversation ensued: 'At first, "condom" was not thought to be the word of a gentleman; but after watching this programme, it has changed.' A fellow participant responded: 'When we go to purchase condoms at the medical store, the shopkeeper (chemist) does not look down upon you as a bad person' (male focus group participants, Madhya Pradesh). Participants readily identified *Jasoos Vijay* as crucial to their increased willingness to discuss condoms, condom use and HIV. For example: 'now we are more aware we can talk freely about HIV and AIDS. Earlier we were scared' (male focus group participant, Uttar Pradesh). This increased willingness to openly discuss HIV applies to men, as well as to women, with a female interviewee from Patna noting that 'whenever I go to the village, I tell them about it [AIDS]. Some people think that it is not correct to talk openly, but we ignore such thinking'.

Although viewers talk about their learning from *Jasoos Vijay* in a way that is reminiscent of a passive sender–receiver model, their choice to discuss HIV and AIDS and share their learning with others suggests an active and engaged audience. Not only did viewers report feeling able to discuss these previously taboo topics more openly, they also reported using *Jasoos Vijay* and associated storylines as a means to convince others to be more open as well:

> At first, the family members objected to my working for AIDS. They said it is not good. Then I explained to my father and asked him to watch *Jasoos Vijay*. Now he is convinced that it is a community awareness program.'
>
> (Male focus group participant, Maharashtra)

Gender

Unsurprisingly, gender was the most frequently cited barrier to discussion of behaviours relating to HIV/AIDS (for more on depictions of gender in *Jasoos Vijay*, see Chapter 5). In 10 of the 12 male focus groups conducted, participants spontaneously mentioned gender differences in social taboos relating to discussing sex. Male participants insisted that with few exceptions men and women could not discuss condoms or other sexual matters with each other. Rather, talk about sexual matters occurs for men and women within primarily separate and gendered social networks. A male focus group participant from Uttar Pradesh notes that 'married women talk among themselves—those who are educated. If they see a male, they stop talking'. Similarly, 'we cannot talk personally with women. We can go anywhere with an i-card [identity card for volunteers allowing them to talk about health matters] and discuss with women, but not personally' (male focus group participant, Nagpur). This suggests that discussion of sexuality and sexual practice is more accepted if it is conducted with a person performing some formal duty.

Data gathered by the BBC WST on this serial support this assertion. In four of the focus groups conducted, male participants suggested that

nurses or midwives should be trained and encouraged to talk to women about HIV. For example, a male focus group participant revealed that 'I told the ANM [Auxiliary Nurse Midwife] to tell the women about it', while another suggested that 'my mother is an ASHA [Accredited Social Health Activist]. I told her to inform all pregnant women that they should go for an HIV test. If it [the test] is positive, take proper treatment, otherwise it can be dangerous for the child' (male focus group participant, Patna). Similarly, other men said that they had asked their mothers or wives to share information about HIV with other women within their community.

Even with medical professionals, women had mixed feelings about discussing sexual matters. When asked about their comfort in discussing urinary tract infections (UTI) with a doctor, one interviewee from Kotputli replied, 'yes, we can discuss it with a female doctor'. She emphasised that the only medical professionals with whom she would feel comfortable speaking were also women. Another woman similarly limited the amount of interaction she felt comfortable having with a doctor on sexual matters: 'Lots of women feel shy. I even ask my husband to write [her problem] on a slip of paper, and then I go to the doctor [and give it to him/her]' (female interviewee, Kotputli).

While our analysis revealed positive action on the part of many of the participants involved, a general reticence to discuss HIV and AIDS, particularly among/with women is still evident. In this respect, one woman commented that 'everybody stays in their own houses. Nobody talks about AIDS' (female interviewee, Jaipur). Interestingly, the most common discussion partner mentioned by women was their husbands: 'I don't feel shy talking to him [my husband] and we talk about condoms also' (female interviewee, Kotputli). Similarly, 'I have discussed this [HIV prevention] with my husband and he is convinced he should not have sex with other women' (female interviewee, Jaipur). This preference was also borne out in survey work, as female respondents were more likely to think it is alright to talk with their partners (96.0 per cent), than with friends or parents (87.6 per cent and 45 per cent, respectively). Chaudhuri (2007) further notes that women were more likely to face stigma as a result of being diagnosed with HIV than men; thus, their greater reluctance to speak may stem from a heightened fear of social and cultural ostracism.

Age and Generation

Age represented a second potential barrier that participants cited as affecting their willingness to talk about HIV. Social taboos in India limit the extent to which people should talk to children and young people, and many participants were shy or embarrassed to talk to their elders. A female interviewee from Maharashtra notes that 'whenever my brother asks about AIDS and condoms, my mother refuses to tell him [anything] as [she feels] he is too young to know about it'. However, highlighting the potential benefits of peer communication another interviewee from Madhya Pradesh reveals that 'I cannot talk about it [AIDS] with my neighbors and elders, but I can talk with people of my age group. For example, I discussed condom usage with my cousin who is getting married.'

The social strictures against speaking to children and elders about HIV and AIDS did not appear to be as strong as those relating to speaking to someone of the opposite sex. When asked whether he could speak to his elders, one man reported, 'not about condoms, but [we] are able to talk about injections and blood [donation/selling]' (Male focus group participant, Jaipur). This suggests that discussions about HIV and AIDS are not entirely taboo, provided they focus on the medical issues such as those associated with transmission, rather than sexual aspects of the disease.

Changing Attitudes

Discussion of HIV and AIDS was further facilitated by the interactive nature of the larger BBC WST campaign of which the *Jasoos Vijay* drama was the centrepiece. One man from Madhya Pradesh said, 'They [*Jasoos Vijay* anchors] also said that if you have any problem or want any information then write to us'. After having done so, he was able to use the information he received: 'We told them [our neighbours] that we are going to collect information regarding AIDS. They laughed. But when I gave this booklet to my friends and seniors, they read it'. The ability to distribute additional material has assisted people in sharing what they learned from the programme with others, which in turn increases the potential for self-efficacy.

Two of the key objectives for *Jasoos Vijay* focused on decreasing the ostracism of people living with HIV/AIDS (or PLWHA). In half of the focus groups, participants spontaneously mentioned that they had learned how to behave towards people who are HIV positive since watching the programme. When prompted, members of four of the remaining focus groups likewise noted the importance of not discriminating against, but instead caring for those with HIV. For example, 'in that programme [*Jasoos Vijay*], they tell about how we should behave with HIV positive people. We should sympathise with them' (male focus group participant, Maharashtra). Describing how his life had changed, another man said that we should 'give care and love to HIV patients' (male focus group participant, Uttar Pradesh). Survey data adds support to these findings. At baseline, 87 per cent of respondents agreed with the statement that 'PLWHA should be treated like a normal person', and 86 per cent of respondents agreed that 'PLWHA have the same rights as those who are not infected'. At follow-up, agreement with both of these statements had risen to 94 per cent.

As noted by the participants, these changing attitudes may have stemmed in part from an improved understanding of HIV and AIDS. Based on the knowledge gained from *Jasoos Vijay* about the routes of transmission of the disease, viewers reported feeling more comfortable interacting with people who are HIV positive:

> We got to know that if we shake hands, AIDS will not spread. At first, it was like: don't sit near him; don't eat with him. These fads have gone. We got information about [becoming] HIV positive. Now one hundred percent of our hesitation is gone.
>
> (Male focus group participant, Uttar Pradesh)

Reflecting a similar acquisition of knowledge concerning HIV transmission, another male focus group participant from Delhi reveals that:

> Our attitude has changed about people living with HIV/AIDS. It is not transmitted and spread by touching them or sharing their things. [There should be] no discrimination with them. Behave normally with them.
>
> (Male focus group participant, Delhi)

In these two quotations, the men show that their thoughts about how to interact with people who have HIV or AIDS have changed. However, their language reveals an us/them perspective that indicates a separation from people who live with HIV or AIDS. In contrast, a male letter writer from Rajasthan provides an example from his personal experience:

> We were not well aware of AIDS before this serial. My uncle is an AIDS patient and we avoided him. Now, our attitude towards him has changed and we decided not to misbehave with AIDS patients in the future. We hope that this serial will continue on Doordarshan.

Similarly, a female letter writer from Uttar Pradesh reveals that:

> My close friend's father has AIDS and he had given up hope to live. He had shut himself in a room and would not meet or talk to anyone. One day when I went to their house I persuaded him to meet me, had a cup of tea with him and spoke to him at length. I discussed with him about your programme and encouraged him to take a lesson from *Jasoos Vijay* who is HIV positive but is able to lead a normal life. Encouraged by this discussion he now wants to live.

These two participants discuss their experiences with people that they know who have HIV/AIDS. They do not differentiate themselves in the same manner, instead talking of 'we'.

In explaining why her opinion of HIV positive people did not change much after watching the programme, one interviewee identified a key variable that differentiates viewers, namely, level of education. Here, a female interviewee from Patna notes that 'illiterate people think that it [AIDS] is caused by touching. But I'm literate, so I already knew that it's a disease' (female interviewee, Patna). The survey data tended to confirm such observations. Agreement that people who are HIV positive should be treated normally and have equal rights was progressively higher with increasing levels of education, both at baseline and follow-up. Moreover, the change from baseline to follow-up was highest among people who were illiterate, with progressively smaller changes for those with a senior school certificate (SSC) and above. Because respondents with the highest level of education (graduate or higher) were more likely to know how HIV was transmitted and therefore support equal rights for HIV positive individuals at baseline, they did not have quite as large an increase, due to a 'ceiling effect'. None of the focus group respondents or interviewees refer to caste at any point nor was it directly probed by the moderators

(possibly partially due to the deliberate downplaying of caste within the *Jasoos Vijay* programme), but mention of education or literacy level may be an indirect way of referring to caste differences.

Despite the general agreement among focus group participants, interviewees and survey respondents that PLWHA should not be stigmatised, many participants noted that people are not comfortable disclosing their HIV status. When asked whether he knew anyone who was HIV positive, a male focus group participant in Madhya Pradesh stated simply: 'People don't tell.' Similarly, another man pointed out the perceived need to be discrete: 'If anybody in the family gets affected by any disease, then we give him/her quiet [discrete] treatment' (male focus group participant, Madhya Pradesh). Yet other participants gave specific stories of people they knew. 'Our neighbor had contracted this disease and he hid it from everyone' (Male focus group participant, Uttar Pradesh). Even within families, HIV status can be a taboo topic: 'First my uncle got infected [with HIV] and then his wife, and then their small daughter, too. He died because of it [and] they feel bad if it is discussed in the family' (male focus group participant, Nagpur).

Thus, our analysis uncovered a discrepancy between viewers' stated understanding that the norm is that everyone should treat HIV positive individuals well and their unwillingness to inform others if they themselves were infected with the disease. The underlying cause of this discrepancy is unclear. It may be that focus group participants perceive their own attitudes to have changed more than the pervasive cultural norms. It is also possible that this discrepancy may reflect a tendency to provide politically correct or socially desirable responses with respect to individuals infected with HIV. Another possibility is that this discrepancy may reflect the difference between descriptive norms (beliefs about what people within the social context actually do) and injunctive norms (beliefs about what people should do) (Lapinski and Rimal, 2005). Although descriptive and injunctive norms may overlap when there is widespread acceptance of the behaviour in question, they are not theoretically constrained to do so. Additionally, even Vijay chose to limit disclosure of his status within the drama. There, too, the programme may have reflected a broader social norm concerning risk of ostracism, even as the show simultaneously attempted to reduce such stigma. The refusal among our sample of viewers to reveal their own HIV status suggests that

despite the popularity of *Jasoos Vijay*, the cultural norms towards those with HIV and AIDS in India still have not shifted sufficiently.

Conclusion

Several factors were responsible for the success of the BBC WST's *Jasoos Vijay* drama. At the outset, an E-E approach was determined to be more promising than a didactic approach for achieving the specific behaviour change objectives of the wider campaign. The concept of a weekly action series that raised awareness of HIV and AIDS, as well as sensitivity towards people living with HIV and AIDS was then developed by experienced professionals, pre-tested and produced in a manner consistent with the high production values and standards of the broader BBC. *Jasoos Vijay's* colourful characters and stories succeeded in engaging a wide audience, as evidenced by Nielsen ratings and the thousands of letters and e-mails that arrived at the New Delhi offices of the BBC WST every month.

One of the major findings of the end-line quantitative research for BBC WST's HIV/AIDS Awareness Project was the mediating impact of self-efficacy and interpersonal discussions in changing viewer's KAP. Numerous psycho-social theories posit that self-efficacy mediates the relationship between attitudes and behaviours. Thus, more enlightened attitudes relating to HIV and AIDS may serve to make individuals more confident that they can successfully perform safer sex behaviours and this self-confidence, in turn, increases the likelihood that they actually do engage in safer sex practices. Similarly, exposure to the programme led to increased interpersonal communication, which, in turn, related to shifts in HIV-related behaviour, such as getting tested for HIV, using condoms and being faithful to one partner (Chatterjee et al., 2009). Both of these findings reinforce Bandura's assertion that in addition to direct effects, the media can also influence audiences indirectly along a 'socially mediated pathway' (Bandura, 2002: 141).

In addition to self-efficacy, collective efficacy and co-viewing appear to be important in understanding the context of dramas for development. Moreover, this analysis reinforces the notion that social norms play a pivotal role in behaviour change communication—potentially

acting as either barriers or facilitators. These findings lend support to the growing chorus of voices calling for more ecological models of health (e.g., Dutta-Bergman, 2005). By situating dramas for development within the socio-cultural and social group contexts, they may be better able to achieve change at the individual, community and societal levels.

Importantly, the programme promoted a sense of efficacy among viewers with respect to HIV, making them feel that they could take action both at the individual and collective level. The series not only pierced cultural and social taboos by delivering messages related to sex, HIV and condoms on prime time television—but it also encouraged individual and community dialogue about these topics. Both the current analysis and a quantitative comparison of the baseline and end-line BBC WST surveys show conversation with family and friends about HIV to be a crucial factor in changing viewers' attitudes and knowledge of HIV and AIDS.

Clearly, drama producers must work with diverse communities to determine relevant cultural norms, and how those norms may vary across key segments of the target audience (by gender, age, religion, region, HIV status and so on). While prevailing norms should be acknowledged throughout the design process, it does not follow that all norms must go unchallenged. *Jasoos Vijay* highlights that sometimes changing existing norms is the primary goal of a campaign. However, researchers must tread carefully and thoughtfully before determining their campaign objectives and manner of implementation. For instance, many campaigns are designed to deliver specific behavioural objectives in the short term with little regard to potential long-term outcomes. Here, Wilkins and Mody (2001) rightly caution against taking such a myopic view. In producing drama for developing countries, producers are morally obligated to not only understand the nuances of the culture in which the campaign will take place, but also to anticipate the potential impact of the campaign both in the immediate and more distant future.

Note

1. Note that Nielsen's panel does not cover towns with populations of less than 100,000. Consequently, the actual reach may have been significantly higher than the figures reported by TAM data.

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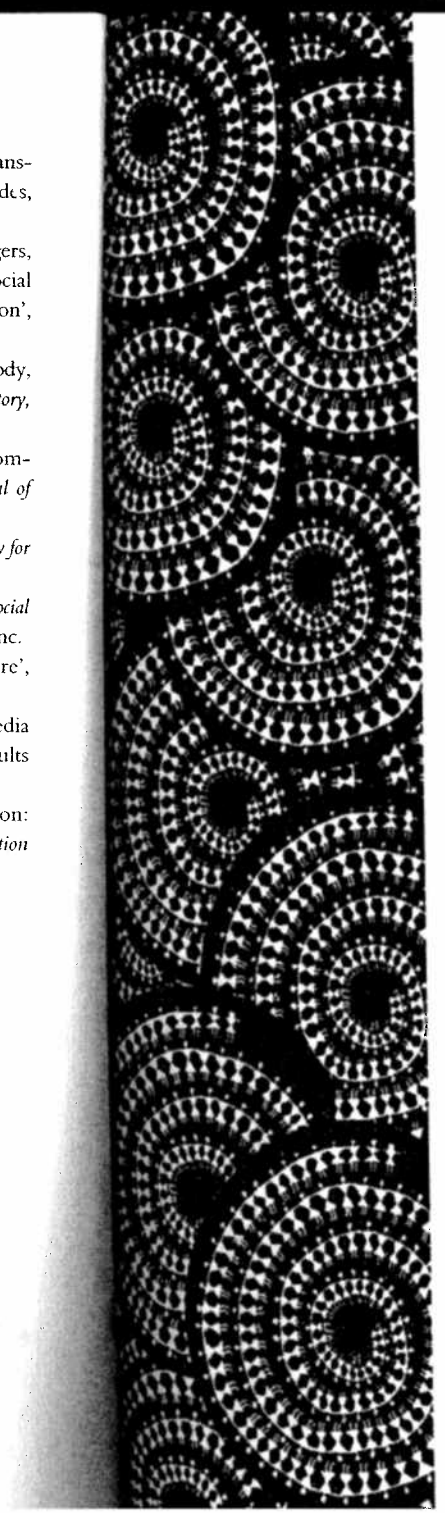

11

'PASSPORT TO LOVE'

DRAMATISING FORCED MARRIAGE BETWEEN PAKISTAN AND THE PAKISTANI DIASPORA

SADAF RIZVI

Introduction

In 2006 the BBC World Service Trust (BBC WST) piloted an Urdu language radio drama entitled *Piyar ka Passport* (*Passport to Love*).[1] It was broadcast in both Pakistan and the United Kingdom in 2006 with a view to raising awareness and stimulating dialogue on human rights and gender issues—most notably on 'forced marriage'—amongst Pakistanis in these two countries intimately connected by history and migration. Forced marriage, in this chapter, refers to a marriage conducted without the valid consent of the people involved, and where pressure or abuse is used in order to achieve it.[2] The idea of addressing the issue of forced marriage emerged from the Public Diplomacy Section of the British High Commission in Islamabad, which at that time was helping British Pakistanis in Pakistan who had become the victims of forced marriage.