

The Limits of Community-Based Theatre

Performance and HIV Prevention in Tanzania

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AIDS has driven African community-based theatre to its limits. Contrary to passé developmental discourses and clichéd academic jargons, there is no assurance about the facility of applied theatre to empower communal groups or change social life, at least not when it comes to dealing with the communicative syndrome in question.¹ Community-based theatre (CBT) is arguably

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1. Applied theatre may, as Helen Nicholson (2005) writes, implicate a gift with ambiguous implications in Mauss's (1990) sense of the concept. On the one hand it offers cultural participation with ample freedom of expression, but on the other hand it is subject to highly uncertain exchange meanings and values in its encounter with target audiences. Theatre against AIDS may then be seen as a gift that most people need but almost nobody wants.

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the most adaptable and probably the most widespread mode of HIV prevention for and with young people in rural Africa, but neither adaptability nor availability necessarily translate as any type or measure of efficacy. The pandemic, which used to be viewed as a medical issue but which is now, more sensibly, considered as a chronic societal and political condition, has exacerbated notorious concerns like poverty and health care on a continent that already lagged behind the rest of the world for decades in these areas.² The pandemic has undermined institutions that people rely on, such as education, marriage, political and judicial bodies, kinship systems, ritual regimes, and faith-based organizations—and it has turned some of them into prime risk factors. In this overarching context AIDS has turned CBT into one of its symptoms, which is apparent in dramatic situations whose crises transgress liminal boundaries of ethical tolerance, existential attitudes, and communal actions. Theatre has the capacity to counter these challenges by offering a cultural-historical retrospective of the epidemic as perceived in performance events, but questions remain about the efficacy of CBT in the quest for HIV prevention. In a research project called “AIDS and the Art of Survival: Community Theatre as HIV Prevention in Tanzania,” I have approached questions through fieldwork about HIV prevention and CBT in two regions in Tanzania.³ In the Kagera region of northwestern Tanzania, where AIDS entered the country in 1983, as well as in neighboring Uganda, it is fair to assume, by correlating data between outreach projects and statistics of prevalence, that traveling theatre troupes and CBT along with other forms of HIV prevention have had an impact on declining mortality rates. The percentage of those dying of AIDS has dropped from a devastating quarter of the population around 1990 to a few odd percent of the population today. Hence, it is only natural to focus a discussion on theatrical efficacy on this region.

Life as Epidemic Mimicry

The AIDS pandemic epitomizes the topical sense of speed and change: it disseminates like a global economy across cultural boundaries and national borders, incognito and yet intimately incorporated in peoples’ metamorphoses from local to global ways of living. The syndrome took on epidemic proportions in central Africa and in the urban centers of the North American coasts at about the same time. Before that, it is reasonable to suppose that it had meandered up the Kongo basin to the highlands of Rwanda before reaching Lake Victoria on the border of Uganda and Tanzania where large numbers of people fell ill in the early 1980s.⁴ A macabre spirit sneaked into people’s lives like a myth from nowhere and haunted them seemingly by quirks of fate; it took possession of their bodies, one by one, invisibly, hollowly, silently, until wearing them down in a slow, unbearable loss of life.

Despite complex epidemiological surveys it is still hard to know where AIDS came from, where it is going, and how to prevent it from getting there. The syndrome is generally acquired in sexual relations and causes a set of symptoms to transpire through quite familiar ways of living and dying.

2. It is by now clear that sub-Saharan Africa will not meet the Millenium goals set for 2015 (see Easterly 2007). The goals include reductions in poverty and child mortality, fighting epidemics such as HIV/AIDS, and establishing universal primary education and gender equality.

3. My research project (2006–2008) is funded by Swedish International Development Cooperation Agency (SIDA) and will conclude in a Palgrave Macmillan monograph in 2010.

4. There are good reasons to assume that the source of the epidemic is to be found in western equatorial Africa due to the vast range of viral subtypes detected in that area (see Iliffe 2006). However, since the virus is constantly changing, the challenge to understand how and where it spreads and to prevent that incidence rate is of much greater importance than to know where it came from.

Figure 1. (previous page) Community performance in the village of Kenyana, Tanzania, 19 March 2004. (Photo by Ola Johansson)

The distinctive features of HIV as a virus were that it was relatively difficult to transmit, it killed almost all those it infected (unless kept alive by antiretroviral drugs), it killed them slowly after a long incubation period, it remained infectious throughout its course, it showed few symptoms until its later stages, and when symptoms appeared they were often those common to the local disease environment. This unique combination of features gave a unique character to the epidemic, “a catastrophe in slow motion” spreading silently for many years before anyone recognised its existence. (Iliffe 2006:58)

AIDS was and still is a “ghost disease” (Hanson 2007:28), which has gradually come to be recognized via corporeal signs that bear various taboo- and stigma-laden code names, sometimes with sexual overtones (Mutembei 2001). An informant in southern Tanzania portrayed an inconvenient truth about the ominous ghost with a Kiswahili aphorism: *umekaa pakunoga*, roughly meaning that it is “situated in a delicious place,” implying the conflation of sexual pleasure with fatal disease. AIDS is a performative double that imitates people’s lifestyles—it does what people do. It travels with people, stays in their houses, goes to rendezvous with them, has sex with them, has kids with them, becomes sick with them, and dies with them. Apparently, AIDS has no traceable origin or fixed identity, it shadows people and mocks scientists in an epidemic mimicry—just like syphilis, the “great imitator” of old—whose transmutations can really only be pursued and interpreted in the nomadic choreography of changing locations, identities, and lifestyles.⁵

Historically, cultural changes in Africa have been induced by geographical and violent political circumstances. The continent is sparsely populated, which means that people have always had to travel long distances for various purposes. Low population density makes services arduous and costly, curbing effective health care.⁶ The geographical predicament was intensified during the long history of the slave trade, which displaced ethnic and demographic groups, and through the colonial division of labor as male work forces were allocated to distant production sites while women were left behind in village households (Barnett and Whiteside 2002: 124–58; see also Iliffe 1995:269–70). The colonial order’s disruption of gender roles—with spouses absent from each other over long periods of time—led to a number of extramarital affairs and thus epidemics of sexually transmitted diseases (STDs), which have become established as crucial causes behind the rapid spread of AIDS in sub-Saharan Africa. In more recent times women are carrying out considerably more work than men in Tanzania and other parts of Eastern Africa, while unemployed men still control the household economy and hold the outreach function of selling and buying merchandise.

On and around Lake Victoria in the beginning of the 1980s the historical traces of AIDS were among fishermen, lorry drivers, and black market racketeers who unknowingly carried the looming epidemic further into Africa via truck stops, bars, and market places populated by penniless local women offering transactional sex.⁷ Early in the epidemic, people in Kagera suspected witchcraft and incriminated the Ugandans (and vice versa). They refused to believe that they got fatally ill from having had sex a decade prior, shunned the sick like the plague (which it was), and were wary of conspiracies among modern doctors with their useless “international” medicines.

5. AIDS is the new “great imitator,” according to Sabin (1987). This follows upon the old characterization of syphilis as a great imitator of other diseases.

6. This relates especially to malaria, which is often caused by rural people arriving too late with their children to dispensaries after lengthy journeys, often by foot. But the long distances and the scarce logistical means will also have an impact on the distribution of antiretroviral medicines for a long time to come.

7. A few years later a similar transnational epidemic emerged in southern Africa where contact between, for example, prostitutes and migrant miners is now threatening about a third of the adult populations in countries like Botswana, Zimbabwe, Swaziland, and South Africa.

Political leaders declared war on AIDS but never identified the enemy.⁸ Religious leaders blamed people for amoral promiscuity but could not avoid contracting the virus themselves. Health researchers eventually held a retrovirus responsible but offered no hope for a cure. At the end of the day the authoritarian speculations, advice, and judgments meant little, and so people on the ground had to look for more precise and pragmatic questions and solutions amongst themselves. To make sense of a world where about a quarter of the population in the Kagera region were sick and set to die, people in towns and in the country began to channel their experiences in narratives by storytelling, poems, choir songs, and modern music.

During March 2004, in the village of Kenyana, just a few miles from the Ugandan border, I saw a community group perform songs that contextualize the epidemic outbreak in detail:

Come gather mothers and fathers / We now know that AIDS is the problem / It was first seen in Kanyigo village and then poured over the border at Mutukula / People didn't know and left behind orphans who became street children / Tanzanians and Ugandans thought they had bewitched each other / in 1981 doctors announced that it is a virus which weakens your immune system / AIDS is caused by sex / Please stop drinking and taking drugs / We urge you to change behaviour to survive [...]. (Kenya, 19 March 2004)

This is an example of how a historical record gets inscribed in a live storytelling tradition in a lyrical mode, invoking the communal reverberations of an incarnated “we” on behalf of those who passed on (see the last phrase of the lyric). Within a few years, in the 1980s, the epidemic became generalized in many parts of Tanzania and East Africa, with prevalence rates exceeding 5 percent in adult populations. The syndrome cut through the social fabric of ethnicities, interests, sectors, and social strata; the major risk groups were no longer sex workers and truck drivers, but traders, farmers, teachers, students, politicians, clerics, housewives—in short, everyone. By 1990 it was obvious that AIDS was much more than a health issue. Yet most governments, including the Tanzanian, delegated the lion's share of their preventive resources to the health sector rather than to initiatives that deal with AIDS as a more integral social and cultural predicament. This deferred an adequate response by about 10 years. Not until New Year's Eve in 1999, when about one in ten Tanzanians were infected, did President Benjamin William Mkapa declare AIDS a national disaster in a speech (TACAIDS 2003:10). Since then, there have been genuine attempts to address the immediate epidemic concerns, even if the discursive openness and political willingness mostly has manifested on a national rhetorical level while the coordinated responses of governmental agencies at district and village levels have been much less open and efficient.⁹

Community-Based Theatre as Epidemiological Counteraction

To prevent the spread of HIV, a mode of prevention that is at once mobile and containing is necessary. Pursuing the movements of AIDS requires an understanding of epidemic determinants in specific areas over a certain time. The critical question is simple: What is it, here and now, that causes the virus to spread from person to person, and from group to group? To respond to the question is infinitely more difficult, but I believe socially inclusive and participatory forms of action such as CBT are vital sources and means of epidemiological counteraction (see also Johansson 2007a and 2007b). In terms of research, it works as follows: When the determinants, or risk factors, have been identified and mapped out by a local group on their home turf, attempts are made to contain the epidemic by virtue of people's shared experiences

8. Michael Douglas said something interesting in the movie *Traffic* (2000), as he depicted an American politician who steps down as head of the so-called war on drugs while agonizing over his son's cocaine addiction: “How can you wage war on your own family?”

9. The lack of local political commitment was recently corroborated in interviews with leaders of the large organization UNAIDS (Meena 2007) as well as the smaller Forum for Grassroots Organisations (FOGOTA) in Tanzania (Kazungu 2007).

of social crises, their traditional ways of redressing cognate critical conditions, as well as their ability to take action against new crises.¹⁰ Both the mobile and containing prevention tactics are integral elements of contemporary African CBT. Counterintuitively, the current need for a mobile strategy has little to do with the classical traveling theatre movements in Africa—the postindependence troupes that performed new plays about rights and commitments for the recently liberated population (see Kerr 1995; Mlama 1991).¹¹ To access and counteract the determinants behind AIDS, the site-specific pertinence needs to be optimized. It is necessary to mobilize the most relevant local individuals and civil society groups who are aware of their own situational limits and possibilities, but who are also ready to acknowledge a crisis without prepackaged empirical solutions or premeditated messages—unlike much previous applied theatre, such as the typically agenda-driven or task-based theatre for development (TFD). In a nationwide HIV prevention scheme called District Response Initiative (DRI), launched by UNAIDS in Tanzania a few years ago (Mazzuki 2002), theatre projects against AIDS were—and, by the way, still are—viewed as crucial to their success, involving theatre based on so-called “community mapping.” Particular risk sites are ascribed narratives of events, constituting a rough draft for eventual performances.¹² The “scripts” in amateur-driven CBT are in fact verbally disposed sketches and always leave a lot of opportunities for improvisation. Improvisation in turn allows for local plot variations as troupes travel their own districts, where nearby wards and villages can typify quite disparate risk scenarios.

In connection with the community mapping and its allocation of narrativized incidents, it's tricky to address daily routines and events when the central issue is sexual affairs, especially, of course, if they are extramarital. It may, for instance, be guesthouses, marketplaces, or schoolyards that are viewed as the crucial sites for casual or transactional sex; there may be unsafe paths for women fetching water at remote wells, or along roads with sporadic traffic after dark or other unreliable heterotopia. The most crucial epidemic hub, however, is the private household. Most spectators know about, or will at least have heard of, sexual relations in all of the mentioned loci and most people surely know about their own homes as a risk site. This is part of the alienation effect of community-based performances: to confront audiences with issues they are well aware of but do not verbalize, let alone act out in the presence of each other.

The community mapping leads to site-specific performances where spectators are familiar with not only the local problems, but also the actors performing them. As opposed to the liminal phases of initiation rites, when social order is turned upside down by defamiliarizing common elements (Turner 1982:27), CBT turns the everyday order inside out by familiarizing taboo aspects of public life. By breaking the silence on issues like sexuality, stigmatization, disease, and death; by exposing unseen affairs and private conflicts; disclosing the secret acts of initiation rites; casting doubt over religious dogma; showing the bedridden in the dark corners of households and bringing into public view the vigils of family members for dying parents or children, the representational distance between actors and spectators collapse into “performative acts.” In J.L. Austin's (1962) functional sense of the phrase (irrespective of his reservation about the efficacy of conventional theatre), this kind of theatre cuts so close to the bone of matters that

10. An alternative vocabulary for the mobile and containing features of CBT would be to use Robert Putnam's (2000) terms of bonding and bridging social capital. The latter concept has already been put to the test in an important social study on the limits of HIV prevention work in South Africa by Catherine Campbell (2003). As will be evident below, the task of bridging communal divisions is a greater and more significant challenge than bonding individual groups.

11. There certainly are a lot of traveling theatre troupes engaged in HIV prevention projects (see Lange 2002), but they are not, in my mind, the most advantageous form of theatre for HIV prevention. AIDS may be a worldwide pandemic, but its determinants are found in specific domestic and local settings, practices, and vernaculars.

12. DRI was the first nationwide initiative against AIDS in Tanzania that directly and explicitly involved theatre. Interestingly, it was the only component in the comprehensive scheme that had a distinct applied function. Unfortunately, though, UNAIDS program associate Henry Meena told me in an interview that theatre had been taken out of the new national HIV prevention initiative (2007).

they *become* the matter. By enacting life-size situations in the public domain with and for social actors who are directly involved, and by incarnating the ailing and dying in real time, the theatre stands in for rites that previously carried the function of fighting afflictions in epidemics. The digits of statistical incidence and mortality rates come alive in events where one's spouse or next door neighbor may turn out to be a typical representation of what otherwise is spoken of as an outlandish scourge. Furthermore, the audience becomes an integral part of the blocking, as it were, of HIV preventive scenarios. To emphasize the participatory dimension, a Boalian Joker commonly steps into the breach of the open-ended plot and asks people what they are going to do.¹³ "Was it a fair depiction?" "Does these things happen among us?" "And, if so, what are we going to do about them?" In other words spectators are reminded of their double roles as theatrical witnesses and social players in the communal events. They also know that they have to act upon such appeals if they want to sleep comfortably that evening.

After the choir in Kenya village finishes their song about the beginnings of the AIDS epidemic, the Joker poses his questions. The villagers remain quiet for a while—and not just because a painful past has been unearthed and pragmatic questions have been posted to provoke action, but also because a scorching sun has forced everyone to seek shade under the slender banana tree leaves (at one point that day I fainted from heat stroke). The local politicians and elders get the shaded seats; the school children are scattered on the ground, while the rest of the villagers sit around the temporary "stage" area. In the background, quite significantly, is a primary school and a little further away the local government office. "We should establish a fund for orphans," a man suggests in the local tongue, Ruhaya. The Joker asks: "How?" No one answers. "Discuss it!" the Joker insists. After some muffled and stumbling exchanges, the Joker puts the matter on its head: "Are we poor? *Can* we start a fund? How many work? How many can help with 500? 300? [Tanzanian shillings, about US\$.20–.40]" A man who presents himself as a mechanic says: "God help me, I'm poor!" But a fellow spectator ripostes: "We should sit down together and find a way. We are not so poor that we cannot help our children to go to school." The Joker pushes that train of thought further: "If you have 800 workers and they contribute with 500 Shilling each, you would get 400,000. That's 10 orphans in school."

So far so good. The post-performance discussion concludes with a promising plan for the local orphans. This kind of fund-raising is something I have witnessed in other villages in the Kagera region (see Johansson 2007b), where several hundred thousand orphans are currently living and dying. It is also something that people should be aware of in the Northern Hemisphere. No matter how much foreign aid a country receives, the overwhelming support for people affected by AIDS and other far-reaching crises is and will always be communal and, ultimately, familial (in Africa pertaining to so-called extended family systems).¹⁴ Local donations

13. Augusto Boal's Theatre of the Oppressed and, in particular, Forum Theatre model influenced African theatre workers as early as the mid-1970s, in, for instance, the Samaru projects at Ahmadu Bello University in Nigeria (Abah and Etherton 1982). About the same time the Laedza Batanani projects at the University of Lesotho, Swaziland and Botswana (later University of Botswana) formed their participatory models of applied theatre with the help of Paolo Freire.

14. It is important not to tap into fatalist fear mongering about "AIDS Africa." I do not agree with Esiaba Irobi when he asserts that the "overall tragic prognosis is that these children are destined to die unless world governments, drug companies, politicians in both the rich Western countries and the impoverished African countries can work out a pragmatic programme for treating the infected, particularly the AIDS orphans, for whom the beginning of life has now become the commencement of an agonizing death sentence" (2006:32). It is true that many AIDS orphans are left without care, but at least as many are taken care of by grandparents, who have taken an unprecedented responsibility in this moment in history. In all fairness, it should also be said that international donors have put quite heavy emphasis on orphan care, much more so than HIV prevention. Painting broad strokes of catastrophe only serves to enhance Western caricatures of Africa. Among the many elderly guarantors I have met in Africa, a woman called Beatrice in Nairobi, Kenya, stands out. She lives in the Mathare slum of Nairobi and takes care of about 40 grandchildren after all of her own 8 children perished from AIDS-related diseases. She is a leading participant in a micro-finance organization called Jamii Bora.

for orphans are tremendously important but not a test of what state-of-the-art CBT against AIDS can achieve. After the one-way communication of the choir, the more interactive drama ensues—and things get much more complicated.

How Neema's Double Bind Tripled

A man comes back to his house after a long absence only to find his family in shambles. The mother has lost control over their two teenage sons, dressed in ragged clothes, who are either fighting each other or smoking opium, probably out of boredom; the boys are stuck between disrupted schooling and permanent unemployment. The older brother barely takes notice of his returning father, not even when he is handed a gift. It is obvious that the father is trying to re-establish his authority as head of the family by material means. This effort is seen as futile by the older brother who soon picks a fight with him.

The father is portrayed as a less-than-desirable role model. As soon as he is left alone in the house, he calls out for the housemaid, Neema. In a softened voice he addresses her as his daughter. She takes the intimate moment as an opportunity to ask for a pay raise. He says she will indeed get something extra and drags her into a room—a fabric-covered booth in the middle of the play area—where he has sex with her. As so often during such scenes, the audience emits a scattered and embarrassed giggle. The sex scene is repeated when the older brother forces Neema to have sex with him in the same place and then threatens her to keep quiet about it. The audience giggles again. Like a farce, the scene is then repeated when the younger brother coerces Neema to have sex. This time the audience laughs nervously as the farce turns into tragedy.

The rest of the intrigue is predictable although mordantly sad. A nurse visits the house—incidentally from Ndorage hospital where the first AIDS case in Tanzania was diagnosed in 1983—and announces that Neema has just died from an AIDS-related disease. The male family members panic and snap back to reality. In this distressed state the mother also figures out what's going on and the family implodes into a jumble of broken relationships beyond remedy in its own home. A priest makes a visit and reads from Corinthians: “now remains faith, hope, love, these three; but the greatest of these is love.” The clergyman grimly asks what happened to love in the house. It is a good question, but begs numerous other more or less related questions. One of the more provocative counter-questions is whether a woman like Neema could actually *afford* real love in her lifetime.¹⁵

So what can an audience say after an in-your-face tragicomedy on AIDS? Well, everyone seemed to be taken aback by the straightforward depiction of sexual abuse. Before a word is uttered the children are escorted back to school. After a lingering silence—which is, of course, as telling as any discourse—a man suggests that the family in the performance perished due to sexual greed. The spectator went on to say that this theme was merely mentioned in the songs while the theatre made it a key theme. No one responded to his comment, perhaps because it tapped into a religious discourse of cupidity and guilt that is too abstract to address on the spot. The next comment by a younger woman was also religiously informed: “Being honest in your marriage is a crucial issue,” she said, and added a warning against the use of drugs and alcohol. The truth is that the audience did not have too many things to say about the performance—the post-performance discussion soon stagnated and petered out.

15. The religious intervention is indicative of the Christian interest organization behind the theatre group, the conservative World Vision. If the priest is inquiring about love according to the creed of World Vision, it is certainly a matter of faithful bonds within monogamous relationships. If the person is not yet married, she or he should abstain from sex until marriage. However, in reality it is much more likely that the love in question is challenged by materialistic and financial constraints and incentives (for an interesting study on the commodification of relationships in Tanzania, see Setel 1999).



*Figure 2. Community performance in the village of Kenyana, Tanzania, 19 March 2004.
(Photo by Ola Johansson)*

There are two major causes for the communicative breakdown in Kenyana, apart from the obvious fact that it is always awkward to discuss sexual matters in public. First of all, seeing a performance on the deadly impact by and on infected families as a result of AIDS in 2004 was to arrive at an eschatological abyss between a defeatist rock and a deadly hard place. Taking an HIV test with a bad outcome prior to the distribution of antiretroviral medicines could, at best, be an altruistic act that gestured an individual behavior change to save others' lives (see Reynolds Whyte 1997:203–32). This was, of course, several years after antiretroviral medicines (ARVs) were made available for infected people in the Northern Hemisphere. Today ARVs are available in selected hospitals in the Kagera region, such as Ndorage, but still not more than a fraction of the sick actually get access to sustainable therapy. According to epidemiologists Gideon Kwesigabo (2001) and Stefan Hanson (2007) predicted scenarios show that only about 25 to 30 percent of the sick will get access to ARV therapies in the coming years.

The other cause behind the communicative breakdown in Kenyana is more complex and has to do with a problematic mix of social and ethnic traditions, patriarchal supremacy, generational discrepancies, and other gender-related predicaments. Yes, I do generalize the complex of problems by pulling together a range of historical and culture-specific issues in terms of “gender inequities.” In this case it is not a matter of boiling down a deductive theory to explain reality, but an inductive procedure whereby a series of different and sometimes contradictory cases can be interpreted as cognate exemplifications of a particular phenomenon, namely how HIV is contracted through nonconsensual sex, especially where women are concerned. Women are not, however, the only subjugated cohort under the current epidemic conditions; young people in general share similar risk scenarios. Young men and women—more than half of the population in sub-Saharan Africa are under 20 years of age—make up the most susceptible strata in the sub-Saharan AIDS pandemic and, not coincidentally, the ones who use CBT more than any other cohort (Johansson 2006). The reason for this is that CBT is probably the most accessible and inexpensive response to one of the most serious democratic challenges since the days of independence in Africa (see de Waal 2006). Young people are open for new identity formations

and thus often clash with older and more obstinate spectators when they meet in performance situations (Klink 2002).

On 11 March 2004, during the same week as the Kenyana performance and located in the same district, in Ijumbe village, I saw a play that depicted the cruel exploitation of a housemaid trapped in the same tight spot as Neema. She was trapped in one of the rare paying jobs available for young rural women in Tanzania, and paying the price: sexual abuse at the hands of her employer.¹⁶ Many poverty-stricken women find themselves forced to become sex slaves, especially if they have children to support. In the Ijumbe play there was another layer of tragedy: the victim of abuse was an orphan. The girl is hired as a maid by a businessman, who takes sexual advantage of her. In this deeply moving story it is the girl's alcoholic aunt who puts her up for sale and who ultimately becomes dependent on the girl when she falls ill in AIDS-related diseases. Epidemiologically, abuse of alcohol is as common a risk factor as sexual abuse and just as obviously linked to problems with social development.¹⁷

After the performance the Ijumbe group put on a dance and sang a hymn for vendors and visitors at a local marketplace. As always, everyone enjoyed the upbeat dance (*ngoma*) and some spectators joined in. But the dirge that followed about AIDS caused nearly every man to turn back to their market activities. This is probably the most evident gender divisive social gesture I have witnessed in connection with performances on AIDS. Unless young males are engaged and enlisted early by means of theatre, they too will escape into an orthodox masculine response of denial.

A similar story was enacted in Bugandika on 10 August 2006. A woman takes her orphaned niece in to live with her and her drunkard husband. The village is located in a severely affected part of the northern Kagera region—just a few miles from Kanyigo village, which was mentioned as the epidemic fountainhead in the chorus above. To the horror of the young woman her auntie soon dies. At the funeral the drunkard begs the community residents for help, but people deny him support since he always refused to cooperate with the village in their fund-raising for other people in his present situation. Things go from bad to worse as the niece finds herself cornered in the disappointed and drunk man's house where he rapes her. The suggested solution is, again, fund-raising for an orphan center.

The three mentioned performances share cognate plots depicting destitute young women who pay the price of having been offered jobs that came with tacit agreements of transactional sex, and, if the agreement is violated, sexual abuse. The idea of using CBT is to expose—in broad daylight and among people who know each other relatively well—such tacit and illicit sides of the sociocultural context responsible for the spread of AIDS. This makes theatre both timely and unique since there is no other cultural discourse or practice that brings people face-to-face with unresolved questions about life and death and on equal terms—and at a time when the need to do so is greater than ever. The way to get this close to issues of sexuality and disease is to get past language by using bodily actions that irrefutably resemble everyday life routines. It is not a simple task of imitation, though; CBT is a way to undo the mimetic ghost of AIDS by divulging its invisible, hollow, and silent ambush against individuals. In performance, the mimetic resemblance is meant to be transposed from internal relations between individuals to the communal relations between performers and spectators. It is through this relationship in open-ended events with participatory post-performance discussions and follow-up action plans that the tacit and sometimes illicit plots are disrupted.

Public discussions on AIDS are tricky to unravel due to the fact that most people by now are well aware of what puts them at risk, but at the same time convinced that AIDS will persist—in

16. For a sociological study of women working as housemaids in Tanzania, see Heggenhougen and Lugalla (2005).

17. Alcohol was the fourth most common topic of focus group discussions in Kagera region in my research project, only exceeded by education, poverty, and development as proposed key risk factors of the epidemic.

other words, that the risky behavior will continue. The discussion in Kenya only confirmed this. How, then, is it possible to critique this practice-based predicament discursively? Most post-performance discussions in Kagera assume the tone of polite commentaries among conversant people or brief sermons by those who are already converted to the agenda of social change. Some plays have dramaturgies with semi-open endings that propose a donation for orphans even before people have had a chance to reflect on the causes behind orphanhood. In Bugandika the performance ends with a suggestion to help the abused orphan: "Let's contribute 500 each and take her to the orphan centre, because they are the ones who can manage the situation. We can't do it." The first sentence could have been taken from an Oxfam or CARE billboard, while the second brief statement borders on defeatism, in a community that appears to have disintegrated into a collection of individuals.

It is as though people, including many performers, have knowledge based on judgments of first-hand experiences but that they doubt that their opinions will lead anywhere beyond the events, let alone to change. It is as if only present people and events are trusted. So the dialogue that is meant to be transferable from the dramatic plot to a communal dialogue appears to be an extension of the plot that, in turn, merely confirms the problems. There is only so much a Joker can do under these circumstances: if people don't believe in the possibility of change their discussion will inevitably revolve around the importance of speaking out about AIDS (see the postperformance comments in Kenya above) rather than about doing something to change its action-driven determinants.

The distrust in one's own influence over the public sphere does not only lead to self-doubt but also a reciprocal mistrust of official information. A number of studies have established that the number of HIV infections have decreased quite dramatically in the Kagera region since the 1990s (Kwesigabo 2001). But many doubt the validity of the reports. In my research project this skepticism comes through in the focus group discussions, which are clearly divided by gender. A male informant in Ijumbe put it this way: "If you see men running around with five women, the numbers [of HIV incidences] are not declining. The problem is still there" (Ijumbe Focus Group, 11 March 2004). In Rubungu the women I talked with believe there has been a decline in AIDS prevalence through education campaigns by theatre and other means, but the problems of unfaithfulness and lack of condom use persist. The men in Rubungu point to poverty as the cause of transactional sex and other predicaments: "Families lack resources. Children run away and become street kids. Girls become prostitutes and boys become thieves. Families give away their kids for housework and other employment. That often leads to sex, not least among housemaids who are not organized" (Rubungo Focus Group, 9 March 2004). If this sounds like they were removing themselves from the scenario, the men in Kamachumu were less successful in disguising their involvement as they discussed transactional sex as a marital mode of corruption from firsthand experiences: "*Changudoa* [a nickname for prostitutes] show up at construction sites, but also village women. Chinese men [who were leading the road works in the district] are involved in sexual affairs—all men!" The man's accusations bring the group to laughter. But it is a nervous amusement since these are the very same men who are sharing households with the village women. Another man then strikes a personal nerve in the group: "Men see their women go away with *chapati* [a bread sold to the road workers], but come back with thousands of shillings. They have sex with contractors" (Kamachumu Focus Group, 13 March 2004).

Ultimately this is what it is about: self-reflection, realization, and the ability to act on these realizations under certain social and political conditions. A woman in Bugandika posited that reflection and knowing the risks doesn't mean behavior will change: "Poverty can make someone sell her daughter to a rich person. You are parents and you see a rich man and you can then push your daughter to that man. If the man is infected, the daughter will also die." Another woman added: "It is not only about rich men, but if a man can offer only so much as 500 shillings and the woman doesn't have food or soap at home, she can give herself to the man." And once the self-confidence erodes, careless behavior ensues regardless of what one knows. "Men take the

opportunity to buy women *pombe* [locally brewed beer]. They get drunk and have sex. The next day the woman gets back to the bar and wants to have the same man again. And if you didn't use a condom last night, why should I demand him to use it tonight?" Casual sex is especially common on occasions like *usiko ngoma* (night dances) and weddings. "At night after weddings, the alcohol flows; when you see that, you realize that the epidemic will never stop," a woman says. Another woman agrees: "The young people say that at the weddings at night AIDS goes on holiday" (Bugandika Focus Group, 10 August 2006).

The discrepancy between knowledge and practice seems to beg a synergy of approaches by way of the revolutionary dialogues and performances of Augusto Boal and Paolo Freire. In a similar pragmatic vein Nelson Mandela has said that AIDS calls for a "social revolution" (in Hanson 2007), a notion that hinges on not only poverty reduction but also radically reformed gender roles in politics. This is a politics in an extended sense. The democratic relevance of CBT against AIDS has to do with substituting health issues for ideologically fettered political agendas and religious dogmas. Ethical and political issues are no doubt intricately linked with health, but in my opinion issues of life and death outweigh dichotomies like right or wrong, or the political left and right. Brecht knew that when he formulated the motto "food first, then morality" in *The Threepenny Opera*.

CBT is—or should be—a processual mode of action research rather than a norm-driven deployment of ideological or other special interests. The exploration of epidemic conditions does not lend itself as much to written research or lab practice as to people with local knowledge and life skills. If action research is allowed to function on a ground level it can flesh out vital features and distinctions in risk analyses that otherwise get diluted when issues are elevated to a conceptual, institutional, or other type of generalized level of reasoning. One of the most common generalizations in discourses on AIDS in sub-Saharan Africa is the view that poverty is the root cause of the spread of HIV. Needless to say, there is some truth to this argument but it is nevertheless vague, and it is not practically adaptable in preventive interventions. Action research such as CBT does not set out from claims or bring closure to inquiries by quantifying issues, it keeps processes and outcomes open as long as social actors have issues to resolve. This makes applied African theatre of this type longitudinal and vast since it is syncretistically designed for "whole communities" in the form of a "drama-which-is-never-finished" (Kerr 1995:151, 161). Exactly the same could be said about the continuing and comprehensive scenario of AIDS. It is no wonder, then, that project stakeholders and theatre workers shy away from the idea of assessments of CBT as HIV prevention.

The Quest for an Efficacious Community-Based Theatre

As my research project draws to a close, its findings indicate a lost war after victory in every battle. The studied projects in Tanzania mobilize the most susceptible epidemic cohorts and offer them participatory and gender-balanced means to catalyze experiences, discourses, and life skills through local modes of traditional performance as well as contemporary international drama methods. The performances consistently attract considerable crowds, who are exposed to and often prone to share taboo-laden topics and, at best, follow-up ventures. In focus group discussions with members of theatre groups and audiences, backstage perspectives on risk scenarios consistently verify the validity of action research through performances by theatre groups. Rural young women repeatedly testify that theatre is their *only* access to public opinion and participation in the development of a sustainable and secure civil society. In interviews with villagers as well as program directors, almost all who have come in touch with theatre perceive it as a serious and significant form of HIV prevention. Government representatives and non-governmental organizations usually praise its emotional and communicative impact. As opposed to economically or biomedically driven campaigns, however, theatre is viewed as a soft preventive means whose appealing and sensitive features draw judgments based on archaic ideas of female qualities. However, few organizations or agencies have anything qualitative to say about

the efficacy or real impact of theatre in the greater scheme of the AIDS epidemic. Epidemiologists and politicians still quantify projects and programs in terms of numbers of people reached vis-à-vis estimated incidence and prevalence rates for areas of implementation, but seldom make qualitative evaluations of the need for interventions with culturally specific tactics for subjugated and therefore more susceptible groups. The most serious implication of this is that even if an intervention driven by theatre would be successful as an epidemic diagnosis and counteraction, it would probably not be noticed by project stakeholders, let alone policymakers who collect reports on AIDS campaigns.

The flip side to this dilemma is to simply presuppose the facility of applied theatre to change the order of things in which it intervenes, without recognizing the complexity of AIDS. The determination of change of course has its heritage in the revolutionary discourses and practical models of Freire (1970) and Boal (1979). Needless to say, any applied theatre project aspires to initiate change. The question is whether change should be a built-in component or even a strategy of projects. Ogah Abah (2002) and many others predicate theatre for development on change by designing and assessing projects in terms of an alternative or new order. James Thompson (2004), on the other hand, disengages this kind of requirement in what he calls theatre action research (TAR) by instead stressing how applied theatre can examine viable conditions for eventual community projects. Helen Nicholson (2005) also leaves outcomes wide-open, but by correlating applied drama projects with an abstract concept, namely the gift and its ambiguous claim and, every so often, paradoxical result in debt. With a slight amount of generosity, I could of course claim that the post-performance discussions leading to donations to orphans and widows in Kagera is proof of both an attitudinal and material change. Discrete and temporary changes, however, have little to do with the driving forces of AIDS. Real changes take effect by transforming ingrained actions among people, not by what is given to them, whether it is money, promises, or knowledge.

Another dominant but equally narrow view on efficacious theatre against the spread of AIDS is justified in the concepts of information and education. Whilst an informative theatre mostly pertains to the transmission of medical or moral messages, educational theatre draws on the notion of drama as a pedagogical mode of telling and showing taboo issues. Early on in the epidemic it was of course urgent to “break the silence.” In her studies on the so-called Ugandan “Campaign Theatre” of the 1980s, Marion Frank testifies that there were always two types of characters involved, those who knew about AIDS and those who did not (1995:147). Almost like an extension of “the old Mr Wise and Mr Foolish formula inherited from the colonial didactic theatre” (Kerr 1995:160) or the Medieval morality plays of northern Europe, the Campaign Theatre against AIDS exemplified stock characteristics of “human genus persona” (Frank 1995:137), targeting often illiterate spectators who were themselves commonly depicted as promiscuous characters in need of pre-colonial moral values (90). The amateur actors were well aware of popular performance styles and local vernacular, but the topics were geared by international organizations with an

organisational framework to both acquire factual information through research as well as to pass the information on to the next element in the chain. In the workshops, however, the communication is made to appear symmetric. The artists are encouraged to ask questions and discuss the information conveyed to them by the workshop organisers. An asymmetric situation is thereby transferred into a symmetric one by giving the impression of arriving at conclusions in a joint effort. (100–01)

As a fastidious semiotician, Frank is actually in favor of the explicatory process whereby performances correct bad behavior by reducing it to clear-cut personal traits (117). Even if the Ugandan Campaign Theatre was part of a national scheme that reduced incidence and prevalence rates, it now seems clear that such an instructive theatre misses various concerns of the epidemic. A cognate form of decontextualized performance can be found in the controlled



*Figure 3. Community performance in the village of Kenyana, Tanzania, 19 March 2004.
(Photo by Ola Johansson)*

workshops of “process drama,” which functions as “an affective engagement with the human dimensions of situations—an essential stage in any effort to encourage safe behaviour in a time of HIV/AIDS” (Simpson and Heap 2002:94). This is suggested somehow in opposition to the public performance-based theatre for development. However, given the volatile sociality and poverty that underpin AIDS, drama in education and therapeutic workshops may work as discrete components in intervention schemes, but they are insufficient as outreach activity. As much as drama in education and therapeutic workshop models are worth for people under epidemic stress, there is still a need for performances with a wider communal appeal. Didactic theatre and workshop training primarily address behavior change, but AIDS is about wider challenges of gendered and other ingrained cultural-political lifestyle metamorphoses.

Today nearly every adult person in East Africa knows about AIDS and its ways of transmission. A crucial challenge thus lies in how to deal with the fact that people are as susceptible to HIV as ever despite sufficient knowledge. It was therefore slightly disconcerting to pick up a supplement of the prestigious medical journal *The Lancet* on health and art and read a couple of articles on theatre against AIDS that seemed no more up-to-date than Frank’s 1995 book. Mbizvo writes that theatre is “an effective and entertaining strategy for dissemination of health information and reinforcement of positive health messages” (2006:30; see also Klink 2002:166). By “effective” she means that theatre breaks down communicative barriers for the sake of behavior change, conveying knowledge about expected aid, and arousing audiences’ “emotions to stimulate acceptance of the messages” (31). To this I feel urged to respond that rather than functioning as a mouthpiece for medical and political authorities, it is more relevant for theatre to show these people how and why their conventional strategies for communication, behavior change, and biomedical aid have proven unsuccessful for the majority of people in Tanzania and most other sub-Saharan countries. And the only way to do this is to do what theatre does best, namely function as a revelatory and relational agency of young people’s interests in cooperation with official agencies and nongovernmental organizations that can meet and support such interests for purposes of a worthy and safe life.

That young people enjoy the privilege of being backed by NGOs, however, does not always sit well with the people who used to control public opinion. Ironically, the fair, unique, and independent features of CBT can also be a curse for its participants since such a mandate has been licensed to young people from nongovernmental organizations rather than earned through official merits (or favors). The groups can easily draw a crowd, bring spectators to laughter and tears, and engender discussions, but without an authorized mandate that would provide the performances with a platform wider than the events *per se*, CBT will remain culturally alienated and not be able to effect a social change.

Hence timeliness and uniqueness in design does not guarantee efficacy in performance. In the case of the performances in Kenyana, Ijumbe, and Bugandika, the actors and spectators are up against an historical horizon with scenarios not only of colonial destruction of societal structures, but also a domestic history of gender inequity where the precolonial Haya kingdoms used tribute systems of slave girls (later encouraged by German colonialists) and where women in postcolonial times have found themselves driven into systematic prostitution in order to cope with a lack of inheritance rights, land rights, and other civil and human rights.¹⁸ Despite recent legal reforms, the hierarchical, polygamous, and patrilineal legacy of traditional Haya societies is still quite obvious in Kagera.

There are reasons to doubt a theatre against AIDS in the name of transformation, education, or donation. What, then, is it good for? If CBT engages the most susceptible epidemic target groups in participatory counteractions against risk scenarios in cooperation with communities, why is it so hard to speak of its efficacy? The only way to approach efficacy in CBT is, I believe, to identify its limits and then troubleshoot its weak points under specific epidemic circumstances. In light of the findings of my research project, it seems obvious that the critical means and ends of CBT, which are so appealing and convenient to celebrate, neither have a recognized place in organizations that use theatre, nor a destination in societies where it performs. CBT does not have ownership over its activities, often due to meager financial means, but even more so because of a deficient social legitimacy.¹⁹ It is directly involved in precise epidemic problem solving and yet cut off, as it were, from epidemic-wide solutions. In Marxist terms one may say that the groups are alienated from the purpose of their social work by being used as exchange items in the production of aid rather than as useful agents in consequential prevention schemes. If this is right, then the most disturbing effect is, again, that a potential achievement of theatre as HIV prevention would not even be noticeable. If it is difficult to appreciate the effects of applied theatre, then at least its use as a means for young people to acquire life skills for a safer social existence should be evident. However, if the quest for efficacy is an epidemiological challenge, then the quest for a pragmatic use of it becomes a political challenge.

As L. Dale Byam (1999) makes clear, the use of Boal's methods in theatre projects stand in need of an awareness of political frameworks such as those discussed by Freire in order to take effect in societal and developmental circumstances. The roles of the Brazilian pedagogues have been thrashed out in debates on African applied theatre since the 1970s, although mainly without much criticality. The reason why the discourse on theatre for development often stagnates is that it tends to hinge on certain celebratory concepts, such as radical change through theatre, economical and political self-reliance of civil groups, and rapid appraisals of project efficacy. The discrepancy between the concepts and real political conditions is an interpretive gap that is often

18. In her excellent book *Women in Development: A Creative Role Denied?* (1984), Marja-Liisa Swantz writes a well-researched chapter on the cultural-historical situation for Haya women and draws the conclusion that "prostitution has been the Haya women's response to the conditions which have too often treated the woman as an inferior being, a commodity of exchange, a tenant and a servant who could be dismissed at the will of the husband, and used for producing children who were then stolen from her" (1984:76–77).

19. In a significant report for UNESCO, Hatar (2001) cracks the myth on performing arts as naturally integrated in Tanzanian society by showing what little support they have received in the educational system since independence.

accrued by extending the methodological scope of Augusto Boal into the pragmatic visions of Paolo Freire. When individual or site-specific modes of understanding reach the level of socially applicable self-reflection, as Freire points out, people enter into the realm of praxis where quite advanced attempts can be made to revolutionize policy making. In particular Freire cautions, with the help of postcolonial philosophers like Frantz Fanon, against unconscious identification with one's so-called oppressors and the need to always uphold a critical dialogue about the means and conditions of liberating strategies—invaluable advice for any CBT group.²⁰ However, in this article I have mentioned project participants whose “potential consciousness” has “[emerged] from reality” and who have already perceived “the causes of their needs” (Freire 1970:117). Through codified acts of problem-posing practices that are discussed in public (122), they have indeed rehearsed their cultural revolution (Boal 1979:141) through critical reflections and actions, attained ownership of their labor (Freire 1970:183), and thus reached an entry point for an applied social performance of durable change. However, the fundamental need for CBT against AIDS has little to do with didacticism, utopian objectives, or radical policy; it has rather to do with an *acknowledgement* of already achieved cultural practices and their participants. Those involved have attained *conscientização* and are constantly, although casually, celebrated for it in quasi-educational terms. Given the lack of proper assessment one may say that the theatre groups have created performances of effective communication although without epidemiological efficacy.

Despite its clear pedagogical, organizational, logistical, critical, and intellectual merits, CBT is not allowed onto the arena of organized aid, public sectors, or real politics. Rather than just pointing to poverty and gender in sweeping arguments, the crux of the efficacy of theatre is its lack of *legitimacy*. This has not only to do with patriarchal communities resisting young people's creation of a new public opinion, but also with an unprecedented political challenge. It is a matter of democratic urgency to acknowledge that young people make up more than half of the population in Tanzania as well as most other African countries. This majority has more site-specific knowledge about the spread of HIV than any outside expert; they constitute the most susceptible groups in the pandemic; and they are the ones who make the most of HIV prevention practices like CBT. What they need is *not* a revolutionary breakthrough of utopian ideology or liberating knowledge, what they need is a *performative democracy* whose functions go beyond flags and polling stations all the way down to the ground level of villages where most people in Tanzania pursue a reliable, healthy, and productive everyday life. CBT is an extraordinary measure of failure when it comes to HIV prevention since it is the most inclusive practice for the greatest number of susceptible people in the pandemic. If CBT fails, or is allowed to fail by disregarding its impact, it is reasonable to assume that every other form of HIV prevention also will fail.

What the national district response initiative (DRI) in Tanzania would have needed when it rolled out in 2002 was not only a poetic license for young people to map out and depict critical behavior patterns, but also a political license to apply its results in local programs. It is difficult to understand why NGOs are willing to give community groups all sorts of education except one in applied politics. In the interest of a more comprehensive democracy young people ought to be provided something like youth councils in local political offices. Meanwhile it is unfathomable, not to say hypocritical, that authorities and NGOs in the districts where I have carried out fieldwork are not deploying voluntary community groups with responsibilities to, for instance, coordinate services like condom distribution out of hospitals, mobilize people for HIV tests and counseling under the aegis of ARV programs, work in closer cooperation with schools,²¹ faith-

20. Kerr makes the observation of the constant risk of self-blame in theatre for development, where poverty stricken theatre workers tend to fall into the paradoxical stance of “scapegoating the poor” (1995:160).

21. There is a prolific and long-term project called Tuseme (“Let Us Speak Out” in Swahili) that is implemented for girls in secondary schools based on the principles of theatre for development. It has yet to be properly evaluated, but it exemplifies both qualitative and quantitative attributes in the application of social theatre. CBT is closely related to theatre activities like Tuseme, but it also takes on the precarious challenge of mobilizing out-of-school youth.

based organizations, and workplaces, and, not least, be allowed to take on a greater role in the research, action, reporting, and evaluation of projects in cooperation with NGOs and AIDS coordinators. It is exciting to imagine what would happen if such a performative coordination and management, where words mean action and vice versa, was in effect in a political office aligned with community performances. The group in Kenya who highlighted the situation of many housemaids, and the group in Bugandika who demonstrated the vicious circle for orphans, would have led not only to discussions and donations but also to enquiries and eventual reforms in communal, judicial, political, and educational systems. But this is, of course, exactly what authorities and NGOs do not want to happen since it would infringe on their agendas and budgets and threaten to take away their work.

After having rehearsed their social revolution, to paraphrase Boal and Mandela in one breath, the community groups I have studied are now waiting at the point of entry to an official stage of real political performance. While waiting some groups have been putting on meta-theatrical shows (see Johansson 2007b) about the inertia of the governments and NGOs. In the meantime, I have made up my mind about what I have seen: community-based theatre has played out its role as opener and mediator in HIV prevention and now needs a political mandate.

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