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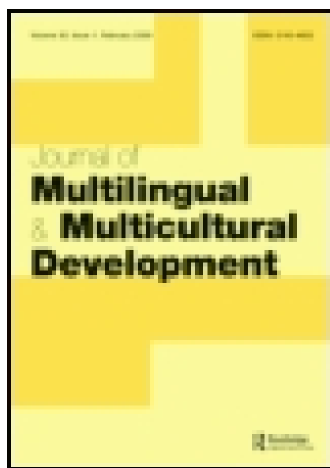

Journal of Multilingual and Multicultural Development
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/rmmm20

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Christina Higgins[a]
[a] Department of Second Language Studies, University of Hawaiʻi at Mānoa, Honolulu, HI, USA
Published online: 22 Apr 2014.

To cite this article: Christina Higgins (2014): Constructing identities through literacy events in HIV/AIDS education, Journal of Multilingual and Multicultural Development, DOI: 10.1080/01434632.2014.908892

To link to this article: http://dx.doi.org/10.1080/01434632.2014.908892

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Journal of Multilingual and Multicultural Development, 2014
http://dx.doi.org/10.1080/01434632.2014.908892

Routledge
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Constructing identities through literacy events in HIV/AIDS education

Christina Higgins*

Department of Second Language Studies, University of Hawai'i at Mānoa, Honolulu, HI, USA

This article examines the literacy events in HIV/AIDS education in Tanzania to investigate how they construct social identities for participants and to what extent they provide opportunities for critical health literacies. The projects took place as collaborative research partnerships with local Tanzanian NGOs in an effort to analyse and improve existing educational practices. Within the framework of multiliteracies, critical health literacies have the potential to engage individuals in the deconstruction of texts and the transformation of their social identities and social relations. Through taking an ethnographic approach to literacy events, I document and analyse the ways that educators convey information about HIV/AIDS and explore how target audiences participate in two kinds of literacy events: (1) instruction using written modes of language from official booklets and on blackboards and flipcharts and (2) breakout sessions in groups that the participants were often assigned, which involved writing out answers to key questions posed by the educators. My analysis shows a predominance of functional health literacy and a lack of pedagogical space for more critical engagements with the social and economic barriers to health that draw on the participants' own knowledge and experiences.

Keywords: literacies; public health; HIV/AIDS; Tanzania; local knowledge

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Introduction

This article examines the nature of literacy practices in HIV/AIDS education in rural areas of Tanzania in order to better understand how literacy events provide participants with opportunities to meaningfully engage with the educational efforts. With the view that HIV/AIDS education is a form of social practice through which people make meanings around literacy events (Barton and Hamilton 2000), I explore how the social context of public health outreach relates to knowledge construction and to the production of agentive identities among educators and their target audiences. Drawing on field work conducted in 2007 and 2010, I examine the literacy events in educational practices provided by local Tanzanian public health educators to poor adults who were either people living with HIV (PLHIV) or who worked to help PLHIV in the form of traditional medicine.

Though the participants did not reveal their struggles directly to the educators, it became clear through my field work that their comfort level with formal literacy practices shaped their participation in certain ways. These educational efforts were comprised of various literacy events, including the delivery of Powerpoints, reading aloud from official booklets, teacher-centred instruction about transmission and prevention of HIV/AIDS through writing on flipcharts and blackboards and group work that involved answering

*Email: cmhiggin@hawaii.edu

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questions in written format on large poster-sized paper, followed by reading the answers aloud in front of the class.

Educational sessions were mostly in Kiswahili,[1] with some use of English and regional languages such as Kisambaa and Kisukuma. I took an ethnographic approach to the literacy events (Barton 2012), which included analysing audio and video recordings of educational sessions and comparing these with photographs, field notes and interviews with participants, which I carried out in Kiswahili. My research was shaped by my relationship with the directors of two non-governmental organisations (NGOs) who offered the education and who allowed me to research their educational practices. My mutually agreed-upon purpose was to research the communication at educational events and to help the NGOs to document their work through research reporting. The general expectation was that my research might also point to promising practices and areas needing improvement, such as the use of culturally specific communication styles that build rapport, miscommunication (due, for example, to differences in ethnicity or religion) and ways of using language that perpetuate specific gender identities and roles. Though I worked with a Tanzanian research assistant over the course of my fieldwork, my analysis is based on my own observations and interpretations of the discourse in Kiswahili, a language that I have developed a high proficiency in as a result of carrying out intensive field-based research in Tanzania for over 10 years.

My analysis focuses specifically on two kinds of literacy events in the context of HIV/AIDS education as a social practice: (1) instruction using written modes of language from official booklets and on blackboards and flipcharts; and (2) breakout sessions in groups that the participants were often assigned, which involved writing out answers to key questions posed by the educators. These events were very teacher-centred in nature and tended to eclipse opportunities for more constructivist, student-centred forms of learning that have potential to lead to dialogic learning and impacts on the lives of participants beyond the contexts of the educational events. The result was that the participants' own *funds of knowledge* (Moll et al. 1992) were often minimised, which also meant that their identities as experts on social life in their communities were largely disregarded.

Health literacies as social practices

In treating HIV/AIDS education as a set of literacy practices, it is important to first establish the concept of literacy as a social practice. Following Barton (1994), the activities of reading, writing and using various kinds of texts create social constructions of literacy, ideological discourses about literacy and ways of using literacy that establish social roles and which draw boundaries around 'official', often institutionally sanctioned forms of knowledge. Literacy thus constructs knowledge as well as the relations between people and across groups and communities (Barton and Hamilton 2000). This is particularly important in public health education, where social relations are central to the spread of HIV and where the topics of risk groups, male–female relationships, parent–child relationships and providing care for PLHIV dominate the curricula of HIV/AIDS education.

The idea of literacy as a social practice relates directly to the concept of *multiliteracies* (Gee 1990; Kalantzis and Cope 2012; New London Group 1996), a framework for researching multimodal literacy practices as they unfold in situated contexts, including educational settings. Multiliteracies pedagogies not only recognise linguistic diversity, but also work to promote a diversity of literacy practices that involve

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the deconstruction of texts, interpretation of ideologies and the reconstruction of meanings in new texts and interactions. Through critical pedagogies, the goal is to provide learners with the opportunity to continually interpret and transform their social identities and social relations by responding to texts and participating in literacy communities, and through creating meanings in new texts that they produce themselves (Janks 2010; Street 2001). Creating new texts may refer to the production of actual texts, such as essays or poems, and it can include more technology-mediated formats, such as participating in online forums and becoming members of web-based communities. As Norton (2014) points out, meaning-making is facilitated when the social, cultural, and linguistic identities of learners are legitimated, and transformative literacy practices can provide learners with the ability to imagine new, agentive identities in their futures.

In regions like Tanzania that have been greatly affected by HIV/AIDS, literacy events in educational practices afford the opportunity to investigate how public health knowledge is taken up, and possibly transformed, by recipient communities. The analysis of health literacies has the potential to demonstrate how individuals may engage not only in the deconstruction of discourses about sexual health, risk, and stigma, but also in the transformation of their social identities and social relations. This view of literacy resonates with the policies informing public health education, as most campaigns in the region are governed by principles from *life skills education* (LSE), a curriculum designed by the World Health Organisation (WHO) and supported by the United Nations Children's Fund (UNICEF) that has the broad purpose of empowering people and equipping them with the social tools to face challenging situations. Though the goal is empowerment, little research in the field of public health examines how educational sessions may provide participants with the opportunity to transform their identities. Hence, research within applied linguistics and literacy studies can contribute a great deal to shedding light on whether and to what degree policies are put into practice on the ground, particularly in rural areas where access to formal schooling is quite limited.

HIV/AIDS and critical health literacies

In recent years, a growing body of scholarship that embraces a multiliteracies approach has developed which seeks to make links between HIV/AIDS health literacy events and the social contexts surrounding them (e.g. Higgins and Norton 2010). This work pays particular attention to the ways that knowledge about the disease is socially and discursively constructed, and seeks to apply these findings in meaningful ways in educational settings. In a critical multiliteracies study by Mutonyi and Kendrick (2010), for example, Ugandan students drew cartoons depicting slogans about the disease, which then provided the research team with materials for focusing the discussion on the locally salient themes raised in the images. Similarly, Mitchell et al. (2010) designed a project in Swaziland with female schoolchildren that made use of photography to express their vulnerabilities to high-risk situations. The students photographed the broken doors on their school's toilets to draw attention to the danger of being raped. After the project was displayed for the entire school to observe, the school began to monitor the toilets to protect the girls. As another example, Norton, Jones, and Ahimbisibwe (2011) discuss how they worked to develop a digital literacy course for young women in rural Uganda as a means of improving their access to globally produced HIV/AIDS education. The young women did not merely become consumers of knowledge about HIV/AIDS through the process of taking the course – they also transformed their imagined futures for themselves, as the course provided them with the opportunity to envision how they

could use their newly acquired digital literacy skills to share their experiences with others on the Internet and to learn more about their imagined fields of study and work.

My own previous research on peer education and LSE in Tanzania reveals that the lessons receive the most enthusiasm when educators connect the LSE curriculum directly to young people's lives in concrete ways. For example, in Higgins (2010a), I analyse how a peer educator in urban Dar es Salaam compels a resistant audience of young men to engage with LSE after they reject the skills as irrelevant to the Tanzanian context. While discussing the somewhat vague life skill of 'empathy', the educator connects to the men's lives by using an example they all recognise, that is, the local practice of paying a stranger's bus fare when she/he realises that she/he does not have enough money. The moment served to bring the audience into the dialogue and to align the goals of the education with the experiences of the young men involved. From my observations, educators also frequently devise role-plays which reflect daily realities of life, including the problem of men providing small gifts for girls, such as sodas and snacks, with the expectation of consensual sex in return (Higgins 2010b). After such role-plays, effective group dialogue about these problems has demonstrated the potential to produce *critical health literacy* or the ability 'to address social, economic, and environmental determinants of health' (Nutbeam 2000, 265), and highlight the social aspects of meaning-making beyond mere *functional health literacy*, or the ability to read and understand health-related information and instructions or to follow the advice of physicians.

Background to the current study

The cases reported on here reflect how public health policies are put into practice in rural areas of Tanzania and are taken from ethnographic research I conducted from 2007 to 2010 in Iringa and Tanga regions of the country. Iringa, which has reported an 18% HIV prevalence rate in 2005, is one of the regions with the greatest demands for prevention and awareness in the country (Tanzania Commission for AIDS 2005). Tanga represents approximately the average rate of infection in the nation at 6.5% (Tanzanian Ministry of Health and Social Welfare – National AIDS Control Programme 2007). The latest reports estimate that Tanzania is reported to have a national average of 5.7% prevalence rate for HIV, a figure that demonstrates a decrease over the past five years (THMIS 2011). Though the Tanzanian government was initially rather slow to respond to the pandemic, only forming a national policy to fight the spread of the disease in 1995, efforts to battle the disease since that time have become quite widespread. Over the past decade, a standardised approach to HIV/AIDS education has developed in Tanzania, following guidelines produced by the Tanzanian Commission for AIDS (TACAIDS) in conjunction with agencies such as the World Health Organisation, UNICEF and the Joint United Nations Program on HIV/AIDS (UNAIDS). In recent years, HIV/AIDS education in Tanzania has been designed to target issues that care providers, medical professionals and PLHIV regularly face, including ways to support *kuishi kwa matumaini* (to live with hope) for HIV-positive individuals.

Though the vast majority of Tanzanians are fluent in Kiswahili, many people living in the two regions that I focus on here speak other Bantu languages as their mother tongues. Most people living in rural parts of Tanga speak languages such as Kisambaa and Kibondei, while most living in Iringa are dominant in Kihehe. Schooling yields varying degrees of Kiswahili language proficiency and literacies, depending on home literacies, teachers' practices and school resources. Kiswahili is officially the medium of primary school, while English is the official medium of instruction beginning in secondary school.

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In the educational events I observed, many of the participants showed conversational fluency in Kiswahili, the medium of instruction, though they did sometimes switch into other languages like Kisambaa or Kihehe. Occasionally, the facilitators asked them how to say something in one of the local languages as well, which appeared to encourage the participants to share their own experience and knowledge. However, many of the participants struggled with pen-and-paper literacy practices in general, and this became limiting for their participation since the sessions were dominated by reading and writing. Very few participants demonstrated any proficiency in English.

Data collection and participants

My fieldwork was made possible through affiliations that I worked to establish with two NGOs that were founded and staffed primarily by Tanzanians. In Iringa, I worked for two months in the summer of 2007 with the African Medical and Research Foundation (AMREF), a large NGO which has offices in seven African countries. AMREF hosted a seminar for *waganga wa jadi* ('traditional healers') that I was able to attend, and this event became the central focal point of my research. For one week, 16 healers attended the seminar in the small town of Kitonga, travelling from rural areas such as Mafinga and Ulete. They were paid a modest honorarium by the NGOs for their participation and were provided with lunch and refreshments each day. In Tanga, I collaborated with the Tanga AIDS Working Group (TAWG) for two months in the summer of 2010. TAWG is an NGO that promotes indigenous knowledge in their education and prevention efforts. TAWG's institutional identity as supportive of indigenous knowledge led me to pay special attention to any social identities marked as 'indigenous' that might be afforded to participants at educational sessions. While working in Tanga, I attended a week-long seminar in the small town of Maramba to learn more about a three-year project that brought 30 traditional and biomedical doctors together to collaborate on providing care, and I travelled to Soni, a small town in the Usambara mountains where approximately 20 PLHIV were educated for three days on a myriad of topics, including reducing the stigma of HIV, in order to become peer educators in their communities.[2]

I took field notes and audio recorded all of the events, paying attention to the ways that literacy events provided participants with certain identity options, which would in turn impact how they participated in the sessions. Since I already had a solid familiarity with HIV education approaches among educated, urban populations from my previous research (Higgins 2010a, 2010b), I imagined that the approaches would be different for the more rural and less-formally educated populations that the NGOs were serving. I thus directed my attention at ways of using language, visuals and instructional methods that might be suited to the different populations' needs. At most of the events, I was accompanied by a Tanzanian research assistant who I hired to help me capture the details of the interactions, to take photographs, to fill in cultural gaps and to act as an additional pair of eyes and ears. Later, my research assistant graciously helped me to transcribe the selected excerpts of data and to occasionally shed light on contextual aspects of the activities that we were examining.

Findings

In this section, I report on the range of literacy practices that both afforded and constrained the multilingual participants' engagement with the educational sessions, paying particular attention to the identities being constructed for the participants. I first

focus on the multilingual and multicultural affordances in the instruction, and I discuss how these led to opportunities for participants to contribute their perspectives, problematise difficult circumstances related to HIV/AIDS transmission, prevention and treatment and discuss ways forward. I then turn to the more widespread and systematic use of instructional practices which did not capitalise on the linguistic or cultural resources of the participants.

Acknowledging local knowledge and local languages

Across the educational contexts, the facilitators sometimes made direct links between the local traditional healing practices and the languages spoken in the regions as a way to frame their instruction. This was especially frequent in sessions held by TAWG, an NGO that explicitly supports indigenous knowledge, during a seminar which was organised to bring traditional and biomedical doctors together to collaborate. In Transcript (1), we see how the facilitator, a biomedical doctor working at TAWG, drew on local traditional health practices in the Tanga region to make the point that biomedical innovations are often built on traditional practices.

Due to restrictions on space, only a translated version of recordings is provided in the transcripts. The use of languages other than Kiswahili is indicated by italics and is labelled in the excerpts. Transcription conventions are based on Atkinson and Heritage (1984).

Transcript (1) Refrigeration and burlap sacks:

1	**Facilitator:**	The foundation for preparing medicine, right? There is refrigeration here.
2		Refrigeration. You know 'fridge' is indigenous language. Burlap sacks is
3		what we use. Now we have this one word, fridge, but the indigenous
4		word for it has unfortunately been erased.
5	**Facilitator:**	This is a way of making refrigeration here. Ther- what's it called ther-
6		Doctor Sulabi I don't know myself – what's it called?
7	**Dr. Sulabi:**	*Silambo*.
		((A Kisambaa word, meaning the use of burlap sacks for keeping things cold.))
8	**Facilitator:**	The local concept didn't become widespread. But everyone needs
9		refrigeration for medicine.

The facilitator made the point that traditional doctors share the same sets of knowledge about healing, including the need to keep certain medicines cold. In line 5, he supported his point by seeking knowledge from one of the traditional healers, who supplied the Kisambaa word for the local practice of placing herbs and roots in burlap sacks and then burying them to keep them cool. By virtue of addressing the traditional healer as 'Doctor' (or *Dakta* in the original Kiswahili) in line 6, an address term normally reserved for biomedically trained doctors, the facilitator also legitimised Dr. Sulabi's expertise about health and healing.

Because the week-long seminar was part of a larger effort on the part of TAWG to bring together traditional healers and biomedical doctors for the purpose of greater collaboration and learning, there were clear efforts to regularly bridge indigenous and local forms of knowledge used in health and healing with biomedical practices. These efforts were matched by the facilitator's sincere interest in the traditional healers' languages and ways of using herbal remedies and other natural medicines for treating people, and interaction would frequently involve traditional healers supplying the facilitator with answers that filled in his own knowledge gaps. Nevertheless, and as

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Excerpt 1 demonstrates, the instruction remained rather monologic, with the facilitator using a lecture-style approach to with ‘fill-in-the-blank’ moments in his teacher-centred instruction.

In Iringa, I attended a similar week-long workshop sponsored by AMREF that also focused on traditional healers and their approaches to treating PLHIV. In contrast to the TAWG workshop, there were no explicit goals of validating indigenous knowledge. Instead, and in line with most NGO-sponsored education in the country, the purpose of the workshop was to provide knowledge across a wide range of areas such as nutrition, home-based care and condom use with the aim of changing behaviour in communities. The group of traditional healers met for their seminar from 8 am to 4 pm each day and followed a set schedule. On the first day, it became clear that conventional teacher-centred instruction would dominate when the AMREF facilitator handed out glossy-covered booklets produced by the Tanzanian government titled *Sera ya Afya ya Kitaifa* (‘the national health policy’), a notebook and a pen to each healer. The facilitator read aloud, and then asked for a volunteer to continue reading. The first volunteer to read, a male healer in his late sixties, read aloud at a very slow pace, often stumbling over words. The four female healers listened attentively, not making use of their pens and notebooks. I later found out that none of the women could read or write beyond a very basic level.

Early on, and in stark contrast with the TAWG setting, the role of indigenous knowledge in the form of *mila na desturi* (‘traditions’) was mentioned in the health policy as a contributing factor to the spread of HIV, which led to a brief discussion of traditional healing and belief systems. In Transcript (2), we see that one of the female healers, Presca, attests to the power of local practices such as the use of animal sacrifice to cure people. Presca was unusual in that she is not originally from Iringa, and her identity as a Sukuma person from Northern Tanzania becomes the focus of the conversation. After explaining that unlike Sukuma people, Islamic sheiks in Tanzania have rituals for banishing evil spirits, she moves on to explain the Sukuma tradition.

Transcript (2) Exorcising evil spirits:

1	**Facilitator:**	Do you have evil spirits that are exorcised in your traditions?
2 3 4 5 6	**Presca:**	No, I don’t have spirits related to any tradition, those are – hh. I did see a young man who was exorcised of an Islamic spirit. An Islamic sheik used *kigai* ((‘charcoal stove’ in Kisukuma)). I watched him do it. He put incense inside and then he began his work […] Until today the person is cured. He was cured by the incense. It exorcised the evil spirits.
7	**Facilitator:**	How do you say that in Kisukuma?
8	**Presca:**	YOU.hh In Kisukuma. *Yanaomba ng’olo*. (‘to sacrifice lambs’)
[…]		
14	**Facilitator:**	Lambs.
15	**Presca:**	Lambs, right.
16	**Healer3:**	Oh (the word is) *ngolo*. (‘lambs’, Kisukuma)
17	**Presca:**	First there are, there are various things that you offer. You see Sukuma offerings, *malado* (‘objects’).
18	**Faciliator:**	Mhm. So, do you even use snakes?
[…]		

((the conversation continues about the ways that Presca uses snakes to cure people and the questions that follow focus on where she keeps the snakes and what she feeds them))

33 **Facilitator:** We've seen that religion remains important and that healers do similar
34 things across contexts. And Presca tells us that religion also heals.

35 **Presca:** It really heals, as I explained.

37 **Facilitator:** Okay. One of us says that religion has great importance. There is a cure for evil spirits. A protector. Okay. (.) Now let's continue with page three everyone, let's read. Can another person begin to read?

Though the facilitator inquired about the possibility of using traditional knowledge or beliefs in the practice of healing, the topic did not get past the stage of description to a more dialogic engagement that might have provided the participants with the opportunity to discuss the value of different kinds of knowledge, including religious and indigenous belief systems. Moreover, as line 18 indicates, the information was treated as exotic and entertaining, rather than meaningfully relevant to the seminar topics. Throughout the week of seminar meetings, the discussion of local knowledge and local language was more often treated as an aside to the official business at hand, which was to read through the NGO-sanctioned materials and fill in knowledge gaps that the healers were presumed to have. Next, I focus on the ways that conventional literacies were part of these practices, and how they shaped social identities constructed within the educational practices.

Teacher-centred, text-based approaches

Despite occasional engagement with local knowledge in both Tanga and Iringa, I was surprised to find that the approaches to teaching were nearly the same as those I had seen used in urban areas with relatively well-educated populations. Despite the great differences in proficiency in reading and writing, formal schooling and linguistic proficiency in English, the instruction took a highly text-based approach to teaching that required the instructors to spend a great deal of time writing notes on poster-sized papers and taping them to chalkboards or walls around the room. This practice also ensured that the NGOs would have evidence of their work, which they needed for reporting to their funding sources.

My field work photographs and notes tracked a heavy reliance on writing that the facilitators used when sharing information about public health issues related to HIV. The facilitators spent a great deal of time writing out definitions for very basic and well-understood terms like HIV (in Swahili, *VVU* [*Virusi vya UKIMWI*]), which were then copied down on paper word for word by the participants seated at the desks. Most of the hours each day were devoted to this style of instruction, where the facilitators would lecture to their 'students'.

Of course, I was interested to know how well the participants were managing with these language demands and to see how their access to this knowledge was constructing identities as future peer educators in their respective communities. In a TAWG-sponsored event in the town of Soni, I observed that half of the approximately 20 attendees were not writing notes in the notebooks provided by AMREF. This event targeted PLHIV and was designed to provide a range of information that they could then pass on to others in their communities. It was clear that writing practices were highly gendered in nature. Among the five men present, all were copying notes dutifully. Of the 15 women, seven were taking notes, though in looking at the notes that they took, I saw that there were

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discrepancies in how complete the notes were since it took a great deal of time to copy the work on the board. In interviews with the women, I found out that several of those who did not take notes themselves had various problems with their eyes and could not see the poster-sized paper posted at the front of the room. Several of the women also revealed that they had not gone to school or had such little schooling that they could not make use of their notebooks. One of the women who could not read or write well brought her 10-year-old granddaughter to the workshop, who took notes for the entire session. When I asked the participants what suggestions that they might make for improvements in the workshops, they expressed that more visual approaches such as videos and role-plays would be useful. The women who did not take notes themselves told me that they planned to photocopy notes from someone else at the workshop so that they could take it into their communities and teach others. There too, though, they would rely on another person to act as their readers.

The strong reliance on text-based literacies seemed to greatly reduce the opportunity for meaningful discussion that might have led to the participants' positioning of themselves as agentive individuals, capable of sharing personal experiences and finding ways to make a difference in their communities. In Iringa, where the workshop for traditional healers was held in Kitonga, interesting discussions that began were often shut down in order to redirect the workshops towards the planned curriculum of getting through the material. Transcript (3) illustrates how an opportunity to engage in more critical health literacies discussions about condom usage was passed by in favour of building some rapport and finding out about the availability of condoms. The conversation begins as the facilitator is reading aloud from the booklet on the national health policy, and one of the oldest male healers in the group spoke up.

Transcript (3) Proper condom use:

1	**Facilitator:**	… use condoms properly for each sexual act.
2 3	**Healer1:**	Condoms are too flimsy ((smiling)). If you go at it ((have sex)) strongly they will break.
4		((many participants smile))
5	**Facilitator:**	WHOA! Father, you tear condoms?
6	**Healer1:**	It's happened.
7	**Participants:**	((laughter, unintelligible conversation)).
8 9	**Facilitator:**	Now grandfather, if you use condoms, if you wear them properly they won't break.
10	**Healer1:**	I've already broken them.
11	**Healer2:**	Oh, cut it out.
12	**Facilitator:**	Therefore, proper condom use everyone. It's necess- protection against infection is from proper usage. Okay.
		((picks up booklet and reads aloud))
13 14 15		There is strong evidence that condoms work to prevent the spread of HIV if they are used properly. Therefore, condoms will work best if they are bought and sold for a good price.
		((facilitator puts booklet down for a moment))
16		How much do condoms cost in your area? There in the village?

17	**Healer1:**	100 shillings for three.
		[…]
	((lines omitted; the facilitator asks the healers about the brands of condoms that are sold and how much they cost))	
25 26 27	**Facilitator:**	So the price has dropped if it's um, 100 shillings. A long time ago you would pay 100 shillings or, I don't know, maybe 150 shillings for one. But they are available?
28	**Healer2:**	There are Dume brand condoms.
29	**Facilitator:**	They are available?
30	**Healer2:**	((nods))
31 32 33	**Facilitator:**	So condoms, everyone, is one way to reduce the spread of HIV. Even those HIV-positive people who are on anti-retroviral therapy should use condoms so that they don't get new viruses.
		((continues to read from booklet))

Here, we see that the facilitator touches on condoms, a topic that has deserved a great deal of attention in Tanzanian health education. Like other resource-poor countries, which receive large sums of financial aid from international development agencies, Tanzania has also implemented the ABC (Abstain, Be faithful, use Condoms) approach, but this discourse does not get invoked in the discussion. Instead, the important topic of condoms is here treated as mostly an opportunity for rapport building, rather than discussing the perhaps real question of whether or not condoms are a trustworthy method for preventing the spread of HIV and other sexually transmitted diseases. The frame of the discussion is built on the booklet guiding the workshop, and the activity of reading through the booklet constrains the opportunity for discussion. Moreover, the questions about the availability (lines 25–27) and the price of condoms (line 29) do not do much to get to address the social and economic determinants of condom usage in Kitonga. There is no discussion of what factors explain the use of condoms and to what degree their use may be stigmatised or awkward. In fact, the information-seeking questions asked by the facilitator only appear to register the availability of condoms, rather than to inquire about the identities of community members who were clearly living in poverty and for whom 100 shillings would be considered a lot of money to spend on a regular basis.

Struggles with group work

A common practice across the sites that I researched was the use of group work to answer questions posed by the facilitators. Like the entire instructional content, these questions were presented in written form on large poster-sized pieces of paper, and participants were asked to work in groups to answer them. In such tasks, the identities given to the participants can be described as 'just-filled vessels' in that the tasks involved providing lists of ideas that the facilitators had discussed.

In Soni, where PLHIV were receiving education to use later as peer educators, the group of participants was divided into groups of four to five people. Though the facilitators did not make any explicit comments about who should take on a leadership role, all of the groups but one had a male participant take charge of the task of writing the answers to the questions. Based on my observations of the note-taking skills in the

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classroom, this was reflective of the paper-and-pen literacies that the participants brought with them into the workshop.

The male participants took on the task of writing the answers with little to no input from their female peers. I also observed that the female participants' suggestions were only sometimes taken up by the writers. Rather than seeing this as only an exclusionary process, it was clear that the work of writing up answers was labour intensive for the participants, and they did not appear keen to revise their writing as more suggestions came from their female peers. This was an example of how an overreliance on conventional literacies prevented the educational sessions from opening up more opportunities for the participants to contribute knowledge and to participate in literacy as a social practice for transforming their own communities.

The participants were also asked to report back to the class once they were finished answering their questions. Similar to the teacher-centred events of the workshops, these moments did not delve very deeply into the contextual determinants of public health. Instead, participants often reported a list of answers to questions such as 'What are the reasons for stigma towards people with HIV?' which yielded lists such as:

(1) *Elimu duni* (low education)
(2) *Imani potofu* (wrong-headed beliefs)
(3) *Homu ya kujamiiana* (sexual appetites)
(4) *Ukosefu wa dawa* (lack of antiretroviral therapy drugs)
(5) *Vyombo vya habari* (news outlets and news reports)
(6) *Ukosefu wa haki za binadamu* (lack of protection of human rights)

Since these topics were generated by the HIV-positive participants living in Soni themselves, they provided the facilitators with interesting opportunities to dig more deeply into the contexts for each of these ideas. However, no follow-up questions were asked about these contributions, nor were they treated as the basis for knowledge exchange and dialogue in the workshop. After the answers were briefly provided, the educators moved along to the next agenda item in their curriculum. Many missed opportunities for critical health literacies passed by such as deconstructing media texts based on the HIV-positive participants' own experiences, discussing reasons for the lack of sufficient antiretroviral therapy drugs or exchanging stories about human rights or belief systems that are seen as contributing to the stigmatisation of PLHIV.

In Iringa, at the workshop for traditional healers, group work was also used. On the second day, the facilitator discussed home-based care (HBC), a public health topic that began to take on an ever-widening circulation in 2007, when the workshop was held. The purpose of HBC education is to train people to consider ways of protecting themselves against transmission of HIV while also providing care and support for PLHIV. On a large poster in the front of the room, the facilitator wrote *Uzoefu wa waganga wa jadi katika uugaziji wa wagonjwa* ('Experience of traditional healers in the care of the ill'), and then divided the 18 participants into groups of six. Though the text she produced was not clearly a question or a prompt, she directed the healers to provide answers in groups at tables in the outdoor seating area.

On the surface, the task provided the healers with the space to claim an identity of knowledge expert since they had been asked to express their own personal experiences caring for HIV-positive patients. However, once again, conventional literacy limitations interfered. Much confusion followed, including the need to redistribute the members so that people with writing skills were a part of each group. I followed one group entirely

comprised of men as they continued with the task. One man later told me that he was a teacher, so I was interested to see how they negotiated the reading and writing demands in their group. Indeed, the teacher (noted as Healer1 in the transcript below) was the person who took charge of the task of writing. The group began with a great deal of attention to the formalities of the writing task, making sure to centre their group name *Kikundi 1* (‘Group 1’) on the paper. Great concern about the appearance of one’s writing was something I noticed among all groups during this workshop, and in the other contexts as well. There appeared to be more importance placed on the placement of words and penmanship, over and above the content of the answers.

The men moved on to transfer what they had written in their notes to the paper, which they read differently from what was originally expressed by the facilitator. Though the instructions were to write about *Uzoefu wa waganga wa jadi katika uugaziji wa wagonjwa* (‘Experience of traditional healers in taking care of the ill’), they began by writing at the top of their paper *Uzoezi wa maganga wa jadi* (‘practices of traditional healers’), which is a slightly different set of ideas that would encourage listing the steps a healer takes when treating someone he or she considers to have HIV. As the transcript of their conversation shows, they struggled to interpret the relationships among healers and sick people easily. Lines 7–10 especially indicate confusion about the topic of their task, namely, their own experience in treating the sick.

Transcript (4) Experiences treating the sick:

1	**Healer1:**	Here it says practices of healers. First, to receive the patient, ((starts writing))
2	**Healer2:**	>Practices of traditional healers < ((slowly stated so that it can be copied))
3	**Healer1:**	<Healers,> ((writing))
4	**Several:**	Traditional.
5	**Healer1:**	That’s what it is.
6	**Healer2:**	Moving on,
7	**Healer1:**	The practices of (.) healers. Sick people.
8	**Healer3:**	Practices of sick people.
9	**Healer1:**	Practices of sick people of trad- of-
10	**Healer2:**	You’ve made a mistake. Don’t you see that you’ve mixed up the ideas?

After realising the mix-up, the group decided to abandon what they had written thus far and start again on the other side of the paper. They also decided to refocus the task to their own experiences helping sick people with their own title of *Mapokezi ya wagonjwa kwa waga(nga) wa jadi* (‘Receiving sick people among traditional healers’). Finally, after the healers completed the task, they were asked to report on what they wrote, with each group representative reading from the paper. In reporting back to the class, their identity in the literacy event was as students who had completed a task, rather than as people with deep insights into treating PLHIV.

In Tanga, at the workshop in Maramba, other problems with reading and writing practices emerged when the traditional healers had to work together with biomedical doctors to develop a workplan for the remaining months of the year, August–December. This was the culminating activity of the week-long meeting, and it was meant to point to future goals that would be achieved together. As the groups worked together, it was clear that the biomedical doctors were generally faster at laying the concepts out on a grid

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without the need to revise. While one group had nearly completed the task of planning when they would distribute condoms, provide community education and provide referrals, a neighbouring group had just organised their chart for a second time. This latter group also realised later that they would need to add subcategories for each month, which meant that they would have to start their task again.

In terms of social identities, the biomedical doctors who were faster at the conventional literacies also took on the work of organising the tasks, guiding the traditional healers as they worked and, in general, taking charge of the activities. The effect of this was that the traditional healers took on identities as followers, rather than as collaborators.

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Discussion

Across the educational sessions, it is clear that that the delivery of knowledge about HIV/AIDS often assumes familiarity among the target audiences with the conventional literacy practice of synthesising information and reporting it back to the instructor(s) in the form of group work. This practice is best described as functional health literacy, and it is the most widespread educational practice in the data that I examined. My analysis shows that participants show a wide range of skill with this literacy practice, and their participation strongly suggests that more attention to participants' various learning styles, language repertoires and scaffolding of biomedical jargon is needed. Because reading and writing skills were not universally strong, it seems important to reconsider the practice of writing-based tasks as the main approach.

Since literacy practices construct social identities, the unfortunate result of these activities was that the participants' identities as novice, relatively uninformed consumers of information were constructed for them through the task of reporting back 'newly learned' information. Though some of the participants occasionally indicated frustration or resistance through side comments and humorous remarks, the monologic script of the education continued on. From my observations, many of the participants eventually tuned out, particularly when reading from texts was the focus of the activity. Though the participants initially appeared to be enthusiastic, their enthusiasm faded across the days, and their interest in when lunch would be served or when tea breaks would take place became the priority. Even the TAWG sessions, where indigenous knowledge was meant to be valorised, failed to provide the participants with room for dialogue due to their teacher-centred structure. Though the facilitators could have easily invited the traditional healers to share their experiences at length, they stuck to a format much like those found in the other settings described in this paper.

It seems obvious to state that opening up more opportunities to move beyond developing functional health literacy and providing spaces for more critical engagements with the social and economic barriers to health is likely to lead to different identities in health education. If public health outreach can be redesigned in ways that treat participants' local funds of knowledge as foundational to the education, there is much potential to be gained. Not only will participants be more likely to engage actively, but they will also experience identities as people who can contribute to change.

Conclusion

Current practices in HIV/AIDS education in Tanzania tend to reproduce relatively passive identities for participants, and the pen-and-paper literacy events that dominate the

education contribute to reducing the realm of possible identities for many of the participants as well. In spite of acknowledging participants' knowledge bases drawn from their own experiences, the pattern in educational sessions is to 'stick to the script' provided by the NGOs, which has in turn been provided by international health agencies such as the WHO and UNICEF. There is not only need to reassess participants' literacy skills, but also more importantly, it is necessary to devise different approaches for teaching that offer alternatives to lecture-oriented education and regurgitation of instruction.

In the spirit of critical pedagogy and critical literacy, the findings suggest a strong and urgent need to redesign public health education in order to engage participants with more opportunity for dialogue and reflection on their own experiences. Doing so could open up productive spaces to address the participants' concerns and real-life challenges. At the very least, those who attend workshops could be invited to talk about the particular problems that they face, whether as HIV-positive individuals, or as care providers of PLHIV, as a starting point for the discussion. Though it is exceedingly difficult to find 'solutions' to the problem of HIV/AIDS in Tanzania, treating actual experience as the basis of education would go a long way in constructing identities that can aspire towards change. At the policy level, more attention should be given to examples of promising practices that promote critical health literacies as a means of providing ways forward. Though some community-based organisations in Tanzania are engaging in their own critical practices in the form of parent support groups and youth clubs (Higgins 2010a), it seems clear that the bulk of resources is put into monologic forms of public health education such as the ones illustrated in this article. If resources are redirected towards supporting more dialogic forums for HIV/AIDS prevention and awareness, critical health literacies can help to contribute towards making changes not only in educational contexts, but also in the lives of Tanzanians outside of public health classroom contexts.

Acknowledgements

I wish to thank the Tanzania AIDS Working Group for welcoming me to research their educational practices in 2010. I would also like to acknowledge the support of the Tanzanian Commission for Science and Technology in carrying out this research.

Funding

This work was supported by a grant sponsored by the University of Hawaii at Manoa Endowment for the Humanities Summer Research Program.

Notes

1. Kiswahili is the national language of Tanzania and it is co-official with English. It is spoken by the vast majority of the country's residents. All of the participants showed high oral proficiency in Kiswahili, though it was clear that for most of them, they had greater oral proficiency in a regional language.
2. Peer educators can take on a variety of teaching topics. In Soni, most of the participants expressed interest in educating their communities about stigma and caring for PLHIV. These concerns appeared to reflect their own status as PLHIV themselves.

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