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Discursive enactments of the World Health Organization's policies: Competing cultural models in Tanzanian HIV/AIDS prevention

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Abstract In the healthcare arena, language policy-related research has thus far been limited to questions about *language access*, i.e., whether individuals are supplied with health information in their languages, and whether interpreters for doctor-patient consultations are provided (Martinez 2008; Ngo-Metzger et al. 2003; Partida 2007; Vahabi 2007). This article seeks to expand this body of research by exploring how health policies and health literacies are languaged in HIV/AIDS educational sessions in Tanzania. Placing health literacies within a *multiliteracies* framework (Cope and Kalantzis 2000), I explore how international public health policies that inform HIV/AIDS education are articulated in educational sessions sponsored by a Tanzanian non-governmental organization (NGO). The article focuses on this NGO's implementation of the World Health Organization's Life Skills Education (LSE) curriculum, a set of ten skills that was designed to promote positive behavior change. Since the LSE curriculum is not designed specifically for Tanzanian target populations, it is important to understand how LSE global health literacies are discursively constructed and disseminated, and to investigate if they are deemed culturally appropriate at the local level. Using Gee's (1990) concept of *cultural models*, I draw on 4 months of fieldwork to interpret how NGO educators and audience members respond to the information in educational sessions. A close analysis of the interactions reveals tensions between the LSE global cultural model and the local cultural models articulated by the educators and the audiences. Suggestions for language policy and planning in HIV/AIDS education are discussed which incorporate local cultural models into educational practices.

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Introduction

Existing language policy research in the healthcare arena has thus far focused on the role of language proficiency and literacy skills in the delivery of health services to clients (Dugassa 2006: Martinez 2008; McGlynn and Martin 2009; Partida 2007; Saha and Fernandez 2007; Vahabi 2007). Such research is important for documenting how language plays a role in people's access to health services and health information, and it also provides a basis for calling for policy changes that can improve health services for minority language speakers. As Martinez (2008) illustrates in his study of healthcare practices in south Texas, Spanish-speaking patients frequently experience knowledge gaps about their own health in spite of federal language-in-healthcare policy that requires the use of interpreters. In this border region, a lack of sufficient resources forces healthcare providers to rely on their own bilingual skills in order to communicate with Spanish speaking patients. The result is a widespread practice of ad hoc interpreting by secretarial staff and nurses who are not trained in interpreting, and their well-intended efforts often contribute to miscommunication of health information and result in greater health disparities among Spanish speakers. Similarly, Dugassa (2006) documents how language policies in Ethiopia deny Oromo-speaking people access to medical services, including critical information regarding the transmission of HIV/AIDS, unless they are proficient in Amharic. Though not framed in language policy frameworks, other studies of medical encounters (e.g., Partida 2007; Roberts et al. 2005; Saha and Fernandez 2007) point to the same inequalities for second and minority language speakers. This research demonstrates an urgent need for policymakers, healthcare practitioners, and applied linguists to work together to find solutions to these fundamental problems. At the same time, as we go about addressing these problems through language policy and planning efforts, it is important to acknowledge that language proficiency and literacy are not the only language issues that call for attention.

Health literacies in language policy and planning

In this article, I argue that greater attention to *health literacies* is also crucial for language policy and planning efforts since health knowledge and health-promoting actions are frequently directly correlated with positive health outcomes (Caldwell 1986; Grosse and Auffrey 1989; Stuebing 1997). I draw on Nutbeam's (2000) three types of health literacies in my discussion: (1) *functional health literacy*, or the ability to read and understand health-related information and instructions; (2) *interactive health literacy*, which refers to taking actions based on health knowledge (typically in the form of following the advice of physicians); and (3) *critical health literacy*, the ability "to address social, economic, and environmental determinants of health" (Nutbeam 2000, p. 265). The majority of studies on literacy practices in

healthcare focus on functional health literacy, and to a lesser degree, interactive health literacy (Davis et al. 2001; Georges et al. 2004; Martinez 2008; Smith and Haggerty 2003). Examples of research on critical health literacies include Norton and Mutonyi (2007), who studied Ugandan schoolgirls' HIV/AIDS peer education clubs, settings which allowed the girls to openly express their worries and to "talk what others think you can't talk" (p. 479) in ways they had never experienced. The clubs addressed challenges such as sexual advances and sexual abuse by male teachers, male reluctance to use condoms, and societal resistance to valuing the education of girls and women. Similarly, Mitchell et al. (2009) describe a literacy project in Swaziland with female schoolchildren that made use of photography to express their vulnerabilities to high-risk situations. The girls photographed the broken doors on their school's toilets and drew attention to the danger of being raped. In the process of developing captions for the photos and displaying their work, the girls not only made use of their own lived experiences to develop their multimodal literacies, but also succeeded in using their literacy practices to draw attention to the dangers they faced at school. After the project was displayed for the entire school to observe, the school began to monitor the toilets to protect the girls.

In this article, I focus on critical health literacies in HIV/AIDS education sessions in Tanzania, and I pay specific attention to the ways that health policies are languaged in educational settings. I draw on research framed by the concept of *multiliteracies* (Gee 1990; Cope and Kalantzis 2000; New London Group 1996) to analyze the health literacy practices and to make recommendations for future language policy and planning efforts. In contrast with traditional literacy studies, which tend to view literacy as the capacity to read and write, the concept of multiliteracies highlights the variability inherent in meaning making in different cultural and social contexts, and it calls attention to multimodal aspects of communication (Cope and Kalantzis 2000; Street 2001). A multiliteracies framework recognizes not only linguistic diversity in educational settings, but also acknowledges that everyday literacy practices involve the deconstruction of texts, interpretation of ideologies, and the reconstruction of meanings through the production of new texts and interactions.

The concept of multiliteracies is important for language policy and planning because it asks policymakers and educators to acknowledge that language is not simply about using one linguistic code or another, but rather, that language encompasses ways of speaking and interacting that are shaped by different worldviews. In this article, I focus on the variability of meaning making in HIV/AIDS education sessions in Tanzania by examining the contrasting *cultural models* (Gee 1990) that are discursively articulated in the sessions. Simply put, cultural models are "people's everyday theories" (Gee 2008, p. 7) about how the world operates and how to make sense of others' behaviors. These models may be articulated through stories, metaphors, proverbs, riddles, and other semiotic devices that allow people to interpret events and experiences. Medical anthropologist Farmer (1994, p. 801) has also used the term in his work on HIV/AIDS in Haiti to describe how stories told about individuals infected with the disease "provide[d] the matrix within which nascent representations were anchored". Farmer examined how retellings of the same and similar stories about HIV/AIDS formed cultural models for understanding the

disease known as HIV/AIDS in Haiti. Likewise, Gee (2008, p. 104) explains the formation of cultural models as akin to "movies in the mind", a large cache of images and memories about life experiences which form the basis for what counts as normal.

As Gee explains, we may see a conflict between cultural models in face-to-face conversations when people contest the meanings that are being claimed, for it is in the act of claiming common ground (and in claiming that common ground is not shared) that cultural sameness or difference is identifiable. With Gee's concept as a framework, I investigate how Tanzanian educators and audience members rhetorically structure their talk with regard to cultural relevance and commonsense understandings of the world. In their interactions, their cultural models emerge in and through language use that takes place in educational events which are governed by global health policies. Though I focus somewhat narrowly on how differing perspectives are constructed in interactions, my analysis is dependent upon an ethnographically informed understanding of the normative approaches in HIV/AIDS prevention, as espoused by the non-governmental organization (NGO) I was affiliated with, in addition to the various and competing cultural models I observed in my fieldwork in 2006 and 2007. I use my ethnographically informed understandings of public health policy to examine how cultural models are articulated in educational sessions, and to examine how local cultural models are used alongside global/western perspectives on sexuality and health. The purpose of this work is to understand how Tanzanians develop their critical health literacies about HIV/AIDS, that is, the literacies that allow them to go beyond understanding health information and to begin to transform the social, economic, and environmental contexts in which HIV is transmitted.

Life skills education and health literacies

To analyze how critical health literacies and health policies are discursively articulated, I focus on Life Skills Education (LSE) sessions carried out by peer educators who were trained by a large Tanzanian NGO. LSE is an approach to problem solving that is employed in thousands of NGOs around the world to address issues such as poverty reduction, conflict management, and HIV/AIDS prevention. It was developed by the World Health Organization (WHO) and is supported by the United Nations Children's Fund (UNICEF) with the broad purpose of empowering young people and equipping them with the tools to face challenging situations. The WHO first defined life skills in 1993 as "the abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life" (ctd. in WHO 1998, p. 15). Like most forms of education, LSE depends heavily on language as a tool for informing, empowering, and changing behavior through effective communication with target audiences. Hence, LSE offers a useful site for studying how health policies and cultural models are discursively enacted, and for analyzing how health literacy events reproduce, and potentially transform, global health policies. In developing nations such as Tanzania, LSE is the primary means of battling the spread of HIV; surprisingly, however, very little research has been carried out on the face-to-face educational

practices that comprise LSE. Consequently, little is known about how high-risk audiences respond to LSE, or whether this form of education provides people with opportunities to develop critical health literacies. To address this gap in the existing research, I analyze the cultural models articulated in LSE, and I investigate how the educators and audience members deconstruct, interpret, and reconstruct their understandings of health and sexuality.

In Tanzania, LSE is primarily used for HIV/AIDS education, and it is typically taught by peer educators who lead community based organizations (CBOs). The skills are taught in the following order, in the medium of Swahili:[1] (1) self-awareness (*kujitambua*);[2] (2) relationship skills (*mahusiano*); (3) communication skills (*mawasiliano*); (4) problem solving skills (*kutatua matatizo*); (5) decision making skills (*kufanya maamuzi*); (6) self-control (*kuhimili mihemko*); (7) stress management (*kuhimili msongo*); (8) creative thinking (*fikra bunifu*); (9) critical thinking (*fikra yakinifu*); and (10) empathy (*ushirikeli*). These skills do not explicitly encompass discussions of sexuality or HIV/AIDS, but instead focus on more general skills that are meant to provide individuals with the capacity to govern their daily interactions with others. For example, in lessons on the life skill of 'self-awareness', a standard activity recommended by AMREF's LSE training manual is a role play activity in the context of a bank. Participants are told that they have a very ill mother who is waiting for them in the village, and that they have to go to the bank to withdraw money. There is a long line at the bank, and on top of this, people are cutting in line. The participants are asked to act out how they would respond to the situation in order to demonstrate 'being assertive'. It is assumed that the ability to be assertive in such situations will somehow carry over into realms involving sexual behaviors as well.

Global and local knowledge in health literacy practices

Both at the levels of international policy making and in policy documents produced by organizations like AMREF, LSE is a form of knowledge production that is presented as universally applicable and relevant. However, according to Boler and Aggleton (2005), LSE has its roots in western psychology since it promotes the idea of the rational individual who can take actions that will improve one's quality of life once the skills are mastered. The LSE approach treats a lack of knowledge as the main obstacle to HIV/AIDS prevention and follows the logic that through expanding people's knowledge base, they will automatically have greater control over their destinies. This perspective is also clearly articulated in World Bank policy. The Bank's 1998/1999 *Knowledge for development* World Development Report claims (1999, p. 1):

[1] Most Tanzanians speak Swahili in addition to ethnic community languages. Those who have attended secondary education have some fluency in English, though this may depend greatly on the quality of their education. The LSE sessions I have observed contain a range of Swahili, Swahinglish, and Swahili-English codeswitching as the mediums of instruction.

[2] The Swahili terms for LSE were supplied by BAKITA, Tanzania's National Swahili Council, which is the nation's language planning council. My observations of education workshops shows that many Tanzanians are unfamiliar with these terms.

> Poor countries—and poor people—differ from rich ones not only because they have less capital but because they have less knowledge. Knowledge is often costly to create, and that is why much of it is created in industrial countries.

This rationalism arguably stems from Enlightenment discourses that treat knowledge as emanating from modern, developed societies (McFarlane 2006). Similar discourses of rationalism have been analyzed in other applications of public health education, including the "quality of life" (QOL) construct that is an increasingly dominant concept in research on HIV/AIDS. Finn and Sarangi (2008) point out that QOL is based largely on white, western-centric notions of selfhood derived from research developed in the U.S. on middle and upper-class male homosexuals. They assert that the global application of such constructs reveals an underlying neoliberal ideology in which all humans are seen as having the capacity to act rationally and without constraints, and that empowerment is the universal key to prevention.[3] They challenge the validity of QOL as a universal indicator of health, and in their research on NGOs in India, they conclude that "as currently prescribed and authorized, [QOL] is for the many poor, unemployed and disenfranchised PLHA[4] in India a troublesome fantasy, particularly for women" (2008, p. 1577). Similar critiques of international development projects highlight the imposition of first world constructs on 'underdeveloped' populations as a form of cultural and economic imperialism in which outside experts provide 'solutions' for local problems (e.g., Briggs and Mantini-Briggs 2003; Escobar 1995).

In contrast to universalist, global forms of knowledge is *local knowledge*, a term Geertz (1983) first used to refer to ways of knowing that people negotiate in their own terms that are typically outside the boundaries of 'accepted' or 'authoritative' paradigms. Rather than deriving knowledge from published accounts or legitimized experts, all forms of local knowledge are grounded in indigenous forms of expertise and lived experience. In the context of HIV/AIDS education, however, local knowledge generally has very little credibility because of the dominance of rationalist approaches drawn from west-based, biomedically oriented health policies (cf. Drescher 2007). This is yet another example of what Canagarajah (2002) describes as the eclipsing of local knowledge in an increasing number of domains as a result of Enlightenment-inspired empiricism. He writes, "as modernism establishes geopolitical networks and a world economy that foster its vision of life, all communities are pressed into a uniform march to attain progress" (2002, p. 245). At the same time, he is quick to point out the danger of drawing clear boundaries between the local and the global, and he encourages us to explore the possibilities of appropriation of dominant discourses.

By viewing language as the central site for the articulation of global and local cultural models, we can better understand how health policies are articulated,

[3] Studies on the effects of LSE-derived knowledge have shown that LSE is not effective in reducing behaviors attributed to the spread of HIV. In their review of the effectiveness of 25 LSE interventions, Yankah and Aggleton (2008) conclude that LSE has no significant impact on HIV prevalence rates. A review of life skills work in southern Africa also asserted that LSE is too simplistic to offer any valuable solution to the complex needs of African young people (Crewe et al. 2006).

[4] People living with HIV/AIDS.

contested, and reproduced. Attention to the role of language and critical health literacies in health-related policies and practices affords the opportunity to investigate, rather than to assume, how imported knowledge is taken up, and possibly transformed, by recipient communities of international aid. In taking a multiliteracies perspective on HIV/AIDS education, we can understand how participants in LSE sessions might deconstruct global and local forms of knowledge, and how they develop transformative critical health literacies in the process.

The research context

I report on research that I have been carrying out since 2005 through my collaboration with the African Medical and Research Foundation (AMREF-Tanzania), a large, well-established NGO funded mostly by outside donors including USAID, Family Health International, the Swedish International Development Agency, and the European Union. AMREF describes itself as the largest indigenous NGO in Africa, with projects and offices in seven countries. Notably, in 2005, AMREF received the Gates Award for Global Health, a million dollar award given by the Bill and Melinda Gates Foundation in recognition of AMREF's contributions to the improvement of public health in Eastern and Southern Africa. The purpose of my research has been to collaborate with AMREF staff to research their educational practices and to help identify any sources of cross-cultural miscommunication due to competing cultural models. The larger aim of the research is to recommend changes in their health literacy educational practices, including their selection of educational materials, their methods of conveying LSE to community audiences, and their ways of training peer educators to communicate with target audiences (see Higgins 2009 for a focus on educational practices related to gender roles).

Tanzania is reported to have a national average of 7% prevalence rate for HIV, though the city of Dar es Salaam, the context for this article, has an average prevalence rate of 10.9% (Tanzania Commission for AIDS 2005). Notably, Tanzania is one of the 15 focus countries which has received special funding since 2003 from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The consequence of the high numbers of HIV-positive people in Dar es Salaam and the attention from PEPFAR and other similar international aid programs is that there is now a high number of programs focusing on HIV/AIDS education and prevention. 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.

The bulk of my research focuses on the Kinondoni district[5] of Dar es Salaam, which contains some of the most densely populated and poverty-stricken wards in the city. Taking an ethnographic approach, I spent a total of 4 months researching AMREF's Adolescent Sexual and Reproductive Health project in this district,

[5] The Kinondoni district houses Manzese, Mwananyamala, Tandale, and Kigogo, four wards that are notorious for high rates of crime, prostitution, illicit drinking, drug use, and harsh living conditions (Kinondoni Municipality 2007). The research I report on here comes from Tandale and Kigogo. Other parts of the district are distinctly middle and upper-class (e.g., Mikocheni, Msasani, and Sinza).

interviewing AMREF staff, collecting training materials, observing workshops, and recording educational sessions carried out by 18 different AMREF-trained CBOs. For the purpose of this article, I focus on two educational events that I recorded in which LSE was facilitated by two different CBOs.

Data analysis

To analyze cultural models in HIV/AIDS education, I focus on how participants make use of *contrast devices*, or discursive actions that show how "an argument or approach is contrasted with another in such a way that the speaker's favoured position is seen to be superior" (Hutchby and Wooffitt 1998, p. 233). These devices are used by speakers where recipients are expected to be unsympathetic or to have opposite viewpoints. The analysis of contrast devices is usually associated with discursive psychology (e.g., Speer 2002) and conversation analytic approaches which eschew the incorporation of contextual information in the analysis. However, it is important to note that similar discourse structures have taken a central role in van Dijk's (1992) critical discourse analytic investigation of positive self-representation in racist discourse, and in Gee's (1999, p. 74) research on how people produce their cultural models through "recognition work". Similar to van Dijk and Gee, I explore how contrast devices help speakers to manage different cultural models, and I do not limit my analysis to the microlevel of talk. Rather, I draw on ethnographic information gleaned from fieldwork in Tanzania to explore how contrast devices signal alignments with particular worldviews about HIV/AIDS prevention.

In the first set of excerpts below, I illustrate how an AMREF-trained educator designs his talk around a contrast device in which he skillfully uses local knowledge as a means of establishing mutual understanding with his audience. The data include instances where members of the audience label aspects of LSE as culturally irrelevant for Tanzanians, and hence irrelevant for themselves. Finally, I show how the educator finds ways to challenge these categorizations by re-entextualizing the problematic life skills through drawing on local cultural models.

Drawing on local knowledge to appropriate LSE

The first set of examples comes from an hour-long session that served as a first-time LSE lesson. The session was led by Hamisi,[6] a peer educator working in Tandale, arguably the 'roughest' ward in all of Dar es Salaam, and one that is notorious for its problems with illicit alcohol, drugs, and prostitution. The audience was comprised of a male soccer club whose members lived in Tandale and were between 18 and 25-years-old. All the members were Muslim, as was Hamisi. Though over half the Tanzanian population is Christian, Tandale is predominantly Muslim, a demographic factor that becomes relevant in my discussion of cultural models below.

Excerpt 1 illustrates how Hamisi skillfully establishes an alignment of shared understandings and shared categorizations among the group in regard to the life skill of

[6] All names are psuedonyms.

'critical thinking' (*fikra yakinifu*). This excerpt shows how the educator uses contrast devices to establish the LSE perspective towards safe sex as superior to lay perspectives, which he labels 'a misconception' (see "Appendix" for transcription conventions).

Excerpt 1: Critical thinking *(fikra yakinifu)*

1 H: *Kwamba yaani kuwa na wasichana wengi kwamba we ndo kidume. (.) Unaona*
For example, being with a lot of girls means that you are really manly.(.) You know

2 *mwenyewe sifa yaani, sawa jamani. Lakini kiuyakinifu, kuwa na*
yourself this reputation, right friends. But critically-minded, being with

3 *wanawake wengi haina maana, tupo pamoja hapa?*
many women has no meaning, are we together here?

4 Aud: *Tuko pamoja.*
We're together.

5 H: *Au (.) mtu anazungumza kabisa yaani- nyama kwa nyama. Haifai bwana,*
Or (.) if a person says that no way- skin on skin. It [condoms] doesn't work pal,

6 *yaani (.) utakulaje pipi kwenye ganda? Pipi we kwenye ganda, bwana.*
y'know (.)how can you eat candy with the wrapper? Candy with the wrapper, pal.

7 *Utamu wenyewe,(.)Pipi ina ganda. Unasemaga misemo yenu.*
The sweetness alone,(.)Candy with a wrapper. This is what people say.

8 Aud: *Ndiyo ndiyo.*
Yes, yes.

9 A: *Huwezi kuoga maji na koti la mvua hh.*
You can't take a bath wearing a raincoat hh.

10 H: *Eeh, huwezi kuoga maji na koti la mvua. Sawa? Kwamba wewe unataka*
Yes, you can't take a bath wearing a raincoat. Right? So you want

11 *nyama kwa nyama tu. Ili raha uweze kuisikia barabara kwa uzuri tu.*
skin on skin only. So that you can feel clearly the pleasure.

12 Aud: *Barabara.*
Clearly.

13 H: *Eeh. Tuko pamoja hapo. Sasa (.) hizo ni fikra mgando. Kiuyakinifu (.)*
Yes. We're together here. Now(.) this is a misconception. If we're critical (.)

14 *kufanya mapenzi au kufanya ngono pasipokutumia kinga unahatarisha*
making love or having sex without using protection endangers

15 *maisha yako.* (0.5) *Kweli si kweli.*
your life. (0.5) True or false.

16 Aud: *Ni kweli.*
It's true.

17 H: *Utamjuaje kama (.) huyu mtu ninayefanya naye ngono nyama kwa nyama*
How will you know if (.) this person I'm having sex with skin on skin

18 *ni mzima au si mzima.*
is healthy or not healthy.

19 B: *xxx*

20 C: *Yaa:ni kwa macho si rahisi yaani,*
We:ll it's not easy to tell by looking y'know,

In lines 1–3, Hamisi establishes the first part of a contrast device by comparing the idea of having sex with many partners as a 'manly' activity, and he treats this as commonsense knowledge through his assertion 'you know yourself' (lines 1–2). He then labels this way of thinking as a 'reputation' that the participants are knowledgeable about in line 2, and he establishes a shared perspective through his request for confirmation from his listeners (line 3). Next, in discussing the idea of having many sex partners and engaging in unprotected sex (lines 5–7), Hamisi confirms a mutual understanding of 'what people say' with the group, which further establishes a shared base of knowledge among this group of young men. He uses idiomatic expressions from everyday youth speech such as 'eating candy with a wrapper' to refer to negative attitudes towards safe sex, and an audience member aligns with this understanding by contributing the idiom of 'taking a bath while wearing a raincoat' (line 9). He establishes a shared perspective by asking the group what other people say and do, rather than what members of the group say or do, which would be a potentially more contentious choice. Next, he establishes a contrast by labeling these practices as misguided and dangerous (lines 13–15), and then he sets up a true/false question that requires that the young men answer in alignment with him. Hamisi has designed his talk so that it is almost impossible to disagree; that unprotected sex does not endanger lives is a ridiculous claim in Tanzania, for knowledge about the transmission routes of HIV/AIDS has saturated urban areas and is circulated in schools, in the news media, and in popular songs. Because of Hamisi's rhetorical design, the conversation seems to go smoothly and Hamisi is able to deliver his messages of prevention and responsibility. From a critical health literacy perspective, he has designed his talk to first effectively deconstruct a local ideology about condoms and secondly, to propose a new way of thinking about condoms as a way to manage high-risk sexual encounters.

The next example demonstrates how the failure to link LSE to local knowledge backfires, and the result is resistance to the lesson. The data come from the beginning of the session, when Hamisi briefly lists all of the 10 skills before going over each one in depth. His mention of the life skill of empathy (*ushirikeli*) is responded to immediately with derision.

Excerpt 2: Empathy (*Ushirikeli*)

Part a

1 H: *Ushirikeli. Yaani ushirikeli (.) >kuna tatizo la mwenzio kama lako*
Empathy. So, empathy (.) >there is a problem your friend has (and you see it as) your own

2 *nakutafuta njia ya kumsaidia kutatua hilo tatizo.< (.) Nimemaliza*
and so you search for a way to help (your friend) to solve the problem.< (.) I've finished (explaining)

3 *ushirikeli.*
empathy.

4 B: ((alveolar tongue click)) *Kwa watanzan↑ ia mambo hayo ya ushirikeli ni*
For Tanzan↑ ians (.) these empathy things are

5 *wachache. Tatizo la mtu..hh liwe kama la kwahh.ko wewe hh.=*
uncommon. The problem of anohh..ther being like your ohh.wn hh.=

6 Aud:=((laughter))

In lines 1–3, Hamisi explains empathy by reciting a definition from his training materials which describes empathy as the ability to view another's problem as one's own. This definition relates to a cultural model that arguably draws on a Christian discourse which requires one to see Christ in others and hence, to love others like the self.[7] The immediate response from the Muslim-dominated audience is cynicism, as expressed by B in the form of an alveolar tongue click, a common way of showing disdain or disagreement in Tanzania. He also labels empathy as 'uncommon' (line 5) and, using breathy speech, he reiterates Hamisi's words, revealing a doubtful stance. This is followed by laughter from the group, which has the effect of categorizing the concept of empathy as laughable. It seems likely that the notion of empathy fails to connect with these Muslim young men because of differing religious cultural models, in combination with the harsh realities of their daily lives that make empathetic problem solving difficult.

Later in the session, Hamisi returns to the life skill of empathy in order to more fully address this concept. The group's previous reactions to empathy surely led him to consider ways to reframe it in more locally relevant ways, and he began by posing a hypothetical situation:

Part b

1 H: *Na unajua hali yao pale ni duni mimi kipato changu ni kikubwa.*
So you know your relatives are very poor and that you are doing fine.

2 *Unashindwa hata siku moja unarudi unabeba kilo tano kilo kumi za*
You don't help until one day when you return and you're carrying five or ten kilograms

3 *kiroba cha unga ukawapelekea (.) >wakati ambao ukifikiria kilo tano au*
of flour to bring them (.) >while at the same time if you think about it five kilograms

4 *kilo kumi ya unga haifanani na hata nukta ya mshahara wako.<*
or ten kilograms of flour is not even a dent in your salary.<

5 A: *Ingekuwa hivyo ingekuwa raha sana.* ((smiling voice))
If it were that way life would be great.

6 H: *Umeona [sasa-*
You see [now-

7 B: *[Ushirikeli wa Tanzania hatuna.*
[In Tanzania we have no empathy.

8 A: *Nilishiwahi kukuambia Hamisi (.) nisaidie shilingi mia, mimi sijala*
I've already told you Hamisi (.) help me with one hundred shillings, I haven't eaten

9 *unashindwa.*
(and) you can't.

10 D: *Wa kwanza wewe mwenyewe (.) Hamisi.*
The first person ought to be you yourself (.) Hamisi.

11 A: *Yaani mfano mfupi kwako uko. Tusiwe tunaenda mbali nyumba ya pili.*
So the easy example is right here. Let's not go far to the second house over.

[7] My appreciation is due here to Claire Kramsch for suggesting this interpretation.

12 D: *Viazi huwa hatuli viazi. Tukikuona tukikuambia Hamisi vipi bwana.*
Potatoes, we don't normally even get to eat potatoes. When we see you Hamisi, we say, what's up.

13 *Unasema,* ((low voice, mimicking Hamisi's voice quality)) *bwana (.)*
You say, (.) pal,

14 *hali mbaya. Kuna ushirikeli ↑hapo?*
things are rough. Is there empathy ↑here?

15 A: *Ushirikeli hakuna.*
Empathy doesn't exist.

The situation Hamisi presents in lines 1–4 could fit a local cultural model, as many Tanzanians of all religious backgrounds help their extended family during hard times if they can afford it; however, the group treats the possibility of having an abundance of wealth as not grounded in their actual lives (line 5), and they focus on empathy as the problematic message (line 7). In other words, they use their own local knowledge to counter the global cultural model being offered to them. A explicitly names a time when he asked Hamisi for a small amount of money for food, but was denied (lines 8–9). The effect of calling out Hamisi as someone who does not follow his own advice here is a challenge to Hamisi's membership in a category of 'empathetic people', and it challenges the relevance of this characteristic for all Tanzanians. D echoes this sentiment, describing Hamisi as someone who has never performed the actions involved in the life skill of empathy through describing him as 'the first person' (line 10). Next, A refers to an earlier point made by Hamisi that neighbors can help each other, and redirects the focus on Hamisi's own (unempathetic) actions, effectively labeling him a hypocrite. In lines 13–14, D mimics Hamisi's 'real' voice, which can be seen as a way to establish more authenticity about how things *really* are in Tandale. Finally, the members of the group restate their stance that the global cultural model involving empathy is not 'here' (in Tanzania) and that it 'doesn't exist', and hence, is irrelevant to their lives.

After several more turns of talk, Hamisi continues to try to explain the relevance of empathy by reframing it with the audience's shared experience (Part c).

Part c

27 H: *Mimi nakiri kitu kimoja (.) kwamba ushirikeli hakuna.*
Now I admit one thing (.) that empathy doesn't exist.

28 A: *>Hilo kwa Tanzania-<*
>In Tanzania-<

29 Aud:[((overlapping talk))

30 H: [*Ah ah. Sikiliza. (.) Ushirikeli hakuna lakini hiyo hali tunaweza*
Uh uh, listen. (.) Empathy doesn't exist but we can

31 *tukatengeneza.*
change this.

32 D: *Sawasawa.*
Right on.

33 H: *Yaani mfano niliyotoa hapo tukiuzingatia (.) wangapi mnawasikia*
I mean, an example I can give that we can consider is (.) how many of you have heard (.)

34 *>kwenye gari mtu anatoa nauli< ah poa bwana. Namlipia na huyo dada*
>in a bus when someone offers to pay the fare< oh thanks friend. I pay for him and this young lady

35 *aliyepoteza nauli yake. (1.0) Hamjawahi kukutana nayo?*
who lost her bus fare. (1.0) Have you ever encountered that?

36 Aud: *Tumewahi.*
We have.

37 A: *Mimi nimeshawahi kumlipia mtu.*
I've paid for someone else.

38 H: *Hiyo ni mojawapo ya hali ya ushirikeli tunayozungumzia hapa sasa.*
So that's one of the things that we're talking about here with empathy.

39 *Sijui umenipata hapo?*
I don't know if you've got me here?

40 Aud: *Ndiyo.*
Yes.

Hamisi recaptures the floor by admitting that empathy does not exist, which appears to be a concession on his part that the young men are telling the truth about his past actions. He then begins to deconstruct the local resistance to empathy by asking how many of them have seen someone pay for another person on a bus, an act of generosity that I too have observed many times in my travels in Tanzania. In asking a yes/no question at the end of this example, Hamisi provides a structure for agreement, and for the first time, the group responds in a positive manner with regard to this life skill. In framing empathy as an act of helping out those in need, Hamisi localizes the concept of empathy by treating it as an *action*, rather than as a *feeling* which inspires action. Taking actions to help those in need likely fits the young men's local cultural model much better, as it conforms to the Muslim tenet of *sadaka* ('charity to the poor'). From a critical health literacy viewpoint, Hamisi succeeds in transforming the health knowledge from a generalized concept of empathy to a Muslim-centered worldview. Moreover, the example is economically feasible, given the relatively small cost of a bus fare. In the end, then, Hamisi succeeds in getting the skeptical participants to consider the concept of empathy as something relevant to their lives by drawing on experiences he knows they can all identify with.

Resistance to educators' efforts to localize LSE

The next set of excerpts illustrates how AMREF-trained educators working for a different CBO were not as successful in localizing LSE. The main reason for their lack of success was their inability to portray the life skill of 'self-control' (*kuhimili mihemko*) as a culturally salient concept in the context of discussing appropriate ways to respond to sexual temptations. From a critical health literacy perspective, they failed to deconstruct the discourses surrounding the resistance, and they failed to transform the LSE messages by localizing them in acceptable ways. Their session took place in Kigogo, another ward in Dar es Salaam characterized by high levels of poverty, high unemployment, prostitution, and frequent abuse of alcohol (Kinondoni Municipality 2007). The educators (Bausi, Adam, Neema, and Fatma, and several others) had set up at the end of the day in a trading center where truckers

delivered produce from other regions of the country and where small traders purchased their supplies of these goods. While Bausi and Adam led the session, their female colleagues sat on a bench and listened attentively. These young women were dressed in form-fitting jeans and t-shirts, and their clothing became topical for one male audience member who appeared to be in his 50s (in Swahili, he would be called *mzee,* a respectful term for an elder).

Using a loudspeaker, Bausi and Adam asked anyone listening to offer their opinions on how to stop the spread of HIV. The *mzee* took an interest in the invitation to express his opinion by pointing out what he saw as a discrepancy between the CBO's messages of prevention and awareness and what he deemed to be a sexualized presentation of the (female) CBO members themselves. In (3a), Fatma dismisses the *mzee*'s depiction of everyday realities by rejecting clothing as the cause of desire.

Excerpt 3: Self-control (*Kuhimili mihemko*)

Part a

1 F: *Unajua kufanya ngono zembe ni tamaa ya mtu binafsi. Mavazi hayawezi*
You know that having reckless sex happens because of individual desire. Clothing cannot

2 *kumchochea mtu akafanya ngono <hata siku moja.>*
cause someone to have sex, <not [ever.>

3 N: [*Kweli.*
[Right.

4 B: *Haya jamani. Ngono zembe ni tamaa ya mtu binafsi. Babu, unasemaje?*
Okay everyone. Reckless sex happens because of individual desire. Grandfather, what do you say?

5 M: *Nasema hivi. Mtu akivaa inaweza ikamleta mtu tam↑ aa maanake akivaa*
I'm saying this. If a person dresses like that, it can cause des↑ ire meaning if she dresses

6 *nguo ilivyombana matako yanatoka nje. Na kwa nini i↑ bane matako? Na*
in clothing that is really tight around her buttocks. Why does it have to gr↑ ip her buttocks? And

7 *unakuta wasichana wengine wamevaa utumbo bado uko wazi kitovu kiko*
you find other girls who dress with their navels

8 *wazi. Na shangaa inaonekana na chupi kinaonekana. Ina maana wanaleta*
exposed. And you can see their beads and their underwear. This means that they bring

9 *vishawishi.*
temptation.

The *mzee* is not impressed with Fatma's argument, and he asserts once more that women's clothing 'brings temptation' (lines 8–9) and causes sexual promiscuity. His comment relates well to differing cultural models for self-control based on religious ideologies, and to Becker's (2007) point that many Christian Tanzanians describe *zinaa* ('sexual desire') as a force that is not necessarily controllable through human action, and hence is seen as a consequence of a corrupt society. In contrast, many Tanzanian Muslims evaluate behaviors that break with *sheria* as acts that are controllable through human action and associated with human weakness (Becker 2007, p. 35).

Instead of taking issue with this line of logic, Neema asks the *mzee* to consider his own circumstances at home in an effort to challenge his representation of desire, which can be seen as her effort to relocate the discussion to a very personal realm of his life and to create a discussion based on highly localized experience.

Part b

28 N: *=Licha ya mitego, akina dada, je, mtoto wako binafsi amekaa uchi,*
=Aside from us girls being 'traps,' now, if your own child were sitting naked,

29 *uta↑ mtamani?*
would you desire ↑her?

30 B: *Ah hah. Swali hiyo. Mwanao kakaa uchi, Babu, eh tunaomba ulijibu*
Ah yes. This question. If your child sat naked, Grandfather, we ask that you answer that if your child sat naked

31 *mwanao kakaa uchi utamtamani.*
if you would desire her.

32 M: *Kuna wazee wamebaka watoto wao. Kuna vishawishi vinakuwepo.*
There are men who have forced their sex on their children. There are temptations that are there.

[. . .]

36 *Na sasa ukivaa vibaya, au mtoto wako kakaa uchi, au mtoto wako*
If you dress without respect, or if your child is sitting naked, or if your child

37 *anakubali kavaa nguo au suruali inayombana kakaa pale nyumbani,*
agrees to wear clothes or trousers that are tight in the home,

38 *inaleta mambo mengine. Ndiyo maana >hata kwenye Biblia< inasema Luti*
it brings on these things. That's why >even in the Bible< it says that Lot,

39 *ali ali- watoto binti zake walitegemeana kwamba wakalala naye wakapata*
he- he- his daughters planned to sleep with him in order to get

40 *mimba. Kwa hiyo kwa nini isi- si- nanii, is- vishawishi iwe ifanye*
pregnant. Therefore, why not- no- uh, te- temptations cause

41 *nini? Ufanye ngono, inawezekana?*
what? They cause you to have sex, don't they?

To highlight her point about self-control, Neema asks the *mzee* to consider whether his own child's nakedness would incite his sexual desire, a clever attempt to deconstruct his resistance to the LSE topic of self-control. However, he does not respond in accord with this logic and instead, he cites a biblical story that supports the idea that women are the agents of sexual desire. He references the story of Lot (lines 38–40), who, according to the Book of Genesis, had fled the city of Sodom with his two daughters before God demolished it. Lot's daughters believed that their family was the only one to survive the devastation, and hence, they forced their father to drink alcohol so that they could have sexual relations with him in order to keep the human race alive. In citing this story, the *mzee* uses circulating discourses of Christianity to challenge the relevance of self-control, and in so doing, he invokes the local knowledge of Christian discourse to provide evidence for his claims that men are the victims of female desire and societal change.

Adam, one of the primary educators of the CBO (who is Christian), responds next, and he takes issue with the *mzee*'s representation of the story of Lot.

Part c

40 A: *Lakini ukirejelea vizuri ile mada mimba ya watoto wa Luti, (.)*
But if you review the teaching of Lot's children, (.)

41 *ilisababishwa na tamaa zao binafsi. Kwa hiyo tunarudi palepale (.)*
it was caused by their own personal desires. If we return to that place (.)

42 *Luti hakuwa na kosa lolote katika kufanya mapenzi na binti zake. Kwa*
Lot was innocent in the act of making love with with his daughters.

43 *sababu yeye alipanda nao mlimani kule walikokuwa wakiishi, watoto kwa*
For he climbed the mountain with them and there where they were living, his daughters,

44 *tamaa zao za mwili, wakafanya mapenzi na baba yao. Hali ya kuwa wakiwa*
with the desire of their bodies, they had sex with their father. In order to do that

45 *wamemlewesha. Sasa (.) basi hata kama ikiwa mtu akitembea uchi, kwenda*
they got him drunk. Now (.) even if a person walks around naked, if you

46 *kumbaka ni tamaaa zako binafsi. Sasa (.) basi ni nini cha kufanya ni*
force yourself on them it's because of your own personal lust. Now (.) what can you do

47 *kuhimili tamaa zako za mwili, au kuhimili mihemko yako.*
to control your desire, to control yourself, or your sexual feelings.

[. . .]

49 *Vile vile kama kuna watu wamepita hata Kigogo hapa, kwa wale wasichana*
Now as we see when people pass through Kigogo here, there are girls

50 *ambao wanauza miili yao >kuna vijana wengine mpaka unaona dhambi*
who sell their bodies >there are some youth who see it as a sin

51 *kutumia condom ukiwa nao<. Nani amejaribu hata kufanya tafiti juu ya*
to have sex with them even using condoms<. Who has tried to research

hilo? Sasa basi kufanya chochote- kumbe inaelekea inatokana na mtu
this problem? Now, doing anything at all- hey it derives from it comes from each person

52 *binafsi. Haijalishi umetegwa, haijalishi una njaa ya kitu fulani,*
themself. This is true even if you have been ensnared, it's true if you have a certain kind of (sexual) hunger,

53 *lakini inatupasa sisi turudi hapahapa kwenye kuwa makini juu ya*
but that's why it's necessary that we repeat this right here while being clear about

54 *maswala yoyote yote yanayozunguzwa,=*
all these topics that we are discussing,=

55 M: *=na vishawishi vikataliwe.*
=and temptations should be stopped.

Taking the perspective that language policy work includes the opportunity to develop critical literacies, it is important to deconstruct how the health literacies and cultural models are being articulated in this session. In responding to the *mzee*, Adam expresses the rationalist (and WHO-sanctioned) perspective that personal desire is

something that can be controlled by individuals, and he explains that the story of Lot shows how the daughters failed to use their own self-control and gave in to 'their own personal desires' (line 41). After reproducing self-control as a central tenet of the global cultural model, he then moves on to address local cultural models by comparing the biblical tale with an example from the Kigogo community (line 49). He states that many young men in the area do not fall victim to sexual relations with prostitutes, and he describes their actions as the result of their own rational choices rather than due to the pressures of scheming women or uncontrollable sexual urges (lines 51–52). In spite of this line of reasoning, the *mzee* responds by reiterating his stance that temptations are the source of the problem, and at that point, the lesson became permanently derailed. The issue of how to interpret the biblical story was not resolved, and after further attempts to illustrate the life skill of self-control through more discussion of local religious leaders who gave into their own lust, the educators abandoned the topic. Later in an interview with Bausi and Adam, both expressed frustration with their inability to sway the *mzee* to open himself to the possibility of reconsidering the source of temptation, and both described him as permanently stuck in his way of thinking. With regard to critical health literacies, very little changed during this session since competing viewpoints did not yield new forms of knowledge about sexual health and HIV/AIDS prevention.

Discussion

In order to engage their audiences in critical health literacy practices, HIV/AIDS educators such as Hamisi and Adam seem to only be successful if they demonstrate the relevance of local knowledge in the global curriculum of life skills, and if they find ways to transform resistance to global cultural models through appropriating and localizing their messages of prevention. The excerpts examined above are representative of a larger pattern that I observed across a number of LSE sessions. Generally, I noticed that the educators who experienced greater tolerance for their ideas by their target audiences often began with local knowledge by telling or eliciting a personal story, or by describing events which were identified as common experiences among both the audience participants and the educators. This pattern is observable in Hamisi's interactions with the soccer club in Example (1), where he began by checking the young men's understandings of 'manly' behavior by drawing on shared expressions for unsafe sex. This pattern is observable in Example (2) as well, for Hamisi eventually manages to reestablish shared knowledge by the group by drawing on the example of paying for someone's bus fare. However, when the educators in Kigogo (Example 3) did not establish their own contrast devices by first describing examples of local practices that they could later challenge, and which their audience could relate to, they failed to instill an atmosphere of open-minded consideration for their WHO policy-based ideas.

These findings suggest that educators and health policy makers would benefit from reconsidering the importance of language and communication in engaging their target audiences in discussions of health and HIV/AIDS prevention. While certain educators such as Hamisi seem to have an intuitive ability to engage

audiences by drawing primarily on local knowledge, others tend to follow the LSE curriculum rather strictly. Strict adherence to the global cultural model in LSE not only seems to alienate audiences, but it also appears to dissuade audience members from fully engaging in critical discussions of how to address the local social, economic, and environmental determinants of risks to their health. Therefore, from a pedagogical perspective that values LSE as an effective tool in battling HIV/AIDS, the implications here are that educators will be more effective in spreading their messages of prevention if they can establish a shared understanding of the local societal problems that their target audiences face, and if they can use local cultural models in teaching life skills. In other words, more inclusion of local knowledge in a globalized health curriculum is likely to yield more culturally relevant pedagogy. The inclusion of cultural models based on religious beliefs should not be excluded here, as the data show that local knowledge may frequently draw on Christian, Muslim, and Indigenous discourses. It should be noted that, in spite of this likelihood, AMREF's training materials on LSE (which are directly based on WHO guidelines) do not discuss religion in any manner. Clearly, language-in-healthcare practices such as the LSE curriculum would be better off if policymakers would reconsider their secular approaches, particularly in nations such as Tanzania, where most people have a religious affiliation.

On the other hand, it is arguable that even with the inclusion of local knowledge, LSE utilizes an approach that is overly rationalist in nature for developing nations such as Tanzania. Rather than talking about material constraints such as poverty, gender inequality, and joblessness, LSE operates on the basis that talk is the solution to real-world problems. Because LSE was borne on a rationalist ideology in which knowledge leads to empowerment, the structural constraints of lived, local experience are entirely excluded from educational sessions. It is clearly difficult for people living under the duress of poverty to prioritize self-awareness, relationship skills, and stress management when they are struggling to make ends meet or, as in the case of many Tanzanian women, if they have little control over their sexual relationships (Bujra and Baylies 2000). Talk alone is not the solution.

As Boler and Aggleton (2005) recommend, the best way forward may well be a two-pronged approach that promotes critical health literacies in the form of culturally relevant dialogue as well as finding ways to address the structural problems that people face in their everyday lives. Tanzanians who are at high risk for HIV/AIDS can be empowered to assert themselves, control their desires, and be empathetic to others in need, but without greater attention to the material and structural challenges they routinely face, they are likely to lack the will to even engage in dialogue about such skill-based paths to empowerment.

Conclusion

Through an analysis of the articulation of critical health literacies in LSE sessions, this article has argued that language policy and planning efforts in healthcare and health education contexts ought to address issues beyond functional health literacy. In addition to providing people with language access, language planning and policy

efforts should be concerned with providing opportunities to develop critical health literacies since they provide individuals with the abilities to take actions to deconstruct, interpret, and transform their understandings of health problems within their social contexts. HIV/AIDS educators, NGO administrators, and health policymakers would benefit from considering how WHO-sanctioned health policies such as LSE are languaged in actual prevention and awareness sessions if they expect LSE to prove successful in battling HIV/AIDS. Since economic solutions are unlikely to develop in a short period of time in resource-poor nations, education in the form of critical health literacy practices remains the single-most important weapon in prevention, but education cannot be effective if target populations resist it or find it culturally inappropriate.

Awareness of the clashes between the global cultural model of LSE and the local cultural models articulated in audience resistance can lead to improved policymaking and peer education practices. Policymakers and educators should find more ways to include local cultural models in policies that seek to transform health problems and risks in order to engage with audiences. As the data in this article have shown, drawing on local worldviews to appropriate the messages of LSE for local contexts is an effective way to challenge the hegemony of global health policies while engaging in critical literacy practices that can possibly transform the social conditions that put people at risk for contracting diseases like HIV/AIDS.

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Appendix (adapted from Atkinson and Heritage 1984)

>talk<	Rapid speech
<talk>	Slowed speech
talk	Emphasis
[	Overlapped speech
[…]	Omitted talk
:	Sound stretch
.	Falling intonation
?	Rising intonation
,	Continuing intonation
-	Cut-off speech
hh	Outbreath
=	Latched speech
↑	Pitch rise
(.)	Micropause
(1.0)	Timed pause
(xxx)	Unintelligible talk
((comments))	Clarifications or descriptive comments provided by the author

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