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MULTIPLE VOICES IN HIV AND AIDS:
A Comparison of the Discourses of Christian Religion and Public Health

By
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A Thesis
Submitted to the Faculty of Graduate Studies and Research
through Sociology
in Partial Fulfillment of the Requirements for
the Degree of Masters of Arts at the
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ABSTRACT

Concern over the devastating effects of HIV and AIDS in Africa has inspired many organizations to develop intervention programmes that aim to reduce the impact and spread of this pandemic. Since none of these programmes is likely to have been created in isolation, the particular socio-cultural experiences and institutional affiliations of the author(s) would have some influence on the ultimate content. This can be problematic within the contested regions of HIV prevention programming, particularly when interventions representing different institutions with conflicting perspectives coexist in a community. The task of this research project is look at two particular institutional voices which are often viewed as conflicting – Christian religion and public health. By comparing the discourses of these institutions as they are presented in programmes which target youth in Kenya, similarities and differences are identified providing suggestions of existing spaces for dialogue between these organizations.
DEDICATION

To my husband and daughter who have been patient and supportive of my efforts to complete this work.
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INTRODUCTION

When confronted with a problem, individuals frequently attempt to resolve the situation on their own. Failing that, they look for help. To whom they turn for assistance depends on multiple factors, including their perceptions about who has the authority, knowledge, and ability to respond effectively. Depending on the extent of the problem, a variety of sources may be entertained. However, it is possible that each of these sources may represent a different perspective on the situation. These variations exist, in part, because of differences in philosophies and methodologies which often raise distinct sets of questions, and hence, responses around any particular situation. The result may be that the messages delivered are different, creating confusion and competition between these voices.

HIV and AIDS is a problem that individuals cannot address on their own. Since this syndrome was identified by the Centres for Disease Control (CDC) in 1982, AIDS has devastated communities across the globe. Reports from UNAIDS (2003) suggest that approximately 27.9 million people have died of AIDS, with another 42 million living with the syndrome by the end of 2002. The biological and social impacts of this epidemic, as well as the economic and political factors which often fuel the ways that communities become infected and affected makes it highly unlikely that a single person or community can address this situation without some external support. Therefore, multiple sources become reference points for information, support and advice around how to best address the extent and impact of this epidemic.

Affecting the health of individuals and communities, it is not surprising that people have turned to public health for a response to HIV and AIDS. Where religion is recognized
as a source for meaning-making, people have also turned to their religious leaders. Each of these voices has a specific world view, with its inherent anthropology, philosophy and methodology through which they encounter this epidemic and subsequently respond to it and the people affected by it. For public health, the focus is on the ideal of good health for all achieved through rational decision-making processes. Alternatively, religion is primarily about faith. For Christian religions this includes a faith in a Triune God which is expressed through the traditions and scriptural precepts accepted by the specific denomination, providing the framework through which individuals and communities are expected to live in relationship with each other, the world and God. These differing perspectives have led to unique responses from these organizations which have become fuel for conflict between them, particularly where there is a disagreement between the rational and faith-based decision-making processes. The result can create confusion among those who recognize both of these groups as authoritative, leaving individuals and communities uncertain about how to respond effectively to the crisis at hand.

Although this disjuncture between public health and Christian religion existed long before the identification of AIDS, the unique way in which perceptions of this syndrome have combined blood, sexuality and death seems to further emphasize the philosophical and methodological differences between these groups. Specifically, knowing that AIDS was originally identified as a result of an investigation into ‘opportunistic’ diseases that were affecting what seemed to be otherwise healthy homosexual males in New York, Los Angeles and San Francisco, a connection between AIDS and sexuality – particularly what, by many, was considered ‘abnormal’ sexual behaviour – was hypothesized. The discovery of HIV and
AIDS among sex workers, and individuals engaging in extra-marital and/or multiple partner sexual behaviours, tends to further this connection. Despite the fact that there are multiple alternative avenues for the transmission and acquisition of HIV, this connection with sexuality remains the strongest. Consequently, HIV and AIDS has become imbued with a moral discourse. Where sexuality is considered simply one potential risk factor, public health is expected to teach ways in which to reduce one's individual risk and make it a moral imperative for individuals to do so for the sake of themselves and the community. Where views of sexuality are based in Christian morality, religion is expected to provide a framework to guide behavioural practices of individuals and communities, establishing behaviours outside of this framework as deviant and unacceptable to the community. These expected responses are fuelled by the social constructions of both public health and Christian religion within any one region.

Just as the social constructions of these institutions may differ across the globe, the global impact of HIV and AIDS places their responses in multiple cultural contexts which can further inform the disjuncture between public health and Christian religion. This can lead to further tension and confusion as the messages from both sides attempt to fit into these various contexts in ways that are consistent with people’s perceptions about their roles, attitudes and behaviours. Consequently, there is an ongoing need for organizations which draw upon the philosophies and methodologies of public health and Christian religion to reflexively consider the ways that they are influenced by and influencing AIDS and AIDS-related knowledge. Since public health and Christianity are themselves social construction, this consideration can be enhanced by recognizing the ways that public health, Christian
religion and culture influence each other and society. By assuming that no single institution functions as the authoritative voice in the construction of knowledge, organizations which are willing to show respect towards and/or enter into dialogue with the other influential voices may be able to develop messages that are better received and understood by local populations.

Africa presents a particularly interesting venue in which to explore the social construction of HIV and AIDS through the discourses of public health and Christian religion. Its historical relationships to these institutions through colonization and the evangelizing missions have evolved so that despite the political independence of many of African countries, both of these institutions remain authoritative voices. Consequently, each of these institutions is powerful, each has a particular role to play in society and hence, in the construction of AIDS and AIDS-related knowledge.

As well, collectively, African countries are over-represented statistically with respect to poverty and disease. Not only has this impacted their development potential, but it has also meant that they have access to limited resources in order to fight this pandemic (Raj et al., 1999). This has inspired multiple appeals to the international and local communities to assist these countries by sharing knowledge and available resources. Among the variety of responses received are those from public health and Christian religion.

Although the institutions of public health and Christian religion are powerful within the African communities, even these must exist within the cultural context through which the African people have survived the various forms of colonization and monopolization. That rich culture continues to play a role in the ways that individuals and communities interrelate
and understand their world. It is within the tensions of these multiple voices that any HIV and AIDS intervention must work. Therefore, even though these programmes may be attempting to construct a particular view of HIV and AIDS, they must always be aware of the cultural constructions around them so that they can meet the people where they are at, and give them information according to what they can hear.

It is within this context that it becomes particularly important to acknowledge the disjunctures that exist between any potentially authoritative voices – such as public health, Christian religion and culture. Conflict and tension between these could lead to confusion, uncertainty and even mistrust among those who receive messages from more than one source. Consequently, establishing some form of dialogue between these groups may help increase the efficacy of the messages delivered. One potential starting point for dialogue is the mutual recognition of the specific philosophies and methodologies of both groups which, in turn, provide the foundation for programming. This should then expand to an appreciation of the ways each group applies its perspectives within their own interventions. In this way, despite the existence of differences, there may be room for dialogue based on the similarities which exist. It is within this space that the organizations referencing these differing perspectives may enter into some level of cooperation, thereby reducing the tension and competition that may have once existed.

Since public health and Christian religion both function as institutions at a global level, their general philosophies and methodologies are accessible. The same cannot be said about culture because it is not institutionalized on a global scale. Therefore, there are many variations in terms of beliefs and practices which cannot be simplified in the same way.
Thus, the goal of this project is to analyse the discourses of public health and Christian religion around HIV and AIDS in the hopes of providing a framework in which a potential dialogue between these voices may be initiated.
HIV AND AIDS INTERVENTIONS, CONSTRUCTING AND CONSTRUCTED: A THEORETICAL FRAMEWORK

AIDS. In the 20 years since it was identified and named, the ways that individuals, communities and the world itself have come to encounter HIV and AIDS have had a powerful influence on the development of meanings and symbols around this epidemic. Death is one of the realities that frequently comes to mind. Death on a global scale, with more than 27 million having already lost their lives (UNAIDS 2002). Death on a local scale, particularly in some of the hardest hit countries in Africa, where communities are being devastated by this pandemic. And death on an individual level, as the ultimate outcome of developing AIDS. Sexuality is also intimately linked to this syndrome inviting moralization into the interpretations of the affects of HIV and AIDS. It is also a truly global epidemic, having spread to all corners of the world so that no place remains unaffected.

These are only some of the experiences associated with HIV and AIDS. To some extent, these are simply the result of a series of biological events as a virus infects the body of an individual, disrupting its normal processes and creating chaos from within. For those with adequate access to health care, food and support, the full impact of this infection may take years, even decades to develop. For those in countries with weakened health care systems and high poverty rates, the impact can be quick and devastating. Yet, regardless of one’s social, political or geographic context, HIV sets in motion a process which causes a failure in the body’s natural physiological barriers. This often leads to the development of AIDS and, ultimately, death.
The infected body does not, however, exist in isolation. The experience of illness is a social one such that a single incidence of HIV can affect an entire community and beyond. In their encounter with the biological virus people search for meaning using the tools of meaning-making that already exist in their societies (Williamson 1989). In doing so, HIV and AIDS encounter the voices and structures of meaning-making, including the local culture.

Out of this impact between HIV and AIDS and society a foundation is established on which systems of individual and social beliefs about this epidemic are built. The symbols and metaphors used to describe this encounter are constructed and mediated through multiple voices, some of which function solely at a local level, while others are more nationally and/or internationally focussed. These include the media, art, politics, religion, medicine and even the bureaucratic machinery which aims to protect society against invasion – both viral and human (Barbour and Huby 1998). These institutions and their more local organizations sometimes work together, and other times compete against each other so that the work of meaning-making around AIDS is imbedded within a particularly complex social structure. Yet through balance and interpretation of the messages presented, a mere biological virus becomes imbued with meanings.

From a sociological perspective, the process through which experiences of HIV and AIDS become meaningful is another example of the ways that individuals and communities socially construct their knowledge about the world around them. Looking to Berger and Luckmann’s text on The Social Construction of Reality (1966), reality is defined as “...a quality appertaining to phenomena that we recognize as having a being independent of our
own volition (we cannot ‘wish them away’)" (1). Thus, reality is something which exists beyond our perceptions or mere beliefs about it. They define knowledge as “...the certainty that phenomena are real and that they possess specific characteristics” (1). For the average person on the street then, knowledge is really about that which he/she comes to believe is true based upon experiences and other information gathered around the given phenomena.

Perceptions of HIV and AIDS represent plausible examples of reality and knowledge as these are defined by Berger and Luckmann. With respect to the former, the biological experience of this syndrome has a quality which is independent of volition. Although the virus may not be seen by the naked eye, it nonetheless exists and impacts the lives of millions around the world such that, as much as many would like to ‘wish it away’, it hasn’t happened yet. With respect to the definition of ‘knowledge’, while most people recognize HIV and AIDS as biological fact, they also ascribe to it characteristics which are influenced by the particular social situation. In this way, what many people have come to ‘know’ about HIV today is that it is a virus that is transmitted through infected body fluids, primarily via certain sexual practices generally undertaken by particular groups of people, with each community having its own definition of what constitutes a ‘high risk’ group. Infection with HIV frequently leads to AIDS, which leads to death. It is through these perceptions which are understood as ‘knowledge’ about HIV and AIDS that the scientist, philosopher or individual person has been able to find relevance in this syndrome.

Using these definitions of reality and knowledge, Berger and Luckmann argue that knowledge of reality is developed, transmitted and maintained within social situations. It is within this social context that ‘knowledge’ becomes imbued with meaning so that it is always
‘knowledge’ from a certain position (Berger & Luckmann 1966). In various ways, these positions are influenced by the multiple voices – including folk or popular culture, religion, medicine and politics – which are prevalent within any one particular society. Within a contemporary context, this has also included the voices of those who often have competing visions of society ranging from traditional bodies and institutions, to the ‘New Right’ and the (homo) sexual counter-revolution (Brown:2000:1274). Each of these voices has, in turn, contributed its perspective to the complex social quilt in which the world encounters HIV and AIDS.

Acknowledging that HIV and AIDS is a global epidemic, it is necessary to recognize the variety of contexts in which knowledge about HIV and AIDS has been and continues to be constructed. For example, when HIV and AIDS were first encountered in North America and Western Europe, it was predominantly among gay males. Following this initial identification, perceptions around who was most ‘at risk’ changed. For example, Patton (1996) suggests that in the United States, drug injectors, homeless people, black people and sex workers were all eventually targeted by prevention programmes. Doing so compounded the stigma and discrimination which already existed for these groups while individuals who didn’t identify with one of these ‘high risk’ groups were expected to be compassionate and tolerant towards these people, without viewing themselves as vulnerable even though some of their best friends may have had AIDS (Patton1996:8).

As a result of their distinct context, African countries have encountered HIV and AIDS in ways that are different from their ‘Western’ counterparts. This encounter must in some way recognize that local practices themselves, including polygamy, wife inheritance,
gender role differences and female circumcision, contribute to the transmission of the virus. As well, the inherent power differentials between African and Western countries which result in increased poverty and lower access to health care, nutrition and education for the former, reinforce the specific dimensions of vulnerability that exist in Africa (Maticka-Tyndale 2001). Throughout Africa, this vulnerability extends beyond the particular individual such that AIDS is viewed as a threat not only to the survival of the person, but also the family, community and even the nation. This context affects the ways that communities in Africa have come to view HIV and AIDS including who is defined as ‘at risk’ and the extent to which any one individual, family or community is willing to acknowledge the presence of HIV and AIDS in their midst.

Whether in North America or Africa, the experiences which arise out of that context results in individuals encountering this epidemic as part of their everyday lives. The interpretation of these encounters helps to form a foundation on which meanings can be developed. In this way, individuals often find themselves interpreting HIV and AIDS within the context of their own social situation in an effort to make it subjectively meaningful as part of their coherent world (Berger & Luckmann 1966:19). These perceptions and the associated experiences also play a role in shaping the face of HIV and AIDS within any one particular community.

This process of meaning making is also influenced by and influences the institutional structures which develop intervention programmes to address the impact and spread of the epidemic. Programmes influence this process by providing information and experiences through a particular presentation of the ways in which HIV and AIDS can be conceptualized,
represented and responded to. These practices become the primary ways in which individuals and communities come to know this syndrome (Crimp 1989). Alternatively, these programmes and the institutions and organizations which produce them, are influenced by the meaning making process in that they must exist and function within the social context and are therefore, themselves products of it. This is highlighted by Berger and Luckmann’s description of the social construction of institutions.

According to Berger and Luckmann (1966), institutions exist as part of a particular historical process. As individuals within a particular social and historical context engage in behaviours, these behaviours evolve into normalized patterns and habits. These patterns can then become institutionalized. The resulting institutions then aim to control human behaviour according to the predefined patterns of conduct (1966:55). Outside of the particular historical and geographic context in which the institution evolved, it becomes external to the life of the individual so that he or she must ‘go out’ and learn about it. In doing so, he/she brings in his/her own cultural experiences and perspectives so that what becomes ‘known’ about the institution and its patterns of conduct is really a hybrid of what was originally established. Since part of this interpretive process includes an understanding of the authority of the institution to establish these patterns of conduct, the potential for deviance from this ‘programmed’ course of action increases as the institution becomes divorced from its original context (Berger and Luckmann 1966). In this way, the authority of each of the multiple institutions which lend voices to the social construction of reality – such as with HIV and AIDS – becomes mediated by the experiences and perceptions of the individual and community.
The authority of these institutions is further mediated by perceptions and understandings of risk. Recognizing that HIV and AIDS programming is often directed towards ‘high risk’ groups and/or ‘high risk’ behaviours, how communities and individuals balance the resulting perceptions of risk with their own social and cultural traditions becomes important. Risk theory recognizes the complicated path through which information about risk becomes socially constructed and transformed into behaviour. Through this process it is understood that the institutions delivering messages about individual risk do not have absolute control over the actions of individuals and communities. This is linked to the recognition that the ability of the rational scientific approach to produce certainty is limited by its own basic principles of scientific advance – that even the most cherished theories and beliefs are perpetually open to revision (Giddens 1998:24). The result is an unending spiral of information from the scientific community from which individuals and communities must make decisions about how to perceive risks and what acceptable levels of risk might be.

This process can be further compounded by the presence of multiple institutions and/or voices of authority which influence interpretations about appropriate risk levels and behaviours. Including traditional authorities, religion, medical science and culture, each of these voices also makes claims about the authority of its message despite the possibility of variations between voices. As a result of the confusing and conflicting messages individuals and communities receive from these claimants to authority, even the voices of the most powerful institutions can come to be seen as merely individual voices within an indefinite pluralism of expertise (Giddens 1991:195). Consequently, any one particular position can be reduced to ‘specialist advice’, decreasing its perceived weight and increasing the potential
for deviance. This is particularly highlighted in the tension between Western medical institutions and the local voices of culture, tradition and religion as they relate to health and risks for illness.

From a medical, scientific, rational perspective, disease is a malfunction within the biological and/or psychological processes (Kleinman 1980:72). In this view, medical practitioners are implicated as the primary voices in the construction of diseases (Kleinman 1988:5). The assumption that these practitioners are rational and scientific in their approach to healing, often leads to the perception that they should also believe that disease and healing must be explicable and understandable on the basis of natural laws — that is, disease and healing must also be rational and scientific. In this way, the ontological construction of disease by the medical and scientific community is that it is a malfunctioning in the normal state of being. This breakdown mandates heroic, aggressive, primarily biomedical measures against it so that, “the patient becomes the battlefield where the foreign invader and the medical warriors do battle” (Kinsley 1996:170).

Medical anthropology/sociology differentiates between illness and disease with illness conceptualized as the psychosocial, personal and social responses to and experiences of this biological and/or psychological malfunctioning (Kleinman 1980:72). From this perspective, the construction of illness widens to include the ways that individuals and communities experience, are affected by, and respond to a particular disease. Thus, the experience of the biological disease is socially mediated (Barbour and Huby 1998:6) with medicine only one of the cultural systems, although most often the dominant one, that defines and influences this experience. In so far as medicine has been institutionalized, its voice not only influences,
but is also influenced by the social context in which it exists. That is, medicine itself is a system of symbolic meanings based upon particular arrangements of social institutions and patterns of interpersonal interactions which systematically interconnect all facets of illness, from individuals and their experiences of it, to those treating it and the social institutions relating to it (Kleinman 1980:24).

Recognizing the extent to which perceptions of health and illness exist within and become part of the social context, it seems inevitable that the cultural system of medicine must intersect with at least some of the other cultural systems, including religion, language and/or kinship. Although each of these voices prefers to believe it is the dominant one, the degree to which any one individual or community accepts its authority varies according to the influence of cultural and subcultural belief systems and power hierarchies that ascribe different degrees of authority and differentially provide space to each. This attempt to balance the influence of various voices becomes more complex in contested regions including understandings of sexuality and relationships. Consequently, the efficacy of programmes which are based in one position or the other, can be impacted by the ways that authority is understood. This can be exemplified by the ongoing tensions between public health and Christian religion around condoms, inviting uncertainty and confusion among individuals and communities around the effectiveness of this prevention technique. Consequently, the efficacy of health interventions around HIV and AIDS is affected by this disjuncture.

Ultimately, the physical and biological impact of HIV and AIDS has been experienced across the globe, challenging societies, and medical institutions in particular, to respond with intervention programmes. Yet, as the work of social construction theorists and other

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sociologists of health and illness demonstrate, experiences of this syndrome are mediated through various cultural and social contexts. What individuals think is real, and how it is explained and understood is further constructed and filtered by their own experiences and relationship to the world. Thus, institutional discourses on AIDS and AIDS-related knowledge are influenced by and influencing the social construction of the pandemic.

Given that HIV and AIDS are closely connected to sex because it is identified as the most frequent vehicle for the transmission and acquisition of HIV, it is also important to recognize the multiple voices which contribute to the social construction of sexuality. Since these voices can influence individual and communal perceptions and definitions of appropriate sexual behaviours, they can also impact assessments of risk, and therefore, behaviour. However, parallel to the voices constructed by and constructing information on HIV and AIDS, the voices which contribute to the construction of sexuality are also influenced by the social construction of knowledge within the context in which they exist. Recognizing these cyclical processes it becomes important for any institution or organization to consider the ways that the programmes produced are influenced by and influencing the social construction of HIV and AIDS and sexuality. In effect, doing so reflexively may help to raise questions around the role of other voices involved in shaping attitudes and behaviours. The result may be a more comprehensive, rather than competitive, approach to HIV and AIDS interventions.

**The Perspective of Public Health**

One of the most influential institutions involved in preparing and delivering intervention programmes on HIV and AIDS is public health. Indeed, because HIV infects
individuals at a biological level resulting in health consequences, public health has essentially been involved from the beginning of the epidemic. As an institution, public health functions as an external reality with its own socially constructed history. Out of this construction has evolved particular philosophies and methodologies which are then used to explore HIV and AIDS. It is this context which becomes the foundation for public health intervention programming.

In order to identify the basic philosophical perspective of public health, it is necessary to consider its role in society. As a science-based discipline, the understanding is that public health experts are the ones who define what constitutes health and what activities may jeopardize it. From this viewpoint it can be argued that the ideological underpinnings of this institution are based in the utilitarian objective to obtain continuing good health for all (Lupton 1995:2, Brown 2000). One of the ways in which this is accomplished is through an emphasis on particular practices of the self, including diet and lifestyle choices, which are supposed to lead to “healthiness”. It is expected that the desire for ‘good health’ – as it is defined by the public health experts – is widely shared and, consequently, that people will readily engage in a rational decision-making process and take up practices that foster/ensure/contribute to good health. This rational decision-making process is treated as the yardstick of accomplishment and proper living as measured by the health practices of the individual (Lupton 1995).

This ‘rationality’ is also assumed to be guiding perceptions of both risk and of behaviours that are risky. Within this perspective, high risk behaviours are seen as generally under the control of conscious processes and therefore amenable to change once the
individual recognizes the need to do so for the sake of good health (Gates and Lanier 1996:538). In this way, ‘healthiness’ is intimately linked to the choice-making agendas that people have for living and dying (Fox 1999:30).

Out of this philosophy, public health organizations use the products of a scientific, rational epistemology to ‘solve’ perceived problems. With respect to the ‘problem’ of HIV and AIDS, this often takes the form of biomedical and/or behavioural approaches based on medical, pharmacological and psychological research and theory. Target groups are identified for intervention, behaviour change and/or treatment through social epidemiological research.

Biomedical approaches to HIV and AIDS are those which generally employ some form of technology in order to prevent transmission or acquisition of the virus. Currently, to address the sexual transmission and acquisition of HIV, these methods include promoting the use of latex barrier methods such as condoms which prevent the live virus from touching genital mucosa (Gibney 1992:2), as well as the prompt and effective treatment of other sexually transmitted diseases (STDs) which have been shown to be cofactors for HIV transmission and/or acquisition (see Dallabetta et al. 1999). Simultaneously, biomedical research priorities are focussed on the discovery of microbicides, alternative physical barriers, and vaccines which are all designed to prevent virus acquisition. Research is also being conducted to test the utilization of preemptive treatment therapies which will ideally prevent HIV infection following exposure to the virus (Gibney, 1999:2). Each of these ‘solutions’ relies on the ability of science to reduce the potential to acquire the virus and therefore, helps to maintain a ‘healthy’ population.

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HIV testing is also a biomedical approach which can be used to identify potential carriers of the virus. Yet, it is how information about a person's HIV status is used that impacts upon its effectiveness in maintaining a 'healthy' population. Consequently, by counselling the patient before and after revealing the results of an HIV antibodies test, including the provision of information about behaviour changes necessary to reduce the potential to pass on the virus (or acquire it in the future, depending on the test result), VCT (voluntary counselling and testing) becomes a combination biomedical and behavioural approach to HIV and AIDS (Allen et al. 1999). It is the combination of biomedical and behaviour change approaches, as exemplified by VCT, which is often promoted by public health organizations as having a higher likelihood of success than interventions which have a single biomedical or behavioural focus (Lawson et al. 1999:43-44).

Behavioural approaches target a reduction in the number or likelihood of exposure to HIV through information about particular high risk behaviours. Many of these initiatives are based in psychological theories of behaviour change which point to a connection between knowledge, attitudes, beliefs and practices (Joffe 1996). Among the most commonly used for this purpose are the Health Belief Model (HBM) (see Mantell et al. 1997; Gates et al.1996; Joffe 1996), AIDS Risk Reduction Model (ARRM) (see Gates et al.1996), Theory of Reasoned Action (TRA) (see Joffe 1996) and other social cognitive theories (see Wingood et al.1999). At their best, these theories are supposed to provide a 'road map' for understanding behaviour and how social and behavioural interventions can be used to reduce exposure to HIV (Wingood et al. 1999:188).
Underlying these approaches is the assumption that providing accurate information about the risks associated with particular behaviours and potential ways to modify these so that they are 'safer' should lead to a change in high risk practices. However, the social construction of both risks and the particular behaviours being targeted by any one intervention, influences the willingness and ability of individuals to modify their behaviours. Within the context of HIV and AIDS, this is particularly true with respect to the behaviours targeted by 'safer' sex campaigns.

The existing discussions around what constitutes 'safer' sex highlights the extent to which it is socially constructed. The most popular perception is that it involves the correct use of condoms by one partner, primarily the penetrating partner (although the development of female condoms has allowed for an alternative form of barrier protection against the transmission and/or acquisition of HIV). Alternatively, it could also imply sexual practices where ejaculation occurs outside of the body (Patton 1996); jack-off parties where only kissing, fondling and mutual masturbation are permitted; as well as the eroticisation of massage; and even sado-masochistic scripts (Altmann 1992). At the heart of these definitions of 'safer' sex is the extent to which particular practices reduce the risks associated with the sexual transmission and/or acquisition of HIV.

The recognition of some sexual practices as being 'safer' also implies that there are practices which are associated with higher risks. In the case of HIV and AIDS, this is primarily vaginal and anal intercourse. Ironically, despite the fact that it is precisely these behaviours that put any one person at risk, many intervention programmes have and continue to target particular groups rather than behaviours as being at 'high risk' (Altmann 2001). The
focus on these target groups is frequently based upon social epidemiology. Epidemiological research provides a foundation for determining which groups should be targeted for intervention based on the commonalities between group members and those who have been found with HIV and AIDS. Consequently, particularly in the United States, the initial response from public health was a focus on gay men who were the first identified as suffering from the diseases later associated with HIV infection. The biomedical and behavioural interventions would later expand to include other ‘high risk’ groups, including drug users, prostitutes, homeless people, blacks and eventually, youth in general (Patton 1996). A similar process of identification of HIV with particular groups has existed throughout the world. This process has not only impacted the construction of HIV and AIDS, but has also influenced beliefs about targeted groups, many of which were already stigmatized by society. As a result, the links between HIV and AIDS, and these ‘undesirable’ groups has increased the potential for stigmatization of individuals who are known to have HIV and/or AIDS. It has also produced a stronger resistance from community members to accept their own levels of risk out of a reluctance to associate their own behaviours with that of the stigmatized group (Patton 1996).

It is clear that these interventions are not without their complications when applied in a social situation. This is partly because people interpret information about HIV and AIDS from within the context of culture, experience, attitudes, and their own cognitive and emotional perceptions of a health threat (Leviton 1989:42). As well, the presence of particular social standards in various cultures can place limits on an individual’s choices and his/her ability to act on those choices (O’Reilly et al. 1999:148). Thus, behaviours that
facilitate HIV transmission or acquisition are not necessarily matters of free choice, subject to rational decision-making or under volitional control. Acknowledging the contextual elements in which HIV and AIDS exist, there have been recent efforts to challenge public health initiatives to take on a more holistic perspective that recognizes the place of social norms and controls in determining attitudes and behaviours (see Schoepf 2001; Piot 1999; Joffe 1996; Patton 1996; Altman 1992). At their foundations, these challenges recognize that there is not a simple linear pathway between knowledge, attitudes, and behaviours. Rather, each of these is imbedded within psychosocial, and cultural elements which, in turn, act as voices informing individuals and communities.

The Perspective of Christian religion

The voice of religion also plays a role in influencing the attitudes and behaviours of individuals and is often viewed as standing in competition with that of public health. Christian religion can be understood as an expression of faith. It is a system of symbols and metaphors which facilitate a relationship to or participation in what members understand to be the fundamental power of life (Ring et al. 1998:61). Therefore, the social construction of these symbols and metaphors provides a context in which individuals relate to the world through their belief in that fundamental power of life. Within a Christian context, that power is called God and many of those symbols and metaphors are drawn from interpretations of ‘God’s Word’ as it is presented in the Bible. It is this Being who is the primary object of religious belief and inquiry such that building a proper relationship with God as understood through the system of symbols and metaphors, becomes the primary goal.
Christian religion itself is a construct of the history, habits and belief systems of men and women who lived primarily in Europe as many as 2000 years ago. As part of the historical process, Christian churches established their own forms of academic rigour in theoretical reflection. This has been labelled theology. According to the *Dictionary of Christianity in America*, theology is defined as "The study of God and of his relationship with created reality" (Reid et al. 1990:1170). This suggests that the practice of theology is intimately tied to a reflexive process of understanding the symbols and metaphors through which Christian religions have come to relate to and understand God and how the belief in such a concept influences the lives of Christians and their understanding of the world. In this way, theology serves as a mirror through which Christianity reflects itself (Lonergan 1971:139). Presentations of this process reflect the nature of Christianity in any one time or place.

Within academia, theology is itself distinct from other scientific disciplines particularly given that its methodologies are heavily inclusive of spiritual reflection. Consequently, the forms which it takes can be based in systematics, the bible, history, pastoral practices, philosophy, morality, nature, spirituality and/or liturgy (Reid et al. 1990:1170). The context and the methodology behind theology frequently sets it apart from — and occasionally in conflict with — other disciplines because it generally lacks the rigour of scientific research, preferring instead to raise questions of cosmology, meaning and practice. It is important to recognize this ontological and epistemological difference when making any attempts to compare and contrast the resulting work of this discipline to that of
disciplines located in the sciences, because it helps to provide insights into the sources of potential areas of disjuncture.

It is also important to understand that regardless of the position of theology within academic circles, religious institutions and belief systems remain influential in society. In fact, it has been said that because religion provides a place for human beings to seek meaning, purpose and an explanation for their lives (Ring et al. 1998), that humans are incurably religious. The presence of religion in all societies and throughout history also confirms that religion is universal (Morris 1992:1-2). When faced with a ‘problem’, individuals and societies turn not only to science but also, and in many cases more frequently, to their religious beliefs and to their religious leaders to help them to make sense of the problem and to help guide them through it. That ‘guidance’ and ‘sense-making’ inevitably take on a particular tone and content that is consistent with the foundational elements of that religion, specifically its messages about personal faith, its body of beliefs, its social dimension and its codes of ethics (Morris 1992:8). Although distinct to each denomination and religion, these elements are influenced in a particular way by the theological processes and resulting doctrines and dogmas as established by the most respected thinkers within that religion.

Morality and ethics become intricately linked with each of these foundational elements insofar as a particular religion provides the norms for both the conduct and character of its members. In this way, patterns of conduct are established so that religions sanction particular ways of doing and being based upon their perceptions of the ultimate ordering in the universe (Ring et al. 1998:101). Within a Christian context this perceived
ordering is based in an European interpretation of the Bible and/or natural law, whereby the call to love as expressed in the ‘Great Commandment’ is one of the over-arching principles.

*You shall love the Lord your God with all your heart, and with all your soul, and with all your strength, and with all your mind; and your neighbour as yourself* (Luke 10:27).

It is this relationship with God and the world around which is interpreted by the Christian theologians as a challenge to individuals to see the inherent beauty (because they are created in the image and likeness of God) and the value (because they are called to serve God) of all human beings. This recognition provides a springboard for all relationships and therefore serves as the framework for behavioural precepts (Morris 1992).

The vision statements of various Christian churches and faith-based organizations actively involved in programming around HIV and AIDS, highlight the extent to which the body of beliefs and call to love can provide a consistent reference in how they socially construct this syndrome.

*The Christlike response to AIDS must be personal -- compassionate, helpful, and redemptive* (Wilson 1990).

*Catholic AIDS Action believes that we are called to bring God's love to all who are sick, no matter what the cause* (WebDesign Plus 2002).

*The church's commitment to prevention recognises that all life is sacred* (CAPA 2001).

The framework in which images of HIV and AIDS are discussed and appropriate interventions are developed remains generally consistent with these beliefs. At an institutional level, this is further reflected in the vision statement of the Ecumenical Advocacy Alliance (EAA) campaign for 2002-2004: “Christians believe that all are created...
in the image of God and understand that the recognition of and respect for the dignity of each human person, regardless of circumstance, is the starting point for all our actions and responses” (EAA 2001). This framework establishes the dignity of human life through its relationship to God and its meaning and purpose in the world. It is this framework which becomes the foundation from which all those who develop and implement interventions are expected to draw (Waliggo 2000).

Methodologically, this framework tends to be translated into expectations about the nature of relationships, including the individual’s relationship to him/herself, to God and to those around him/her. Within this framework, individuals and communities are expected to respect themselves and others as gifts from God. In various ways, this incorporates the need to respect and care for those who are infected and affected by HIV and AIDS, as well as valuing oneself in such a way as to desire the ultimate loving relationship, a heterosexual marriage.

It is this framework which has led Christian churches to privilege abstinence from sexual intercourse until marriage and fidelity to one’s partner within a heterosexual marriage as the ideal approach to the prevention of HIV transmission and acquisition. This position has evolved out of a complex history which weaves together a Jewish promotion of married, heterosexual intercourse for procreative purposes with a Platonistic perception that puts suspicion on the body in general, and sexuality in particular, in a highly misogynist way. Specifically, women become linked with matter, sex and reproduction, while men are linked with mind, spirit, and the divine (Jantzen 2001:4). The result is that while Christendom has never quite condemned sex, it sees its expression as good only when it is contained within
a heterosexual marriage and is intended to lead to a 'higher' purpose than mere fulfilment of bodily desires, i.e., reproduction. Any other use or expression of sex, including same-sex coupling, autoeroticism, and heterosexual coupling outside marriage, are forbidden (Jantzen 2001:5).

In contemporary society, this underlying interpretation of appropriate sexual relationships remains, but each denomination uses its own modes of belief to justify this position. For example, some denominations tend to focus heavily upon Biblical traditions and thereby emphasize the sacredness of life and therefore of procreation, that sex is a gift from God, and/or that marriage is a metaphor for the relationship between the church and God, as the primary justification for their position on sexual morality. For others, this is founded upon a sense of what is deemed ‘natural’, that man and woman are made to procreate through a specific form of sexual relationship, namely that which is found in a heterosexual marriage. Despite the theoretical orientation, the message remains fairly consistent across the denominations, thereby sending a message that individuals are expected to abstain from sexual intercourse prior to marriage, and to remain faithful to their spouse within marriage (see The Council of Anglican Provinces in Africa 2001; Seventh-Day Adventist Executive Committee 1998; Catechism of the Catholic Church 1994).

Although this is the ideal presented by most of the Christian churches, it has become apparent that there are people all over the world – including Christians – who do not live up to this ideal. Each denomination has its own way of addressing this disjuncture. Some have developed open policies which accept certain forms of sexual behaviour, others condemn all sexual behaviour outside marriage, and others simply ignore the existence of such practices.
by focussing completely on the ideals of abstinence and fidelity. These differences are further complicated by geographic location such that where the Christian churches tend to appear more conservative, there are greater restrictions on the extent to which these discordant behaviours are addressed regardless of the denomination.

It is often because of this approach that the Christian churches (particularly the Catholic church) are criticized within public health discourse as being counterproductive to the reduction of risk for HIV transmission and acquisition and therefore, maintaining a good health status. Yet, with respect to prevention, abstinence and fidelity can be viewed as primary behaviour change because this approach targets behaviour patterns which precede sexual intercourse and hence the need for harm reduction approaches such as the promotion of condoms and STD treatment (Green 2001). By establishing criteria for proper (Christian) behaviour, this approach circumvents the need to make existing practices which fall outside of this particular framework, safer.

Remaining within this framework, some religious institutions have come to see condoms as a technical tool which is inadequate for addressing HIV and AIDS (Simard 1997) because limiting sexual expression to its sole appropriate context – i.e., a heterosexual, committed, faithful, marriage – is viewed as the only way to eliminate the possibility of sexual transmission and acquisition of HIV. However, the positions of the Christian churches around condoms cannot be generalized as easily as their statements around sexual morality. Although the Catholic church tends to be the most vocal about discouraging the use of condoms, there are also a number of Protestant denominations which take a similar stand. Some religious leaders and theologians, however, use the same theological tools to come to
different conclusions. These can be presented as part of the formal statements of a particular denomination as is found in the positions expressed by the Anglican church in Africa, which includes a recognition of the value of the correct use of condoms among adults, particularly in sero-discordant couples (CAPA AIDS Board Meeting 2002). It is also presented as dissenting voices arguing for a change in the positions expressed by the particular church’s leadership. This is exemplified by the various Catholic voices, including some notable theologians, which make moral arguments to emphasize the value of condoms as a life-saving tool.

Religions have also shown concern for the ways that disease affects the individual and the community. For Christian traditions, this readily links to their perceptions of the work of Jesus Christ in the Gospels. Specifically, almost one-fifth of the Gospels are concerned with the healing miracles and discussions of the consequences of these (Kinsley 1996:89). Out of this foundation, Christian churches have historically become involved in ministering to body as well as soul, including the establishment of local healthcare centres, particularly as part of their missionary practices (O’Connell 1986). In many countries, these healthcare centres continue to be crucial providers of service. For example, in Kenya it is reported that the Roman Catholic Church alone offers 40% of the national healthcare with up to 90% in some remote areas (East African Standard 2003). Within these areas it should not be surprising that religious faith and spirituality have been major resources in coping with disease and illness and promoting health and wellness.

Although there have been some critics who suggest that the churches have not been involved enough in addressing HIV and AIDS, churches have been present through these
healthcare systems. In particular, many African churches and faith-based organizations have been at the forefront in the development and spread of innovative approaches to the HIV and AIDS epidemic including home-based care, counselling, peer education and community support for those affected by the epidemic (Byamugisha et al. 2002:1). To some extent this work is driven by the belief that “In this ordeal, it is in essence the body of Christ which has AIDS. No matter how AIDS was contracted. Once it is there, there is a body suffering and...it’s the body of Christ” (Simard 1997:150).

**Christian religion and Public Health in an African Context**

It is hoped that these presentations provide some insights into the ways that public health and Christian religion are socially constructed and also contribute to the social construction of knowledge and reality. As institutions, both are connected to a particular history, of which each is a product. This has helped to form the specific philosophies and methodologies each draws upon in response to phenomena such as HIV and AIDS. Socially constructed in this way, the questions raised and the responses developed around HIV and AIDS are all based within the particular philosophical and methodological perspectives of that institution and/or discipline. Consequently, there are natural areas of disjuncture which arise out of these basic differences in perspectives. However, this does not exclude the possibility that there are also areas of confluence.

Within the African context, the histories of public health and Christian religion have had some parallels. Neither is native to the continent, both having been imported by colonizing nations, although each has its own historical construct within these original communities. Encountering native communities and institutions which had their own
philosophical and methodological perspectives, both public health and Christian religion became divorced from their original European contexts. As a result, both had to find ways to ensure that the rules of conduct and behaviour established by their institutions would be followed. They also had to address the potential for deviance.

One way to accomplish this was through the connections of public health and Christian religion to modalities of power. Without suggesting that colonization is a unifying totality, it is important to recognize that the ways in which colonizing nations encountered indigenous cultures and people frequently involved the violent abuse of power to gain conformity and acquiescence to their authority. At times, this was also used in combination with or in contrast to forms of governmentality through which the political-economic knowledge of a complex assemblage of institutions and procedures allowed power to be exercised over populations through careful management (Thomas 1994:42). Regardless of the approach, it was often the paternalistic nature of the colonizers experienced in these modes of domination that served as the fuel for the development of a relationship between the two groups (Thomas 1994). In this way, the institutions of public health and Christian religion rationalized their actions by suggesting that it was ‘for the good of the people’.

For public health, this meant the introduction of sanitation and a particular form of health care which marginalized the knowledge of indigenous healers. For Christian religion, this meant the introduction of a single Christian God to whom belief and loyalty was to be absolute, while previous religious beliefs and practices were to be eradicated. Both of these institutions also brought their own codes of ethics and standards of behaviours. Thus, local populations were required to change some traditional practices, such as the inclusion of
certain types of animals within a compound, because they were constructed as health hazards. As well, traditional patterns of relationships and forms of sexuality, such as polygamy, were marginalized because they contradicted the standards of Christian sexual morality. In this way, the Eurocentric interpretations of health, religious and sexual practices became imposed upon indigenous cultures with little respect for their histories and traditions.

The evidence presented in Edward Said's Orientalism suggests that, despite the independence of colonized nations from their colonizers, this relationship has not changed substantially. Instead, the imbalances of domination and power inherent in colonial discourse continues to reproduce the identities of many indigenous populations throughout the world (1979). Where development projects exist within the resulting relationships forms of power and modes of domination which maintain the paternalistic relationships between colonizer and colonized are perpetuated (Thomas 1994:170).

The presence of this paternalistic attitude seems particularly evident in the production and distribution of Anti-Retroviral Treatment Therapies (ART) for HIV positive patients. Specifically, multi-national pharmaceutical companies based in Western nations have been able to utilize global structures to put limits upon the development of generic forms of ARTs, particularly in many of the formerly colonized nations. Simultaneously, the efforts of indigenous health practitioners (including herbalists and traditional doctors) to develop alternative treatments for HIV and AIDS have been marginalized and discredited by the global community. The result has been that governments have been expected to purchase drugs from the large companies rather than develop generic compounds or research
alternative treatments. Fortunately, recent legal battles have helped to change this imbalance by allowing greater access to and the possibility of developing generic drugs for HIV.

As this example demonstrates, the complex structures of globalization continue to influence the relationship between the nations of the North (previously the colonizers), and those of the South (previously the colonized). This influence takes place despite the fact that most of these nations now have political independence. However, it is important not to underestimate the abilities of the local populations. In the same way that colonial histories were shaped by indigenous resistance and accommodation (Thomas 1994:15), contemporary relationships between nations are influenced by the agency of the local people. It is here that the diversity of the indigenous cultures and people encountered through the practice of development, augment the colonizing relationship with the power of their own histories, customs and traditions. In this way, the power of such institutions as public health and Christian religion are balanced by local cultures so that the three stand in various forms of tension as they influence the social construction of knowledge. It is somewhere within this discourse that the indigenous health practitioners continue to find a space to treat those with HIV and AIDS within local communities using traditional herbs and medicines, despite the marginalization of these practices by certain institutions.

This can also be evidenced in the social construction of HIV and AIDS, particularly in the ways that this syndrome intersects with sexuality. As previously mentioned, public health maintains the belief that sexual desire and drive are biologically rooted, while sexual practice is culturally and individually determined. Since some practices provide a medium for virus transmission and acquisition, changes to reduce this possibility are necessary. Such
changes are considered secondary behaviour change since they do not necessarily seek to eliminate or change the sexual behaviour itself but to modify it or introduce technologies as adjuncts to it such including condoms and testing, which help to reduce risks.

In contrast, Christian religions use natural law and/or the Bible to privilege abstinence from sexual intercourse outside of marriage and fidelity within it as the ideal forms of behaviour in general. An added benefit is that this approach can also be viewed as a form of primary behaviour change which is ideal in the prevention of HIV transmission and acquisition. These perspectives from public health and Christian religion are frequently juxtaposed against cultural views which themselves have unique philosophies and histories regarding sexual expression which reflect those of the community in which they were produced.

For example, in some areas of Africa sexual relationships have their legitimate purpose only in the formation of kinships and kinship-solidarity (Megesa 2000:79). Some tribal groups contend that to die without a child would break the generational chain between the living and dead, thereby potentially destroying any path for remembrance for the individual. Sex provides the means for this procreation of self (Nioka 2000:8). As well, cultural traditions in various regions within Africa continue to include expressions of sexuality such as polygamy, wife cleansing, wife inheritance, ritual sex and/or practices around circumcision and rites of passage. These practices, along with other ceremonial occasions or relationships frequently obligate participants to engage in various forms of sexual contact. Participation in these rituals is essential to establishing and maintaining one’s membership in the family, clan, community or tribe. Without this one becomes an outcaste
both within the community and the family. This can include the physical casting out from the community and denial of access to home, food, shelter or family. As well, the consequences of failing to participate can extend to one’s identity so that the individual becomes essentially a non-person both personally and socially (Luginaah, et al.).

When these differing perceptions of sexuality are juxtaposed, what emerges are multiple disjunctures that inform individual assessment of risk. Recognizing that individual choices are mediated by social construction and individual perceptions, experiences and goals, attempts to discuss this sensitive topic with respect to HIV and AIDS prevention needs to consider all of these voices and their potential to influence attitudes and behaviours. In this way, the perpetual need for intervention programmes to reflexively consider the ways that they are constructed and constructing AIDS and AIDS-related knowledge can be seen. With this ideal in mind, it is hoped that by reviewing public health and Christian-based intervention programmes in this way, insights might be gained both into the disjunctures that could lead to a confusion and/or competition of messages and the areas of confluence which could provide a foundation on which cooperation and understanding could be built and then later extended to include the other voices influencing the construction of AIDS and AIDS-related knowledge at the local level.
CONSIDERATIONS FOR COMPARING THE DISCOURSES OF PUBLIC HEALTH AND CHRISTIAN RELIGION

Few people would deny the global devastation caused by the AIDS epidemic over the last 25 years. Through this recognition, multiple organizations worldwide have developed and implemented a variety of intervention programs aimed at both addressing the effects of this disease and reducing its further spread. Although the sources of these programs vary, two of the most prevalent philosophical foundations seem to be those from the public health based perspective targeting good health for all, and the relational approach of Christian religion. Unfortunately, these two voices in particular can sometimes be found in conflict with each other. This can confuse local interpretations of their messages and impact upon the ways that these groups come to inform perceptions around HIV and AIDS and the risk of transmitting or acquiring the virus. Consequently, it is hoped that by comparing and contrasting the discourses of public health and Christian religion on HIV and AIDS, both of these voices may become better aware of the similarities and differences that may exist between intervention programmes.

One way to accomplish this ideal would be to analyse the messages from programmes representing both sides of this potential dialogue in order to determine the extent to which these programmes are influenced by the methodologies and philosophies of public health and Christian religion, while attempting to identify the similarities and differences between the programmes themselves. In analysing these data, the primary question becomes:
In what ways do public health and Christian religion utilize their particular philosophical perspectives in order to accomplish their goals of reducing the spread and impact of HIV/AIDS and how are these similar/different from each other? Using this question as a focal point, it is hoped the analysis of these discourses will suggest some spaces for an invitation to dialogue between public health and Christian religion.

Sample of Programmes

Practically speaking, because public health and religious interventions are often part of a greater institutional structure – public health programs are usually tied to government and/or non-governmental organizations, while religious programs are generally connected to a particular institutional church – there is a strong likelihood of gaining access to resources used within their programs. As well, participation in the evaluation and research component of one particular school-based intervention programme in Kenya\(^1\) has provided access to a snowball sample of informants representing organizations that work within each of these perspectives. Through these contacts and the Internet, it has become possible to obtain curricular materials, videos, resource manuals, and story books which target HIV and AIDS prevention among youth and are written from either a public health or religious perspective.

The programs that will be used in this thesis include *Bloom or Doom: Your Choice* (Kenya Institute of Education1999) and its companion manual *AIDS Education for Youth Action Programme: Facilitators’ Handbook* (Kenya Institute of Education1997), *Stepping\(^1\)

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\(^1\)Specifically the Primary School Action for Better Health (PSABH) HIV/AIDS prevention programme being implemented across 1500 schools in Kenya for which a team at the University of Windsor is responsible for the research and evaluation component (Commonwealth Secretariat, 2003).
Stones: A training package on HIV/AIDS, communication and relationship skills (Welbourn A 1999), Challenge and Change video series and Why Wait? Family Enrichment Curriculum units 1 & 2 (Chimombo M 2000). These programmes were selected primarily because of their accessibility, target audience and representation.

Given that the focus of this research is Africa, and the researcher lives in Canada, accessibility of the programmes was a key issue. Consequently, despite the reality that there are multiple interventions which are active throughout Africa, the fact that these particular programmes could be ordered via the Internet and/or were made available through informants in Kenya played a key role in their selection for this research. The first programmes to be accessed in this way were Bloom or Doom and Why Wait?. Since both of these programmes target secondary school aged children, which had some parallels with the researcher’s past experience, it was important to attempt to obtain other programmes with similar target audiences. Challenge and Change does fit this profile to the extent that it does primarily target youth. However, unlike Bloom or Doom and Why Wait?, it does not heavily depend upon implementation within an educational context.

Stepping Stones also incorporates information about targeting youth, although it is primarily written for adults. Because of its particular framework, it too does not rely heavily on implementation within an educational environment. On the contrary, the focus tends to be on peer group workshops which could include older children or simply be composed of older children. In this way, the philosophies and methodologies of the programme are stretched to incorporate the needs of the youth.
Finally, a balance was sought in selecting the programmes so that there would be equal representation from public health and Christian religion. In this case, since the cultural frame of reference for this research is based in Kenya and includes primarily Christian churches and/or Christian sponsored schools, it was decided that restricting the selection of religious programmes to this framework would be appropriate for this context. Identification of the programmes with one perspective or the other was established based on the particular organizations that were involved in the development and implementation of these programmes. Specifically, *Bloom or Doom* was developed by the Kenyan Institute of Education (K.I.E.) with assistance from the Centre for British Teachers (CfBT) with the intention to reflect a perspective that is sensitive to cultural and religious diversity while maintaining an emphasis on health. Although it is not purely secular in origin—religious and ethnic leaders had an opportunity to review the materials and provide input\(^2\) — its primary support system is within the public health realm. Consequently, it is treated as representing a public health perspective.

*Stepping Stones* is also heavily connected to secular organizations and is focussed on good health. Produced as part of the Strategies for Hope Series—a project of ACTIONAID—this programme is one component in an overall effort to promote positive thinking and practical action in the field of HIV and AIDS care, support and prevention, particularly in sub-Saharan Africa. Because of these connections, this programme is also considered within the perspective of public health.

\(^2\)According to personal communications with members of the CfBT staff involved in the creation of the *Bloom or Doom* curriculum, that input included potential veto power over content.
In contrast, the Challenge and Change video series was developed by the Daughters of St. Paul with the cooperation of a variety of Catholic organizations in Kenya, and is currently being distributed by Paulines Audiovisuals. The Daughters of St. Paul is an international religious congregation which uses communication media to spread the Gospel message and promote the dignity of all people. Paulines Audiovisuals is simply the logo of the apostolic identity of this congregation. This connection to active religious organizations and its use of biblical references and church locations within the videos, places it within the Christian religious framework.

Why Wait? has been adapted for use in Kenya from curriculum materials produced for secondary schools in Malawi by the African Inland Church (A.I.C.) AIDS division in conjunction with the Kenya Students Christian Fellowship (K.S.C.F.) SAFE/LIFE Ministry Educational Programme. The A.I.C. is an evangelical-protestant church organization operating throughout Africa, with international ties to on-going mission work. Consequently, the primary author of these texts was able to spend a considerable amount of time in California while she was preparing this programme. During this time, she reports connections with local Christian churches and schools. In addition, the information presented within the text includes various bible references. Consequently, these connections suggest that this programme should also reflect a Christian perspective on HIV and AIDS awareness and prevention.

The following chart shows a further breakdown of information about each of the programmes:
<table>
<thead>
<tr>
<th>Bloom or Doom</th>
<th>Challenge and Change</th>
<th>Stepping Stones</th>
<th>Why Wait?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discipline</strong></td>
<td>Public Health</td>
<td>Christian religion</td>
<td>Public Health</td>
</tr>
<tr>
<td><strong>Primary Resource</strong></td>
<td>Kenya Institute of Education</td>
<td>Daughters of St. Paul</td>
<td>Strategies for Hope</td>
</tr>
<tr>
<td><strong>Other Funding Sources</strong></td>
<td>UNICEF Kenya Country Office</td>
<td>ACTIONAID; CHARITY PROJECTS; OXFAM; REDD BARNA (Norway); SWISS DEVELOPMENT COOPERATION; UNDP (Regional Bureau for Africa); WHO (Global Programme on AIDS)</td>
<td>Feed the Mind</td>
</tr>
<tr>
<td><strong>Distributed By</strong></td>
<td>Kenya Institute of Education</td>
<td>Paulines Audiovisuals</td>
<td>ACTIONAID/Strategies for Hope</td>
</tr>
<tr>
<td><strong>Format Analysed</strong></td>
<td>2 Texts: Resource book for youth; facilitators' handbook.</td>
<td>3 Videos: <em>Be Afraid!</em>, <em>Think! Sex or Love</em>, <em>Why Me</em>? Each with an accompanying study guide</td>
<td>1 Manual the optional video was not obtained prior to analysis and therefore is not used in this research</td>
</tr>
<tr>
<td><strong>Target Audience</strong></td>
<td>Resource book : Youth in and out of Secondary school Facilitators' Handbook : Teachers (specifically for Kenya)</td>
<td><em>Be Afraid!</em> : youth and parents; <em>Think!</em> : youth and facilitators; <em>Why Me?</em> : all those living south of the Sahara, those infected and affected by AIDS</td>
<td>Older children and adults in communities (anywhere in the world) where an HIV/AIDS programme exists or is planned</td>
</tr>
</tbody>
</table>
| Length | Resource book: 143 pgs  
Facilitators’ Handbook : 84 pgs. | Be Afraid! : 30 min. 15 page study guide;  
Think!: 20 min. 11 page study guide;  
Why Me? : 37 min. 15 page study guide. | 230 pages. | Unit 1 : 104 pgs  
Unit 2 : 93 pages |
|---|---|---|---|---|
| Content | Resource Book: 9 chapters, each with information and activities  
Facilitators’ Handbook: 12 units, each with information and sample activities | Be Afraid!: video aims to create awareness and give the facts about HIV and AIDS.  
Think!: video aims to help youth develop a better understanding of human sexuality according to God’s plan.  
Why Me?: video aims to raise awareness of people living with HIV and AIDS.  
Each of the study guides review the content of the video and includes questions for discussion. | Begins with instructions to the facilitators, then provides information and activities for an initial open community meeting, followed by 7 peer group workshop sessions, a full workshop meeting, 5 more peer group workshop sessions, another full workshop meeting, 2 more peer group sessions and a final open community meeting. | Unit 1: Information to the teacher, followed by 25 lessons to be used in the classroom.  
Unit 2: Information to the teacher, followed by 25 lessons to be used in the classroom. |
| Implementation | Teachers in the classroom, ideally with training from PSABH | Schools, youth organizations, churches, any interested groups with a VCR | Communities where HIV/AIDS programming is already available, by leaders with a variety of specific qualities ranging from experience in adult learning techniques to a fluent understanding of the language of the text and the languages of the community | Teachers in the classroom with some training available through the African Inland Church AIDS Division |
Role of Informants/Resource People

To a great extent, access to these resources is due to informants in Kenya. From a public health perspective, representatives from PSABH have provided both the sample text for *Bloom or Doom*, and have played an important role in clarifying initial insights about the social, cultural and economic context in Kenya. From a religious perspective, informants for both the Catholic and the A.I.C. churches have not only pointed to and/or provided resources for analysis, but have also made themselves generally available for clarification questions. The informants in this regard are both employed by the larger institutional church structures and have been assigned to work in Kenya with a significant focus on HIV and AIDS interventions.

In return, for their assistance, it has been agreed that these informants will be given access to the results of this research both for their own information and as a way to further enhance the member checking process.

Analysis Techniques

Given that the majority of the program materials used in this study are textual, qualitative analysis will be the primary methodological tool for this research. Specifically, a combination of rhetorical, discourse and content analysis will be used as a way to analyse how each program uses the philosophical perspective of public health or Christian religion to socially construct health and illness, sexuality, and HIV and AIDS in particular in order to entice behaviour change. This process will be enhanced through the use of QSR N6 software (QSR International Pty Ltd 1991-2000) which allows for the categorization of data in a variety of ways.
Rhetorical analysis can be described as a reconstruction of the manifest characteristics of the text. In particular, this may include the message's construction, the form it takes, the metaphors being used, the structure of the arguments and/or the choices made around its presentation. Thus, the emphasis within this approach is not so much on what the message says as it is on how it is presented (Neuendorf 2002:5). This analytic approach should prove useful in assessing the various ways that organizations present their programs. From the appearance of the front cover, to the selection of diagrams and pictures, the types of messages that are emphasized, the various word processing techniques, all of these issues can provide valuable insights into the underlying philosophies that are presented in these intervention programs. This information can then be compared across the programmes and disciplines (Christian religion and public health) for similarities, differences and points of dialogue.

Discourse analysis seems to closely parallel this approach in as much as it is concerned with the manifest characteristics of language and word usage (Neuendorf 2002:5). However, divergence emerges where discourse analysis focusses on the ways that knowledge and reality are produced in discourse through social construction and reflexivity (Silverman 2001). Specifically, this incorporates a recognition of the social context in which the programme, in this case, has been developed and how this might affect the philosophies and methodologies that result. In this context, this will be accomplished by establishing thematic categories which correspond to the particular philosophies and methodologies of public health and Christian religion and determining the extent to which the content of the various programmes converge and/or diverge from these. As well, an effort will be made to identify
the ways each programme attempts to work within the particular cultural context in which it exists.

Finally, content analysis provides the objective framework for this task, in that it is a process which allows researchers to examine artifacts of social communication through the quantification of qualitative data (Berg 2001). In this case, as discourse analysis establishes thematic categories based on the particular philosophies and methodologies of public health and Christian religion, key terms surrounding this coding scheme will be identified and quantified using text searches which identify the number of references including a particular word or term, as well as the percentage of the text which includes such references. In this case, the percentage is based on the number of lines of text which contain the required reference. The results of these searches will then be further analysed with respect to the various ways in which the terms are being used. This process can provide insights into the forms of language used by the programmes to communication a particular message.

Limitations

Regardless of how rigorously these methodological techniques are applied, there are always threats to validity and reliability in this process. In this situation, validity can be understood as the extent to which the discussion of these programs accurately represents the philosophies of the individuals and groups who designed and implemented them, as well as the ability to generalize the findings. With respect to the latter of these goals it is recognized that because of the limits established with respect to accessibility, target audience and representation, there are multiple interventions which have not been reviewed as part of this research. With these limitations in mind, it must be admitted that there is no guarantee that
the results of this research can be generalized across geographic, philosophical, disciplinary, cultural and/or other boundaries. However, it is hoped that, because of the institutional nature of both public health and Christian religion, by providing examples of potential areas of disjuncture and confluence between the two discourses, an awareness of parallel and alternative approaches to HIV prevention can be built.

As for the former, the accuracy of representation is tied to the extent to which bias and value judgements can enter into and potentially distort the research process. According to a variety of social scientists (Myrdal 1969, Nagel 1961, Weber 1949), these can come into play from the selection of subjects and methods through to the analysis process itself, simply because “We cannot rid ourselves of the cultural self we bring with us into the field any more than we can disown the eyes, ears, and skin through which we take in our intuitive perceptions about the new and strange world we have entered” (Scheper-Hughes quoted in Olesen 1998:314-315). Consequently, there is a growing discourse which suggests that the values of the researcher should be declared in order to properly inform the research process at every stage.

In this situation, it should seem obvious that a particular set of values guide the preparation of the various programs and, to some extent, it is the differences in these value systems which invites the conflict and confusion between the two approaches. This is a particularly important point to make because of the underlying belief held by this researcher that the harm reduction approach to HIV and AIDS which focusses heavily upon condoms and ‘safer sex’ is not necessarily the best way to reduce HIV rates in every community. On the contrary, culturally sensitive interventions should readily recognize traditions and beliefs
which may conflict with this approach and reduce the likelihood that people will change their behaviour. To that end, in part because this researcher has a faith-oriented background which includes a degree in theology, there is a natural assumption that the religious orientation to sexuality and health has a place in addressing this disease and the potential prevention approaches.

Simultaneously, as a white, Canadian, female who has travelled to Africa only once, this researcher is relying heavily upon her experience working on the research and evaluation component of PSABH and her informants as a source of information around the social, cultural and spiritual context in which these programs are taking place. In fact, these sources have already proven helpful in clarifying ideas around how HIV and AIDS is being understood and addressed at the local level. Furthermore, there is a general expectation that these sources will be given access to the results of this research as a further way to check accuracy of representation. Ultimately, it is hoped that the reflexive consideration of bias and this form of member checking will increase the validity of this research.

As for reliability, the provision of an objective coding scheme through content analysis is meant to provide a foundation for the potential replication of this research. Simultaneously, it is believed that the focus on the institutional level philosophies and methodologies to inform the construction of this scheme provides another layer from which other researchers could feel comfortable exploring this potential for dialogue in a rigorous manner. Through these techniques and a reflexive attempt to remain open to what both types of programs have to say, it is believed that other researchers could also apply this methodology to this context, and potentially others, with similar results.
Ethics

In consultation with Dr. Maureen Muldoon, Chair of the University of Windsor Ethics Review Board, it was decided that this particular research project did not require an ethics review simply because the primary sources of data are text and video materials. Consequently, even though informants are being used to gain access to this material as well as for clarification of programme information, since they and the information they provide is not being used as data, there is no personal risk for them in this regard.
AN INTRODUCTION TO THE PROGRAMMES

Stepping Stones, Bloom or Doom, Why Wait? and Challenge and Change are among the programmes which are available in Kenya and can be used with youth in and out of school. Each, in its own way, represents either the institutional structures of public health (Stepping Stones and Bloom or Doom) or that of Christian religion (Why Wait? and Challenge and Change). The influence of these institutions provides some foundation for understanding the philosophies and methodologies of the programmes themselves. Since each programme was developed for a particular social and cultural context, recognition of this context is also necessary. The recognition of these two influences can be helpful in building a conceptual framework from which to analyse the philosophies and methodologies of each intervention. The results of this process can then be used in comparisons across programmes. Consequently, the task of this chapter is to draw from the contextual information provided in each programme in order to identify its underlying philosophies and methodologies. This information provides the foundation for later cross comparisons.

Stepping Stones: A Training Package on HIV/AIDS, Communication and Relationship Skills

Since the intention of this programme is that it can be implemented in a community with little external support, the manual necessarily provides sufficient information to achieve this task. This includes a full 22 pages of introductory information which outlines what is contained in the manual, for whom and why it was prepared, where, when and with whom the package could be used, and how the sessions are structured (Stepping Stones:1). As a result, this manual provides the greatest contextual detail of the four programmes.
Although the primary author of this programme is listed as Alice Welbourn, it is evident from the first few pages that she accessed many sources as part of the overall development process. These included a medical advisor, a representative from the Ministry of Information in Kampala, the director and staff of ACTIONAID-Uganda, and the Sisters and staff of Kitovu Missionary Hospital in Masaka, Uganda. As well, financial support was provided by international organizations such as ACTIONAID, OXFAM, UNDP (Regional Bureau for Africa) and WHO (Global Programme on AIDS). This extensive funding and support network, along with the ability to produce three more reprints following its original release in 1995, suggests that this programme likely has the largest budget of the four. This budget and the accessibility of the programme across geographic boundaries, has also meant a greater diversity in local implementation including the existence of text translations into Portuguese, Spanish and French.

The international scope of this programme has a variety of implications for implementation. Some of these are addressed in the text itself where the focus remains on the ability of the local community to address the issues themselves.

*We do not offer any simple solutions, because we believe strongly that communities are capable of developing their own solutions to their particular problems and concerns (Stepping Stones:v).*

This confidence in the ability of local communities is further highlighted as part of the explanation provided as to why this programme has been established.

*Instead of being told WHAT to do by outsiders, this manual and video show HOW you and your community members can begin to discuss and decide for yourselves what we can all do in our own social contexts, ... (Stepping Stones:9)* [emphasis original]
Indeed, as this statement suggests, it is the desire of the authors that this programme be adapted to the particular social and cultural contexts in which it is being delivered.

This is further emphasized in the reference to the companion project, the “Stepping Stones Training and Adaptation Project”. The manual for this project is recommended as a way to enhance the implementation of *Stepping Stones* because, in part, it provides information about the adaptation of the programme to any local context. As suggested in a brief description of the manual for the project,

*The SS TAP can...send you guidelines about adapting Stepping Stones for your context (Stepping Stones iv).*

By including information about this companion manual, the authors help to emphasize the importance of local communities addressing the issues in ways that are relevant to the local people.

As the title of this programme suggests, *Stepping Stones* contains a discussion of three primary elements: HIV and AIDS, communication and relationship skills. The first of these seems to be the most crucial of the three, as indicated in the welcoming message at the beginning of the text.

*We offer you and your community some ‘stepping stones’ for avoiding the threat of HIV, but also for coping with the reality of AIDS,... (Stepping Stones:v)*

Communication and relationship skills are added because they provide the means, that is the ‘stepping stones’, to build awareness and reduce risk. Out of this connection, the link between certain sexual behaviours and HIV and AIDS is identified within the introductory pages of the manual:

*Yet nowadays in many parts of the world we know that AIDS is here with us. And AIDS has close connections with both sex and death (Stepping Stones:8).*
Since the sexual behaviours that increase the potential for transmission and acquisition of HIV require at least 2 people, relationships come into play. Therefore, communication is also implicated. Stepping Stones takes these connections one step further, by suggesting that problems with communication around these sexual behaviours are at the heart of the issue.

*This training manual and the accompanying video have been produced in response to a growing need for material to address our communication problems about sexual attitudes and behaviours (Stepping Stones:8).*

The reference to ‘stepping stones’ itself serves several purposes. The most prominent is translated into a metaphor which is illustrated throughout the text, the most detailed of which can be found on the front cover and on page 3 where the metaphor is explained. These pictures show a series of men and women holding hands while happily jumping from stone to stone across a river containing a crocodile. Accordingly, the image of the river reflects the river of life which is meant to sustain body, mind and spirit (v). The stones provide a path on which to cross this river safely, not unlike the programme itself which is designed to:

...explore ways in which we can all begin to find a safe way across the river of life (Stepping Stones:9).

As previously suggested, this is accomplished by focussing on communication and relationship skills. The crocodile represents the potential dangers that exist, in this case, the danger of HIV and AIDS:

*Now, the river carries a new danger, a virus called HIV, which can bring illness, suffering, death and grief to many (Stepping Stones:v).*

This metaphor is also extended to the methodology of this programme, specifically, that it is a step by step process in which each subsequent session builds on what has taken place previously. Drawing from the metaphor, attempts to skip steps – i.e. stones – could
prove problematic. Therefore, this approach is considered crucial to the success of the programme:

*It is important to follow the sequence of exercises in the sessions as described and not to jump in and out of exercises in different sessions. Otherwise, the experiences of the earlier exercises will not help participants to cope well with the harder, later exercises (Stepping Stones:2).* [emphasis original]

In this way, the combination of exercises provides a foundation on which the participants can gradually explore issues around HIV and AIDS, communication and relationship skills so that:

*The whole workshop aims to enable individuals, their peers and their communities to change their behaviour, individually and together through the stepping stones which the sessions provide (Stepping Stones:3).*

As this statement suggests, this is a community-level intervention programme, the goal of which is to entice behaviour change across a community by challenging individuals to change their behaviour.

*The manual is based on the assumption that community-wide change is best achieved through a personal commitment to change from each of its members (Stepping Stones:3).*

This is accomplished by providing a space for small groups of community members to meet and communicate within a variety of workshops that target issues including relationships, sexuality, condoms, and HIV and AIDS. The length and breadth of these workshops is flexible, based on the needs and input of the members of the group. However, the format has been standardized to include an opening game, followed by a variety of exercises and discussions to help direct the group to comfortably address the topic at hand. Interspersed among these workshops are a series of 15 video clips which highlight the journey of one particular group through these topics.
The manual stresses the importance of restricting group membership for these workshops based upon standard divisions established by the community. It advises that the group’s facilitator should also mirror these characteristics and act not as a leader but as a member of the group. The specific divisions recommended within the manual are based on gender and age—older men, younger men, older women and younger women. The value of this division is highlighted by an illustration of a group of men sitting on the ground with one quoted as saying:

*I'm glad we're all guys here. I wouldn't have dared discuss these things with women around* (Stepping Stones:11).

In essence, the suggestion is that, given the sensitive nature of some of the topics, individuals may be far more comfortable discussing these issues among peers. This process is then used as a springboard to develop communication tools that will be used in the two full workshop meetings and, ultimately, in their presentations to the general public at the end of the workshop process.

Generally speaking, the programme tends to target adults. This target audience is reflected visually in that all pictures depict adults. As well, the metaphors and examples incorporate expectations of greater life experience, particularly with respect to the types of relationships involved—i.e. reference to relationships with a spouse and/or one’s own children. However, space is provided for targeting and/or including older school-aged children. Accordingly, it is suggested that these young people may be old enough to join the younger men/women’s groups or they may prefer to form their own peer groups (Stepping Stones:10). In sessions where certain life experiences may be assumed, the text suggests that
the young people consider the issues from a hypothetical standpoint – i.e., what they think their married relationship will be like?

Certainly there are advantages to focussing on adults. Among these may be the ability to more openly discuss issues of sexuality and sexual behaviour. In fact, *Stepping Stones* includes the most explicit references to sexual behaviours, and sexual language in general. This is accomplished with an ever present sensitivity towards the cultural context, including a recognition of the potential awkwardness around discussions about sexuality:

*In almost all societies around the world, sex and death are taboo subjects. People may question our morality if we know or use certain words or actions concerning sex.* *(Stepping Stones:8).*

It is this sensitivity around the ways that this workshop might be perceived at the local level which permeates the advice provided to the facilitators. It also permeates recommendations about who is best qualified to act as a facilitator. This is established with the inclusion of an 18 question ‘quiz’ which asks the individual to be honest about him/herself by responding yes or no to a series of statements about his/her skills such as:

*Fluency in your community’s first language (including the first language of the women in this community)*

*The trust and respect of a wide variety of people in your work area (old, young, male, female, rich, poor)* *(Stepping Stones:5).*

Those who answer ‘no’ to at least 4 of these statements are advised to think twice about acting as facilitators for this programme, while those who score higher are encouraged to review the manual and video.

Ultimately, for those who decide to proceed with this programme, the active participation of peer group members is stressed. This is identified as an ideal approach to learning.
We believe strongly that the best way in which people learn is from listening to and talking to others like themselves (Stepping Stones:20).

Consequently, the facilitator is encouraged to avoid lecturing, but instead to be open to the learning opportunity presented by participating in the peer group.

We should not pretend to ourselves that we have nothing to learn about better communication and better understanding of ourselves and one another. If you use the words ‘we’, ‘us’ and ‘our’ during your sessions, you will find that your participants will quickly develop confidence in you as someone who is ready to recognise your own needs alongside theirs (Stepping Stones:20).

This seems to remind the potential facilitator that the goal of improving communication skills is something that every person can benefit from even beyond addressing the crisis of HIV and AIDS.

Bloom or Doom

The manuals selected for analysis from this programme are actually part of a larger series of texts that have been produced by the Kenya Institute of Education (KIE) through the AIDS Education Project, with assistance from the Centre for British Teachers (CfBT). Part of the development process for this programme included solicited input from religious and community leaders. This input was viewed as necessary because, despite the fact that schools in Kenya are publically funded, there are many that continue to receive various forms of support from community and religious sponsors. Consequently, these leaders can carry substantial power with respect to what can be done within the local schools. This dialogue was viewed as one way to facilitate cooperation within the school communities.

In its entirety, this programme targets the full range of school-aged children from the beginning of primary through to the end of secondary school. Bloom or Doom and the AIDS Education for Youth Action Programme: Facilitator’s Handbook have been selected for
analysis because these are the elements of the overall programme which target secondary school-aged youth and the teachers who would function as the primary facilitators for this programme, thus providing a comparison point with the other programmes selected.

According to the information provided in these texts, the content was ultimately developed by a group of writers from the AIDS Education Project Implementation Team (PIT). The acknowledgments further suggest that an invaluable contribution to the writing process was provided by various members of the KIE, as well as representatives from the Ministry of Education and Tambach Teachers College (for the Facilitator’s Handbook) and Lenana School, the Provincial Director’s Office, Nairobi, the University of Nairobi, and Jomo Kenyatta University (for Bloom or Doom). The primary source of outside funding was provided by UNICEF, Kenya Country Office. The expected scope of this project is limited to Kenya particularly since the texts are written to work within its school system.

Based on the information provided in the Facilitator’s Handbook, it is actually the needs of the school system which have been the impetus for the development of this programme.

From the findings of the survey [carried out by the KIE, AIDS Education Project in the UNICEF focus districts] it became clear that teachers needed guidance on how to handle AIDS Education (content and methodology) in schools (Facilitators’ Handbook:iv).

Perhaps in part because of this connection with the school system, introductory information about philosophies and methodologies is minimal in these texts. In fact, there is no such introduction in Bloom or Doom, and the Facilitator’s Handbook contains a total of 3 pages referred to as a “General Introduction”. This information includes a description of the background to the handbook, a definition of AIDS Prevention Education, a list of general
objectives and a description of the target audience as well as discussions of the format of the
text and a paragraph on potential techniques which could be used to teach AIDS education.

It is important to recognize that the information provided in the Facilitator’s
Handbook specifically addresses the needs of teachers.

_The handbook is primarily for practising teachers...It also caters for those who are
undertaking Teacher Education Courses..._ (Facilitators’ Handbook:v).

Consequently, the descriptions of the philosophies and methodologies of this programme are
addressed in this context. This includes not only the identification of needs specific to
teachers, but also discussions around the needs of the students from the perspective of the
teachers. For example, the background information emphasizes to teachers that:

_The teachers [sic] role is,..., important in that, through AIDS EDUCATION the youth
will be provided with knowledge, skills and attitudes which will enable them to
remain free of HIV infection and also communicate effectively with their peers on

Perceptions around the overall role of teachers extends beyond the classroom and the
school building, increasing the perceived importance of providing teachers with information,
resources and education on important issues such as HIV and AIDS.

_As a member of a society, the teacher’s role go [sic] beyond the school community.
Teachers are expected to extend their experiences and knowledge to other members
of the community_ (Facilitators’ Handbook:v).

To further assist teachers in performing this task, the manual suggests that they need
to consider the cultural context of the community. Since this context will have some
influence on young people’s values and behaviours, the manual also directs teachers to use
particular participatory methods which are designed to:

_...involve the youth and the teacher in active development of knowledge, skills and
attitudes._ (Facilitators’ Handbook:vi).
The value-laden nature of some of the issues addressed in AIDS education further suggests the importance of value-clarification methods. According to the handbook, these include:

*Debates, Discussions, Role Plays, Case Studies and Games* (Facilitators’ Handbook:iv).

From this perspective, the handbook provides both information and sample exercises to assist in delivering appropriate messages around HIV and AIDS. The content of these activities is further emphasized through the use of diagrams and text boxes which highlight the points being made.

Interestingly, as Table 1 shows, a quick content analysis of the actual types of exercises provided suggests that despite these statements about the importance of participatory activities, there is still a heavy emphasis on teacher-directed methods, including didactic methods in which the teacher poses questions and the students respond with very little room for discussion. The deviation from the ideal approaches suggested in the handbook becomes even more evident when compared to the actual approaches used in *Bloom or Doom*.

*Table 1: Methodological approaches in the facilitator’s handbook and Bloom or Doom*

<table>
<thead>
<tr>
<th>Exercise Type</th>
<th>Facilitator’s Handbook</th>
<th><em>Bloom or Doom</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Didactic</td>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>Debates</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Discussions</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Role Play</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Case Study</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Games</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total number of Activities</strong></td>
<td><strong>34</strong></td>
<td><strong>39</strong></td>
</tr>
</tbody>
</table>

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Where the Facilitators’ Handbook specifically targets teachers, *Bloom or Doom: Your Choice* targets the youth. Consequently, activities are presented complete with tables to be filled in, pictures to illustrate concepts and text boxes to highlight particular points. The content also targets youth and does not provide the same contextual information contained in the Facilitators’ Handbook with respect to how to address these topics. Although there is an initial discussion on sexuality and appropriate relationships, the majority of the lessons focus on health issues related to sexuality and HIV/AIDS.

It is important to stress that since this programme ultimately targets youth, there is a focus on what youth are expected to know and how they should behave. Within this context, there are more social constraints with respect to how sexual behaviour is raised and discussed. Perhaps in order to avoid this contested terrain, particularly in light of the dialogue with religious and community leaders, it is noticeable that this programme seems to have the strongest emphasis on a scientific approach including providing detailed information about a nutritious diet (particularly for those with AIDS), as well as the specific biological way in which HIV infects the body and develops into AIDS.

**Why Wait? Family Enrichment Curriculum**

*Why Wait?* was originally designed and implemented in Malawi. Hence, the author, Moira Chimombo, is actually a professor of education from the University of Malawi. According to the acknowledgements, she received initial funding from First Fruits Inc. and The JESUS Film Project which allowed her to take a sabbatical to write these texts. Upon her return, Unit 1 was field tested in a secondary school and appropriate revisions were made with further assistance and testing with students and teachers at a second school.
Within this process, a dialogue was initiated with representatives from the International Schools Project (ISP) of the JESUS Film Project which allowed the author to rewrite the curriculum in a format closer to that of the ISP and thereby increase the final scope of the target audience for the programme. Subsequent to this, representatives from the African Inland Church (A.I.C.) AIDS Division in Kenya reviewed the programme and decided to adapt it for their local context with assistance and initial training from Malawi. Feed the Mind became the financial contributor to the printing of the adapted manuals for the Kenyan context.

Underlying this entire process is the evidence of a particularly strong emphasis on faith. The author emphasizes this in her acknowledgements as she recognizes the important connections she was able to make with Christian groups while writing in California. As well, her final statement highlights her own commitment to faith in the Lord:

As always, my greatest debt of gratitude goes to the Lord...

It is this perspective which helps to distinguish this curriculum from Bloom or Doom which is also available in secondary schools in Kenya. This is evidenced not only by the multiple biblical references used within the lessons, but also by the Christian framework identified in the Key Concepts section and drawn upon throughout. This includes references to creation as a foundational principle in establishing a proper relationship with God, self, others and the world

We have been created in God's image that we might have a living relationship with Him and that we may honour and glorify Him. The very essence of the Christian life
is built upon relationships and the development of godly character through the relationships (Unit 1:4).

This faith-based perspective provides the foundation on which the goals of the programme are addressed. As the title—Why Wait? Family Enrichment Curriculum—suggests, the primary goal is to provide young people with reasons to abstain from sexual intercourse until marriage. Among these reasons is a strong emphasis on the nature of love, what constitutes true love and the potential consequences of failing to wait not only for oneself, but also one’s family, present and future.

Because the focus of this programme is on the needs of youth, these goals are not limited to HIV and AIDS, but also include a recognition of the many problems that currently confront young people. This holistic approach is meant to extend through the four years of secondary school with a different focus each year. According to the texts:

The first year...focuses on the physical, socio-cultural, and environmental reasons for delaying sexual involvement until committed to a monogamous, mutually faithful marriage relationship.

The second year turns to psychological, emotional, and relational factors influencing youth to become involved in pre-marital sexual relations.

The third year attempts to show the students the life principles by which people live and encourages them to choose a biblical life principle which will apply not only to their sexual behaviour but to all aspects of their life.

The fourth year is devoted to positive parenting,...(Unit 1:2). [emphasis original]

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3Note: the introductory information for Unit 1 and 2 are virtually identical. Thus, where references are required, the information will be taken from unit 1 only.

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Given this diversity in purpose, only the first two units have been selected for analysis because they are more directly targeted to HIV prevention and are presently more readily available in Kenya.

Parallel to Bloom or Doom, this programme targets youth, particularly those in school. However, the manuals are also designed to assist teachers to deliver the programme. Consequently, each lesson (25 per unit), contains information about the main principle behind the information presented, the benefits to society and objectives of the lesson, as well as a list of materials needed. The lessons also include supplementary information such as references to articles and research which highlight the associated topics.

Methodologically, teachers are encouraged to apply active learning principles within each lesson. The author suggests that this is accomplished through the use of five key components – namely readiness, exploration, discovery, appropriateness, and assumption of responsibility – which are incorporated as part of the structure of each lesson. Other advice included for teachers is the importance of specific forms of teacher-student interaction which recognize and draw from the inherent developmental characteristics of the students. This includes the on-going application of principles which govern how young people think.

1) A young person's thinking is limited by their perspective.
2) Much of the youth's thinking depends on the quality and quantity of first hand experiences.
3) Students need activities. (Unit 1:10-11).

It is this framework which serves as a springboard for helping teachers to explore the abilities of young people to develop their communication skills around HIV and AIDS, sexuality and relationships.
Finally, since the manuals suggest that they serve a dual purpose, acting both as a teachers’ and students’ manual, the lessons include text boxes which emphasize the points being made. These seem to be present for the benefit of the students more so than the teachers. Interestingly, although there are some diagrams to assist young people in understanding complex points, the only picture which appears in either of these manuals is an artistic rendering of a content-looking young woman with an infant in a sling around her neck entitled ‘Love’. Found in unit 2 beside the first lesson ‘Love: An Act of Will’, this image seems to reinforce the notion that love can be experienced in many ways, with the bond between parent and child being one that is particularly strong.

**Challenge and Change**

The *Challenge and Change* video series is meant primarily to function as a companion to an existing HIV and AIDS programme. This is in part due to the fact that the videos and associated study guides are meant to inspire discussion around the specific topics addressed, while assumptions are made about prior knowledge. Produced by the Daughters of St. Paul, an international Catholic congregation, this programme is potentially available beyond Kenya.

Among the videos selected for research, *Be Afraid...Be very afraid: AIDS is deadly* provides basic facts about HIV and AIDS as a way to:

...*give the youth the facts about AIDS and to emphasise that only chastity will save us from the HIV/AIDS pandemic (Be Afraid:2).*

Specifically, this video begins with a sombre funeral, a young person has died of AIDS. Her friends gather together afterward to discuss what has taken place. Their conversation quickly moves into one about the spread and impact of AIDS. Presumably, since none of the young
people can claim to know everything about HIV and AIDS, this conversation is interspersed with ‘expert’ advice from a medical doctor and a counsellor. As popular myths are dispelled, the young people are led to the solution that the only real answer is chastity.

Although Think! Sex or Love also targets youth, it takes a different direction in that it specifically addresses sexuality with only a passing mention of HIV and AIDS. This fits well with the goal of this component:

...the youth...will be able to have a better understanding of the overall purpose of human sexuality according to God’s plan (Think!:2).

This is accomplished by bringing an adult in to challenge the perceived sexual norms of a group of young people gathered in a local community centre. Specifically, the adult suggests that the ideal is to wait until the diamond in the rough can be found and then, once married, the resulting sexual experiences will be that much more gratifying.

The third of these videos, Why Me? AIDS a Call to Love aims to raise awareness about HIV and AIDS by demonstrating the reaction individuals and those around them might have to discovering one is HIV-positive. This is told as part of a story in which a young woman is diagnosed as HIV-positive following an illness. She decides to inform her family and friends of this fact, providing a forum for demonstrating potential positive and negative reactions. Because this video addresses stigma and treatment of those infected and affected by HIV and AIDS, the target audience extends beyond the youth to include:

All those living South of the Sahara where the AIDS pandemic has had such a heavy toll. Brothers, sisters, parents, relatives and friends of People Living with HIV/AIDS (PLWHA) (Why Me?:2).
Together, these videos provide an holistic presentation of the various elements around HIV and AIDS. Since the primary characters in each of these videos are young people (generally teenagers), and the settings for the videos are places where young people congregate, it is more likely that youth will relate to the videos, increasing the potential for dialogue among that age-group about the issues presented. As well, the study-guides provide questions to help facilitate discussions about these issues with young people. In this way, there are points of comparison between this video-based programme and the others in this research.
COMPARISONS OF PROGRAMMES WITH THE PHILOSOPHIES AND
METHODOLOGIES OF PUBLIC HEALTH

Since the previous chapter has outlined the framework on which each of the
programmes has been built, it now becomes possible to compare that framework with the
philosophies and methodologies of the institutions to which each programme is connected.
In this case, the programmes have been selected because of their relationships with the
institutions of public health and Christian religion. Recognizing that both of these
institutions have been socially constructed within the particular historical, cultural and social
circumstances in which they exist, neither should be treated as a homogeneous entity.
However, at a macro level, each has philosophies and methodologies which tend to have
some influence across multiple boundaries. By looking for this influence in the messages
presented by the related programmes, it is hoped that the identification of similarities and
differences between programmes and across institutions may help to increase awareness of
a potential for dialogue between the many voices involved in the construction of AIDS and
AIDS-related knowledge.

The focus of this particular chapter will be a comparison with the philosophies and
methodologies of public health. As previously discussed, the underlying philosophical goal
for the institution of public health is good health for all, which is achieved through
biomedical and behavioural interventions. This is set within a language of science so that
rationality, individualism and harm reduction underlie the messages presented. Thus, the
question posed in this analysis is:
To what extent do the messages in these programmes coincide with the philosophies and methodologies of public health? An addendum to this is whether there are similarities and differences between those programmes selected because of their connection to public health and those which are connected to Christian religion.

**Good Health for all**

Establishing a framework which will optimize the health and longevity of the community is a fundamental ideology of public health. Recognition of this philosophy has implicitly given permission for this institution to impose upon the general population guidelines for behaviours that will help them to individually maintain good health. In this way, adherence to harm reduction strategies has become the moral imperative of public health programmes, with judgements about particular behaviours treated as secondary. Since *Stepping Stones* and *Bloom or Doom* were selected because of their connections to the institution of public health, the expectation is that they will incorporate elements of this philosophy within the content of the programme.

The ideal of good health for all can also be reasoned from the philosophies of Christian religion. This arises out of a recognition that the human person should be respected, both body and soul. Therefore, behaviours that could lead to a negative change in health would be injurious to the person and should be avoided, where possible. Since *Why Wait?* and *Challenge and Change* draw heavily from a Christian perspective, the expectation is that they could also address good health, using this particular framework.
In fact, content analysis reveals that all of these programmes do include references to 'health'. Proportionally, *Bloom or Doom* has the highest number of references, making statements about 'health' 33 times or in 1.1% of the lines of text in the Facilitator’s Handbook and 35 times or in 0.89% of the lines of text in *Bloom or Doom*. Although a handful of these are general references to the health care system or health professionals, the majority do provide insights into the ways that health is conceptualized and used within this programme. For example, the scientific, rational approach which individualizes responsibility for health choices is echoed in *Bloom or Doom*.

> We have a responsibility to respect our and others’ safety, health and welfare (*Bloom or Doom*:16).

This responsibility extends to a concern over both mental and physical health.

> A healthy balance between work and leisure can result in a happier, and fulfilled, life (*Bloom or Doom*:29)

> Have you ever thought what smoking can do to your health? (*Bloom or Doom*:43).

Since this programme focusses on HIV and AIDS, it is not surprising that health is frequently defined in these terms. Consequently, the goal of the programme is described in terms of maintaining good health by avoiding infection.

> In a nutshell, the handbook focuses on knowledge, attitudes and skills needed in order to help the youth avoid being infected with HIV/AIDS and other sexually transmitted diseases (*Facilitators’ Handbook*:IV).

This position is reiterated in the definition of AIDS prevention education which also affirms a connection to education and remaining healthy.

> AIDS Prevention Education is a body of knowledge, skills and attitudes meant to assist the learners to develop, adapt, and adopt behaviour that will enable them to
prevent themselves and others from being infected with HIV (Facilitators’ Handbook: IV).

This goal makes sense within a context of continuing good health status and is further emphasized in the list of general objectives, including:

...develop life (survival) skills that will enable them to lead AIDS/STDs free lifestyles;

...make decisions about personal and social behaviour that reduce the risk of HIV infections and STDs;

...participate in school and out of school activities aimed at prevention of HIV/STDs infections (Facilitators’ Handbook: V).

Since the Facilitators’ Handbook targets teachers as facilitators of AIDS education, further emphasis on the importance of teaching young people how to avoid infection is provided. This includes breaking down stereotypes about who could transmit the virus.

Most people with HIV look perfectly healthy before they develop full blown AIDS and they transmit the virus to others (Facilitators’ Handbook: 8).

In both Bloom or Doom and the Facilitators’ Handbook, avoiding HIV transmission and acquisition is viewed as a positive step towards good health for all, not only because it maintains the health of the individual, but also because of the ways that HIV and AIDS have impacted the health care system and overall health of Kenya.

Even before the AIDS epidemic, our country has been straining to improve the general health status of Kenyans. Now we [sic] require to cope with growing demands for hospital beds, health personnel and drugs (Bloom or Doom: 134).

Among the multiple consequences of HIV and AIDS which affect the health status of families, communities and the nation, this programme identifies several:
• loss of income transferred to medical expenses and/or following the death of the primary bread earner.
• loss of human productivity affecting the ability of the community and country to provide for the needs of its members – fewer teachers, doctors, farmers, etc.
• overloaded health care system.
• orphans left without adequate material, emotional and moral support (*Bloom or Doom*:132-135).

This programme extends its focus on health beyond a concern over the potential for HIV transmission and acquisition in that it also addresses the health of those who are living with HIV and AIDS. Specifically, both manuals discuss the physical, mental and spiritual needs of people living with HIV and AIDS (PLWAs). In *Bloom or Doom* this is accomplished in a 13 page section which includes a dialogue between an HIV-positive person and a health worker, followed by activities which require the young people to compose a series of menus, information about opportunistic infections and material needs that are appropriate for this person. This is set in a framework of care and compassion for those infected with HIV.

*Love, acceptance and assistance can make a difference in the lives of PLWAs and HIV infected persons* (*Bloom or Doom*:70).

The Facilitators’ Handbook also addresses forms of support for those infected and affected by HIV and AIDS. This is accomplished through a short section which discusses nutrition as one avenue for staying healthy.

*A well nourished person is less vulnerable to illness whether or not they have HIV infection* (Facilitators’ Handbook:75).

As well, in recognizing teachers as facilitators of AIDS education, there is one section devoted to guidance and counselling as one of the primary ways that teachers could be called upon to help teachers, pupils and community members who are infected or affected.
As a teacher you will need to be familiar with guidance and counselling techniques in HIV/AIDS related problems. This knowledge and skills will enable you to assist those who may need help in coping with various HIV/AIDS situations (Facilitators’ Handbook:28).

This is accomplished by providing a case study for teachers to review, then asking them a series of questions about the advice and information they might provide in this circumstance. Underlying this task is the recognition that guidance and counselling includes providing information affecting the health of the person and those around him/her. This includes advice about:

[How] Not to be reinfected and not to spread the disease...[and] How to continue living a productive life and take measures to improve her health (Facilitators’ Handbook:29-30).

Stepping Stones

With 56 references to health representing 0.57% of the lines of text, Stepping Stones is actually on par with the religious-based programmes. Approximately one dozen of these references are part of statements about health care facilities and/or professionals and are not substantially related to the ideal of good health for all. The remainder of the these references do closely resemble the concern for good health as outlined by public health with the exception that this programme frequently equates health with sexual health. This seems to permeate from the impetus for the programme which grew out of a concern for the ability of people to communicate about sexuality. In fact, the programme includes a definition of sexual health which highlights the physical and psychological components of sexuality.

Sexual health can be defined as being to do with [sic] sex that is pleasurable, free from infection and unwanted pregnancy and abuse (Stepping Stones:50).
Parallel to *Bloom or Doom*, *Stepping Stones* acknowledges that health is an individual responsibility.

*Someone's health status is their own business and not everybody else's* (*Stepping Stones*: 218).

As a result of this perception, individual behaviour change becomes a focal point for promoting good health for all.

*The manual is based on the assumption that community-wide change is best achieved through a personal commitment to change from each of its members* (*Stepping Stones*: 3)

The individuality of health is also used to justify motives for participating in the workshop.

*We still consider that sexual health and AIDS concern people enough for them to be ready to become involved in this workshop* (*Stepping Stones*: 14).

The primary metaphor of *Stepping Stones* is also used to illustrate the importance of a 'safe' journey through life.

*This training manual and video are designed to explore ways in which we can all begin to find a safe way across the river of life* (*Stepping Stones*: 9).

Recognizing that disease and illness are among the many potential hazards, the programme suggests that 'safety' includes remaining healthy, specifically by avoiding HIV transmission and acquisition. This is one of the identified purposes of this programme.

*...we offer you and your community some 'stepping stones' for avoiding the threat of HIV, but also for coping with the reality of AIDS, as you cross the river of life* (*Stepping Stones*: v).

According to this programme, there are several social, cultural and economic factors which influence the spread of HIV and AIDS.

*Many argue that the high prevalence of AIDS and the severity of its impact in Africa is closely linked to the lack of health and social service facilities, lack of formal*
education (especially for women), lack of equality between people in sexual relationships, and sheer general poverty (Stepping Stones:14).

Within this context, Stepping Stones also recognizes that HIV and AIDS is one health problem among the many that Africans must deal with on a daily basis.

For many people in Africa, AIDS is just one of many problems that they are having to face every day... Other health problems, such as malaria, TB, diarrhoeal disease, accidents and injuries and so on also need to be addressed (Stepping Stones:14).

This includes a recognition of the variety of sexual health problems across Africa.

There are also many other problems to do with sexual health, such as fertility control, infertility, sexually transmitted diseases (STDs), sexual abuse, female circumcision and others, which are rarely adequately addressed (Stepping Stones:14).

Consequently, the goals of one of the exercises aims to connect the definition of sexual health to the promotion of good health for all through informed, rational decision-making.

To enable participants to ask and discuss more questions regarding HIV, condoms and other issues to do with sexual health and safer sex.

The use of health workers as a source of information when addressing these problems is highlighted by one of the workshop activities, the goal of which is described as:

Two members [referred to as ‘health workers’] of the group try to give directions to the rest of the group about how to disentangle themselves from their problem (Stepping Stones:35).

However, the moral of this exercise is to present the ideal of working together with health workers rather than simply taking their instructions literally. This seems to reinforce the importance of communication as one of the primary ideals of the programme and of achieving good health for all.

Through better communication, community members may be helped to achieve something that they want for themselves, their families and their communities.
namely, improved care and support for those who are sick and improved HIV prevention practices for everyone (Stepping Stones:9).

**Challenge and Change**

Proportionally, the *Challenge and Change* study guides actually had slightly more references to ‘health’ than *Stepping Stones* with a total of 10 references representing 0.63% of the lines of text. However, the vast majority of these references specifically address HIV and AIDS as a health issue. This includes a mention of the macro level health impacts of the epidemic.

*From any standpoint human, economic,[sic] as a global health issue HIV/AIDS is a calamity (Be Afraid!:5).*

Although HIV infection does suggest a failure to maintain good health, this programme provides a recognition of the possibility of a continuing good health status even when one is HIV-positive.

*People infected with the HIV virus may remain perfectly healthy for even up to ten years before developing full-blown AIDS (Be Afraid!:3).*

*But if one should get infected to remember that it is still possible to lead a healthy, productive life; "that there is still so much to live for." (Why Me?:2).*

Although remaining healthy is treated as important, it is set within the greater context of physical, emotional, and spiritual health, which is achieved by making moral choices.

*It is a call and a challenge for everyone to think about one’s lifestyle and the choices one makes; to lead morally upright lives (Be Afraid!:2).*

Like *Bloom or Doom*, this programme moves beyond the ideal of health as prevention of HIV by including various discussions of the individual health impacts of being infected with HIV.

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[PLWAs] require a lot of support from family and friends to be able to maintain a positive attitude even with all the very serious issues they must grapple with (Why Me?:5).

**Why Wait?**

Proportionally *Why Wait?* has the fewest references to health, with 31 or 0.53% of the lines of text in unit 1 and 38 or 0.58% of the lines of text in unit 2. Most of these references seem to take a holistic view of health such that the ideal is to:

...*promote a healthy body, mind, and soul* (Unit 1:55).

This is set within the context of the definition of health given by the WHO:

...*one's complete physical, spiritual, social and mental well being and not merely the absence of disease or infirmity* (Unit 1:1).

Using this definition, the programme then goes further, suggesting that research from the WHO points to the efficacy of education based interventions – such as *Why Wait?* – over those of medical care projects.

Parallel to *Challenge and Change*, *Why Wait?* also highlights the need to make healthy choices that incorporate a concern for physical, emotional and spiritual health, suggesting that this programme:

...is more than simply admonishing them [the students] against harmful behaviour. It also extends to providing hope of a joyful and fulfilling future family life which comes from making healthy moral choices (Unit 1:1; Unit 2:1).

In this way, one of the primary goals of the first year of the curriculum is that:

[Students] learn to accept themselves, as they are, and to promote greater physical health by examining and choosing to avoid behaviours that can prove harmful (Unit 1:2, Unit 2:2).
Unique to this programme, the notion of emotional health is presented as an essential concept for understanding the health of individuals. So much so that an entire lesson in unit 2 is devoted to discussing what constitutes healthy and unhealthy emotional responses.

People need to identify how they respond to their emotions prior to learning to distinguish between healthy and unhealthy strategies for responding (Unit 2:83).

This concern for the relationship between emotions and health is further extended into an interpretation of the potential risks of sexual relationships.

Because of the emotional dynamics of a sexual relationship, one can be drawn into superficial relationships that will hinder the development of health, identity and true intimacy (Unit 1:47).

Consequently, abstinence from sexual intercourse until marriage is viewed as having a positive impact on one’s overall psychological, emotional and physical health.

By waiting, you’ll guarantee your physical health, emotional maturity, relational happiness and spiritual growth. (McDowell & Day, 1987) (Unit 1:23).

In this way, abstinence contributes to what becomes defined as a ‘healthy’ marriage.

If teenagers understand the physical, psychological, and spiritual reasons for a man and woman waiting until they have made a public commitment before sleeping with each other, ..., they are much less likely to choose the wrong partner and subsequently be victims of unhappy marriages and/or divorces (Unit 1:86).

Summary

Overall, there seems to be general agreement that HIV and AIDS is a significant health problem in Africa today. This is explicitly stated by all but Why Wait? which maintains a more holistic focus on problems facing youth, of which HIV and AIDS is one. As well, concern for health is also expressed by all of the programmes. However, the nuances are slightly different. Bloom or Doom appears to have the greatest consistency with the scientific, rational, harm reduction ideal of good health as is presented in public health.
Stepping Stones does mirror this interpretation while highlighting communication as a preferential medium for influencing the health status of communities.

Although not substantially concerned with health, Challenge and Change presents the topic within a framework which easily parallels the fact-based approach of public health and, therefore, its treatment of the concept of health fits well with both Bloom or Doom and Stepping Stones. Simultaneously, there are small nuances which, although not particularly explicit, underlie the programme’s holistic, faith-based understanding of health – as expressed in the ideal to Glorify God in your body (Think! :). This has parallels with Why Wait? which seems to be on the opposite end of this continuum between public health and Christian religion. Specifically, Why Wait? tends to focus more on the holistic interpretation of health by incorporating a recognition that health includes body, mind and spirit. In this way, Why Wait? appears the most distinct in presentation. However, parallels in terms of what is being communicated still exist so that it would appear that the common message in all of these presentations is that choices affect health. Therefore, the ideal is to optimise health by making the ‘right’ choices. What constitutes a ‘right’ choice is further influenced by the institution to which the programme is connected.

Biomedical Approaches

Recognizing that there are some general overlaps among all of these programmes with respect to the ideal of maintaining good health for all, the possibility exists that there may be some commonalities in the approaches used to achieve this. Within a public health framework, this specifically includes biomedical and behavioural methods.
From a public health perspective, recognizing that the primary target audience for these intervention programmes is the youth and other members of local communities, substantial discussion of microbicides, vaccines or alternative barrier methods as biomedical approaches to reduce exposure to HIV and AIDS (Gibney 1992), is generally not practical. Yet, given that these individuals are aware of the value of science as a problem-solving tool, failure to identify the potential existence of this research may lead to confusion or misinformation. Consequently, programmes from both institutional groupings do include references to vaccines, but only as a caution that they do not exist, and therefore behaviour is key to prevention.

There is no medicine or vaccine for HIV/AIDS (Bloom or Doom:95).

At present there is no cure and no preventative vaccine for HIV/AIDS (Why Wait? Unit 1: 66).

The Stepping Stones programme was the only one to identify other rare biomedical technologies, but again as a caution around their on-going development and/or difficulties around access.

In this manual we have not discussed the female condom or viricides. Whilst both of these are exciting developments,..., female condoms are still too expensive for widespread use and viricides are still only being developed (Stepping Stones:89).

Sexually Transmitted Diseases

Given that many sexually transmitted diseases have been found to be co-factors in HIV transmission and acquisition, the importance of discussing their early treatment and control is frequently raised as a biomedical approach (Dallabetta et al. 1999). Consequently, it is not surprising that the existence of STDs was included in all of the intervention programmes to varying degrees. Scientific in its basis, Bloom or Doom has the greatest
number of references to STDs/STIs with 33 references found in approximately 0.84% of the lines of text in *Bloom or Doom* and a further 11 references accounting for 0.36% of the lines of text in the Facilitators’ Handbook. *Why Wait?* referenced the topic 32 times, representing 0.55% of the unit 1 lines of text but only had 1 reference in unit 2. Similarly, *Stepping Stones* only included a total of 3 references and there were only 2 references in *Challenge and Change*.

As well, the perceptions around the specific reasons and approaches used to address STDs varied. At its simplest, the study guide for *THINK!* identified STDs as an undesirable consequence of inappropriate sexual behaviour.

> Pre-marital sex 'spoils' the sexual union. It is often done with many fears: of becoming pregnant or of being infected with sexually transmitted diseases (*THINK!* Study Guide: 6).

The brief coverage in *Stepping Stones* focusses on their role as risk factors for HIV transmission and acquisition.

> Open sores on the vagina or penis or sexually transmitted diseases (STDs) also increase the possibility of HIV transmission (80).

Alternatively, the greater number of references to STDs and STIs in *Bloom or Doom* – in both the resource book and facilitators’ handbook – as well as *Why Wait?* – primarily in unit 1 – suggest that both of these programmes are willing to provide details on this topic. In fact, both include an extensive discussion of the most common STDs, their symptoms and their potential long-term effects when left untreated. Although the information is parallel, there is a divergence in the interpretation of behavioural context in which STDs and STIs exist.

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Specifically, *Why Wait?* begins by linking behaviour and consequences while making an effort to stress that avoidance of the behaviour leads to avoidance of the consequences.

*In the decision making process it is important to know the consequences of STD's and since STD's are primarily behaviourally transmitted diseases, they can be avoided by right choices (Why Wait? Unit 1:55).*

Hence, the focus in *Why Wait?* is really on one’s ability to choose to avoid sex and therefore protect oneself from the harm of an STD. This position is further emphasized through the presentation of global statistics highlighting the prevalence of STDs among youth. Through the visual demonstration of a complex web of partners, it becomes clear that simply one encounter can be the equivalent of a “genital Russian roulette” because

...if YOU have sex with one person PARTNER 1, you are also by default, choosing to have sex with every other PARTNER that PARTNER 1 has had sex with (Why Wait? Unit 1:56).

A text box at the bottom of the page then suggests in bold capital letters that:

*IT’S YOUR CHOICE (Why Wait? Unit 1:56).*

In contrast, *Bloom or Doom* is set within a framework whereby STDs are defined based on their transmission through sex in such a way as to suggest that one person is responsible for giving the other the disease.

*An STD is a disease that is transmitted through sex. It therefore means that for you to get an STD you would have engaged in sex with somebody who has such disease (Bloom or Doom:51).*

*People become infected with STDs when they have sexual intercourse with infected persons (Facilitators’ Handbook:1).*

This sense of responsibility for transmission is carried further in the example of a story where a boyfriend and girlfriend have sex, then later she has sex with another boy with the latter two ultimately showing signs of an STD. The first question asked following this story is:
Among the three youths whom do you think was the initial carrier of the STD? (Bloom or Doom:51).

As the lesson progresses, questions of transmission become muted to those of action so that the seriousness of the situation is clearly brought to light and highlighted using several mediums which include a graphic box with a single line border and larger print, bold text reading:

*If You Suspect You've An STD Consult A Doctor Immediately* (Bloom or Doom:54).

Two stories used as examples – the first providing information about signs and symptoms, the second discussing some of the myths about STD treatments – are then used as a catalyst for discussing HIV and AIDS.

Ultimately, all of the programmes do recognize STDs as a potential consequence of sexual behaviour and/or as a risk factor for HIV transmission and acquisition. However, again divergence occurs with respect to the particular philosophies underlying the programmes. This is exemplified by the extent to which *Bloom or Doom* shifts to a rational, cause and effect interpretation of the acquisition and treatment of STDs as compared to the integral relationship oriented approach of *Why Wait?* Even with this difference, the inherent message of don’t have sex and you won’t get an STD seems to exist across the programmes.

**Condoms**

Since condoms function as a barrier method to stop the live virus from touching genital mucosa (Gibney 1992:2), they too are a biomedical intervention in the fight against AIDS. They also represent one of the most contentious issues raised within the context of HIV and AIDS prevention, particularly between public health and primarily Christian, religious organizations. However, in Africa, there are also cultural barriers to discussing
condoms, particularly with youth. Consequently, it is not surprising that 3 of the 4 programmes spend very little time addressing condoms.

The writers of *Bloom or Doom* seem reluctant to discuss this contentious issue and provide absolutely no references in the resource text which targets the youths. In part, this may be a result of the influence of religious and community leaders in the development process of this programme. The Facilitators’ Guide provides only a handful of references, specifically 9, representing 0.29% of the lines of text. These references aim to inform potential teachers about the efficacy of this technological tool. By limiting this information to the Facilitators’ Handbook, there appears to be an implicit suggestion that the decision to discuss this topic should be left to the adults. Consequently, the handbook contains primarily a simple, factual reference to the ability of condoms to protect against HIV and AIDS.

*The proper use of condoms prevent the transmission of HIV from one person to another* (Facilitators’ Handbook:9).

The authors also provide the various caveats which, although advocating for condoms, can have negative connotations by recognizing their fallibility and establishing their usage for particular types of people.

*The use of condoms as a contraceptive makes sex safer but not completely safe* (Facilitators’ Handbook:8).

*If you have broken skin in the private parts... If you have to have sex use a condom* (Facilitators’ Handbook:18).

*You can make sure by having some HIV tests in the district hospital and if one of you is infected or both, use protective measures like condoms for protection and avoidance of infection* (Facilitators’ Handbook:24).

In contrast, perhaps because it targets a somewhat older audience and was originally intended for use internationally, *Stepping Stones* provides the greatest discussion on
condoms, mentioning the word a total of 126 times in approximately 1.3% of the lines of text. This includes factual information aimed at dispelling myths around condoms during a discussion on HIV and an entire session devoted to learning about condoms and their usage. As part of the factual information presented, it is stressed that condoms are reliable but only if used correctly and consistently.

...this method is reliable only if the condoms are used correctly and with every act of sexual intercourse (Stepping Stones:84).

This is further substantiated by reference to a study of sero-discordant couples in Europe for whom those who consistently used condoms correctly over a 22 month period had no transference of HIV. Opportunity is also provided at this time to address fears around condoms, including that a condom could get stuck inside the female and cause her harm.

The session on condoms includes a video clip which shows how different peer groups can learn about condoms and their use as a way to encourage participants to overcome potential embarrassment around the topic. Interestingly, the text for this session is highlighted by a picture of a group of women putting condoms on bananas suggesting that this will be one of the tasks for the session. Following the viewing of the video, the group gathers for a facilitated discussion on condoms prompted by a series of questions provided in the manual. For illustrative purposes, each question is posed by a character and the response is located in quotes in a text box below him or her. Throughout this process, participants are encouraged to become familiar with condoms provided by the facilitator. A sample exchange is provided below:

What is the most important thing about a condom?

"To be sure you have one before you need it!"

(Hold the condoms up.) (Stepping Stones:94)
Instructions for this session emphasize the importance of allowing participants to respond to these questions as much as possible, as well as allowing them to raise and respond to their own questions. Therefore, the role of the facilitator should be limited to providing information when it is otherwise not given.

The ability of this programme to raise this discussion in so frank a manner seems natural given that it has greater flexibility with respect to the age of the participants and is designed to segregate participants by age and gender, making a discussion on condoms more viable. In fact, the writers feel so confident that providing factual information on condoms will increase interest and usage, they actually suggest that part of the preparation for the implementation of the programme should include an assessment of the availability of condoms in the area.

You also need to check whether, ..., a good regular and sustainable supply of condoms is available to the community, at a cost which can be afforded by women as well as men (Stepping Stones:22).

Given the philosophical and practical connections between the writers and implementers of Why Wait? and Challenge and Change, specifically the AIC and Catholic churches respectively, it is expected that there would be little mention of the word ‘condom’ in these programmes, or that, where discussion did occur, it would include multiple caveats against condom usage.

In fact, the Challenge and Change videos include approximately 11 references representing 1.2% of the lines of text about the videos themselves, all of which are found in Be Afraid! as part of a discussion on sexuality. There are a further 5 references representing 0.31% of the lines of text in the study guides. Proportionally, Why Wait? includes far fewer
references with 5 references in 0.09% of the lines of text in the unit 1 curriculum and 3 references in 0.05% of the lines of text in unit 2. The singular treatment and/or scarcity of references in this context shows an unwillingness to fully address condoms, regardless of where the authors themselves might stand on the topic.

Specifically, these programmes provide a variety of caveats around the value of relying on condoms for protection.

*Condoms have a significant failure rate and even with a perfect condom there are many opportunities for the transfer of fluids. Condoms are an unreliable means of protection against AIDS (Be Afraid Study Guide:8).*

*Don't buy the garbage of safer sex from they that seek money; They would sell you poison to get business while you slowly die; Why? With 15% failure rate of condoms, you cannot trust socks [to protect against thorns] (Why Wait? Unit 1:61).*

Highlighting the fallibility of condoms does not seem to exclude the possible recognition that they do provide some protection. Therefore, in a questionnaire about HIV and AIDS, *Why Wait?* includes the statement:

*The use of condoms reduces the likelihood of one partner getting HIV/AIDS from the other (Why Wait? Unit 1:62).*

In the solutions to this questionnaire, the response is true, suggesting that there is a willingness to recognize the benefits of condom usage when necessary.

In the end, however, both of these programmes seem to prefer to discourage the use of condoms as a way to reinforce the importance of abstaining from sexual intercourse.

*Condoms change the beautiful act into a matter of sexual convenience you are merely using your partner for your own pleasure which you must admit is pretty demeaning for both of you (Be Afraid).*

This is even incorporated into responses young people can give when being pressured to have sex as is demonstrated visually by a group of young boys circling Africa, one of whom states:
In this way, *Why Wait?* and *Challenge and Change* seem to downplay the rational application of condoms in favour of abstinence from sexual intercourse. This is not completely in contradiction with public health approaches as exemplified by *Bloom or Doom* and *Stepping Stones* which, although more positive about condoms, also recognize the inherent value in presenting a combination of techniques in their efforts to reduce the overall risks around HIV and AIDS. However, the possibility does exist that the contrasts between these messages will be confusing for the recipients.

**Behaviour Change Approaches**

As indicated in the theory section, public health based behavioural approaches aim to reduce the number of exposures to HIV by making connections between knowledge and attitudes and their influence on behaviours and practices. Consequently, the presentation of factual information is often used as a starting point to encourage individuals to modify risky behaviour. This is consistent with the methodologies of many religious organizations which also believe that facts are needed to make informed decisions. As a result, it is not surprising that all of the programmes included a generous supply of facts and information around HIV and AIDS in order to inform their target audiences about this syndrome.

This included definitions of HIV and AIDS:

*The Acquired Immune Deficiency Syndrome (AIDS) is caused by the Human Immune-deficiency Virus (HIV). This is a very strong rapidly multiplying virus that exclusively attacks and destroys the controller cells of the Immune system thus throwing the body's defence mechanism into total disarray. If destroys the body's immunity rendering the body open to infection and attack by a whole range of diseases (Be Afraid Study Guide:3).*
Statistical information about the spread and impact of HIV and AIDS throughout Kenya:

...in 4.5 days more than 3000 [people in Kenya] die from AIDS. Kenya is no exception. In sub-Saharan Africa, in the year 2000 it is estimated that 2.3 million died, with another 28 million living with the disease (Be Afraid).

In one part of Kenya a study showed that 18% of women were infected [with HIV] within 2 years of becoming sexually active (Why Wait? Unit 1:67).

Information about the modes of transmission:

HIV is transmitted from an infected person to another mainly through body fluids. These fluids are blood, vaginal secretions, semen and saliva (Bloom or Doom Resource Book:59).

Blood splashed into the mouth, eyes and on broken skin can transmit HIV (Why Wait? Unit 2:65).

And identification of some of the general signs and symptoms of AIDS:

<table>
<thead>
<tr>
<th>Major Signs</th>
<th>Minor Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unexplained weight loss of more</td>
<td>Recurrent shingles (herpes zoster).</td>
</tr>
<tr>
<td>than ten percent of the body in</td>
<td>etc...</td>
</tr>
<tr>
<td>three months</td>
<td>(Facilitators’ Handbook:2).</td>
</tr>
</tbody>
</table>

Within this framework, the programmes were also clear about the problems associated with assumptions around who may or may not be infected.

People infected with the HIV virus may remain perfectly healthy for even up to ten years before developing full-blown AIDS. However, during this period that they remain healthy, they may infect others (Be Afraid Study Guide:3).

You cannot tell by looking at anyone whether or not he/she carries the germ that causes AIDS (Why Wait? Unit 1:66).

Instead, all interventions emphasized the importance of testing as a way to ensure that any one person is HIV free.

The only way to know is through a test. This voluntary testing is essential if the epidemic is to be brought under control (Be Afraid).
...it is encouraged and highly advisable to undergo a HIV/AIDS test first [before marriage]. This should be done by both partners in an approved health facility (Bloom or Doom:23).

The importance of this test was also accompanied by a precaution because of the existence of a ‘window period’ during which someone could have a false-negative result for an HIV test.

...there are up to 3 months between the date of infection and the date when a test result would normally show positive (Stepping Stones:82).

This information was balanced by activities and stories that highlight how quickly HIV can spread to reinforce the need to be realistic about one’s risk for transmission.

Ask all those who have a "+" on their paper to come forward. Explain that this game is pretending that these people are HIV positive...Then ask those who greeted any of those who came forward first to come forward also to join their friends. Explain that this game is pretending that these people are at high risk of being infected with the HIV virus (Stepping Stones:76-77). [emphasis original]

As part of its scientific approach to HIV and AIDS, Bloom or Doom also provides detailed information about general health. This includes a description of how the immune system functions and the way that HIV attacks it. To assist students in learning this information, a role play exercise is provided as a visual demonstration.

I am HIV. I am deadly. I destroy the body’s immune system...My target cells are Helper T cells (lymphocytes) and macrophages (Bloom or Doom:87).

In some programmes, these facts were further emphasized through the use of pictures and other visual aids which occasionally appeared more frightening than informative. This is consistent with the use of fear based information as a deterrent for risky behaviour.

Pictured in the Facilitators’ Handbook: A young male is shown in the various stages of AIDS moving from appearing healthy to losing weight, becoming sickly looking,
losing hair, in a hospital bed and, ultimately, in a coffin. Each of these stages is then explained in the text following (3).

Be Afraid from the Challenge and Change video series also relies on fear as a deterrent for risky behaviour. This is enhanced through both images and facts. Specifically, by beginning with the funeral of a young woman, who, it is later revealed, died of AIDS which was transmitted by her one and only sexual partner, there is a clear sense that no one is immune. This point is reiterated in Why Me? when it is discovered that the main character who is now HIV positive, had sex only once. Simultaneously, the visual images of the deaths caused in the U.S. Embassy bombing in Nairobi and the Trade Centre disaster in New York provide a comparison point with respect to the number of people who die in Kenya on a daily basis from AIDS. These images are meant to outrage, and overwhelm viewers to the epidemic proportions of the impact of this syndrome on the country. This focus is further highlighted in the general objectives presented in the study guide which includes the belief that:

Any risky sexual behaviour and sooner or later it [AIDS] WILL get you. "Sometimes fear can be life-saving." (Be Afraid Study Guide:2).

In fact, it is this last quote that is echoed at several points within the video as a suggestion that knowing the extreme consequences associated with these risks could not only help to change behaviour, but ultimately to save lives.

Simultaneously, within this same series, Think! challenges the efficacy of fear based messages with respect to modifying behaviour in the long term.

Abstinence based on fear says: "I am avoiding sex so that I don't get AIDS." This kind of abstinence may help initially, but it is not a definitive solution. Living in fear is not healthy (Think! Study Guide:7).
Instead, they prefer to suggest that *Christians seek love* (7) and therefore, abstinence behaviour should be motivated by more than knowledge of risks.

Certainly, the belief that knowledge alone is insufficient for behaviour change does not negate the need for accurate information. An effort was also made by all programmes to identify and refute some of the commonly held myths about HIV and AIDS in order to ensure that the messages people were using to inform their behaviours were in fact true. These included myths around the existence of HIV and AIDS as a biological disease.

*I know for sure HIV/AIDS is a curse!* (Facilitators’ Handbook:21).

*Some people say that it is not a disease at all. That it is some sort of curse, that it is due to witchcraft* (Be Afraid!).

The existence of a cure:

*Jane:* *Come on, didn’t we read in the papers that they found a cure at KEMRI the other day?*

*Josephine:* *Oh yes, don’t forget the herbalist from Ukambani also who has found the cure* (Facilitators’ Handbook:20).

*I’ve heard it said that a man with AIDS can cure himself by having sex with a virgin or a small child. Now I find that hard to believe. Is there any truth in that?* (Be Afraid).

As well as addressing myths about how it is transmitted:

*You cannot give or get HIV by sharing food, touching, hugging, shaking hands, crying, sneezing, coughing, sitting close to other people or holding other people in normal ways* (Why Wait? Unit 1:65).

*Research has shown no evidence to support HIV transmission by mosquitoes* (Facilitators’ Handbook:9).

And who contracts HIV and AIDS:

*HIV/AIDS he says, is only contracted by prostitutes and truck drivers in the big towns* (Facilitators’ Handbook:20).
There was even a recognition of myths which associate future health problems with abstaining until marriage.

Yes, and there are some other stories I have heard about AIDS. For instance, not having sex could lead to sickness or madness (Be Afraid!).

[Young women may have a] fear of infertility if sex [sic] delayed (Stepping Stones:52).

Within the context of providing information for appropriate risk assessment and informing decision-making, building awareness of myths as myths reduces the likelihood that this false and/or misleading information will obscure the truth and thereby lead individuals and communities to underestimate their risk of acquiring HIV.

Of course, the types of decisions to be made and/or the behaviours being targeted through the provision of this factual material varies according to the type of programme. This was already evident in the discussion of condoms where public health based organizations – such as those which produced Stepping Stones and Bloom or Doom – provided a positive version of facts about condoms in order to advocate their usage as a risk reduction technique. Alternatively, the religious based organizations which produced Why Wait? and Challenge and Change preferred to emphasize the fallibility of condoms in order to discourage their use in favour of abstinence. Although both of these appear to be a manipulation of the information to suit the particular ideals being presented, it is nonetheless consistent with the philosophies and methodologies of the group in which these ideas have been constructed.
Risk Behaviours

In public health terms, part of the goal of establishing a continuing good health status for all involves calculated harm reduction as highlighted in the behaviour change models. Using facts and information, it is expected that not only will individuals know which behaviours are risky, but that they will be able to make rational decisions to reduce or completely avoid taking those risks. This perspective is reflected in both the public health programmes.

In AIDS Education we are encouraging the youth to know that AIDS is not an accident. AIDS is AVOIDABLE...Young people can avoid it if they are helped to acquire the necessary skills that will enable them to make rational decisions when confronted with situations that may lead to infection with HIV/AIDS (Facilitators’ Handbook:52). [emphasis original]

[the goal of the exercise is] To help participants consider situations which involve sex and risk-taking in their own experiences; and to help them think of other ways of handling them through analysis of the circumstances (Stepping Stones:119).

Since the primary focus of these programmes is HIV and AIDS, risk is overwhelmingly defined in these terms particularly within the two public health interventions. As a result, the concept of risk generally carries a negative connotation and is associated with people making bad choices that lead to unfortunate consequences, the most problematic being AIDS. This invites an attitude of ‘blame the victim’ that is highlighted in the discussion of ‘Taking Risks’ in the Stepping Stones programme.

We often tend to feel that it is OK to take risks, if they turn out well. We might be praised for our courage! But we tend to blame others if they take risks and things go wrong (Stepping Stones:68).

Despite this possibility, these programmes prefer to provide in-depth information about potential risks, expecting that this presentation of outcomes as negative and
undesirable, will, ultimately, encourage positive behaviour change. The *Bloom or Doom* Facilitators' Handbook demonstrates this conceptual link through a table which shows how particular behaviour patterns which are perceived as inappropriate or risky—such as misuse of leisure, multiple sex partners and social/cultural risks—can lead to negative consequences—including STD/HIV infection, pregnancy, and other social consequences.

Both *Bloom or Doom* and *Stepping Stones* appear to draw from the social and cultural contexts in their description of risks as they relate to the transmission and acquisition of HIV. Thus, some of the risks discussed include:

- **social risks** such as excessive use of alcohol or drugs (*Bloom or Doom*: 40-50; *Stepping Stones*: 122-125).
- **risks from a transference of body fluids** from blood transfusions, the use of unsterilized needles or razors, exposure through open wounds (*Bloom or Doom*: 59-61, Facilitators' Handbook: 13; *Stepping Stones*: 80-81).
- **cultural activities** such as circumcision rites, wife inheritance, a new bride having sex with her husband's father, widow cleansing, sexual promiscuity at wedding and funeral ceremonies (Facilitators' Handbook: 12-14; *Stepping Stones*: 119-122).

Concern for these patterns of behaviour and perceptions around their associated risks are raised throughout these programmes as a way to inform the target audience and assist them in reducing their risk exposure by behaving responsibly. Within *Bloom or Doom*, this is translated for the young people as follows:

*Being responsible means:*-

*Not being careless about yourself and about other people.*
*You are able to make rational decisions about how to conduct yourself.*
*You are able to use your energy, knowledge, experience and other talents to help yourself and others* (*Bloom or Doom*: 16).

Since the preference in *Challenge and Change* and *Why Wait?* is to focus on relationships and behaviour within a particular moral framework, there is little discussion about these forms of risk. Although *Why Me?* does include a mention of potential risks from
blood exposure, and Think! highlights social influences on the behaviours of young people, the difference in context suggests that the focus is not as heavily about reducing risk to avoid transmission and acquisition, but rather about making choices which fit within the faith-based framework of the associated religion which have the added benefit of preventing HIV transmission and acquisition.

Sexual Behaviour

In the context of HIV and AIDS, it would be irresponsible to talk about risk and behaviour change without some consideration for sexual behaviour. Thus, since the majority of HIV infections occur as a result of sexual encounters, this was one of the primary foci for all of the programmes. Consequently, each makes some reference to abstinence from sexual intercourse as a way to reduce the risk of HIV transmission and acquisition, prevent unwanted pregnancy and the transmission of other STDs.

Changes in sexual behaviour remain the cornerstone of prevention. The only true solution is a moral one. As Paul affirms in the film "the only way of prevention is chastity." (Be Afraid!)

Stop don't' gamble with life, you have others to think about; Life, yours and others, depend on your chastity and integrity;...AIDS is a reality and a disaster (Why Wait? Unit 1:61).

Also, you have to abstain from sexual activity which may lead to getting pregnant, STDs and the dreaded AIDS (Bloom or Doom:7).

Children should be taught to abstain from sex until marriage (Facilitators' Handbook:24).

Within this context, both Stepping Stones and Bloom or Doom also make reference to the ABC's of safer sex.

The AIDS messages we hear all around us are simplified into an ABC of rules: Abstain! or Be faithful! or use Condoms! (Stepping Stones:9).
For the latter, discussion of this process is restricted to those who are already HIV positive and is contained only in the Facilitators’ Handbook – the portion of the programme which is not readily available to the youth. This may be due to the influence of social, political and religious leaders on the development and implementation of this programme.

_Begin living positively with HIV infection i.e. feed well, seek medical care, practice ABC of safe sex_ (Facilitators’ Handbook:34).

The philosophical and methodological differences between public health and Christian religion seemed to contribute to the general differences with respect to how sexuality was addressed in the various interventions. As was previously discussed, the public health literature suggests that sex is a biological fact such that most people will engage in some form of sexual behaviour during their lifetime. Consequently, it becomes essential to consider the forms which that behaviour takes and make suggestions about the ways to restrict potential avenues for HIV transmission and acquisition.

Given their connection with public health, it is not surprising that _Stepping Stones_ and _Bloom or Doom_ primarily stayed within the behaviour change model of knowledge and attitudes informing risk and requiring changes in behaviours. However, the extent to which they made recommendations within this framework seems to have been influenced by their respective target audiences. Thus, since _Stepping Stones_ primarily targets adults, but may include youth, it tended towards a more liberal treatment of sexual practices. This was translated into a thorough discussion of various sexual activities and their potential risks. For example:

_Drying the vagina by any means makes tearing and bleeding more likely. This makes the risk of HIV transmission greater, not less_ (Stepping Stones:84).
This leaves them in the unique position of being able to recommend various forms of ‘safer sex’ as viable alternatives. These include:

- no-penetrative sex, such as masturbation, massage, rubbing, and hugging;
- using a condom for all penetrative sex (vaginal, anal, oral);
- staying in a mutually faithful relationship, where both partners are uninfected (Stepping Stones:80).

It is emphasized that the ultimate goal with respect to sexual practices is to reduce potential exposure as much as possible.

*If we are involved in sexual activities, the safest way of limiting transmission of the virus is for us all to adopt safer sexual practices, whether we are negative or positive. This allows us both to protect and care for others, as well to protect and care for ourselves (Stepping Stones:84).* [emphasis original]

Alternatively, because *Bloom or Doom* targets specifically youths in and out of schools, they seem more hesitant to recommend any form of sexual activity as a way to reduce risk. This was already reflected in their slight reluctance to advocate for the use of condoms. Instead, it would appear that their goal is to teach young people simply to abstain from sexual intercourse.

*Children especially those who are sexually active like teenagers stand a high risk if they engage in sexual intercourse with infected partners. Children should be taught to abstain from sex until marriage* (Facilitators’ Handbook:24).

The emphasis placed on sexual behaviours that may be practised by youth in this context actually seems to carry a highly judgmental quality. Specifically, there is a section in *Bloom or Doom* entitled “WRONG SEXUAL RELATIONSHIPS” (17). In fact, they are so emphatic about this judgment on these behaviours that this title is included as the first subtitle in the section on “Responsible Behaviour”, therefore it is not only written in bold capital letters on the page, but this topic title is also listed in the table of contents.
Within this section, these relationships are identified as *Sugar Daddy/Sugar Mummy relations with adolescents* (Bloom or Doom:17) – that is young girls with older men or young boys with older women, an image of which is included with the discussion, *Commercial Sex* (Bloom or Doom:18) and *Homosexuality and Lesbianism* (Bloom or Doom:19). Included within this section are two other subsections “Consequences of Commercial Sex” (Bloom or Doom:19), which poses questions about potential physical, health and legal risks associated with this activity, and “Consequences of Wrong Sexual Behaviours” (Bloom or Doom:20), which primarily focusses on unwanted pregnancies and its related effects. Since this particular text targets youth, this section reinforces rigid sexual standards which coincide with both the Christian and cultural sexual norms.

*Risk in the Christian Programme Context*

Ultimately, the public health programmes identify risk in order to suggest alternative ways to avoid a particular end. The programmes which are based in Christian religion also discuss risk, however the focus remains on faith and its connection to appropriate behaviour. Thus, as previously indicated, *Be Afraid* does associate sexual behaviour with risk for HIV acquisition. However, because of the desire to focus on abstinence, the ideal is to avoid all sexual contact outside of marriage. Thus, the possibility of acquiring HIV even though one is in a monogamous relationship is also raised.

*You heard this story about a girl who only had sex with her boyfriend. She was shocked when she found out that she was HIV positive. Her boyfriend had slept with only one other girl who had slept with 5 other men who had in turn slept with 19 other women. Between them, these girls had slept with 65 other men (Be Afraid).*

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Certainly *Why Wait?* also recognizes that there are risks for HIV transmission and acquisition which individuals are able to avoid.

*While there is this need, we children should do everything possible within our capacity to stop the spread of the disease. I therefore call on all fellow school goers to avoid risky behaviour* (*Why Wait?* Unit 2:42).

However, within this programme, risk is not solely defined in reference to HIV and AIDS. Instead, as part of a larger Christian framework, the concept of risk is also used to connote a positive quality necessary in developing relationships and discovering one’s true self.

*Empathetic listening involves risk.*

- *It takes a great deal of security.*
  - You open yourself up to be influenced.

*It is only in taking risks that we discover who we are, thus making it possible for us to explore our potential and develop higher levels of skills, competencies, values and attitudes* (*Why Wait?* Unit 2:91).

It is this treatment which highlights the philosophical difference between a rational approach to behaviour change which is based upon adequate knowledge of risk as presented in public health based programmes, and the holistic understanding of one’s relationship to God, self and others which provides the foundation for the religious programmes. Thus, although there are spaces in which the Christian religion programmes coincide with the philosophies and methodologies of public health, they do so within the framework of their own institutional philosophies and methodologies. The question then becomes: Is there a similar overlap with the public health programme and the philosophies and methodologies of Christian religion?
COMPARISONS WITH THE PHILOSOPHIES AND METHODOLOGIES OF CHRISTIAN RELIGION

Continuing with the analysis of programme content within the framework of its institutional influence, this chapter will look specifically at the ways that the philosophies and methodologies of Christian religion are reflected in these programmes. Recall that religion is an expression of faith. In the case of Christianity, it is an expression of faith in a Triune God which carries certain expectations around attitudes and behaviours which have been constructed in a particular European context. Among the fundamental precepts established in that process is the call to love via the ‘Great Commandment’. This is addressed through a focus on expectations about forms of communication and expressions of agency with respect to how these are practised and impact upon one’s relationships with God, self and others. These ideals of how one should relate to the world are described using theological language which variously references forms of reasoning, the Bible, spiritual expression and perceptions of God within the messages. Thus, the question posed in this analysis is:

To what extent do the messages in Why Wait? and Challenge and Change coincide with the philosophies and methodologies of Christian religion? An addendum to this is whether there are similarities and differences between these programmes, which were selected because of their connection to Christian religion, and Bloom or Doom and Stepping Stones, which were selected because of their connection to public health.
Love as an Expression of Faith

A focus on the call to love and the resulting expectations around behaviour presents one of the major disjunctures between public health and Christianity. Specifically, where the goal of public health is to challenge individuals to behave in such a way as to maintain good health, the goal of many of the Christian denominations is to challenge individuals to behave according to the moral precepts reasoned based on the call to love. Therefore, while public health considers the nature of the behaviour as secondary to its impact on health, Christian religions believe that it is the nature of the behaviour that will influence one’s ability to maintain a ‘right’ relationship to God, self and the world.

This reference to the call to love as a way to establish behaviour patterns consistent with a particular interpretation of a ‘right’ relationship to God, self and the world is evidenced in Why Wait? and Challenge and Change where the word ‘love’ itself appears proportionally at least 6 times more often than in either Bloom or Doom or Stepping Stones. There are also differences in the ways that ‘love’ is referenced. Specifically, for Bloom or Doom and Stepping Stones it is discussed as a way to distinguish certain types of relationships as with courtship or marriage. There are also references to expectations with respect to the treatment of PLWAs. Why Wait? and Challenge and Change include these types of references, however, they are set in a more holistic context whereby all relationships are expected to incorporate some form of love because of humanity’s relationship to God.

For example, in Bloom or Doom, of the 13 references representing 0.33% of the lines of text, more than half are directly related to showing love and compassion to those who are infected or affected by HIV and AIDS.
It is important to treat the infected persons with a lot of love and understanding (Bloom or Doom:130).

Certainly this attitude is echoed in Challenge and Change both in its discussion of PLWA through Why Me? AIDS – a call to love, as is demonstrated by its extended title, as well as being discussed in Be Afraid.

It is important to show love and compassion to the sick and dying, and their families (Be Afraid:12).

However, there is a sense in Bloom or Doom that showing love and compassion for PLWAs is practical because of the potential impact on the individual’s health. This can be contrasted with Challenge and Change which underscores the expectation that Christians should love for the sake of love.

[PLWAs] should be assisted to live meaningful lives within the community and with their families. Love, acceptance and assistance can make a difference in the lives of PLWAs and HIV infected persons (Bloom or Doom:70).

[This programme is a] ...call to love, to see ourselves in those with the virus and to treat them with compassion (Why Me?:1).

Among the remaining references found in Bloom or Doom, there are some connections to love as part of courting rituals.

...learning to know and to love one another, these activities are known as courtship. If the boy and the girl get to love each other, they may propose to marry (Bloom or Doom:23).

In parallel with this connection, the 4 references found in the Facilitators’ Handbook are focussed on the exploitation of the concept of ‘love’ as a way to pressure the girl into sex during a dating relationship.

Jane: Yes. You know I love you. But we have to wait until we get married. Don’t forget your promise (Facilitators’ Handbook:56).
Using the notion of love in a similar context, virtually all of the 35 references representing 0.36% of the lines of text in *Stepping Stones* are contained in one session entitled *What is Love?* The primary focus of this exercise is to explore the socially constructed meanings of love between siblings as compared to spouses as compared to 'lovers' (i.e., not publically acknowledged partners). This leads the discussion to the questions:

- *Does love = sex, or does love = marriage? Do they automatically go together?*
- *If love does not = marriage, what at least are the minimum levels of respect which they think each member of the couple should show each other?* (*Stepping Stones*:60-61).

These questions are also explored among the 46 references representing 2.9% of the lines of text found in the *Challenge and Change* study guides. This is evident in the extended title *Think! Sex or Love?*, which, in the video and study guide includes a discussion of the overall purpose of human sexuality as it relates to God's plan and to love (*Think!*:2). Similar to *Stepping Stones*, the distinction is made between sex and love so that the latter does not -- should not, according to the expectations of Christian religion -- necessarily lead to the former.

*When two young people "fall in love" they start thinking that it is all right to have sex; after all, they love each other. They begin to confuse their sexual attraction for love...love is more than emotions; love requires commitment and you are not committed until you get married."* (*Think!*:4).

*Why Wait?* also includes a discussion of what love is and what constitutes a loving relationship in its 150 references found in 2.6% of the unit 1 lines of text and the 353 references found in 5.4% of the unit 2 lines of text. This is highlighted in the lesson entitled *Is it Lust or Love?* (Unit 1).
All too often individuals confuse love and lust. God’s kind of love is directed outward toward others and their well being, not inward toward oneself. True love will not use other people. True love will wait for the commitment of marriage to express love sexually (Why Wait? Unit 1:39).

Despite these similarities in content, there is a difference in the underlying context in which love is understood. Specifically, for the programmes based in Christian religion, it is evident that the understanding of love and its impact on relationships permeates from a theological framework which sets the model for human relationships as God’s relationship to the world. The layers of this framework can be viewed in the content of the Why Wait? manuals simply by looking at some of the titles for the lessons. These include:

Unit 1:
- True Love Provides and Protects;
- True Love Provides Security and Significance;
- Is it Lust or Love?;
- Love is a Choice;

Unit 2:
- Love: An Act of Will
- Responding with Love
- Learning to Search for and Identify True Love;
- Loving Your Neighbour as Yourself;
- The Characteristics of Love;
- Love is Patient;
- Love is Obedient;
- Love is not Jealous;
- Love is not Arrogant;
- Love is not Resentful;
- Love endures All;
- Love is Faithful;
- Love, Sex and AIDS.

Since many of these titles reflect the discourse on love found in Paul’s letter to the Corinthians (1 Cor 13), this suggests that the characteristics of love within this programme are connected to Biblical presentations and constructions of God’s relationship to God’s people. This is one of the ways in which, historically, Christians have explored the ‘Great
Commandment' as it ought to be lived by the people. By deconstructing love with such
detail, it seems as though this programme is making an effort to help young people
understand love in this traditional, European way. In fact, both of the Christian-based
programmes seem to highlight and reinforce this particular perspective on love.

Using the Bible and theology, Challenge and Change and Why Wait? develop this
Christian approach to love in order to reinforce the established Christian framework for
relationships and behaviours and relate this to HIV and AIDS. This process is founded upon
the recognition that because human beings are created in the image and likeness of God, they
are special. It is in this creation that humans are called to live in relationship with God and
others.

We have been created in God's image that we might have a living relationship with
Him and that we may honour and glorify Him. The very essence of the Christian life
is built upon relationships and the development of godly character through the
relationships (Why Wait? Unit 1:4).

As well, God, through Jesus Christ provides the model for understanding the nature of these
relationships and establishing the criteria for behaviour.

There is a connection between vision and virtue, i.e. what we perceive to be real and
true, right and wrong. One has to see correctly in order to act correctly. It is for this
reason that the person of Jesus Christ becomes the model for character development
(Unit 1:1; Unit 2:1).

Since Jesus showed love and compassion to all people, including the sick and the sinner,
Christians are expected to do the same. This ideal is extended to people living with HIV and
AIDS.

We ought to follow the example set by Jesus. He always showed love and compassion
(Be Afraid:12).
Doing so, provides the individual and his/her family with a sense of hope that can help sustain them.

*It is important to show love and compassion to the sick and dying, and their families. Give them hope. It is hope that keeps a person going when he would normally be defeated (Be Afraid:12).*

It is in living these ideals that Christians can become models for the world, showing others the importance of sharing God's love.

*The expression of love to others is the ultimate witness of the Christian faith to the world (John 13:35) (Why Wait? Unit 1:4).*

It is within this context that expectations are placed on the moral decision-making processes of individuals based upon the specific belief systems and codes of ethics for that particular expression of Christianity. For example, according to the curriculum goals of Why Wait?, a relationship with God and Jesus Christ are expected to provide the foundation on which individuals make decisions about appropriate behaviour in general.

*The WHY WAIT? Programme is designed to educate the school children and youth in God's principles of character and moral development and sexual purity; introduce them to Christ and His principles in order to develop a godly self-concept; and show how He can empower them to withstand social and sexual pressures (Unit 1:1; Unit 2:1).*

Similarly, the study guides for the Challenge and Change video series also highlight the importance of the particular belief systems and codes of ethics of Christianity in guiding behaviour both with respect to avoiding HIV transmission and acquisition and interacting with those already infected or affected by it as part of their general and specific objectives.

*Emphasise that life is a precious gift from God and it is everyone's responsibility to make the right choices (Be Afraid:2);*

*Illustrate that in making the right choices we obey God and lead happier lives (Be Afraid:2).*

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A call to love, to see ourselves in those with the virus and to treat them with compassion (Why Me?:2).

Within the context of the Christian concept of love, the love between husband and wife is described as one of the most intimate relationships one can experience. Sex is viewed as an expression of that intimacy and love. Consequently, the patterns of behaviour and codes of ethics established by the various denominations incorporate some understanding of the specialness of the love between married partners. Since Challenge and Change is connected to the Catholic church, its belief systems and codes of ethics include the Catholic ideals of sexual morality. Within this context, the programme describes sexuality as a gift from God which allows humans to participate in creation, bringing them closer to God and to humanity. Consequently, it is expected that sex should take place only within a framework that will honour its specialness, namely a loving, committed, married relationship.

In Genesis 1:27, we see God created man and woman in His image and this clearly tells us that our sexuality is a gift from God (Think!:7)

Through the gift of our sexuality, every man and woman can in marriage participate in God’s sacred act of creation, through the procreation of children (Think!:8).

The act of sex itself is not only described as a gift from God, but it is also seen as a gift of love between married partners. This metaphor underscores the perception that in marriage, the two become one and should not be divided.

When you give your body to someone of the opposite sex, you are giving your very self. This gift has to be total, you give yourself to one person and one person only it is a permanent gift, you can never get it back (Think!).

Since sex is viewed as a total gift of self, virginity is constructed as one of the most precious gifts of all because it is a challenge to young people to save the gift of one’s sexuality for one
person. Giving one’s virginity away prematurely makes an individual incomplete when the time comes to join in marriage.

*Virginity is precious. Once given, you can never take it back. Having pre-marital sex is like giving away something valuable because we do not know how much it is worth.*

In the video, Steve gives the example of a half bottle of soda. One would feel cheated buying it (Think:5).

Using a parallel interpretation of the special quality of sexual intercourse, *Why Wait?* also encourages young people to search and wait for that ideal marriage partner rather than allow themselves to be confused by lust.

*When young people understand the true meaning of love as a triangle of commitment, intimacy, and passion, rather than just an emotional feeling, they are less likely to succumb to infatuation and lust, and will thus make wiser choices in identifying a lifetime partner (Why Wait? Unit 2:34).*

*When two young people "fall in love" they start thinking that it is all right to have sex; after all, they love each other. They begin to confuse their sexual attraction for love. As Steve points out in the video, "love is more than emotions; love requires commitment and you are not committed until you get married." (Think Study Guide:4).*

In this way, the focus in these programmes is on recognizing that love is not found by simply having sex. On the contrary, sex is best experienced once ‘true love’ has been found and expressed it in the commitment of marriage.

*You just mentioned sex and love. They are not the same thing. We all want to love and be loved. And many teenagers think they will find love by having sex. That isn’t true. Having casual sex is like picking up a rock from the ground. Not very difficult for there are plenty to be found. But finding love is like a diamond it’s as precious as that. Finding it is one of the most difficult goals of your whole life (Think!).*

*All too often individuals confuse love and lust. God’s kind of love is directed outward toward others and their well being, not inward toward oneself. True love will not use other people. True love will wait for the commitment of marriage to express love sexually (Why Wait? Unit 1:39).*
Failure to wait is constructed as having implications for finding that future love and being able to participate fully in a married, committed, loving sexuality. This occurs because efforts to give one's self totally to one's married partner are clouded by past sexual experiences with others, reducing the ability to focus on his/her partner.

*Our mind is like a piece of film or a video tape—it will record these peak experiences and then play them back. They are "reruns in the theatre of our minds." We can't control the flashbacks. Consequently we take these "reruns" or flashbacks with us to the marriage bed. Instead of the full focus of love and desire toward our marriage partner, we also take the memories of past sexual desires and experiences with us—thus defiling or deluding the sexual expression of committed love to, our marriage partner (Why Wait? Unit 1:84-85).*

It is this construction of the quality of love as experienced in marriage and its connection to one's ability to relate to his/her ‘true love’ sexually which sets the parameters from which individuals are expected to make choices about their sexual behaviour. The moral imperatives of sexual behaviour come from these ideal visions of sexual relationships.

**Relationships and Behaviours**

Constructing the explanation and interpretation of the ‘Great Commandment’ in this way becomes the catalyst for establishing proper behaviour particularly with respect to various forms of relationships. In particular, this perception mediates ideas about the ways people communicate and the extent to which they can express personal agency.

**Communication**

The ability to pass messages from one person to another is at the heart of the cycle of communication. However, the context and purpose behind this interaction can influence how this process can be explained. Consequently, as public health focusses upon the use of communication to pass on information so that individuals can make informed decisions
around 'safe' behaviour, effective communication is frequently measured by whether the message was properly received. It is this focus which permeates Bloom or Doom’s discussion of communication as indicated in their objectives for the section.

In chapter 2 you learned about responsible behaviour. You also wrote something about how you can pass messages about AIDS through games and other activities. To pass a message is to communicate (Bloom or Doom:109).

This form of communication becomes two way when the message is received and an answer is given. In this way, effective communication is defined as a skill which can be developed and learned. This process includes the need to also draw upon other skills.

A good communicator must use interpersonal skills so as to bring the acceptance of a message and also to cause the recipient to act on it. Persuasive skills are used by a communicator to help the recipients in making decisions towards the desired direction (Bloom or Doom:16).

Although this is described as particularly important when communication takes the form of counselling whereby the counsellor becomes the primary informant for information passed on to others, it is also possible for peers to simply pass information to each other. Thus, the programme cautions students to consider the potential reactions of their peers when communicating information.

Try never to frighten your friends. Give information in a friendly atmosphere; Always make sure you have the facts so as to avoid misinforming your friends (Bloom or Doom:19).

Communication is also listed as one of the primary goals for Stepping Stones. Specifically, in the introductory section, the explanation states that:

This training manual and the accompanying video have been produced in response to a growing need for material to address our communication problems about sexual attitudes and behaviour (Stepping Stones:8).
It is with this in mind that several complete sessions explore the hows and whys of communication by looking at everything from listening skills, to perceptions and judgments of others, to the ability to be more assertive in making requests. In fact, bringing together the knowledge and experience gained from all of the sessions, the participants are asked to prepare and present a request to the community for a final open meeting. This process is meant to draw particularly upon the communication skills that participants have developed during the course of the workshop sessions, leaving them to:

...think of and decide upon one special request concerning their own lives and HIV, which they would like to ask the whole of their community to accept (Stepping Stones:188).

In this way, it is expected that the communication skills learned become the catalyst for a more communal transformation in behaviour.

Although Challenge and Change does not include an explicit discussion of communication, likely due to its format as a series of stories, Why Wait? does provide a contrast to this information-based form of communication. Specifically, this programme describes interpersonal communication as having both breadth and depth such that friendships are built by moving from impersonal to personal forms of communication. These are listed as follows:

- **CLICHES involve the least self-disclosure**
- **FACTS also involve little self-disclosure**
- **OPINIONS, IDEAS and JUDGEMENT involve a somewhat greater amount of self-disclosure**
- **FEELINGS shared involve a much greater self-disclosure**
- **TRANSPARENCY takes place as we share to a significant degree personal information about ourselves** (Why Wait? Unit 2:74-75).
Utilizing forms of communication which involve more and more self-disclosure is described as allowing individuals to come to know each other and express love for each other. The ideal of transparency is further exemplified using an example from the life of Christ.

Unlike gurus who have remained aloof from their disciples, he [Jesus] lived out his life squarely in their midst. Breaking bread with them, praying with them, weeping with them, helping them resolve their quarrels, he was intensely involved in their common life (Why Wait? Unit 2:75).

It is this sense of open and honest communication between people which is held as an ideal foundation for loving relationships.

Transparency leads to true intimacy.
Intimacy can be described as: "In-to-me-see." (Why Wait? Unit 2:75).

In this way, the programme suggests that communication needs to extend beyond facts to include spaces of vulnerability and openness which reveal not only what is 'known' but what is 'self'. Although achieving this level of communication may be difficult, it is expected that to do so can result in a deeper sharing of experiences between friends and spouses.

Sexual Relationships

Recognizing that Christian perceptions of sexual relationships are rooted in both the Platonic rejection of the body and the Jewish ideals of marriage, this framework has become the foundation on which precepts around these relationships are built. Consequently, abstinence outside of marriage and fidelity within it are generally privileged by the moral discourses of Christian religion. This becomes the primary expectation for sexual behaviour. Therefore, the goal of the programmes is to provide the justification and tools necessary to achieve this ideal.
Justification is achieved by using the language of abstinence and chastity, the latter of which is not included in *Bloom or Doom* or *Stepping Stones*. Referenced 10 times in *Challenge and Change* representing 0.63% of the lines of text, and 5 times in unit 1 of *Why Wait?*, chastity is identified as one of the virtues that can help youth lead a righteous life. In this context, it is defined as:

...abstaining from sex outside marriage; pure, decent or modest (*Think!*:9).

To reinforce the importance of living this virtue, the programmes describe sexuality as having a special quality which requires that young people be taught about chastity.

...the underlying philosophy involved in teaching children the value of fidelity and chastity is that sex is too beautiful and too good to be given or used or thought of loosely or without commitment (*Why Wait?* Unit 1:81).

The reasons to remain chaste are further outlined in *Think!* and include the paradox of saying ‘no’ today as a committed ‘yes’ for a future marriage.

*Abstinence based on love means ‘No’ in view of saying a committed ‘Yes’ in marriage when you give yourself completely to your spouse* (*Think!*:7).

This commitment is presented as important not only for the married relationship, but also because it reflects upon the character of the individual suggesting that one who is unable to abstain lacks self-control which can then influence one’s sense of self-respect and dignity.

*No self control, no self respect, no self dignity* (*Think!*:7).

From a practical perspective, both *Why Wait?* and *Challenge and Change* present chastity as the ideal way to prevent HIV transmission and acquisition among youth.

*Changes in sexual behaviour remain the cornerstone of prevention. The only true solution is a moral one. As Paul affirms in the film "the only way of prevention is chastity."* (Be Afraid!:7)
"Stop don't' gamble with life, you have others to think about; Life, yours and others, depend on your chastity and integrity;...AIDS is a reality and a disaster (Why Wait? Unit 1:61).

Although *Bloom or Doom* and *Stepping Stones* contain no references to 'chastity', they do include a handful of references to abstinence, although proportionally the number of references in *Challenge and Change* and *Why Wait?* are at least twice as common. Specifically, *Bloom or Doom* mentions abstinence twice representing 0.05% of the lines of text with a further 6 references representing 0.19% of the lines of text in the Facilitators’ Handbook. *Stepping Stones* mentions abstinence 5 times representing 0.05% of the lines of text. In comparison, *Challenge and Change* includes 7 references to abstinence representing 0.44% of the lines of text and *Why Wait?* includes 22 references over 0.38% of the lines of text in unit 1 and 16 references over 0.25% of the lines of text in unit 2.

As already discussed, some of these references address the ideals of behaviour change and risk reduction so that abstinence becomes one way in the public health context, but essentially the only way in the context of Christian religion\(^4\) to avoid HIV transmission and acquisition and/or the possibility of pregnancy or the transmission of other STDs. All of the programmes also include some discussion of the expected norms for sexual behaviour. Among the references found in *Stepping Stones*, there includes a discussion of some of the problems associated with abstaining. This suggests that it may not be possible for all people to abstain, recognizing that not all people live up to ideals, and reinforcing the public health position that alternative harm reduction approaches are needed.

\(^4\)Recall, *Why Wait?* does include one reference to condoms as a form of protection.
However, many people also find this [abstinence] a difficult option, perhaps especially because of peer pressure on young men to prove their manhood by having sex with their girlfriends (Stepping Stones:84).

In contrast, Why Wait? and Challenge and Change both make an effort to address some of the misconceptions that may be used to argue against abstaining.

Here are a few of the myths that are circulating and used to justify sex outside of a committed marriage relationship. They are completely false.

- There are health risks in repressing sexual urges.
- If you don't use it you will lose it - the idea that the lack of sexual activity will cause impotency (Why Wait? Unit 1:49)

Virginity does not lead to problems in childbirth. Abstaining from sex does not lead to sickness or madness (Be Afraid!:9).

Breaking down these myths seems to be used as a way to help reaffirm the possibility of waiting until marriage. It is then further assumed that this information helps to eliminate the necessity of providing harm reduction approaches for those who cannot or do not wait.

Beyond these particular myths, there are also discussions to address the various forms of pressure which confront individuals and have the potential to push them into sexual activity. These influences are seen as impediments to any one person’s ability to express his/her agency in sexual relationships by abstaining from sexual intercourse.

Agency

Both public health and Christian religion recognize the ability of the individual to make choices. However, as previously mentioned, public health focusses on the need to use a rational approach to this decision-making process which privileges the public health experts’ perceptions of what constitutes good health and the risks to it. Religious approaches also recognize the need for rationality but expect that this process will privilege the precepts outlined by Christian reasoning. Consequently, all choices reflect a faith in God and affect
one's relationship to God, self and others. Since the expression of love towards God, self and others is viewed as one of the markers of proper behaviour, love can be seen as more than an emotion.

*Love is more than simply a desire, it is an act of the will, a choice* (Why Wait? Unit 2:14).

Sex is viewed as the product of choices. Consequently, the expectation is that young people should make the 'right' series of choices in order to avoid engaging in sexual intercourse prior to marriage.

*Most young people do not make a single, wilful decision to engage in pre-marital sex. Rather, it is a series of smaller decisions which allow for improper thinking. Once the mind has been contaminated with impure thoughts and desires, it becomes easier for one to make wrong decisions. There is a great need to protect the most vital sex organ: the mind* (Why Wait? Unit 1:82).

The ability to make these proscribed choices is confounded by the multiple voices which place pressure on the individual to choose differently. These voices can include peers, boy/girlfriends, and the media all of which have the potential to pressure young people into having sex. These forms of pressure are discussed in various ways in each of the Christian-based programmes.

For example, *Think!*, identifies the exploitation of sexual images in the media as one important form of pressure. Including this discussion at the beginning of the video seems to highlight the ways that exposure to sexuality has changed over the years.

*The media use sex either directly or indirectly to keep the audience captivated* (*Think!:3*).

The use of these images is viewed as particularly problematic given the physical changes young people experience which also serve as a form of pressure.
The desire for sex is one of the strongest emotions we have to cope with. It hits hardest when we are teenagers, when we first find that we are attracted to those of the opposite sex (Think!:3).

Recognizing these as potential influences on whether or not young people choose to engage in sexual activity, the video advocates that young people should “choose carefully” about what they expose themselves to, in order to avoid “bad things”.

Choose carefully what you read or watch, for you can very easily be sold on the wrong things, the bad things (Think!).

The recognition that the changes that come in adolescence can also contribute to perceptions around sexual agency is described in the first chapter of Bloom or Doom. This includes a discussion of some of the physical and psycho-social changes which can influence perceptions of sexuality and the desire for sexual behaviour. Although these are identified as normal and the need for a coping mechanism is acknowledged, there is little advise on how to actually cope with these changes.

We have learnt that changes that occur in adolescence can be physical and psycho-social... We should therefore learn to cope with them... As we said earlier, we should accept to live with the physical changes that occur in our bodies (Bloom or Doom:13).

A subsequent exercise does challenge young people to provide reasons representing both sides of the discussion of whether or not to engage in sex. In the examples provided, the reasons to have sex appear to include social pressures:

Friends are doing it. I want to be like my friends.
To prove I am a man or a woman.

While the reasons for not engaging in sex are fear based.

Fear of pregnancy
Can catch AIDS and other STDs (Bloom or Doom:21).
Why Wait? also provides some practical tools for addressing the pressures young people may experience around engaging in sex. In this programme, however, there appears to be a greater focus on the influence of the dating relationships, including a desire to teach young people how to respond to their partner’s statements. Among the most interesting approaches to this concern is the inclusion of a ‘game’ called pressure lines.

**AIM:** to give teenagers the chance to learn and practice the rejoinders they need to give those who want to pressure them into engaging in premarital sex (Why Wait? Unit 1:101).

The colour coded cards in this exercise include one stack of ‘pressure lines’ such as:

- *If you LOVED me, you’d let me*
- *You can’t get PREGNANT if you do it just this once*
- *It’s NATURAL to want to have sex (Why Wait? Unit 1:101-102).*

Which are paired with rejoinders.

- *If you really LOVED me, you’d be willing wait*
- *Of course I can get PREGNANT, because I’ve already reached puberty*
- *So is burping, but that doesn’t mean it’s NATURAL to do it any time, any place, any how. Just because it’s natural doesn’t mean its proper (Why Wait? Unit 1:101-102).*

The responses in this case seem to incorporate not only fear, but a practical sense of the way that relationships ought to be within this context. Consequently, instructions for two different approaches to explore the content of these cards are included in the text with a further recommendation to make the cards available even outside of class time.

A further concern expressed in the texts is that the possibility does exist that the pressure to have sex could come in the form of abuse and/or violence. Although Challenge and Change does not address this topic specifically, the emphasis it places on the ideal that sex should take place only within a committed, married relationship suggests that rape and abuse are not acceptable expressions of the intimacy at the heart of loving relationships.
However, the existence of this possibility was seen as sufficiently important in the eyes of the authors of the Why Wait? programme so as to warrant an entire lesson on the topic. Entitled Sexual Abuse: A Violation of Human Dignity, this section addresses the presence and implications of behaviours in which there is a reduced ability for one of the parties to fully consent to the sexual act. Methodologically, this is approached by challenging students to analyse individual behaviour in order to determine those actions which may have either left the victim vulnerable or resulted in the aggressor taking action. For example, one of the activities requests that the teacher:

*Read out to the students the story of Jamie and Todd, "It Can Happen to You" (slightly revised). Tell the girls to focus on Jamie and the boys on Todd, and to note down what mistakes they think either Jamie or Todd made for Todd to go too far and actually rape Jamie (Why Wait? Unit 1:68).*

Certainly, in this context it is made clear that rape is against God’s plan (73), and that it shows a lack of respect for the victim. However, in line with the programme’s position on the ability of individuals to make the ‘right’ choices about their sexuality, this text also recognizes that there are actions both parties can take to help reduce the likelihood of such a violent encounter. These include:

*For girls [i.e., potential victims of date rape]*

- set your limits and communicate them;
- be aware of unintentional messages;
- trust your instincts;
- etc.

*For boys [i.e., potential rapists]*

- realise that it is never okay to force a girl to have sex;
- stop what you are doing when she says no;
- avoid the stereotype of dominant, aggressive male
- etc (Why Wait? Unit 1:74).
Although this is phrased in a way that suggests a blaming of the victim, it could also be construed as an effort to empower both parties to avoid behaviour that might lead to sexual abuse.

Both Stepping Stones and Bloom or Doom identify rape and/or sexual abuse as being some of the negative consequences of sexual behaviour. This includes an example in Stepping Stones which links alcohol abuse to rape through one of the video clips. Although the sexual abuse is not the primary focus of the discussion, the following caveats are added to raise questions about communal perceptions of such behaviour.

Some people viewing the older men's rape scene would blame the woman for being there, rather than the man for being drunk and behaving so badly. Is it fair to blame the woman for being there? Some people may say that the woman should have struggled even more and shouted out. But in many places, women being attacked are afraid of screaming, for fear of being cross questioned and blamed, which would bring shame on her family. Is this fair? (Stepping Stones:124).

In Bloom or Doom, the focus remains on sexual responsibility which includes a responsibility towards others but does provide concrete tools for preventing the possibility of physical or other forms of force.

It is very important to respect friends and others' rights. This means that no one should be forced into sexual activity through physical force, seduction, manipulation, downgrading, blackmailing, enticing or use of guilt for selfish motives of wanting to engage in sexual activity. We have a responsibility to respect our and others' safety, health and welfare (Bloom or Doom:16).

Recognizing that all of these pressures may have resulted in an individual choosing to have sexual intercourse outside of marriage, Why Wait? and Challenge and Change suggest that it is always possible to seek forgiveness for this action and return to the ideals of Christian morality. This is accomplished through 'secondary virginity'. Although this
does not allow the individual to become a virgin again, it does challenge him/her to commit to showing restraint from that point until ‘true love’ is found and expressed in marriage.

By that I mean that although people have made a mistake by having sex without marriage, they can make a commitment to themselves, to the person they truly love and to their God, not to do it again until that moment when they give themselves to their wedded partner (Think!).

The benefits of making such a commitment go far beyond what is shared on the wedding night. In fact, ‘secondary virginity’ is said to help remove some of the negative consequences of sexual behaviour and refocus energies.

A sexually active young person who chooses secondary virginity is released from all the pressures, worries, consequences of continued sexual involvement. This will allow them to refocus and establish long term goals for their future development educationally, morally, relationally, etc (Why Wait? Unit 1:50).

As well, it is suggested that those who are willing to change their behaviour in this way, will be the ones who will ultimately turn the tide of this epidemic.

Those who are willing to change their behaviour are the key to controlling the spread of AIDS, and thus limiting the devastation that deaths due to AIDS can cause a society (Why Wait? Unit 2:58).

Looking at these examples underlines the emphasis that Christian religion places on making choices in line with the moral principles of the religion. With respect to sexuality, individuals are expected to privilege the position that sexual intercourse should take place only within a loving, committed, heterosexual marriage. Sex outside of that framework betrays a lack of self-control and a breaking with the expected moral agency. Consequently, the Christian-based programmes take the time to provide the tools necessary to make the ‘right’ choices. Although these are not included in the public health programmes, they are also not in contradiction with the principles presented by these programmes. In this way, the
Christian-based programmes provide valuable information to address the goal of abstinence. However, there is little information in these programmes to assist those who choose, for whatever reasons, to engage in sexual intercourse outside of marriage and refuse to accept 'secondary virginity'. It is this void that can be filled by the rational, decision-making processes of the public health programmes.
CONCLUSIONS

The discourses of Christian religion and public health are typically seen in conflict in the arena of HIV prevention. Since individuals and communities come to know HIV and AIDS through the practices which conceptualize it, represent it and respond to it (Crimp 1989), the ways that this pandemic is addressed in the public arena influences its social construction. Consequently, conflicting discourses can affect the perceptions of HIV and AIDS and, in turn, the effectiveness of intervention programmes. Still, the influence of any single organization or institution is not absolute. Individuals and communities often weigh the information gained from each source against their own prior knowledge of the world, beliefs about what is probable or unlikely, and what is serious or trivial as they make choices about acting on these messages (Fox 1999). In this way, information from HIV interventions becomes mediated by the multiple voices that influence perceptions around the many issues associated with HIV and AIDS, connecting these to cultural norms, beliefs and values, as well as with social structures and environmental conditions (Loustanau and Sobo 1997).

By drawing from this understanding of how the institutions of public health and Christian religion are influencing and influenced by the social construction of HIV and AIDS, the goal of this research has been to analyse the discourses of public health and Christian religion in order to identify how these are being applied in intervention programming. As part of this process, areas of disjuncture and confluence have been identified. The presence of areas of disjuncture seems to reinforce the different ways in which these institutions understand and influence AIDS and AIDS-related knowledge. Without proper reflection on the source of these differences, they can be perceived as areas of conflict. However, if these
differences are mediated by a recognition that there are areas of confluence, the potential exists for the initiation of a dialogue and cooperation between public health and Christian religion.

**Philosophies and Methodologies**

At a basic level, there are inherent similarities between public health and Christian religion as institutions. Both have been socially constructed within a particular historical framework, and, despite becoming displaced from these historical roots through colonization, both continue to make reference to their pre-established, institutional patterns of conduct (Berger and Luckmann 1967). The disjunction occurs in the underlying philosophies and methodologies used by these institutions. For public health, the utilitarian goal of a good health status for all (Lupton 1995) continues to establish the foundation on which intervention programmes can be built. This is frequently accomplished through the use of biomedical and behaviour change methods. For Christian religion, faith remains the key as identified through the theological language of the particular religious organization. In the Christian churches that predominate in Kenya, this is often accomplished through a focus on the nature of one's relationship to God, self and others.

*Challenge and Change, Why Wait?, Bloom or Doom* and *Stepping Stones*, are each founded – in varying degrees – upon one of these sets of philosophies and methodologies. By analysing the content of these programmes, it has become possible to describe the institutional influence on the programme while also identifying areas of divergence and confluence between programmes – and hence, institutions.
**Good Health for All**

Given that all of the programmes in this research have – at least as one of their implicit goals – the desire to reduce the impact and spread of HIV and AIDS, it is not surprising that the ideal of good health for all is common to all of the programmes. However, this potential area of confluence must be mediated by the different interpretations of this ideal. These differences are reflected in the respective programmes.

Public health recommends that certain behaviours should be avoided and/or modified based on rational decision-making processes in order to maintain good health. *Bloom or Doom* reflects this in its discussion of smoking, alcohol and drug use, as well as certain 'wrong' sexual behaviours, while *Stepping Stones* suggests that it will provide the tools necessary for the participants to make good choices about their health.

Within the context of Christian religion good health fits within a framework in which humans are created in the image and likeness of God and therefore, body and soul should be treated with respect. In this way, good health is part of a more holistic interpretation of the ways that humans should relate to themselves, God and the world. The perception is that by living in 'right' relationship to God, self and the world, as defined by the particular codes of ethics and patterns of behaviour established by that denomination through the theological analysis of its leaders, good health will likely result. It is this perspective that is presented in both *Challenge and Change* and *Why Wait?*

**Love as an Expression of Faith**

The interpretation of behavioural patterns based on a particular definition of love is viewed as one of the major sources of the disjunctures between public health and Christian
religion. Specifically, most Christian traditions have a particular view on how individuals are expected to relate to others, themselves and God. As a result, codes of ethics are rationalized through an analysis which emphasizes the ‘Great Commandment’ as establishing a foundation on which these relationships should be built. Recognizing that the ‘Great Commandment’ incorporates a challenge to love God and neighbour, Challenge and Change and Why Wait? provide a demonstration of the process through which codes of ethics can be developed out of this framework of love. The end result provides a foundation on which love is understood as an eternal, sacred, and idealistic expression of faith that is modelled by God’s love for the world. Out of this framework the nature of courting relationships, married partners and interactions with those living with HIV and AIDS can be further explored.

Stepping Stones and Bloom or Doom also address questions of love. Therefore, this represents a potential area of confluence. Although focussing primarily on the relationship between love, courting and marriage, as well as relationships to those living with HIV and AIDS, the recognition that sex and love are not the same, and that PLWAs should be respected and loved, are easily accepted and reflected in the Christian programmes. However, slight differences remain in the ways that these messages are presented because of the variations in the underlying philosophies and methodologies of the respective institutions.

Sexual Behaviour/Relationships

Since the most frequently reported mode of transmission and acquisition of HIV is through certain forms of sexual activity, it is natural for programmes which aim to address this pandemic to include a discussion of sexuality. In fact, the understanding that abstinence from sexual intercourse is an effective prevention method exists across both public health and
Christian religion, providing an important area of confluence particularly in cultures where the abstinence message is the most readily accepted. The divergence in this case occurs with respect to the extent to which each side chooses to focus on this message.

Christian sexual morality tends to focus heavily on the place of sexual intercourse as part of a loving, committed, heterosexual marriage. Consequently, programmes such as Challenge and Change and Why Wait? privilege the ideals of abstinence from sexual intercourse outside of marriage and fidelity within it. Methodologically, these programmes provide justification on the need to remain abstinent based on a particular moral perspective, while also providing the tools that young people can use to do so. This is exemplified by the inclusion of the ‘Pressure Lines’ game in Why Wait?

In the event that individuals have strayed from this ideal and engaged in sexual intercourse outside of marriage, both Challenge and Change and Why Wait? advocate for ‘secondary virginity’. These programmes argue that a commitment to ‘secondary virginity’ is beneficial not only to one’s own health, but also, to one’s future, married relationship. No other alternatives are provided in these programmes. Instead, the message relayed is consistent with basic Christian sexual morality, sexual intercourse belongs in a heterosexual, committed marriage.

Public health programmes are not satisfied with the abstinence/secondary virginity message. When individuals choose not to adhere to this programmatic, harm reduction approaches mandate that some alternative needs to be presented. This is highlighted in the use of ‘safer sex’ campaigns, the focus of which are often condom use. Stepping Stones provides the greatest connection to these types of messages and includes a list of alternative

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forms of sexual expression which carry little to no risk of HIV transmission and acquisition. Many Christian organizations would be reluctant to even suggest such alternatives.

Even when public health programmes focus on the abstinence message because of cultural considerations, there can be differences in the approach used. This is demonstrated in *Bloom or Doom* which discourages some forms of sexual behaviour as simply 'wrong', while providing fear-based reasons to abstain (i.e., failure to do so could lead to AIDS and death). In this way, this programme's discussion of abstinence differs from the Christian-based programmes.

Condoms

The promotion of condoms is frequently viewed as one of the primary sources of conflict between public health and Christian religion. However, it would be highly inappropriate to treat all Christian religions as homogeneous, particularly on this topic. In fact, the understanding that condoms can reduce the risk of transmission and acquisition of HIV is recognized by 3 of the 4 programmes – *Bloom or Doom*, *Stepping Stones* and *Why Wait?* Of these, only *Stepping Stones* includes an extensive discussion of condoms, providing substantial information about their usage and addressing concerns and myths about them. Recognizing the cultural barriers that exist with respect to condom promotion in Africa, the extensiveness of this presentation may be related to the older target audience, while the absence of this information in *Bloom or Doom* is likely related to the influence of community and religious leaders in the development of the programme.

While both *Bloom or Doom* and *Why Wait?* do include positive references to condoms, these are mediated by concerns about their overall effectiveness. *Challenge and
Change focusses completely on this pessimistic view of condoms. Particularly for the Christian based programmes, throwing doubt on the effectiveness of condoms allows the discussion to return to one of abstinence from sexual intercourse outside of marriage and fidelity within it.

**Other Similarities and Differences**

Certainly because of the different foundations on which public health and Christian religion construct their images of sexuality, health and HIV and AIDS, there are differences in the messages presented by programmes which are influenced by these institutions. The most extreme differences are generally with respect to perceptions of sexuality and condom usage, as well as the moral framework which underlies these constructions. There are also elements in HIV interventions for which there are little more than nuanced differences between these discourses and thus represent potential areas of confluence. This includes the ways that facts and information are presented about HIV and AIDS, discussions of STDs, and treatment of people living with HIV and AIDS.

In fact, all of the programmes in this research provide some basic information about HIV and AIDS. This ranges from a simple definition of the syndrome (as is provided by Challenge and Change), to a thorough discussion of the ways in which HIV infects and affects the body (see Bloom or Doom). It can also include discussions and demonstrations of how easily HIV could be spread (see Stepping Stones and Why Wait?). In fact, the only real difference in this information is the way that it is used. From a public health perspective, the emphasis is on rational behaviour change and harm reduction. From the Christian perspective, the information is used to help justify its particular moral imperatives.
Similarly, the importance of assisting people with HIV and AIDS is also raised in the programmes, however, the justification for this behaviour has slightly different nuances. For *Bloom or Doom*, the goal is to help because it will have a positive effect on the health of the PLWA. For *Challenge and Change* and *Why Wait?* one should treat a PLWA with respect and love because it is the Christian thing to do.

Ultimately, this research does acknowledge that a disjuncture exists between the discourses of public health and Christian religion around HIV and AIDS. However, it also shows that there are similarities which permeate the messages presented in interventions that draw from these two discourses. Although this research only included 4 programmes, all of which were available in Kenya, and targeted (at least to some extent) youth, it has been recognized that the use of such a small sample with such a narrow scope makes it difficult to generalize beyond the current study. Simultaneously, recognizing that public health and Christian religion are frequently seen in conflict, being able to identify these similarities in only 4 programmes reinforces their potential existence in a wider diversity and greater number of programmes. This suggests that spaces do exist in which public health and Christian religion could dialogue around HIV and AIDS. In doing so, both sides may become better aware of alternative voices which inform the construction of AIDS and AIDS-related knowledge. This could lead to greater respect and/or cooperation between these organizations which could ultimately affect the efficacy of their messages.

**The Question of Culture**

What is missing from this analysis is the role of culture in constructing AIDS and AIDS-related knowledge, and its resulting impact on the ways that these programmes are
received, understood and acted upon. This has occurred in part because the evaluation of these programmes, if available, was not included in the data for this research. Thus, it is difficult to ascertain the influence of these programmes on their target populations. As well, the presence of language which is consistent with the institutional level philosophies and methodologies of public health and Christian religion seems to blur the cultural context. For example, although there are multiple cultural practices which have great meaning to the local populations targeted by these programmes, the potential of these practices to perpetuate the spread of HIV seems to be the only reason these are mentioned, if they are mentioned at all. Similarly, the ideals of equality and agency which are common in a Western setting seem to permeate the philosophies and methodologies of both public health and Christian religion so that all of the programmes appear reluctant to substantially address gender inequalities and their influence on AIDS and AIDS-related knowledge.

The absence of substantial language to acknowledge and address these important cultural factors, seems to invite questions about the ways that these programmes attempt to balance their messages with the influence of culture. By building awareness around the ways that public health and Christian religion present their messages on HIV and AIDS, it is hoped that this research will also open the door to the recognition that it is not only public health and Christian religion which inform the construction of AIDS and AIDS-related knowledge. Consideration should also be given to the local influences including cultural practices and traditions.

**Future Directions**

The hope of this research has been to show that the perceived disjuncture between the discourses of public health and Christian religion should not prohibit the possibility of
dialogue and cooperation between the organizations which are influenced by these institutions. By providing information about the sources of this disjuncture, as well as identifying potential areas of confluence with respect to the messages presented by either side, this research has attempted to provide insights around the potential spaces in which dialogue and cooperation can take place. This is only a starting point. Further research into the role of public health and Christian religion in the construction of AIDS and AIDS-related knowledge in Africa and around the world, could prove helpful to future efforts to establish such a dialogue. It could also be valuable in determining alternative voices involved in the construction of AIDS and AIDS-related knowledge.

Culture is one such voice. In fact, the ways intervention programmes are received, understood and acted up can vary from community to community based on local cultures and traditions. Consequently, culturally sensitive forms of research are necessary to evaluate programme development and implementation, as well as to create spaces for future research around the potential spaces of disjuncture and/or confluence between the philosophies and methodologies of the programme and the culture.

Ideally, by paying attention to all of these influential voices, it is hoped that future efforts to address HIV and AIDS may better target the decision-making processes of their intended audiences.
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