

**BRAZILIAN ADOLESCENT WOMEN TALK ABOUT
HIV/AIDS RISK: RECONCEPTUALIZING RISKY SEX
- WHAT IMPLICATIONS FOR HEALTH PROMOTION?**

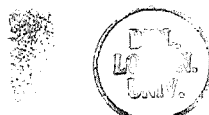
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I dedicate this work to Clarissa and Carolina, the adolescent
women who inspire everything I do.

ABSTRACT

This thesis explores how adolescent women see the risk of contracting AIDS in heterosexual relationships, 'how' in terms of viewpoints but also of the processes in which these viewpoints are constructed. The thesis is based on sociological theories of 'health' and 'risk' and sociological critiques of the scientific approach to 'risk' adopted by health promotion. The thesis draws on focus groups data gathered in twenty-four group meetings with adolescent women from a big city of the South of Brazil. The thesis develops the argument that 'sexual risk' in general and 'HIV/AIDS sexual risk' in particular are epistemological constructs, for 'risk' is not an event 'per se', but an event constructed through knowledge. The thesis assumes that it is important to investigate the many layers of knowledge that underpin adolescent women's conceptions of 'sexual risk' because this provides information about what they mean by that and how those meanings are constructed.

The thesis challenges health promotion's idea that adolescent women's practice of 'unsafe sex' is the result of ignorance or incorrect perception of the risks of sex. The thesis demonstrates that adolescent women are very good learners of health promotion's messages on 'safe sex'. They know the risks and the available self-protection strategies. They also know that it is their responsibility to take care of themselves and how important this is in a social environment that is continuously risky. The thesis argues that although sexual risk assessment is an operation influenced by a number of knowledges, health promotion's knowledge is the most influential of all. To learn the lessons of health promotion discourses on 'choice' implies to invest in 'self-governance'. The thesis concludes that this ideal of self-governance underpins adolescent women's conceptions of risky/safe sex and that it produces conceptions of risky/safe sex that are distinct from those used by health promoters.

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CHAPTER 1

INTRODUCTION

Is it not true that no adolescent would ever choose to be infected by the HIV virus? Is it not true that we have so frequently told adolescents about the risks of unprotected sex? Is it not true that nearly every adolescent has a reasonable knowledge of the sexual means of HIV transmission and strategies of self-protection? Is it not true that health authorities have invested a lot of money and effort in educational campaigns and programs aiming at informing those who are not sufficiently well informed or not convinced about the risks? Is it not true that health researchers have long been doing their best to advance their understandings of the HIV/AIDS problem and to communicate their findings to adolescents? Is it not true that health professionals, teachers, community workers have tried everything to raise adolescents' awareness of the continuing growth of the HIV/AIDS epidemic?

‘So, why do adolescents insist in turning their backs to our knowledge of the risks?’

Probably because they think they are invulnerable to the HIV/AIDS risk. Maybe it is a lack of maturity. Probably because they do not understand the information. Maybe because they like to take risks. Probably because they are unrealistically optimist. Maybe because condoms are not easily accessible.

Questions and answers such as these were a source of constant anxiety for me in my time as a nursing student, a nurse, a nursing teacher and a health promoter. Similarly to other health professionals, I had been taught that adolescents were special; that we should give them special attention because they were young and youngsters were different from adults in their responses to the risks of sex. And so, like others, I embarked on a sort of mission to ‘save’ adolescents from the risk of catching HIV/AIDS by telling them what to do to save themselves. To achieve that I invested in two main tasks: to teach future nurses my knowledge of the problem and of its solutions and to work as a health promoter directly with communities, in particular with adolescents.

In spite of my efforts and apart from the little empirical data on the effectiveness of my information-giving activities, I could never see the efficacy of my work. Sexual risk-taking or sexual risk-protection are not situations that can be externally assessed. I had just one real clue about whether or not my work was contributing to promote adolescents' health, specifically in the case of HIV/AIDS prevention. The clue was that, unfortunately, the percentage of HIV positive young people in Brazil was increasing, most of them infected via sexual intercourse (Brasil 2000a).

In spite of the frustrations, I continued repeating the same messages to my audiences for some time: that adolescents were especially at risk, that adolescents needed to know how to take care of themselves and that doctors, nurses and teachers are the ones who could help adolescents to do that. I could not see any other way of doing health education differently from teaching my knowledge (let's say other's knowledge that I took as mine) about the risks of unprotected sex. Moreover, I could not see any other way of explaining to my nursing students the risky sexual behaviour of adolescents than saying that they tended to be careless.

It was, however, not possible to continue to be passive to all that. I had too easily accepted other's discourses. I had to find other answers to my questions. The answers I had were not satisfactory at all. They were too simplistic. They seemed to show that adolescents were not able to think rationally, at least in a consistent way, about the risks of sex. And if that were true, would it help to continue appealing for their rationality? I felt that there was a gap between their and our ways of thinking. I got the feeling that we did not understand each other.

My professional and moral commitments stimulated a search for my own knowledge about the question of adolescents' sexual risk behaviour. With that in mind I decided to invest in a doctoral course where I could expand my 'reduced' knowledge about health promotion and health education, and question with more 'authority' my own and others' beliefs about the origin of the problem of adolescents' HIV/AIDS sexual risk-taking.

I had three main motivations to choose 'girls' as my research subjects. As in other countries, we have witnessed in Brazil the heterosexualization of the HIV/AIDS epidemic, with a continuing increase of the rates of women's infection (see Appendix

I, page 220). In 1986 only 3% of all AIDS cases were attributed to heterosexual transmission. By 1997 this figure increased to 28%, which is equivalent to 56% of the AIDS cases attributed to sexual transmission. Also, in 1985 there were 25 male cases to 1 female case, whereas in 1998 the ratio reached 2:1 (Brasil 2000b). The production of knowledge about young women's responses to the HIV/AIDS sexual risk should then illuminate health promotion's approach and understanding of the problem.

A second motivation was that since I started my career in higher education and as a nursing teacher. I had always worked in the context of adolescents' health promotion. By focusing my doctoral research on 'girls' I would have then the opportunity to use my own experience and to meet my personal professional interests. The knowledge produced with my research could help my own practice as a health promoter and in the training of nurses to be health promoters.

The third motivation was that I wanted to listen to girls' own accounts of sexual risk-taking, for I was tired of listening and repeating what others thought of it. With my work I could make 'girls' visible, for as subjects they have been neglected both in discourses on adolescence and those about the risks of sex. Unconsciously I was, perhaps, also seeking responses to personal dilemmas concerning the health and sex education of my adolescent daughters.

Gender blindness is a common feature of studies and theories about the 'problem' of adolescents' sexual risk-taking. As some have argued, apart from the consideration of their biological differences, 'adolescents' (or the group of 'teens') are usually treated as a 'risk-group', a category of similar 'risk subjects' who occupy similar positions within the social and cultural milieu (Frankenberg 1992; Wyn and White 1997). That has been the case with research on adolescents' sexual risk behaviour. Most of what we now know about adolescent women's responses to the risks of sex has been produced by such studies. The emphasis on the psychological construction of adolescents' sexual risk behaviours has led researchers to mistakenly treat boys and girls as if both experienced sex within the same structural conditions.¹

¹ See for example Hingson and Strunin 1992; Meltzler, Noell, and Biglan 1992; Moore and Rosenthal 1991.

The idea that adolescence is an undifferentiated experience has its roots in psychological theories of human development. The 'youth' paradigm developed within this framework conceptualizes 'adolescence' as a universal phase of human life that is constituted by developmental stages (mental, physical, psychological). These stages are seen as comprising developmental tasks that must be completed by young people during their 'growing up' process if they are to become 'normal' adults. The idea that to be an adolescent is to be in the process of 'becoming adult' confers great significance to adolescence and creates a stereotypical notion of adolescence as a dangerous time (Wyn and White 1997). Adolescence is seen as a period in which the emphasis on experimentation and identity construction exposes individuals to a climate of uncertainties and potential risks. Adolescents are expected to "...make rational choices about their future identity, 'trying on' a number of personae before finding their appropriate place in the social order" (Wyn and White 1997, p.53). The youth paradigm conceives the 'adolescent self' as a 'self' that exists independently from social circumstances. It is a 'self' that is there to be found and developed during adolescence and that once found and developed will be the same throughout one's life. This assumption leads to the idea that adolescents have essential characteristics that make them different from adults (Wyn and White 1997). It is during such a crucial period that by making the 'wrong' choices young people may become deviants (from the mainstream), which will spoil the whole process of becoming a 'normal' adult.

The premise that 'youth' is the 'at risk' generation seems to emerge from that. The assumption that in every adolescent there is a 'self' that can be corrupted by the social before being 'appropriately' shaped is used to argue for the vulnerability of young people (Wyn and White 1997). To be 'at risk' is seen as a perennial status; a status that will endure until the entrance into adulthood. The widespread use of theories of youth development in the problematising of adolescence has resulted in a frequent association of risk-taking with youth delinquency and anti-social behaviour. "From this perspective [...], 'risk-taking' is a term that describes behaviour that is defined as unconventional by professionals" (Wyn and White 1997, p.68), and thus needs correction. In this paradigm the only differentiation accepted within this single entity of youth is the one that separates the 'normal' from the 'deviants' (Wyn and White 1997).

While 'girls' seem to have been forgotten in many discourses on adolescence, apparently they have a place within discourses that associate 'adolescent women' with 'sexual risks', in particular 'HIV/AIDS risk'. The emergence of the HIV/AIDS epidemic brought with it the notion of heterosexual woman as a 'risk identity', either as a 'risk subject' (the HIV/AIDS victims) or 'risk object' (the HIV/AIDS carrier). Like adult women, 'girls' have been included in the monolithic biomedical categories of those 'at HIV/AIDS risk' and not 'at HIV/AIDS risk', depending on the classificatory system employed (Treichler 1988). Despite the visibility of women in AIDS discourses since the earlier stages of the epidemic, it was not until recently that the specific effects of HIV/AIDS on women have become recognized (Richardson 1996). The emergence of "heterosexual AIDS" (Gorna 1996, p.5), until then recognized as predominantly a homosexual disease, brought about a shift of focus. It was not possible to see the disease as confined to the gay community anymore; it became obvious that the spectrum of the epidemic was much broader than that. The biomedical message was that everyone was equally at risk of contracting HIV/AIDS, including 'ordinary' heterosexual men and women (Gorna 1996). With the 'unexpected' increase in the rates of the heterosexual transmission of the HIV virus heterosexual women began to be seen as 'risk subjects'.

If, on the one hand, the 'heterosexualization' of AIDS has had the advantage of including 'ordinary' woman (Gorna 1996), on the other, its inclusiveness has not resulted in the acknowledgment of the specific conditions of women's exposure to the risks of heterosexual sex, above all in biomedical discourses. On the contrary, it has served to reaffirm the normality of heterosexuality and heterosexual sex. It is often the case that heterosexual women contract AIDS from infected men during sexual intercourse (Brasil 2000a). This implies a logical association between men, women and AIDS. But, the connection heterosexuality-AIDS does not emphasize women's position; it is focused on "the safety of notions of heterosexuality" (Gorna 1996, p.5). The predominant representation of HIV/AIDS as a 'problem of deviants' posits female heterosexual sex as risky if and only if it does not follow the socially accepted norms of the institution of heterosexuality (for instance, sex outside marriage, sex for pleasure, or sexual practices not limited to vaginal intercourse). This constructs a very specific notion of heterosexual woman 'at risk': the one who does not practice the socially accepted and 'normal' heterosexual sex (Richardson 1996).

Even though ‘women’ are represented in the discourses on heterosexual HIV/AIDS, the emphasis on normative assumptions about sexuality and ‘normal’ heterosexual behaviour have resulted in a sort of ‘gender blindness’ concerning the different risk positions occupied by women and men in the context of heterosexual sex. Both adult and young women occupy similar spaces of power in the biomedical discourses of sexual risks (which locate the feminine in the same position as the masculine subject). For women, however, these are ‘unreal’ positions or positions that in real life are actually not available to them (Jones 1993). Women’s “presumed power” in sexual encounters with men is no more than “an *apparent* or *potential* power” (Browne and Minichiello 1994, p.248, authors’ emphasis).

“Heterosexual AIDS serves more to obscure women than to reveal the reality and potential of the crisis facing women; it shifts attention from the complexities of individual women to the bland, massed ranks of heterosexuals” (Gorna 1996, p.5). In this sense, the term ‘heterosexuals’ is misleading, for it is women who have more often been contaminated through heterosexual sex (Treichler 1988). Contradictorily enough, even when women gain a very visible position in the heterosexual AIDS discourses, the term ‘heterosexual’ continue to be misleading. I am referring to the specific discourses of AIDS prevention from which heterosexual men are virtually excluded. When it comes to promoting heterosexuals’ protection against HIV/AIDS, the targets of health education are invariably heterosexual women who are to be the caretakers of themselves and also of their male partners (Petersen and Lupton 1996). The inclusiveness of discourses on heterosexual AIDS is then ‘softened’ when responsibility for risk prevention is ‘the’ message.

The point I have tried to make in the paragraphs above is that of the invisibility of ‘girls’ within both the discourse of adolescence and of the risks of sex. This is important because it highlights the empty space that my thesis intends to occupy. The relevance of improving our empirical knowledge of girls’ experiences and ideas about the risks of sex is that it may provide elements for the development of an understanding of what risky/safe sex means to them, why it has such meanings and how these meanings are constructed. I am convinced that there is no better way of starting a theory on girls’ sexual risk behaviour than to analyse the process by which they are made ‘risk subjects’.

I started my doctoral course with all the expectations registered above in what I have meant to be the autobiography of my research question (Miller 1995). The question became defined as ‘how do adolescent women see the personal risk of catching HIV/AIDS in heterosexual relationships?’. My ultimate goal was to produce knowledge with which I could question the theories of health promotion concerning adolescent women’s sexual risk-taking.

The more I studied health promotion theories, especially those in the context of HIV/AIDS, the more it became clear that their emphasis was on risk discourses. As we will see in this thesis, the use of the notion of risk in health promotion’s discourses has been criticized by sociologists. It is argued that in health promotion’s discourses of risk is embedded the individualistic idea that we are able and have the moral obligation to protect ourselves against health-related risks by making the healthiest choices possible [Lupton, 1995 #439; Petersen, 1996 #347]. The critiques emphasize that this type of discourse ignores the social factors that constrain choice, so that it is not always possible to make the healthiest choice. They also point out that ‘the healthiest choice’ does not mean the same to everyone.

With the help of sociological theories on risk I will argue throughout this thesis that the contributions of my study on adolescent women’s ways of seeing the HIV/AIDS sexual risk are not limited to the context of HIV/AIDS prevention. More fundamentally, my work contributes to the re-thinking of the project of health promotion as a whole. The thesis will show that, as opposed to what health promoters seem to think, the risk lessons taught by health promoters to adolescent women are very well learned; but that what adolescent women make of those lessons is not always congruent with health promoters’ intentions. In that sense it will be argued that risk meanings are dependent on knowledge and that, although influential, health promotion is not the only institution that shapes the knowledge background employed by adolescent women to make sense of ‘risk’.

Strikingly, while I started my research with the idea of developing a theory about the participants’ ways of seeing their personal risk of catching HIV/AIDS via sex, the data collection process did not follow the direction originally planned. Actually, only a small proportion of the data gathered was specifically related to ‘HIV/AIDS sexual risk’. Most frequently conversations about HIV/AIDS risk did not remain focused on

the theme for long. This seems to suggest that my decisions with regard to methodology as well as its underpinning assumptions had a major impact on data. From the beginning, it was assumed that if I was to explore the participants' viewpoints on HIV/AIDS sexual and their epistemological nature, the data collection process should provide as much space as possible for the participants to articulate and express those viewpoints. So, from the beginning, the method employed in the data collection was intended to be as open as possible to the participants' guidance. A theoretical standpoint was behind this methodological option, which was the assumption that risk meanings are dependent on the sociocultural context. So, to find out about 'ways of seeing' the risk of being infected by the HIV virus in heterosexual relationships it should also be necessary to open the research to other matters like the meanings attached to sex and all other related meanings that are in one way or another incorporated in the general context where sex is to be experienced. In the end, the data gathered and the theory developed from it was not focused on HIV/AIDS sexual risk *'per se'* but on the elements upon which the research participants make sense of it.

A particular theme that will permeate my thesis is the Foucauldian notion of 'the care of the self' (Foucault 1984). The theme is at the core of the thesis argument that 'risk' (either taken in general terms or as applied to sex) is an epistemological construct, its conceptions being dependent on social knowledge and values. I will argue in this thesis that knowledge about 'the care of the self' and of its social value is highly influential in the way adolescent women define what is 'risk' and what is 'safety', particularly when it comes to the assessment of sexual risks. I will also argue that although health promotion is not the only source of risk knowledge, it is mainly through health promotion's discourses on risk that adolescent women learn how important it is to take care of oneself in a 'risk society' (Beck 1992) like the one they live in.

Brazilian society is governed by a neo-liberal regime in which 'the care of the self' is an imperative. It is valued as an ideal of 'good citizenship'. It is a duty and a privilege, it is an obligation and a gift (Foucault 1984). To be able to take care of oneself is understood as an exercise of power and freedom. It implies to be able to choose how to live life or what to do with it. It also implies independence from external government; it is oneself who is in charge of one's life.

The incorporation of the notion of ‘the care of the self’ into health promotion is revealed in its discourses on risk. For health promoters, risks to personal health are not located outside the ‘self’, but within it. Individual lifestyle, the outcome of personal choices about how to live life, is the origin of risks. While safer options are available, to expose the ‘self’ to a given risk is a choice. The individual is responsible for her/his own safety. The role of health promotion is to offer help and advice about the pros and cons of certain options. It is the individual’s duty to get informed about the menu of options, the pros and cons of each of them, and to choose the safest option possible. Accepting that we live in a ‘risk society’, to promote health means to teach lay people where and what the risks to their health are, and more fundamentally what they need to do to protect themselves against those risks. Health promotion is then the promotion of ‘the care of the self’; ‘one’s health’ meaning one’s ability to take care of oneself.

The thesis will discuss the consequences of the use of the imperative of ‘the care of the self’ in adolescent women’s responses to the risks of sex, including HIV/AIDS risk. It will conclude that the conscious production of strategies of self-surveillance creates an illusion of self-governance, which is very difficult to sustain in the risky terrain of heterosexual relationships, traditionally dominated by men.

The thesis has the following structure. In Chapter 2 I review the theoretical framework of the thesis, focusing on key debates in the sociology of health and risk to contextualise the argument of the thesis. The chapter is focused on the issues raised by the sociological critique of the scientific approach to risk adopted by health promotion. Those issues are used as starting points for the development of my thesis argument, which is that ‘risk’ in general, and HIV/AIDS sexual risk in particular, are epistemological constructs. In Chapter 3 I describe how the research was carried out and justify the choice of ‘focus groups’ as the main research procedure. Here I raise two particular methodological concerns that impact upon my thesis as a whole: the impact of translation of data; and post-structuralist arguments about the nature of the ‘subject’ (girl). In Chapter 4 I start to build up the thesis argument by uncovering some of the layers of knowledge that exist behind the girls’ ways of seeing HIV/AIDS sexual risk. Drawing on the research subjects’ accounts of everyday risks I argue there that the knowledge background that underpins their ways of seeing risk originate from their life experiences in Brazilian ‘risk society’. In Chapter 5 I explore the girls’ ways of seeing

HIV/AIDS sexual risk through a focus on their specific accounts of the risks attached to heterosexual relationships. In the data analysis presented in the chapter I argue that the knowledge of the value of ‘the care of the self’, which I see as learned mainly from health promotion’s discourses of risk, is particularly influential in the girls’ ways of seeing and responding to the risk of heterosexual HIV infection. In Chapter 6 I present my concluding comments reminding the reader how and with which concerns the research was carried out, and the ways by which the thesis argument was developed. I also revisit my argument concerning the epistemological nature of risk and point out its implications for health promotion, particularly in the context of HIV/AIDS prevention amongst adolescent women.

CHAPTER 2

HEALTH PROMOTION AND RISK

“Margarine may be better than butter, but it also has its risks. Driving without a seatbelt is dangerous, but eating apples is as well. Smoking kills, but so does nearly everything”. (Sapolsky 1990, p.83)

INTRODUCTION

This chapter presents the theoretical framework of the thesis. It reviews the literature that addresses ‘health promotion’ and ‘risk’ from a scientific and a sociological point of view. The aim of the chapter is to get a picture of the field where my thesis is located - the sociology of health and risk. The sociological theories on risk reviewed here inform the thesis argument which is that ‘risk’ in general, and HIV/AIDS risk in particular, are epistemological constructs. Consequently, ‘risk’ is not seen here as an event ‘per se’ but as an event in knowledge. From that, my thesis explores the question of how adolescent women see ‘risk’ when the hazard considered is the HIV/AIDS sexual infection. I believe that the answers to this question bring important contributions for health promotion.

The chapter is divided into four main parts. The first part presents a literature review on the foundations of health promotion. It discusses the underpinning ideologies, concepts and discourses of the so-called ‘new’ public health, where health promotion is located as a discipline. It also looks at Health Education, the main strategy of health promotion. Showing the background of ideas that exist behind contemporary public health should contribute to understanding why and how discourses of risk have become key to the context of health promotion. The proliferation of discourses of ‘health risk’ is certainly not a phenomenon that has happened out of a context. The emphasis on ‘risk’, either in the context of public health or in other areas, is the result of a combination of social, cultural and political factors that has set the scene for contemporary society’s obsessive interest in risk knowledge. The second part of the chapter looks at the sociological perspectives on risk. It introduces the issues discussed in the third part, where the literature on ‘risk’ as applied to health promotion is reviewed. This third part of the chapter gives special attention to the sociological

critique of health promotion's approach to 'risk'. The fourth and last part is focused on what the literature says about health promotion's specific approach to the risk of the sexual transmission of HIV/AIDS, an issue that is further explored in the coming chapters.

THE 'NEW' PUBLIC HEALTH AND HEALTH PROMOTION

The expression 'health promotion' was first used in 1974 by the Canadian Minister of National Health and Welfare, Mark Lalonde, in a document called 'The New Perspectives on the Health of Canadians'. The document emphasized the influence of environmental factors, individual behaviors and lifestyles on diseases and death. The proposed working strategy for health promotion was to combine environmental improvements - 'a structuralist approach' with behavior changes - 'a lifestyle approach'. This should reduce morbidity and premature deaths (Macdonald and Bunton 1995).

Health promotion emerged as a fundamental strategy of a movement that intended to renovate the field of public health. It was a response to many factors, amongst which, "...growing disillusionment with the limits of medicine, pressures to contain medical care costs, and a social and a political climate emphasizing self-help and individual control over health" (Minkler 1989, p.18). As opposed to the 'old' public health, which focused on individual causes of diseases, the new movement emphasized social and environmental influences on health patterns (Lupton 1995a). Those ideas were further discussed in the context of WHO conferences and, in 1986, at the WHO conference in Ottawa, the ideological basis of health promotion was finally formulated (Tones and Tilford 1994).

The Ottawa Charter (World Health Organization 1986, p.220) defines health promotion as "...the process of enabling people to increase control over, and to improve, their health", which represents a recognition of the importance of power and control for health promotion. The document also proposes a positive view of health, highlighting its importance for a socially and economically productive life. Health is seen as "...the resource for everyday life, not the objective of living". It is "...a positive concept emphasizing social and personal resources, as well as physical capacities" (World Health Organization 1986, p.220).

The directions proposed by the WHO for the 'new' public health and health promotion point towards the need to reduce social inequalities, constructing an active and empowered community. Health is seen as influenced by physical, socio-economic, cultural and environmental factors. Health promotion is to invest in the 'engineering' of these factors, aiming at maximizing opportunities for health and to avoid disease and disability (Tones and Tilford 1994). The success of such an 'engineering' should facilitate 'healthy decisions' and 'the healthy choice' should become the "easy choice" (Tones and Tilford 1994, p.7).

As the WHO (1994, p.236) states, "the essence of health promotion is choice", meaning that health promoters should inform the public "...of the merits and demerits of the various options open to them and resources should be made available to make the option chosen possible". The 'new' approach to public health with its emphasis on the multidimensional nature of health-related problems, along with that on informed choice, opens up the 'investment on the health of the populations' to all sorts of professional expertise. Petersen and Lupton (1996, p.5) argue that "the new public health encompasses such concepts and strategies as health promotion and health education, social marketing, epidemiology, biostatistics, diagnostic screening, immunisation, community participation, healthy public policy, intersectoral collaboration, ecology, health advocacy and health economics", among others. At the level of strategies, the 'new' public health counts on the cooperation between state institutions, private agencies and 'the public'. As Petersen and Lupton (1996) suggest,

"with this expansive agenda, involving professional experts, bureaucrats and ordinary citizens, everyone is, to some extent, caught up within what has become an expanding web of power and knowledge around the problematic of 'public health'" (pp. 5-6).

The changes in the field of 'public health', in particular the creation of the health promotion movement, have brought about fundamental changes in the underpinning principles of health education. In the 'old' public health, health education had a sole focus, which was the prevention of diseases. The 'new' health education should overcome the biomedical conceptualization of health and encompass wider aims. Health is no more only the absence of disease, but a resource of life. So, in its contemporary version, health education no longer aims at simply preventing diseases but at preparing the individual for the fight for a healthier life. Within the 'new'

paradigm the individual should be encouraged to make decisions about his/her own life. This notion of autonomy creates an ideal of self-governance. As Lupton (1995b) puts it, “the self that is being privileged and normalized in such discourses is that of the enterprising and entrepreneurial self, the individual who is interested in and willing to take action to improve his or her health status” (p.61).

In political terms, a new form of political rationality that has been predominant in modern western societies, that is neo-liberalism, supports health promotion’s emphasis on individual autonomy and choice. As Rose (1989) argues, underpinning this form of rationality is the idea that the ‘public’ should not be allowed to interfere in individuals’ private life. Freedom is to be regulated by individuals themselves, who have to be committed to choose a way of life that ‘respects’ the moral code of society. This freedom exercise takes place in the form of consumption. Optional products are legitimized and promoted in a variety of ways; yet the chosen products are experienced and justified as personal desires (Rose 1989). Rose points out that this new form of rationality has a great impact upon the ‘self’, as “every aspect of life, like every commodity, is imbued with a self-referential meaning; every choice we make is an emblem of our identity [...], each is a message to ourselves and others as to the sort of person we are...” (Rose 1989, p.231). He goes on to suggest that within the neo-liberal society

“The self is not merely enabled to choose, but obliged to construe a life in terms of its choices, its powers, and its values. Individuals are expected to construe the course of their life as the outcome of such choices, and to account for their lives in terms of the reasons for those choices. Each of the attributes of the person is to be realized through decisions, justified in terms of motives, needs and aspirations made intelligible to the self and others in terms of the unique but universal search to find meaning and satisfaction through the construction of life for oneself” (Rose 1989, p.231).

The next section focuses on health education, a very important strategy of health promotion. It discusses the co-existence of conflicting forms of health education. It shows how difficult it has been to apply the ideological background of health promotion to health education, especially because the emphasis of the health promotion rhetoric on autonomy and choice conflicts with the goals of health education.

Health Education

Despite the new propositions, it has not been easy to avoid the traditional discourses of public health in the contemporary practice of health education (Lupton 1995a). There has been a confusing overlap between ideological positions (often conflicting old and new positions) and technical definitions of what it is to educate people about health. A number of different models of health education can be found in the terrain of practice. For instance in Britain alone, Rawson and Grigg (1988) discovered seventeen taxonomies of health education. While it is possible to accommodate all these taxonomies into two basic approaches to health education - the 'preventive model' and the 'radical model' - the literature shows an awareness that the differences between them are not 'clear cut'. Theoretically, and also in practice, there are overlapping objectives and perceivable gaps between progressive intentions and real achievements.

Preventive Health Education

The "preventive model" of health education (Tones and Tilford 1994, p.12), also called "conventional" health education (Rodmell and Watt 1986, p.2), remains influenced by the principles of the 'old' public health. Fundamentally located within the biomedical model, it aims at preventing disease. Disease prevention is mainly conceptualized according to the postulations of two paradigms: behaviourism and individualism (Rodmell and Watt 1986). The preventive approach of health education supports the idea that individual lifestyles- poor diet, lack of exercise, smoking, etc.- are the main causes of ill-health; unhealthy habits being the consequence of mistaken individual decisions. Such an emphasis on the individual produces a representation of ill health as a 'personal moral failure' (Doyal and Pennell 1991) and a master discourse that blames the victim for her/his own misfortune (Crawford 1977). The aim of preventing diseases is to be fulfilled by means of persuading individuals to adopt healthy lifestyles, or behaviours considered by medical professionals as compatible with health. In sum, the preventive model of health education assumes that health professionals 'know' what constitutes a healthy lifestyle and that the adoption of a medically oriented healthy lifestyle is a matter of personal choice. The individualistic tone of such a discourse is highly problematic and, as we see next, has been a target of critique.

Individualism and the Problems of the ‘Preventive’ Model of Health Education

Amongst the critics of the preventive model of health education there is a consensus that, considering the holistic principles of the ‘new’ public health (see pages 13-14), it is difficult to see such an individualistic enterprise as a health promotion strategy (Crawford 1977; Naidoo 1986; Thorogood 1995). And here, the criticism addressed to individualism includes a strong questioning of its emphasis on ‘free choice’, also a feature of the health promotion movement (see previous section on health promotion, p.13). Naidoo (1986, p.17) defines ‘individualism’ as “...the ideology which views individual free choice as both an accurate account of the status quo, and as a desirable goal for which to aim”. In her analysis, individualistic health education can be questioned on the basis of at least three arguments. Firstly, because it does not consider the influence of the ‘social’ in determining, structuring and patterning illnesses, it reduces health, a social product, to a thing that the individual shall be able to control. Secondly, in ignoring the ‘social’, it seems to consider that everyone lives under the same social conditions and so will be equally able to take care of themselves (as long as they have the knowledge to do so). And thirdly, an individualistic health education is ineffective in its own terms. It invests in education about prevention in the belief that this will directly result in behavioural change and healthier lifestyles. Such an approach has proved to be highly inefficient (Naidoo 1986) as some contemporary classic examples indicate, HIV/AIDS prevention being one of the most representative of all.

Empirical research has already firmly suggested that even when well informed about forms of contamination people may yet not adopt the preventive measures prescribed by health professionals (Hillier, Harrison, and Warr 1998; Holland et al. 1991; Woodcock, Stenner, and Ingham 1992). Individualistic health education ignores that behaviour is always interactive; meaning that individuals’ lifestyles are the product of an interplay of socio-cultural and individual factors. Environmental circumstances, including the social norms to which individuals are subjected and among which few have the power to change, and the well-established cultural values that organize everyday life, have a direct impact on the choices made, for they constrain available options in the first place.

Individualism is then a problematic feature of the use of the notion of 'lifestyles' in the messages of 'preventive' health education (Calnan, Boulton, and Williams 1986; Rodmell and Watt 1986). But this association between health and individual lifestyle is a problem that goes beyond the question about the mistaken idea that health and diseases result from personal behavioural choices. The first difficulty is that it implies an oversimplification of the notion of 'lifestyles', which tend to be classified according to the binary category of 'rights'/'wrongs' (a judgment obviously biased). As Rodmell (1986) points out, the presumption that there are 'lifestyles' that should be 'reformed' to become more 'healthy' is generally informed by medical stereotypical perceptions about the 'adequacy' of certain ways of life. The judgment of individuals' behavioural 'adequacy' is usually based on health professionals' perceptions about the patterns of behaviour of the groups to which these individuals belong. Thus, it is common to see health educators targeting specific social groups (adolescents and women, for example), which are usually taken as particularly inclined to 'deviance'. In pathologising typical conducts, preventive health education contributes to the reinforcement and reproduction of dominant ideologies, facilitating the social control of individuals and groups. Considering WHO's affirmation mentioned earlier (see p.20) about 'choice' being the 'essence' of health promotion (World Health Organization 1994), it is indeed difficult to think of a form of health education that imposes certain options as a health promotion strategy.

There is a second problem resulting from this idea that individual lifestyles might be the cause of diseases and that, if necessary, they must be changed on the basis of what is considered a 'medically correct' behaviour. This assumption may promote human behaviour being dependent upon a medically-defined 'correctness'. The resulting jurisdiction of medical profession over people's lives, also called "medicalization of life" (Illich 1990, p.86), has two consequences. First, it imposes the social acceptance of medicine as the legitimate source of truth, transforming it into an institution of social control. In addition to that, given the fact that the focus on 'lifestyles' implies the possibility of multi-causal diseases, preventive interventions undertaken by public health professionals may also result in a proliferation of medical interference in extended areas of human life (Armstrong 1993; Bunton, Nettleton, and Burrows 1995; Illich 1990; Zola 1972)

The ideology of individualism has also influenced the choice of persuasion as the main educational method of preventive health education (see examples given by Naidoo 1986). Unhealthy lifestyles are seen as related to ignorance about the ‘medically correct’ way of life. The provision of health-related information is then seen as the solution. By teaching individuals about the association between ‘incorrect’ behaviour and diseases, health educators expect to persuade them to behave ‘adequately’. To regard education as a simple ‘transmission of information’, in the sense of a “banking education” (Freire 1972, p.58), is to see the educational enterprise in a conventional way. In such a context, the learner is seen as a passive recipient of the knowledge that shall be provided by the ‘know-all’ teacher. The effectiveness of a ‘banking education’ is evaluated by assessing the quantity of knowledge acquired. The knowledge ‘learned’ after the intervention of the expert is expected to be higher than that acquired before the intervention. The ‘know-all’ teacher is supposed to use his/her expertise to deliberate on what kind of knowledge the learner needs to learn. The top-down imposition of knowledge to be learned, the active position of the ‘teacher’, and the passive role of the learner is exactly what happens when health educators invest in individual behavioral changes (Downie, Fyfe, and Tannahill 1990; Katz and Peberdy 1997; Watt 1986).

In his analysis of diverse forms of talk about health, Beattie et al.(1993, p.265) suggest that different strategies for promoting health are based on different political standpoints which are often not explicit and yet very influential. In a similar vein, it has been argued that to opt for an individualistic approach to health education has everything to do with specific political positions (Beattie et al. 1993; Crawford 1977; Tuckett 1979). To Beattie, persuasion campaigns commonly used to change individual behaviour are compatible with the biomedical model of health because of the proximity they both have to ‘conservative’ political ideology. Under the influence of this sociopolitical philosophy, health is seen as related to ideas like ‘individual inadequacies require correction’ and ‘risks to order require control’, among others. Beattie (1993) comments that “this [philosophy] no doubt sees such campaigns as an acceptable ‘*minimal*’ intervention by the State: giving people information ‘*for their own good*’, so that if they don’t act upon it, that’s ‘*their bad luck*’” (p.265, author’s emphases).

Like Beattie, Crawford (1977) also argues that individualistic positions and ‘victim blaming’ discourses have not become essentials to health education in a vacuum. The reference to the American origin of the ideology of individual responsibility elucidates the emergence of the ‘victim blaming’ discourse for the promotion of the public health.² Crawford (1977) regards it as a response to a health crisis in the USA, which had two conflicting pillars: the increasing concern about the social construction of disease and the inefficiency of a costly medical system. The author affirms that, in this context, to blame the victim for his/her illness was a political strategy that operated in an ideological form. As Crawford states, the ‘victim blaming’ ideology reflects the way contemporary society is structured, as well as its contradictions. The social circumstances of the development of the ‘victim blaming’ ideology are seen by Crawford (1977, pp.665-668) as related to three political phenomena: “a crisis of costs”, due to increasing costs of insurance and health benefits in the industrial sector; “the politicization of the social production of disease”, resulting from the political appropriation of public concerns about environmental health dangers and occupational health; and the view of “medical care as a right”, at a time when people’s dependency on medicine grows and medical credibility drops.

Even though Crawford’s analysis of the origins of the ‘victim blaming’ discourse was formulated more than twenty years ago, his arguments seem to offer clues to understanding its continuing powerful influence on the present shape of the preventive model of health education. To Crawford (1977),

“At a time when people seem to want medicine most, its continuing availability and expansion threaten [...] economic and political interests. Further, [...] medicine is clearly inadequate in dealing with the contemporary social production of disease, and is...unable to perform its traditional role of resolving societal tensions which emerge when people identify the social causes of their...pathologies. In the face of these trends, it is...revealing that we are witnessing the proliferation of messages about our own personal responsibility for health and an attack on individual life-styles and at-risk behaviours” (p.668).

² As Macdonald & Bunton (1995) state, the conceptual development of health promotion is largely influenced by the developments in Europe and North America. That is why to understand the origins of the ‘victim blaming’ discourse in the USA helps to grasp its importance in health promotion discourses in other parts of the world.

The links between the focus of preventive health education on lifestyles, its investment on individual behavioural change and the production of 'victim blaming' discourses can be explained in yet another way. In an analysis of the history of health education Minkler (1989) argues that in the implementation of the health promotion program in the United States the program was directed towards two distinct goals: health promotion (focusing on behaviour and lifestyles changes) and health protection (focused on the physical environment). This dichotomy, the authors suggests, may have limited the successful production of a broader view of health promotion. Using the words of another commentator, Minkler argues that "we Americans allowed our health promotion terrain to be restricted to lifestyle determinants of health but we also allowed lifestyle to be interpreted too narrowly as pertaining primarily if not exclusively to the behaviour of those whose health is in question" (L.W. Green, cited by Minkler (1989, p.19). One can perhaps conclude on the basis of what has been said so far that the simplistic conceptualization of lifestyles as the result of personal choices constitutes a fundamental difficulty of the preventive model of health education.

Even though health education has gained importance in the context of health promotion, it has been a struggle to incorporate the holistic proposals of this 'new' movement into health education practice. One may suggest that the predominance of medical professionals in the field has complicated the adoption of a theoretical framework other than the biomedical for the development of health education discourses and practices (Rodmell and Watt 1986). The contemporary 'epidemic' of health educational campaigns - practice safer sex!, exercise your body regularly!, do not smoke!, do not drink and drive!, eat fruit and vegetables! - aiming at promoting 'free' informed health-related choices, underscores the importance of 'medical prescriptions' for the current project of health education. In spite of the proposals of the supposed 'new' approach to public health, health education usually remains concentrated on the prevention of diseases and focused on individual responsibility (Naidoo 1986). With that, the social causes of ill health are left practically untouched and the goal to promote health as a life resource rather than an end in itself has remained a matter of rhetoric.

But if it is true that the implementation of a veritable 'new' health education is still problematic, and that for the health educators caught up in the proposed transition it

has been a struggle to cope with the conflicts between new theories and old practices and also with the powerful influence of the medical model, it is also true that there have been attempts to overcome the difficulties. The next section focuses on the ‘radical’ model of health education, which encapsulates the proposals of the health promotion movement, its principles standing in direct opposition to those of the preventive model.

Radical Health Education

In opposition to the ‘preventive’ health education, a modern approach has emerged. It has been a response to the new ideological premises of the health promotion movement described earlier (see section on page 13). It encapsulates the complexities of the ‘new public health’ and modern approaches to education. Its main aim is to promote health in a positive sense. In educational terms, the “radical model”³ (Tones and Tilford 1994, p.16) is centered on “critical consciousness raising” (Tones and Tilford 1994, p.20), a term associated with Paulo Freire’s notion of ‘conscientização’. Tones and Tilford (1994, p.20) argue that such an objective can be achieved by following a four-stage process:

- “1- Fostering reflection on aspects of personal reality;
- 2- Encouraging a search for, and collective identification of, the root causes of that reality;
- 3- Examination of implications and
- 4- Development of a plan of action to alter reality”.

Instead of working with individuals, considered as isolated targets, radical health education seeks to achieve its goals by working with groups. A group environment is expected to facilitate “critical consciousness raising” (Tones and Tilford 1994, p.20) because of its potential in promoting the exchange of ideas amongst its members. The dialogue created in such a context is believed to result in a collective understanding of living conditions and in the realization of both the individuals and group’s potential for change. The ‘radical’ approach rejects the use of persuasion for promoting behaviour

³ The term ‘radical’ is used by Tones and Tilford to indicate the need to reveal the roots of ill health. It is also used in the sense of questioning the dominant ideology, represented by the preventive medical model.

change. This doesn't mean that it is not to do with behavioural changes. What is different is that it seeks to achieve the aim of social rather than personal change (Tones and Tilford 1994).

'Radical' health education intends to promote individuals' involvement in decisions related to their own health and those concerning the social groups to which they belong. Conscious individuals are supposed to be able to take responsibility for their personal health, not only in the sense of responsible health-related decisions but also in relation to their ability to articulate responsible interventions in the environment in order to maintain their health status. In order to achieve this level of active participation, the educational process is to be developed through an egalitarian relationship between the learner and the educator in which both recognize the value of the other in the dialogue established (Laura and Heaney 1990).

In the same way as health promotion (see pages 18-21), 'radical' health education emphasizes power as a fundamental condition for the success of its enterprises. Therefore there is the need to incorporate the empowerment of individuals and communities as a '*sine qua non*' condition for the fulfillment of the health education objectives. (Tones and Tilford 1994)

Within the radical model, to empower individuals and communities goes beyond promoting "critical consciousness raising"; it also includes the provision of relevant information about health and life skills (Tones and Tilford 1994, p.20). Empowered individuals and empowered communities are not exactly the same although they have a reciprocal relationship, that is, one is a pre-requisite for the other. To be empowered means to have autonomy to make informed choices, which as mentioned earlier (see section on health promotion) is seen by the WHO as the focus of health promotion.

While the 'radical' model is in theory congruent with the proposals of health promotion (see pages 18-21), its focus on the promotion of autonomy via education has been the target of criticism. The critics have also exposed the contradictions of health promotion as well as its privileging of behavioural interventions and neglecting the proposed structural approach. The next section reviews the main issues raised by the critics.

Autonomy and the Problems of the ‘Radical’ Model of Health Education

Even with the support of a powerful institution like the WHO it has been highly problematic for health educators to apply the principles of health promotion to health education practice. The aim of promoting individual's autonomy is pointed out by the critics as the main difficulty. Weare (1995) summarizes the problem:

“The logical consequence of accepting autonomy as a goal is to agree that if educated people choose to act in an unhealthy way then, provided it does not impinge on the freedom of others, this must be seen as an acceptable end result of an educational process” (p.71).

The notion of ‘empowerment’ as a key strategy for promoting autonomous choices with regard to health is particularly problematic. For health professionals, it may be a dilemma to forget the scientific knowledge concerning health and disease and accept others’ life perspectives and values, in which the biomedical conceptions of health may not be included. Also, for those who got used to the conventional health education practice, it may not be easy to abandon the pastoral role of ‘helping’ people to make their decisions about health (Weare 1995).

The discussion about autonomy brings back the question of authority, which as commented on earlier in the chapter, is seen by the critics as a problematic point of ‘preventive’ health education (see pages 16-17). As a matter of principle and in direct opposition to the traditional model of health education, the radical model does not accept ‘impositions’ of any kind, because it is considered antithetical. ‘Imposition’ means a lack of respect for individuals’ will. From that, some questions emerge which may not only be applied to the specific field of health education but more fundamentally to health promotion as a whole. How can one deal with the contradictions posed by the task of promoting freedom and health without imposing particular beliefs about what is health and what is freedom? Is it possible to respect individual's decisions, and, at the same time, take into account the health-related consequences of individual's freedom of choice?

The problem is not that it is impossible to promote choices; the problem starts when the task is to promote ‘free’ choice, which seems to be a goal compatible with that of the promotion of autonomy. Baelz (1979) reminds us that choices do not happen in a

vaccum, but are made with reference to the material and social context within which they are determined. If we accept the assumption that the environment imposes limits to our everyday choices, then we may agree that even with no direct interference of health educators to promote this or that health-related choice, it would be an illusion to think of the 'act of choosing' as the result of and resulting in freedom.

A number of commentators have argued that health educators need to acknowledge the complex framework that stands behind decisions, whose elements are often not controllable by individuals (Naidoo 1986; Thorogood 1995; Tones and Tilford 1994). For Thorogood (1995), the empowerment of individuals and communities as a form of promoting free and rational healthy choices, is subjected to pre-determined norms and values. The promotion of healthy choices in such a biased environment may well be seen as more likely to reinforce social inequalities than result in emancipation (Lupton 1995b; Rhodes 1994; Thorogood 1995).

Another point that has been raised in the literature with respect to the empowering goals of health promotion and health education concerns the uncritical acceptance of the proposition of an egalitarian relationship between health educators and learners. Baelz (1979) remarks that any learning process implies reciprocal influences between the educator and the learner, which may lead to the conclusion that the promotion of health-related choices through education is not exactly the promotion of absolute independence. It has been argued that even for conscious radical health educators it is hard to promote a balanced distribution of power in their relationships with the subjects of their actions. Health professionals are usually seen as 'experts' and this may undermine the health educators' (usually health professionals) investment in the promotion of 'free choice' (Jones and Cribb 1997).

With respect to the 'natural' pressure of the health professionals' knowledge on peoples' choices, it is also important to bear in mind that in some cases the promotion of autonomous decisions is further complicated because it may involve class, gender, age and race power relations. The conflict between the pursuit of freedom to choose and the promotion of health for building a healthier society demonstrates the moral contradictions implicit in health promotion's discourses and in its model of health education. Jones (1997b) captures the dilemma faced by health promoters:

“On the one hand we have noted that the ethical basis of health promotion includes a commitment to enhancing autonomy; on the other, the search for the ‘healthy society’ requires people to value their own health more and to make healthy choices rather than unhealthy ones. How is to be ensured that people make healthy choices if making up their own minds about health matters is also high on the agenda?” (p.99).

Jones and Cribb (1997) suggest that the answer to those questions lies in the development of a healthy public policy, which might result in making the healthy choices easier, a point also made by others (see for example, Tones and Tilford 1994). Whatever the arguments, it is worth noting, the moral imperative of ‘being healthy’ (whatever the meaning of it) holds true.

The investment in autonomy has also been seen as problematic in the arena of community development. Lupton (1995a) argues that the empowerment of communities is contradictory in two senses. Firstly, the term ‘empowerment’ is linked to “individualistic meanings of rationality, autonomy and responsibility” (p.60). Secondly, empowerment implies the paternalistic idea of power ‘transmission’ from a powerful person to a powerless one. Lupton also remarks that the well-known difficulty of modern health educators to overcome the conventional individualistic approach is also a problem for the empowerment of communities. Although some have argued that the choice of an active learning constitutes progress from the traditional preventive approach of health education (Tones and Tilford 1994), Lupton (1995b) maintains that the empowering model or ‘radical’ health education remains focused on the acquisition of individual skills. To Lupton, these skills are results of a training process through which people are expected to acquire “*appropriate* ways of thinking and doing” (p.60, author’s emphasis). She also emphasizes that apart from a normalizing effect on social groups, health education has achieved few results in the empowerment of communities.

An important point made by Lupton (1995b) refers to the effects of the dependency of health promotional activities, like ‘radical’ health education, on scientific expertise and so on state social policies and capitalist ideologies. She argues that “while health promotion shares the rhetoric of other social movements [...] the origins of health promotion lie within the state rather than directly challenging the state” (p.61). In such circumstances, Lupton comments, the aim of promoting empowered communities and

political action tend to be approached as short-term commitments as other state projects that rarely last more than a few years. Citing Stevenson and Burke, Lupton points out that “this fundamental paradox ensures that health promotional activities, for all the rhetoric about social change and challenging the status quo, will inevitably be limited in their political scope and objectives” (Lupton 1995b, p.61).

Like Lupton (1995b), Jones and Cribb (1997) also remind us about the difficulties of health promotion and ‘radical’ health education. They argue that in the ‘new’ public health, ‘old’ individualistic ideas - like ‘lifestyles’- appear to be ‘new’ ones - the ‘healthy choices’- just because they are expressed in a modern way. The influence of individualism on ‘radical’ health education is obviously related to its emphasis on behaviour, which implies a neglect of its proposed structural approach (for an account of health promotion’s working proposals, see the section on the ‘new’ public health and health promotion). In maintaining ‘behavioural change’ as one of its goals (Macdonald and Bunton 1995), health promotion cannot avoid the use of the same contested focus of the ‘old’ health education model, which is the change of individual ‘lifestyles’.

In spite of the criticism addressed to the individualism embedded in the notion of ‘lifestyles’⁴, it remains a theme on the agenda of the WHO. But the organization has dealt with the issue with care. The recognition that discourses on ‘lifestyles’ can blame the victim if used without consideration of the influence of environmental factors on health behaviours has led the WHO to emphasize that if health is to be promoted, the social determination of patterns of behaviour must be taken into account. In the words of Milio, quoted by the Health Education Unit of the WHO (1994, p.230),

“Lifestyles are patterns of (behavioural) choices made from the alternatives that are available to people according to their socio-economic circumstances and to the ease with which they are able to choose certain ones over others” (p.230).

In the rhetoric of the WHO, the notion of the social construction of ‘lifestyles’ has additional implications. It implies that patterns of health behaviour are not fixed because they are dependent on the flow of life, which is dynamic. In this respect, the WHO (1994, p.230) states,

⁴ See page 27 for the critiques of ‘lifestyles’ as applied to health education.

“An individual lifestyle is made up of the standard reactions and behaviour patterns that are developed through processes of socialization. They are learned through social interaction with parents, peer groups, friends and...through the influence of schools, the mass media, etc. They are continually interpreted and tested out in social situations and are therefore not fixed...but subject to change based on experience and reinterpretation” (p.230).

To accept the WHO's statement means also to recognize that 'the social' is not only the social material from which 'patterns of behaviour' are developed but also the framework within which these behaviours are situated. In accepting the developmental character of 'lifestyles' and its consequent social contingency one may reach the conclusion that 'lifestyles' are not necessarily individually controllable. In addition, one should recognize that if a pattern of behaviour is developed in response to social experiences, then it may not be easy for a member of a social group to change his/her conduct just because health professionals recommend people to do so (Rodmell and Watt 1986).

Another question involving power and health education is related to the fact that since its earlier times, the 'new' public health has been theoretically defined and made visible to professional and lay people through discursive means and practices. Health professionals have usually invented the language used in the discourses of the 'new public health'. The medical management of the public health 'glossary' has been regarded as reinforcing the contradictions of the rhetoric of community empowerment (Lupton 1995b; Rhodes 1994). What is 'public', what is 'healthy', what is 'unhealthy', what is 'community', what is 'empowerment' are some of the definitions established under an almost complete dominance of health professionals.

The last two sections have exposed the contradictions of the 'new' public health. They show that the 'environmental engineering' project of health promotion (see pages 19-21) and the goal to intervene in the structural causes of ill-health are actually abandoned when health education becomes its primary strategy. As we have seen, it has been easier to develop a holistic theoretical approach to health than to transform this theory into practice. As some commentators have argued, while the idea that health is more than just the absence of disease is well accepted nowadays, in practice, contemporary health education is still focused on disease prevention (Lupton 1995a; Seedhouse 1986).

Lupton (1995a) questions the alleged progress made by health promotion from an 'old' to a 'new' model of health education by suggesting that even the differentiation between health promotion and health education has been rather elusive. She comments that sometimes health education is identified as part of the health promotion project, sometimes it is seen as having an interchangeable meaning with health promotion. She also considers that the contemporary simultaneous use of 'old' and 'new' strategies for preserving the health of populations may confirm that previous approaches have remained influential. As examples, she cites the use of "health protection" or isolation for preventing contagion, of "preventive medicine" for treating illness in its earlier stage, of "health education" for promoting healthy lifestyles, of a "healthy public policy" for intervening in the structural causes of ill health and of "community empowerment" for promoting the development of social groups (Lupton 1995a, p.52). Lupton agrees with Rawson (1992) when the latter argues that the difference between health education and the 'new' public health is, perhaps, "...more a shift in title than a true paradigm shift" (p.204).

Considering the literature review undertaken here, one can conclude that health promotion has been facing big challenges posed by its own internal contradictions. How to promote 'free' choice and, at the same time, aim at informing health-related decisions through education? Will not the provision of health information restrict the possibility of freedom? Is it not true that 'free' choice is incompatible with the pre-establishment of options, like those based on the biomedical definition of health? How to forget all these years of knowledge about the scientific meanings of health and accept alternative conceptions that may be behind individuals' choices? How to accept people's free choices when they are not compatible with the 'common sense' ideal of the pursuit of a medically-defined healthy living? How to promote rational decision-making without advocating particular 'rationalities' and repressing others? These are some of the questions that are still to be answered in the discourses and practices of health promotion.

It seems to be clear that, as Lupton (1995b) remarks, despite the critiques, 'health' continues to be seen in the terrain of the 'new' public health and health promotion in an individualistic way. In the new approach, Lupton argues, health' has predominantly been represented as a matter of personal responsibility and a sign of a 'good' use of

individual autonomy. It is conceptualized as the outcome of rational decision-making concerning personal behaviour. To Lupton, despite the discourse of innovation, in practical terms, the 'new' public health, health promotion and health education are still focused on promoting individual behavioural change. The focus on individual causes of diseases that is supposed to have been overcome in the 'new' public health has been replaced by another form of individualism, which is that of the emphasis on individual autonomy. A good indication of that is the proliferation of empirical research and theories in the field that are based upon psychosocial models of behaviour, such as the Health Belief Model and the Theory of Reasoned Action (see for example Ajzen and Fishbein 1980; Jemmott and Jemmott 1991; Rosenstock, Strecher, and Becker 1988). In this respect Lupton (1995a) remarks:

“Although the term ‘theory’ is commonly employed in the health promotion literature, that use is generally limited to explaining links between attitudes and behaviour, adopting a cause-and-effect model, rather than overarching attempt to construct an epistemology of public health” (p.55).

As Lupton stresses, the very names of those models suggest the importance of rationality and cost-benefit calculations for contemporary health promotion and health education. At the basis of this emphasis on rationality there is the assumption that knowledge is directly related to change in attitudes and change in attitudes should result in behavioural change. This linear progressive logic has been applied to all sorts of recognized public health problems. Such problems are seen as likely to be solved by means of health education, which are to teach individuals how to behave properly in order to keep their original healthy living.

With the help of the literature, I have tried to delineate a picture of contemporary health promotion and health education. I have also presented most of the elements that appear in their discourses and the criticism that those discourses have generated. But this picture would not be complete without reference to 'risk', a theme that has gained increased relevance in contemporary societies as a whole and especially in the general rhetoric of medical sciences where public health and health promotion are located. The next three sections are focused on 'risk'. The first presents the sociological approach to 'risk', which is dominated by theories on the centrality of 'risk' in the constitution and organization of modernity. The second section looks at the way the notion of 'risk' has

been incorporated into health promotion discourses and practices. In the third section we shall see that although ‘risk’ is a later addition to health promotion discourses and despite critiques, the way health promoters have theorized about the question of ‘health risk’ is still very much focused on an individualistic approach.

RISK

‘Risk’ originates from the French word ‘risque’ and was initially employed in a neutral sense. It could mean ‘good’ and ‘bad’ risk (Gabe 1995), an interpretation that lasted until the beginning of the nineteenth-century (Ewald 1991). As the definition that appears in the dictionary demonstrates, ‘risk’ is nowadays equated with ‘bad risk’ (Douglas 1990). According to ‘The Concise Oxford Dictionary of Current English’, ‘risk’ means “the chance or possibility of danger, loss or injury” (Allen 1990, p.1040). The mentioning of ‘chance or possibility’ to define ‘risk’ indicates that it incorporates in its meanings the property of ‘objectivity’. Other sources of defining ‘risk’ corroborate this argument. For instance, The Royal Society has similarly conceptualized ‘risk’ as “the probability that a particular adverse event occurs during a stated period of time, or results from a particular challenge” (quoted in Heyman 1998a, p.5).

While the term ‘risk’ is not new in our vocabulary and it has become a very popular word in contemporary day-to-day life, there is no consensus about the meanings of risk. This is perhaps a surprise, given the objectivity of the definition of ‘risk’ that appears in the dictionary. But, along with the ‘risk is’ approach there are assertions that put in doubt a common sense definition of ‘risk’. Affirmations such as “defining risk can be risky” (Arnett 1996, p.465) and “people disagree more about what risk is than about how large it is” (Fischhoff 1985, p.89), found in the risk-related literature, suggest that ‘risk’ is not always perceived in the same way.

As we will see in the section below, modernity provides material for the production of an array of risk meanings. In everyday life we do not make sense of ‘risk’ by looking for its meanings in the dictionary. What we mean by ‘risk’ depends on a number of elements that constitute the context where risk meanings are to be applied. This theory

about the association between risk contexts and risk meanings in circumstances of modernity is at the core of the sociological approach to risk, which is presented next.

Risk, Modernity and the Socio-Cultural Approach to Risk

This section reviews the theories on the socio-cultural aspects of risk in circumstances of modernity. The socio-cultural approach has been, along with a more technical theorizing of risk (see section on page 47), a way of seeing risk that is much emphasized in the literature. The present section will be mainly focused on the work of Anthony Giddens, Ulrich Beck, Mary Douglas and their followers. Giddens, Beck and Douglas are the exponents of the sociological and anthropological debate about the use of the notion of risk in modernity. My aim here is not to give a full account of their theories, as this goes beyond scope of the thesis. The themes presented were selected according to the interests of this thesis, and are, in one way or another, re-visited in the analytical chapters (Chapters 4 and 5). The selected themes are used for the elaboration of my thesis about the epistemological nature of 'risk', in which I make the point about the influence of the discourses that permeate life in modernity in adolescent women's ways of seeing 'risk'.

Nowadays there has been an increase in the general level of concern about safety and risk (Jones-Lee 1989). From dangers of nuclear products to risk in business and finance, from the hazards of medical treatments to the risks of urban violence, every moment of modern day-to-day life has been immersed in what Giddens calls a "climate of risk" (1996, p.114). In the academy, risk issues have increasingly been the focus of research within a number of different disciplines, such as medicine, epidemiology, statistics, philosophy, sociology and anthropology. Amongst the disciplines that have developed a special interest in risk issues, medicine is perhaps the most interested of all (Heyman 1998a). In a study carried out by Hayes (cited by Heyman), 100,000 references to risk were found in the Medline database over the period 1985-1991. Heyman (1998a) comments that it was not until the mid-1990s that social science began to develop interest in 'health risk'.

Both Giddens and Beck agree that a combination of factors is involved in the proliferation of risk discourses in modernity. The authors point out the development of

science as the main factor involved in the establishment of the climate of risk that dominates modernity. For them, because of the development of science, a multitude of experts' networks have been created and, with it, a growing number of uncertainties. They also argue that in modernity the reliance on experts' knowledge to reduce uncertainties has resulted in an increase in the reflexive potential of everyday life. All this, they affirm, has put scientists at the forefront of risk discourses. In the next paragraphs I present how those points are explored in Giddens' and Beck's specific theories. I start by presenting Giddens's view.

In spite of arguing for the importance of 'risk' in contemporary societies, Giddens (1996) stresses that to affirm that "modernity is a risk culture" (p.3) is not to say that nowadays our life is more risky than it was in the past. Rather, the contemporary climate of risk has to do with the high relevance of the 'risk' construct in the organization of current social life. Giddens (1996) refers to 'modernity' as "the institutions and modes of behaviour established first of all in post-feudal Europe, but which in the twentieth century have become increasingly world-historical in their impact" (p.15). To Giddens, modernity means the "industrialised world" (p.15) and the changes in social life it entails: industrialism - the new forms of social relations attached to production processes; capitalism - a competitive system of commodity production; and systems of surveillance - the basis of organisational power that emerges in circumstances of modernity.

In Giddens' view science plays two roles in the establishment of a 'risk culture' in "high modernity"⁵ (1996, p.243). On the one hand progress creates new risk parameters. On the other, it brings the possibility of predicting and protecting individuals against the new and the old risks. According to the author, the increased production and diffusion of scientific and technological information has created a social environment in which everybody is more or less aware of the possibility of a "self-inflicted harm" (Jones-Lee 1989, preface) and of controlling the extent of damage from man-made and natural causes. Also, everybody knows that it is impossible to live

⁵ "High modernity" is an expression used by Giddens (1996) for designating "the current phase of development of modern institutions, marked by the radicalising and globalising of basic traits of modernity" (p.243).

in a totally risk-averse environment because it is not feasible to know everything about the natural world.

Giddens (1996) talks about the increased specialisation of forms of expertise as a feature of modernity. He argues that if on the one hand it is fair to affirm that the knowledge incorporated in those forms of expertise is in principle available to everyone, it is also correct to say that experts cannot be experts in more than one or two fields of knowledge. In Giddens' view, it follows that when it comes to risk knowledge, we are all lay people because to have expertise in one small field necessarily leaves many others uncovered. A given situation or problem may have different interpretations, depending on the expertise that is used in its framing. Also, the same form of expertise can change its knowledge on the basis of new information. In modernity, Giddens argues, there are many risks that cannot be clearly assessed, because of the mutable knowledge environment that frames risk assessment. From that he concludes that "the risk climate of modernity is thus unsettling for everyone; no one escapes" (1996, p.124).

Science reveals the uncertainties of late modernity. Although contradictory, the increasing development of technology seems to reinforce human incapacity for understanding nature. The more people learn about the world, the more they become aware of how much more they have to know. This seems to be implicit in the contemporary use of the concept of 'risk' itself. If some future outcome is guaranteed, there is no risk. In other words, as Yates (1994) comments, "every conception of risk requires that there must be uncertainty about the outcomes of prospective actions" (p.11). To Giddens (1996), in circumstances of modernity, "to accept risk as risk, an orientation that is more or less forced on us [...], is to acknowledge that no aspects of our activities follow a predestined course, and all are open to contingent happenings" (p.28). The word 'risk' incorporates, then, the uncertainties produced and communicated by science.

Giddens is emphatic about the association between the climate of uncertainty created by modernity and reflexivity. To Giddens (1996), "modernity's reflexivity refers to the susceptibility of most aspects of social activity, and material relations with nature, to chronic revision in the light of new information or knowledge" (p.20). This reflexivity is an effect of the proliferation of expert systems and of lay people's need to trust the

knowledge that is incorporated into those systems. The future, Giddens argues, "...is continuously drawn into the present by means of the reflexive organisation of knowledge environments" (p.3). He claims that in modernity knowledge becomes hypotheses and systems of accumulated expertise are created as sources of authority over knowledge. Without 'certainty' about which knowledge to take on board or which knowledge is more valid, Giddens (1996) argues, these systems are likely to be externally and internally contested. According to the author, this creates the "principle of radical doubt" (p.3), which is the product of, and also stimulus for, the production of new scientific knowledge.

Another point made by Giddens is that the reflexive character of modernity has implications in the formation of self-identities. He argues that in the same way that reflexivity is at the core of late-modernity, it is also at the core of the 'self'. That is, in modernity, the 'self' becomes a reflexive project. Giddens asserts that in pre-modern societies, changes in individuals' identities occurred as natural processes of transition between for example, childhood and adulthood. This transition was based on traditions that were passed on from generation to generation; identity change had a more or less static reference. In late-modernity, however, Giddens argues, the 'self' has to be continuously constructed in a reflexive process that connects personal and social change. In late-modern societies, to have a given lifestyle is a conscious choice amongst an array of possibilities. To Giddens (1996), the implicit uncertainties of a life that is the result of personal decisions and always involves some sorts of risks generate anxiety. "Risk assessment is crucial to the colonisation of the future; at the same time, it necessarily opens the self out to the unknown" (Giddens 1996, p.182). Giddens reinforces his argument by asserting:

"In the reflexive project of the self, the narrative of self-identity is inherently fragile. [...] A self-identity has to be created and more or less continually reordered against a backdrop of shifting experiences of day-to-day life and the fragmenting tendencies of modern institutions" (p.186).

According to the author, in an environment dominated by doubt and multiple choices, the notion of lifestyle takes on particular significance. He explains: "...because of the 'openness' of social life today, the pluralisation of contexts of action and the diversity of 'authorities', lifestyle choice is increasingly important in the constitution of self-

identity and daily activity” (Giddens 1996, p.5). He goes on to comment that to choose a lifestyle and a consequent identity includes to reflect upon what risks to avoid and what risks to accept, which suggests that the importance of ‘risk’ in modernity is to do with the identity work that it stimulates. In that sense, Giddens (1996) asserts: “reflexively organised life-planning, which normally presumes consideration of risks as filtered through contact with expert knowledge, becomes a central feature of the structuring of self-identity” (p.5).

Giddens suggests that in circumstances of modernity, there is a tendency to see ‘risk-taking’ as a product of irrationality. He comments that there have been two ways of interpreting ‘risk-taking’, either as the effect of misleading information about the true levels of risk of a given action or because individuals are not sensitive to risk information. To Giddens, both interpretations are not satisfactory. His theory is that specific practices are usually clustered into lifestyle habits and the risks that they involve are not assessed as separate items in their respective domains.

“Life-planning takes account of a ‘package’ of risks rather than calculating the implications of distinct segments of risky behaviour. Taking certain risks in pursuit of a given lifestyle, is accepted to be within ‘tolerable limits’ as part of that overall package” (p.125, authors’ emphasis).

I have so far presented the main points of Giddens’ theory about the elements of modernity that have contributed to the proliferation of risk discourses. Giddens talks about the importance of scientific knowledge for the creation of a number of forms of expertise, the influence of experts’ knowledge in the generation of high levels of uncertainty and reflexivity and about the impact of uncertainty and reflexivity upon the importance of ‘risk’ in our lives. Beck’s theory does not differ much from Giddens’, although Beck’s analysis is focused on the contemporary multiplication of risks at a macro level. That is, the risks referred to by Beck are those resulting from global threats, like ecological and nuclear disasters. I present below the main points discussed in Beck’s theory about how the notion of ‘risk’ has become important in circumstances of modernity.

In his book ‘Risk Society: Towards a New Modernity’ (1992) Beck, like Giddens, also points at the links between experts’ knowledge and the contemporary pervasiveness of ‘risk’. To Beck, the existence of risk experts’ networks, which hold the responsibility

for the production and communication of risk knowledge, guarantees the sustaining of the contemporary western 'risk society'. Similarly to Giddens, Beck argues that one of the features of modernity is the multiplication of uncertainties and risks and that uncertainty is an implicit characteristic of risk. Beck suggests that it is the amalgamation of uncertainty and risk that makes the latter dependent on knowledge, especially scientific knowledge.

Beck argues that "risk consciousness" (1992, p.53) results from two types of what I would call 'risk education': the acquisition of risk information and personal risk experience. Affirming the importance of the acquisition of risk information for the development of "risk consciousness" (p.53), he concludes that those who have more access to risk information, like rich people and rich countries, are more likely to acknowledge the risks.

These reflections are followed by the affirmation that 'risk' creates new forms of social organization, which differ from the traditional model of class division. Beck (1992) suggests that in the past, class positions dictated people's fate, in the sense that if "one was born into it, it stuck to one...it was contained in everything, what one ate, how and with whom one lived..." (p.52). In the present time, however, he argues, the knowledge of risks has come to play an important role in the determination of the boundaries of pre-existent social groups. Beck remarks that the reference for a sense of 'belonging' to a certain group is not clearly visible anymore because it is now dependent on "external knowledge" (p.53), rather than on cognitive experiences as it was in the past. To Beck (1992), the essential difference between "class and risk positions" (p.53) is determined by differences in knowledge. "In class positions, being determines consciousness, while in risk positions, conversely, *consciousness (knowledge) determines being*" (Beck 1992, p.53, author's emphasis). These differences in knowledge are particularly related to personal experience. Beck (1992) states that knowledge about the threats of a class situation is shared by everyone affected by them. In that case, there is no need of an external knowledge to configure the dimensions of such 'affliction'. In a "risk society" (p.1), however, "the affected parties are becoming incompetent in matters of their own affliction" (p.53).

"Whether DDT is contained in the tea or formaldehyde in the cake, and in what dose, remains outside the reach of their own knowledge just as much

as does the question of whether and in what concentrations these substances have a long- or short-term deleterious effect". (Beck 1992, p.53)

Beck insists on the importance of knowledge for the existence of 'risk'. His theory seems to suggest that the distinction between 'objective' and 'subjective' risk is a fiction. In this respect, Beck writes:

"The latency phase of risk threats is coming to an end. The invisible hazards are becoming visible...It is not clear whether it is the risks that have intensified, or our view of them. Both sides converge, condition each other, strengthen each other, and because risks are risks in knowledge, perceptions of risks and risks are not different things, but one and the same." (p.55, author's emphasis)

Another point emphasized by Beck is the political importance of scientific knowledge in the 'risk society'. He suggests that the rationality of scientific conceptualizations of 'risk', understood as 'the risk', may be challenged by 'perceptions of risk' but that it is always possible to avoid confrontation by using scientific-oriented judgments through which deviant understandings of 'risk' may be classified as 'irrational' or resulting from 'ignorance' (Beck 1992). Until a given 'risk' is legally, medically, technologically, or socially recognized, he argues, it does not exist; at least not in a concrete way, or in a way that it can be prevented, treated or compensated for. For a given 'risk' to have a recognized existence, Beck suggests, there is the need to prove it on the grounds of scientific knowledge. "Scientific judgments' monopoly on truth therefore forces the victims themselves to make use of all methods and means of scientific analysis in order to succeed with their claims" (Beck 1992, p.71). Beck argues that the recognition of modernization risks involves not just knowledge but also collective knowledge of them and belief in them. It is also an outcome of the political illumination of cause and effect systems. For Beck, "where this happens the risks develop an incredible political dynamic". He refers to this political dynamic as "dynamics of *reflexive politicization*" (Beck 1992, p.77, authors' emphasis), dynamics that produce risk consciousness and conflict, which in his view open new areas of, and opportunities for, action.

In the same way as Giddens, Beck also makes the point about the increased reflexivity of modernity. To Beck (1992), modernization is in the process of becoming reflexive. That is, modernization is in the process of becoming its own theme because it produces

‘risk’ and also knowledge about ‘risk’. The knowledge of the risks created by technological processes of modernization are always open to re-consideration and everything depends on scientific disputes, that are also political disputes, over the truthfulness of risk knowledge.

It has been suggested that although Beck and Giddens agree about the importance of reflexivity for the constitution of modernity, their approaches to reflexive modernization are different (Lupton 1999). While Beck argues that late modernity is reflexive because of an increase in the production of risks, Giddens asserts that the centrality of the notion of ‘risk’ in late modernity does not mean that we are experiencing more risks now than in the past. To Giddens, the difference is that nowadays we are more interested in knowing the ‘risks’, for they are to be given importance in our ‘projects of the self’.

The emphasis that Giddens gives to ‘trust’ can also be regarded as a difference between his theory of modernity and that of Beck’s. Giddens contends that in contexts of uncertainty and multiple choice the notion of trust is particularly important. He makes a distinction between trust as a generic phenomenon of personal development and as specific life resource in circumstances of proliferating “abstract systems - the “symbolic tokens and experts systems taken generically” (p.242). In generic situations, trust is used to achieve a sense of security, as is the case of the trust established between a child and its caretakers. Trust here protects the ‘self’ against the potential threats of everyday life. In the latter case, trust, a medium of interaction with abstract systems, results from the reliance on expert knowledge produced by unknown people to alleviate uncertainties. To Giddens, without trust in ‘abstract systems’ individuals would not be able to face risks and take action in a ‘risk culture’.

Along with Giddens’ and Beck’s theories about the association between modernity and the proliferation of risk discourses, the work of the anthropologist Mary Douglas has also been influential in the way ‘risk’ has been theorized in the context of social sciences. Douglas’ work explores the connections between cultural contexts and risk meanings. I look next at the main points of Douglas’ theory on risk.

In a series of essays the anthropologist develops the theory that risk perception is culturally, politically and morally biased (Douglas 1994). She argues that risk

perception theorists should study risk-taking and risk-aversion within a cultural framework. In Douglas' theory of risk, culture is defined as "the publicly shared collection of principles and values used at any one time to justify behavior" (Douglas 1986, p.67). Douglas asserts that 'culture' includes the institutional foundations of behaviour, that is, the principles and values that uphold forms of institutional life. In that sense, 'culture' also represents the individuals' awareness of the social environment, in which individual and collective interests coexist. 'Culture' is then "...the coding principle by which hazards are recognized" (Douglas 1986, p.68).

"The cultural standards of what constitute appropriate and improper risks emerge as part of the assignment of responsibility. They are fundamental to social life. When asked about the risks he takes, an individual has to make his answer start from some culturally established norm of due carefulness. So a daring mountaineer will rather boast of how he refused to budge when certain bad weather signs appeared; an Olympic skier will rather boast of his care equipment. Both denying that they take risks, but assert they avoid silly risks" (Douglas 1986, p.68).

Douglas makes the point that the answer to the question "how safe is safe enough" (Douglas 1994, p.41) cannot be found without reference to the cultural context where 'safety' and 'risk' are defined.

"Some cultures demand public commitment from individuals, while some expect individual self-interest to be the dominant motive, others expect nothing of the sort; some respect compromise that enables all disputants to seem to have won, others fiercely reject ambiguous solutions" (Douglas 1994, p.41).

Douglas suggests that the question about 'risk' should be "how safe is safe enough for this particular culture" (Douglas 1994, p.41). In her view we select certain risks to take, and others to avoid, based on an evaluation of the probable losses and gains of our choices. Those choices, she suggests, are outcomes of personal judgments, which are preceded by a revision of personal and collective values. In that respect she writes:

"A real life risk portfolio is not a selection made by private ratiocination. In real life the social process slides the decision making and the prior editing of choices onto social institutions. Shared values do more than weight the calculation of risks. They work on the estimates of probabilities as well as on the perceived magnitudes of loss" (Douglas and Wildavsky 1982, p.85)

Douglas argues that "risks are always political" (p.44). This suggests that even in the case of risk experts' perceptions of risk, it is problematic to affirm neutrality. Similarly

to Beck, she also emphasizes the risk analysts' political commitments as evidence of their biased risk calculations. Also, similarly to Giddens and Beck, Douglas talks about the uncertainty of contemporary life and of its links with the increased use of the notion of risk. She points out that there is a sort of irony of timing in the political use of the notion of risk. At a time when politics needs the authority of science - certainty- the most, the probabilistic analysis of risk cannot promise certainty.

Douglas (1994) rejects the scientists' view that lay people lack the ability to think in probabilistic terms. She contends that they exercise this calculation in their everyday lives, but not in the formal way carried out by science. Arguing that cultural theory can provide the means to understand how lay people make their risk calculations, Douglas stresses that they "scan frequencies and assess them in everyday decisions" and that their probabilistic thinking does not approach risks as technical matters but as moral and political ones. Risk experts, Douglas argues, take the individual as a 'decision-making unit'. It is then excluded "from choice any moral or political feedback that he may be receiving from his surrounding society" (1994, p.67).

We have learned so far that, from a sociological point of view, although scientific knowledge has much to do with the emergence of 'risk' as a fundamental concept of modernity, risk meanings are not restricted to technico-scientific theories (Lupton 1999). They also encapsulate social, cultural and political meanings. A basic conflict between the sociological and the technico-scientific perspectives is that the former affirms that risk is not definable in a value-free process and the latter argues the opposite. The next section will review the sociological debate about the supposed 'objectivity' and 'neutrality' of technico-scientific theories on risk. This is important because it constitutes the basis of the sociological critique of the predominance of 'scientific risk' in the field of public health and health promotion, a matter that will be discussed on page 53.

The 'Technico-Scientific' Approach to Risk and Sociological Critiques

As Lupton (1999) suggests, diverse disciplines inform the 'technico-scientific' approach to 'risk', such as engineering, statistics, actuarialism, psychology,

epidemiology and economics. She cites cognitive science, an approach based on psychology, as an example of a major area that adopts the technico-scientific perspective. Such disciplines, she argues, associate the notion of danger with calculations of probability.

The association of danger and probability that underpins 'technico-scientific' theories of risk can be clearly identified in the definition of 'risk' that appears in the Concise Oxford Dictionary - "the chance or possibility of danger, loss or injury" (Allen 1990, p.1040). Dictionaries are supposed to present the common sense meanings of words and expressions of a given language. This suggests that, as a number of commentators have argued, the daily use of the notion of 'risk' is influenced by the technical approach of science (Beck 1992; Giddens 1996; Lupton 1995a; Petersen and Lupton 1996). Lupton (1999) describes how the proponents of a technico-scientific approach to 'risk' develop their work by commenting on the nature of the debates over risk that they produce and on their tendency to know 'risk' in a calculable way:

"Debates over risk in these technico-scientific fields tend to revolve around issues of how well a risk has been identified or calculated, the level of seriousness of a risk in terms of its possible effects, how accurate is the 'science' that has been used to measure and calculate risk and how inclusive are the causal or predictive models that have been constructed to understand why risks occur and why people respond to them in certain ways" (p.18).

One important feature of what Lupton calls 'technico-scientific' conceptions of 'risk' is that they tend to present the knowledge produced in their risk calculations as 'the truth'. The objectivity, rationality and neutrality that are supposedly implicit in any scientific enterprise, are also understood as valid here. To understand what the emphasis on the objective character of 'risk' means or what effects this has on the discourses of 'risk' that this approach produces, one may begin by considering the definitions of 'objectivity' and 'objectivism' that appear in the dictionary. The Concise Oxford Dictionary defines 'objective' as "external to mind, actually existing; real" and 'objectivism' as "the belief that certain things [...] exist apart from human knowledge or perception of them" (Allen 1990, p.817). 'Risk' is seen by the proponents of the technico-scientific approach as a phenomenon that exists independently of human perception; that is, it is statically out there waiting to be discovered and rationally explained, calculated and controlled (Heyman 1998a; Lupton 1999). The scientific

exploration of 'risk' is to be undertaken by means of scientific methods, mainly probabilistic risk assessment, for they are believed to be value-free and to guarantee a neutral and objective knowledge of facts (Gibson 1986; Lupton 1999).

We have learned from the sociological theories on risk discussed so far that, as opposed to the affirmation of the objectivity of 'scientific risk', sociologists believe that the attachment of meanings to risk is always biased. As proponents of the sociological approach to risk, Petersen and Lupton (1996) comment:

“the focus on the social construction of risk is not to argue that there are no ‘real’ dangers and threats to which humans may fall prey [...] but rather is to contend that our understanding of these dangers and hazards, including their origins and outcomes, are constituted through social, cultural and political processes. It is through these processes that dangers and hazards become risks” (p.18).

A major problem pointed out by the critics of scientific interpretations of risk is that, despite the alleged objectivity and neutrality of science, scientific theories on risk are subjectively produced and so can be externally manipulated to direct risk discourses towards specific interests (Beck 1992; Castel 1991; Gabe 1995; Heyman 1998a; Lupton 1995a; Lupton 1999; Petersen and Lupton 1996). The critics argue that because scientific calculations of 'risk' are not neutral, nor objective, they should not be uncritically accepted as picturing the reality about risks. For the critics, risk assessment always involves some sort of subjective judgment, which is influenced by social and cultural bias (Beck 1992; Gibson 1986; Lupton 1995a; Lupton 1999). In that sense, it would be a mistake to distinguish subjective ways of seeing risk from objective conceptions of risk.

Heyman (1998a, p.5) makes a meticulous analysis of what he sees as the critical points of an objective approach to 'risk'. He argues that objective definitions of 'risk' represent it “as a property of the world rather than of our knowledge” and that, in doing so, tend to attach pre-determined meanings to it. The author makes his point clearer when he examines minutely The Royal Society's definition of 'risk' presented earlier. In his view, to define 'risk' as “the probability that a particular adverse event occurs during a stated period of time, or results from a particular challenge” (quoted in Heyman 1998a, p.5) is problematic in five different aspects. First, the notion of an “event” presupposes a sort of categorization of heterogeneous phenomena, which may



vary not only between individuals but even between different groups of professionals. Secondly, the use of the word “adverse” implies an externalisation of adversity onto events, ignoring the fact that ‘adversity’ is a concept internally defined by individuals and social groups on the basis of their values. The third critique has to do with the idea of “a stated period of time”, which seems to imply that the temporal frame of ‘risks’ can be externally established. Fourth, The Royal Society uses the notion of “probability” as a way to externalise uncertainty, in the same way of “adversity” as an “externalisation of value” (Heyman 1998a, pp. 5-6). In addition, to work with the idea of ‘probability’ rather than ‘probabilities’, Heyman argues, is to forget that, on the basis of a combination of uncertainties, one can correctly attribute more than one probability to the same event. To him, the tendency of science based cultures in externalising uncertainty, “...creates a cognitive illusion that multiple probabilities of the same event are logically impossible” (p.7). The last critique pointed out by Heyman refers to the reduced focus of The Royal Society’s definition - a single “adverse event”- which fits with the tradition of science in investigating and managing isolated problems. In this respect, Heyman (1998a) remarks,

“...individuals who manage personal risks are not usually concerned with predicting the probability of one form of adversity in terms of multiple indicators, but with its obverse. They seek to predict the multiple consequences, positive and negative of a single type of action” (p.6).

One indication of the ideal of objectivity implicit in the disciplines that adopt a technico-scientific perspective is their emphasis on numerical representations of ‘risk’ (Lupton 1999)⁶. Allen and Crump (1986) define quantitative risk assessment as “that portion of the overall risk management process concerned with the quantitative estimation of risk, relating numerically specified levels of exposure to probabilities of response” (p.129). One of the fields where quantitative risk assessment is more common is the field of public health, in which probabilistic estimations of risk are used as a scientific and rational support for political and professional decisions concerning health-related risks (Gabe 1995). Allen and Crump (1986) exemplify with the case of cancer the ways in which quantitative estimations of risk may assist public health professionals:

⁶ See section on ‘risk and epidemiology’, page 55.

Because of the many known or suspected carcinogens encountered in the workplace, released to the ambient environment, or imposed by lifestyle choices, it is important to decide what levels of risk are entailed, which carcinogens should receive attention, and how risks might be reduced (p.129).

Douglas (1990) argues that the word 'risk' has been substituted for 'danger' in a number of professional discourses because the former is considered to be 'more scientific' than the latter and so subject to 'precise' calculations. Danger was transformed into 'risk' to attend the demands of contemporary western societies. Lupton (1993) explains how the numerical logic that underpins objective approaches to 'risk' works:

"...risk analysts speak of the statistical likelihood that an event may occur, and use the mathematical model produced to assist in decision-making in such areas as economics and management. The risk, or likelihood, of an event happening can be calculated to numerical odds - one in fifty chance, one in a hundred, one in a million - as can the magnitude of the outcome should it happen" (p.426).

Gibson (1986) also offers her critique of the alleged objectivity of quantified risk. She affirms that quantitative risk assessment is potentially manipulative, because it is carried out according to a certain background and the choice of this background is always value-laden. One indication of the subjective character of discourses of risk produced through a technico-scientific approach is reflected in the disputes over health risk matters that are daily presented in the media.⁷ Gibson (1986) gives an example how subjective and influential the choice is of the referential point against which conceptions of risk are produced:

"Which of indefinitely many possible comparisons among risks one elects to make is not a neutral matter. When we are told that the risk of death to any individual from a nuclear power accident in any given year is less than the risk many of us take each day driving or riding in an automobile, it is being suggested that we ought to accept the nuclear risk" (p.181).

According to Thompson (1986), the proper goals of quantitative risk assessment suggest the mistaken conception of 'risk' that underpins the technico-scientific

⁷ An example is the current debate about the safety of British beef in the case of the human form of 'mad cow disease'.

approach. As the author notes: “ ...the need to reflect one’s level of confidence probabilistically and [...] to evaluate events constitute sufficient demonstration of the inadequacy of founding the concept of risk wholly on how things stand in the world” (p.279).

For the proponents of the socio-cultural approach to ‘risk’, technico-scientific discourses of risk do not acknowledge the implicit need to make choices in order to attach meanings to ‘risk’ and the consequent involvement of the ‘self’ in such an operation. The conceptions of ‘risk’ produced according to technico-scientific perspectives are believed to be unbiased pictures of reality. Supposedly, they represent the only correct way of looking at the risks in question. From scientists’ point of view, scientific theories of risk are the product of scientific rationality. So, they cannot be the result of subjective choices as, allegedly, there is no more than one option.

But if the literature shows how problematic it is to affirm the objectivity of ‘risk’, it also indicates that an expansion of risk meanings is equally complicated. Heyman (1998a) recognizes those problems by suggesting that whatever the approach, conceptions of risk are dependent on a value judgment, for example, about the importance of each of the multiple consequences of a given situation. Such a judgment, he points out, necessarily involves a subjective reasoning that is socially and culturally contingent. Gibson (1986) makes a similar point. She exemplifies her position with the case of air pollution. In the example the association between the choice of the background within which to carry out risk assessments and conceptions of risk is clear.

“Sulphur dioxide contributes not only to acid rain, but also to respiratory disease and distress. So, when we measure or state the risks of sulfur dioxide, do we include only respiratory effects, or all potentially harmful effects...? And against what set of initial conditions do we determine what all the potentially harmful effects are?” (p.181)

For those who adopt a technico-scientific approach to risk (and who usually suggest the absolute correctness of their knowledge about it) there seems to be no other option than to distinguish the ‘right’ - objective view of risk - from the ‘wrong’ version of risk - subjective view of risk - (see pages 58-62). The literature shows a number of examples of studies in which lay people’s perceptions of risk are investigated with the implicit aim of establishing the gap between what they know about ‘risk’ and the scientific and

‘correct’ knowledge of risk (Hemmelstein 1995; Moore and Rosenthal 1991; Moore and Rosenthal 1992; Weinstein 1984).

An individualistic notion of behaviour underpins such explanatory projects. It is believed that it is because lay people have a subjective and biased approach to ‘risk’, which results in the use of a ‘wrong’ knowledge to make decisions, that they do not behave properly. In that case, the solution to the problem of ‘wrong knowledge’ and ‘wrong behaviour’ is addressed in conformity with tradition, that is, via education and the provision of ‘correct’ information. Lupton (1999) comments on the distinction between ‘objective risk’ and ‘subjective risk’ that was proclaimed in the Royal Society’s report on risk. According to Lupton (1999) “it was argued in this report that a range of ‘objective’ risks exist in any situation, to which individuals and social groups respond in more or less ‘subjective’ ways” (p.19). This question of the ‘subjective risk’ will be further discussed in the section on the social psychology approach to risk (pages 58-62).

We will see next that, following its traditional scientific orientation public health and health promotion have not taken into consideration the socio-cultural contents of risk. For public health workers in general, and health promoters in particular, ‘risk’ is a ‘technico-scientific’ construct, that is to say, ‘risk’ is defined from a technico-scientific perspective (Lupton 1999). The technico-scientific approach to risk adopted in the field of public health has often drawn on two disciplines: epidemiology and social psychology. The former has theorized ‘risk’ in terms of the calculation of risk distribution in populations and the latter has developed a particular understanding of the ‘subjective’ features of risk and risk behaviour. The specific use of both disciplines in the theorizing of health risk will be discussed elsewhere.⁸

‘SCIENTIFIC RISK’ AND PUBLIC HEALTH

Over the last two decades the notion of ‘risk’ has become key to the production of public health discourses, in particular those of health promotion (Lupton 1995a; Nettleton and Bunton 1995; Petersen and Lupton 1996). Lupton (1995a) classifies the discourses of ‘risk’ produced in the field from two main perspectives. The first one

⁸ See page 55 for the epidemiological approach and page 58 for the social psychology approach.

focuses on risk as a threat to the health of populations. Pollution, nuclear waste and other environmental hazards represent the danger. In such a perspective, the health of ‘the public’ is seen as threatened by external dangers over which people have little control. ‘The public’ is to be protected by an environmental policy, projected and implemented by governmental institutions. The second one sees ‘risk’ as a result of lifestyle choices, as an individual responsibility. The emphasis then shifts from little control to self-control. In the latter case, the operation of self-management is opened to the interference of health educators who have the responsibility of promoting what biomedicine defines as healthy lifestyles. In both cases, conceptions of ‘risk’ and the orientation for risk-management are established in accordance with the risk scientists’ knowledge. The literature reviewed here primarily focuses on the second perspective, for the risk discourses of health promotion are produced around the notion of ‘risk’ as “*internally imposed*” (Lupton 1995a, p.77, author’s emphasis).

The analysis of how ‘risk’ has been defined and theorized in the context of public health suggests that the scientific model of risk underpins the risk discourses produced in the field. Objectivity, individualism and the tendency to use numbers to refer to ‘risk’ are all features of public health discourses of risk that seem to have been inherited from the scientific paradigm. Although epidemiology and social psychology take different standpoints, their ways of seeing risk are both recognized as ‘objective’, hence scientific. It is this ‘scientific’ status that has given both disciplines important places within the theoretical background of public health and health promotion, particularly in problematizing the question of risk.

As a modernist institution, scientific medicine is traditionally dependent on the knowledge produced by ‘science’ for gaining and maintaining its credibility. It also relies upon ‘rationality’ for achieving its goals in the fight against diseases. It believes in human power over the forces of nature (Petersen and Lupton 1996). In modernity, chronic diseases constitute the main public health problem. In contrast to the past, when diseases were caused by single pathogens, diseases of modernity result from a combination of ‘unspecified’ factors (Susser and Susser 1996) believed to be the consequence of interactions between individuals and environments. And, to follow the traditions, diseases of modernity also need to be dealt with by rational means.

For obvious reasons, modernist institutions, like scientific medicine, seek to use modernist strategies for dealing with the problems of modernity (Petersen and Lupton 1996). The development of quantitative measures of 'risk' can, apparently, help to resolve these problems. Numbers have a 'real existence'. They can be 'rationally' handled (Lupton 1995a) and scientifically 'recycled' as material for developing and proving arguments. More importantly, they can be useful for materializing phenomena that are difficult to visualize. Numbers can turn 'risks' into concrete entities, which may then become subjected to external intervention (Lupton 1995a).

Ultimately, the goal of health risk assessments is "to find out what the risks really are", an optimistic goal that relies on the idea that "all risks are discoverable and measurable and can be controlled with the requisite skill and expertise" (Gabe 1995, p.2). Risk assessment and management has been introduced in the health care systems of industrialised countries as a way of reducing risks and controlling costs (Gabe 1995; Lupton 1993). Epidemiological calculations are the most common means utilized for the 'new' public health workers to problematize health-related risks. The next section discusses the use of epidemiology in the field.

'Quantitative Risk' and Epidemiology

There is an intrinsic relation between 'risk' and 'epidemiology'. As some have argued, epidemiology can be seen as "the study of disease and illness and their risk factors as they occur in groups rather than in individuals" (Petersen and Lupton 1996, p.27). However, as Susser (1996) remarks, although the definition of epidemiology refers to 'groups' as targets, epidemiology usually focuses on the individuals within those groups. Similarly, while public health conceptions of risk are mainly based on (epidemiological) studies of groups, the definition of problems of health-related risks, and also of their solutions, remains focused on the individual (Lupton 1999). It is not surprising, then, that the alleged progress of public health from the 'old' individualistic approach to a 'new' holistic one has been contested.

The aim of epidemiology is to identify "patterns in diseases at a population level, seeking to discover *reasons* for certain groups developing diseases over other groups" (Lupton 1995a, pp.65-66, my emphasis). Public health workers have utilized

epidemiology not only for finding out ‘where’ and ‘what’ the potential problems are but also, and more importantly, for pointing out ‘why’ they are there. The determination of ‘why’ is used to reveal who the potential risk subjects are, who in the case of self-imposed risks are obviously taken as the origin of related problems.

In his review of the history of epidemiology, Susser (1996) remarks that when the epidemic of chronic diseases emerged in the latter half of twentieth century, the need to find out the origins of the diseases resulted in the development of descriptive studies of disease distribution. Also, it resulted in the development of exploratory research, which had the aim of finding out the potential risk factors. Susser comments that later the procedures were gradually refined with the help of statistics and analytical methods and became known as ‘epidemiology’.

‘Epidemiology’ has the same etymological roots as the word ‘epidemic’ (Lupton 1995a). To call a phenomenon an ‘epidemic’ means “to label a collection of cases of an illness or disease”, which is the same as to “give certain meaning to these cases” (Lupton 1995a, p.65). ‘Epidemic’ also suggests a “societal disorder” that suddenly spreads without warning, and “the need for harsh and decisive measures to be taken to keep the disease in check” (Lupton 1995a, p.65). Given the scientific status of epidemiology, its methods are understood as ‘rational’ ways of dealing with such an emergent situation and so of “re-establishing the social order” (Lupton 1995a, p.65).

Ideological and political reasons are behind the interest of the ‘new’ public health in the quantification of health-related risks (Petersen and Lupton 1996). To begin with the ideological reasons, one can follow Lupton’s affirmation that in contemporary societies, diseases may threaten social life by exposing the fragility of social order, an affirmation that relies on the ideological assumption of human progress and rationality (Lupton 1995a). In affecting a large number of people, epidemics can be particularly threatening. They may threaten human beings’ power over nature (Lupton 1995a, p.63). They may also challenge the competence of ‘rational’ methods of traditional medicine for dealing with sickness (Lupton 1995a).

Once again one can argue that the ideology of individualism influences the way the ‘new’ public health approaches risk (see section on health education, p.16), as the emphasis on individuals’ responsibility for health seems to be behind the interest in

epidemiology. The environment may frame individuals' behaviour but, in the end, it is the response of the individuals to their environmental circumstances (or their lifestyles) that can threaten their health status. In the 'new' public health individuals are not considered in isolation. They are part of the 'social', an idea that expands the notion of 'environment' and re-conceptualizes it in holistic terms. The individual is seen as having a dynamic and symbiotic relationship not only with the environment as a material world, but also with the political, social and economic aspects of it. In this sense, the 'social' also incorporates the relationships between individuals within a given material world (Petersen and Lupton 1996). In such a context, the state of health of an individual body affects the health of the others, and so of the 'social body'; just as the 'social' also influences the health of the individual. In order to control the health of the 'social body' it seems necessary to develop mechanisms of surveillance through which a 'clear picture' of individuals' behaviour can be obtained.

Castel (1991) argues that in preventive medicine the assessment of risk factors is used as an innovative strategy of surveillance, in which there is no need for an actual contact between the agent and the subject of prevention. In this new system of administration, he stresses, the monitoring of the "assisted subjects" (Castel 1991, p.287) is now undertaken through the prediction (and anticipated prevention) of the events that may result in "undesirable modes of behaviour" (Castel 1991, p.287). In this sense, "risk does not arise from the presence of particular precise danger embodied in a concrete individual or group. It is the effect of a combination of abstract factors that render more or less probable the occurrence of undesirable modes of behaviour. (Castel 1991, p.287, author's emphasis).

As Yen (1995) remarks, this focus on 'risk factors' indicates an understanding of the individual based on an understanding of the group of particular risk factors he/she displays. To represent an individual as a collection of risk factors has the effect of reducing the integrated person to a "limited set of behaviours and characteristics" (Yen 1995, p.35). If that is true, then, to be a patient is no longer confined to manifesting symptoms of ill-health (Castel 1991). For someone to be seen as a patient (and subjected to health professionals' intervention) it seems to be enough to display the characteristics defined by the experts as 'risk factors'. The dissociation of the notion of 'risk' from that of 'danger', Castel (1991) argues, may result in a multiplication of

possibilities for experts' intervention, for virtually everyone may display a number of risk-factors. More specifically, it opens up the definition of what health is or what an individual or group required to be considered as healthy according to medical professionals' judgments. And this involves biased decisions.

Citing Frankenberg, Petersen and Lupton (1996) stress that when epidemiology deals with risk situations two initial choices are posed: first, "which outcomes to focus upon" and second, "which risk factors ought to be given priority" (Frankenberg 1993, p.236). Along with Frankenberg, Petersen and Lupton suggest that those choices are biased as they "are surrounded by culturally defined moral problems in which power relations always have a central position" (Frankenberg 1993, p.236). Petersen and Lupton (1996, p.47) exemplify the argument by commenting on the usual representation of the causes of smoking:

"...the 'web' of causation that is often constructed to show why individuals may choose to smoke draws attention to such factors as stress, lack of knowledge about the side-effects of smoking, addiction to nicotine, low self-esteem and low self-efficacy. While the sociocultural context is clearly important here, it is generally reduced to the individual level: a person feels stress and smokes to alleviate it, lacking the self-esteem and self-efficacy she or he requires to give up".

But if epidemiology has been useful for the general purposes of the public health, helping with the identification of individuals and groups 'at risk', social psychology has served more specific purposes. While the former informs the definition of risk and the identification of 'risk subjects', the latter is used in the study of how 'risk subjects' perceive the 'risk' in question or what needs correction in this 'process of perceiving'.

'Subjective Risk' and Social Psychology

Psychology is used in the field of public health to fill the space created between external and internal conceptions of 'risk'. By being mostly concentrated on individual's risk perception, psychologists' studies of 'risk' obviously adopt an individualistic approach.⁹ Health promotion's individualistic approach to risk has much to do with the psychologisation of risk.

⁹ See for example Hemmelstein 1995; Irwin Jr. 1993; Moore and Gullone 1996; Weinstein 1982.

Psychologists' study of the subjective character of risk has been focused on risk perception, or to be more precise on 'lay people's risk perception'. Risk perception is understood as a 'mere' subjective and often mistaken process of making sense of scientific risk, which is supposedly the objective, neutral and correct way of seeing risk. Research subjects rarely include scientists. Scientists are not supposed to 'perceive' but, 'to know for sure'. Strikingly, as the sociocultural analysis of scientific risk discourses reviewed so far suggests, it is precisely because scientists perceive 'risk' in the way they do that they 'believe' it is only others' perceptions that need to be investigated (Beck 1992; Giddens 1996; Heyman 1998a; Lupton 1995a; Petersen and Lupton 1996).

Adolescents are common targets of research on risk perception. Here are some examples of the focus of this type of research: 'adolescents' perception of the risk of drug use' (Hemmelstein 1995); 'adolescents perception of AIDS sexual risk' (Abrams et al. 1990; Bartelli et al. 1996; Maswanya et al. 1999; Moore and Rosenthal 1991); adolescents' perceptions of health-related risks (Moore and Rosenthal 1992; Weinstein 1984), adolescents' perceptions of the risk of sexually transmitted diseases (Moore and Rosenthal 1994).

A common aim of psychology is to explore the gap between technically defined risks and public perceptions of them (Gabe 1995), which is allegedly one of the main causes of risk behaviour.¹⁰ As Gabe (1995) argues, the focus on personal perceptions of risk rather than on impersonal 'risk factors' should result in understandings that could be less technical than those resulting from epidemiologists' studies, for example. However, this is not the case. As a scientific discipline, psychology seeks to develop theories in a 'rational' and objective 'environment'. This purpose has lead psychologists to use quantitative methodology to assess people's perceptions of risk (as it is seen as more scientific). Thus, similarly to epidemiologists, psychologists have also produced a body of knowledge on 'risk' supported by what Gabe calls a "technical risk assessment" (1995, p.4). Lupton (1999) calls this type of operation "psychometric risk analysis" (p.21), a quantitative analysis to measure the relationship between cognitive factors and lay people's attitudes and behaviour concerning risk. Those types

¹⁰ See section on page 65 for the limitations of risk perception research to explain the specific case of sexual risk behaviour.

of studies seek to examine the cognitive processes through which lay people perceive 'risk' and act accordingly (Denscombe 1993).

Here is an example of how the focus on individual risk perception may orient the definition of a given health risk-related problem. On the basis of the assumptions that "perceptions of vulnerability predict preventive health behaviour" and "people's comparative risk judgments are optimistically biased", Weinstein (1984) carried out a quantitative study with the aim of analysing 'how' young people's perceptions of susceptibility and risk factors were formed. The author concluded that perceptions of susceptibility and risk were constructed through a process of comparative risk judgments which basically took into account the relationship between objective and perceived risk (particularly with regard to perceptions of risk factors of oneself and of others). Self-esteem, egocentrism and optimistic bias were found to be the most influential factors affecting such processes. In the concluding comments the author pointed out the importance of his findings for the prevention of risky behaviours:

"Several of the findings reported here-the weakness of the links between behavioral risk factors and perceived susceptibility; the tendency for young people to view their actions as both desirable and as better than the actions of their peers - have clear implications for prevention. It is common for public health campaigns to point out risky behaviors [...]. It appears necessary, in addition, to strongly emphasize the link between behavior and susceptibility, stressing that the people who engage in high risk behaviors should see themselves as the ones most likely to suffer harm" (Weinstein 1984, p.455).

It seems to be apparent in the statement above that, as Gabe (1995) argues, the underlying assumption of this kind of psychological approach to 'risk' is that individuals are "free agents in terms of their response to risk, ignoring social factors which constrain choice" (p.5). This contradicts the empirical findings of sociological research that strongly suggest that 'risk', 'risk perception' and 'risk behaviour' are all culturally and socially produced (Frankenberg 1994; Green 1997a; Paiva 1993; Rhodes 1997) (see section on page 38).

Most of the theories on health risk behaviour utilized in the field of public health and health promotion are based upon the models of behaviour developed by socio-psychology. The most influential model is the 'Health Belief Model' (HBM). The HBM is an explanatory model employed to predict health behaviour. It is based on the

assumption that individuals make conscious decisions concerning personal health after taking into account a number of factors (Rosenstock 1974; Rosenstock, Strecher, and Becker 1988). The HBM hypothesizes that health-related risk behaviour is dependent on three categories of factors: the existence of motivation or health concern, perceived vulnerability and the belief that it is worthwhile to take a particular health recommendation in order to reduce a perceived threat (Rosenstock, Strecher, and Becker 1988). Individual rational thinking is thus a major feature of such a theory. The focus on individual rationality to theorize risk behaviour can be criticized on the basis of the same assumptions used to question the individualistic approach of health promotion. Simply put, individual factors cannot be indicators of behaviour, for behaviour is socially constructed (Bunton, Murphy, and Bennett 1991).

The employment of social psychology to theorize health-related risk behaviour has reinforced the tendency of health professionals to conceptualize ‘risk’ as a phenomenon that has a ‘life of its own’ and can therefore be externally visualized, defined and studied on the basis of scientific knowledge. Psychology-based theories on risk are the targets of the same critiques received by other theories of risk that take a technico-scientific approach (see pages 47-53).

Psychologists’ theories of risk perception often do not take into account the influence of the socio-cultural context on the way people perceive ‘risk’ (Gabe 1995; Lupton 1999). Perceptions of risk are assessed as isolated ‘facts’, which are seen as dependent on cognitive and rational operations (Joffe 1999; Lupton 1993; Lupton 1999). The assessment of ‘perceptions of risk’ constitutes an attempt to find out how those cognitive operations work (Joffe 1999), using behavioural theories as a theoretical background. Joffe argues that such inquiries draw on “information process models”, which are focused on “...the ‘errors’ that interfere with logical processing” (Joffe 1999, p.138, author’s emphasis). Within such a paradigm, risk behaviours are supposed to result from internal cognitions and individual rationality. What matters in these studies is “the lone thinker’s subjective processing” (Joffe 1999, p.138). The social is either taken as secondary or irrelevant.

The sociological critique of the alleged objectivity of ‘technico-scientific’ approaches to risk imply the affirmation of the subjective and biased nature of conceptions of risk, which the proponents of the technico-scientific approach to ‘risk’ seem to accept only

when it comes to lay understandings. As commented earlier, technical risk assessment and related knowledge are supposed to be ‘immune’ to subjective judgments and, thus, to be far more accurate than any lay attempt to assess the risks by themselves. In that sense, Lupton (1999) points out: “such risk calculations tend not to acknowledge the role played by the ‘ways of seeing’ on the part of experts themselves that produce such calculations” (p.19, author’s emphasis). Whatever the background, either scientific or lay, to deal with ‘risk’ always entails some sort of subjective calculation (Giddens 1996).

Along with the argument that conceptions of risk extrapolate the technico-scientific meanings of risk and the affirmation of the subjective character of risk, the sociological literature also develops another important argument. Some sociologists have argued that public health workers’ emphasis on the individual perspective of risk has had implications for the production of individuals’ subjectivities. This argument is further developed in Chapter 5 (page 156), where I make the point about the influence of health promotion on the ways in which the girls whom I talked to make sense of themselves in their responses to the risks of sex. The section below points out the main issues raised by the sociologists that make the point of the relationship between ‘subjectivity’ - the sense one makes of oneself - and ‘risk’.

Subjectivity and Risk

Considering the literature reviewed, we can assume that in the view of sociologists risk has been defined in the field of public health as a person-centered problem, with an obvious effect on the production of identities and forms of governance. It seems that, as far as the ‘new’ public health is concerned, we are legitimate gatekeepers of our own health and, thus, surveillance needs to be doubled. We need to be externally and internally monitored; we become not only a target of health professionals’ surveillance but also, and more importantly, we need to be constantly controlled by ourselves. It has been argued in the sociological literature on risk that this discourse of self-governance that is incorporated into conceptions of ‘health risk’ has had a great impact on the production of new shapes for the ‘self’ (Greco 1993; Nettleton 1997; Ogden 1995; Petersen and Lupton 1996; Petersen 1996).

In contemporary society, risk is not considered as external to the 'self' as it was perceived in the past (the risk of being invaded by a virus or harmed by pollution), but located within the 'self'. In Ogden's words, "...the individual has become at risk from his or herself" (Ogden 1995, p.413). Petersen and Lupton (1996) make a similar point. They remark that by having the moral commitment of protecting the 'self' against the health-related risks that can be produced by lifestyle choices, the individual may "...become 'at risk' from their own ignorance or lack of self-control" (Petersen and Lupton 1996, p.115). AIDS is cited as a case in point.¹¹ "The HIV virus itself is no longer a risk to health: the individual's ability to control their sexual behaviour is now the risk" (Ogden 1995, p.413). As we will see in Chapter 4 (page 130) this association between 'risk' and 'self-control' is not, however, limited to health hazards and sexual relationships. It can also be incorporated to other risk contexts of everyday life.

To Greco (1993, p. 357), 'to be well' has become a 'duty' in an environment where to live is to be increasingly 'at risk'. 'To be well' is perceived as a possibility as long as the individual takes care of himself/herself. "The mastery of the self is thus a prerequisite for health" (p.361). And, suggesting that the imperative of self-government created by risk discourses is implicated in the production of 'selves', Greco remarks that 'risk' is "...directly associated with biography, meant as the path between the different things that one *is* and *becomes*, rather than with the 'objective' circumstances met thorough life" (p.360, my emphasis).¹²

Petersen and Lupton (1996) add another point to this question of the production of 'selves' within a context that relates 'risk' to health to individual behaviour. They argue that members of specific groups (gay male, women, the poor, etc.), who are portrayed as more 'risky' than the members of other groups are also expected to regulate themselves for the sake of the others. The "risky persona" (p.117), the authors argue, is not only a risk to himself or herself but also a source of risk to other people. In the case of a failure of self-control, he or she should be blamed for his/her misfortune and also for the misfortune of the others.

¹¹ See page 65 for a specific discussion of the way health promotion has dealt with the case of AIDS risk.

¹² See Chapter 5 for the development of the argument in my own work.

Nettleton (1997) agrees with the argument that the new forms of surveillance that emerged within the context of health risk discourses have contributed to the formation of a “risky identity or risky self” (p.322). But she argues that this is not to say that people are simply shaped by the dominant discourses of the day. For her, the ‘risky identity’ forged by contemporary surveillance techniques and by the proliferation of discourses on risk is constituted by an active interaction of the ‘self’ with its risky environment. We will see examples of this in my own work (see Chapter 5).

Nettleton comments that as a member of a liberal and democratic society and a consumer of health promotional goods the individual has the right to choose between ‘buying’ these goods or not ‘buying’ them at all. To Nettleton (1997), the possibility of resisting the advice of health promoters and deciding to take the risks is a condition for the success of the forms of governance that rely on techniques of surveillance. Nettleton (1997) goes on to argue that:

“the decision to follow or not the expert’s advice is part of an ongoing process of the formation of this new conceptualisation of ‘self’, one which is perpetually both cognisant of, and resistant to, risk” (p.314).

I will return to this question of the identity work that the notion of risk generates in Chapter 5. I will argue there that health promotion’s discourses of risk play a fundamental role in the way the girls I interviewed see the risks of sex. My point will be that health promoters’ emphasis on ‘self-care’ influences a great deal the girls’ production of their ‘selves’ as ‘sexual risk subjects’ and that this impacts upon their ways of seeing and responding to the risks of sex.

Before concluding the present chapter I wish to address one more issue, one which refers to a crucial problem of modernity, and one that may represent the struggles of modern societies to dominate nature and to move towards the incorporation of rationality and self-governance as individual and collective ideals. That is the problem of ‘HIV/AIDS risk’. The next section is concentrated on health promotion’s response to the case of the sex-related HIV/AIDS risk, one of the biggest challenges faced to date by the ‘new’ public health. It draws on the socio-cultural theories of health risk presented above and on the sociological critiques of the ‘new’ public health approach to the HIV/AIDS epidemic.

The Case of the Sex-Related HIV/AIDS Risk as a Health Promotion Problem

I do not offer here an extensive account of the literature about how HIV/AIDS risk has come to be defined as a 'health promotion problem', for much of what could be said was presented in the sections above. It is sufficient to say that HIV/AIDS is "...a late addition to the growing portfolio of risks which individuals are expected to manage in the everyday worlds" (Scott and Freeman 1995, p.161). The contemporary production and use of risk discourses, scientific conceptions of health risk, ideological basis of the 'new' public health and health promotion are all constitutive elements of the framework employed in the definition of HIV/AIDS risk as another 'health promotion problem'.

As has happened with other 'public health problems', the theorization of HIV/AIDS risk has predominantly been informed by the biomedical model (Guizzardi, Stella, and Remy 1997; Plummer 1988; Waldby 1996). Those who have AIDS are under strict surveillance of medical professionals. From HIV tests to the HIV/AIDS language, from HIV/AIDS treatment to research on vaccines, everything involving HIV/AIDS has become incorporated into the rhetoric of medicine (Plummer 1988). Those who do not have HIV/AIDS are also in the limelight. Epidemiological surveillance is put in place in the name of the general population's protection against the risk of HIV infection.¹³ Everyone is, in principle, at risk, risk levels depending on epidemiological risk estimates.¹⁴

There is nowadays a consensus that, in spite of all the efforts and recognized advances in biomedical interpretations of HIV/AIDS, the future of the epidemic is currently not in physicians' hands (Aggleton 1989; Plummer 1988; Wiseman 1989). As long as biomedicine does not discover the cure for HIV/AIDS or a vaccine to prevent the HIV infection, it appears that the only means to reduce the spread of the epidemic is to promote behavioural change. As Scott and Freeman (1995) argue, "AIDS exemplifies a process by which the incapacities of state and expert systems come to require the

¹³ See page 56 for Petersen and Lupton's argument on the need to protect the social body through the surveillance of the individual body.

¹⁴ See pages 57-58 for a discussion of Castel's and Yen's arguments on the matter.

individual management of risk” (Scott and Freeman 1995, p.155). To the authors this has resulted in a “*personalisation* of risk politics” (p.155, authors’ emphasis), that is, public policies are now focused on individual responsibility (Scott and Freeman 1995). In the terrain of AIDS prevention, public policies have relied almost entirely on health education (Wilton 1997). While HIV/AIDS and health education are both guided by biomedical professionals, the aim of promoting individual responsibility and behavioural change has directed much attention to the cooperation of the so-called ‘general public’, in an attempt to make them partners of public health (where medical professionals predominate) in its preventive projects. One consequence of using the biomedical model to problematize the HIV/AIDS sexual risk is that the resulting theories are very simplistic.

As in other areas, health promotion’s theories of sexual risk-taking are informed by social psychology and its reduced emphasis on the cognitive aspects of sexual behaviour (see page 58). Risk perception and individual factors that are believed to contribute to, or impede the (right) perception of, HIV/AIDS as a threat to personal health are common foci of this type of research. It is understood that once scientists know about how ‘risk perception’ operates at the level of the individual, responses about why some groups ‘dare’ to resist to the sexual behavioural change recommended by HIV/AIDS experts will emerge. Beneath this logic lies the idea that one’s exposure to the risk of HIV/AIDS sexual infection is either the outcome of irrational individual decision or of an inadequate and subjective cost-benefit calculation.

Another factor that contributes to the limitations of health promotion’s definition of the problem of the HIV/AIDS sexual risk is the frequent employment of questionnaires as a research method to investigate sexual risk behaviour. Just to cite an example of this type of research, Maswanya and colleagues (1999), carried out a questionnaire survey in Tanzania with the aim of evaluating “...the relationship between HIV/risky sexual behaviour and anti-condom bias, as well as, with AIDS-related information, knowledge, perceptions and attitudes” among Tanzanian students of secondary schools (p.185). On the basis of their questionnaire data they concluded that, although the respondents were well informed about the risk of HIV infection in sexual relationships, they tended to take sexual risks due to a widespread prejudice against condoms. The researchers argued that the main problem outlined in the research findings was that

there was a gap between perceptions of risk and behaviour. The suggested solution was the improvement of educational measures in schools and communication with teachers, classmates, health educators and parents. Behind this suggestion there seems to be the simplistic assumption that knowledge is directly connected to behaviour.

In a similar vein, Fawole and colleagues (1999) carried out research aimed at comparing knowledge, attitudes and sexual risk behaviours of 223 Nigerian secondary students who received a comprehensive health education intervention with a group of 217 controls who did not. A post-test concluded that the participants of the intervention increased their knowledge of HIV/AIDS transmission and prevention and that the reported number of sexual partners decreased, while it increased among the 217 controls. The researchers also concluded that consistent condom use increased among the members of the intervention group, which they believed to corroborate the argument that “the education programme succeeded in *improving* students’ sexual practices” (p.681, my emphasis). The authors went on to explain that this ‘improvement’ occurred especially with regard to behaviours like the frequency of sexual intercourse and the number of sexual partners. In their final remarks the authors suggested that schools have an important role to play in the prevention of HIV infection. For them this would be achieved by teaching students to adopt safer sex practices or to abstain from sexual intercourse.

It has been stressed that questionnaire data are too restricted to give an account of the complexities of sexual behaviour determinants (Ingham, Woodcock, and Stenner 1992). It is based on simplistic definitions of the variables taken into account, such as ‘knowledge’, ‘risk perception’, ‘sex’ and ‘sexual risk’. Also, the choice of the variables to be considered is biased, for the variables taken as characterizing risk behaviour and ‘at-risk’ situations are strictly informed by biomedical knowledge (Bastard and Cardia-Vonèche 1997). This may well be the reason why the concepts employed in the study of the problem of sexual risk behaviour are often narrowly defined. It is often the case that, as in the research commented upon above, the suggested solution to the problem of sexual risk behaviour is the provision of information. It is usually implicit that ‘more information’ means ‘more technical information’, suggesting that the only type of knowledge that is significant in the prevention of HIV infection in sexual relationships

is the scientific knowledge concerning modes of transmission and prevention techniques. As Hart and Boulton (1995) argue,

“this essentially epidemiological account of risk for HIV infection, while informing us of the ‘mechanical’ dynamics of transmission (excluding biological parameters such as infectivity, or individual susceptibility) does not address an entirely separate, but equally significant dimension of risk, notably how and why this occurs to particular individuals, in specific contexts and at certain times. That is, it cannot (and is not intended to) inform our understanding of the social determinants of risk”. (p.55).

Similarly, ‘sex’ is usually limited to sexual penetration, meaning that sexual behaviour or sexual practices are only to do with sexual intercourse. In consequence, the definition of ‘sexual risk’ is also restricted to the possibility of negative outcomes resulting from heterosexual and homosexual penetration, such as HIV infection and other sexually transmitted diseases. As some have argued, the use of such a restricted way of defining sex and the risks of sex can result in a very partial conception of ‘safe sex’ which would consider safety as strictly related to protection against sexually transmitted diseases, especially AIDS (Hillier, Harrison, and Warr 1998, citing Singer, 1993).

One can suggest that when the focus of the research is knowledge and behaviour concerning HIV/AIDS risk, it is ‘natural’ to reduce the definition of key concepts to their disease-related meanings. But the problem is that AIDS is more than a disease. As many have argued, it is also a social and cultural phenomenon, thus a problem whose definition(s) goes beyond biomedical problematization.¹⁵ The use of a single “health-rationality perspective” (Flowers et al. 1997, p.82) is problematic. It reduces sexual risk behaviour with regard to HIV/AIDS to a matter of personal significance, for instance, giving importance only to individual health. This inevitably simplifies a problem that has already proved dependent on a multifaceted association of individual and socio-cultural factors (Crawford 1994; Frankenberg 1992; Holland et al. 1991; Merchán-Hamann 1995; Stiffman et al. 1995). The use of a theory of AIDS that fails to embrace its complexities results in the proposition of simplistic solutions to the problem (Scott and Freeman 1995).

¹⁵ See for example Ingham and Zessen 1997; Patton 1990; Watney 1989.

Guizzardi et al (1997) make an important point concerning the problematic emphasis of a simplistic health-related rationality in the domain of HIV/AIDS prevention. The authors contend that the problem is that behaviour is tied to two different forms of rationality that exist side-by-side in the same social context: “that proposed by medical knowledge, which is abstract and considered to be universal, and a concrete, pragmatic rationality that has come about subjectively, worked out in small networks of social relationships” (p.160). What is more distinct in both rationalities, the authors argue, is the logic that they follow. In the HIV/AIDS case, “the [...] medical logic attempts to impose an order in which health is paramount, whereas the individual, subjective logic arranges itself and adapts the unruly dimension of pleasure to medical discourse...” (p.160).

Following their general approach to risk (see pages 37-53), sociologists have criticized the logic of ‘individual rationality’ that forms the basis of the conception of sexual risk behaviour adopted by health promotion. The critiques follow the general lines that are applied to other risk-related matters. Firstly, the critics argue that it is inappropriate to apply the logic of ‘individual rationality’ to situations like sexual encounters, which are individual experiences, but also social and interactive events (Bloor 1995; Ingham and Zessen 1997; Ingham, Woodcock, and Stenner 1992; Moatti, Hausser, and Agrafiotis 1997). Sexual relationships are also social relations and the practice of unsafe sex may well be the result of a power imbalance within relationships. Secondly, a monolithic ‘individual rationality’ is said to be inappropriate for the development of theories of sexual behaviour because sexual behaviour is produced through a range of rationalities that operate at the same time (Bastard and Cardia-Vonèche 1997; Ingham, Woodcock, and Stenner 1992). ‘Individual rationality’ is then rejected as a predictor of sexual risk behaviour. Following the argument of the sociological approach to risk (see pages 37-53), it is emphasized the need to adopt instead what Bloor calls a “situated rationality approach” (1995, p.22).

Researchers who adopt a ‘situated rationality approach’ investigate sexual risk behaviours by taking into consideration risk takers’ own accounts of risk-taking.¹⁶ Bloor points out that those studies have been very efficient in questioning the pathological view of risk-taking as the product of irrational thinking (Bloor 1995). He

¹⁶ See for example Ingham, Woodcock, and Stenner 1992 and also Paiva 1993.

remarks that “instead, researchers have stressed the situated rationality of their subjects’ decision-making in terms of the subjects’ own definitions of the situation” (p.22). As Bloor contends, those types of research also present some difficulties. While they have been illuminating, their conclusions are limited to specific contexts and subjects. So, those theories cannot be applied to other contexts without problems (Bloor 1995). They are consequently inadequate for generalizations, which might be regarded as a problem if the aim is to respond quickly to the epidemiologically-defined urgencies of the HIV/AIDS epidemic.

In health promotion’s theories of sexual risk behaviour, the phenomenon is over-simplified. Along with a reduced conception of ‘rationality’ there are other simplifications. Ingham and van Zessen observe that most of the recent research on sexuality has been carried out with the aim of developing theories of AIDS, which has reduced the focus on sexuality almost entirely to a health concern (Ingham and Zessen 1997). The result has been that, from the point of view of health promotion, sexual risks encapsulate only disease risks, which are nowadays predominantly focused on HIV/AIDS risk. The authors quote Gagnon’s analysis of the consequences of this. First, “...what is interesting about sex is what the disease makes interesting” (Ingham and Zessen 1997, p.96, citing Gagnon). And second,

“...sex itself can become confused with disease and being sexual in various ways becomes treated as an illness or as evidence of illness...Even within the constraints of a concern for AIDS, a narrow view of sexual behaviour may be effective if all that we are concerned with is social book-keeping and epidemiological modelling, but it will be inadequate to the task of *understanding behaviour in a way that results in behaviour change*. Sexual conduct is embedded in culture and in social relations-as we begin to deal with this dimension...we will need to know a great deal more about the why”. (Ingham and Zessen 1997, pp.96-97, citing Gagnon, author’s emphasis).

Ingham and van Zessen (1997), along with others, assert that there is the need to pay more attention to the contextual and interactive character of sexual behaviour in order to develop a fair understanding of the complexities of individual’s sexual-risk taking.¹⁷ For example, in research carried out in Australia with young women Hillier et al (1998) found out that the loss of a good reputation was a sexual danger shared by every

¹⁷ See also Ahlemeyer 1997; Hillier, Harrison, and Warr 1998; Holland, Ramazanoglu, and Scott 1990.

young woman in the town. The authors suggest that, according to their research, the current concept of 'safe sex' is inadequate to accommodate meanings other than biological ones, a point already made by other commentators (Gorna 1996; Scott and Freeman 1995). They note that in spite of their concern with reputation the girls interviewed never mentioned this risk when explicitly asked about the meaning of safe sex. They wrote: "it may be that this is because "safe sex" campaigning has rendered the word "safe" inaccessible as a descriptor of culturally and socially based, as opposed to biologically based dangers of having sex" (Hillier, Harrison, and Warr 1998, p.26, authors' emphasis).

In a similar vein, Holland et al. (1990) call for an expansion of empirical knowledge about the meanings of 'safe sex'. Referring specifically to the case of the risks facing young women, the authors argue that it is necessary to contextualize the notion of 'safe sex'. That is, conceptions of 'safe sex' have to be formulated in conformity with "...the ways in which young women identify risk and negotiate definitions" (Holland, Ramazanoglu, and Scott 1990, p.132).

Ahlemeyer and Ludwig (1997) argue that in the specific case of HIV/AIDS risk-related sexual behaviour it is necessary to investigate 'meanings' rather than 'thinking'. The authors stress that when qualitative research pays adequate attention to individuals' perceptions of situations involving sexual risks it is not knowledge about HIV transmission and prevention that are the first focus but for instance, "knowledge related to factors of good health, to other sexual risks such as pregnancy, being seduced, isolated or loved" (p.30).¹⁸

Qualitative exploratory research on sexual risk-taking suggests that a significant amount of relevant data is lost when the questionnaire method is employed as the main research tool. It also suggests the inappropriateness of the use of individual rationality to make interpretations about the production of sexual behaviour. To Ingham and van Zessen, as opposed to what social psychology theories of rational behaviour proclaim (see page 55), risk perception is not static, that is, it changes over time and space (Ingham and Zessen 1997). If that is true, present perceptions of risk will then not necessarily inform future sexual behaviour. This makes it difficult to predict sexual

¹⁸ For examples in my own work see Chapter 5.

behaviour on the basis of data on perceptions of risk. The authors also argue that, as opposed to what questionnaire-based studies seem to suggest, the balance between costs and benefits of sexual risk-taking cannot always be anticipated through previous attitudes towards the risk in question. Costs and benefits of a given sexual practice are also time and space contingent. The authors call attention to the fact that, in general, those types of studies are simplistically focused on a specific behaviour, like condom use, and make their points on the basis of the relationship between very few variables such as attitudes to condoms and actual condom use, which contradicts the already proved complexity of combined variables attached to sexual behaviour.

Qualitative research has demonstrated that when carrying out cost-benefit analysis with regard to sexual risk-taking, individuals do not consider only the association of condom use and health risk reduction (Browne and Minichiello 1994; Davies and SIGMA 1992; Holland et al. 1992; Ingham, Woodcock, and Stenner 1992; Rhodes 1997). For example, Ingham and van Zessen found out that young people calculate the costs and benefits of condom use on the basis of reputation, fear of not having a good sexual performance or appearing to have lack of trust and concerns about infection risk (Ingham and Zessen 1997). In their research with young women Holland et al. (Holland et al. 1991; 1994a) found out that reputation, trust, love and power constituted key elements in the decision-making process concerning condom use. In a study with Australian adults Browne and Minichiello found that heterosexual couples' condom use was dependent on mutual sexual decision-making and that the interviewees negotiated condom use differently on the basis of their perceptions of the 'appropriate' sexual behaviour for men and women (1994). Gender norms were then at the core of their decisions to practice safe sex.

The problems of the cost-benefit analysis are directly related to the restricted conception of rationality employed by social psychology theories of behaviour. What it means to be 'rational' in situations involving sexual decision-making is key to the definition of the problem of sexual risk-taking (Davies and SIGMA 1992). Mistaken interpretations of sexual behaviour as non-rational only because it does not follow biomedical expectations concerning health risk avoidance have resulted in mistaken definitions of the problem of sexual risk-taking. Davies and colleagues found in their

research with gay men that the decision to have sex with another men, either with or without a condom, was not simply the result of a rational evaluation of individual susceptibility to HIV/AIDS, nor the product of a non-rational or intuitive-like decision (Davies and SIGMA 1992). Replicating the findings of other studies, this decision was taken on the grounds of interactive factors; not psychological ones as some could argue, based on the assumption that the increased practice of anal intercourse among gay and bisexual men is a 'relapse to unsafe sex'. According to the authors, their data suggested, for example, that one of the reasons for the practice of unsafe sex among the men interviewed was their engagement in long-term or medium-term relationships. Commenting on the problematic use of the notion of rationality to understand sexual behaviour, the authors point at important questions. The first point they make is related to the misuse of the term 'rational' as related to final decisions rather than to the process of decision-making itself. They remark:

“...a decision is rational if it is made after a consideration of the available evidence in the light of the circumstances pertaining at that time. By contrast, an irrational decision is one which ignores, dismisses or otherwise deems irrelevant available information” (Davies and SIGMA 1992, p.136).

And linking their analysis to their research focus, the authors argue that “...a decision to fuck may [...] be right or wrong according to the epidemiological or other criteria, but the rationality of the decision process is independent of the rightness of the outcome” (p.136). They then map out what could be concluded from that: “... an individual can (i) rationally come to the right decision, (ii) irrationally come to the right decision; (iii) rationally come to the wrong decision; (iv) irrationally come to the wrong decision” (p.136). The authors finally argue that the criteria to evaluate if a given decision is right or wrong is distinct from that used to judge if a process is rational or irrational. While questioning the employment of the rational model for the theorizing of sexual behaviour, the authors point out that it is unclear if the model has been used in a descriptive - “a representation of what actually happens” or prescriptive manner - “a description of the truly rational response” (p.137). As a descriptive method, the authors claim, it presents a number of difficulties. They highlight three main problems. First, the decision to have a sexual intercourse, they argue, is not made prior to the sexual encounter itself, nor does it happen at a given point in time during the encounter, but throughout. Second, the authors affirm the interactive nature of

sexual decision-making, emphasizing that it involves “a complex social negotiation, which we understand poorly” (p.137). Third, and more crucially, they make the point that the rational decision-making model is inappropriate to describe the decision-making process concerning sexual behaviour because it assumes that individuals employ perfect knowledge in their decisions. In fact they “...work with subjective probabilities and assess the various elements of the model in different and sometimes idiosyncratic ways” (p.137).

Bloor also criticizes the logic of cost-benefit analysis in the investigation of the causes of sexual risk-taking (1995). To him, it does not take into account the habitual nature of behaviour. In his research with male prostitutes Bloor concluded that most prostitute men who had anal sex with other men did not use condoms because this was a habit among their clients (1995). Taking into account the importance of traditional gender norms and imbalance of power in the shaping of heterosexual sex, it can be argued that habituation appears also to influence the adoption of safe or risky sexual practices among heterosexuals (Browne and Minichiello 1994; Goldstein 1994; Hillier, Harrison, and Warr 1998; Holland et al. 1991; Ingham, Woodcock, and Stenner 1992; Paiva 1993).

Because sexual risk-taking has been simplistically defined in person-centered terms, the proposed solution for the protection of the population against HIV sexual infection has also followed the same individualistic logic (Caplan and Nelson 1973). If it is believed that it is personal decisions and behaviours that expose individuals to infection, then the task of health promotion is straightforwardly put as the promotion of the adoption of individual strategies of protection against the HIV infection (Fisher 1988; Scott and Freeman 1995). Assuming that ‘inappropriate’ behaviour is the cause of HIV infection, health promoters have urged lay people to correct deviant sexual practices and adopt what biomedicine calls ‘safe sex’. Education is believed to be the means *par excellence* by which the ‘safe sex’ message is to be disseminated to the public.

‘Risk’, ‘sexual behaviour’ and ‘individual rationality’ have all been fused in the expression ‘safe sex’. Highly influenced by the biomedical paradigm, ‘safe/unsafe sex’ inherits the limitations of ‘the’ scientific definition of ‘risk’ and ‘sex’. For health promotional purposes, ‘unsafe sex’ equals ‘unhealthy sex’ and ‘safe sex’ means

‘healthy sex’. The expressions ‘risky sex’, ‘unsafe sex’, ‘unprotected sex’ and its opposite ‘safe sex’ or ‘protected sex’ are key to discourses of HIV/AIDS prevention. While the biomedical discourses of ‘safe sex’ intend to promote a linear correspondence between risk awareness and risk avoidance, ‘safe sex’ means the consciousness and acceptance of risk (Scott and Freeman 1995).

Although the expression ‘safe sex’ is well known amongst the general population, it is not quite clear what it means. The meanings of ‘safe sex’ are confused because scientific knowledge about which practices are safe and which are not with regard to HIV/AIDS, has frequently changed due to new scientific findings. From ‘risk groups’ to ‘risk behaviours’, from homosexual to heterosexual risk, from the affirmation of ‘safe’ oral sex to the suspicion of its riskiness, there have been several shifts in the discourses of HIV/AIDS prevention. In the face of so many changes in the scientific knowledge on HIV/AIDS the reliability of new findings has been doubted. For this reason each of these shifts have not been completed. That is, the former ‘information’ has never been completely abandoned. This has generated confusion about what actually makes sex safe. Both scientists and ordinary people share the idea that present doubts may become certainties one day. Because there are still many questions to be answered concerning the transmission of the HIV virus and the history of AIDS-related diseases, research continues to be undertaken and new findings are expected to result in new and more efficient ways of fighting it.

It has been suggested that ‘safe sex’ was invented by gay people not so long ago (Patton 1990). But, for example in the case of women, the need for protection against the negative outcomes of sex, like unwanted pregnancy and sexually transmitted diseases, is not an innovative concern (Dubois and Gordon 1989; Hart 1993). Nevertheless, as Hart points out, it was within the American gay community that these strategies of protection came to be named as ‘safe sex’ in response to the HIV/AIDS epidemic (Hart 1993).

The ‘safe sex’ message promoted by health education contains simplistic definitions of ‘safety’ ‘sex’ and ‘sexual risks’. By aiming at preventing sexually transmitted diseases, in particular AIDS, the ‘safe sex’ message is focused on the promotion of condom use during sexual intercourse, which delivers the message that ‘safety’ means ‘condom use’ and ‘sex’ equals (hetero- or homo-) ‘sexual intercourse’. Informing this definition

of 'safe sex', there is the notion that the only significant risks of sex are diseases (Hillier, Harrison, and Warr 1998). Pregnancy is another important danger of heterosexual intercourse but, given the contemporary priority of AIDS prevention, pregnancy may occupy the second place in the order of importance.

It has been argued that the promotion of sexual safety through the single target of preventing sexually transmitted diseases suggests that the message of 'safe sex' addresses men's needs, who perhaps do not need to worry about anything else (Hillier, Harrison, and Warr 1998). For women, however, sex represents many more dangers, which makes women's sexual safety a target not so 'easily' achievable (Hillier, Harrison, and Warr 1998).¹⁹ Gorna suggests that "...for many women, the concept of 'safer sex' may speak more to a woman's need for physical safety from aggression, or emotional safety from abuse, than to the longer-term threat of a new virus" (1996, p.261). The complexity of women's definition of 'safe sex' is one of the points I raise in this thesis (see Chapter 5).

Although definitions of 'safe sex' can be relatively varied, they contain a similar message - to practice 'safe sex' is to use condoms in 100% of penetrative sexual practices (vaginal and anal) or not to engage in those practices at all, and also to reduce the number of sexual partners. In a book in which several European researchers offer their analysis of different conceptual frameworks for the study of HIV/AIDS risk, 'safer sex' is explicitly defined as "the behaviour that tends to reduce the likelihood of sexually transmitted infection, e.g. using a condom, having sex without penetration, etc." (Campenhoudt et al. 1997, p.250). For Hart, 'safer sex' is "...any sexual activity which reduces the risk of transmission of HIV infection and some other sexually transmissible diseases..." (Hart 1993, p.73). Both Campenhoudt's and Hart's definitions of 'safer sex' show uncertainty about the efficacy of the proposed risk preventative measures.²⁰ In a more narrow vein and in my view not the most accurate, Waldby and colleagues (1993) point out that the official version of 'safe sex' for heterosexuals is "...a combination of monogamy and condom-use, [...] alternatives to penis-vagina intercourse; mutual masturbation [...], and oral-genital sex [...]" (p.251).

¹⁹ See examples of the girls' perception of the possible dangers of heterosexual sex in Chapter 5, particularly on Fig. 2, page 195.

²⁰ See Chapter 5 for examples of the uncertainties implicit in the girls' definitions of safe sex.

At least in Brazil, the ‘official version’ of ‘safe sex’ for heterosexuals does not go beyond penetrative sex with a condom and a reduction of sexual partners. I do not recall any official campaign in Brazil in which the word ‘sex’ of the expression ‘safe/r sex’ has accepted other meaning than ‘penis-vagina’ and ‘penis-anus’ penetration. In European countries the position seems to be similar.

Most of HIV/AIDS-related health promotional interventions are focused on educating lay people. As we have seen earlier, there is more than one way of carrying out health education. Different models of health education are based on different and conflicting ideologies and conceptions of health (see section on health education, pages 22-37). Given the ideological, political and social background of contemporary public health, the preventive model of health education is now predominant in the field. To be fair, there have also been few initiatives, above all from non-governmental organizations, which work with a holistic approach.

Preventive AIDS education works with information provision with the aim of bringing about changes in individual behaviour (Aggleton 1989; Scott and Freeman 1995). Lay people are informed of “the facts about HIV” (Aggleton 1989, p.223), which include modes of transmission and risk-levels, how to avoid the risk of being infected, the consequences of infection and the identity of risk-group members. By sharing with HIV/AIDS experts ‘relevant’ scientific knowledge about the risks, lay people are expected to modify their behaviours in order not to expose themselves and others to the risk of infection (Aggleton 1989). Everything follows the logic of rational decision-making governing sexual behaviour: ‘knowledge - leads to - attitude-change – leads to - behaviour change’.

Patton (1990) argues that while there is an increased awareness that information does not change attitudes about AIDS, the AIDS education ‘mission’ of providing information about ‘the facts’ or ‘the truth’ is difficult to change, for audiences expect answers that are framed in the same way as their questions. ‘The truth’ about the ‘HIV/AIDS facts’ is delivered to the public, Patton suggests, as if it is neutral, but that is not the case at all. As the author contends, one cannot negate that AIDS is politicized. Stigmatized representations of AIDS as a gay disease and a disease of addiction suggest that from the beginning, pre-existing ideological and moral positions

toward health, sexuality and drug use have influenced the way scientific knowledge has generally been assimilated.

Holland et al (1994b) make a similar point. They write:

“Health education policy does not emerge fully formed in response to a particular ‘new’ problem, but draws on a range of existing ideological positions. Nor does the language of health education draw only on the scientific discourse of health and medicine. Medical and moral positions on AIDS interact with each other and can be seen to come together in problematic ways in the context of the AIDS public education campaign” (p.16)

They go on to exemplify their argument by referring to the case of the risk of HIV/AIDS sexual transmission:

“Discussion of risk reduction [...] draws on a pre-existing moral discourse which stresses monogamy, and thus takes insufficient account of both the social context and the actual sexual experience of the individuals whose behaviour it seeks to influence” (p.16).

Information on HIV/AIDS is usually spread through mass media campaigns. Outdoors, TV and cinema advertisement and distribution of informative material are all used to raise general consciousness about the risk of HIV infection and modes of risk protection. HIV/AIDS education campaigns are usually produced and managed by governmental public health agencies, sometimes specifically created to deal with the HIV/AIDS problem. HIV/AIDS education campaigns emphasize behaviour change as the result of personal and responsible choices. Slogans such as “You know the risks, the decision is yours” of a British AIDS education campaign promoted by the ‘Health Education Authority’ in 1988 (cited by Holland et al. 1994b), and “To live without AIDS depends only on you”, a Brazilian national campaign promoted by the Brazilian Ministry of Health in 1999, are expected to deliver the message of the moral accountability for personal welfare. As Holland et al (1994b) stress, this type of message neglects the importance of power in choice-making and does not take into account the problem of the gap between knowledge and action. A striking detail of the two campaigns mentioned above is that although they were produced in very different contexts and a decade apart, they express the same meaning. This suggests that the neo-liberal discourse of autonomy and responsible choice that permeates health promotion (see section on page 19) has had a globalized impact, and also, that there is

not much difference in the perspectives taken to define HIV/AIDS risk as a 'health promotion problem' in the past and present.

Further information about the Brazilian campaign makes visible the neo-liberal positions of its proponents. The aim of the campaign was to raise awareness about the individual responsibility for the fight against AIDS and inform the population on how to prevent sexually transmitted diseases. According to the Brazilian Ministry of Health that objective consisted in an innovative approach of the Brazilian government to the fight against the disease. The Brazilian Ministry of Health stressed that this innovative approach was a response to the 'new' evidence that 90% of the Brazilian population had already basic information about forms of AIDS contagion and even so only 20% of the adult population used condoms. At the time of the launching of the campaign, the Health Minister commented: "there is a disparity between consciousness and providence" (Correio do Povo 1999, p.4). The campaign meant, thus, to correct such a disparity through an appeal to the moral commitment of 'self-care'.²¹

Along with mass media campaigns, school-based AIDS education has also been commonly used by health promoters. In the latter case, there is a very specific target, that is the adolescent population. Those initiatives work as mass education as large numbers of adolescents are expected to be involved (Aggleton and Warwick 1997). Apart from the 'quantity' reason, school-based AIDS education is also motivated by the taken-for-granted common-sense that adolescents are, by their own nature, risk-takers '*par excellence*', an idea that is based on psychologists' theories of behaviour (Aggleton and Warwick 1997).

The literature on adolescent's risk behaviour has been dominated by taken-for-granted assumptions concerning the 'risk essence' of adolescents. Adolescents are stereotypically represented as unrealistic optimists (Moore and Rosenthal 1994); having a sense of invulnerability (Hemmelstein 1995; Koniak-Griffin et al. 1994; Mickler 1993) and a sexual adventure drive (Hein 1992); as featuring cognitive problems and being ignorant on risk matters (Abrams et al. 1990; Fawole et al. 1999; Irwin 1993). These are the dominant discourses of 'science' concerning the reasons for adolescents' risk behaviours (in particular those concerning health), although I

²¹ See Chapter 5 for the girls' interpretation of the lessons of 'self-care' taught by health promoters.

acknowledge that such discourses usually take ‘adolescents’ as an ‘essential’ category, without distinguishing between ‘boys’ and girls’. I presume that that is why, for example, the masculine stereotype of “sexual adventurers” (Hein 1992, p.9) is taken as one of the origins of the problem of adolescents’ risky behaviours. As Aggleton and Warwick (1997) point out, none of those stereotypes considers gender, culture, race or class differences among the members of the adolescent population; they are taken as universal. This also has the effect of universalizing adolescents’ needs concerning the prevention of HIV/AIDS. Affirming the reductionism of such an approach, Aggleton and Warwick (1997) write:

“In many ways this is curious given the care now taken in the literature on adults and AIDS to distinguish between gender, social background ethnicity and, most especially, sexuality, in determining HIV-related risk. It is, however, indicative of the extent to which popular ideologies of adolescence seem literally to have won the hearts and *minds* of those working in the field” (pp.80-81, authors’ emphasis).

Adolescents’ AIDS education and also most other contemporary accounts, the authors argue, are monolithically focused on sexuality in its negative sense. The positive potentials of sexuality for either adolescents’ or adults’ lives are often forgotten. Referring specifically to the case of adolescents’ HIV/AIDS-related health promotion, the authors argue that if it “...is to be meaningful, it must speak to lived experience” (p.81). A meaningful health promotion, they affirm, “...should engage with what young people believe to be true about their own lives - their concerns and aspirations, and the everyday dilemmas that confront them” (p.81). They go on to contend that a meaningful health promotion is to differ from others “that may seemingly be concerned with the promotion of health, but which in reality fail to engage with experience as it is actually lived” (p.82).

While school-based AIDS education is often focused on information provision, it sometimes also includes participatory activities. Educational activities like role-play, games and skills training are generally understood as empowering strategies. Although the rhetoric of ‘participation’ easily fits the empowering project of health promotion, the goals of the ‘participatory’ approach do not appear to go beyond behavioural change.

The 'participatory' approach of HIV/AIDS-related health promotion is supposed to work towards community emancipation, its ultimate goal being people's autonomy and power to construct a healthy living. In spite of the rhetoric, however, strategies employed as 'empowering health education', such as role-play and games, still work with a maximum participation of 'HIV/AIDS risk authorities' and minimum involvement of the 'lay others'. Lupton (1995a) argues that there is a paternalistic emphasis on empowering health promotion. Referring specifically to 'participatory' health education, she writes:

“The emphasis on personal learning activities such as role play still focuses on the individual acquiring skills to go out and influence events. The model used is still that of the health education approach, devoted to training people in the ‘appropriate’ ways of thinking and doing but with little emphasis on enhancing the opportunities for collective action born of conflict and tensions between subcultures” (Lupton 1995a, p.60).

Peer education is another strategy that is sometimes employed in HIV/AIDS-related health promotion; once again it is one that targets adolescents (Aggleton and Warnick 1997). It is based on the idea that young people may be better influenced by their peers. Peer education works with peer educators in the provision of information, group discussions and counseling (Aggleton and Warnick 1997). Similarly to 'participatory' HIV/AIDS education, this strategy also seems to operate through persuasion.

HIV/AIDS-related health promotion is still very restricted. As we have seen, it is concentrated on the provision of technical information with the aim of promoting behavioural change. As at the beginning of the epidemic, it continues to invest in two poles: 'the general population' and specific groups which are seen as especially in need of health promoters' help. When the target is the population, mass education campaigns is the preferred strategy. When aiming at 'helping' those more 'at-risk', face-to-face methods are more common. None of them, however, seems to have been effective, as the HIV/AIDS epidemic continues to grow, especially through sexual infection.

Obviously, the aim of preventing the sexual transmission of HIV/AIDS is also the aim of promoting health, and projects designed to achieve this are informed by conceptions of 'health' (Gorna 1996). This makes the current AIDS education activity a field full of contradictions. Informed by overly simplistic definitions of the problem of sexual risk-

taking, with ‘sexual risk’ meaning simply ‘disease risk’, AIDS education has addressed the message of ‘safe sex’ towards disease prevention. And this creates a paradox. AIDS education is a crucial arena of contemporary health promotion and for health promotion ‘health’ is supposed to be more than the absence of disease. But the notion of health education inserted in the current model of AIDS education does seem to encapsulate the premises of the (supposedly overcome) preventive model and its ‘victim blaming’ discourses. Contradicting its proposal of community empowerment (see page 20), official health promotion projects, which have financial support to actually make a difference, are yet insisting on individual behavioural change as the recipe for a successful HIV/AIDS risk prevention.

There is plenty of evidence of the social dimension of HIV/AIDS.²² Also, governments and public health corporations have already admitted that to be healthy or unhealthy is not only a matter of individual decision (see page 33). Nevertheless, it is still on the basis of individualistic theories of behaviour and emphasis on responsible choices that official programs of HIV/AIDS prevention have been carried out. This emphasis on choice has led health promoters to invest in information provision in the hope that this will persuade people to adopt safer sex practices. However, as Denscombe (1993) puts it, “selling personal health as a preference will be effective in so far as people are in a position to ‘buy’” (p.515). In a similar vein Gorna (1996) remarks, “the technicalities of preventing HIV infection are remarkably straightforward, it is the contexts within which risky behaviour takes place which complicate matters” (p. 260).

This subject of how health promotion has dealt with HIV/AIDS prevention is re-visited in the conclusion of the thesis. That is where I address the implications of my research findings upon current HIV/AIDS education contents and methods, specifically in the context of adolescent women’s protection against the risks of sexual relationships.

In sum, the sociological critiques of the health promotion’s approach to ‘risk’ suggest that its difficulties originated from the simplistic way in which the problem of risk behaviour is defined. Although referring to ‘social problem’ in a different context, Caplan and Nelson (1973) make some points about the importance of the definition of

²² See for example Barbosa and Villela 1996; Guizzardi, Stella, and Remy 1997; Holland et al. 1991; Rhodes 1997.

a given problem for the ‘production’ of its solution that can be also applied here. They do this in a discussion about the use of psychological research and behavioural science in the understanding and improvement of ‘social problems’.

By ‘social problem’ they mean “problem behavior” or “social pathology” (p.199), which are exemplified by delinquency, drug abuse, mental health and unemployment (and I would add ‘health- related risk behaviour’). Central to their critique of the way psychology has researched ‘social problems’ is the idea that, in general terms, problems are defined on the basis of “assumptions about the causes of the problem and where they lie” (p.200). To the authors those assumptions are essential for the definition of a given problem as they determine how the problem shall be approached. In the specific case of “social problems” the authors argue that there are two possibilities of problem explanation: through a “person-centered” and through a “situation-centered” causation (p.200). They cite ‘delinquency’ as a case in point. Taking into consideration a “person-centered” (p.200) explanation to the problem, like “inability to delay gratification” or “incomplete sexual identity” (p.199), it is logical, the authors argue, to deal with it at an individual level. In such circumstances, person-change treatment techniques”, “intervention strategies”, “medical solutions” and “confinement” can be employed (p.199) in order to change and correct deviant behaviour and make it more conventional. As the authors emphasize, this way of approaching the problem can have two immediate consequences. First, “...those officially defined as delinquent would have to relinquish autonomous control over their behavior and other rights in the service of the common good” (Caplan and Nelson 1973, p.199). Second, the structural causes of deviance would be left ‘untouchable’.

“...where person-centered interpretations provide the foundation on which corrective intervention is based, little need to be done about external factors since they would presumably be of lesser or no etiological significance in the determination of such behavior” (Caplan and Nelson 1973, p.200).

If, on the other hand, the problem of delinquency is defined in “situation centered” terms (p.200), they stress, the intervention will aim at changing the social factors that might be causing the problem. Delinquency can be seen, for example, as the result of poverty. In that case, the targets for change can be the social and economic structure rather than “individual psyches” (p.201). Although the authors recognize that this

“either-or” model of causality is very simplistic, they nevertheless take it as a reference point because they consider that this is the usual notion of causality used by the public and that political actors often take advantage of it.

For Caplan and Nelson, the origin of the difficulties of the psychologists’ approach to ‘social problems’ is their usual focus on individuals and “their mental states” (p.202), like thoughts and attitudes. According to the authors, psychologists tend to see these factors as “...independent variables, that is, antecedent and causal in relation to other behavior...” (Caplan and Nelson 1973, p.202). The authors go on to argue that

“...when it comes to the...study of ...why he [sic] behaves as he does, we [psychologists] are more likely to limit our search for etiological evidence to what goes on between his ears and to ignore or exclude from consideration a multitude of external impingements that could justifiably be hypothesized as causal” (1973, p.202).

The authors argue that such an approach results in ‘person-blame’ definitions of social problems and obvious projections of ‘individual change’ solutions. If the intervention fails, the failure will seldom be considered as resulting from a mistaken interpretation of the problem. The blame will be located in the target group and the failure interpreted “as a further sign of the seriousness of the *pathology* being dealt with” (Caplan and Nelson 1973, p.201, authors’ emphasis), reinforcing dominant stereotypical ideas.

As the literature indicates, similarly to delinquency, ‘risk behaviour’ is also a problem of society. Like the so-called ‘delinquents’, ‘risk-takers’ are also believed to be deviant people whose problematic behaviour is not only a threat to their own safety but also to the safety of society as a whole. In the same way as delinquency, ‘risk behaviour’ is usually scientifically defined in person-centered terms, which results in blaming the ‘risk-taker’ for his/her deviancy. Because ‘risk behaviours’ are seen as caused by some ‘natural’ characteristics of ‘risk-takers’ and/or by their choices, research usually focuses on the analytical deconstruction of individual behaviour in the belief that this would provide clues about solutions for risk behaviour problems. Also, a person-centered definition of a given risk behaviour problem entails individual correction via individual behavioural change. Like in other situations involving the implementation of individual solutions to social problems, if this intervention fails its subjects are to be blamed. The failure will reinforce not only the ‘bad behaviour’ of those people but also the correctness of targeting them as the subject of intervention. It will also support the

argument that more research is needed in order to find out how to reach those who are 'hard to reach'. As it has been noted, in a such situation the influence of the social system on health risk-taking will tend to be forgotten.

When doctors, epidemiologists, engineers, and psychologists (amongst others) approach 'health risk' in an objective way, advocating individual solutions to resolve social problems, they seem to be applying what Archibald (cited by Caplan and Nelson 1973, p.202) called a "clinical orientation" to social scientific knowledge, which is characterized by the assumption that "if the shoe doesn't fit, there's something wrong with your foot" (Archibald 1970).

CONCLUSION

In this chapter I have presented the theoretical framework of this thesis, focusing on the main issues raised in the sociological debate on health promotion and risk. The aim of the chapter was to contextualize the argument of my thesis which is that 'risk' in general, and 'HIV/AIDS sexual risk' in particular, are epistemological constructs. We have learnt here that, from a sociological point of view, the increased importance of the notion of 'risk' in modernity has much to do with the development of science and technology. We have also learnt that in the context of health promotion 'risk' has been defined in 'technico-scientific' terms and that this has had an impact in the way health promotion has approached the problem of 'health-related risks', like HIV/AIDS. Technico-scientific theories on the HIV/AIDS sexual risk define 'risk' as an objective entity, one that can be observed, analysed, calculated and interpreted in a value-free process. My thesis develops a counter-argument. Drawing on the literature reviewed here and on my data analysis, I will argue throughout this thesis that 'risk' is an epistemological construct, for it is not an event *per se*, but an event constructed through knowledge (Beck 1992; Heyman 1998a; Thompson 1986).

With my work I intend to contribute to the sociological critique of technico-scientific theories on risk. By doing that, I hope to be able to offer a theoretical alternative for the sociological understanding of adolescent women's responses to sexual risk, especially HIV/AIDS.

The next chapter presents the history of the research process through which I develop my thesis. It will provide a detailed picture of my fieldwork and of my trajectory in the process of making sense of the data gathered.

CHAPTER 3

METHODOLOGY

INTRODUCTION

In this chapter I describe how and why I came to collect and interpret the empirical data in the way I did. I am making three arguments. The first argument is that for the particular purposes of my research, and despite all the limitations which I will discuss, the ‘focus group’ technique was the best research procedure available. The second argument is related to the idea that problems in translations from spoken to written language were significantly compounded by the need to translate, also, from Portuguese to English. The third argument impacts in particular on the ways I understood the data and this is to do with the formation of subjectivity from a feminist post-structuralist perspective.

The chapter is divided into three main parts. The first part presents the research problem. The second gives an account of the research design, making explicit the research questions and describing the fieldwork. This part also presents a discussion about the reasons why I have made some particular methodological choices, including the choice of following a qualitative research paradigm. The third and last part of the chapter describes the processes through which I have organized and interpreted the data gathered.

THE RESEARCH PROBLEM

When it comes to theorizing the responses to a given communicated message it is important to take into account the receptor’s understanding of it and what contributes to the production of this particular understanding. In addition to that, if the communicated message is intended to change the receptor’s behaviour, it is also relevant to understand what lies between the reception of the message and the adoption or not of the prescribed behavioural change. If we are to understand HIV/AIDS sexual risk-taking and responses to programs developed to promote safe sex behaviour it is

crucial to map out the meanings attached to HIV/AIDS sexual risk-taking and the processes through which people make sense of it.

The research process that resulted in this thesis is based on the assumption that the way people see the HIV/AIDS sexual risk is not 'immune' to what they know about the world they live in. On the contrary, it is actually produced by it. Also, at a more specific level, it assumes that the meanings of HIV/AIDS sexual risk do not stand on their own. That is, they are part of a much wider and general risk discourse that has been increasingly used in contemporary western societies.

We have learned from the literature reviewed in Chapter 2 that health promotion defines 'risky sex' and 'safe sex' in terms of their health-related meanings established by scientific medicine (see section on page 65). We have also learned that, for sociologists and anthropologists (Beck 1992; Douglas and Wildavsky 1982; Giddens 1996; Lupton 1995a), scientific knowledge is only part of the knowledge background used by lay people to make sense of risk (see pages 47-53). As argued in Chapter 2, this suggests that there might be similarities between what biomedicine means by 'safe sex' and 'risky sex' and what so called 'lay people' understand by it. However, along with those similarities there may be also important differences.

The sociocultural nature of 'risk' indicates that risk meanings cannot be externally imposed, for they are dependent on what we value in life and also on the knowledge we use to make sense of it, personal values and acquired knowledge being context-dependent (Douglas and Wildavsky 1982; Gibson 1986; Heyman 1998a; Thompson 1986). We are not static and isolated entities and our beliefs are not separable from public discourses. Individual behaviours cannot be understood outside the boundaries of cultural contexts. We learn about the meanings of risk through social interactions and we act upon this knowledge in a social context (Kitzinger 1994a).

To explore what health promoters' audiences understand by 'safe/risky sex' and the mechanisms through which this understanding is constructed is important for the theorizing of their responses to scientifically defined sexual risks, such as HIV/AIDS risk. The aim of this research is to investigate how adolescent women, a usual target of health promotion discourses, make sense of 'risky sex' (and consequently of 'safe sex') when the 'risk' in question is that of the personal HIV/AIDS infection. Particular

attention will be given to the meanings attached to 'risk' as applied to sex-related situations and the ways in which those meanings are constructed. With this I intend to produce knowledge about the epistemological nature of risk. It is also my objective to contribute to the sociological critique of the limitations of health promotion's definition of the problem of HIV/AIDS sexual risk-taking, in particular when the risk subjects considered are adolescent women.

THE RESEARCH DESIGN

Research Questions

The following question and sub-questions orient the research:

How do adolescent women see the personal risk of catching HIV/AIDS in heterosexual relationships?

- What are their views? (what are their theories about adolescent women's sexual-risk taking with regard to sexual risks, in general, and HIV/AIDS risk, in particular?; how do they position themselves within those theories?)
- How are those views constructed? (what are the meanings implicated in those 'ways of seeing'? what do they mean by 'risk' in general, and 'risky sex' in particular? how does 'risky sex' become personal?)
- What are the implications of the research findings for health promotion in the specific context of adolescent women's protection against the sexual transmission of HIV/AIDS?

Why Qualitative Methodology?

Apart from more general considerations, like the methodological traditions of the field where my thesis is located and my previous methodological preferences, specific motives concerning my particular research interests influenced my decision to use a qualitative research methodology. The very nature of my research problem was the main point considered. Given my interest in the exploration of meanings and processes of 'meaning making', I believed that the only way to carry out my research would be by using the inductive potentials of a qualitative mode of research design. Also, the recognition of the impact of the researcher's and the researcher subjects' participation

upon the data gathered reinforced the idea that I would need to use a qualitative approach, in which this is not only accepted but also valued as an important part of the research process. Another point taken into consideration was my intention to carry out the data collection in a flexible way, that is, through a methodology that could allow me to change the directions of the research process as it progressed.

Amongst an array of possibilities, I chose to use a qualitative research procedure that seemed to be the most suitable for the type of research I intended to do, which was the 'focus group' technique. Next I present the main features, potentials and limitations of the technique as well as the accounts of focus group researchers and theorists about its use as a qualitative research procedure.

'Focus Groups' as a Methodological Option

'Focus group' is a "...a semistructured group session, moderated by a group leader, held in an informal setting, with the purpose of collecting information on a designated topic" (Carey 1994, p.227). Kitzinger points out that in 'focus groups' "the group is 'focused' because it involves some kind of collective activity - such as viewing a film, examining a single health education message or simply debating a particular set of questions" (Kitzinger 1994b, p.103). Morgan argues that "... it's the researcher's interest that provides the focus, whereas the data themselves come from the group interaction" (Morgan 1997, p.6).

Commenting on when it is appropriate to use 'focus groups', Kitzinger and Barbour affirm that the technique is "...ideal for exploring people's experiences, opinions, wishes and concerns." (Kitzinger and Barbour 1999, p.5). They go on to emphasize that "the method is particularly useful for allowing participants to generate their own questions, frames and concepts and to pursue their own priorities on their own terms, in their own vocabulary" (p.5).

Developed by Merton and his colleagues (cited by Catterall and Maclaran 1997) in the 40s, the 'focus group' technique was first used for marketing research purposes. More recently, 'focus groups' have been increasingly employed in the context of social sciences research, particularly in health-related inquiries (Carlini-Cotrim 1996). A range of research topics related to sexuality have been investigated via 'focus groups',

such as perceptions of sexual behaviour (Stanton et al. 1993); peoples' understandings of HIV/AIDS media messages (Kitzinger 1994b); HIV/AIDS risk-related behaviour (Koniak-Griffin et al. 1994); drug abuse (Carlini-Cotrim 1996); social and sexual identities (Mann 1996) and sexual decision-making (Rosenthal, Lewis, and Cohen 1996).

Along with the reliance on the researcher's interest for the establishment of the 'focus', the 'focus group' technique is also characterized by its emphasis on group interactions (Catterall and Maclaran 1997; Kitzinger 1994b; Rosenthal, Lewis, and Cohen 1996). Morgan sees the strengths and weaknesses of the 'focus groups' technique as related to its two main features: "the reliance on the researcher's focus and the group's interaction" (Morgan 1997, p.13). For him, being oriented by the researcher's interests 'focus groups' can "...produce concentrated amounts of data on precisely the topic of interest" (p.13), which could be regarded as a way of increasing the efficiency of the data collection. Nevertheless, he argues, 'focus groups' are not always uniformly easier to carry out than individual interviews, particularly because groups are sometimes more difficult to assemble. For Morgan, the possibility to direct the 'focus groups' according the research interests can also have a negative impact upon the data collected, as the researcher or the group moderator has the power to influence the group's interactions. This, the author argues, may compromise the accuracy of the data collected. However, as Morgan points out, this is not a particularity of 'focus groups', for "the researcher's influence on the data [...] is an issue in almost all qualitative research, and those who rely on focus groups must attend to it because it does affect the quality²³ of the data" (pp.14-15). For Morgan, the second source of strength of 'focus groups' is that related to the use of group interaction as data generator. Other authors also highlight this advantage.

Kitzinger and Barbour argue that "crucially, group work explores how accounts are articulated, censured, opposed and changed through social interaction..." (Kitzinger and Barbour 1999, p.5). Richard Krueger suggests that group interactions facilitate the sharing of ideas, allowing participants to make use of others' concepts in the

²³ As far as I understand, the author is not referring to 'quality' as 'a degree of excellence' of the data but as its 'nature'. Throughout the thesis I will use the word 'quality', when referring to data, in the same way.

formulation of personal opinions (Krueger 1995). Rosenthal comments that in a focus group discussion the research participant can raise issues that are not anticipated by the researcher (Rosenthal, Lewis, and Cohen 1996). The group dynamics, Catterall and Maclaran claim, "...become an integral part of the procedure with participants engaged in discussion with each other rather than directing their comments solely to the moderator" (1997, p.1). For Merton et al, the use of group interaction as a generator of data is productive in the sense that it widens "...the range of responses, activating forgotten details of experience, and releasing inhibitions that may otherwise discourage participants from disclosing information" (cited by Catterall and Maclaran 1997, pp.1-2). Citing his work with Krueger (1993), Morgan argues that "...the comparisons that participants make among each other's experiences and opinions are a valuable source of insights into complex behaviors and motivations" (p.15). He also calls attention to the importance of groups' discussions for the investigation of issues related to consensus and diversity. In a similar vein, Kitzinger and Barbour (1999) argue that "focus groups [...] enable researchers to examine people's different perspectives as they operate within a social network" (p.5).

As for the weaknesses that resulted from the focus groups' reliance on interactive data Morgan comments on the 'group-effect' on individuals' contributions. This would influence the data gathered in two ways: individuals can feel constrained by the group and not say things that they would be able to say in private. In contrast, individuals can feel more comfortable to say things in a group environment than in private. Another issue raised by Morgan is the influence of the group on the ability of a specific set of participants to discuss a given topic. Some topics can be controversial; others can be of a greater or lesser interest to some research participants.

Taking on board the potentials and limitations of 'focus groups' highlighted in the literature and also considering all the other options of qualitative research methods, I came to conclude that 'focus groups' would ideally fit into my research design. In the next section I present the main reasons for that.

‘Focus Groups’ as a Personal Choice

A number of personal reasons informed my decision to use ‘focus groups’ to collect data for the research. The first motivation was related to my argument that ‘risk is an epistemological construct’. The idea that ‘risk’ does not exist until it comes to be known leads to the assumption that ‘risk’ is defined on the basis of a combination of subjective and sociocultural elements and that its meanings originate from social interactions. So, from the beginning, I assumed that to investigate the girls’ ‘ways of seeing’ their personal risk of HIV/AIDS infection in the context of heterosexual relationships I should find a method that allowed their own perspectives to emerge. I believed that it would be through the analytical exploration of their discourses that I would be able to understand their various ways of making sense of risk in general, and HIV/AIDS risk in particular. I was looking for a method in which my own ideas about how girls see or should see HIV/AIDS risk could interfere as little as possible with the girls’ expression of personal views. In addition, the presumption that risk meanings are both ‘individual’ and ‘collective’ led me to think of a method that could provide a setting for social interaction; where individual positions could become visible ‘in relation to’ group perspectives and where the ‘collective’ could be expressed not as a fixed pattern but as a dynamic combination between individual and group perspectives. Ideally, it should be a method based on group conversation. In this way, I thought, I would be able to gather information about ‘ways of seeing’ HIV/AIDS risk, and also about the processes of production of those ‘ways of seeing’ and the knowledge involved in it. So, the initial motivation to choose ‘focus groups’ had to do with my own ‘way of seeing’ ‘risk’ and the specific HIV/AIDS risk. And it was the literature on ‘focus groups’, a procedure that was entirely new for me, that provided the first clues about its adequacy for my research design.

The second general motivation resulted from my wish to carry out my research by following a ‘feminist style of knowing’²⁴, which coincidentally (or perhaps not) ended up by being compatible with my personal conceptions of the epistemological nature of ‘risk’. Arguing that feminist research is research ‘for’ women, rather than ‘on’ women, Klein stresses that sometimes what is supposed to be feminist research actually

²⁴ I am inspired here by the Hilary Graham’s phrase “a female style of knowing” (Graham 1983, p.136)

contributed to the perpetuation of the dominant androcentric research because of mistaken methodological choices (Klein 1983). Referring to this type of inquiry as research ‘on’ women, Klein argues that it is “...often [...] conducted without careful examination of the suitability of the methods used for feminist scholarship and the researchers do not state why they chose a particular method and what problems occurred during the research project” (p.90). For Klein, this results in research that may make women visible but not in “a feminist frame of reference” (p.90). She stresses that in order to use this frame it is necessary to employ research methods that take women’s experiences into account.

In her analysis of the usefulness of ‘focus groups’ in feminist research Wilkinson (1999) argues that while this is a procedure of increasing interest in social sciences, it is still limited among feminists. She cites as evidence the limited appearance of ‘focus groups’ in texts on feminist research methods texts and the fact that in her own literature review she did not find more than two dozen publications reporting the use of the method in feminist-oriented studies.

Although it has been argued that there is no special method for feminist research, feminist methodology follows some principles. Those principles are all juxtaposed to the supposed objectivity and neutrality of scientific inquiries, which are recognized as androcentrically derived ideals (Code 1991). Renzetti and Lee summarize the basic orientation of feminist methodology:

- “(a) open acknowledgment by the researcher of her or his assumptions, beliefs, sympathies, and biases ...
- (b) rejection of the traditional separation of the researcher from the researched; and
- (c) adoption of the goals of the research as consciousness-raising and empowerment” (Renzetti and Lee 1993, p.177).

Feminists criticize more traditional methods of scientific inquiry, particularly those that postulate an objective positivism (Wilkinson 1999). As Wilkinson (1999) points out, feminist researchers usually stress the contextual nature of data. Researchers or research participants do not think or act in isolation. And this is true regardless of the method used. Wilkinson (1999) therefore suggests that, since they rely on interaction, ‘focus groups’ can offer feminists what is lacking in other methods.

In considering the influence of the context on the research process a number of other motivations to use 'focus groups' started to emerge. One was related to the nature of the topic to be investigated. The disclosure of information about sexual experiences or beliefs and attitudes about sex-related issues involves revealing intimate data. I assumed that a degree of intimacy and friendship among the research participants and between them and myself should facilitate our conversation about such sensitive topics. And that was what I could promote with the use of 'focus groups', taking advantage of the possibility of incorporating the group interaction as a research facilitator.

While the 'focus groups' technique was consciously chosen according to my personal interests, it also intended to fulfill the objective of making the data collection process enjoyable and somewhat useful for the research participants. I was willing to include as an explicit research interest the development of a research process 'for' the adolescent women I was about to talk to. My commitment to this particular task was primarily due to the feeling that because the girls let me invade their private lives and showed a willingness to provide the intimate information I wanted, I owed them something in return. I was, I suppose, thankful for that, recognizing that probably only very few intimate friends would have ever had access to such information. One can perhaps argue that with my thesis I would, in one way or another and at least indirectly, give the research participants something back. Even agreeing with that, I could not help feeling that the data collected would be the result of a sort of exploitation. In the end, I think that the intention of making the data collection environment pleasurable worked very well in both ways, either with respect to the interests of the research or of the research participants. The fact that the girls did not seem to find it difficult to talk about their sexual experiences or other sex-related issues, which appears to be demonstrated in the richness and depth of the data gathered, can, perhaps, be regarded as evidence of the positive effect of the group environment in the data collection. Also, the fact that against the girls' wishes I had many times to interrupt the session because we had already exceeded our proposed limit of two hours, seems to suggest that the girls enjoyed their participation in the focus groups sessions.

It has been argued that 'focus groups' are social events (although not 'natural' ones) that are enjoyed by its participants, regardless of the personal level of involvement with

the topic discussed (Catterall and Maclaran 1997). I would agree with this as far as the potential of ‘focus groups’ for providing enjoyable moments to research participants is concerned, but I consider that the more the interest in the research topic, the higher the motivation and the level of interaction among the research participants. In the case of my research I think that the girls’ motivation to engage in the discussions during the focus group sessions was especially influenced by the importance of the matter of ‘sexuality’ in their day-to-day life. And this contributed to making the ‘focus groups’ experience more enjoyable. While knowing that because of their interactive nature ‘focus groups’ are expected to be more enjoyable than other types of data collection procedures like questionnaires and individual interviews, I still tried to enhance the participants’ pleasure and involvement with the research by starting each meeting with what I call an ‘integrating activity’, a sort of ‘warming up’ game. I will explain in detail what I mean by that later on. For now I think it is sufficient to say that those activities were designed to stimulate interaction, spontaneity and intimacy and constituted an important addition to the meetings, contributing a great deal to the group interaction and making the meetings enjoyable.

Before going on any further, I wish to clarify why I use the word ‘sensitive’ when I refer to the intimate nature of the issues to be investigated in my research. As Farquhar and Das (1999, p.48) argue, ‘sensitivity’ is a subjective construct, in the sense that “what feels sensitive or threatening to one may not to another” (p.48). It should then be clear who is judging the research as ‘sensitive’, what is being considered as ‘sensitive’, and to whom the research is ‘sensitive’. In my case, I take issues related to sexuality as ‘sensitive’ in both ways, either with respect to the girls’ or to my own feelings. For the girls, to express personal positions about sex meant to release private information about sexual knowledge and experiences into the public space of our meetings. And because the research involved pre-existing groups whose members had a continuing relationship before and after the fieldwork and within and beyond the context of the research, this could signify the danger of seeing secrets being spread out into the community. I also consider my research ‘sensitive’ because to talk about ‘risk-taking’ may involve the disclosure of perceived moral failures. This can be especially problematic for research participants when the risk one talks about is recognizably a health risk (like HIV/AIDS) and the person who is supposed to guide the conversation is, like me, a health professional. Although ‘risk’ is not commonly taken as a sensitive

research topic, few authors have recognized that, in certain research settings, research participants can feel inhibited to disclose stories involving personal risk-taking because it can be disapproved by others.²⁵

For myself, even being an adult women, married, with two adolescent daughters and with experience in the field of sex education, I still cannot talk of sex in a relaxed way and the reason for that is quite simple. I find that to talk about issues surrounding sexuality ‘touches’ the most intimate dimension of me, involving my own intimacy with my ‘self’ and revealing the complexities and contradictions that are combined in ‘who’ I am. Feelings, values, knowledge, beliefs, experiences are all parts of me and are revealed through my talk about sex. In a way, when talking about sex I feel like I am exposing my own body to ‘others’. And the same is true when I think of the ‘other’ who is involved in the conversation with me. I always try to anticipate the embarrassment that certain questions or assertions can create to others. In sum, I categorized my research as ‘sensitive’ because its two main research topics - ‘sexuality’ and ‘risk’ - potentially involved embarrassing topics of discussion, either for the girls or for myself.

Kitzinger and Farquhar (1999) argue that in focus group research on sensitive topics the style of the group moderator is crucial. On the one hand, they suggest, it is obviously important to avoid asking highly personal questions; on the other, to marginalize some issues simply because one assumes that no one could possibly want to disclose private experiences to other group members is also ethically problematic. One way of dealing with this dilemma is, the authors suggest, to let sensitive discussions to be maintained by the research participants rather than the researcher. I tried to follow this advice by avoiding personalizing my questions, in particular when they could involve the assumption that the girls were already sexually active (although I knew that some of them had already had sexual intercourse experiences). I assumed that this could embarrass them for, from what I have experienced, adolescent women’s sexual activity is generally still a taboo in Brazilian society. So, it was not the case that sensitive questions were off my agenda but that I tried to formulate them in a way that would not directly implicate the ‘self’ with them. If the ‘self’ became visible it was

²⁵ See for example Green and Hart 1999.

because the participants themselves were interested in making 'the personal' visible. Despite my intentions, I cannot be sure that this was always the case. If the researcher is very much involved in the group interaction, like I was, it is difficult to always maintain a certain level of rationality and self-consciousness about how the decisions should be taken or which rules they were supposed to be following. In my particular case, the flow of the focus group discussions was very often their own regulator.

Issues surrounding sexuality are commonly taken as 'sensitive' topics (Farquhar and Das 1999). Power and gender relations, the question of sexual identity, the social and cultural norms that organize sexual behaviour, race, religion, age, etc. are all social determinants of the 'sensitivity' of talk on sexuality. This 'sensitivity' is ultimately constructed according to the norms and taboos of a given culture (Farquhar and Das 1999). As Farquhar and Das argue, because individuals belong to different groups at the same time, they are likely to experience different sets of norms and taboos and, in consequence, different levels of 'sensitivity' to the same topic.

Sensitive topics are not new on feminist researchers' agenda. Feminists have characterized 'sensitive research' as research in which the revealing of the 'private' to the 'public' is an expected outcome. Bergen (1993) describes her research on marital rape as 'sensitive' because of the dangers faced by women who share their private sexual experiences with the researcher. Edwards (1993) considers her study 'sensitive' because it investigates women's accounts of family lives, which involves the uncovering of private information. Bendelow's report (1993) of a research project on gendered notions of pain highlights the sensitivity of pain perception, for it involves emotions and feelings. In my case, the 'private' to be revealed by the girls I was about to talk to would also be expressed with a mixture of emotions and the information disclosed would likely represent a threat to their moral integrity.

Apart from reasons related to the sensitive nature of the research and the aim to make the group meetings pleasurable, the option for 'focus groups' was also based on my desire to create within the research limits a forum for individual and collective reflection. I assumed that this was not commonly available to girls, either in research contexts or in the more natural settings of everyday life. Girls' narratives of personal sexual stories or expression of points of view about sex-related issues are traditionally under adults' surveillance. This has the effect of reducing the spontaneity of girls'

conversations on sexuality, limiting the possibility of sharing of experiences. The less directive character of the ‘focus group’ technique could, and indeed did, offer the girls a chance to expose and share more freely their ideas, and time and space to rethink and change points of view before expressing them. Considering the specific benefits of this to the research participants, in terms of reducing their vulnerability, and also to the data collection itself, one can say that rather than feeling pressured to give immediate responses to satisfy the researcher (as it is usual in one-to-one and in more directive group interviews), the girls would “...have the potential power to redefine the topics of conversation (Burgess 1984, p.107).

Because focus groups allow spontaneity, the girls should be able to discuss the topics, directing the conversations towards their own interests (Burgess 1984). Confirming my expectations, the consequence of this was a reduction of the gap between the power held by me as the researcher and the power made available to the girls as research participants. It would be obviously naïve to affirm that this had the effect of eradicating the power differences inherent to researcher-researched relationships (Maynard 1994; Stanley and Wise 1993). Even in such an informal environment and with the emphasis on interaction and good intentions to distribute power, my role as the ‘mentor’ of the research process did not permit me to give away my task of coordinating the fieldwork. What was possible to achieve was a partial opening of the research process to the research participants’ guidance. In fact, from the beginning, the data collection was designed to foresee the acceptance of that guidance.

The ‘focus group’ technique has already been recognized as a research method that can fulfill the feminists’ goal of doing research in which research participants are not mere ‘objects’ of the research (Wilkinson 1999). Wilkinson highlights this question of the distribution of power in focus group research as one of the key features that makes the method useful for feminist research. She recognizes that “...focus groups are a relatively *non-hierarchical* method: that is, they shift the balance of power away from the researcher towards the research participants” (Wilkinson 1999, p.64, authors’ emphasis).

This question of hierarchical power relationships as intrinsic to research processes has been a traditional concern among social researchers, receiving particular attention from feminists (Maynard 1994; Stanley and Wise 1993). Research that does not take into

account the influence of the researcher upon the data gathered takes the research participants as "...passive givers of information, with the researcher acting as a sponge soaking up the details provided" (Maynard 1994, p.15). Maynard argues that feminists reject the inevitability of the power imbalance generated in this type of researcher-researched relationship and that they propose, instead, a non-exploitative interaction between them. She writes: "research becomes a means of sharing information and, rather than being seen as a source of bias, the personal involvement of the interviewer is an important element in establishing trust and thus obtaining good quality information" (Maynard 1994, p.16).

Maynard affirms that feminist scholars have dealt with the dilemma of the biased involvement of the researcher in the research process through an emphasis on the importance of researchers' reflexivity. By being reflexive, the researcher is able to follow her/his personal trajectory in the research process as it is developed and to become aware of the bias that is behind a given conclusion or decision. So, it is not the case that subjective thinking is avoided. On the contrary, it is stimulated, accepted, and ultimately, desired. In a similar vein, Stanley and Wise argue that researchers cannot separate themselves from the research process. They write:

"one's self can't be left behind, it can only be omitted from discussions and written accounts of the research process. But it is an omission, a failure to discuss something which has been present within the research itself" (Stanley and Wise 1993, p.161).

Without referring to the specific advantages of 'focus groups' for feminist research, Carey's affirmation that in a focus group "...group members can describe the rich details of complex experiences and the reasoning behind their actions, beliefs, perceptions, and attitudes" (Carey 1994) suggests that, whatever the approach adopted, the technique may increase the reflexive potential of the research process. In a group conversation both the researcher and the researched can, according to their interests, shift their positions from passive observers or listeners to active members of the group discussions. By being allowed to keep some distance from the research setting, both have the opportunity to reflect on individual experiences or assess personal beliefs, knowledge, attitudes about the issues that are being raised, and this may have implications in the 'quality' of what is being asked and the answers it produces.

If it is argued that the dialogue between the researcher and the researched is important, it has also been recognized that for the researcher it is equally important to be able to listen to the research participants, especially when the research deals with sex-related issues (Kitzinger 1994a). For Kitizinger, this "...gives the group facilitator time to acclimatize to, for example, their preferred words for speaking about sex" (p.160). She also emphasizes that such circumstances "...[prevent] the researcher from prematurely closing off the generation of meaning in his or her own search for clarification" (pp.160-161). This advantage highlighted by Kitzinger was indeed very significant for me as, like her, I was interested in the exploration of meanings - what do the girls mean by risk, sexual risks, risky/safe sex, and HIV/AIDS sexual risk? And how are those meanings produced?

In sum, the decision to choose 'focus groups' had two main reasons, both related to the epistemological starting points of the research. First, it would allow me to investigate 'HIV/AIDS risk' in the way I understand it; that is, as a sociocultural construct. Second, with 'focus groups' I would be able to conduct the research process in the way I believed it should be conducted in order to fulfill not only my research interests but also those of the research participants. Kitzinger (1994a) captures exactly what I had in mind when I chose 'focus groups': "group work ensures that priority is given to the respondents' hierarchy of importance, their language and concepts, their frameworks for understanding the world" (p.161).

In reflecting on the judgments I made in order to choose 'focus groups' and discard other research methods, I should say that it was a process strongly influenced by 'who I am': my views, knowledge, experiences, projects, ideals. So, while the literature review helped me to justify the choice of the method, the decision was primarily taken on the basis of a reflection on what 'I' wanted to do. Other methodological decisions, like those described next also reflected my personal approach to doing qualitative research, especially the research I had in mind.

The Groups' Constitution

Given the characteristics of my research, I decided to limit the groups I would work with to two. I thought that two groups would be ideal due to the limited amount of time

I had to collect the data and also the hard work involved in being a focus group researcher involves. I do not consider the small number of groups to be a weakness of my research design. On the contrary, it was this feature that allowed me, I think, to keep a high level of involvement with the groups and to explore the research topic in the expected depth. As Kitzinger and Barbour highlight, “statistical *representativeness* is not the aim of most focus group research” (Kitzinger and Barbour 1999, p.7, authors’ emphasis). Like the majority of focus group researchers I was not interested in making generalizations, in the sense of saying “all girls or even all working class girls see this in a particular way”. We must be very cautious, given the qualitative and small-scale nature of the research. I considered however that it was possible to theorize on the basis of the data gathered, seeing it as a sample of available discourses. As we will see some of this information can also be seen in the work of others (for example in the work of Holland et al. 1991, 1994a, 1994b and Green 1997a). In sum, I was not looking for simple generalizations. My objective was to explore the research participants’ views about the HIV/AIDS risk in heterosexual relationships and obtain data about the ways in which those views are constructed.

Another important reason for me to choose to work with only two groups of girls during the whole process of data collection was related to the ‘fieldwork logistic’. The data collection process was going to rely entirely on me. The planning of the meetings, including the provision of material for each meeting and the monitoring of two weekly focus group sessions would demand my full-time involvement with the research during the twelve weeks of data collection.

It has been argued that in focus group research there is no rule for the number of group sessions as it will depend on the characteristics of the research, including time and resource limitations, and the researcher’s interests (Kitzinger and Barbour 1999, p.7). Morgan (1997) affirms that the number of group sessions is directly related to the amount of data gathered. The author emphasizes the impact of the number of groups on the size and organizational level of the research team. He says: “conducting many groups almost ensures the need for a larger research staff, the only other alternative being to extend the data collection and analysis over a longer period of time” (Morgan 1997, p.43).

In the published reports of focus group research I came across the average of group size ranged from six to ten members. My original plan included two groups of at least seven members. Although I thought that it would be better to work with groups smaller than this, I took into account the experience of other focus groups' researchers. Some of them advise that it is better to begin with bigger groups because of the potential discontinuance of group members during the data collection process (Dilorio et al. 1994; Morgan 1995). In the two schools from which I drew my groups, however, I could not find more than six girls in each interested in participating in the research. The data collection happened during the period of the '1998 Football World Cup'. This was a very special time in Brazil, the country of football. Furthermore, the data collection coincided with the winter time there (June, July and August). Winters in the south are very cold, the days are short and adolescents tend to take advantage of being on their school holidays to wake up later in the mornings or simply to have fun indoors. Initially, both groups were composed of six members, but as the research progressed each group lost one of its members. In the end, the number of five members proved to be good, for, as anticipated, the coordination of the data collection proved to be a hard task. I had to conduct the group meetings, listen to the tapes after each meeting, re-plan the meetings according to the issues raised each week and, after finishing the data collection, transcribe about 40 hours of tape recorded group conversations, and conduct a qualitative analysis of the huge amount of data that it generated.

Morgan (1997) suggests that the rule for the size of groups in focus group research specifies a range from 6 to 10 members. Nevertheless, he points out, one should not be limited to the rules when planning the research design. In his personal experience, he adds, to have groups of three can also work very well, depending on the level of involvement with the topic. This was also experienced by Green and Hart (1999) in their study on children's views of accident risks. Morgan suggests that when the participants are highly involved with the topic to be discussed, as was the case in my research, it is better to work with smaller groups because all the group members will then have the chance to participate in the discussions.

I did not select the research participants directly. I just established the geographical context of the fieldwork and advertised the research in two public schools situated in

the area. My purpose was to work with working class girls who were genuinely interested in participating in the research. The choice of working class girls had to do with my commitment to listen to girls whose views on sexual risk matters are more likely to remain invisible in the generalizing discourses of biomedicine. This does not mean, however, that I consider that upper class Brazilian adolescent women, for example, are visible as such in so traditionally androcentric discourses. That is, it is not my idea to affirm that, apart from the working class girls, the others are represented in scientific discourses of risky sex and HIV/AIDS risk. What, perhaps, might differentiate the working class girls from, for example, those from the upper class, is that the latter are more likely to share with the well-educated elite of HIV/AIDS theorists some of the social knowledge, values and interests that are somehow implicit in their discourses. Also, I do not mean to imply that the entire working class population of adolescent women is represented in my research. I am not willing to take feminine experiences in the risky terrain of sex and its (in)visibility in scientific discourses as homogeneous. Nevertheless, I believe that by opening space for working class girls to express their understanding of sexual risks, including HIV/AIDS risk, I can challenge the monolithic (and androcentric) conception of risky/safe sex used by biomedicine to define ‘the problem’ of girls’ sexual risk-taking. It would also be relevant to explore what other women (either adolescent or not) have to say about risky/safe sex and the specific HIV/AIDS risk, but I think that if we are to start from one particular social group, let us start from women who will probably have less chance to find a legitimate space to speak out.

A common feature of each of the two groups I worked with was that the group members knew each other very well either because they studied in the same classroom, lived in the same neighborhood and/or belonged to a friendship network. Kitzinger and Barbour (1999) point out that one of the important decisions to be taken by a focus group researcher is whether or not to work with people who already know each other. Pre-existing groups, the authors argue, have the advantage of being constituted by individuals who are, in one way or another, bound up with each other “through living, working or socializing together” (p.8). The authors go on to emphasize the importance of those types of social networks for focus group research: “these are, after all, the networks in which people might normally discuss (or evade) the sorts of issues likely

to be raised in the research session and the ‘naturally-occurring’ group is one of the most important contexts in which ideas are formed and decisions made” (pp.8-9).

To work with girls who knew each other so well was good because it guaranteed the level of intimacy necessary for the discussions of the sensitive topics of the research. It also contributed to the level of homogeneity of the groups; ‘homogeneity’ in the sense of the sharing of a very similar sociocultural background. Morgan (1997) refers to the ‘homogeneity’ in focus groups’ composition as a means to facilitate the flow of conversations within groups and also the analysis of the differences between groups. He points out that the level of ‘homogeneity’ among group members, considering either race, sex, social class or other common background as the variable, is to be decided taking into consideration the research topic.

It has been recognized that in focus group research it is important to work with group members who share a similar sociocultural background. Morgan (1997), for example, stresses that “participants must feel able to talk to each other, and wide gaps in social background or lifestyle can defeat this requirement” (p.36). However, as Morgan (1997) comments, homogeneous background does not mean homogeneity in attitudes or in ‘ways of seeing’ a given topic as this may result in unproductive group discussions.

In my research at least three variables contributed with the homogeneity of the groups - sex, age and sociocultural background. The groups were constituted by 14-17 year-old girls, who studied in the same school and lived in the same area. Although most of the members of the two groups were classmates (with only one exception) they were not of the same age due to the way the Brazilian educational system works. Students can stay in the same school grade for more than one year, depending on their academic performance. Grade retention occurs when, at the end of the academic year, the student fails to meet the academic expectations. In Brazilian schools it is common to find students of different ages in the same class.

Having presented how the two groups I worked with were constituted, in terms of who the group members were and how they came to participate in the research, I now move on to a more descriptive approach. The next sections give a picture of the

process of data collection, describing the research setting and the procedures employed to collect, record and analyse the data.

The Research Setting

The chosen area for the development of the fieldwork was a working class 'villa' of the city of Porto Alegre, the capital of the state of Rio Grande do Sul, which is located in the very south of Brazil. The city was chosen because I was born and lived my entire life there (except for the four years of staying in London for my PhD), which facilitated my contacts and actual 'survival' whilst collecting the data.

Even though I decided to recruit the research participants from two local public schools, I did not want to conduct the group meetings within the physical space of a school. My desire to avoid the school settings was based on the assumption that the context influences the data produced. I was thinking about the sensitivity of the topics to be discussed and the potential threat represented by the school environment to free discussions about sex. I wanted independence from school rules and bureaucracies. I also did not want to 'contaminate' the girls' conversations with the formality of the schools' environment. I ended up by conducting the meetings in a room that was used by the community for functions. Sometimes this room was also used by the staff of the health centre situated nearby for health promotion activities. More than once I could not work in the 'function room' because another activity was programmed. On those occasions I had to work in one of the small rooms of the health centre building. When this happened, it was a struggle to work with some group activities that required more space. Also, the group interactions did not follow the same pattern of informality and spontaneity that was apparent when the group met in the 'function room'.

It has been pointed out that there are advantages and disadvantages in working with focus group in informal settings (Green and Hart 1999). Green and Hart comment that in their experiences, group conversations conducted in informal settings were 'chaotic' and more difficult to transcribe than those occurred in formal settings, because of the amount of interruption and unstructured ways of talking. The researchers point out, however, that this is not necessarily a negative point as it may exemplify how real life interactions are constructed (Green and Hart 1999). I cannot say that the informality of

the research setting resulted in 'chaotic' discussions. The girls themselves contributed a lot to the order of the group discussions. They helped me to get a balance between informality and order. Many times, when everybody was talking at the same time and it was impossible to get a sense of who was defending this or that point, the girls themselves tried to organize their interactions by establishing a 'speaker order' or asking for silence or calling attention to one of the group members who was trying to make her point.

While it was not my objective to look at the differences of data produced in different contexts, I noticed that, similarly to the children interviewed by Green and Hart (*ibid.*), the girls' involvement with the group discussions was influenced by the informality of the 'function room' and the formality of the health centre. In the former, they looked more relaxed. In the latter, they seemed to be less spontaneous and apparently did not enjoy the discussions in the way they did when we met in the 'function room'. One factor that definitely contributed to this shift in attitude was the difficulty in carrying out the 'integrating activity' in the small spaces available in the health centre building, which also did not offer us enough privacy. Also, it may well be that the girls felt inhibited to talk freely about the risks of sex because of the proximity of the medical staff, who they reported had already had conversations with some of them about sexual risks and the responsibilities of sexual activity. Another factor that could have also contributed with the girls' less relaxed attitude in the health centre was the fact that, by working in the community, the health centre's staff were likely to know the girls, their families and records. The possibility of letting a doctor or a nurse know about their sexual experiences and viewpoints about sex-related issues could threaten the girls' reputation within their families and the community. And that seemed to be a common concern.

Having described the research setting, I now move on to the description of how I conducted the focus group sessions. My research project, fieldwork diary, transcriptions of the tape-recorded sessions and my memories will help me to bring to the present time a reconstruction of what happened in the past when I put my fieldwork plan into practice.

The Group Meetings

General Format of the Meetings

Each focus group was constituted of three moments: an ‘integrating activity’ (lasting about 35 min.), an interval (lasting about 20 min.) and a focused discussion (lasting about 50 min.). As mentioned earlier, I had separate weekly meetings with each of the two groups. The focus group meetings were planned in advance, but the plans were relatively flexible. The literature recommends that focus group research should be preceded by a phase of preparation in which the researcher studies the research topic and develops a protocol of broad concepts and guideline questions to be explored in the group discussions (Carey 1994; Kitzinger and Barbour 1999). Before starting the data collection I had a plan for the fieldwork, in terms of the general format of the meetings and the orienting themes for the first five. I did not prepare a plan for the rest of the fieldwork because of my wish to work with a ‘stratified fieldwork plan’, that is to say, a plan that was going to be constructed step by step as the data collection progressed.

My idea was to start from the participants’ general ideas about risk, which I thought were embedded in their views of ‘everyday risks’, and then move on to the more specific ‘HIV/AIDS sexual risk’. With this in mind I organized an initial agenda with questions and topics that I considered relevant to be answered and/or discussed. However, I was prepared to re-think the agendas during the course of the data collection, as other relevant topics should emerge from the group interactions. Sometimes I just added another topic or question to the initial agenda of the first five meetings; at other times I changed the previous plan completely. In sum, the orienting themes for the first five meetings, designed before the starting of the data collection, were opened to changes and the other subsequent seven meetings were planned as the data collection progressed (see Appendix II, p. 221 for the focus groups plan).

The way I managed to work with what I called a ‘stratified fieldwork plan’ demanded a high level of personal involvement with the research. After each meeting I had the task of listening to the focus group recorded tape, writing down in my diary some notes about what would possibly be important to discuss in the next focus groups and why.

This procedure allowed me to develop a reflexive interaction with the data from the earlier stages of the data collection process onwards. The next task was to compare the topics listed as relevant with the previous agenda and decided what was going to be the topic explored in the next focus group meeting. As I worked with two groups separately, I had to follow those procedures at least twice a week. This proved to be a demanding and time-consuming task, but also a rewarding one. The more I opened to the participants the direction of the focus group discussions, the more I was able to approach the 'reading grid' they use to make sense of the risks of sex in general, and HIV/AIDS risk in particular.

I think it is worth explaining that the focused discussions, which occupied the last part of each meeting, were concentrated primarily on the same topic explored in the integrating activity. For the purpose of planning the topics to be explored in the group meetings, I took into account the two groups separately. There was not, however, much difference between what emerged in the integrating activities with both groups. So, the agenda of the actual group meetings was nearly the same.

The First Meeting

As planned, I met the two groups separately. The agenda for this first meeting included mainly introductory and organizational issues. I asked the participants, for example, to discuss and decide what would be the best day and time for our next 11 weekly meetings. The consensus was reached after a negotiation of individual interests. We also discussed the rules that would apply to the meetings and to the group members' participation, including myself. I explained the points I thought were important for the organization of the meetings and group discussions, such as punctuality, commitment to the research (in the sense of avoiding discontinuity), respect for other opinions and the need to keep the participants' knowledge, opinions, experiences, within the limits of the group meetings. They were then allowed to discuss the issues and had an opportunity to raise other points not mentioned by me, although in both groups the discussion was limited to my proposal. In the end we came up with a list of rules, which everyone agreed to.

I used this first meeting to get to know the research participants and to let them know about me. In both groups I was the only stranger. Although they had already been informed about the general design of the research, I described with more detail the research procedures and my objectives. In both groups, the girls were proving to be very curious, even excited, about the fact that I was living in London and my task of writing a thesis in English. Later, during one of our last meetings one girl suggested that one of the reasons why she and her friends were interested in the research was because, to participate in a research like mine, would make them feel important.

At the end of the meeting I reminded the participants about the rules we had just set up, emphasizing the principle of confidentiality, which should be followed by all the research participants. I also emphasized my commitment to this confidentiality.

Integrating Activities

What I called the ‘integrating activity’ (see Appendix II, p. 221) was a sort of ‘warm-up’ group activity, lasting approximately 30 minutes and designed with the primary purpose of making the group meetings as enjoyable and interactive as possible. Secondly, the ‘integrating activity’ was also thought of as a means to facilitate the participants’ involvement with the research and to generate focus for the group discussions. In the end, what was experienced in an ‘integrating activity’ - the stories created, the jokes, the language used, the roles played, the insights, the issues raised - became substantive material for the focus group discussions. Like other focus group researchers, I developed my own way of getting the participants’ involvement in the research. Barbour (1999) used vignettes to explore how team members make sense of each other’s roles and responsibilities. Kitinger used photographs from TV news bulletins to stimulate the participants’ interaction with media messages about AIDS within the focus group settings. She also employed a ‘card game’ to explore different perspectives on ‘who was at risk from AIDS’. As Kitinger and Barbour (1999) recognize, “collective tasks, such as these, encourage participants to concentrate on one another (rather than the group facilitator) and may force them to explain and defend their different perspectives” (p.12). The authors emphasize however, that such a stimulus is not always necessary or even appropriate, as some may feel uncomfortable with the idea of participating in activities that sometimes may remind them their school

time. They recommend that the appropriateness of group activities should be evaluated carefully and monitored throughout the research.

Although the ‘integrating activity’ was supposed to be experienced as an imaginary situation, the participants’ involvement with it was not fictitious. Although imaginary, the situation experienced was a representation of something that actually happens in reality, one to which the participants had some sort of connection. I tried to ensure that connection by working with common themes of everyday life, especially those that I assumed were of the girls’ interest. To work with a ‘stratified fieldwork plan’ was particularly helpful for the selection of those themes.

The idea of using ‘integrating activities’ to begin the group meetings was based on the assumption that “...the point of doing group interview is to bring a number of different perspectives into contact” (Morgan 1997, p.46). In this sense, the use of the ‘integrating activity’ to provide space for the participants to interact with others on a given topic had the advantage of stimulating the awareness and defense of personal positions before the actual focused discussion took place (Morgan 1997). The differences between personal positions started to emerge and become clear to the participants themselves during their involvement with the integrating activity. As a result, the participants became more responsive to the themes to be discussed in the focused group discussions and the group interaction, which had actually started before, was of a high standard.

Commenting on ways of facilitating the discussion of sensitive topics in focus group research Farquhar and Das (1999) cite the recommendations of Hoppe et al (1995), according to whom warm-up activities should precede the discussions in research with children. In their experience with adults however, Farquhar and Das did not find that warm-up activities were welcomed. Even in a group of strangers, they comment, adults resisted to participate in such activities, especially if the theme of the activity did not appear to be related to the main topic. Farquhar and Das (1999) suggest that the adults had a problem with the childish tone of the word ‘games.’ I was actually worried that, for the same reason, the girls would resist participating in the ‘integrating activities’. After all, they were in a transition between childhood and adulthood, but trying hard to present themselves as adults. I did not have any problem with this, however. The girls’ involvement with the games and role-plays that constituted the ‘integrating activities’

was, from the beginning, very good. One reason for that was, perhaps, the fact that the orienting themes of those activities were partially produced in the actual interactions between the participants, either in the focused group discussions or in the integrating activities themselves.

‘The simulation of a judgment’ is an example of what I call ‘integrating activity’. This activity was a sort of role-play in which the participants simulated a ‘trial’ situation. There were two ‘lawyers’, one defending the ‘pros’ of adolescents’ sexual activity and another presenting arguments against it. There was also a ‘jury’, whose responsibility was to balance the pros and cons, and after discussing privately, finally reached a consensus, presenting its decision and the reasons behind it. During the ‘trial’ the ‘lawyers’ and the members of the ‘jury’ had the opportunity of discussing their arguments.

When I planned the fieldwork I had the idea that it would not be appropriate to tape-record the ‘integrating activities’ because this could threaten the participants’ spontaneity, for some could feel embarrassed to being involved in ‘childish’ activities. Also, it would be very difficult to transcribe the girls’ words in such an informal setting. Nevertheless, it was the participants themselves who influenced a final decision to use the tape-recorder during the ‘integrating activities’. In the first two meetings I did use the tape-recorder only during the focused group discussion of the day. In my third meeting with one of the groups, the participants asked me why I thought it would not be good to use it while they were participating in an ‘integrating activity’. Strikingly enough, they had voiced the opinion that I was mistakenly thinking they would be ashamed of playing games, which they were not. I asked the other group if they, too, would not mind if I used the tape-recorder and they said no. I then recorded the subsequent meetings almost in their entirety, with the exception of their intervals. When I carried out the data analysis, I many times came back to one of the recorded ‘integrating activity’ to try to understand what the starting point was for a particular discourse explored in the focused group discussion of the day. Apart from the tapes, which I did not transcribe, I also used to take notes about the issues raised and also about the insights I had during the development of the activity. What would be worthwhile to discuss in the focus group? Which questions were occurring to me at that time? What points would be useful to explore in more depth? At the end of each

integrating activity I usually had a list of topics which constituted the guidelines for the focused group discussion that would be conducted shortly after the integrating activity. Sometimes, depending on the importance of the issue, it could come to constitute the orienting theme for one of the next group meetings.

Conducting the Focused Group Discussions

I took advantage of the interaction created in the 'integrating activity' and in the subsequent 'interval' (where we used to have snacks, sometimes brought by one of the participants, sometimes by myself) to extend the informality and spontaneity to the third part of the meeting. All the sessions were conducted in a relaxed way. I tried to interfere as little as possible in the groups' discussions. My role as a facilitator included reminding the participants at the beginning of the session about the theme to be discussed. I sometimes used a question or a statement related to the original theme but produced in the 'integrating activity' to start the session and then left the participants free to embark on a conversation about it or to present their points of view (in a way already displayed to the others in the earlier moments of the meeting). The main difference between the display of positions in the focused discussions and in the 'integrating activity' was that in the former there was more time and space for the exploration and/or clarification of ideas.

As a facilitator I could not be passive, for it was not always possible to leave the discussions to the exclusive guidance of the participants. A more "interventionist style" (Kitzinger 1994b, p.106) was used to stimulate the continuing exploration of a given theme, knowing that this would provide relevant information for the research. At other times I simply brought the discussion back to a theme that had been emphatically discussed before but in a superficial way. The 'coming backs' were also useful when I thought it was necessary to clarify personal positions and/or conflicting discourses somehow lost in the heat of the group interaction. Self-evident assumptions were also treated as matters for more careful examination within the groups. For example, in a discussion about the reasons why some girls do not use condoms in spite of knowing the implications of not using them, more than one participant began by stressing that the main reason was because those girls do not care. I then asked them to review each step a girl has to take in order to be a successful condom user, giving them time to

reflect about the answers to questions related to the difficulties of condom use. Is it easy for girls to buy condoms? Do they have money? Is it easy to ask for condoms in the community health centre where condoms are free? Are there risks in doing that? How about the risks to reputation? Even by having easy access to condoms, is it easy for the girl to use it consistently? So, in a way I directed their thinking and consequently the discussion generated by it.

When intervening in the group's interaction, I was attentive to the participants' reactions to my positions or to my interpretations of their positions. I usually called for a more explicit manifestation of those reactions. This had the effect of maximizing the interactions between the participants, for to explain a reaction included pointing out its reasons and presenting to others an exploration of personal arguments. Once the interaction started to be productive, I used to return to a less interventionist style. On those occasions I could see the advantages of the use of group interaction in exploratory research, as the direction of the discussions was set by the participants' themselves. To clarify my point here I use Kitzinger's words as if they were mine:

“When group dynamics worked well the co-participants acted as co-researchers taking the research into new and often unexpected directions and engaging in interaction which were both complementary (such as sharing common experience) and argumentative (questioning, challenging, and disagreeing with each other)” (Kitzinger 1994b, p.107)

With regard to my involvement with the discussions, I adopted a position where I was not totally open to disclose personal experiences and ideas to the research participants. I was continuously worried that my participation could inhibit their manifestations, in the sense of setting unintended limits to it. I was aware that to be a middle class adult, perhaps representing a ‘mother figure’, a health professional, a university lecturer, a doctoral student, a person who lived in Europe, had an impact in the way the participants saw me. I was definitely different, but this was not perceived as such in a negative sense. I was seen as a model to be followed. I felt that the differences between the participants and me were seen as a gap that most of them would like to reduce, indeed an aim that they were trying hard to achieve mainly through education. So, there was always a tension between my conscious presence within the group and how much of me could be revealed without compromising the presence of the participants and the consequent production of data. In the end, I did not follow any self-imposed rule. My

tendency was to respond to the participants' demands for my explicit participation in the group dynamics.

Sometimes the participants were keen to hear my opinion about a particular subject, especially when there was a strong divergence amongst various perspectives. In such situations I usually did not avoid disclosing my opinion. After all, the participants were there talking about themselves. So, why would it be more risky for me to mark my presence there than for them? I answered their questions, trying, however, to get the participants back to the discussion as soon as possible. A good technique to achieve this was to ask the participants to explain in what sense their opinions were similar or distinct from my own. Another circumstance in which the participants were keen to hear from me was when they wanted to check their knowledge about biological phenomena such as human reproduction, contraception and HIV/AIDS transmission and prevention. On the whole, they were very well informed about all those issues but were proving to be insecure about the accuracy of their knowledge. They also wanted to know about scientific advances in those fields. Although it was not my objective to provide this type of knowledge, when asked I took some time from the group meeting to give the participants the answers they wanted.

So far, I have made very little distinction between the features of the meetings with the two groups, which I identify as group 't' and group 'j' after the initial of the names of the schools where the group members were recruited. While both groups had focus group sessions separately, the fact that I was in both cases the facilitator produced a sort of homogeneity in the way the sessions were run. This does not mean, however, homogeneous data. Actually, each group meeting and focus group session was seen as unique, independently of which group I was working with. If we are to compare the data produced in the group discussions one can notice similarities as well as differences either across groups or within each group. Soon I realized that I should not be worried about setting strict boundaries between the themes proposed to be discussed in one group and in the other. I just conducted the meetings by following the same principles, including the use of a flexible agenda, and let the data emerge.

Before starting the data collection I suspected that because the groups were different I would have separate agendas for the meetings with each group. As the data collection progressed it became apparent that the 'reading grids' the participants of both groups

used to make sense of risk, sexual risk and HIV/AIDS sexual risk were very similar. What differentiated the participants' perspectives were the values, knowledge and experiences that gave shape to the 'reading grid' through which they made sense of risk. And, strikingly enough, even those differences did not always follow a pattern. The same person could employ congruent, or different, or contradictory 'reading grids', depending on the situation (see Chapters 4 and 5). So, I thought, as long as there is space for the participants to express their personal ways of reading 'sexual risks', including HIV/AIDS sexual risk, it does not matter much if the focus group sessions with the two groups occurs in a similar fashion.

As I have commented above, the agenda for the focus group sessions was constructed as the data were being produced. This work-in-progress-type of agenda had the advantage of capturing the experiences, meanings, knowledge and views of the members of both groups as they were being expressed. What I thought was important to explore in one group was often the result of my knowledge of and reflections upon the data produced by the other group and vice-versa. So, there had always been an intrinsic link between the interactions in-group 't' and in group 'j'. I think that the similarities between the two groups were due to my personal interventions but also to the features they have in common, like age, sex, class and sociocultural background.

As the groups I worked with were small in size I did not have a problem ensuring that everyone had the chance of speaking. However, individual characteristics influenced the amount of intervention each participant made in the group discussions. In group 'j' one participant was less talkative than the others. In group 't' there were two who were more shy. There were times when I had to intervene to get their views or hear about their experiences. Strikingly, more than once, when I asked them to present their viewpoints about what was being discussed, those girls came up with a well elaborated explanation of the reasons why they saw the issue the way they did. In such situations I always got the feeling that before my intervention they were silent because they were reflecting on the subject. I had the impression that they were trying to make up their minds about something that, perhaps, they never had opportunities to think of and develop a related conscious viewpoint. This made me think once again about the advantages of focus groups for an exploratory research project like mine. In this respect, I agree with Kitzinger and Farquhar (1999) when they suggest that with focus

groups “the researcher is creating a setting where, at the very least, a subject is addressed in greater depth than usual” and that “ often research participants are discussing issues [...] which are seldom mentioned in an everyday context beyond the routine exchange of jokes and platitudes”. The authors go on to suggest that “sometimes this will be the first time that they have articulated certain views or experiences (to themselves, to each other, or to a particular friend in the group)” (p.165). This may have been the case when some of the research participants remained silent during the group discussions.

Before finishing this section I think it is worthwhile summarizing how the agenda for each focus group was produced, although on a number of occasions this has already been explained in the present chapter. Each focus group session had an orienting theme. Before the session I always had a short list of the topics I would like to explore. However, this initial agenda was flexible enough to be totally or partially changed in order to accommodate new questions or topics of interest brought from the group interactions during the integrating activity of the day. The adaptation of the initial list of topics to what emerged in the ‘integrating activity’ did not mean the definite setting-up of what would be discussed in the focus group. The agenda for the session remained flexible. In the end, what was finally discussed in each session was the result of interactive guidance exercised by everyone involved in the discussions, including me. The opportunity to share the direction of the data collection with the research participants is one of the positive features of focus group research. As Greg Myers and Phil Macnaghten (1999) comments, in focus groups the “...participants guide the moderator as well as the other way round” (p.181).

MAKING SENSE OF THE DATA

The main source of material for data analysis consisted of 24 tapes recording the 12 focus group sessions I had with the two groups. In addition to that, the fieldwork diary where I registered my impressions and notes soon after each meeting also contained data. This source of data, along with the tapes of the ‘integrating activities’, was mainly utilized to clarify why I took this or that decision concerning the research design in general, and the focused discussions in particular. In this sense, it was especially useful for making visible the bias that influenced the data collection. With respect to the

‘integrating activity’, the data produced within it was usually explored in detail in the focused discussion of the day. So, in my analysis I rarely considered it as substantive data, preferring to explore the analytical potential of the more consistent data generated in the focus groups.

To follow my original fieldwork plan I also carried out individual interviews. However, as the amount of focus group data proved to be overwhelming and sufficiently complex, rich and informative I decided not to use the individual interviews as source of empirical data in my analysis. Nevertheless, when analysing the focus group data I could not avoid using my memories of what the girls said in our private meetings. For instance, although the focus group material did not provide direct information about who was and was not sexually active I was actually informed about it as this was a sort of data usually revealed during the individual interviews.

The Transcribing-Translating Tasks

All the recorded focused discussions were transcribed. Taking into account that I was not interested in the actual features of the conversations but in their contents I did not transcribe all the sounds and utterances that appeared in the original conversations. The transcripts contain only words and pauses. The only exception was the transcription of the participants’ laughs.

I could not help feeling that, in spite of considering this decision virtually unavoidable, it constituted a sort of deliberate manipulation of the data. This dilemma occurred to me once again when I had to carry out Portuguese-English translations. Actually, as far as the ‘manipulative effect’ is concerned, I think that there is no difference between transforming spoken into written language and Portuguese into English. The act of translating spoken words into written texts is problematic. In an analysis of her own dilemmas while transforming Brazilian women’s life story narratives into written documents, Daphne Patai (1988) affirms that there is “[...] a distance separating the spoken word from the written word that is insurmountable” (p.147). Any attempt to make this distance invisible, let us say by presenting a spoken discourse in a written form has the effect of distorting the former. Patai regards this distortion as inevitable and, considering her own work affirms that, face with the need to translate spoken

Brazilian Portuguese into written English, this distortion is doubled. I exemplify some of the dilemmas I came across when making my transcripts with Patai's description of the way she produced written documents that ended up by distorting the interview material:

"My work on Brazilian women did not begin as a literary project, nor is it intended to end as one. But on some levels, the literariness of the narratives struck me soon enough. The problems I faced with the transcripts resembled in certain respects those I have encountered translating fiction-problems of how to retain the tone, style, and flavor of the original. However, I also did some things we would rarely do in translating a text already marked as "literary": cutting, reorganizing, and shaping the material I had gathered. I did not realize at the time that this was because I assumed that the final written product would be a prose narrative whose primary function was to convey information" (p.148, authors' emphasis).

I did not translate all the focus group materials. I worked on the transcripts written in Portuguese and only translated the passages that I decided to include in my research report. Where I could not find any satisfactory English translation for a given word or phrase I have kept the original speech and tried to explain in a footnote what that would mean. In the translated material it was difficult to keep the original structure of the sentences and their punctuation. I felt that this distorted the participants' original discourses a bit further. In practical terms, I consider it impossible to do translations of group interactions without changing the original discourses. In theoretical terms, I find in Stanley and Wise's work (1993) not a proper justification for this 'distorting effect' but assumptions that may suggest one. They write:

"*All* research involves the production of the textual representations of a research reality, using whatever conventional stylistic and rhetorical devices are considered appropriate by the various theoretical and other allegiances a researcher locate themselves by. Within writing, researchers have the last - or rather the penultimate (for readers have the last) - say about what 'the research' meant, found, concluded. Writing dispossesses the researched. Although the researched may exert a good deal of influence on the interaction that composes research, when it comes to *writing* researchers can - and indeed in a sense ultimately must - take responsibility for the research carried out, because it comes to bear their names as textual products of the academic labour process. The written product of any research process is a construction, and not a representation, of the reality it is about" (p.218, author's emphasis).

Following those assumptions, the theoretical justification can be that, in order to produce a theory and communicate it to others, scientists cannot avoid the 'processing'

of the material gathered in a way that can be analysed, reported and read. This implies that to do research always involves some sort of translation work.

After transcribing the data the next step was to start the data interpretation. This process was informed by feminist post-structuralist theories on subjectivity. In the following section I present the feminist post-structuralist arguments used in the process of making sense of the data.

The Influence of Post-Structuralist Feminism

Post-structuralist feminist perspectives on subjectivity helped me to solve some of the analytical problems created by my interest of producing a theory on girls' ways of seeing risk without overlooking the girls' individualities. While it was not my intention to affirm the absolute 'sameness' of the 'girls' I interviewed, it would be impossible to make any kind of analysis of the girls' ideas about risk without considering their similarities. I dealt with this problem by adopting the alternative suggested by Alison Jones (1993), which consisted in using as well as rejecting the term 'girls' in a strategic way by asking "where and how is it helpful to treat girls as a single category? and where and how is it important to focus on differences among girls?" (Yates 1990, p.40, conf. Jones, p.158).

In the data analysis I looked for what the 'girls' had in common, either in terms of personal experiences concerning risk or with respect to their beliefs, ideas, knowledge, etc. about issues around risk. On the other hand, the analysis of the contradictions and differences in their approach to risk was also considered as very relevant for it confirmed the argument that individuals do not necessarily see risk in the same way and that personal approaches to risk can vary from one situation to another.

Post-structuralist feminists have pointed to the theorizing of 'girls/woman' as problematic (Alcoff 1997; Jones 1993; Walkerdine 1998). To take 'woman' as a concept may mean neglecting the differences among women's experiences. On the other hand, to overemphasize differences and reject the idea that women have something in common among each other may disarm feminists in their attempts to theorize and fight against women's oppression. Alcoff (1997) describes this dilemma as "the identity crisis of feminist theory" (p.330). She asserts:

“...as a concept it [‘woman’] is radically problematic [...] because it is crowded with overdeterminations of male supremacy, invoking in every formulation the limit, contrasting Other, or mediated self-reflection of a culture built on the control of females” (Alcoff 1997, p.330).

Alcoff points out that male-oriented conceptions of ‘woman’ have defined it as an essential conglomeration of attributes that differ from ‘man’ for, as opposed to the “male free willed subject” (p.331), ‘woman’ is governed by ‘nature’. Alcoff summarizes men’s construction of ‘woman’:

“[M]an has said that woman can be defined, delineated, captured-understood, explained and diagnosed - to a level of determination never accorded to man himself, who is conceived as a rational animal with free will. Where man’s behavior is undetermined, free to construct its own future along the course of its rational choice, woman’s nature has overdetermined her behavior, the limits of her intellectual endeavors, and the inevitabilities of her emotional journey through life” (Alcoff 1997, p.331).

Alcoff suggests that the responses of feminists to the dilemma created by the theorizing of ‘woman’ have emerged from two feminist lines of thought: cultural feminism and feminist post-structuralism. Like Alcoff, I find those responses problematic. Firstly, while claiming to be legitimate voices on behalf of women, cultural feminists have tried to challenge men’s definitions of ‘woman’ by arguing that they have developed a wrong conception of women because it has been based on man’s interests and on a perspective that takes into consideration men’s culture. Cultural feminists have then assumed that the alternative is to ‘correct’ men’s description of ‘woman’ (Alcoff 1997). In this respect, as Alcoff points out, “cultural feminists have not challenged the defining of woman but only the definition given by men” (Alcoff 1997, p.331). While the generalizing tone of Alcoff’s critique of cultural feminists is a matter of concern for me, I agree with its main point.

Alcoff argues that the second major response to the feminist dilemma of the theorizing of woman’s identity is to negate the existence of ‘woman’, for the ‘feminine’ is seen as totally plural, diverse, multiple. To me this is highly problematic as it raises the obvious question of how to develop a theory on girls/women, or more precisely on their points of view, if, as subjects, they do not exist. The idea that ‘girls/women’ is a fiction could destroy any personal goal of understanding the ways the girls who I talked to see the risks of sex. The dissolving of the female subject (Alcoff 1997) seemed to

make it impossible to think of the materiality of girls' disadvantaging situation with regard to sexual risks (which were so powerfully expressed in their talk) or to think of girls as 'real' persons who talked about 'concrete' lives, 'concrete' bodies, 'concrete' fears and who did seem to be alive independently of my imagination.

For feminist post-structuralists, to reject essentialism in the name of what Alcoff calls "nominalism" (p.338) - "the denial of sexual difference" (p.344) or "the idea that the category of 'woman' is a fiction, and that feminist efforts must be directed toward dismantling this fiction" (p.338) - means to discard the discourse of 'woman' which is seen as guided by a male-oriented concept of 'woman'. In man's discourse 'woman' is the other, the subjugated pole of binary oppositions like self/other, culture/nature; rational/emotional, etc. (Alcoff 1997; Tong 1992).

The political project of feminist post-structuralists is to fight against these binary oppositional thoughts in the hope that this will liberate women from the kind of discourse that may have existed before 'woman' was 'invented' (Tong 1992). For the French feminist Julia Kristeva, the political struggle of feminist post-structuralists has a "negative function", rejecting "everything finite, definite, structured, loaded with meaning, in the existing state of society" (Kristeva cited by Alcoff 1997, p.338).

While I could dedicate several pages of this chapter to the discussion of feminist cultural and post-structuralist theories and to the critiques, I do not have space to do it here. My aim here is just to present the main points raised by Alcoff in her attempt to show why she does not agree with the contemporary approach of feminists to the problematizing of woman's identity and ends up by proposing an (promising) alternative.

How could I think of different 'girls' without limiting 'girl' to its semantic determinations? How could I work with 'girls' as plural without neglecting the commonalities of their histories? Alcoff (1997) offers an alternative to the essentializing and deconstructing extremes of contemporary feminism in its theorization of woman's subjectivity. She proposes a conception of subjectivity as "positionality within a context" (p.350), which implies

"...that the concept of woman is a relational term identifiable only within a (constantly moving) context" [and] "...that the position that women find

themselves in can be actively utilized [...] as a location for the construction of meaning [...] rather than simply the place where a meaning can be discovered (the meaning of femaleness)” (p.349).

The positional definition of woman does not accept the idea of innate characteristics; ‘woman’ is not independent from its external circumstances but a construct that is made in relation to it. The metaphor of a chessboard illustrates Alcoff’s definition of the subject as “positionality”: “the external situation determines the person’s relative position, just as the position of a pawn on a chessboard is considered safe or dangerous, powerful or weak, according to its relation to the other chess pieces” (Alcoff 1997. p. 349).

Alcoff’s concept of ‘positionality’ was very influential in my interpretation of the data. With it I could understand how and why the same girl could produce discourses that were internally coherent but incoherent in reference to previous personal positions, and also, to see the ways by which those conflicting discourses were, at the same time, shaping and shaped by different and contradicting ‘selves’. Perhaps more importantly, by understanding the girls as subjects of their own discourses, I realized how important risk discourses are for the formation of their subjectivities. And, also, how complicated it can be to combine a personal discourse of risk with other similarly relevant discourses at the same point of view.

Along with Alcoff’s concept of ‘positionality’ I used another feminist post-structuralist argument to make sense of the data. That is, the argument about the association between discourses, agency and subjectivity. Agency has been a point of debate among feminist post-structuralists who have been contesting the idea of an unitary ‘self’. Alison Jones (1997a), for example, argues that the concept of agency mistakenly assumes a pre-discursive ‘self’, which she claims is only possible within a humanist discourse. As opposed to the subject of humanist discourses the subjects of post-structuralist thought, Jones maintains, are not to be understood as actively making rational choices and taking positions within discourses. It is in fact a subject whose choices are limited by the discourses that produce her or him as a subject. In sum, for Jones, from a post-structuralist perspective, the agency of the ‘self’ is no more than illusion.

Jones' claims have been emphatically questioned by other feminist post-structuralists like Bronwyn Davies (1991), who argues that it is precisely the fact that post-structuralism conceptualises the subject as discursively made, that opens up the possibility of the existence of an agentic 'self'. For Davies, the awareness that our 'selves' are constructed through discursive positionings can give us the ability to find new alternatives of being in the new discourses that we might come across. So the very idea that we are the result of discourses that co-exist around us shall not erase our authority or agency (Davies 1991).

Davies' analysis of the definition of agency is facilitated by her critique of the conceptualisation of the subject in humanist theories. She makes the point that "within the humanist discourses that predominate in the social sciences, agency is synonymous with being a person" and "...is used interchangeably with such concepts as freedom, autonomy, rationality and moral authority" (Davies 1991, p.42). In a humanist sense, Davies argues, a person "...has an obligation to take themselves up as knowable, recognizable identity, who "speaks for themselves" and who accepts responsibility for their actions" (1991, p.42, author's emphasis). The importance of this, she stresses, is that "it is this discursive placing of responsibility that makes us, in a legalist sense, agents by default" (Davies 1991, p.42).

The assumption that agents are persons who can rationally control themselves implies an understanding of those who are emotional or non-rational as non-agents. Within this type of discourse the agentic person is assumed to make rational choices as long as the choices made are approved by those who have the power to prescribe what is and is not rational. This is an idea elaborated by Benson who is cited by Davies: "the necessary agreement and approval that makes the act in question definable as a rational one must be given by those who have access to the same value system and the same forms of reasoning and who would concur with the *free* choice that has been made" (Benson, 1990, cited by Davies 1991, p.44, author's emphasis).

Davies' ideas about the possibility of an agentic 'self' are helpful in the analysis of the contradictory positionings available to and taken up by the girls in the discursive intersection between gender and risk. The first point I want to make is that of the affirmation of agency in the scientific discourses produced around the notion of risk. As it is repeatedly emphasized in this thesis, contemporary discourses of risk are

underpinned by the assumption that individuals are free to choose between safe and risky options. In having authority over their actions, individuals are expected to be able to make the right decisions with regard to their safety and well-being. Risk-avoidance ('risk' in scientific terms) is the only alternative for the 'free-chooser' if she/he is to be accepted among those who are morally and politically correct.

If we take Davies' description of humanist discourses, we may argue that this type of discourse is humanist, in that it describes a subject that rationally chooses what to do, and thus, who to be. Agency seems to be seen by risk experts as the ability to act intentionally. In the case of women there is a serious problem here. Scientific discourses of risk take for granted everyone's ability to do what they intend to do. The problem is related to the conception of agency. By affirming the importance of language in the production and re-production of the dualism male/female, from which it is difficult to escape when we think and act, Davies traces a parallel between the definition of agency in humanist discourses and that proposed by post-structuralism:

"To think of agency while the male/female dualism is intact is to think, inevitably, in terms of male, other-than-female heroic individual who stands out from the crowd, whose life is the stuff of history. To conceive agency once the male/female dualism is abandoned is to think of speaking subjects aware of the different ways in which they are made subject, who take up the act of *authorship*, of speaking and writing in ways that are disruptive of current discourses, that invert, invent and break old bonds, that create new subject positions that do not take their meaning from the genitalia (and what they come to signify) of the incumbent." (Davies 1991, p.50, author's emphasis)

Humanist discourses, Davies suggests, do not take women as agents (Davies 1991). In thinking of risk experts' discourses, I would agree with Davies, but only partially. I would say that in their own terms technico-scientific discourses on risk actually take women (as nearly everybody else) as agents (see pages 47-55). That is, risk discourses are apparently congruent with the definition of agency taken by their authors, 'agency' meaning 'power to choose'. We may disagree about what agency means but cannot help recognizing that we may find internal coherence in others' discourses. In the context of HIV/AIDS, for example, the idea that women (like men) are free to make autonomous and rational decisions with regard to sexual risks is quite common.²⁶ Of

²⁶ See pages 65-85 for a discussion of how the problem of HIV/AIDS sexual risk has been defined by the technico-scientific discourses of health promotion.

course, by considering my knowledge background (academic, empirical and personal) I cannot accept the assumption that women have the power to do what they want in sexual encounters. So, to me, in their own terms, the scientific discourses of risk that are applied to sex, particularly those targeting women, are based on an 'imaginary' female agency. Safe sex campaigns focused on female assertion often neglect the power imbalance that usually permeates female/male relationships. As it has already been argued, what is presumed to be woman's power within heterosexual relationships is not more than an "apparent or potential power" (Browne and Minichiello 1994, p.248). But if I have reservations with the 'agentic woman' of such discourses, the same happens with Davies' propositions concerning female agency.

Women, at least the ones who I talked to, were very far away from post-structuralists' discourses and their proposals of innovative ways of subjectivity production. Actually, if we are to compare the influence of humanist and post-structuralist thought in the ways the girls positioned their 'selves' during the focus group sessions we can perhaps say that the former is more influential (probably because it is more easily available) than the latter. Post-structuralists' discourses are still largely limited to the academy, and even academics (like myself) are still struggling to understand and make the best use of it (both at a professional and personal level). In sum, what I am trying to say is that both views of 'agentic woman', the one of the scientific discourses of risk that are applied to sex and the one described by Davies, are still products of our imagination, perhaps dreams.

As a political project towards women's emancipation I can share with Davies a discourse in which women are to be discursively positioned as agents in sexual encounters. Nevertheless, there is still a lot to be done until the girls who I talked to can reach the point of speaking themselves into existence as agents in their sexual relationships with boys/men. For now what I can perhaps do as a starting point of such a project is to uncover with my analysis the dangerous contradictions produced in the intersection between discourses of gender and risk; the first positioning girls/women as subordinated to boys/men and the second affirming female agency without breaking out the hierarchy of gender that makes sex a terrain of male dominion.

Before going on any further, I still want to remark that it is not the case that the girls who I talked to ever tried to disrupt or invert current discourses of risk and gender with their talk, which proves that they can create new subject positions for themselves within such discourses. The problem is, however, that their agency was spoken into existence without the consistency necessary to break up old and powerful discourses of gender. As Davies herself recognizes, agency is "...a discursive position that can be occupied within one discourse simultaneously with its non occupation in another" (1991, p.52). The discursive taking up of an agentic positioning with respect to sexual risks management was usually dismantled by a discourse of subordination attached to the female condition of the subject.

In sum, informed by a feminist post-structuralist perspective, the process of data analysis that will be described below was not an attempt to find the truth about the girls' ways of seeing the risks of sex and HIV/AIDS risk, but to explore the diverse perspectives through which their risk discourses were produced and communicated during the focus group sessions.

Data Analysis Procedures

In spite of the diversity of books on qualitative data analysis, specific instruction on how to analyse focus group material is still underdeveloped (Frankland and Bloor 1999). By being essentially qualitative focus group data analysis follows basically the same procedures of the analysis of data collected via other qualitative methods (Miles and Huberman 1994; Strauss and Corbin 1998). There is more than one way of carrying out qualitative analysis. Textbooks on qualitative methodology are full of examples of how to do that. Also, there have been few publications reporting focus group research that give an idea about the way the researcher (s) proceeded the analysis (although in general this is not the main objective of the author).²⁷

The 'modus operandi' of my fieldwork favored one of the most traditional principles of 'grounded theory', which is that of the systematic analysis of data throughout the research process (Strauss and Corbin 1998). 'Grounded theory' means theory grounded on data, that is, the researcher does not begin a project with a preconceived theory in

²⁷ See for example Frankland and Bloor 1999, Green and Hart 1999.

mind, but lets the theory emerge from the data (Strauss and Corbin 1998). The notion of a wholly grounded theory has been much criticized, for the idea that researchers can start their researches without any theoretical reference is problematic (Stanley and Wise 1993). However my work is grounded on data in the sense that that it is data-led.

While the data analysis accompanied the whole process of data collection, there was a moment in which the analysis was refined and more explicit theoretical findings began to emerge. This moment of the analysis had two basic stages: (a) data coding and (b) data interpretation.

At the time of the coding I was already very familiarized with the data. Nevertheless, the complexity and richness of the focus group material made the data analysis surprisingly difficult. As Kitzinger (1994a) appropriately suggests in “Focus groups: method or madness?” to analyse the amount of data generated by the 24 focus group sessions I had conducted seemed to me something like ‘madness’. The author, herself a focus group researcher, affirms that focus group data “...is not the kind of data that are easy to quantify or even to classify” (Kitzinger 1994a, p.159). She talks about contradictory data, interrupted statements, and incoherent points of view to give a picture of focus groups material as sometimes messy. It was precisely that type of data that I had to make sense of.

Morgan (1997) affirms that one important question to be considered in the coding of focus groups data is which unit of analysis to use. For the author, “neither the individual nor the group constitutes a separable “unit of analysis”; instead, our analytic efforts must seek a balance that acknowledges the interplay between these two “levels of analysis” (p.60. authors’ emphasis). I assume that I managed to maintain the balance suggested by Morgan by coding all mentions of a given topic as either originating from individual or group-produced discourses. As Morgan himself suggests, coding all mentions of a given theme will also reveal if it is a specific individual or a given group that is making the point.

Following the traditions of qualitative research I started the analysis with the “open coding” procedure (Strauss and Corbin 1998, p.102). “Open coding” is a procedure in which “data are broken down into discrete parts, closely examined, and compared for similarities and differences” (Strauss and Corbin 1998, p.102). However, when I cut

selected extracts of the transcripts from my computer's screen and pasted them into a different document/file, the data seemed to lose part of their meanings. I got the impression that outside the context where they were produced they did not make the same sense. This should not be a surprise since the research was designed to explore risk meanings as well as links between meanings and contexts. I was counting on group interactions to provide information about 'how' risk meanings were produced. The only way I found to cope with this problem of maintaining the links between quotes and context was to attach to each quote removed from the main text memos describing briefly its contexts.

The coded quotes were grouped into categories and sub-categories. When I thought I had a fair idea about which categories of data were gathered in the focus group sessions I started another stage of the analysis in which connections between categories were established, resulting in the interpretative framework upon which my thesis was developed. In which ways could the data be read in order to provide answers to my research questions? Starting from that I concentrated the analysis on the framework used by the research participants themselves to make sense of the HIV/AIDS sexual risk. I found out that it was mainly around 'self-governance', 'choice', 'knowledge' and 'being careful' that their risk discourses were produced. These categories were then taken as central to the development of my theory. Amongst an array of possibilities for the theorizing of the data I finally chose one that seemed to better summarize the story I wanted to tell. My thesis is an attempt to tell this story.

CONCLUSION

In this chapter I have tried to make clear to the reader how I collected, organized and interpreted the empirical data and why I did it in a particular way. In the next chapter I start to tell the reader about my reading of the data gathered. The chapter will be focused on the girls' accounts of everyday risks and on the picture of Brazil as a 'risk society' produced in those accounts.

CHAPTER 4

‘RISK SOCIETY MEMBERSHIP’ AND THE GIRLS’ INITIATION INTO RISK MATTERS

INTRODUCTION

In the last two chapters I have made clear my theoretical positions with regard to ways of seeing risk. I have stressed that my thesis is an attempt to expand our understandings of risk in general, and HIV/AIDS sexual risk in particular. I have also pointed out that to do this, I believe we require to do more than analyse other persons’ knowledge of risk, sexual risks and HIV/AIDS risk in the light of our own. I have suggested that what we need to do to expand our conceptions of risk is to listen to other people’s ways of seeing ‘risk’ - what they mean by that, what risks they fear most and least, which values are attached to those risks, how they assess those risks and tend to deal with them, etc. This information may provide a picture of other persons’ own ‘reading grid’ of risk matters. With this at hand we can, perhaps, start understanding other person’s approaches to risk (or what we ourselves understand by that), with which we may avoid common assumptions to be taken as ‘truths’ about why, despite all the risk information available, others keep exposing themselves to what we take as well known risks, such as the risks of sex, in particular HIV/AIDS risk.

The starting point of my research is that, despite the involvement of scientists in risk definitions, ‘risk’ encapsulates not only scientific, but also social and cultural meanings. I argue in this thesis that ‘risk’ does not exist as an objective reality. It is essentially an epistemological phenomenon, for it is constructed through knowledge. This immediately leads to the question of what counts as knowledge in conceptualizations of risk. With that in mind, my first preoccupation with the analysis of the girls’ accounts of risk aimed at exploring the perspectives through which they make sense of risk in their everyday lives. Not surprisingly, their views of everyday life were embedded in their accounts of everyday risks. I took that as a chance to highlight the issues about context raised in those accounts, which in my view constitute the girls’

knowledge about the 'risk society' they live in. This is important because it reveals the background of contextual knowledge in which the girls' approach to risk in general, and HIV/AIDS sexual risk in particular, are embedded. The analysis undertaken here constitutes my first step towards the exploration of the girls' ways of seeing the HIV/AIDS sexual risk. I assume that 'ways of seeing' a particular risk are primarily informed by 'ways of seeing' risk in general.

In this chapter I sketch out the context within which the girls make their choices in relation to sexual risks. I argue that the girls are very aware of the material context in which they make their choices with regard to how to behave, what to do and value or who to be in everyday life. The girls have an incredible knowledge about the menu of options available in such a context and of the possible threats that specific choices may represent to personal safety. They are also aware that they cannot escape making choices, for this is what everybody else does for the organization of personal life and the fulfillment of personal goals.

To know the structure of the social context generates consciousness of a reality in which there is no risk-free choice. This imposes the need for constant monitoring and assessment of the risks attached to personal decisions. The data analysis shown in the present chapter suggests that in such circumstances the girls are forced to choose not between 'risk' and 'safety', but between different kinds and levels of risk, all embedded in what I call 'risk portfolio'. The girls know that life carries multiple risks, which are not detachable from each other and so cannot be taken as isolated, but interrelated problems. Throughout this thesis I will call this association of risks a 'risk portfolio'. The risks included in the risk portfolio depend on the background of knowledge and values that set the boundaries of the risk context considered. For instance, as we will see in the next chapter, 'risky sex' includes many possible and interrelated dangers seen as part of sexual encounters, ranging from emotional to moral to physical harms (see Fig. 2, page 194).

I will start my analysis of the contextual knowledge that informs accounts of everyday risks by looking at the girls' lists of 'top ten' risks. After that I will analyse the discussions generated by the need to find a consensus about what to include in this list and how to position the risks within it. This analysis will provide data about the epistemological nature of risk, for it will expose some of the elements of the

knowledge background that underpinned the girls' conceptions of 'everyday risks'. I will argue that the girls' knowledge of the structure of Brazilian 'risk society' strongly influences their definitions of and approach to 'everyday risk'. The section will be divided into four sub-sections: education, social inequalities, gender relations and neo-liberalism. These are the aspects of the structure of Brazilian 'risk society' that are commonly addressed in the girls' accounts of everyday risks. In the final section I will point out some of the meanings of risk that appeared in those accounts.

THE 'TOP TEN' RISKS OF EVERYDAY LIFE

It has already been argued and empirically documented that 'risk' can be conceptualized in various ways (Green 1997b; Memon 1991; Moore and Rosenthal 1991; Rhodes 1997) and that lay understandings of risk can be distinct from those of experts (Grinyer 1995; Kaufert and O'Neil 1993). Following these sociological arguments, my thesis assumes that it is problematic to develop theories of risk behaviours, like HIV/AIDS sexual risk-taking, drawing strictly on scientific understandings of 'risk' (see section on page 47). As Heyman (1998a) remarks, the term risk is, in spite of its scientific origins, no longer an exclusive 'property' of science since it is nowadays widely used by the public. Once incorporated into culture at a large, the concept of risk becomes subjected to transformations and, apart from its continued and specific use in scientific discourses, it is now a cultural resource in the modern negotiations of day-to-day life (Heyman 1998a).

The pervasiveness of risk in the life routine of contemporary Western societies means that we are always seeking and getting information about the risks of living (Giddens 1996). The same knowledge background that informs our sense of everyday life also informs our ways of seeing the risks we face in everyday life. Our 'ways of seeing' and attitudes towards risk vary according to, for example, what has happened to us in everyday life and what we expect, feel, know and care about in our lives. We would not be able to understand scientific information about the risks of genetically modified crops if we had not have acquired previous knowledge about the importance of food for health, about genetics, about plantations, experiments, etc., just to cite the most general knowledge that we have to mobilize in order to make sense of risk. Consequently, I decided to start my analytical approach to the issue of 'how the girls

see the HIV/AIDS risk in heterosexual relationships' by exploring their general understandings of 'risk'. I was assuming that the girls' understandings of specific risks, like the HIV/AIDS risk, were initially informed by previous knowledge of risk matters.

In one of the first focus group sessions I asked the girls to list ten risks they run in their lives, taking into consideration the possibility of these risks becoming reality. I assumed that the perception of the chance of a risk becoming reality gives importance to it. The more the chance of a risk becoming reality, the more concern it generates and the more its importance. The first one would then be the one that was most likely to occur. Neither group could find a consensus with regard to the 'top ten' risks. Their lists contained only nine risks. In the end, the list resulted from a negotiation of arguments between the girls and was accepted by the majority. The hierarchy of everyday risks established by the first group was:

- (1) to be assaulted or robbed,*
- (2) to have an accident,*
- (3) to die,*
- (4) to lose someone we like*
- (5) to catch a disease (including AIDS),*
- (6) to be disillusioned,*
- (7) to lose our boyfriend,*
- (8) to get pregnant,*
- (9) school failure.*

The second group listed similar risks but positioned them differently:

- (1) to die,*
- (2) to be happy,*
- (3) to be betrayed and disappointed,*
- (4) to hurt somebody,*
- (5) to catch a disease (including AIDS),*
- (6) to be assaulted or robbed,*
- (7) to get pregnant,*
- (8) drugs,*
- (9) loneliness.*

The analysis of the two lists shown above leads to two immediate insights. First, just by looking at the risks listed, we may visualise the context in which the girls experience everyday risks. Second, we may deduce that the production of a list of 'top ten' everyday risks implies the judgment of the values attributed to each risk, values that I believe are learned from everyday experiences. By saying that, I want to argue that to share a common knowledge about the context in which they live is a condition for the girls to be able to produce a joint list of everyday risks like the ones shown above.

It is worth noting that the risks strictly related to sex appeared only once in the lists of the 'top ten' everyday risks. Although the presence of pregnancy among these 'top ten' risks denotes its importance in the girls' lives, its location at the end of the list suggests that it is secondary to other risks. In the collective 'ways of seeing' their reality, the girls consider pregnancy as a risk they are less exposed to. Another point to note is the location of AIDS, which appears among other diseases, in the fifth place in the hierarchy of everyday risks. This indicates that AIDS is just one more possible risk but one that does not have much relevance considering all the other risks that constitute the girls' day-to-day risk portfolio. The relevance of sexual risk is then relative. As we will see in this thesis, 'risk' is not assessed in isolation from all the other possible dangers that are seen as probable threats of the same risk situation or context. For that, I conclude that conceptions of risk are relational. That is, in the definitions of a certain risk it is included the meanings and values of the other risks that are equally perceived as present in the same context. In my view 'risk' is a relational concept because to live in a 'risk society' makes it impossible to be exposed to a single risk, but not only for that. Also, as we will see throughout this thesis, it seems that 'a single risk' is *'per se'* a combination of a number of possible dangers.²⁸ 'Everyday risks' and 'sexual risks' are both systems of associated dangers, which I call 'risk portfolio'. Considering the contextual nature of risk, I take the latter as an element of the former. These issues will be further discussed in the next chapter where I analyse the girls' accounts of 'risk' as applied to sex.

As a Brazilian I recognize that many of the risks listed above are indeed fears that are nowadays shared by most Brazilians. In the next section I sketch out the context of

²⁸ See examples of this on Fig. 2, page 195.

everyday life that appears inherent in the girls' discussions about everyday risks. I will also show some examples of how difficult it was to reach a consensus about what to include in the list of 'top ten' risks and how they should be ranked. As we will see, the difficulties basically originated from the existence of different backgrounds of knowledge and values upon which personal positions were adopted.

THE KNOWLEDGE OF THE CONTEXT AND THE EPISTEMOLOGICAL NATURE OF RISK

The task of preparing a consensual and hierarchical list of everyday risks made the epistemological nature of risk explicit, for it was necessary to defend personal positions in favor of the importance of certain risks and to the detriment of others. The background of knowledge and values against which the risks of everyday life were assessed was then exposed. As Douglas (1990) argues, to make sense of 'risk' implies the need to evaluate the probability of the realization of an event and the magnitude of its outcome. The way people see 'risk' depends on the value they give this outcome in comparison with other things they value in life. Although we may consider personal ways of seeing risk as partially resulting from individual thoughts, we cannot forget that the process of thinking is dependent on the social and cultural context within which it is embedded. If this is true, then, the girls' ways of seeing risk are attached to their ways of seeing the context in which 'risk' is to make sense.

Diverse evaluative criteria were used to take decisions with regard to the presence or position of certain risks in the list. We can see that the personal values that underpinned personal judgments were always presented in a certain contextual frame, even if sometimes this was not explicit. For example, there were disagreements about the probability of the realization of certain risks, such as the risk of being robbed and contracting a disease. For sure, this probability calculus could not be carried out without taking into consideration the knowledge of the routine of everyday life.

"Marta - I think that robbery could be before the risk of diseases..."

Katia - No...

Fatima - You can be robbed at any time...

Maria - Yeah...

Suzana - But it's easier to get a disease...

Katia - *Yeah, to me it's also easier to get a disease...for example, I've got sick many times but I've never been robbed.*

Marta - *Yeah...everyone is subjected to the risk of catching a disease...no one is safe."*

Some girls made their judgments on the basis of the knowledge of past experiences, like Katia who considered the risk of diseases as more important than the risk of being robbed because the former had already become reality in her life more than once and the latter had never happened. Without giving much importance to having experienced a robbery or not, Fatima, however, took into account the knowledge about the frequency of her exposure to the risk of being robbed as a reason for considering it more important than getting a disease. The evaluation of the frequency of risk exposure - "*you can be robbed at any time*" - was certainly also based upon Fatima's knowledge of the context where she lived.

There were also disagreements about the possibility of personal exposure to the risk of pregnancy. This time, however, past experiences and the frequency of personal exposure were not the explicit motives of disagreement.

"(...) Claudia - Let's put 'to get pregnant' because everybody mentioned that...

Dora - Well, I don't know...does everybody agree that all of you run the risk of pregnancy?

Vera - I don't.

Tania - I agree...I'm a woman...

Ines - Yeah...me too...

Vera - I don't take this risk...

Ines - Ah...an unwanted pregnancy can be...

Dora - It's only Vera that thinks she doesn't run the risk of pregnancy?

Julia - Me too...."

In the discussion shown above, two criteria seem to underpin the acceptance or not of 'pregnancy' as a communal everyday risk. The first one had to do with the judgment of the future consequences - 'I won't get pregnant' - of present actions - because "*I don't take this risk*". In that case, the risk of pregnancy was judged as irrelevant because it simply did not exist. The other criteria originated from a wider background. To get pregnant could actually be a possibility as 'pregnancy' was, in theory something attached to women's nature.

The assessment of the risk of school failure was carried out on the basis of a combination of an analysis of past and present actions and their related consequences.

“Julia - I wouldn't put the risk of school failure, because I've never failed and I think I'll never have bad results at school...I think I take it too seriously...”

Claudia - Of course we run this risk...

Tania - Claudia is saying that because she has already failed twice...

Julia - Yeah...

Claudia - Ok...but this can also happen to you...it's a risk...

Julia - Not for me....”

To Julia, the risk of school failure should not be included in her everyday risk portfolio, as she did not see herself as someone subjected to having bad results at school. So, this was a risk that did not exist in her life. To Claudia, however, it was easier to admit the risk as she had already had past experiences with failure at school.

The girls' ways of seeing everyday risks were produced against different backgrounds. The use of distinct backgrounds resulted in distinct interpretations of everyday risks and added complexity to the process of making sense of the risk in question. It may well be that in day-to-day life the girls use different backgrounds to interpret different risks, similar backgrounds to interpret different risks or, yet, different backgrounds to interpret similar risks. Each background may contain specific knowledge about the elements of the structure of everyday life that are, in certain ways, related to the 'risk' in question.²⁹

My argument about the influence of values in the girls' discussions on how to organize the list of the 'top ten' risks does not only refer to the sort of judgment that was obviously involved in decisions on how to locate the risks in a specific order. I consider that value judgments also underpinned the definition of risk itself. In the conversation shown below we can see how the use of value judgment worked in both ways, either to define what risk is or to establish its relative position in the 'hierarchy of everyday risks'.

“Maria - I think that in my case it's first the risk of happiness before that of being disappointed.

²⁹ For a discussion of the dependency of the notion of risk on knowledge see pages 37-64.

Suzana - *No...I run the risk of being disappointed more than that of being happy...*

Katia - *I don't know...maybe it's the two at the same time, because at the same time that we run the risk of being disappointed, we also run the risk of being happy...*

Suzana - *Ah...we are much more likely to become disappointed...we may not pass the 'vestibular' [a kind of exam every student, who is in the same year as the girls, has to pass in order to get a place in university], so we may not get the job we want and we may not have the money to buy the things we want...*

Marta - *No...We have many good things in life. I have my family, I have friends, I have a house...Everybody has that, including you Suzana...Although you might not have everything in life, you have to put value in things you have and not in things you don't have...*

Maria - *Yeah, I agree."*

Suzana's interpretation of the risk of "*to be disappointed*" illustrates the judgmental character of 'risk' and the importance of the knowledge of the context in the determination of the relative value of each of the risks of everyday life. To Suzana, the risk of being disappointed could be realized if she did not pass the 'vestibular', an exam that she would be doing soon. This would result in her not getting a job and not having money to buy what she wanted. To Brazilian adolescents, competing for a place in the university is perhaps the biggest challenge of all. There are not vacancies for everybody in good universities and in universities where one does not pay fees, so the level of competition is high.

The 'vestibular' represents the possibility of realizing personal and familiar life projects, as graduation is regarded as key to a promising professional future. The exam is so important in Brazilian family life that it is not unusual to see parents accompanying their sons or daughters to the sites where it takes place. The parents want to give their children support. They want to participate as much as they can in such an important moment of their children's lives. The 'vestibular' means competition and, as such, generates anxiety and puts a lot of pressure on adolescents. The exam is also a kind of rite of passage through which the youngsters are supposed to prove their maturity and readiness to becoming adults. After passing the exam they are going to enter a new life, in which education is no longer imposed, but personally chosen by the student, according to her/his interests.

Apart from personal values, there are also social values attached to the ‘vestibular’. Those who succeed are regarded as ‘winners’ and their names are listed in the newspapers. To Suzana, to take such an exam was of a high risk. She was aware that her chances of being successful were low because she had been studying in a state school in which the ‘quality’ of education did not meet with the high standard required to compete with students from independent schools for a place at university.

It is therefore easy to understand why, to Suzana, who was about to take the ‘vestibular’, being successful was so important. One can also see why she valued the exam so much and selected it as the key element of the risk of disappointment or the element around which its meanings were defined. Considering that the risk of disappointment depended on her performance in the ‘vestibular’, the probability of its realization was regarded as very high.

Differences in the values attributed to various aspects of everyday life resulted in distinct definitions of everyday risks. For instance, although all the other members of Suzana’s group were also preparing themselves for the big event of the ‘vestibular’, none of them defined the risk of being disappointed in terms of the probability of their failure in it. Teresa, for example, defined the risk of disappointment as attached to the possibility of romantic disillusion, a risk that perhaps Suzana could not consider, since, at that time, she did not have a boyfriend:

“Teresa - For me, the risk of disappointment has to do with having a disillusion with my boyfriend... For example, if he betrays me...you know, you would be disappointed in this case, wouldn’t you?”

To Marta and Fatima, the risk of disappointment was also to do with possible problems with romantic relationships and disillusionment:

“Marta - When I think about that [the risk of disappointment], I think about the possibility of finding out that my boyfriend is not faithful or that I shouldn’t have trusted him...Yeah...definitely...I would become very disappointed.

Fatima - In my case it’s the same thing...if my boyfriend betrays me...ah...what a disappointment!”

The difficulty in reaching a consensus apparently confirms the idea that ‘risk’ is not an objective construct as it is perceived against a background that is selected through a value-laden decision (Douglas 1990; Douglas and Wildavsky 1982; Gibson 1986;

Heyman 1998b; Rhodes 1997). It also suggests that everyday risk assessments are carried out 'in context'. As I commented earlier (see page 134), the girls assessed the importance of a given risk, taking into consideration the relevance of other risks they 'knew' were also possible dangers of everyday life. All those dangers were included in a sort of portfolio of everyday risks that were taken into account when the need arose to assess a certain risk. It appears, then, that the girls' approach to risk was indeed, as sociological theories suggest, based upon a background of contextual knowledge and values (see pages 38-53).

Drawing on the girls' discussions about the risks of everyday life, I now want to concentrate my analysis on the context that these discussions delineate. The data shown above suggests that the girls had a fair knowledge of the material reality of Brazil, where they learned what to value and what there is to be risked in life. While discussions about everyday risks did not focus on one specific element of the structure of the Brazilian society, some themes were more commonly addressed. Education, social inequalities, gender relations and neo-liberalism were the most common themes. I will start by discussing the girls' knowledge of the situation of education in the structure of Brazilian society.

Education

Suzana's definition of the risk of disappointment as meaning 'failure in the vestibular', gives an idea of her knowledge not only of the Brazilian educational system as a whole but also of her and her peers' position within it. The public educational sector is commonly not prepared to provide the level of education that students need in order to be successful in the 'vestibular', unless competition to gain access to a chosen course and/or university is low. Usually, low competition arises when the exam concerns independent universities, which are very expensive. Even in that case, chances of success are more restricted to courses in which the competition is low. Public universities have the highest status in the Brazilian educational system and among Brazilian people. So, it is to public universities that Brazilian families want to see their children.

The ‘unequal’ preparation of students from public and independent schools for the ‘vestibular’ results from accumulated gaps in the quality of primary and secondary education. Similarly to other public institutions, public schools in Brazil have been affected by a lack of state funding. The schools are generally poorly equipped in terms of teaching resources and do not have the capacity to follow the technological advances in teaching materials. Libraries are inadequately stocked and teachers have very low incomes. The public educational sector has additional problems, like the chronic problem of illiteracy which has been inherited from the past and, without an efficient solution, has passed on from generation to generation. Although a slow decrease in illiteracy rates has been recorded since the beginning of the 20th century, an increase in absolute numbers of adult and young illiterates, from 18.7 million in 1980 to 19.2 million in 1991, can be observed (Brasil 1991).

Only 56% of the Brazilian children reach Year 5 of Primary School (which comprises eight years), while, according to UNICEF (1995), the percentage should be 85% for the Brazilian level of per capita gross national product. The children who do not reach Year 5 are usually those from poor families. The need to work and grade retention are the main reasons for academic failure and school dropouts.

Academic failure is mentioned in one of the lists of ‘top ten’ everyday risks. It was the focus of the discussion shown above between Julia, Claudia and Tania about whether the risk of school failure could be considered a personal risk or not. To Claudia, “*school failure*” was a an obvious risk for her and her peers - “*of course we run the risk*” - , for they were all sharing the same educational environment in which not only she had already failed twice, but others had too. The disagreement of Julia about the inclusion of the risk of “*school failure*” as an element of a joint list of everyday risks was underpinned by a comparison between what she considered conditions for school failure and her perception of her own school performance - “*I wouldn’t put the risk of school failure, because I’ve never failed and I think I’ll never have bad results at school...I think I take it too seriously*”.

On another occasion, Vera complained about the insistence of Ines on talking about education as “*a promise of a good future*”:

“Vera - *Please don’t say that...you know that’s not true. You cannot compare our school with independent schools. How many of us will really*

be able to get a degree in the course we want and get a very good job and a very good salary? ...For example, even if I wanted I wouldn't be able to do Medicine, for this is not for us...

Ines - *Why not?*

Vera - *Because, you know...A friend of mine said that most of the people who pass the 'vestibular' for Medicine are sons or daughters of doctors.*

Ines - *But that's not fair...*

Vera - *Of course not...."*

Other examples of the girls' knowledge of the situation of education in Brazil emerged in their discussions about other types of everyday risks, which suggests that their knowledge of the context where they experience everyday risks is not fragmented. For instance, the problems with the educational level of the Brazilian population were considered as related to those concerning health. Marta's reply to Suzana's comment that many poor adult women still become pregnant despite having free access to medical advice and contraceptives was: *"What do you want? Most of them do not even know how to write or read. How can they understand what a pill is and how to use it?"*.

Similarly, in a discussion about mothers who do not take their babies to health centers for vaccination, educational problems were once again pointed out as the causes of ill health.

"Claudia - For you it can be easier to see the problems of these mothers as just a matter of irresponsibility but I don't...

Tania - Yeah...it's not...this is because they sometimes don't understand the benefits of vaccines...because, you know, it's perhaps the case that they did not have the opportunity of getting education, to learn how to read...imagine they don't even know how to read a word...

Vera - I don't know...I think that sometimes it's because they don't mind...then their children get a serious disease and they cry...

Julia - But it's not because they don't care...I think that's because they are ignorant. And you cannot compare yourself, who is being educated, with them because they didn't have this opportunity."

The situation of education in Brazil was also discussed in a conversation about the causes of the high robbery rate in everyday life.

“Teresa - Everybody knows that to be robbed is a risk. But I disagree that robbers are always to be blamed. You cannot expect them to do otherwise if they do not have conditions of living decently...you know...they don't have money so...”

Marta - (...) Yeah...I don't know...maybe they did not get the chance of being anything but robbers because they did not get a good education, I mean, a good school or teachers who were interested in their future...

Teresa - But I also think we cannot blame the teachers...do you know that primary school teachers from public schools earn less than the minimum wage?”

As we can see, the girls' knowledge of the situation of education in Brazil was intertwined with their knowledge of the economic problems of the country and the social inequalities that it has generated. The next section focuses on the girls' specific knowledge of social inequalities-related issues like poverty and violence.

Social Inequalities

Social inequality in Brazil is seen as a trace of the colonization of the country by the Portuguese (Holanda 1973). While the year 2000 marks the 500th anniversary of Brazil's discovery, the country is still experiencing huge socio-economic disparities. The richest people become richer by the day and the poorest become poorer at the same rate. As shown in the World Development Report 1999/2000 (World Bank 2000, p.230), Brazil is the 8th largest economy in the world. Nevertheless, the country has the 2nd worst income distribution (the first is Sierra Leone; *ibid.*, pp. 238-9).

During the last half of the twentieth century, the country experienced the problem of high inflation rates. Inflation was seen as the major economic problem in the 80s and 90s, with an accredited heavy impact on the poorest groups of society and an increase in social inequalities. In 1994, the Brazilian government implemented a successful anti-inflationary policy, which was expected to reduce the social inequality gap. However, the policy, as delineated, required interest rates to be raised. This resulted in an increase in the Brazilian government debt, leading international agencies, such as the International Monetary Fund, to put pressure on the government towards a budgetary equilibrium. This has brought about large expenditure cuts on public institutions such as hospitals, schools and universities, public safety, transport systems, amongst others. The anti-inflationary measures have subsequently had a great impact

upon the quality of life of Brazilian population as a whole. But it has been the poorest people, who rely heavily on public services to survive, who have suffered most.

Considering once again the lists of 'top ten' everyday risks, we have learnt that the risk of "*to be assaulted or robbed*", of "*to have an accident*", of "*to die*" and "*to lose someone we like*" can all be related to the social inequalities of the Brazilian society. For instance the risk of "*to be assaulted or robbed*" and "*to have an accident*" is part of the climate of violence that Brazilian population has increasingly experienced over the last twenty years. The likelihood of being robbed is high everywhere, although people who live in working class villas of big cities, like the girls, are more in danger because there are areas with potentially high concentration of drug dealers and/or where the police are less present. To have a car accident is also a constant danger for everyone in Brazil. Car accidents are, along with homicides, the second major cause of deaths in Brazil (Grupo Abril 1998). Brazilian highways are poorly maintained and the motorists themselves tend to drive abusively. The location of death among the first three risks in the 'hierarchy of everyday risks' established by both groups is understandable, as it is a danger that accompanies the risk of being robbed and of road accidents. It is not rare to see robbers and assaults being carried out at gunpoint and each day there are new cases of victims who are injured or even killed. Homicides and car accidents constitute 60% of the causes of death amongst young people: 25% caused by homicides and 15.3% by car accidents (Grupo Abril 1998).

"Claudia - Do you remember that guy who was assaulted in daylight near the bakery? The robber...I think there were two men...each had a gun...I'm scared to death...I fear my own shadow..."

Julia - I was not living here at that time. Did he die?

Claudia - I think so...that's why I'm always attentive when I am walking down the street, even if it's during the day...

Julia - I'm scared as well but...I always think 'what if people didn't need to rob anymore' or 'what if everyone in Brazil could have enough money to feed their children'...

Claudia - Yeah, but in that case it was because they wanted money to buy drugs..."

Although during the whole data collection process the girls always referred to risk control as primarily a personal matter³⁰, the awareness of the social causes of some risks led the girls to think also of socially and politically oriented alternatives to personal actions. We can see that they are very critical with respect to the social problems of Brazil. While they probably would not be able to talk about it in statistical terms, their perceptions of the material reality of Brazil seem to be congruent with the picture of Brazil addressed by the World Development Report referred to at the beginning of this section.

Next, I take a look at the third element of the context of everyday life that was more commonly referred to in the girls' conversations about everyday risks. The section shows the girls' knowledge about the way gender relations are organized in the context of Brazilian society.

Gender Relations

'Disillusion', 'betrayal', 'disappointment' and the 'loss of the boyfriend' appear among the 'top ten' risks of everyday life as indicators of the girls' knowledge of the structure of gender relations in the Brazilian society. For example, as shown on page 139, in the discussion about what the risk of disappointment meant to her, Teresa suggested that she trusted her boyfriend but that there was a possibility of her being eventually betrayed - *"for me, the risk of disappointment has to do with having a disillusion with my boyfriend. [...] if he betrays me...[...], you would be disappointed in this case, wouldn't you?"*.

In the same discussion, Marta also related the risk of being disappointed in everyday life with romantic disillusion. Like Teresa, Marta also positioned herself as a possible victim of betrayal - *"When I think about that [the risk of disappointment], I think about the possibility of finding out that my boyfriend is not faithful..."*. The subsequent disappointment should be the result of a mistaken faith in her boyfriend's loyalty - *"...or that I shouldn't have trusted him (...)"*.

³⁰ See brief discussion on 'everyday risks management' on Chapter 4 and a more elaborate analysis of 'sexual risks management' in Chapter 5.

In a patriarchal society like Brazil it is indeed not rare to see a man betraying his girlfriend, partner or wife. Also, considering the cultural meanings of 'woman' produced in this patriarchal structure, it is highly possible to see a woman disappointed or disillusioned due to a man's betrayal, as a woman is expected to be loyal to man, trust his words and to passively accept his acts. It is not the case that every woman and man in Brazil behave in this way but, certainly, this ideology is very influential in the organization of gender relations in the Brazilian society. To be aware of the "*way things are*" in terms of the structure of gender relations and what to expect from men within this structure leads to the idea that the only way of controlling the risk of disillusion is to monitor and control personal expectations.

"Dora - What could be done to prevent the risk of a romantic disillusion?"

Tania - Don't be too much deluded...[...]

Claudia - In the way things are nowadays, first don't delude yourself, in order not to be disillusioned later [the girls laugh]."

As in other patriarchal societies, gender relations in Brazil are organized in accordance with the ideological structures of the patriarchal tradition, in which the question of power is fundamentally important. It is on the basis of power differences that the system of hierarchical relations that frames the relations between Brazilian women and men comes to be constructed and socially legitimized. Within this gender hierarchy, men occupy a position of authority and domination, while women are distinguished from men through their position of submission and subjugation (Parker 1991).

This gender hierarchy obviously impacts upon the sexual morality that regulates men and women's sexual behaviour. In a context of dual morality, Brazilian men experience an almost complete sexual freedom, while women's sexual life is expected to be limited to stable relationships and marriage. The patriarchal nature of gender relations in Brazil also provides specific coordinates for men's and women's sexual behaviour itself - man is to be the 'active' subject of the sexual act, whereas woman is to be its 'passive' object (Parker 1991). It is also along those lines that the cultural meanings of masculinity and femininity are produced. The quotation below shows how those meanings can be applied to the definition of the risk of disillusion as an everyday risk.

"Fatima - Look...I have a story of disillusion to tell and I think that in the world we live almost every woman has a similar story to tell. This happens every day. That's why I said that women are always at risk of being

disappointed. My boyfriend once kissed another girl and it was his own niece that told me that...then he said that it was the girl's fault and that he didn't want to upset me with that story...Ok, although I was very disappointed I believed in him...that time I forgave him...but if he did that again then I wouldn't forgive him...and he...I don't know if he would forgive me...I think that man think that forgiveness is a feminine thing...I don't know maybe it's men's personality or this thing of being 'macho'...I think that he wouldn't forgive me".

As the data analysed in the next chapter will show, the girls' knowledge of the patriarchal structure of the Brazilian society can be unconsciously and consciously used to make sense of and respond to the risks of heterosexual sex. We will see that amongst the risks of sex are included the dangers associated to the gender hierarchy that organize heterosexual relationships. Those dangers are all constitutive elements of the 'sexual risk portfolio' (see page 195).

Apart from the knowledge about the situation of Brazil in terms of education, social inequalities, violence, poverty and gender relations, the girls also demonstrated they had a very good knowledge about the political ideology that is behind the Brazilian government nowadays. Although the next chapter will give special attention to this issue, I could not finish the present chapter, whose purpose was to sketch the structure of everyday life that is embedded in accounts of everyday risks, without mentioning the girls' knowledge of neo-liberalism.

Neo-liberalism

The girls did not talk openly about the neo-liberal government that rules Brazil nowadays. Nor, did they mention the expression 'neo-liberalism' as such. It is their emphasis on the individual management of everyday risks that I take as indicating an implicit knowledge of the predominance of neo-liberal ideas in the organization of everyday life in Brazil. As I argue throughout this thesis (see pages 15-16, 167, 184, 190, 216), 'the care of the self' has a fundamental value in a neo-liberal regime, which is structured to promote individuals' freedom and independence from the state government.³¹ Next I will show very briefly how the knowledge of neo-liberal

³¹ See pages 78-79 for examples of the influence of the notion of 'the care of the self' in Brazilian public policies.

ideologies appeared in the girls' discussions about strategies for the management of everyday risks.

The emphasis on self-responsibility for risk management was evident, for example, in the case of the protection strategies suggested against the risk of being robbed.

"Dora - What has to be done for to avoid the risk of being robbed?"

Tania - To walk with attention on the streets.

Vera - No...Not with attention because there are many people that walk like that on the streets and are robbed...so don't walk on the streets anymore...then it's impossible...

Ines - Ah...don't walk on the streets always alone...

Tania - Yeah...don't walk on the streets with your mind on another planet...

Vera - To walk with a group like...do not walk alone during the night...

Claudia - To carry a gun...."

The importance of self-care was also mentioned in the prevention of the risk of road accidents.

"Ines - [You've got] ...to be careful. "

"Tania - We need to pay attention to what we are doing..."

"Marta - A car accident usually happens because the driver is not careful enough or because the person who is crossing the road mistakenly thinks that it is safe to cross the road...we need to be careful with those things."

The same emphasis on the individual ability to look after the 'self' was also shown in the case of the prevention of the risk of disillusion.

"Suzana - We cannot trust a man...it is a mistake to trust man...we cannot assure that he will be faithful...make sure that you don't trust him, this is the only way of avoiding the risk of being disillusioned."

"Teresa - I trust my boyfriend...but I think I shouldn't...if you trust him and he betrays you the disillusion is very painful, I know that...I think that if he betrays me I will not forgive myself for trusting him...."

When I tried to extend the discussion about risk prevention beyond self-care, at first the girls kept their position.

“Dora - Does the prevention of everyday risks only depend on us?

Tania - We have to ask the guy ‘please don’t rob me’...

Claudia - It depends on both of them [the robbed and the robber], doesn’t it?

Julia - But we can only think by ourselves...we can’t think for the others....”

“Dora - We always think that the responsibility is ours.

Marta - Yeah...

Dora - If we think a bit more we’ll see that actually it’s not only our responsibility...

Maria - Yeah but we can take care of ourselves, can’t we?. ”

As I insisted on other strategies of risk prevention, the girls started to think about the social roots of their day-to-day risks.

“Dora - We’ve been saying that risk prevention depends on us...do not walk alone on the streets, to close the front door, the risk always depending on us. Is there any other factor that influences the risk?

Suzana - The government...”

“Maria - I think that diseases depend also on the social condition.”

They also started to consider socially and politically-oriented alternatives to the proposed individual solutions.

“Marta - The robbery, I think that...first the education and the social condition...[...] Here in Brazil [...] the social condition is horrible, there is much money in the hands of few people...many people rob for getting food...but [...] in a first world country, where the money is better distributed, there are robberies but less than in the third world.... ”

“Claudia - If the robbers had been treated as human beings before becoming robbers... I think this is not the case... but if they had had a good life, then I think they would not rob...Ok, we have to take care of ourselves but we wouldn’t need to be afraid of robbers if they didn’t exist. I’m sure there are robbers that would give up if they could get a decent job.... ”

Although the girls demonstrated a good level of knowledge about the social problems faced by Brazil and about the influence of those problems on the risks faced by the Brazilian people, they nevertheless insisted on defining the management of everyday risks in terms of ‘self-care’. It seems that the social and political consciousness lost its

importance, as the sense of individual power over the circumstances of private life and of self-governance looked more appealing. Apparently, although the state was believed to be responsible for the lack of ‘better education’ and ‘a better distribution of money’, this had only to do with the prevention of public risks like ‘diseases’ and ‘robberies’. When it came to the personal risk of contracting a disease and being robbed, then, the ‘self’ was seen as holding the responsibility of risk prevention.

By being socially constructed, conceptualizations of risk are impregnated with the social ideologies that organize everyday life. As many have argued, in contemporary western societies the ‘self’ has been subjected to new forms of governance (Castel 1991; Giddens 1996; Nettleton 1997; Ogden 1995; Petersen and Lupton 1996; Rose 1989). These new forms of governance, “...the means by which we fashion our thoughts and conduct” (Nettleton 1997, p.320), have emphasized individuals’ accountability, encouraging people to take care of themselves. The modern ‘self’ is to be accountable for making informed decisions and acting upon rational choices concerning its own welfare (in which is included the management of personal risks). This discourse is particularly articulated through neo-liberal philosophies (Petersen and Lupton 1996), which are at the core of a number of social institutions, like those in the area of public health for example (see pages 21, and 63-65).

In a neo-liberal society, the state is no longer responsible for the welfare of the citizens. The citizens are free consumers of the available options, either with regard to housing, education or health (Nettleton 1997). They have not only the right to choose their own destiny but also, and, perhaps, more importantly, the duty to do so (Greco 1993). As Petersen and Lupton (1996) stress,

“discourses of personal responsibility and good citizenship have great appeal to the late modern subject, who has been acculturated to accept and privilege the notion of autonomous individuality [...] through such institutions as the family, the mass media, and the education and the legal systems” (pp.175-76).

Considering the girls’ good knowledge of the structure of the Brazilian society, it is not a surprise that they see the management of day-to-day risks as a matter of individual responsibility. Their understandings of risk management seem to coincide exactly with what society expects from them as young prototypes of good citizens. To ‘choose’ to be a good citizen means to ‘choose’ a particular lifestyle. It means to ‘opt’ for a

particular narrative of the 'self' that will define not only "how to act" in risk situations, but more importantly, "who to be" (Giddens 1996, p.81).

Before concluding this chapter I would like to make some considerations with regard to what the girls meant by 'risk' when talking about everyday risks. This will be an initial exploration of risk meanings. I will come back to risk meanings in the next chapter where I carry out a detailed and specific analysis of the girls' conceptualizations of risky and safe sex.

RISK MEANINGS

The first point I want to make is that although 'risk' was more commonly referred to in a negative sense, it could also mean a 'good risk'. This is what we can conclude if we consider the inclusion of "*to be happy*" in the list of the 'top ten' risks of everyday life. To run the risk of being happy may be a contradiction in terms if one follows the sociological argument that, in modernity, 'risk' has been used only in a negative sense (Douglas 1990; Gabe 1995). It is, indeed, striking to think about 'risk' as something that may have a positive outcome as it is commonly understood as 'danger'. We could maybe conclude that the girls were wrong in considering the possibility of a 'good risk' or that their understandings of what 'risk' is were mistaken. However, I do not want to argue that the girls were right or wrong, for I believe there are no 'rights' and 'wrongs' in interpretations of 'risk'. What I want to highlight is that even accepting that negative definitions of 'risk' are dominant we cannot neglect the possibility of existing definitions that take a different or opposite starting point. Also, it is likely that the same person takes contradictory starting points - risk as something bad and as something good -, depending on the type of risk that is being considered. This was demonstrated when the girls included the risk of "*to be happy*" and the risk of "*to die*" in the same list of everyday risks.

If, on the one hand the view of 'risk' as something good can be striking, on the other, this can be understood as congruent with the idea of the entrepreneurial subject, a discourse underpinned by the neo-liberal ideology (Friedman and Friedman 1980; Hayek 1944). In this particular discourse, to take risks is regarded as positive and a typical choice of entrepreneurial citizens. From this perspective, those who are

prepared to take risks are believed to have the right to the benefits coming from that, like a better quality of life, which includes higher income, better health, better education, etc. This is a strong argument, one that is difficult to contest even for contemporary theorists of equality. Those theorists have considered that privileges resulting from inherited inequalities may be wrong but that privileges that come from risky choices might be justified (Philips 1999).

Drawing on the analysis of the meanings the girls attached to 'risk', I want to make a second point. While it was not easy to establish a collective ranking of risks (which suggests variations in the way the girls understand 'risk'), the possibility of a collective labeling of day-to-day risks demonstrated that the girls shared a general level of common-sense about what 'risk' meant. If it was possible (actually, it is not) to encapsulate all the meanings the girls attached to 'risk' in just one word, this word would be 'danger'. The Concise Oxford Dictionary presents 'danger' as meaning "exposure to harm" and "a thing that causes or is likely to cause harm" (Allen 1990, p.292). "Exposure to harm", for example, seems to be a meaning implicitly alluded to in Marta's statement "*everyone is subjected to the risk of catching a disease...no one is safe*". It also appears to be what Fatima meant when she said "*you can be robbed at any time*".

In my view the girls' 'ways of seeing' everyday risks were based on conceptions of risk as something that is similar to, but not the same as, 'danger'. The most important difference between 'danger' and 'risk' seems to be related to the incorporation of 'uncertainty' into the meanings of the latter. I take that as a sign that the girls' understandings of risk are influenced by the features of modernity (Beck 1992; Giddens 1996).³² As Carter (1995) remarks, 'risk' is a concept that is more ambiguous than 'danger'. 'Danger' means an undoubted "state of peril", while "risk alerts us to uncertainties about whether the future is safe or dangerous" and "...it simultaneously points to the possibilities of security and insecurity" (p.135). As Yates and Stone (1994) points out, in its current use 'risk' incorporates the affirmation of the uncertainties of prospective actions. Indeed, we can note in the girls' accounts of everyday risks that 'risk' has ambiguous meanings. Drawing on the data gathered, I want to argue that to them 'risk' is not a definitive state of affairs in at least two senses:

³² See section on 'risk and modernity', page 38.

first, implicit in its meanings there is the idea that by means of external interference it can be annulled, reduced or increased³³ and second, 'risk' is conceptualized according to levels of riskiness - low, medium and high risk.

'Danger' is only part of risk meanings. Everyday risks include everyday dangers but not only that. What is missing in the definition of 'danger' is the attribute of 'uncertainty'. In this sense, the notion of an 'uncertain danger' can, perhaps more appropriately, encapsulate what the girls meant by 'risk'. The dangers are potentially there but if they are going to represent future personal risks or not is yet unknown. To define a certain danger of everyday life as a 'risk' there is the need to undertake a sort of probability estimation about the matter. The quotations below illustrate the view of risk as an 'uncertain danger' or as a danger that may or may not be experienced in the future.

"Vera - Tania, talking seriously, do you run the risk of getting pregnant?"

Tania- Now, now I don't ...Maybe one day.... "

"Katia - When you are in love, you cannot guarantee that you will be loved in the same way. Actually, you run the risk of not being loved in the same way...This is a possibility."

The continuation of the conversation initiated by Katia (and shown above) demonstrates how reflections about an 'uncertain future' are linked to the meanings of the risk in question.

"Dora - So, what kind of risks do you, girls, run when you fall in love? Katia has already mentioned the risk of not being loved..."

Katia - And also, the boy may not think of us...think much of himself and in his fame.

Maria - Ah...also the risk of disappointment isn't it? ...you fall in love and think that he is like you and then you realize that this person doesn't take it seriously...

Suzana - ...Of disillusion...we are full of hopes and...

Teresa - That it was just a 'moment thing' and [...]

Dora - The risk of disappointment then...

Maria - Yeah...this I think that is one of the worst...

Suzana - I think that it is the worst.... "

³³ By 'external' I mean any deliberate or non-deliberate action that changes the course of the risk event.

I want to make one last point here. It is my impression that whatever the risk in question, the meanings attached to it are relative. To me, this is only partially due to the ambiguities of 'risk' and the uncertainties that its definition incorporates. In my analysis of the girls' accounts of everyday risks I noticed that to talk about a certain risk implied considering an array of other possible dangers, known to be present in the same context of the former. Those dangers were generally directly related to the risk in question, like those considered in the discussion about the risk of 'to fall in love' shown above. The inclusion of related possible harms in the interpretation of the risk of 'to fall in love' makes its definition complex, for it can result from a varied combination of elements and meanings. Another example shown earlier is Suzana's definition of the risk of disappointment in terms of 'passing or not passing the vestibular', which is itself taken as a risk. Also, if we take the list of 'top ten' risks we can, perhaps, suggest that there was a sort of association between them. That is the case of the list that includes *"to be assaulted or robbed"*, *"to have an accident"*, *"to die"*, *"to lose someone we like"*, all in a way related to the likelihood of being subjected to violence in the event of an assault or robbery. Obviously, those risks can yet encapsulate other meanings when considered in other contexts and associated with other risks.

Although I thought it was worthwhile pointing out some issues concerning the attachment of meanings to risk, I take the same position as some risk theorists about the riskiness of defining risk (Arnett 1996; Fischhoff 1985). I did not intend then to provide a full account of the girls' definitions of risk. I consider this impossible. Even if it was possible to combine all the elements they use to make sense of 'risk' in only one definition, this would reach beyond of the scope of this study. Given its complexity, this would constitute, perhaps, a thesis on its own. In addition, the information analysed in the present chapter merely represents a fragment of the data gathered. It intended to offer a first overview of girls' general understanding of risk. The data analysis carried out in the next chapter should provide new insights, as it will consider 'risk' in the specific context of heterosexual sex. My interest in showing and analysing information that could exemplify what the girls meant by 'risk' when talking of the dangers of everyday life was to give the reader a preliminary idea of what goes into definitions of risk.

CONCLUSION

I have argued in this chapter that the analysis of the girls' accounts of 'everyday risk' illustrates the epistemological nature of 'risk'. The analysis uncovers some of the elements that constitute the knowledge background the girls use to make sense of 'risk'. The data shown in the chapter indicate the dependence of 'risk' on contextual knowledge and on the values that are attached to it. It has also shown that this constellation produces unstable, complex, varied, contingent, and sometimes contradictory definitions of 'risk'.

We have learnt in this chapter that the girls had a very good knowledge of the structural conditions of Brazilian 'risk society'. They knew about the precarious conditions of education, about the social inequalities that permeate everyday life, about the way gender relations are constituted and about the political ideology that is behind the current Brazilian government. The girls use this knowledge to make sense of the risks of everyday life, which indicates that as sociological theories of risk suggest, 'risk' is socially constructed. That is, the girls' understandings of 'risk' seem to be, indeed, produced through social, cultural and political processes (Petersen and Lupton 1996).

The data analysed here has suggested that to know everyday life as a 'risk context' means to be aware of the many risks attached to everyday life, and that there is no risk-free choice. We have learnt that to talk of a particular everyday risk implied considering many possible dangers that were seen as related to the risk in question. I have argued then that in their everyday life the girls assessed risks not as isolated, but as interrelated dangers. I called this association of dangers a 'risk portfolio'.

This chapter focused on the girls' knowledge of the structure of Brazilian 'risk society'. The next chapter will go further in the analysis of the relationship between 'knowledge' and 'risk'. It will look at the specific types of knowledge (learned also from life experiences) that underpin the girls' ways of seeing the risks of sex. Special attention will be given to the influence of the knowledge about the importance of 'the care of the self' on the girls' understandings of 'risky sex'. The chapter will show that the relevance of the knowledge about this particular aspect of the context of the Brazilian 'risk society' is not limited to its use in conceptions of 'risky sex'. It also, and

more fundamentally, informs the girls' ideas about identities within it and their own projects for the 'self'.

CHAPTER 5

SELF-GOVERNANCE AND THE GIRLS' WAYS OF SEEING RISKY AND SAFE SEX

“I think that when a woman is too pressured into it [to have sex before she is sure that he is the right guy, which is defined as risky] she ends up by thinking like that...ah...I don't know if I want...but she doesn't do it forcibly. She thinks, and then one day she decides ah I'm going to do it...but she does it with consciousness of what she's doing...but it's not forced...[...] she's going to do it because she is being pressured into it and decides to do it... [...]” (Tania).

INTRODUCTION

In the last chapter I have started my analysis of the epistemological nature of risk. By looking at the girls' accounts of everyday risks I have uncovered some of the layers of knowledge that exist behind the girls' conceptions of risk. My general aim there was to explore the knowledge that goes into conceptions of risk, when 'risk' is considered in its broader sense. In the present chapter I narrow the focus of my analysis by looking at the knowledge that goes into conceptions of risk, when 'risk' is specifically applied to heterosexual sex. I explore here the girls' conceptions of risky and safe sex, investigating the process in which those conceptions are produced. The analysis focused on 'risk' in general, and 'sexual risk', in particular, will both contribute to the development of my understanding of how adolescent women see the personal risk of contracting HIV/AIDS in heterosexual relationships.

We have learned so far that to live in a 'risk society' is an opportunity to know what and where are the risks of daily life are, and how to deal with them. Drawing on my reading of the girls' accounts of everyday risks I have argued in the last chapter that risk meanings are constituted by a shared knowledge about the social context where they live. As we have seen, to live in a 'risk society' means to experience 'risk' as a combination of probable dangers that are interconnected. I have concluded there that 'risk' is not a monolithic entity, but part of a system of interconnected dangers that are

assembled in a sort of 'risk portfolio'. This turns risk assessment into a complex operation, for it involves the consideration not of one single hazardous outcome of the risk assessed, but many. The data analysed here will show that HIV/AIDS risk is only one of the possible dangers included in the girls' sexual risk portfolios. It will also show that the value of HIV/AIDS risk is relative to the value of all the other possible dangers considered in sexual risk assessments.

In the present chapter I develop the argument that although the girls' ways of seeing the risks of sex are underpinned by a number of different social knowledges, one type of knowledge in particular is very influential on their approach to risky/safe sex. That is the knowledge about the importance of 'self-care', which in discourses of risk means 'self-governance'. In my analysis I will make the point that this knowledge is mainly learned from health promotion's discourses on risk and that this implicates health promoters in the way the girls see and respond to the risk of heterosexual HIV infection. As we will see, the girls' emphasis on self-governance has two immediate consequences. First, it generates a continuous identity work. Second, and related to that, it creates the illusory identity of 'self-governed girl', one who is to be able to control the risks of sex by making autonomous choices.

'Self-governance' is one of the principles of the ethical systems of high modernity (Rose 1989). It is, as Nikolas Rose (1989) argues, a mechanism of production of subjectivities. Those mechanisms are forms of government that act upon individuals' choices and behaviour in an indirect manner. They are mechanisms that permit an alliance between personal and institutional (or social) objectives by creating the illusion that individuals are free to choose who to be and how to live their lives.³⁴

The data gathered shows that risky and safe sex are thought and talked about by means of self-inspection, self-problematization and self-monitoring. As we will see, discussions around the meanings of risky/safe sex always involve the self (even when sexual activity is not a personal practice yet). The quotation presented at the beginning of the chapter, where Tania explains her theory about adolescent women's sexual risk-taking, illustrates the intrinsic relation between 'risk' and 'subjectivity'. By

³⁴ For a discussion on the importance of the idea of 'self-governance' in the context of health promotion see page 21.

‘subjectivity’ I mean the sense we make of ourselves according to our position within a certain context (Alcoff 1997). The quotation is an example of the association between the meanings of risky and safe sex and the notion of risk and safety as personal choices, thus of self-governance.

The first part of this chapter focuses on what the girls mean by risk when they think and talk of sex. As in my analysis of their understandings of everyday risks, I intend to get a broad overview of sexual risk meanings before embarking on a deep exploration of sexual risk meanings. The next section continues to look at the ways by which the girls make sense of sexual risks. It analyses sexual risk meanings but, more fundamentally, it looks at the processes in which those meanings are produced. The section is focused on the personalization of risky/safe sex. In the section I develop my argument about the links between this process, self-governance and the girls’ ways of seeing risky/safe sex.

MAKING A PERSONAL SENSE OF RISKY/SAFE SEX

The General Meanings of ‘Risk’

I start the analysis of what the girls mean by risky and safe sex through the more general meanings attached to ‘risk’ and ‘safety’ in the context of sex. The comparison between the ways the girls define risk/safety in the context of their everyday lives (see Chapter 4, page 130) and their ways of seeing risky and safe sex demonstrates that in the girls’ discourses of risk ‘risk’ follows general patterns of meaning. Either when contingent to the specific settings of sexual encounters or when it is applied to the more general context of daily life ‘risk’ seems to be understood as something similar but not equal to ‘danger’. Similarly to ‘everyday risk’, ‘sexual risk’ is not exactly the same as ‘sexual danger’. By saying that my intention is not to point out a definitive deconstruction of the meanings the girls attach to ‘sexual risk’. The idea is to highlight once again the complexities and ambiguities of the notion of ‘risk’.

In the quotations shown below we can note that like in conceptualizations of ‘everyday risk’, the transformation of ‘danger’ into ‘risk’ is value-laden. Probability estimations are used to ascribe value to the hazards in question.

“Tania - I don't think AIDS is a danger for me. As far as I know I don't run this risk. Ok, in theory it can be a danger...you know...but if you don't use drugs and are a virgin the risk is minimum...”

“Claudia - There are some girls, friends of mine, who don't care...they know that sex can be dangerous but they don't care...[...] Then there is always that possibility, and they know that, but I think they pretend there is no risk of getting pregnant or catching a disease like AIDS, but the risk is really high”.

Another similarity between everyday risks and sexual risks is that in both the notion of risk cannot be dissociated from that of safety. The ambiguity of the notion of risk turns ‘safety’ into an intrinsic element of risk meanings. As Carter suggests, risk “...alert[s] us to uncertainties about whether the future is safe or dangerous” and “...it simultaneously points to the possibilities of security and insecurity”(Carter 1995, p.135). To be ‘safe’ or to be ‘unsafe’ in sexual encounters is contingent to a given time and space; the same situation can be defined as ‘safe’ in certain circumstances and ‘risky’ in others. What matters is not the fact *‘per se’* - *“a friend of mine has had sex with her boyfriend without protection”* - but the judgment of the circumstances in which this fact happened - *“but I don't think that she has run any risk of catching AIDS because they have been together for two years now and she trusts him”*.

While ‘safe sex’ is referred to as the opposite of ‘risky sex’, these are not references to absolute state of affairs. According to the data gathered, in the terrain of sex ‘risk’ and ‘safety’ are always relative-*“...we cannot say ‘to have sex with this guy is safe’ or ‘it is risky’ and that’s it...you never know, it depends...”*. The contingency of ‘risk’ and ‘safety’ results in risky and safe sex being treated as provisional categories. In similar situations sex can be ‘risky’ and ‘safe’, depending on certain conditions. The conversation shown below illustrates how the relativism of definitions of risky/safe sex appears in the girls’ conversations.

“Vera - Ah...I don't know...safe sex is to protect yourself and to do it where there is no risk of somebody catching you...”

Claudia - It depends, isn't it? If it's a friend that's not so bad but if it's your mother...

Vera - But if your mother had a young mind, like my mother, then this shouldn't be a problem...that's why it depends....

Claudia - Yeah...right...I always hope that one day my mum will understand these things better. If...I'm saying if...if she changed then it wouldn't be a problem...

Julia - *Ah...to me [safe sex] is to let my mother know...If I tell her it will be safe, if I don't, then, it will become risky...*

Tania - *Ah... it depends...in my case it's the opposite, if I tell my mum, then, it will become very risky indeed".*

Considering that risky and safe sex are not detachable, my analysis will take both as encapsulating complementary meanings; the information about one may illuminate the analysis of the other. The conversation below is an example that to define 'risky sex' implies to make use of the meanings of 'safe sex' and vice-versa:

"Claudia - *For you to be safe you first have to be sure that you know the risks. When you know the risks you run, then you are able to...[...] then you can protect yourself...and when you don't protect yourself it's because you've decided to take the risks.*

Julia - *Yeah...but safe sex does not mean to know all the risks...sometimes a girl doesn't know all the risks she's run in the past and even so she doesn't catch any disease...*

Ines - *[...] And you can also know all the risks, feel safe but still risk your life..."*.

This finding about the contingency of risk and safety in sexual encounters is replicated in other studies that similarly investigated the way people assess personal sexual risks. For example, in a qualitative study carried out with gay men the authors found out that the majority do not make a once-and-for-all assessment of their personal risk of becoming infected with the HIV virus in sexual relationships with a given sexual partner (Davies and SIGMA 1992). The conclusion was that the HIV/AIDS risk assessment consisted in a dynamic process, "varying from minute to minute before and after, and [...] from second to second within the sexual encounter" (p.139).

The observation that definitions of risky sex extrapolate the meanings of dangerous sex, are not detachable from conceptualizations of safe sex, and are always relative, are the more immediate and general findings of my analysis of the girls' ways of seeing risky/safe sex. Furthermore, a closer exploration of the girls' discourses about risky/safe sex leads to the conclusion that to make sense of risky/safe sex implies its personalization. 'Personalization' here has a double sense: it means to identify risk/safety as belonging to a particular person who can be the 'other' and/or 'me'. As we will see, it is via this process of personalization that risk meanings become specifically related to sex. For that reason I will give special attention to the analytical exploration of how this process operates and to what extent it is important in the

production of meanings and ‘ways of seeing’ risky/safe sex. I will start by arguing that the personalization of risky/safe sex is the basis of sexual risk assessment.

Personalizing Risky/Safe Sex and Assessing Sexual Risks

To evaluate the risks of sexual encounters involves the prior establishment of the boundaries between ‘risk’ and ‘safety’, that is, what is ‘risky’ and ‘safe’. It is by personalizing ‘risk’ and ‘safety’ that the girls distinguish risky from safe sex. By sexual ‘risk assessment’ I mean not only the evaluation of the potential risk of a sexual encounter - ‘is it risky or safe?’ - and if risky, - ‘which risks does it comprise?’; but also, the value judgment that will establish the importance of each of the risks considered - ‘how significant are the possible outcomes of each of those risks?’. The personalization of risky/safe sex may not be a surprise since discourses on sex, with the reinforcement of the individualistic tenor of those of risk, involve the identification of the individuals who happen to be the characters of the risky/safe sex scene.

A review of research in which lay people’s ideas of risk are considered shows that the tendency to personalize risk and safety when thinking of sex is not a peculiarity of Brazilian adolescents. For instance, with the aim of investigating the construction of common-sense knowledge about the sexual transmission of HIV among heterosexual young adults, a study developed in Canada concluded that for the interviewees AIDS was “...caused by individuals rather than by a virus” (Maticka-Tyndale 1992, p.248). While in my research the girls also talked about sexual risks as located in individuals or in ‘risk objects’ (who are to be the threat to those they sleep with), the personalization of risky/safe sex was not, however, confined to the HIV/AIDS risk. It was also related to other risks included in the sexual risk portfolio like the sex-related moral risks, among others (see page 195). This suggests that the definition of ‘risky sex’ as ‘sexual intercourse without wearing a condom’ employed by health promotion is too narrow for its underlying conception of sexual risk restricts risk meanings to biomedical assumptions.³⁵

³⁵ For a discussion of the meanings of ‘safe sex’ in which it is included those of ‘risky sex’, see pages 75-77.

Evaluating the potential risk of a given sexual encounter, which happens on the grounds of personal experiences, knowledge and values, offers the possibility to adjust the available meanings of risky/safe sex to personal interests. Once put into a more familiar context, the meanings of 'risk' and 'safety' can be 're-invented'. This is illustrated in the conversation shown above (page 159), where a collective process of risk assessment constructs a definition of risky/safe sex that is very different from its 'classical' conception of 'condom non-use/use'. Risky/safe sex is defined there in terms of the danger of "*somebody catching you...*", particularly the girls' mothers.

For the girls whom I talked to, the assessment of the risks of sex involves the setting of the boundaries between 'risk' and 'safety' through the identification of 'risk subjects' (the potential victims) and 'risk objects' (the potential threats), to which I will refer with more detail later on. Inspired by Carter (1995), I use the word 'boundary' "...because it calls to mind both the idea of change occurring as it is crossed and that such boundaries are socially constructed" (p.141). Although Carter talks about the boundaries that define the space of safety within scientific risk assessment, the point he makes about the function of the 'other' in the definition of spaces of danger and safety can also be applicable to the girls' discourses of risk. According to my analysis, the 'other' plays an important role in the girls' assessment of sexual risks. It can be either the 'risk subject' or the 'risk object' of a sexual encounter. As a 'risk subject', the 'other' may represent, as Carter suggests, the person who occupies the space of danger, as opposed to the 'self' who may be located in the space of safety.

"Marta - There are many girls who don't take care of themselves...don't use a condom...[...] There are some girls who don't accept using condoms, they say that they don't feel pleasure, that it's not good, I don't know..."

Maria - Ah...that's bullshit...I would never make love without a condom".

"Maria - I think that [the girl] doesn't think so much [about AIDS as about pregnancy] also because she thinks that she knows the guy..."

Teresa - Yeah...that's it...

Maria - Ah...he doesn't have this and that, neither do I, so...this won't happen to me....

[...] Dora - Do you think like that as well or you are talking about the others?

Maria - *I think that that thing has to come out...that thing about knowing that you have to take care of yourself [...]*

Suzana - *Ah...you have to look at things in their two sides, you know...you can't look at it like ...like looking at appearances, only because he is a tidy guy [...], from a good family...[...]*”.

“Vera - *Tania, talking seriously, do you run this risk (of getting pregnant)?*

Tania - *Right now no...*

[...]Claudia - *You run, you run because you are a woman...*

Tania - *Ok, but I know how to hold myself on...*”.

The notion of risk is, as Carter argues, useful in the establishment of the boundaries of the danger/safety dichotomy because it encapsulates the idea of knowable and predictable dangers. In the conversations above, the existence of a sort of knowledge background about the dangers of sex is apparent. To have sex without using a condom, give importance to the guy's appearance, to not take care of oneself, AIDS, and pregnancy seemed to be all dangers that were known as such previously. It is these known dangers that the girls seek to assess when evaluating the potential riskiness or safety of a sexual encounter.

The identification of what is dangerous leads to that of what is safe. Given that the imperative of risk avoidance has a moral impact upon the ‘self’ (see pages 62-65), the possibility of keeping its identity away from the recognized dangers may lead to the protection of the moral integrity of the ‘self’. The space of danger can then be left to be occupied by the deviants (see page 85). “As long as we are ‘good’, [...] then danger is elsewhere, not part of the ‘self’” (Carter 1995, p.143, author's emphasis). What we will see in the analysis presented in this chapter is that, as Carter stresses, the boundaries between ‘risk’ and ‘safety’, the ‘self’ and the ‘other’ are fluid. In my view, the risk that this implies is the fact that these are boundaries that can be easily crossed, at least at an individual level. However, as Carter argues, the social control over the movement between the boundaries of danger and safety is not in the girls' hands but with the experts; their emphasis is on boundaries, not on connections. To Carter (1995), “crossing these boundaries actualises a shift from safety to danger, from ‘self’ to

‘other’. Yet the connections between these spaces remain socially obscured by their being placed in the control of the expert risk assessor” (p.145).

Carter’s contentions lead me to wonder about the various ‘selves’ and simultaneous and contradictory spaces occupied by the girls during the focus group sessions. It is indeed the case that the official boundaries between ‘risk’ and ‘non-risk’ are established by risk experts’ discourses and also that these are powerful discourses, but they are not the only discourses available. Although as members of the category ‘adolescents’ ‘girls’ are usually seen by risk experts as ‘risk subjects’, that is, those who ‘probably’ occupy the space of danger (see pages 10-11), their multiple identities give them the possibility of breaking out the scientifically defined boundaries between risky and safe sex. I am not saying that the girls are able to dissolve the dichotomy risk/safety, which is already well established, but that they can, at least to a certain extent, dislocate the transgressing point of its boundaries. I suggest that this relocation and the redefinition of risk and safety that it entails have the effect of softening the rigidity of the scientifically established risk boundaries³⁶ and that this challenges the power of experts’ knowledge. In a way, I think, we are witnessing the effects of this as risk experts have put all the efforts on ‘correcting’ adolescents’ ‘misconceptions’ about where safety finishes and risk begins.

The process of sexual risk assessment and the definitions of risky/safe sex appear to be symbiotically related. On the one hand, risk assessment is an operation that serves as a contextual frame for the attachment of meanings to risky/safe sex. On the other, the meanings of risky/safe sex orient the estimations of sexual risks. The following conversation shows the importance of risk assessment in the determination of risky/safe sex meanings and vice versa. It took place in one of the integrating activities that usually preceded the focused group discussions. In this particular case the integrating activity was a ‘problem solving fishbowl’ which I called “If I were you...”. Each girl was asked to write down on a card a problem, question or doubt concerning the pleasures and dangers of loving relationships. They were to pretend they were asking for advice. After that, the cards were distributed amongst themselves and then answered by one ‘adviser’, who was to write down on the same card her advice. The

³⁶ See section about the ‘technico-scientific’ approach to ‘risk’ on page 47.

cards were returned to the person who was seeking advice and who, then, would read the question and the answer to the group.

“Fatima - (Her question) ‘Even in a stable relationship and knowing that he loves me, shall I use a condom in order to not run risks?’

Fatima - (The adviser’s answer) ‘One does not know completely a person and one can’t be sure...even if you love him, you don’t know if he is going to be faithful...and the condom is always necessary....

Dora - And what do you think about that advice?

Fatima - I thought it was right...

Dora - Why? Does anybody think it’s not right?

Katia - Ah! One can get pregnant and even if one knows the person one will never know everything he does...

Suzana - One doesn’t know what he did and with whom he had a relationship...

Katia - He can have a disease...and you can get pregnant as well...

Dora - Ok, but for pregnancy one can use pills, for example, not necessarily a condom...

Suzana - Yeah, but the pill is not so safe as the condom is...

Katia - I think like you...the condom is much more safe...”.

One could, perhaps, be tempted to conclude that in the conversation shown above the girls define ‘risky sex’ as ‘not using a condom’, a definition that would satisfy most sex educators. However, a more careful analysis leads to the conclusion that ‘risky sex’, and also ‘safe sex’, mean more than that. ‘Risky sex’ is defined as ‘not knowing the ‘other’ completely’, including ‘not knowing everything he does and did, and also with whom he had a relationship’, ‘not being sure that the ‘other’ is faithful and if he is healthy’ and ‘not using a condom’. By ‘safe sex’ the girls, apparently, mean the opposite. It seems to be defined, for example, in terms of ‘knowing the ‘other’ completely’, ‘being sure about everything he does and did’ (although this was considered as unlikely), and also ‘using a condom’. Personal understandings of what is risky/safe sex are crucial for the establishment of what is to be assessed when it comes to sexual risks.

In this section I have addressed some of the issues concerning the importance of the personalization of risky/safe sex for the production of risk meanings as applied to sex. I have argued that it is mainly through the personalization of risky/safe sex that risk assessments are carried out and that risk assessments and risk meanings are intrinsically related.

The analytical deconstruction of the process in which risky/safe sex is personalized reveals the knowledge backgrounds that underpin the girls' conceptions of sexual risk and, also, how the girls interpret this knowledge in order to make sense of risky/safe sex. According to my analysis, the personalization of risky/safe sex is organized through a discursive construction of 'risk subjects'- those exposed to risks, and of 'risk objects'- those who may be the source of risks. In my view, the production of 'risk subjects' is the outcome of individual investments in the "care of the self" (Foucault 1984, p.47). The production of 'risk objects' results, on the other hand, from the interest in the 'knowledge of the other'.

I take 'self-care' and 'knowledge of the other' as the two poles around which the girls' discourses concerning sexual risks are articulated. I want to argue that the simultaneous interest in 'the care of the self' and 'the knowledge of the other' is related to the girls' desire to be recognized as self-governed women and persons who not only know the alternative options and the risks involved but also know how to deal rationally, responsibly and autonomously with them.

The diagram shown below is an attempt to represent what I identify as the different levels of the process through which risky/safe sex is personalized. Although it may appear that this process is so simple and rigid that it can be represented in a diagram, this is actually not the case. The transmission of the idea that the process of personalizing risky/safe sex always happens in the same way for all the girls is a negative effect of my attempt to capture its complexities in a picture that does not show the dynamic of this process. In 'real' life the personalization of risky/safe sex is much more flexible than my diagram represents (see Fig.1).

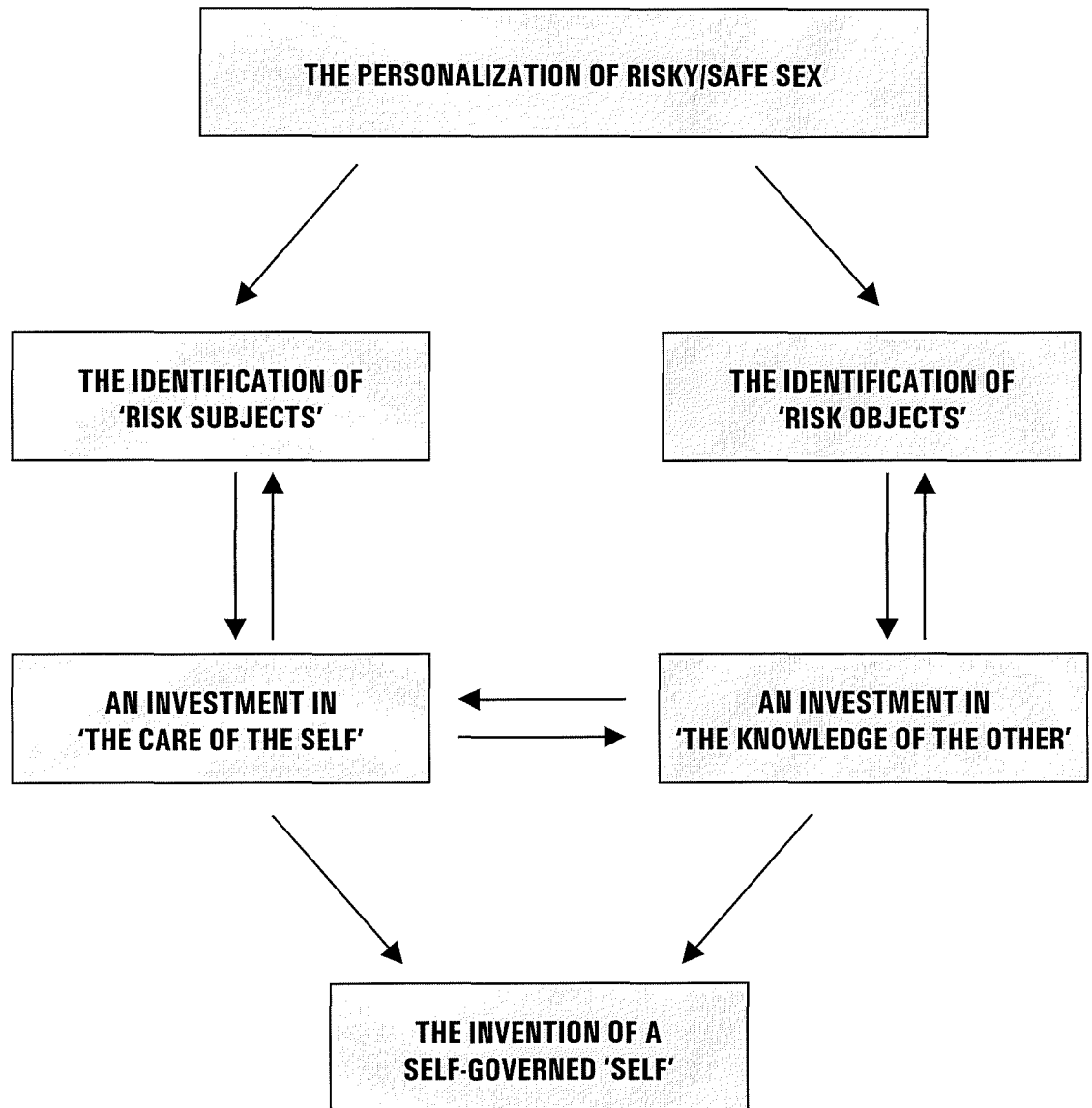


Fig.1 - Process of Personalization of Risky/Safe Sex

I now want to move my analysis on to one of the stages of the personalization of risky/safe sex - the discursive production of 'risk subjects' -, which are of two types - the 'self' and the 'other' - and on its links to 'the care of the self' and self-governance. The analysis will reveal some of the constitutive elements of the knowledge backgrounds used by the girls in the process of making sense of risky/safe sex.

Personalizing Risky/Safe Sex (Part A): The Production of 'Sexual Risk Subjects' and 'Careful Selves'

The first point I want to stress is that knowledge about the contextual positions of the 'self' within heterosexual relationships constitutes a fundamental element of the knowledge background used in definitions of risky/safe sex. In the girls' discussions about sexual risks 'risk subjects' are identified through a sort of 'discursive positioning' that narrates 'where' the subject is in relation to the external circumstances that constitute the risk to be assessed. 'Where' means here not only the material circumstances of the risk situation - the elements used to describe the scene -, but more importantly, the girls' interpretation of these material circumstances. Diverse perspectives inform this interpretation. Different interpretations of the circumstances that delineate the risk scene result in/from different types of discourses to which the girls are subjected.

The position of the 'risk subject' is a referential point for the development of personal discourses of risk/safety in the context of sex. In a discussion about who runs the risk of being infected by the HIV virus in a sexual encounter Suzana takes a discourse in which the 'self' is positioned as safe. For Suzana, to be at AIDS risk, however, does not seem to be out of the question, as in the same discourse the 'self' is positioned as a 'risk subject' through the act of kissing. One can also note that in her discourse the 'others' and the 'self' occupy same equal positions, as she uses 'I' and 'we' as intertwined subjects. The discourse that describes the perspective from which Suzana considers the risk of kissing intrinsically describes the context where the 'risk subject' is positioned.

"Suzana - ...Me too [I don't think about the risk of catching AIDS in a sexual relation but about the AIDS risk in general] ...like sometimes when

we are in a party...and we flirt with someone...we know that we won't catch it through a kiss...but we are scared like...he is a stranger, we don't know where he came from...that scares us...[...]”.

Suzana's talk identifies her 'self' as a subject who, like others, goes to parties, flirts, kisses, is well informed about the HIV/AIDS risk and yet does not feel completely safe in spite of 'knowing' that HIV/AIDS is not transmitted through kissing. She makes it clear that the information she (like others) has got is not enough to make her (and others) feel safe because she still sees strangers as potential 'risk objects'. The 'self' is not positioned on the grounds of Suzana's (scientific) knowledge of the safety of kissing but on her belief that to have an intimate contact with a stranger (in this case through kissing) might be risky despite what scientists say. Suzana's discourse emphasizes the importance of knowing the boy she kisses. Knowledge about the 'other' would reduce uncertainties, hence risks. By knowing "*where he came from*" Suzana would be able to make informed decisions and evaluate if he could or could not be a 'risk object' through the act of kissing. She would rely on her own judgments.

Within the context described by Suzana her 'self' is not exposed to the risk of contracting HIV/AIDS through sex. If HIV/AIDS is to be a threat, it is not by means of sex. Suzana introduces her 'self' to us (the other girls and me) as an HIV/AIDS 'risk subject' but not in the way I was proposing (which was by thinking of sexual risks). She resists being positioned as a subject of the risks of sex. To talk about risk, however, implies personalization; the 'self' is involved in one way or another with it. The alternative for Suzana is to describe her 'self' as worried about the possibility of being subjected to the HIV/AIDS risk through kissing, which is the only risky practice she admits to.

Suzana's resistance to take up a position as a 'risk subject' in the discourse of risky/safe sex is a reflexive exercise. Such a position seems to be coherent with the type of girl/woman she wants to be or the one she would like to present as herself in the research context. When talking about her plans with regard to sex she makes it clear that she is still a virgin and that if one day she decides to have sex, it will be with protection - "*I haven't done it yet and I don't know if I'll do it before marriage but if it happens it'll be with a condom and that's for sure*". On the other hand, at that moment, she was not pressured to revise this personal project as she was currently

‘single’ - *“Right now I don’t have a boyfriend, I am not at risk of doing what I don’t want to”*. So, the only possibility of positioning her ‘self’ and being positioned as a risk subject in discourses of HIV/AIDS risk is to think and talk about the risks of kissing a stranger.

The emphasis on the need to know *“where he came from”* in order to feel safe in a relationship reflects the subject Suzana wants to be: one who is able to assess and manage the dangers of her personal life, in particular those related to the intimate moments of her relationships with men. Suzana’s discourse about the risk of kissing seems to be underlined by a personal project of ‘self-governance’. As we will see, this is not only Suzana’s personal project. Amongst the girls ‘self-governance’ constitutes a common ideal. This emphasis on ‘self-care’ appeared also in the girls’ discussions about everyday risk management (see pages 147-150). This suggests that different risks can be seen through similar lenses. Another way of looking at this finding is to say that ‘to kiss a stranger’ is actually an everyday risk and that, so, the meanings of the former are embedded in the meanings of the latter.

In a group discussion about the risk of HIV/AIDS in sexual encounters Maria also talks of her ‘self’. This time, however, sex is not rejected as the context where the ‘self’ might be subjected to risk.

“Dora - [...] Let’s describe a risky sexual relation.

Maria - I met a guy today and had already had sex with him without using a condom, without precaution...that’s totally risky...”

While the self-positioning as a ‘risk subject’ is originated in a hypothetical situation, the identification of the ‘self’ as the subject of the described risky sex situation has the effect of personalizing the meanings of risky/safe sex. Like Suzana, Maria relates ‘risk’ to the lack of information about the ‘other’. ‘Risky sex’ is primarily defined as a sexual encounter in which the ‘risk object’ is a stranger ‘other’, and secondly by sex with this stranger without a condom. Like Suzana, Maria also seems to invest in a self-governed ‘self’. The ‘risk’ and ‘safety’ of sexual encounters are not totally defined in terms of the use or non-use of a condom. The movement of the ‘self’ between risky and safe positions is more a matter of the mobilizing of internal resources of self-defense and

less of the employment of external means of protection. It is a question of the individual ‘talent’ for taking care of the ‘self’.

Contradictorily enough, while the meanings of ‘safety’ are attached to those of ‘carefulness’, that is, a ‘safe self’ is also a ‘careful self’, the discursive association between the two relies on a prior positioning of the ‘self’ as a ‘risk subject’. That is to say, the acknowledgment of the risks is a condition for the construction of the ‘careful self’. If the ‘self’ is not at risk there is no need to look after it. This is additional evidence that, as I have argued previously, the girls’ conceptions of risk are not dissociated from those of safety (see pages 160-161).

As I pointed out earlier and the examples given above illustrate, ‘self-governance’ is an implicit reference for the girls’ discussions about the risks of sex. But the investment in a self-governed ‘self’ can also be discursively explicit. In the following cases it is accompanied by the display of a self-attribution of carefulness.

“Claudia - It depends...in my case I wouldn’t do it if I didn’t want to...we are the owner of our mind and we have to keep in mind that we need to take care of ourselves because if we don’t people can rightly say that we are careless and irresponsible...I’m not like that, I take care of myself...I don’t know, this is the way I am, I never forget that I have to be careful...”

“Laura - [...] Are you crazy? I know perfectly well that sex is a risky thing...I have to keep my eyes wide open, I mean, we have to be very careful...I am conscious about the risks and I know how to take care of myself...those who are careful are those who have less chances of getting pregnant or catching AIDS...”

“Maria - We’ve got to protect ourselves. It doesn’t matter if it’s a boy or a girl. I think that it’s not only the boy that has to carry a condom...only because he is the man and the girl...ah! she is ashamed of...or because in this case she has prejudice against it...”

While Claudia’s, Laura’s and Maria’s discourses of self-care are all good examples of the investment in an autonomous and careful self, it is Maria’s talk that I wish to deconstruct next because it leads to a number of insights that have to do with the argument that I want to develop here. The argument concerns the conflicting subject positions made available to the girls in the intersection between gender and risk discourses.

In Maria's discourse of 'self-care', the 'self' speaks in the name of the entire adolescent population. To be able to protect the 'self' against the risks of sex is both an individual and collective agenda. To Maria, gender shall not count when it comes to the subject's responsibility to take care of the self. Boys and girls have all got to be careful and assume equal responsibility for safety in sexual encounters. A discourse of 'gender equality' underpins Maria's discourse of 'self-care'. However, her consciousness of the different girls' and boys' locations in the gendered discourses that organize sexual agendas (expressed in the statement about the reasons why girls do not carry a condom) creates an unconscious paradox. The fact that "*she is ashamed of*" and "*has prejudice against*" carrying a condom defines the paradox. Girls and boys are actually not the same gender subjects. The masculine 'other' has a different attitude towards the mastering of his personal protection in sexual encounters. He is not ashamed of carrying a condom and does not have prejudice against it, "*only because he is the man*". If, in order to be able to take care of the 'self' (represented by the carrying of a condom), the girl/woman needs to be equal to a man, then this discourse of self-responsibility for sexual protection does not seem to hold a position for subjects who happen to be feminine.

The paradox expressed in Maria's discourse of risk prevention and self-care originates from the gendered nature of her talk. It reveals the notion of a dualistic gender order, a discourse that has traditionally constructed 'woman' not simply as different but, essentially, as inferior. While Maria's declaration in favor of women's rights expresses her desire to assure gender equality and girls' autonomy with respect to sexual protection, the attachment of her subjectivity to the category 'we as girls' creates a contradictory position for the 'self'. The imagined 'self' or the subject that Maria wants to be - the careful and self-governed feminine 'self' - becomes blurred by the alternative positions available to girls in the terrain of sex.

Advocating gender equality without discursively breaking out of the boundaries of the dualism feminine/masculine undermines the coherence of Maria's narrative of her autonomous and careful 'sexual self'. The discourse about boys' and girls' equal rights and duties concerning sexual self-protection sustains this dualism. Thus it does not question the power of boys/men, which is the essence of the construction of gender and woman's subordination to man (Davies 1989, Holland et al. 1998).

As feminist poststructuralists argue, “power remains fundamentally contradictory to the *idea* and the idealisation of the idea of being female” (Davies 1989, p.71, author’s emphasis). In practice, the positioning of the ‘self’ as an autonomous and empowered subject in matters of sexual protection will possibly expose Maria (and also Claudia and Laura) to risks. The ‘risk subject’ resulted from that would either risk her gender identity or her autonomy. As others have already argued, in the dominant system of gender, to be female is incompatible with performances of autonomy, in particular when it comes to sex, which is constituted as a *legitimate* male domain (Holland et al. 1998).

The discursive positionings taken up by the girls are results of personal choices (unless they originated from physical pressure or even violence, which did not seem to be the case) but they do not seem to be free choices. In the case of decisions related to personal sexual safety, the choices made are constrained by gender ideologies and models of femininity. Maria, for example, made explicit her belief that shame and prejudice against carrying a condom were part of being female. It seems that in her own evaluation this could result in girls’ exposure to the risks of sex, as they could end up by not carrying a condom.

To recognize their ‘selves’ as women or to construct their subjectivities upon conventional femininity may indeed be very risky if we consider the lack of legitimate power associated with being female (Davies 1989), particularly in the context of sexual relations. And this is not a risky position only for the Brazilian girls whom I talked to. In their analysis of English young women’s accounts of sexual behaviour Holland et al. (1998) also concluded that it is precisely the mark of femininity that makes girls’ sexual identities unsafe. That is, it is by behaving like ‘feminine girls’ that they become subjected to sexual risks.

Condom use can be seen as antithetical to femininity. As Holland et al. (1998) argue, “to be conventionally feminine is to appear sexually unknowing, to aspire to a relationship, to let sex ‘*happen*’, to trust to love, and to make men happy” (p.6, authors’ emphasis). To insist on condom use for personal safety may then threaten women’s feminine identity. It may mean “a lack of sexual innocence and so a lack of conventional, reputable femininity” (ibid., p.33).

The deconstruction of the girls' discourses about the risks of sexual encounters suggests that it is not easy for them to be the (safe) sexual subjects they want to. While discourses of woman's freedom and right to choose are nowadays widespread, the conditions for putting those discourses into practice are hard to achieve. Because the girls recognize their 'sexed selves' (Probyn 1993) as the feminine pole of the binary opposition feminine/masculine, their choices concerning sexual behaviour become constrained by the conventions of gender (Holland et al. 1998). There are a number of examples of how gender establishes the girls' menu of sexual behaviour options. In spite of having limited space to present all the data gathered here, I think it is worthwhile picking up some of these examples as a means of illustrating and highlighting the explicit gender basis of the girls' production and presentation of their 'sexed selves' during the focus group sessions. It is worth noting that the discourses in which this gender basis is expressed end up by positioning girls/women similarly. Usually they are represented as subordinate to boys/men. That is the case, for example, of female sexual initiative. According to the girls, because women are supposed to have less sexual knowledge than men, those who demonstrate having a good knowledge about sex can get into trouble.

"Marta - If a woman knows [the knowledge necessary for having a good sexual performance] she is discriminated against...she is condemned...because of what people are going to think about her...ah, she has already had..."

[...] Fatima - ...Many kilometers..."

Sexual initiative is not a real option for girls. Under dominant gender regimes 'initiative' and 'action' are masculine roles. Girls' sexual initiative may be seen as sexual knowledge expertise, a sign of previous and multiple sexual experiences, which does not fit into the conventional model of feminine passivity/masculine activity³⁷ and also contradicts the ideal of feminine monogamy and innocence (Holland et al. 1998). As reflexive subjects of gender discourses, the girls cannot help to recognize that the subversion of the norm of feminine repression of desires may bring with it some risks.

"Vera - The woman, even if she wants, she can't ask the man to have sex with her..."

Claudia - She can but she is not going to do that..."

³⁷ For a discussion about the influence of this ideology in the organization of gender relations in Brazil see section on page 145.

Ines - *She is going to be afraid of being rejected...*

[...] Claudia - *It's more simple for men to want it [sex]...*".

"Katia - *There are some boys who like it when their girlfriends have the initiative but I think that there are some who don't...*

Teresa - [...] *I think that in that case the boy becomes suspicious about the girl...he starts having bad thoughts about her....*

Dora - *What does the boy think if the girl has the [sexual] initiative?*

Marta - [...] *He thinks that she has already had sex with other guys...*".

Sexually assertive girls may be seen as 'easy' and this is a risk to reputation. 'Easy girls' are not however exclusive to men's vocabulary. Teresa's talk is an example that even girls may judge other women's sexual initiative as morally wrong. This suggests that ideas of 'appropriate' feminine sexual behaviour are constructed through what Holland et al. (1998) have called "the-male-in-the-head" (p.171). This expression was coined by the authors to signal the privilege of masculine interests within heterosexuality. To Teresa, when a boy comes across someone who is 'easy', he is expected to take advantage of her. Such a reaction to the girl's 'easiness' may be taken as a deserved response to her lack of self-respect.

"Teresa - *I think that the boys are not all that bad...I think that they value those women who have self-respect, those who are not easy...but those...of course that they are not stupid...they can't help taking advantage of those who demonstrate to being so easy...it's going to be one more, isn't it? But when somebody who is like...hard to get, I think that they don't think about her like they think about those who are easy...*".

The use of 'the-male-in-the-head' to make sense of girls' heterosexual behaviour legitimizes male domination in heterosexual relationships. Teresa's position concerning the meaning of women's self-respect can be regarded as an example of her knowledge about gender models. It is probably the case that she will use (or was already using) those models to produce herself as a feminine subject. In producing herself as feminine, Teresa is likely to contribute to the reproduction of male dominance (Holland et al. 1998).

To be a 'hard to get' girl, in the sense of hiding desires and waiting for boys' demonstration and fulfillment of theirs, constrains the girls' 'ways of being' in sexual encounters. The menu of options is packed with ideals of altruistic behaviours and self-sacrifice, which are supposed to have the rewarding outcome of respectability. What is

noticeable from the data gathered is that the proposed selflessness in which this project of the 'self' is embedded is not an objective that is to be fulfilled when the girls start being sexually active. Before that the girls have other opportunities to learn that to be feminine in heterosexual relationships (meaning all sorts of interactions between males and females, men/boys and women/girls, including sex) implies experiencing the active 'nature' of men and to conform to feminine passivity. For example, according to the girls, women are not supposed to take the first step towards starting a romantic relationship.

"Suzana - If you are interested in somebody of course you're going to wait for him or ask a friend to talk to him..."

Teresa - But you'll never go by yourself...

Suzana - You'll never go like...ah, I want to flirt with you..."

They are also not expected to orient intimate encounters with men, who are actually 'in command' of what shall or shall not happen in the relationship. Boyfriends usually initiate kissing and hugging for example. It is possibly the case then that when the girls have their first sexual experience, they have already got used to their passive role in the context of romance as opposed to boys' initiative and control over it.

"[...]Dora - ...Who takes the initiative of, for example, kissing and hugging, when they are not in public?"

Maria - Normally it is the boyfriend...

Katia - Yeah...

Suzana - Most of the times it's him..."

"Dora - Those intimate events that happen in relationships, apart from sex, for example kissing and hugging, who initiates that? The boy or the girl?"

Claudia - The man...

Vera - The guy...

Tania - The boy, most of the times, isn't it?"

It seems that it is not only experience that plays a role in girls' acceptance of boys' sexual initiative. Knowledge about and belief in the "male sexual drive discourse" (Holloway 1984, p.23) also appears to be influential.

"Claudia - The girl is not going to ask him to have sex with her, is she? [...]"

Tania - And men are generally 'warmer' than women...

Dora - More what? Warm?"

Ines - *It's him that always asks more...*

Dora - *What do you mean by 'warm'?*

Tania - *More 'fire' ...*".

Understandings of men's nature complement and are complemented by those of women's nature. Those complementary understandings constitute a circuit of reproduction of gender differences (Holland et al. 1998). Because the girls see boys as naturally 'warmer' than themselves, it is also 'natural' to interpret their sexual initiative and power over sexual encounters as normal. In the end somebody has got to be in charge of the sexual relationship and if it is not the girl because she is ashamed of it, then it must be the boy. These representations of 'women' and 'men' may not change over the years. As the quote below suggests, they can even be reinforced by the repetition of dis-empowering sexual experiences in adulthood.

"Ines - *The man always takes the initiative before the woman...*

Vera - *It has been like that for years, hasn't it? Now, to change that...*

Claudia - *Yeah it is difficult...*

[...] Tania - *It's already a tradition...*".

The girls seem to generalize girls' passivity and boys' control over sexual encounters. Yet they try to assure room for diversity by affirming that there may be women (perhaps including themselves) that think and act distinctly from the majority.

"Claudia - *It's [the tradition of male sexual initiative] because the man always wants to shag first...the woman can wait...the woman waits some time...*

Ines - *It depends on the woman, doesn't it?*

Claudia - *Yeah...it depends...*".

If the girls were including themselves as the exceptions to the supposed norm of female acceptance of male control over sex, this could imply that they had not resigned themselves to the imbalance of power perceived as permeating sexual encounters. It could also mean that they hoped to resist the traditional norms. But, as the data collection progressed I got the impression that what they meant by "*it depends on the woman*" was perhaps more a way of expressing the possibility of an isolated case of deviancy from the norm than a personal motivation to challenge it.

"Dora - *Do you think that it's correct to see a woman who takes the initiative as vulgar and consider a man's initiative fine?*

Claudia - [...] No...

Vera - *I don't think it's correct...both should be able to ask...why not?...if both feel the desire of...[...]*

Claudia - *Yeah...this is bullshit [...]*...

Vera - [...] *if both of them want to, both should be allowed to ask...*

Claudia - *Yeah...but it's vulgar, isn't it?"*

The data suggest that it is easier to criticize social norms as an outsider viewer than compromising the 'self' in changing the traditional positions of girls/women in sexual encounters. The contradictory interpretation of female sexual initiative as correct and, in the end, naming it "*vulgar*", made me wonder about the appropriateness of the affirmation that our society is now governed by new values which overcome traditional morality. The use of feminist speech in defense of women's sexual rights, like that expressed in the conversation above, does not seem to open new real alternatives to the girls as they continue to make choices concerning sexual behaviour in conformity with tradition. New alternative positions are theoretically offered to modern women, but in practice to go against tradition is still something that demands audacity.

"Dora - *Would you take the sexual initiative?*

Vera - *I wouldn't have the courage...*

Claudia - *Yeah, I wouldn't...*

Ines - *Neither I...*

Claudia - *I wouldn't have courage but I don't have anything against it...*

Vera - *Me too..."*.

"Dora - *What would you think about a girl who asks a boy to have sex with her?*

Maria - *I wouldn't say anything...I think that it's normal...*

Suzana - *Normal?*

Teresa - *Not normal but...*

Suzana - *This is not normal...*

Marta - *I don't think so...*

Suzana - [...] *Ah no...this is vulgarity...I think this is horrible...do you think I would be able to ask somebody to have sex with me? What's that? In which world are we?"*

Being a 'girl' in a sexual encounter means to take up a 'non-boy' position, which apart from accepting lack of power implies having different concerns.

“Claudia - Boys are worried [about diseases] but...at that time [during the sexual encounter] they don't care...the girl is more careful...the girl is worried about getting pregnant and catching a disease...then it's her that uses [precautions]...”.

“Teresa - Boys are worried about the same things that girls are but their major concern is with their performance...girls don't worry so much about performance like boys do...they have other things to be worried about”.

“Marta - I think that [boys are worried about] many things, about extending their fame, their experience. They are worried about pregnancy like girls...well, not so much I think...but also about what the girls are going to think about their sexual performance”.

“Claudia - Boys don't think about pregnancy and diseases like girls do...I think that what they most fear is the possibility of not getting it up...”.

In considering boys as capable of embarking on sexual encounters to improve their sexual experience or to prove their sexual potential, the girls become obviously concerned about the possibility of being sexually (ab)‘used’ and disposable.

“Fatima - Sometimes the girl's concern is that she will be rejected by the boy after [the sexual relationship]...[...]

Dora - But why? I don't understand this fear...why after sex there may be that rejection?

Katia - Ah...it may well be that he wants her only for having sex...she has this fear...[...]

Suzana - It's because the girl is more worried about if he really likes her...if he is doing that because he likes her [or if it's] because of his development, you know [...]

Marta - And also if he is going to reject her after [them having sex]...if he wants her only because of sex and then will look for another girl...It happens [...]...the guy is with the girl for a long time and after having sex with her all that love ends...”.

The awareness of the problem of women's autonomy in sexual encounters gains relevance when the issue in question is the riskiness of sex. It is a type of knowledge that may undermine the fundamental characteristic of the ‘self’ that the girls want to be. This characteristic is one that implies self-mastery in matters of personal protection against sexual risks.

“Dora - Are girls worried about catching diseases when having sex?

[...] Ines - It depends...they are worried, but sometimes [...] he is pushing her and...then the girls do it without taking precautions...".

"Dora - Are you sure that you'll be able to protect yourself against the risks of sex?

Fatima - O course I am...I mean, I intend to do so...while I could say no...I mean, I intend to resist and I hope he will understand and will be able to wait until I'm prepared.

Maria - As far as I know many girls say the same and got pregnant because he didn't want to use the condom and they didn't want to upset him...".

"Vera - [...] we can't say I won't have sex with you but you also can't have sex with anybody else...it's not like that...".

It does not seem to be difficult to repeat the main messages of current discourses of risk, like those concerning the mastery of the 'self'. What is clearly difficult is to accommodate new discourses, like that of risk, with traditional ones, like those of gender and sexuality. In the quotations shown above, the conflicting messages of risk and gender discourses are evident. Power is at the core of their incompatibilities. The girls identify the power imbalance of heterosexual relations as an obstacle to the practice of self-governance. Male power may spoil the realization of the reflexive project of their 'sexed self' (Probyn 1993) towards autonomy and ability of self-protection against the risks of sex. But there are other messages available, which are not always congruent with previous experiences and/or knowledge.

Are girls/women really able to take control of her sexual life, as risk prevention campaigns seem to suggest, when for example, they say, "living without AIDS depends only on you"?³⁸ Or are they powerless subjects who give up their desires, for example of protecting themselves against the risks of sex, only because 'he' is the man and "is pushing her" or because they "didn't want to upset him"? For the girls who have already experienced sex the answers may be derived from personal experiences. Those experiences may or may not confirm previous information about women's agency in sexual encounters. For those who are still waiting for the 'right man' and the 'right

³⁸ This was the slogan of a recent campaign of the Ministry of Health, which was launched by the beginning of 1999 and whose aim was "to stimulate the individual responsibility for the combat of the disease and inform the population about the prevention of sexually transmitted diseases."- Correio do Povo-5/2/99

moment' the answers may come from others' sexual experiences and from the general information they come across. There is no single answer to those questions, or a simple logic to be followed. Experiences may be conflicting as well as the interpretations they entail. As the girls kept repeating to me, in a glimpse of the multiple realities they have dealt with and the consequent multiple positionings they have taken up, *"it depends"*.

To make decisions is naively seen by the girls as a way of being in control of their own lives. This is not, however, a representation of autonomy that is only part of the girls' world. As pointed out earlier, for health promoters, too, the promotion of choice is taken as a way of promoting agency (see section on page 19). As emphasized by the sociological literature on 'health' and 'risk' (see Chapter 2) individuals are encouraged to believe that by knowing the risks and making their own judgments and choices about them, they are conducting their private lives according to their will. In the girls' and health promotion's imagination, the capacity of the 'self' to control its own life also means the ability to control the risks. But, as we all know now, our social environment is permanently risky. It is thus a fantasy to believe in risk-free decisions.

In spite of the problems with the imaginary woman's agency in the scientific discourses of risk, it is not hard to understand why the subject's positions that are available within it are of great appeal to the girls. Autonomy, independence, freedom are nowadays all social and personal imperatives. The insistence of health promotion mass campaigns on everyone's power to choose and implement 'safe sex' has turned women's sexual autonomy into a taken-for-granted condition. This has created the illusion that this is a common feature of women's sexual life (Browne and Minichiello 1994). While at an individual level this condition can be contested, at a collective level this is more difficult, for it may mean singularity and/or deviation from the category of 'women', which has already been 'identified' by others as agentic in sexual encounters. The following conversation captures the conflicts between the positions of girls/women within others' risk discourses and those that arise from lived experience.

"Teresa - If it's difficult to talk (with a boyfriend) about it (the use of a condom), imagine how difficult it is to use it, it's even worse.

Maria - But nowadays it's so common...everyone talks about it...to use a condom is now normal, that 'bogy man' doesn't exist anymore.

Teresa - The thing is...it's too common to use a condom nowadays...It seems that everything comes all together...it's difficult to say why do we

still feel that it is a problem...and we know that if we don't use it we put ourselves at risk...".

When contradictions between others' risk discourses and personal experiences emerge, the solution can be to take up a position in which the 'risk subject' becomes the self-confessed origin of the problem. The knowledge that 'safe sex' has been advertised as an easy choice leads the girls to position their 'selves' as subjects who are, perhaps, different from the majority because strangely enough, unlike the others, they do not find condom use that easy. The assessment of the deviance of the 'self' from the norm strengthens the norm itself. It also compromises the girls with the correcting of this deviance within the 'self' (Crawford 1994). The gap between the supposed experiences of others and personal experiences produces anxieties. The girls express their difficulties in understanding why they have different experiences with condom use. *"It's difficult to talk about it", "it's difficult to use it", but "everyone talks about it" and "it's too common to use a condom"; so, "why do we still feel that it is a problem" in spite of knowing "that if we don't use it we put ourselves at risk"?* The continuation of the conversation suggests that the girls' problem is not so much that they do not know why others' theories do not match with their experiential knowledge. The problem seems to be that the former constitutes the reference against which personal judgments about the 'correctness' of the latter are made.

"Teresa - Yeah, everything seems to come together, it's like a package...

Maria - Yeah, [...]

Fatima - You buy the product (sex) and it comes with a condom...

Teresa - Yeah, but it's not easy to use everything that comes in this package [laughs]. Maybe for most of them (the girls) it is, but not for everybody...there are some who are different from those who want to use condoms and actually use it...that's why some of us take risks, it's because sometimes we are not as good at these things or are different...".

The commonest message that is nowadays addressed to adolescents is that sex is (or should be) inextricably attached to risk/safety. This makes sex look like a *"a package"*, a set of combined meanings and rules concerning sex and safety that cannot be divided up. The term 'package' is well known in Brazil as a metaphor that represents a common political strategy of the Brazilian government. This involves the setting up of a combination of 'new' rules or laws, especially economic ones, that are, overnight, imposed on the population and are to be implemented all together. Teresa's

discourse suggests that girls like her, who are in danger of not committing or cannot commit their 'selves' to "*a package*" which links 'sex' to 'safety', may have a 'bad essence', one that is different from the mainstream. In such a discourse the 'self' is identified as a 'risk subject', as opposed to the 'safe subjects' who are assumed to be "*so good at these things*" as the majority. The evaluation made by Teresa seems to be underpinned by a moral commitment to the care of the self, which she takes as held by everyone, including herself. The view that the girls who do not find it easy to "*use everything that comes in this package*" - sex and safety - "*are not as good*" implies a value judgment. One might suppose that for Teresa, who seems to believe that she, along with others, may not be a good caretaker of herself, the next step is to invest in the improvement or perfecting of the 'self' (Foucault 1984). The ideal 'self' she will seek to be will have many faces each produced in a combination of discourses that are made available to her in each context where she has to make her 'self' present. I am talking about multiple discourses, contexts and 'selves'. In spite of that, I maintain that among such a variety of compositions there were some discourses, contexts and 'selves', like the self-governed and careful self, that were made more visible to me during the course of the focus group sessions.

The positionings taken up during the whole process of data collection and the 'selves' produced during the course of the research were not fixed. The creation of a diversity of discourses and subjectivities did not mean, however, that the 'selves' made during the focus group sessions were simply invented by the girls themselves, nor that alternative identities were already there just waiting to be taken up. If we assume that the girls' 'selves' were not embodied in any one moment or place but could appear at certain intersections (Rose 1998), we can perhaps say that the focus group sessions provided a discursive environment in which certain subject's positions (and not others) were made available to them. That is, there were certain discourses intrinsically and explicitly related to the research, like discourses on risk, AIDS and sexuality, which were already constitutive of the discursive background of the group discussions. The girls themselves, individually and collectively, also brought other discourses into the discussions. So the discursive elements - the words and the practices that were meant to be the translation of reality - that the girls used to speak themselves into existence in our meetings were already there. By making a number of combinations and reinterpretations of those elements the girls were able to (re)produce multiple

discourses (sometimes contradictory, sometimes congruent) in which multiple readings of their 'selves' were made possible (Davies 1991).

The data analysis shows that one of the main routes of the construction of multiple readings of the 'self' is self-inspection. Through self-inspection personalized discourses of risky/safe sex are created and discursive positionings made available to the 'self'. The exercise of self-inspection guides the "reflexive project of the self" (Giddens 1996, p.). It connects elements of the outside world - the social order - with those of the inside - subjectivity -, providing answers for existential questions such as 'who am I?' and 'who do I want to be?'. The outside world (at least with regard to Brazil) is governed by a neo-liberal regime, in which optional 'ways of being' are created and presented to individuals as goods to be consumed (see page 147). In such a world, as Rose (1989) stresses, "individuals are to become [...] entrepreneurs of themselves, shaping their own lives through the choices they make among the forms of life available to them" (p.230). 'Ways of being' and their correspondent forms of conduct, then, are not imposed by any coercive force. As Rose (1989) points out, "forms of conduct are governed through a personal labor to assemble a way of life within the sphere of consumption and to incorporate a set of values from among the alternative moral codes disseminated in the world of signs and images" (pp. 230-231).

The 'risk subjects' - risky/safe selves - produced through taking up positions within discourses on sexual risks are made in reference to the 'sexual selves' the girls want to become. Who they want to be in the risky/safe situations of sexual encounters embodies the individual characteristics chosen as personal ideals among an array of options. Self-inspection is a mechanism of discovery of personal desires. It is the starting point of an individual elaboration of the 'self'. To be spoken into existence as a 'risk subject' within discourses on sexual risks implies identifying the 'self' either as a risky or safe 'sexual subject'. It makes possible the attachment of self-referential meanings to 'risk' and 'safety', which are some of the most important commodities of contemporary life. As Rose (1989) argues, "consumption requires each individual to choose from among a variety of products in response to a repertoire of wants that may be shaped and legitimated by advertising and promotion but must be experienced and justified as personal desires" (p.231).

The 'sexual self' that the girls want to be is influenced by the knowledge they have about what it means to be 'feminine' in sexual encounters. To come to know what it is to be feminine implies learning a number of lessons. Nowadays, at least in the context of sexuality, one the most common lessons to be learned by 'feminine' girls is that, from the point of view of the practice of heterosexual sex, this is a risky identity. Ironically, it seems that it is the discourses of those who are supposed to promote adolescents' sexual risk protection that produce the discursive positioning through which the girls transform their 'sexual selves' into 'risk subjects'. Health and education professionals have a fundamental role in the production and communication of such discourses.

Marta's story tells us about the health professionals' power in constructing the image of girls as 'risk subjects' in sexual encounters. It also illustrates the closeness of the girls' investment in self-governance concerning sexual protection and the project of health professionals.

"Marta - One of those days I went to the health center...it's because I have anemia...and my boyfriend went with me...then the nurse...there are two pregnant adolescents that always go there...then, when I was leaving the nurse saw me and she called me - Marta - she said - Marta, come back here...she took a bag full of condoms and gave it to me in the middle of the room...everyone looked at me, my boyfriend looked at me...I looked at her and she said - even if you are not doing it yet take it with you and protect yourself because you can see what might happen to you, can't you? if you want the pill come here. And I took the bag full of condoms to my place...I was so embarrassed...[laughs]"

To be publicly recognized as a 'risk subject' is embarrassing. Risk-taking is morally wrong. It goes against the ideal of self-preservation and the duty to be well (Greco 1993). In addition to that, to be considered as a 'risk subject' on sexual matters may spoil the girls' public reputation with respect to feminine attributes. Firstly, it may contradict the ideal of 'well-behaved girls' (those who are responsible, careful and behave according to the norms) as opposed to 'badly-behaved boys' and secondly, it means that somebody suspects that they might be sexually active.

Ines has another story to tell. This time the embarrassment comes from her teacher's assumption about girls' carelessness and the resulting identification of her 'self' as a potential 'risk subject' in sexual encounters.

“Ines- A teacher of ours has always said that we’ve got to be careful and I’ve always agreed with her. But that time it was too much...Do you know what she did? She said to me: ‘ Ines, I know that sometimes it’s difficult for the girls to keep their minds when they are with they boyfriends...I mean, to say no, without a condom no deal...Girls are not always careful with these things...If I were you I would make sure that I always have a condom in my handbag’...at that moment my wish was to disappear because she said that in front of my classmates...how can she know if I am or am not doing it already? Only because she saw me with my boyfriend in the supermarket the day before”?

The surveillance function of discourses on risk (Castel 1991; Crawford 1994; Douglas 1990; Giddens 1996; Lupton 1993) seems to be a marked presence in the girls’ daily life, particularly in relation to the boundaries between health and sickness encapsulated by the notion of risky/safe sex. Girls are considered as ‘risk subjects’ before their exposure to sexual risks occur and/or are confirmed. In fact, in this case there seems to be no need for personalized evidence. As Castel (1991) suggests, publicly recognized ‘risk subjects’ are constructed on the grounds of general conjectures derived from the health professions’ milieu. The public representation of girls as ‘sexual risk subjects’ follows the contemporary tendency of health professionals to label and group individuals into categories of human beings who are supposed to share a specific ‘essence’, in this case a ‘risky essence’ (Castel 1991; Yen 1995).³⁹

Crawford (1994) comments on the effect of the health promotion’s creation of this modern notion of ‘self’ as the subject of risk:

*“in contemporary health promotion discourse, the healthy self is portrayed as a composite of risk - behaviours, ‘life events’, and a host of other stress factors. The new health consciousness is, on a practical level, a response in part to this risk awareness. The healthy individual has, in a sense, been converted into a person who is *potentially* sick, even well on the way to becoming sick”* (p.1357, author’s emphasis).

To health risk experts, the category of girls have already proved to be constituted by ‘risk subjects’ (as they are getting pregnant, contracting sexually transmitted diseases and AIDS)⁴⁰. Once communicated to the population, this type of discourse, which is based on experts’ knowledge, becomes one of a public domain; it sets boundaries for its subjects. To be publicly identified as a ‘risk subject’ of sexual encounters it seems

³⁹ For a discussion on this matter see page 57.

⁴⁰ See pages 12-13 for a discussion about the presence of adolescent women in discourses on AIDS risk.

to be enough to display certain characteristics (scientifically known as risk factors). To look like a girl seems to be one of them. This suggests that the girls are the targets of what Castel calls modern systems of administration, where individuals have been transformed into subjects of prediction and prevention (Castel 1991).

As it has been argued, these mechanisms of government inculcate upon the 'self' the responsibility for its own surveillance (Greco 1993; Nettleton 1997; Ogden 1995; Petersen and Lupton 1996; Petersen 1996; Rose 1989). As Nettleton (1997) argues, in this self-surveillance exercise new identities are formed', 'selves' that are recognized as 'risky selves' (see page 64). This is not to say, however, that the official discourses pronounced by health care and education workers (like the nurse and the teacher who appear in Marta's and Ines's talk) have the power to determine girls' subjectivities. In my view, the 'creators' of 'selves' are the girls themselves but the creation processes in which the 'selves' are produced are informed by a number of dominant discourses that present the alternative positions for these 'selves'. In Probyn's words, "the self is [...] never transcendent of its discursive reality...", that is, it is "[...] formed in the material limits of its discursive context" (Probyn 1993, p.167). From a poststructuralist perspective, the importance of this discursive context is not so much that they offer positioning alternatives but that they show which ones are desirable or possible to take (Jones 1993). A conclusion to be drawn from this is that, when the girls speak of their 'selves' as 'sexual risk subjects', "...they are taking as their own the discourses through which they are shaped" (Davies and Banks 1992, p.3).

Before finishing this section I would like to present some examples of the girls' identification of others as 'risk subjects'. As I mentioned before, the discursive production of 'risk subjects' is not constrained to an exercise of self-inspection; the 'other' is also scrutinized. The aim of this chapter is to analyse the links between subjectivities and risky/safe sex meanings, that is, it is the 'self' as a 'risk subject' that is my main interest here. Nevertheless, I consider it worthwhile to have a brief look at the girls' identification of others as 'risk subjects'.

In the girls' talk, the 'other', identified as a 'risk subject', represents someone who is very close to the 'self', usually a female friend or relative. The importance of the scrutiny of female 'others' risky/safe positions in sexual encounters is that it can also be a means to assess personal risks. The 'other' in question shares with the 'self' the

same gender identity and is a known figure. What can be thought of the 'other' can be also applicable to the 'self'. Because the 'other' is known, it is possible to evaluate what she has in common with the 'self'. As a result, the similarities and differences between the risk positions of the 'self' and 'other' can be established. In any case, the evaluation of the position of the 'self' with regard to the assessed risk is simultaneously undertaken with that of the 'other', either via a sort of identification to, or differentiation from, this 'other'.

An important finding related to the girls' identification of others as 'risk subjects' is that they are usually recognized as women, like the 'self'. In the data analysis I found very few examples of men being positioned as the subjects of sexual risks. The quotations shown below exemplify how other girls/women whom I talked to position other girls as 'risk subjects'.

"Maria - I think that the girl doesn't think so much [about AIDS than of pregnancy] also because she thinks that she knows the guy..."

"Suzana - 99% are like that...they [girls] have sex [without precautions] because they like them [boys]..."

Teresa - Not because they [girls] like...[but] because they got emotional and don't care about anything else..."

"Maria - We've got to protect ourselves. It doesn't matter if it's a boy or a girl..."

In the next group of quotations the examples are about the way male 'risk subjects' appeared in the girls' talk about risky/safe sex.

"Vera - [...] The [...] only thing he can catch is a disease...he is not going to get pregnant..."

"Claudia- The boys are worried [about diseases] but...at that time [during the sexual relationship] they don't care...[...]"

"Dora - Do boys face the same dangers as girls [in sexual encounters]?"

Fatima- Yes, depending on the girl..."

Why would it be that 'sexual risk subjects' were usually identified as women? I would suggest that this had to do with the subjective character of girls' definitions of

risky/safe sex, that is, the 'self' was unavoidably involved with the risk in question. So, in the 'we' and 'they' the 'I' included was explicitly identified as feminine. I would suggest that the girls' desire to be in charge of the risk situations of sexual encounters ended up by restricting the position of 'subjects' in their discourses of risk to female characters. Could this be considered a discursive strategy to underscore the point about female agency and self-governance in sexual encounters? Maybe it was.

To look at the surface of the girls' talk reveals some of the discourses that shape them as 'sexual risk subjects'. This allows us to discover some of the lenses through which they make a personal sense of risk and safety when it comes to sex. Obviously, the discovery of the discourses that are behind the subject positionings that make the 'self' a 'sexual risk subject' cannot be completed as the 'risk subject', a form of subjectivity, is itself an ongoing construction. Nevertheless, the data analysis undertaken shows that there are some discourses whose importance in the positioning of the 'self' as a 'sexual risk subject' is more evident than others. Self-governance and gender, of which I have talked so far, are two of them. In the next section I will explore a bit further the girls' investment in self-governance. This time my focus will be the discursive production of 'risk objects' or the source of sexual risks, which results from the girls' interest in the 'knowledge of the other'. In the way I read the data, the 'knowledge of the other' and 'the care of the self' constitute the two main story-lines upon which the girls discursively 'invent' themselves as 'self-governed' girls.

Personalizing Risky/Safe Sex (Part B): The Production of 'Risk Objects' and 'Knowers of the Other'

"Dora - What could possibly help you to come to the conclusion that a sexual relationship is risky or not?"

Teresa - I think that the partner...

Dora - In what sense?

Teresa - Ah...like...if he is truthful, if you know the environment he lives, the persons with whom he is associated, the methods he is used to use [...]...

Maria - If one thinks...every relationship is risky...[...] if you don't take care of yourself every relationship is going to be risky...

Marta - Ah...I think that it is risky because in general when the girl start a relationship she doesn't know him...there are cases in which you know but sometimes the girl knows him in one day and starts a relationship...you don't know from where he came from, how he acts, thinks, how he protects himself...so she has to know him first...

Maria - Or with whom he had been...

Dora - Ok...but even if you know him can you guess about it?

Marta - No...it's like I've already said, 'quem ve cara nao ve AIDS'".⁴¹

In my analysis, the production of 'risk objects' is the outcome of a process in which the 'significant male other' (the probable male partner of the proposed heterosexual sex scene) is in the limelight. He is the target of a sort of biographical investigation that is to be carried out by the girl with the aim of assessing his risk potentials. This investigation is focused on the 'knowledge of the other', which will establish if a given sexual encounter is risky or safe. I take the production of the 'risk object' - the 'other' who is under scrutiny -, and of the 'knower of this 'other'' - the one who is to proceed with the investigation, as the girls' response to the need for taking personal action in the management of sexual risks. To me this is a direct result of the emphasis on self-

⁴¹ In English this would be "don't judge AIDS by its cover". It is a slogan of a Brazilian AIDS prevention campaign that comes from a Brazilian popular proverb and has a similar meaning to the English proverb 'don't judge a book by its cover'.

control and self-governance that has dominated the individualistic discourses of health promoters in the field of sexual risk prevention (see section on page 65).

As some have argued, while biomedicine can, in general terms, provide (epidemiological) information for the assessment of the risk of HIV infection in sexual relationships, it can offer little help with regard to the evaluation of the risks attached to specific sexual partners (Scott and Freeman 1995). For people embarking on sexual encounters it is then a necessity to get expertise on sexual risk assessment. And the main strategy to develop this expertise is to build up a sort of “informational basis of risk assessment” upon which the ‘self’ acquires knowledge about the ‘sexual biography’ of a sexual partner (Scott and Freeman 1995, p.162).

According to the data gathered, the production of ‘risk objects’ is not gender-exclusive as is that of ‘risk subjects’. ‘Risk objects’ may either represent female or male characters. However, ‘risk objects’ never include the female ‘self’. The source of risk is always the ‘other’. For instance, the sexual risks to which boys are exposed may depend on their female partners:

“Dora - Do boys face the same dangers as girls [in sexual encounters]?”

Fatima - Yes, depending on the girl...”.

In another example, the risks brought by sexual encounters to girls’ reputations appear attached to those who value virginity. The conversation suggests that in this case, “everyone”, no matter the gender, is a potential threat.

“Suzana - I think that women run more risks [in romantic relationships] than men...[...] in everything...even in relation to sex. In the end there is always [...] a kind of prejudice...[...] ah, she’s already had sex...it’s always like that...”

Katia - Yeah...so young...[...]

Fatima - Because even with the evolution of this thing of [girl’s] virginity and sex in romantic relationships, there’s always been a little of [prejudice]...

Suzana - Everyone values it [virginity]...[...] Everyone prizes it...”.

The tendency to see the ‘other’ as the source of risk has been pointed out as a common feature of lay and professional thinking in the context of AIDS epidemics (Crawford 1994; Frankenberg 1992). Although the girls’ conceptions of sexual risks are not limited to diseases, but also include pregnancy and emotional and moral harm, AIDS is

one of the most frequently mentioned threats in their talk of risky/safe sex. It is the contemporary proliferation of discourses on HIV/AIDS, I think, that is mainly responsible for making the notion of 'risk' such a marked factor in the girls' daily life, particularly when it comes to sexual issues.

It may well be that the girls' ways of seeing HIV/AIDS risk influence the ways they see sexual risks in general. If that is the case, we can perhaps apply here what Crawford (1994) says about the "identity work - protecting or reformulating self boundaries, reinforcing images and reimagining the other" (p.1348) - resulted from our need to assure our healthy state against infectious diseases like AIDS. Crawford's argument is that the modern and valued notion of health and the healthy being, who embodies what it means to be a good person, has generated an intense elaboration of the 'self' (Crawford 1994). In contemporary societies, he argues, health has become a social and personal ideal that was incorporated into the 'self' as a language of identity. In such contexts the body is assumed to be originally healthy. Those who are the recognized 'unhealthy' bodies are believed to be the deviants from the norm of healthy beings. Disease is then seen as deviancy from the norm; diseased beings lose their original healthy state through deviancy within the 'self'. Diseased bodies are also diseased identities. Health is a reward, disease is a penalty.

As Crawford (1994) remarks, in the health promotion discourses, the 'healthy self' is a composite of risks that have to be controlled within the 'self'. Loss of control will result in 'unhealthy' behaviour and deviancy from the norm. Boundaries between the 'healthy self' and 'unhealthy others' are then created to protect the healthy identity of the 'self'. "The other just becomes the person who, unlike self, does not properly manage risks once they (the risk and the person) are identified" (Crawford 1994, p.1357). In the context of AIDS the immorality of the disease is reinforced. The sick person is suffering the consequences of his/her risky behaviour. Unlike me, he/she did not behave well.

I would like to suggest that the categorical labeling of AIDS as a disease of deviant persons is quite influential in the girls' tendency to personalize the risks and safety of sexual encounters, even when AIDS is not the risk considered. I suspect that it is so influential because the discourses on AIDS and the notion of risk that they encapsulate have been massively targeting adolescents, above all in the terrain of sexual

transmission. It is my impression that although ‘risk’ appears in all sorts of discourses, it is via discourses that are focused on the risks of the sexual transmission of HIV/AIDS that the girls become more familiarized with the notion of risk. If this is true, there may be two reasons for that. First, sexual experiences are highly important for the girls, sex is constantly on their agenda. So everything that has to do with sex becomes equally relevant. Second, discourses on AIDS risk contain a conception of prevention that points out the route for the production of the ‘self’ as a competent manager of personal life, which is congruent with the ideal of self-governance emphasized by neo-liberal regimes like those of contemporary Brazil.

I come back now to the point about who is identified in the girls’ talk as the source of risk. While the identity of ‘risk objects’ can vary, ranging from girls to society as a whole, it is boyfriends (or boys/men with whom girls/women are romantically involved) who are most commonly identified as the source of sexual risks. So, in this case, the ‘risk object’ has his gender specified; he is definitely a man.

“Dora - Do girls run the risk of being seen as easy (when they sleep with their boyfriends)?

All of them answer at the same time - Yeah.

Claudia - It depends...if the boyfriend is a ‘dog’⁴², yes...

Ines - Yeah...there are some who comment on it with everybody”.

“Dora - Do girls run the risk of being seen as easy (when they sleep with their boyfriends)?

Marta - Yes, sometimes, but it depends on the boyfriend...

Teresa - If he really loves her he is not gonna do that...”.

I have chosen to illustrate the girls’ tendency to represent ‘risk objects’ as boyfriends, two examples that are not related to what are conventionally regarded as sexual risks, like sexually transmitted diseases and pregnancy (which are more commonly emphasized as risks to girls’ health). My intention here is to highlight that the risk portfolio attached to sex is broader than many would think⁴³ (see Fig. 2).

⁴² To be a ‘dog’ means to be a despicable person or someone who cannot be trusted.

⁴³ See my interpretation of this notion of ‘risk portfolio’ on pages 131 and 157-158.

Figure 2 – The Girls' Perceptions of Sexual Risks According to the Harms They Can Cause

TYPES OF RISKS ASSOCIATED WITH HETEROSEXUAL SEX	EXAMPLES OF THE HARMS THAT THESE RISKS CAN CAUSE
Emotional Sexual Risks	to be deluded, to be betrayed, to lose her boyfriend after the first sexual relationship
Moral Sexual Risks	to be forced to quit school in case of pregnancy, to be abandoned by her boyfriend in case of pregnancy, to assume responsibility for the baby alone, to disclose her sexual activity, to be a one night stand only, to get
Physical/Health-Related Sexual Risks	to be seen as easy, to not know how to make love
	to not give pleasure to the sexual partner, to not have personal pleasure
	to get pregnant, to contract AIDS and other diseases

In the conversations quoted above, the risk considered is the girl's loss of reputation, which would be the result of her boyfriend's betrayal. A research finding illustrated by those two examples is that not every boyfriend is recognizable as a 'risk object'. In the cases above only those who are a "dog" or do not really love their girlfriends are potential threats. To be a 'risk object' means to have a particular identity. 'Who' is the 'significant male other' is then a key question that will have to be repeated again and again each time the risks of sex are to be assessed, for everything "depends", that is, everything is contingent.

According to the girls, the identity of the man with whom a woman sleeps is directly related to the dangers that this woman will possibly face in her sexual encounters with him. The boundaries between risky and safe sex are, then, to be defined in relation to what the woman knows about the 'significant male other'.

"Claudia - [Safe sex] is to protect yourself and to know with whom you are, isn't it? To know if he doesn't have any dangerous disease..."

"Ines - [Safe sex] is to know that after having sex with him he won't kick your arse..."

The importance given to *“to know with whom you are”* for the categorization of sexual relationships into risky and safe and obviously for the identification of ‘risk objects’ implies that to get to know the ‘other’ is crucial for the assessment of sexual risks. The quotations shown above suggest that the process of knowing the ‘other’ is focused on the identification of specific attributes of this ‘other’, to which some value is ascribed. In practical terms, *“to know with whom you are”* relies on searching and finding out ‘signs’ of the attributes that in the end will make the difference between the ‘risk-man’ and the ‘safe’ one. This procedure is a complex one, for ‘signs’ are symbolic constructs.

To discover ‘who is he?’ in the assessment of the riskiness/safety of a sexual encounter means to go through a reflexive journey that will first find personal signifiers for risk/safety and then utilize the resulting image of risk/safety to check its identification with, or distinction from, the ‘other’. For example, in the quotations above the assessment of the riskiness/safety of having sex with the ‘other’ is based on the ‘signs’ that he does not *“have any dangerous disease”* and that he will not *“kick your arse”*. In another conversation, *“the way the person reacts”* and *“the way he treats you”* are suggested as ‘signs’ of the ‘significant male other’s’ faithfulness and sincerity. Each of those ‘signs’ seems to be read as symbols of safety.

The ‘other’s’ state of health, is another attribute that seems to be important to assess. Claudia’s and Suzana’s comments illustrate how the ‘signs’ concerning personal appearance can help to assess whether the ‘significant male other’ is a ‘risk object’ or not.

“Claudia - Ah...he can’t be slim like...[...] he can’t be very slim...if he is with something like coughing, the way he is...I don’t know [...]”.

“Suzana - If he is pale or too slim then I think this is a sign that he is not fine...or that he is not healthy...he may be hiding something, you know...”.

“To know with whom you are” is based on subjective evaluations. The dependence on subjective criteria reveals the fragile accuracy of the girls’ sexual risk assessment (which the girls seem to be aware of). The sincerity of the ‘significant male other’, for example, is an attribute that is completely up to the judgment of the ‘self’. ‘Sincerity’ is a relational concept. It is not something that can be measured or concretely

visualized. To be sincere is also an attribute that is time- and space-contingent. Somebody can be sincere now and here and be false tomorrow and anywhere else. Given that it is a moral attribute, 'sincerity' can imply various meanings, depending on the values ascribed to it. The next quotation shows the level of subjectivity inherent in the assessment of sincerity and the primary reliance of sexual risk assessment on the ability of the 'self' to evaluate the risks. It also indicates that the evaluation of the risks depends partially on the 'assessed other', or better, on his willingness to show his 'true self'.

"Dora - How are you going to know that [he is sincere]?"

Ines - ...[If] he tells me everything he knows [...]

Julia - No...there are persons who know how to tell a perfect lie.

Ines - Ah...being with him for a long time...he is going to tell me the truth..."

The data analysis suggests that the importance given by the girls to 'the knowledge of the other' is associated with the need to trust this 'other' before having sex with him. To know the 'other' is a '*sine qua non*' condition for building up trust.

"Fatima - If you know your boyfriend well you, at least in theory...you do not think that you run the risk of being abandoned after your first sexual relationship..."

"Maria - [...] A girl usually tries to know very well a boy before sleeping with him...I think that girls do not feel safe if they do not trust their boyfriends..."

"Claudia - If a boyfriend is faithful and the girl trusts him, then AIDS and 'other' diseases do not cross her mind when she has sex with him..."

"Julia - I think that most of the girls plan to wait until they know a boy very well before they can even think about sex...at least the girls I know, and I agree with them [...] because if you don't know the person, you know, how can you trust him to the point of sleeping with him? It would be risky, wouldn't it?"

Trust receives the highest value in the value hierarchy upon which the possible risks of a given sexual encounter are evaluated. For the girls, trust 'shall be' the synonym for safety. A faithful 'significant male other' 'cannot be' a source of risk. I will show later on that these assumptions are not used as absolute truths in the girls' discourses of

sexual risks. Trust appears to be an ever-revisable item in the girls' evaluations of the risks of sex. The employment of the criterion of 'trust' in the assessment of the risks of sexual encounters has the effect of individualizing 'safety'. That is, 'safety' becomes a sort of belonging, a mark in the identity of the faithful and truthful 'significant male other'. As a consequence it is also a mark in the identity of the 'self' with whom this 'other' will sleep.

The safety line created around the 'self' and its truthful male 'other' generates a sense of self-immunity, although this is not a strong sense of safety. It is the unknown male 'other', the options not taken, that 'shall be' the 'risk object'; not the girl's choice: the well-known and truthful boyfriend.

"Katia - I never had a boyfriend but I know from my friends' experiences that they trust their boyfriends...at least this is what they say...I don't know but I think that after being with him for quite some time you start to know him and to recognize his qualities and problems...you can say that he is like this or like that...and if the girl decides to have sex with him I think that it's because she trusts that he is different.

Marta - Yeah, and if she thinks that he is different from others [...] it's because she trusts him...

Teresa - Of course, you would not choose someone that was not different from others...first you feel that he is different and then you need to know if he really will not do the same things that others do to their girlfriends...

Marta - ...It's rare to find a girl who has sex with someone she doesn't know well to the point of trusting him...those who do that...the girls who shag with strangers usually pay a price...

Katia - Yeah...they put themselves at risk..."

While the development of trust constructs a protective barrier against the risks that are to be found outside the relationship between the 'self' and the 'significant male other', the assessment of truthfulness, like of other attributes, is heavily dependent upon subjective judgments. The possibility of not being told 'everything' may undermine the assessment of sexual risks, for it partially relies on what the 'significant male other' tells to the 'self'. However, there are mechanisms for making such evaluations look more objective and accurate. The focus then shifts from the 'significant male other' and his attributes to the relationship itself. The variable of time is then considered.

The more time the girl spend with her 'significant male other' before having sex with him, the more chance there is of him telling her *"everything he knows"*. In a lasting

relationship the girl might have time to know the ‘other’ and establish with him the intimacy and the sort of commitment that is considered as indispensable for making a sexual encounter safe. The problem is that it is not men’s ‘nature’ to wait.

“Claudia - I think that it’s more difficult for boys [to have a long lasting relationship without sex than it is for girls] because they like more to have a relationship with sex...they feel better I think... The woman may also feel like that but she knows better how to hold on...”.

“Claudia - The man is more hasty isn’t it? The man wants that the woman give, you know? ...”.

“Vera - The role of the man is to put pressure on the woman for her having sex with him”.

When to lose virginity is, then, not always a decision taken on the basis of the projects of the ‘self’:

“Tania - The girl cannot plan the day she is going to lose her virginity...[...]

Claudia - It’s a thing of the moment...

Tania - Like...I think that- in that specific moment I am going to decide to have my first sexual relationship...then the boyfriend is one of those who used to put pressure on you...and in the end you give up before the time you had predicted...”.

It seems to be common-sense among the girls that “to know with whom you are” is important for the building up of trust and in the personal establishment of the boundaries between risky and safe sex. They also seem to think that the attributes that matter in the ‘process of knowing’ are variable. Personal values influence individual judgments about which knowledge to treat as relevant. For example, not everybody agrees about the importance of appearance:

“Julia - For me appearance doesn’t matter [...] I have to know him for quite some time...I have to know about his whole life to know well how he is ...[...] to know if he is a good person”.

In the case above, to be “a good person” matters more than ‘good appearance’. This suggests that personal values are very important in the girls’ identification of ‘risk objects’ and also that their definitions of what is risky and what is safe sex are necessarily subjective. To estimate if somebody is “a good person” depends on an evaluation that is informed by the moral code assumed by the individual who makes

the judgment. In Julia's case, the signs she could look for in her evaluation of the goodness of the 'other' could be those concerning honesty or moral correctness.

"Dora - What is to be a good person?"

Julia - Ah...not being a robber..."

And also signs of good health, which would confirm the moral character of the 'other':

"Julia - Also, you ought to know if he doesn't have any disease that I can catch...I'm going to protect myself you know, but I don't know..."

The reliance on personal judgments about the faithfulness and truthfulness of the 'significant male other' in the assessment of sexual risks does not seem to mean that the girls are naive, which could perhaps be easily assumed by risk experts. The conversation shown below suggests that they are well aware that this is a risky way of assessing the dangers of sexual encounters.

"Marta - I know that sometimes we can be terribly wrong...we think that because we are in a stable relationship with our boyfriends they are going to be faithful and we can really trust them..."

Fatima - It's always like that, the girl thinks that time implies love but...

Marta - Yeah...to trust your own feelings can go terribly wrong...we can be risking many things without knowing it...

Suzana - I think that's the case of a married woman. They think that their husbands are faithful but they are not..."

Also, it does not seem to be the case that to rely on trust for the assessment of sexual risks is the result of a lack of knowledge or misunderstanding about the risks involved.

"Maria - [...] It's not rare to see husbands sleeping with other women while their wives stay there waiting for them and trusting that they are just playing football with friends. That's why married women are catching AIDS...you know, they don't protect themselves because they think that their husbands are faithful..."

Fatima - Yeah...and this can also happen to us..."

"Ines - We know that men are not always faithful. We know that there are boyfriends who betray their girlfriends. You can catch AIDS..."

Tania - *Yeah, not only AIDS...you know, he can say that you are the only woman in his life, but...he can be sleeping with other girls and you think that he loves you but in reality he is laughing at you in your back...*

Julia - *I agree...it's not only AIDS...if we think of pregnancy for example, he says 'don't worry, if something goes wrong I will assume everything' and I know many girls who trust their boyfriends' words and...*

Ines - *[...] but I think this is not so important...the worst of all is when a boy sleeps with a girl and tells her lots of beautiful words and repeats them to another woman and you trust that he is sleeping only with you and you can be risking your life...".*

If it were neither because of naivety, nor of ignorance, then why would the girls consciously employ such an unsafe way of distinguishing risky from safe sex? I suggest that, in the same way of the emphasis on the 'care of the self', the importance given to the 'knowledge of the other' for the attachment of meanings to risky/safe sex is influenced by what the girls know about the society they live in. The girls' interest in taking 'safety' into their own hands may well be a response to the climate of individualism and emphasis on self-governance that permeates life in the 'risk society' (Beck 1992).

In contemporary Western societies individuals' accountability for personal welfare is the motto (Rose 1989). In circumstances of modernity safety cannot be externally assured and the awareness of the risks is expected to be translated into the adoption of self-care measures. In the specific field of health, risks are not taken as external enemies, nor considered as a product of social interactions. Risks to health are seen as coming from the individual's presence or absence of self-control; the self is supposed to manage and master the drives that put the body at risk (Crawford 1994; Ogden 1995; Scott and Freeman 1995; Lupton 1995b). The 'self' is the risk itself. Commenting on the specific case of the current phase of AIDS epidemic, Ogden remarks, "the HIV virus itself is no longer a risk to health: the individual's ability to control their sexual behaviour is now the risk" (1995, p.413). In such circumstances, the estimation of the potential riskiness or safety of personal actions, like embarking on sexual encounters, and also the consequences of right and wrong judgments have got to be assumed by the 'self' who has the moral obligation to be 'careful'.

The reliance on a personal identification of 'risk objects' is, as I have stated previously, part of the process in which risky/safe sex is personalized. In my view, to see risk/safety as belonging to a given person and to assume personal responsibility for finding out 'who is risk' and 'who is safety' in the realm of sex, is an attempt to reduce the uncertainties, hence the risks of sex (Thompson 1986). In spite of the efforts, however, doubts about the faithfulness of the 'significant male other' seem to be ever present in the girls' mind. As Thompson (1986) suggests, to get to know about a potential threat, like that represented by a 'sexual risk object' may reduce the risks, not eliminate them. Such a reduction is not achieved by changing the situation in question but the level of knowledge about it. The knowledge acquired can only make a difference in terms of an increase in the girls' ability to 'colonise' their future by making informed decisions concerning present actions. What are the risks of the present choices? Among those risks which ones are tolerable and which are not? The decisions are made on the grounds of what kind of future they seek to colonise for themselves (Giddens 1996), in the sense of who they want to become and what they want from their future life.

"Marta - [...] This (the prevention of the risk of a boyfriend's betrayal) has no solution.

Suzana - It's a question of destiny, I think...or of luck.

[...] Dora - Is it possible to protect oneself against the risk of betrayal?

Marta and Suzana - No...

Katia - It depends because we might like a person who is not worth anything...the most that we can do is to try...

Teresa - Ah...I think that it is not so impossible...

Fatima - [...] We trust that person (boyfriend) and never expect to be betrayed...

[...] Katia - I think that you have to trust that he likes you because if he doesn't...()...if he stops liking you, he betrays you...

Maria - I don't know but this thing that if you love someone you don't betray, I don't know...

Teresa - Ah...but I think that you can still find those who don't betray...

Katia - Me too...They exist...

Teresa - Come on, there must be someone...

Maria - There are some who don't betray...for example, Fatima has never betrayed her boyfriend, has she?

Suzana - *I don't know, everything depends...you can't guarantee anything...*

Katia - *Yeah...I think we can't...*”.

To be aware of the options and obliged to make choices have already been highlighted in this thesis as marks of modernity (see Chapter 2). If, on the one hand, this can be regarded as positive because it may represent one's ability to master one's own destiny, on the other, there is a price to pay. The awareness of the existence of options allied to the reflexive act of choosing inevitably generates insecurity. Did I take the right decision? Am I assessing the right risks? Will my decision have the expected outcomes? All these questions may come to people's minds when they take decisions with regard to risks. That seems to be the girls' case. Their emphasis on “*to know with whom you are*” as a form of developing trust in the ‘other’ and the ability of taking care of the ‘self’, does not appear to generate a sense of complete safety. Trust is something that seems to remain open to reconsideration. To trust the ‘other’ and to trust the self-competence to make right decisions apparently brings more uncertainties to the context of relationships. As the quotations below demonstrate, the dependency on knowledge (which can always be subjected to changes) makes the assessment of the risks of sexual relationships only “valid until further notice” (Giddens 1996, p.32).

“Teresa - [...] *I can say that I trust him...but I don't know if I want to trust or if I really trust him...I can't say that I don't have loads of doubts...but...ok, then I see how the things happen, then I forget it and think that it's rubbish...but I always have a bit of suspicion*”.

“Maria - *I don't know but I think total trust doesn't exist...One never knows completely the other...like affirming that he didn't or won't do that...*”.

“Suzana - *You've got to trust him with suspicion, haven't you? I think that in the end the man is not...[...] they don't put the same value as we do, you know? I think that even if it was my husband I wouldn't trust him. I wouldn't feel safe...*”.

“Ines - *This thing of trust is complicated...you never know...each day is a surprise...*”.

“Maria - [...] It’s difficult to know if the person loves you so much that he is not going to do anything wrong...maybe only knowing him very well and even so one can’t know someone so well...”.

“Claudia - To trust that a man is telling you the truth is like a lottery, you cannot say that you know everything about him...”.

The emphasis on trusting the ‘other’ as a prophylactic measure in the risky context of heterosexual sex was also found in other studies investigating feminine understandings of risk/safe sex. In Brazil, for example, Guimaraes (1996) found similar results in a study that aimed at investigating women’s perceptions of AIDS risk. They interviewed women between twenty and forty years of age who were married or in steady relationships. Those women belonged to two groups - one of HIV positive and other of supposedly non-infected women. One of the most common justifications used by the supposed HIV negative women for not taking precautions against AIDS, mainly with respect condom use, was ‘but I know him’ and ‘I trust him’. The author has called attention to the fact that justifications grounded on ‘knowledge’ and ‘trust’ are not restricted to this specific feminine population but are present in every social segment. My data suggests that this is a correct argument, at least as far as women of different ages are concerned. For Guimaraes, given its recurrence, ‘knowing the other’ is the most common method of prevention of AIDS and sexually transmitted diseases amongst the feminine population. According to my data, ‘knowing the other’ is also a strategy of prevention of other sex-related risks, like the risk of disillusion and betrayal. This broader use of ‘the knowledge of the other’ as a prophylactic against the risks of sex are referred by Guimaraes’ interviewees: ‘I’ve never thought that he would do this to me’ and ‘he betrayed me’. These phrases expressed the disappointment of the HIV positive women when talking about their failed attempts at assessing sexual risks on the basis of the knowledge about the ‘other’.

In a study with British young women, Holland et al (1991) have also found that ‘trust the other’ is part of feminine strategies to deal with sexual risks. According to Holland et al, ‘trust’ was used by young women as a way of developing a sense of steadiness in their relationships. As the authors have argued, because steady relationships are ideologically constructed as monogamous and basically safe, trusting the ‘other’ can signify that the use of other precautions, like condoms for example, is not only

unnecessary but also indicates a lack of trust and, therefore, of love. According to the data analysis carried out by Holland et al., condoms were only necessary in the context of casual sexual encounters. After the establishment of intimacy and a certain level of trust, the only precaution seen as necessary was the pill, which suggests that the only risk considered was the risk of pregnancy.

It is worthwhile coming back for a moment to the idea that the girls' reliance on "*to know with whom you are*" for the estimation of sexual risks is a reflexive way of seeing and constructing the 'self' as a 'careful self'. My point now is that the contribution of the emphasis on 'knowing the other' in the development of girls' subjectivities goes beyond that. As the conversation shown below suggests, being careful and responsible is perceived as typical of girls/women as opposed to boys/men who do not take sex, among other things, seriously. The girls' emphasis on the 'knowledge of the other' in order to position the 'self' within discourses of sexual risks as a 'careful self' can then be interpreted as a means of gendering the 'self', which is carried out according to what is perceived as a 'normal' feminine behaviour.

"Teresa - [...] Girls are always much more worried than boys about everything..."

Dora - Do girls think more?

Teresa - Girls almost burn their brains...

Fatima - Girls take it more seriously...

Maria - It's because they (boys) see the sexual act differently than girls [...]

Dora - And how do boys see that?

Maria - [...] For him to have sex is beautiful...the girl has got to be kept for the person she likes [...]...so for them [the boys] to shag is a thing more...

Fatima - ...Normal...a normal thing...

Maria - Yeah...it is part of...the girl has all that taboo...that thing, hasn't she?

Teresa - ...That preparation...

Maria - ...To be ready...

Teresa - ...To find the right guy...[...]"

What I am trying to say here is that the reliance on the 'knowledge of the other' for the development of a sense of security within relationships also results from the influence

of gender ideologies in the girls' ways of seeing and being. It is a sort of common-sense (at least in terms of 'normalized practices') that the feminine participation in sexual relationships is to take place in the context of steady relationships. At least this is what it is expected from a 'naturally' responsible woman.

To have sex with a known man symbolizes commitment between the 'significant male other' and the 'self'; a commitment that is only possible after some time of emotional involvement and a sharing of biographical information. In Brazilian society women who have sex in casual relationships are still implicitly condemned. In my view, to seek to know the 'significant male other' before having sex with him provides a sense of security for at least three reasons. Firstly, it increases the ability to make informed decisions concerning present and future sexual encounters with this 'other'. Secondly, it makes the sexual encounters in which the 'self' may be involved fit into social norms. And thirdly, it may be a protection against diseases.

For girls it is safer to have sex with somebody they know, trust and love and to be seen as behaving like 'normal' women and also to show it to others (Holland et al 1991). To behave according to expectations provides a means for the anticipation of others' reactions to personal behaviours. In contrast, it is risky to go against the norms. To have sex without commitment to the 'other' and to the relationship might mean sex for pleasure, something that remains a male privilege, or in the other extreme, a thing related to female prostitution. In the realm of female sexual activity there is still the feeling that it is safer to embark on sexual encounters for love, which can only happen in the context of steady and monogamous relationships. In a similar vein and on the basis of their study with young women in Britain, Holland et al (1991) write: "most young women are reluctant to describe themselves as having casual sex when the culturally approved objective is to be in a steady, preferably monogamous relationship, supported by the ideologies of romance and love"(p.18).

Apart from agreeing about the influence of the culture of monogamy in the girls' emphasis on sex for love, I would argue that this is also to do with the fear discourses that circulate within the 'risk society'. It appears that for the girls to whom I talked, sex is unthinkable, unspeakable and undoable outside the context of romance.

"Maria - I think that I couldn't have sex with a man without liking him".

“Julia - I don’t plan anything...I don’t know my future, but one thing I know, I’m not gonna have sex with any man [...], only with someone I like...”.

“Tania - I think that [the woman] must not give herself to the first man [...] because it [sex] has to be done with somebody you like...that you know also likes you...”.

“Ines - I don’t know yet but I think that sex shall be good when the partners like each other...”.

The quotes shown above suggest that romance is the social context of girls’ sexual encounters. The girls’ knowledge of romance gives them a fair idea about the available options in terms of men’s and women’s ways of being and behaving in romantic relationships, hence in sexual encounters. How to behave as a ‘girl’ and what to expect from boys in a love-based sexual encounter is then prescribed by the menu of options of ‘ways of being’ in a typical romantic relationship.

“Ines - Girls are better behaved in relationships...”

Claudia - Girls take it more seriously...

Dora - What’s that to be well behaved?

Claudia - ...only those who want to take the relationship seriously [are those who behave well] [...]... the girls take it more seriously. The man doesn’t...if the man is supposed to go to the girl’s place...The girl doesn’t, the girl thinks I’ve set up the appointment I’ve got to go, you know? It can be raining cats and dogs...at least I’m like that...If I set up something I will be there...”.

While the girls have no problem in affirming that to have sex for love is typical of girls, they suggest that in general this is not for boys.

“Katia - [...] Many times the girl ‘reserves’ herself for the guy she thinks is the right guy...the boys don’t...I know an awful lot of boys that were only flirting with the girls and had it [sex with them]...”

Marta - Yeah, just for self-assertion...

Maria - ...For having experience...for being experienced and then knowing how to do it with their girlfriends...”.

“[...] Fatima - I think that in general it’s for getting experience...for knowing how it is [...]...in general I think that the first time of some boys is not even with whom they like...it’s just for knowing how it is... ”.

This suggests that to find the ideal male partner, one who among other differences would not want sex unless it is for love may not be easy. This type of boyfriend would be someone who is different from the mainstream men.

“Dora - *Is every boy like that?*

All answer - *No...*

Vera - *The majority...*

Tania - *Yeah...but we find some exceptions [...]”.*

The idea that ‘my man’ is essentially different from the majority creates an idealized image of boyfriends. The stronger the emotional bond between the girl and her boyfriend, the more this image is reinforced. What seems to happen then is that as the time passes and the relationship becomes more intimate it gets more and more difficult to make objective evaluations about the riskiness/safety of the relationship. The feeling seems to be that ‘my man is each time more perfect and even if he is not that perfect this does not matter because we love each other’.

The assessment of the risks of sex is recognizably biased by love: “*when you love him you make the most silly mistakes*” . Emotional risks like the risk of being rejected after having sex and moral risks like reputation-related risks, for example, have a low probability of being realized, for this is what others would do not the one “who likes me”. Implicitly, it is difficult to question the state of health of a morally correct ‘other’. So, the risk of sexually transmitted diseases is also ‘almost’ out of question.

The imaginary boundary between ‘typical’ ‘others’ and the ‘different’ ‘significant male other’ is fed by discourses of morality that impregnate the messages of sex education, particularly those concerning the health-related risks of sex. Biomedical discourse strongly suggests that ‘risk groups’ for HIV/AIDS and other sexually transmitted diseases are constituted by deviant people (Gorna 1996). The ‘morally wrong’ persons are the risk carriers - those who have sex outside steady relationships, who do not take care of themselves and do not always use condoms, who have homosexual relationships or use injecting drugs.

For the girls, to whom sex has a great appeal, to survive in such a risky environment it is compulsory to look for a man who is outside the boundaries of ‘risk groups’, one who is an exception to the rule. As in a terrain where male nature is believed to be in

principle a risk, anything more concrete can guarantee safety (neither scientific methods of protection, nor personal strategies). The hope is then that affection might bring about a sort of 'subversion' of man's nature, which may mean a promise of safety.

With my analysis of the production of 'risk objects' in the girls' discourses of risky/safe sex, I hope to have made clear my point about the connections between the girls' interest in 'the knowledge of the other' and 'the care of the self'.

CONCLUSION

I have reached the conclusion that in the process of developing a personal approach to the risks of heterosexual sex the girls are caught up in a cycle of personal projects for the 'self'. First, under the influence of the dominant discourse of individual accountability for personal welfare there is the investment in the production of a 'careful self'. A 'careful self' needs to do something to assure protection against the risks of sex. The primary means of self-protection is the investment in the knowledge of the 'other'. However, to know the 'other' is not sufficient to guarantee safety. On the contrary, it is a recognized risky strategy. The need to be 'careful' is then reinforced, but not as a way of getting rid of the risks for good.

The impossibility of guaranteeing a risk-free sexual practice adds another project to the 'self', one that is more complex than the other ones, but perhaps one that can confer a sense of security to the 'self'. This project is that of 'self-governance', without which it is problematic to think of taking care of the 'self' in the risky environment of sexual encounters. In such a context to be a 'careful self' does not mean to be risk-averse but to be able to take control of the risks by choosing which risks to take. And this is (in my view, quite accurately) seen by the girls as only achieved by those who are the owners of their own life, agents who are free to manage their risk portfolio.

My conclusion then is that the girls' 'invention' of themselves as 'self-governed' beings is a necessity. Without this illusory sense of the 'self' it would be complicated to 'survive' the awareness that sex always involves some sort of risk, no matter how careful one is and, at the same time, to respond to the social demands for self-protection.

CHAPTER 6

CONCLUSION

The argument of this thesis is that 'risk' is an epistemological construct, an assumption that originates in sociological theories of risk. To say that is to assume that risks exist only in terms of our knowledge. This is not imply that the dangers of everyday life are not real threats, but that danger does not become risk until it comes to be known as such. The idea that 'risk' is an epistemological construct leads to further assumptions: first, that the 'process of knowing' in which risks become recognized as such involves judgmental considerations; second, that this 'process of knowing' is framed by the sociocultural environment where what comes to be known as 'risk' is to make sense. The knowledge that goes into it is then considered as a by-product of the sociocultural interactions of daily life. The attachment of meanings to risk is taken as value-laden, an idea that contests the neutrality and objectivity of scientific conceptions of risk and argues, instead, that conceptions of risk, either produced in scientific settings or not, are subjective 'ways of seeing' it.

Influenced by such ideas, I designed a research topic to investigate the ways by which a group of Brazilian adolescent women see the risk of HIV infection in heterosexual relationships. Adolescent women's accounts of risk have usually been absent in health promotion's theories about adolescents' risk-taking. Health promotion has privileged biomedical perspectives in theorizing about the way adolescent women see the specific HIV/AIDS risk. Health promotion's empirical approach to the subject has often looked for data about the (ir)rationality of risky sexual behaviour, with an interest in the evaluation of what is wrong in adolescent women's ways of thinking that make them decide to take risks. My intention, however, was not to use data to judge if the girls' risk perceptions were correct or not. My research was exploratory rather than evaluative. It was an attempt to study the 'HIV/AIDS sexual risk' from the perspective of its subjects, in my case here from the perspective of adolescent women, thus expanding our understandings of the meanings of sexual risks in general, and HIV/AIDS risk in particular. As some sociologists have suggested, if we are to

understand people's responses to risk, we need to look at what they mean by 'risk' in the specific contexts where 'risk' makes sense to them.

The research question became defined as: "how do adolescent women see the personal risk of catching HIV/AIDS in heterosexual relationships?", followed by the sub-questions "what are their views?", "how are those views constructed", and "what are the implications of the research findings for health promotion?". Because most of the health promotion theories about the way adolescents approach the 'HIV/AIDS sexual risk' have drawn on empirical research about their responses to the message of 'safe sex', I decided to use the same focus to explore the girls' ways of seeing HIV/AIDS sexual risk. I consider 'safe sex' and 'risky sex' as expressions that are now in common use amongst lay people when they talk about 'HIV/AIDS sexual risk'.

The main method of data collection was focus groups. While the focus group technique is not new in the context of social science empirical research I have worked with an innovative approach. The use of what I have called 'integrating activities' to enhance group integration facilitated a great deal the exploration of what risk and sexual risk meant to the girls. The qualitative analysis of the data was carried out in two parts; the first explored accounts of risk in its broader context (in the form of everyday risks) while the second looked at accounts of risk as applied to heterosexual relationships.

In this thesis we have expanded our knowledge about adolescent women's approaches to risk. We have learned, for example, that while the notion of risk can be applied to different contexts, risk meanings follow a basic pattern. For instance, whatever the risk context, the girls with whom I talked usually employed the word 'risk' in the sense of an uncertain danger that may or may not be realized in the future. Probability estimations were added to the meanings of danger to transform 'danger' into 'risk'. Risk assessments were carried out on the grounds of a sort of pragmatic rationality, a subjective and situated way of reasoning constructed in accordance with the knowledge and values learned in life experiences. This way of reasoning proved to be quite different from the universal and abstract rationality used by health promotion's risk theorists when they make their risk calculations or interpret the risk estimations undertaken by lay people (Guizzardi, Stella, and Remy 1997). This immediately led to the conclusion that the girls' approach to risk is extrapolated from traditional technical interpretations of adolescent women's risk-taking. The girls' discourses of risk were

produced in reference to a given knowledge background and set of values, which strongly suggested that research and theories on adolescent women's approach to 'risk' should consider 'risk' as an epistemological construct and that more attention should be given to its social and cultural meanings.

According to my analysis, the girls' views, beliefs and knowledge of the world they live in constitute the raw material upon which conceptions of risk are constructed. Risk meanings are produced at the interface between the girls and the sociocultural context where they experience their daily life. The knowledge background that each girl uses to make sense of risk appears to have a common basis - the same ordinary social knowledge used to make sense of the other constitutive elements of private and public life. However, this does not mean that every risk is understood via the same combination of knowledge, nor that different risks are interpreted through different knowledge. To make sense of a given risk seems to imply choosing, amongst the available knowledge, the background upon which the risk in question is going to be understood. This choice is value-laden. The data analysis has suggested that distinct individual combinations of knowledge and personal values informed different positions with regard to the same risk.

We have also learned from this thesis that for the girls to talk of risk inevitably meant to talk of 'self'. Discourses of risk seemed to imply an obligation to make the 'self' visible, or better, of making its positions explicit. So another conclusion with regard to the knowledge that goes into conceptions of risk is that of the knowledge of 'self'. 'Who is the 'self'?' and 'what are the projects of 'self'?' were questions whose answers came to be intertwined with risk meanings.

In the girls' accounts of the specific risks of sex, to be 'at risk' or 'safe' was reported more as a matter of the individual ability to assess the risks accurately and to act accordingly than in relation to the use of external means of protection like condoms. To make sense of risky/safe sex was a reflexive exercise that included self-inspection, self-problematization and self-monitoring. The data analysed in Chapter 5 has indicated that risky/safe sex meanings are produced as representations of 'self'. It seemed that they are used as expressions of 'risky' and 'safe' identities. This suggests that the scientific definition of 'risk' as something that is located within the 'self' (Ogden 1995), a form of thinking usually employed by health promoters in their

theories on HIV/AIDS risk, also underpins the girls' 'ways of seeing' the risks of sex. Two conclusions have emerged from this. Firstly, this is an indication of the influence of health promotion's discourses on risk on the identity work that seems to be in place when the girls make sense of risky/safe sex. Secondly, it suggests that the individualistic approach to risk adopted by health promoters also orients the girls' understandings of risky/safe sex. The girls' individualistic approach to risky/safe sex was clearly emphasized in the data analysed in Chapter 4. Their discourses were focused on 'risk' and 'safety' as personal choices, implying a focus on self-governance. As we have seen in Chapter 2, this association between risk and choice has also been especially important for the production of risk discourses in the terrain of health promotion.

Another similarity also shown in the analysis was that the girls perceived the boundaries between 'risk' and 'safety' in heterosexual relationships as predictable. However, similarly to health promoters, they also talked about such predictions as uncertain and revisable. In the girls' talk, 'risk' did not refer to an absolute state of affairs. Depending on the circumstances, the same situation could represent 'risk' or 'safety'. The data analysis has shown that conceptions of risky/safe sex were ambiguous, unstable, contingent upon a given time and space, and frequently contradictory.

In the analytical chapters I have developed the notion of the 'risk portfolio', through which I have argued that for the girls 'risk' was not a monolithic entity, but part of a system of interrelated dangers. I have also made the point about the importance of this notion of the 'risk portfolio' for the understanding of the girls' ways of assessing sexual risks. Given the contextual and judgmental frame of risk meanings, 'risk' could never be thought of in isolation from the many other matters that were also part of the risk context. This implied the need to see sexual risks and HIV/AIDS in reference to an array of other risks that were equally perceived as possible hazardous outcomes of heterosexual relationships. In exploring the girls' specific accounts of risky/safe sex I have concluded that sexual risks constitute a veritable web of risks - a risk portfolio -, a system of interconnected elements each holding a relative significance within the system. HIV/AIDS is considered as just one of the many risks that adolescent women generally face in sexual encounters. For example, the risk of contracting HIV/AIDS in

a sexual encounter also carries with it risks of reputation and self-esteem, and other things that may be seen as more important than the HIV/AIDS threat itself. Actually, for the girls, the HIV/AIDS sexual risk does not have a special importance, as, allegedly, it can be more efficiently controlled than other risks. The girls also fear other sexual risks, like the risk of being (ab)used by the boy/man with whom they slept or the risk of having sex with somebody who lied about his sentiments and just wanted sex for pleasure.

The analysis undertaken in Chapter 5 has indicated that the monolithic notion of risky/safe sex conceptualized by health promotion as representing a single health hazard had limited space in the girls' discourses about risky/safe sex. It existed only as an abstract entity, which was made concrete when it became personal, that is, when the 'self' became involved in its definition. As soon as personal experiences, beliefs, points of view, values started to be articulated to produce a personal approach to it; the health meanings that risky/safe sex encapsulates became just one more meaning amongst a variety of other relevant meanings. This is an indication that the sole focus of AIDS education on disease prevention needs to be reformulated, for HIV/AIDS risk does not mean only a health hazard.

We have learned that in the process of making sense of risky/safe sex the girls personalized the risks. This is strikingly similar to the way in which health promoters theorize risky/safe sex (Scott and Freeman 1995). In AIDS discourses, the risk is not the HIV virus, but the 'self' whose personal characteristics may result in an incapacity to control behaviour. The 'process of personalization' means the understanding of 'risk/safety' as belonging to a specific person, something attached to identity. This has indicated that the identity work that was attached to the process of making sense of risky/safe sex was not restricted to self-identity, but also to the production of representations of others' identities. The data has shown that 'risky sex' was usually referred to as 'sex with a stranger other', although it could secondarily also mean 'sex without the protection of a condom'.

We have learned that personalization of risky/safe sex constituted the informational basis of sexual risk assessment, knowledge about 'risk subjects' (the potential victims) and 'risk objects' (the potential threats) being its specific substantive material. The identities of 'sexual risk subjects' and 'sexual risk objects' were discursively produced.

That is, they were shaped in the girls' discourses about risky/safe sex, which were themselves constituted by a combination of other discursive elements. While a variety of discourses was involved in defining 'risk subjects' and 'risk objects', the discourse on self-governance seemed to be especially influential. The production of the 'sexual risk subject' figure was an outcome of personal investments in "the care of the self" (Foucault 1984, p.47), whereas the production of the 'risk object' was the result of an interest in the 'knowledge of the other'. This desire to care for the 'self' by knowing the 'other' denotes the extent to which social knowledge, particularly as understood in neo-liberal discourses and messages of health promotion, influences the girls' approach to the risks of sex.

The analysis undertaken in Chapter 5 has suggested that, as opposed to what health promoters have been saying about adolescent women, the girls are neither ignorant, nor naïve about the risks of heterosexual relationships. The girls have also shown that they are not naïve, nor ignorant about their responsibility in the management of those risks. Although they may resist accepting that they need to practice what AIDS experts have called 'safer sex', they generally agree that 'girls' are 'sexual risk subjects'. So, they accept the need to take precautions. While stereotypical representations of adolescents have affirmed their 'universal' sense of invulnerability, my conclusion is that the girls whom I talked to do not perceive themselves as invulnerable to the risks of sex, including HIV infection. And it is exactly because they accept their 'risk position' that they do the best they can to control their vulnerability. Without perceiving themselves as 'at risk' it would make no sense to invest in 'the care of the self'.

It is part of AIDS education messages that, in theory, everyone is a 'risk' and 'at risk', but that certain persons are more 'risky' and 'at risk' than others. AIDS education also teaches that it is up to the individual to manage the risks. 'More knowledge' is recommended to reduce the risks. This 'more knowledge recipe' is what risk experts themselves use to minimize the effects of doubt when assessing risks. Knowledge should reduce uncertainties, hence risks. Health promotion generally assumes that the more knowledge we have, the more we are able to see and assess the risks we are exposed to and that this is sufficient for us to be able to make safer choices concerning the direction of our private lives. It seems that the girls follow the same logic when

they seek to know the 'other' in order to assess the risks of sex and take the necessary measures to assure security.

Misled by the liberal discourses on rational autonomy and health promotion's assumption of everyone's (respons)ability to make safer choices, the girls seem to be naïve. Apparently they assume that knowledge leads to safer choices (Guizzardi, Stella, and Remy 1997). This logic, also employed by health promoters, does not take into account the social factors that constrain choices (Gabe 1995; Lupton 1995a; Petersen and Lupton 1996), nor the impossibility of totally safe positions in circumstances of high-modernity (Beck 1992; Giddens 1996).

The girls' theories about adolescent women's sexual risk-taking portray the latter as free agents, a very problematic position if we take into account the power imbalance inherent in heterosexual relationships (Holland et al. 1998). To the girls, adolescent women not only know the risks but are also able to protect the 'self' if they so wish. In general, when they expose the 'self' to a given sexual risk, it is because they calculate the costs and benefits of their action, in terms of all the risks involved and of those which are less costly, and then choose to take one risk and not the other. Although there are some mismatches in the girls' and health promoters' theories of adolescent women's sexual risk-taking, like the girls' affirmation that they have sufficient knowledge about the risks and strategies of protection and the health promoter's insistence that they need more knowledge, the core of both theories remains the same. The choice discourse, the presumption of everyone's equal power to act according to their will and the simplistic view of behaviour as an individual matter are some of the ideologies that seem to underpin both approaches.

The data analysis made clear that by being socially constructed, the girls' conceptions of risky/safe sex are impregnated with the social ideologies that organize their everyday life. It also showed that the idea of the individual accountability for personal welfare, one of the most pervasive forms of governance to which the modern 'self' has been subjected, plays a very important role in the girls' approach to the risks of sex. It offers the girls the desired position of autonomy, a position that is apparently welcomed by all the social institutions - family, school, health organizations, legal systems, political corporations. By taking up subject positions within discourses of self-governance, the girls end up by recognizing themselves to be the mentors of their

own fate, which suggests a sort of alliance between their personal projects and the institutional projects of contemporary neo-liberal regimes (Rose 1989).

But if on the one hand the way the girls see the risks of sex demonstrates that they are trying hard to produce their 'selves' as self-governed individuals, knowing what everyone else 'needs' to do to be a good citizen, on the other, there are other projects for the 'self'. The girls also want to be 'feminine girls', an imperative for those who wish to have heterosexual sex experiences. Knowledge about what it means to be 'feminine' is obviously part of the knowledge background the girls mobilize to make sense of risky/safe sex. As we have seen in Chapter 5, the girls' attempts to associate knowledge learned from public discourses of risk to gender knowledge creates a paradox. The limited menu of options posed by gender discourses contradicts the focus on autonomy that is at the core of public discourses of risk.

The girls' accounts have shown very clearly that health promotion's discourse of 'autonomous choice' in circumstances where the options are very limited, or even null, is problematic. The problem is that the subject positions made available to the girls in public discourses of risk conflict with those available in gender discourses. In practice, agency is commonly not at hand when the girls need to negotiate personal sexual safety (see also Holland et al. 1998). The girls were rarely able to recognize that. Strikingly, their conversations provided many examples of a shared knowledge about the dynamics of gender relations and its inherent imbalance of power. When talking about their personal relations with men, the girls made explicit their complaints about women's disadvantages in relation to men but, contradictorily, they never gave up portraying themselves as autonomous individuals on matters of sexual risk protection.

We have seen that, as far as the messages of health promotion are concerned, the girls are very good learners (although they seem to use health promotion knowledge in a way that is not expected by health promoters). This contradicts the alleged inefficiency of health promotion, often pointed out as the reason for its failure in promoting behavioural change and the adoption of safer sex practices. It is my conclusion that the girls have assimilated not only the substance of health promotion, but also its form. The conclusion that a project of self-government is key to the way the girls make sense of risky/safe sex indicates that among a number of different types of knowledge that go into definitions of risk, the knowledge taught by health promotion is perhaps the most

influential. That is to do, I think, with the emphasis on choice that appears in a very explicit way in health promotion's discourses of risk. My idea is that for the girls it is very tempting to recognize the 'self' as an agent as 'agency' is a moral value in high-modern societies. It represents an ideal of citizenship.

Health promotion's discourses on risk present girls (and nearly everybody else) as agents. Such positions determine symbolic spaces for 'good citizens'; citizens that are able to fulfill their moral obligations with regard to personal protection against risks. Obviously, when confronting events where agentic potentials are to be used, like the risk situations posed by heterosexual relationships, the girls face difficulties in putting into practice the power and autonomy that they were told to use. Even so, whenever possible, the girls insist that they have the power to choose what they want to do and if they want to expose themselves to risk or not. This shows that, at least at a discursive level, they are determined to keep the illusory identity of self-governed girls.

To adjust its discourses to adolescent women's 'real' experiences of sexual risk management, health promotion needs to consider the meanings attached to sexual risk via other types of learning processes that are experienced in daily life, which for sure transgresses the boundaries of health promotion. Health promoters have to abandon the arrogant idea that 'risk' is a property of science, that 'health risk' and HIV/AIDS risk can only be definable with reference to health parameters and that 'risky sex' is a category that encapsulates only health meanings. Health promoters have to recognize that, in a society where everything is risky, adolescent women are made 'risk subjects' in a variety of other ways, and that given the reflexive management of the 'self', it is their duty to know all the risk possibilities.

We can see that although the girls demonstrate that they are very good learners of health promotion's lessons, they continue to risk their lives by having sex without the protection of condoms. The need to use condoms is the logic followed by health promoters. For the girls, however, the logic is different. They see themselves as investing in self-protection as they are trying hard to make informed decisions concerning their sexual life. To know the 'other' is used as a substitute for condom use. This strategy is seen as one that 'saves' many risks. The girls do not need to risk their relationships, as boys usually do not like condoms; they also do not need to risk their reputation because to ask a boy to use a condom may be interpreted as a girl's fear of

passing the HIV virus to her partner, and they also do not need to risk being caught buying or carrying a condom which would ruin their image of a 'passive sexual being'. For the girls, the best option seemed to be to take care of the self 'privately', that is without external interference, a strategy that they themselves recognize as carrying its own risks.

My conclusion is that to be able to make a difference in terms of adolescent women's protection against the risks of sex health promotion needs first to redefine the problem of sexual risk-taking; working with discourses and practices that acknowledge the epistemological nature of sexual risk behaviour and its special dependency on gender ideologies. This redefinition would result from a shifting approach. In the health promotion that I imagine, quantitative risk estimations would be accompanied by 'qualitative risk assessment', an operation that would be focused on the meanings and value of the risks for its subjects. Risk discourses produced by this 'new' health promotion would not teach 'choice lessons' without talking about the options available. Also, they would not invest in women's empowerment as a means to promote individual assertiveness, but in empowerment as a political action, whose target would be to challenge dominant masculinity (Holland et al. 1994a). Considering that 'risky sex' is not only a sexual relationship that carries the risk of infecting sexual partners with HIV, health promotion should also amplify its focus and target sexual risks as a category of risks that includes associated hazards. To promote adolescent women's protection against a given risk of sex would then also imply to deal with the other threats feared by them.

As for the specific case of the work of health promotion to promote adolescent women's (and indeed every women's) ability to protect themselves against the HIV/AIDS sexual risk, I suggest with Tamsin Wilton (1997) that this would require an investment in the monumental task of changing the world. And the first step would be to understand the influence of gender on adolescent women's sexual risk-taking. As Wilton (1997) points out, to promote health in the context of safer sex or "to make the healthiest choice the easier choice demands no less than the absolute eradication of the institution of male supremacy"(p. 52). With that we could perhaps dream of producing discourses on risk compatible with ideals of autonomy, where there would be legitimate agentic positions available to women whatever their age.

Although my research illuminates in various ways how adolescent women approach the risks of sex and HIV/AIDS risk, there are still many gaps in our understandings of their theories of and responses to risky/safe sex. For instance, it would be worthwhile to explore more carefully the influence of the values and meanings of love in their conceptions of risky/safe sex. While I chose to explore the emphasis placed on ‘self-governance’, ‘love’ also appeared to be an important theme in discourses about risky/safe sex. Given the limited space of the thesis, I also could not give enough attention to the importance of gender issues to the attachment of meanings to risk and safety as applied to sex. Thus, this could be another focus of more research in the field.

My research was limited to a small group of girls whose views were investigated in a given period of time. Their views may have changed since then, for as I show in this thesis, risk perceptions are dynamically produced. My part in the research process as the researcher and the interpreter has to be taken into account in making sense of the data that I have analysed here. Generalizations can only be cautious both because of the small-scale nature of the research and the contextual nature of ‘risk’ and of the research process. My thesis does not propose any universal ‘way of seeing’ HIV/AIDS and the other risks of sex; rather, I am arguing for a contextualization of health education, which addresses material, ideological and cultural conditions rather than just individuals. The commonalities found in the girls’ discourses suggest that the results are not unique and idiosyncratic to specific individuals, but more commonly available.

My research suggests that if we are to develop a good understanding of responses to HIV/AIDS sexual risk, more research about the way members of other groups see risky/safe sex is needed. In the particular case of adolescents, there is an incredible lack of knowledge about boys’ approach to the risks of sex in general and HIV/AIDS sexual risk in particular. In the face of the increasing rates of HIV infection amongst heterosexual young adults, I take the matter as something that has to be urgently investigated, along with further research about girls’ approaches.

My work has pointed out a number of relevant elements that adolescent women take into account in the process of assessing the risks of sex. Many of those elements were so far unknown in the field of health promotion. My thesis shows how simplistic the current theories of health promotion about girls’ sexual risk-taking are. By deconstructing the many layers of ‘risky sex’ it provides important information about

how and where the risk meanings used in conceptions of 'risky sex' are produced. Health promoters can use this information to criticize their own discourses, while realizing that much of what girls think about the risks of sex is the product of the work of health promoters, and that much of what girls do to protect themselves against the risks of sex is not more, nor less, than what they can do in the disadvantaged circumstances which health promoters do nothing to change.

APPENDIX I

DISTRIBUTION OF AIDS CASES IN BRAZIL FROM 1983 TO 1998

Distribution of AIDS cases according to the year of diagnosis and gender

DIAGRAM REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



AIDS case male-to-female ratio according to the year of diagnosis

DIAGRAM REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



Source: Brasil, Ministerio da Saude (2000)
<http://www.aids.gov.br/tabnet_aids.htm>

APPENDIX II

FOCUS GROUPS PLAN

WEEK 1

- 1- Presenting the Research Process - 15 min.
- 2- 'Knowing each other' - 20 min.
- 3- Interval (snacks) - 20 min.
- 4- 'Negotiating the Rules' (The deal) - 50 min.

WEEK 2

- 1- 'Remembering the Rules' (Time for Changes) - 10 min.
- 2- Integrating Activity - Cards Game - 25 min
 - (1) Proposed Topic: "Everyday Risks"
 - (2) A Topic Generated in Past Discussions
- 3- Interval (snacks) - 20 min.
- 4- Group Discussion (discussing and generating topics for next discussions) - 50 min.

WEEK 3

- 1- Integrating Activity - 'Adolescents' Love Affairs' (role-play) - 35 min.
 - (1) Proposed Topic: 'Male and Female Behavior in Love Affairs'
 - (2) A Topic Generated in Past Discussions
- 2- Interval (snacks) - 20 min.
- 3- Group Discussion (discussing and generating topics for next discussions) - 50 min.

WEEK 4

- 1- Integrating Activity - 'If I Were You...' (Problem Solving Fishbowl)- 35 min.
 - (1) Proposed Topic: 'The Pleasures and Dangers of Love Affairs: differences between girls and boys'
 - (2) A Topic Generated in Past Discussions
- 2- Interval (snacks) - 20 min.
- 3- Group Discussion (discussing and generating topics for next discussions) - 50 min.

WEEK 5

- 1- Remembering the Deal - 5 min.
- 2- Integrating Activity - 'The Simulation of a Judgment' - 35 min.
 - (1) Proposed Topic: 'The Pros and Cons of Male and Female Sexual Activity During Adolescence'
 - (2) A Topic Generated in Past Discussions
- 3- Interval (snacks) - 20 min.
- 4- Group Discussion (discussing and generating topics for next discussions) - 50 min.

WEEK 6

- 1- Integrating Activity - 'I Remember that...'
 - a) writing up a story - 20 min.
 - (1) Proposed Topic: 'Sexual Relationship: a risky experience'
 - (2) A Topic Generated in Past Discussions
 - b) reporting the story- 15 min.
- 3- Interval (snacks) - 20 min.
- 4- Group Discussion (discussing and generating topics for next discussions) - 50 min

WEEK 7

- 1- Integrating Activity - a) Report I- 20 min.
 - (1) Proposed Topic: 'What Does It Mean To Make Safer Sex?'
 - (2) A Topic Generated in Past Discussions
- b) Reporting Interviews - 15 min.
- 3- Interval (snacks) - 20 min.
- 4- Group Discussion (discussing and generating topics for next discussions) - 50 min.

WEEK 8

- 1- Integrating Activity - a) Report II - 20 min.
 - (1) Proposed Topic: 'In Your Opinion What Are Adolescents' Worries When Having Sex?'
 - (2) A Topic Generated in Past Discussions
- b) Reporting Interviews - 15 min.
- 3- Interval (snacks) - 20 min.
- 4- Group Discussion (discussing and generating topics for next discussions) - 50 min.

WEEK 9

- 1- Integrating Activity - Role-play - 35 min.
 - (1) Proposed Topic: 'Love Is Trusting In *The Other*. Love Is Taking Risks'
 - (2) A Topic Generated in Past Discussions
- 2- Interval (snacks) - 20 min.
- 3- Group Discussion (discussing and generating topics for next discussions) - 50 min.

WEEK 10

- 1- Integrating Activity - Letters from Women Seeking Advice I - 15 min.
 - (1) Proposed Topic: 'Girls' Doubts Concerning AIDS Risk Via Sex'
- Letters From Women Seeking Advice II - 15 min.
 - (1) Proposed Topic: 'Adult Women's Doubts Concerning AIDS Risk Via Sex'
 - (2) A Topic Generated in Past Discussions
- 2- Interval (snacks) - 20 min.
- 3- Group Discussion (discussing and generating topics for next discussions) - 50 min.

WEEK 11

- 1- Integrating Activity - Role-play - 35 min.
 - (1) Proposed Topic: 'What? To Ask My Boyfriend to Use Condom?'
 - (2) A Topic Generated in Past Discussions
- 2- Interval (snacks) - 20 min.
- 3- Group Discussion (discussing and generating topics for next discussions) - 50 min.

WEEK 12

- 1- Integrating Activity - Cartoon- 35 min.
 - (1) Proposed Topic: 'Male And Female Reaction To The Safer Sex Initiative'
 - (2) A Topic Generated in Past Discussions
- 3- Group Discussion - 40 min.
- 4- Impressions about the Personal Participation in the Focus Group Sessions - 40 min.

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