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Executive Summary

**Anthropological Perspectives on AIDS in Africa:
Priorities for Intervention and Research**

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Fhi AIDSTECH PROJECT

P.O. Box 13950 • Research Triangle Park, NC 27709

Telephone: 919/544-7040 • Fax: 919/544-7261

Telex: 579442 • Cable: FAMHEALTH

Executive Summary prepared by the
Institute for Development Anthropology

ANTHROPOLOGICAL PERSPECTIVES ON
AIDS IN AFRICA

Priorities for Intervention
and Research

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Prepared by

David Brokensha
Kathleen MacQueen
Lewis Stess

Institute for Development Anthropology

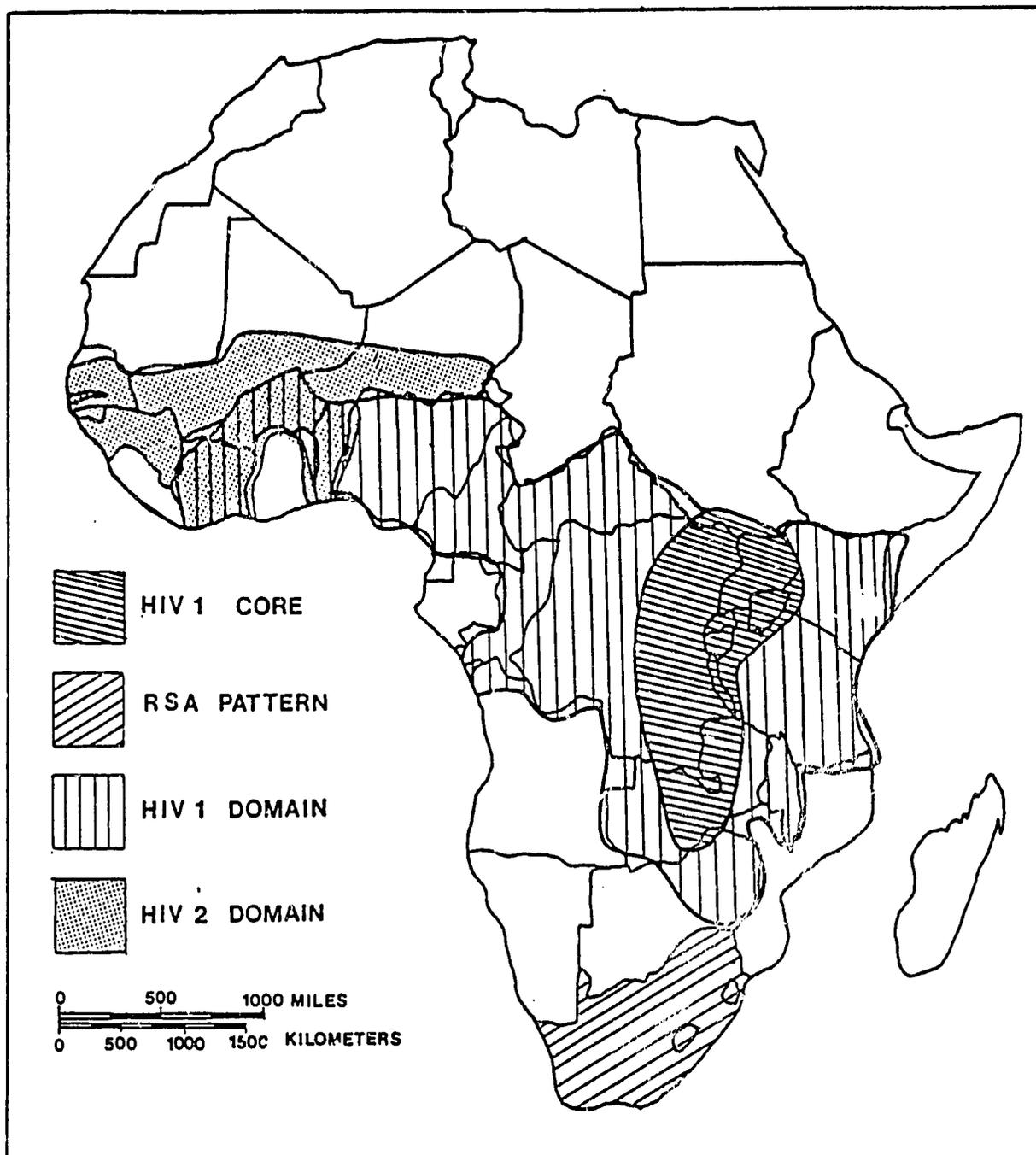
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ACRONYMS

AID	Agency for International Development
AIDS	Acquired immunodeficiency syndrome
HIV	Human immunodeficiency virus
NGO	Nongovernmental organization
PHC	Primary health care
STD	Sexually transmitted disease
TH	Traditional healers
TMG	Therapy-management group



HUMAN IMMUNODEFICIENCY VIRUS IN AFRICA

The map shows the approximate area of the major patterns of HIV infection on the continent. In the HIV 1 core area the virus appears to be widespread in both rural and urban areas; in the HIV 1 and HIV 2 domain areas it appears to be limited mainly to urban areas. The Republic of South Africa (RSA) pattern reflects that found in Western countries, rather than the predominant pattern of heterosexual transmission found in the other African countries.

1. INTRODUCTION

The National Institute of Allergy and Infectious Diseases and the United States Agency for International Development cosponsored a two-day workshop on Anthropological Perspectives on AIDS in Africa: Priorities for Intervention and Research at the United States Department of State in Washington, D.C., on January 7th and 8th, 1988. The objectives of the Conference were to brief and sensitize individuals from various disciplines who will be involved in AIDS research and intervention programs concerning the behavioral dimensions of the distribution, transmission, and prevention of the disease.

This executive summary of the workshop is intended to facilitate fulfillment of the Conference goal to develop preliminary guidelines and priorities for behavioral components in AIDS research and intervention programs. It does not aim at being comprehensive, as full proceedings will appear later, and therefore seeks only to summarize the main points. While there was not unanimous agreement on all issues, a consensus did emerge, and we attempt to present this consensus. Where specific comments were particularly insightful, we have attempted to attribute such remarks, but time and space constraints do not allow us to identify all speakers.

The workshop was attended by 122 participants. Apart from officials from the sponsoring institutions, participants included epidemiologists, physicians, public health officials, sociologists, anthropologists, geographers, and historians. There were over twenty formal presentations, and substantial time was allocated for open discussion.

Participants included several Africans: Dr. Maxine Ankrah (working in Uganda), Dr. Peter Lamptey (from Ghana, working in the US and Director of the AID-sponsored AIDSTECH Project), Ms. Elizabeth Njeri Ngugi (from Kenya), Dr. Fathia Mahmoud (from Sudan), and Dr. Rutayuga (from Tanzania).

A basic aim of the workshop was to explore ways of learning how people react to disease, to education, and to interventions, and how to use that knowledge to bring about positive changes in human behavior (Langmaid).

2. AIDS IN AFRICA: PROJECTIONS

Specific projections are difficult to make due to the problems in extrapolating from small samples. Most of the information available for projection is drawn from two projects in Kinshasa and Nairobi. Nonetheless, it is clear that we are dealing with a formidable epidemic that will slow population growth from its current rate of approximately 3 percent for the

continent as a whole to approximately 2 percent. Despite a substantial rise in the death rate, population growth will still be positive, and overall the population will continue to grow rapidly despite the epidemic (Bongaarts).

The AIDS epidemic is but one component of African morbidity and mortality, and it will interact with other components. We can expect a much higher prevalence of all diseases and a greater intensity of the diseases associated with AIDS, especially tuberculosis.

In making projections we must remember that the AIDS epidemic is an evolving epidemic, and the dominant modes of transmission may change (Beasley). Currently, seroprevalence shows two patterns, one of rapid increase and one of gradual increase. Both patterns may be present in different populations in a single area (Piot).

3. PROFILE OF AIDS IN AFRICA

(A) Overview

Central and East Africa have the highest rates of HIV infection: Zaire, Rwanda, Burundi, Uganda, Kenya, and Tanzania. Rwanda and Burundi exhibit the most advanced stages of the epidemic, with the highest incidence rates. AIDS is also found in southern and western Africa, and at least one variant of HIV is found in West Africa. The cities especially, such as Kinshasa and Nairobi, show high seroprevalence for HIV. In one Kinshasa hospital, 25 percent of the male patients and 31 percent of the female patients on any given day are HIV positive. But we must exercise care in extrapolating from those places where the most research has been done. In much of Africa, seroprevalence simply is not known.

More females than males are HIV positive in the younger age categories, e.g., ages 15-30, while at older ages, there are more males than females. The age pattern probably reflects the general tendency for older men to have sexual relationships with younger women.

AIDS is mostly an urban disease, but villages in Rwanda and Uganda are showing high HIV seropositive rates, as much as 30 percent prevalence. It is generally expected that seroprevalence will increase in the rural areas in the near future. However, one Zairean village was found to have an identical seroprevalence (0.8 percent) in 1976 and in 1986, which is puzzling (Feldman).

Although most Africans live in rural areas, the cities are growing very rapidly, and there are many links between town and country. Anthropologists have described urban and rural

residents as forming "a single social field," because of these links, and because one area cannot be understood without reference to the other. We can expect the rural incidence of AIDS to rise dramatically, as people with AIDS return home to die, and as the virus spreads due to the mobility of many African populations. Therefore we should monitor selected rural communities.

We cannot understand AIDS in Africa if we isolate it from the larger global context. The policies of the United States and other world powers affect Africa in many ways, including availability of funds, commodity prices, and debt burdens. With respect to AIDS, Africa is also affected by the numbers of tourists and other visitors, some of whom undoubtedly carry the virus.

(B) Transmission

1. Heterosexual contacts

Studies to date indicate that 90 percent of HIV transmission in Africa is attributable to penile-vaginal intercourse; anal intercourse apparently is not an important factor in transmission.

Many surveys of sex workers¹ show a high rate of HIV infection. Despite concern about biases in studies of sex workers (e.g., definitions and sampling strategies, among others), it is clear that multiple sexual partners increase the risk of HIV infection. This is true for both sex workers and their clients. In Kigali, Rwanda a study of the sexual contacts of men showed that the risk for HIV infection increased with the frequency of contact with female sex workers. It is not clear that the type of sexual intercourse (e.g., anal versus vaginal) has any relevance for risk. One study of Kinshasa sex workers failed to show any difference in HIV prevalence based on type of sexual intercourse.

2. Homosexual contacts

It is not clear how relevant homosexuality is in the spread of HIV in Africa. Bisexual "friends" can be found in Nairobi, Lusaka, and Kinshasa, but it is not known how widespread such relationships are. In southern Africa, all-male mine compounds have had institutionalized homosexuality for many years.

¹There was some discussion over the use of the term "prostitute," which is imbued with Western ethical values and moral issues that tend to ignore economic realities in much of Africa. Participants in the workshop therefore preferred the use of the term "sex worker."

It was suggested that the nonexistence of homosexual behavior in Africa is greatly exaggerated, and that we need to distinguish between exclusive homosexual communities of the type found in the West, and the homosexual or bisexual behavioral patterns of Africa that may include heterosexual marriage. We should look for "communities within communities" rather than lifestyle patterns.

In all major cities on the continent, there are likely to be coterries of young men, including male sex workers, who cater to the needs of expatriate homosexuals.

3. Perinatal factors

At present, it appears that at least 50 percent of infants born to HIV-positive mothers are themselves infected, probably in utero.

There are many questions concerning the transmission of HIV through breastmilk. In Western countries such as the US, Britain, and France, HIV positive mothers are warned against breastfeeding as a preventive measure against transmission. These are misleading guidelines for most African women who fear that they may carry the virus, as their infants often are at a substantial health risk if the mothers do not breastfeed. Due to the risk of diarrheal mortality, it would be unwise to discourage mothers from breastfeeding. Unless we are certain that breastfeeding is a significant contributor to the spread of HIV, we cannot afford to subject these infants to the severe mortality risk of unsanitary milk substitutes. Some manufacturers of baby food apparently are claiming that their products are "safe food." It would be a tragedy if this led to a renewed use of infant formula, with all the dangers to health (McCormack).

4. Blood contact

Blood had a special, mystical significance in many societies and was regarded--as was semen--as hazardous and potent. Traditionally, there were prohibitions against sexual intercourse during menstruation, but they seem to be going by the wayside in the urban areas. Is this a significant issue? Blood exchange through "blood brotherhood" covenants, would, on the surface, appear to be a potent transmitter of HIV, especially since such rituals were traditionally carried out with strangers as a means of facilitating relationships of trust (Gottlieb). However, these rituals have decreased in importance in recent years. "We do not have such blood exchanges [in Tanzania]. I have heard of them from old men, when I was a boy, but during my entire life I have not witnessed such things" (Rutayuga).

Nonetheless, once HIV moves from urban to rural areas, blood practices could exacerbate the spread. When one mode of disease transmission predominates, in this case sexual transmission, it may mask the significance of other modes of transmission should the context of the disease change. For example, it took many years to determine that hepatitis B was sexually transmitted, because infection occurred prior to sexual maturity in most areas. It was not until the disease began to appear among Western homosexual males that this mode of transmission was recognized (Beasley). Research on hepatitis also demonstrates the importance of longitudinal studies, as it was long-term research in Asia that led to major breakthroughs in our understanding of hepatitis transmission. It is difficult to establish clear causal connections between a disease and particular factors without such studies.

5. Scarification

Scarification is practiced for a variety of reasons: to enhance fertility, to promote good health or prevent poor health, and to enhance physical appearances in accordance with cultural concepts of beauty. Generalizations cannot be made as to the importance (or lack of importance) of scarification practices. While scarification is still found, it, too, is decreasing in occurrence.

6. Circumcision

Female circumcision, though often cited as a possible factor in the spread of HIV, is practiced mainly outside the core area of HIV infection. It was suggested that despite increased focus on female circumcision, not enough is known about male circumcision, which is much more widespread. However, many of the men who are circumcised have the surgery done in hospitals.

7. Injections

Despite a concern about injections being linked to AIDS, there is no evidence that the valuable immunization programs are in any way linked to the spread of the virus.

The role of injectionists does not appear to be a major one for the disease. However, there are many amateur illegal injectionists traveling over wide areas, providing both intramuscular and intravenous (IV) injections (Piot). Although a low risk is associated with any given needle injection, the number of injections is so high that, cumulatively, they may be a contributor of some significance.

We cannot make direct comparisons between the use of injections in Africa and IV-drug use in the United States. There are specific behavior patterns involved in needle-sharing among

IV-drug users that facilitate HIV transmission, and these patterns have little, if any, relevance for the use of injections in Africa.

Unsterilized needle use is probably more common than realized. It took a medical anthropologist four months of residence in a village to discover that there was an illegal injectionist in residence (Feierman). In such situations, surveys do not reflect the actual situation. Large numbers of drugs and needles coming into many African countries disappear and are undoubtedly falling into the informal sector at an unknown rate.

It is ironic that the "needle" should now be life threatening, when the popularity of injections resulted from their potent "magic" in alleviating the suffering from yaws in the 1920s in Kenya (Good).

4. POPULATIONS AT RISK

(A) Monetary Resources

Funds are severely limited. It is estimated that \$800 million, minimum, is needed to deal effectively with HIV in Africa, but there is only \$140 million available (including \$30 million from AID in FY '88).

It was therefore strongly felt that we must use a "fire-extinguisher" approach, and seek to deal with those areas where the outbreak is most severe. We must focus on high-risk groups, for the simple reason that a few people with many partners can spread AIDS faster than many people with a few partners (Potts).

(B) Downstream and Upstream

People with HIV or those directly exposed to HIV infection can be seen as caught in a dangerous stream and at serious risk of drowning. Intervention can then be viewed in terms of "upstream" and "downstream": most interventions have thus far focused on pulling people out of the stream after they have fallen in, hence, they are "downstream" approaches. But we also must consider what got them into the stream in the first place, i.e., what factors are pushing them off the bridge upstream, and can we "catch" them before they fall or are pushed in (Margo)? We need to consider risk-inducing or high-risk behaviors other than prostitution and work with groups other than sex workers, such as teenagers, school children, communities, and especially the partners of sex workers.

(C) High-Risk Persons

"The enemy is not sex, nor the prostitute, but the virus" (Potts).

While sex workers need special attention, we must guard against scapegoating. "Free women" for many years have been harassed and rounded up and sent "home" in African cities. For example, at one point in Kigali, Rwanda, prostitutes were defined as "single mothers" (Allen). All African cities--and rural areas, too--have a growing number of female-headed households and independent women, who would be threatened by draconian laws ordering expulsion or "repatriation" of such women. If the sex workers, who have obviously been meeting a need, and who have no alternative source of income, are removed, what will the consequences be? Previous experience suggests that the women will still be working in the sex trade, but they will become dependent on male protectors and thus even more vulnerable to exploitation. This is not a solution to AIDS.

There needs to be an understanding of the total situation, not just a "witch hunt" of unattached women (La Fontaine, McCormack, Ngugi, White). Attention must be paid to the high-risk groups, but nonrepressive measures are needed (Feldman).

Attention should also be paid to the male clients of sex workers. Research on other STDs, notably gonorrhoea, have demonstrated the benefits of concentrating on "core transmitters" as an effective way of tackling the disease (Piot).

In Tanzania, the decline of polygyny actually contributed to a situation that is more conducive to the spread of HIV, as women falling out of the system (i.e., those who do not belong to a male-headed household) often turn to prostitution, due to a lack of access to social and economic resources. "The community-support system fizzles out for widows," and these women, who are socially invisible, are at significant risk. They have no place in their own societies, and often migrate to urban centers in their struggle to survive (Feierman).

Many women exchange sexual services for cash or gifts as one of several strategies for survival. Some come to town because of lack of access to land, or crop failure at home. Some are refugees (of whom a large number are women, usually with children). Thus, in looking at sex workers, we must also look "upstream" at their rural origins.

(D) Potentially High-Risk Persons

We need to look at cofactors, especially the role that other diseases may play in increasing susceptibility to HIV infection,

or the onset of AIDS in infected individuals. STDs and tuberculosis are significant in this regard. There are also social cofactors that appear to be of significance, such as income insecurity, poverty, and malnutrition (Good).

Teenagers may be sexually active at an early age and should be educated about AIDS before they are at risk. One study in Uganda found 20 percent of the teenagers surveyed were sexually active by age 14, although parents perceive them as "innocent." Most (57% in one study) of the teenagers are, however, aware of the sex/AIDS link. Many traditional restraints, training, preparation, and sanctions have gone. There are more pregnancies, more abortions; and there is still much ignorance about sex and pregnancy.

We must also recognize the role played by "sex tourists" and expatriates who make demands for "exotic" sex of both a heterosexual and homosexual nature.

There are a number of mobile groups who may be at risk, including students, smugglers, officials, migrant workers, traders, and public transport workers (e.g., truckers, riverboat workers, and airline stewards). We may also be able to identify high-risk regions---areas that have historically been loci of labor out-migration, such as the Kwango region in Zaire or parts of Southern Mozambique (Packard), or areas of chronic episodic malnutrition and poverty where a population's immunological systems may be suppressed, putting it at higher risk of AIDS infection.

It was suggested that more attention be paid to the members of the armed forces, which is mainly comprised of young, sexually active, and mobile individuals. However, this is a very sensitive area.

5. INTERVENTIONS

(A) Condoms and Other Barriers

"The virus is telling us that we need to promote barrier contraceptives" (Potts).

It was generally agreed that condoms are "the way to go." Condoms and spermicides can halt the spread of the disease (Potts), and high-risk groups should be encouraged to use both (Lamphey). We must teach people how to use condoms and to say no to sex without condoms.

At present, the total number of condoms used in Africa represents a small fraction of all condoms used worldwide. In addition, those available are sometimes old and defective. The

tropical climate dictates that condoms be top quality; and the size of the virus dictates that they be of very fine texture (McCormack). Spermicides are often viricides, and condoms should be lubricated with spermicides to enhance their effectiveness as a barrier, not only to HIV, but to the STDs that appear to play a cofactor role. Spermicides have been shown to slow the transmission of STDs, and they may slow the transmission of HIV as well.

A number of logistical questions were raised regarding the distribution and availability of condoms. We cannot expect the medical profession to act as gatekeepers for condom distribution; different outlets should be sought (McCormack). Bars might be an appropriate place. At present, condoms are being distributed free of charge in many areas, but this may not be a feasible long-term strategy due to the severe constraints on funds. Should they be given out free, or should they be sold? There is often a gender-based difference in ability to pay for condoms in Africa, with women less able to afford them than men. It was observed that in Kampala only the more wealthy are buying and using condoms (Ankrah).

Where condoms are distributed for free, how can their use be ensured (Feldman)? What do people actually think of condoms, and how can their use be made attractive? There is conflicting evidence on the extent of condom use. In one study in Uganda, despite awareness of fatality of AIDS and of possible preventive measures, only 2 percent of the married women surveyed used condoms, and of these 42 percent used condoms irregularly. On the other hand, Dr. Lamptey and Ms. Ngugi presented information on effective programs. It is not clear what correlation there is between AIDS awareness and condom use.

There may be other effective AIDS barriers available. What are indigenous methods of fertility control, and are these still practiced? One study showed that older prostitutes had lower rates of HIV infection than younger prostitutes. Why? Are they using spermicides that are also acting as viricides in this context?

(B) Education

Education needs to be addressed at several levels:

- individuals with multiple sex partners
- communities
- schools, especially the science curriculum
- adult education

Many parents do not, and cannot, discuss sex with their children, and some oppose sex education in the schools. Great care must therefore be used in efforts to educate the young.

At issue is our ability to change (a) concepts and beliefs, and (b) behavior. One participant noted that "cognitive interventions may lead to cognitive change, but are unlikely to lead to behavioral change." Despite all the difficulties, we must strive to make changes in sexual-behavior patterns. In working with teenagers, nonpenetrative sex should be discussed, as it could reduce or eliminate the risk of infection. (In many cultures, there were traditional modes of nonpenetrative sex, such as interfemoral.) Because AIDS is a new, and threatening, disease, people may willingly change their patterns when they are given other options. The question is, can they change more rapidly than the virus will spread?

There is a need not only to change behavior, but to sustain the changes. What lessons can we learn in this regard from family-planning programs? People can change their sexual behavior, and when they do, they do not abandon new ways unless outside factors, such as the unavailability of condoms, prevail.

AIDS has already generated more educational materials, including posters, brochures, videotapes, pamphlets, TV advertising, and radio messages, than any other disease. However, messages must be very carefully planned, or they may be misinterpreted, as happened with some family-planning messages.

In planning educational programs, we can learn from advertising and marketing, as William Smith showed with his five principles for a successful media campaign:

1. *Think like your audience;* use their words, pictures, stories, and music.
2. *Be convincing.* Use admired and trusted people. Talk feelings as well as facts. Give them a benefit they care about. Give them reasons they understand.
3. *Be clear and be honest.* Talk behavior--what they can do to protect themselves. Talk consequences--what happens if...? Clear up myths and falsehoods. Deal with fear and anxiety directly. Don't promote AIDS services you can't offer.
4. *Get the message out.* Keep it simple. Repeat it over and over, in different ways. Use many channels (posters, radio, TV) at the same time. Don't contradict yourself.
5. *Test your materials.* Find out if your audience: understands the idea; believes the message; thinks it relates to them; gets confused or dislikes some part of the presentation; says they will do it.

Participants agreed that these constitute clear and helpful guidelines for AIDS educational programs.

Programs can use theatrical groups, puppets, or song contests. Radio is a powerful medium. It is important to use television, even if relatively few people view it, as this legitimates the message. There is a tradition of lorry park literature that may be a suitable, and effective, place for messages.

Provision of information is the most important first step, but we need to consider what the next steps will be. We should not have unrealistic expectations. We should remember the problems of inducing change in our own society in regards to life-threatening behaviors such as smoking, and drinking and driving.

Several studies from Africa showed that even where there was an awareness of the sex/AIDS link, and of the possible precautions that can be taken, relatively few people changed their sexual behavior immediately (Ankrah). Many women feel they are at risk, because they believe (or know) that their husbands have other sex partners, but women are often socialized into submission and feel they have little control over their sexuality (Allen).

Finally, it must be recognized that, for poorer people, "sex may be their only affordable comfort", which makes it even more difficult to change sex behavior.

We need to involve people with AIDS and people who are HIV positive in education efforts, as it is their behavior in particular that will determine the spread of the virus. We know that people with AIDS often remain sexually active; we cannot assume that onset of the disease removes them from the pool of potential transmitters.

Despite all these problems, there have already been successes in the realm of AIDS education, as shown in the presentations by Elizabeth Njeri Ngugi (Kenya), Peter Lamptey (Ghana), and Maxine Ankrah (Uganda).

Ms. Ngugi discussed the results of a project working with sex workers in Nairobi. The three major conclusions of this project were:

-- The most effective measure seems to have been assuring the easy availability of condoms (Potts and LaFontaine also stressed this point).

-- Increased use of condoms resulted from relatively simple education activities.

-- AIDS/HIV education has had a significant impact on altering male sexual behavior as well, as evidenced in an increasing demand on their part for use of condoms during intercourse with the prostitutes.

Dr. Ankrah discussed the challenge of developing materials that would effectively educate children and adolescents concerning AIDS without being offensive to their parents in their sexual content. A strategy of "explicit AIDS/implicit sex" was devised, which focused on the way in which AIDS is transmitted, the symptoms of the disease, and other clinical aspects that children could understand within the context of a biology class. Acknowledgment of the sexual mode of transmission was made, but there was no explicit discussion of the sexual act, its components, or frequency of sexual intercourse.

Successful education of a group of prostitutes in Uganda was built on the informal support networks of the women (Ngugi). The project focused on the leaders of these groups, training them in informal, one-on-one sessions using frank language and explicit pictures. The leaders then shared the information they gained with the other women in their networks. One of the most effective educational tools was a picture of a terminally ill AIDS patient.

(6) PRIMARY HEALTH SERVICES

"AIDS points to all the weaknesses in primary health care--in health education, blood supply, laboratory services, STD control, sterilization techniques, and preventive programs" (Piot).

(A) Formal Health Services

As with all other aspects of AIDS intervention, formal health services have severe budgetary problems. For example, Zambia's health budget has been cut by 20 percent. There is an urgent need to strengthen the existing structure of health services, which is weak in many areas. In Tanzania, for example, health workers often work half days as they have to work on their farms in order to survive, and the World Bank disallowed an increase in funds for social services. One solution was to provide health workers with "field allowances," which had the added benefit of not being taxable (Janzen).

Midwives (both modern and traditional) need to be taught how to protect themselves from the risk of HIV infection.

There are problems in diagnosing infected people, as other diseases may produce symptoms similar to those of AIDS, and because of the long (2-1/2 to 5 years) incubation period. Better diagnosis of STDs is needed, because of the close link to AIDS. Partners of HIV carriers should be screened.

(B) Informal Health Services

The informal health services offered by THs (traditional healers) need attention, as many Africans in both rural and urban areas consult THs.

There are many different types of THs, but in general they use two strategies:

-- They live in their home villages and generally treat their own relatives for low rates, often advising that their clients go to the hospital. Some of the village THs have other occupations, and often operate as part time healers. These are essentially advisors, making many of the basic health-care decisions.

-- They are traveling THs who charge large sums of money and do not limit treatment to their own relatives. They are often "famous specialists" who basically work as consultants. Some even have their own hospitals.

Charles Good, who has done a recent comprehensive study of THs in East Africa, estimates there is a ratio of 1 TH per 200 rural people, and 1 TH per 400 to 800 urban residents, and states that THs are increasing most rapidly in the cities.

THs have many different roles, as herbalists, birth attendants, psychotherapists, or specialists in specific diseases. They have a diversity of skills, reputations, and spatial mobility. The bona fide healers are an integral part of the rural therapy group, discussed below.

THs are said to be eager to learn, and keen to cooperate with their respective governments in tackling AIDS. As they will be involved with people with AIDS, systematic efforts should be made to assist and train them. Medical services have often failed to recognize bona fide THs, because of a minority who are charlatans or "bush-doctors." Some biomedical professionals may resist cooperation with THs; hence, roles and activities will have to be carefully defined. Failure to use THs would be a waste of a crucial resource: we cannot afford such waste.

People with AIDS are likely to increasingly consult THs, as (a) the disease is chronic, endemic, and life threatening, and (b) modern health services will not be able to cope. Also AIDS

dementia may lead kinsmen of people with AIDS to take patients to a TH to find out the cause of the "madness".

7. RESEARCH PRIORITIES AND STRATEGIES

(A) General Priorities

AIDS research must:

- *be undertaken immediately: "the time frame is now" (Ngugi)*
- *be multidisciplinary, involving both biomedical and social scientists*
- *concentrate on policy-oriented aspects, and on intervention issues*
- *be aware of African sensitivities on the whole question of AIDS in Africa*
- *involve African researchers to the greatest extent possible*
- *collaborate with African universities and research institutions*
- *avoid gender, class, ethnic, or other biases*
- *integrate information from different disciplines*
- *build up baseline data on sexuality, using cultural-specific studies and avoiding sweeping and misleading generalizations (Lamprey)*
- *avoid undue concern with disciplinary boundaries: "Those of us who have worked with AIDS in Africa are too familiar with death and dying and grieving" to have this concern (Ginzburg)*
- *avoid making sweeping generalizations based on small and unrepresentative samples*
- *encourage broad-based serological studies to investigate patterns of transmission, then follow up seropositive cases*
- *encourage epidemiologists and anthropologists need to learn something of each other's craft: The best way to do this is by working together, from the beginning*

stages of project design, on common problems, in small teams.

-- encourage people, including sex workers, to cooperate in studies through inducements such as medical care, or small gifts

-- learn from earlier research on other diseases, such as STDs and hepatitis B to ascertain the lessons for AIDS research

(B) Social Science Priorities

AIDS research must:

-- go beyond details of sexual behavior to look at the wider cultural context

-- critically analyze existing data, and estimate their reliability, validity, and currency

-- avoid esoteric ethnographic research, while concentrating on specific AIDS issues

-- include long-term studies as well as rapid appraisals: the former are often of major significance in epidemiological research (cf. the hepatitis example cited previously)

-- examine population-mobility patterns, not only of sex workers and truckers, but other groups that move about, i.e., migrant workers, traders, smugglers, officials, military personnel, students: High mobility undoubtedly helps to spread AIDS to rural areas (Ngugi)

-- pay attention to new patterns of individualism, as well as the maintenance of traditional values

-- examine the situation regarding traditional healers and therapy-management groups in specific areas, and ascertain what help they need to be most effective

-- include monitoring and evaluation of projects: In evaluation, lessons can be drawn from family-planning programs that have asked (of contraceptives): Are they available? Are they advantageous? Are they acceptable? (Reining)

-- identify, for both urban and rural areas, which social units are relevant for targeted intervention

efforts (villages, lineages, clans, voluntary associations)

-- move beyond details of sexual behavior to identify economic factors that structure its expression and impact (especially poverty cofactors and their impact on rural/urban labor migration, involvement in sex trades, nutritional status, and immunosuppressive response).

(C) Methodological Priorities

AIDS research must:

-- use innovative methods such as rapid rural-appraisal techniques

-- include both quantitative and qualitative approaches:

It is vital for social scientists to include quantitative data to the greatest extent possible. Epidemiologists are accustomed to numbers, and social anthropologists must adopt a quantitative approach if they are to communicate in this "lingua franca" of science. On the other hand, epidemiologists will need qualitative information of the type traditionally collected by anthropologists in order to interpret their results in a meaningful fashion (O'Reilly).

-- avoid grandiose and large-scale surveys in favor of very specific local studies that are focused on AIDS-related topics

-- use appropriate methods for obtaining relevant information: For example, to understand the breadth of sexual behavior, we will need to collect qualitative information. To understand the extent or frequency of specific risky behaviors identified through qualitative methods, we will need to collect quantitative information (O'Reilly).

(D) Questions

There are a number of issues for which there is so little information that we cannot bring together a consensus of comments. Indeed, some generated only questions. We present these issues here, along with the thoughts and comments of the participants where appropriate.

(1) *Should the research emphasis be on countries with high or low HIV prevalence?*

We do not have a cure for the disease; once it is in the population, it will run its course, and at present we can only hope to alleviate actual suffering as far as possible. Containment, at this point, is more feasible; hence an emphasis on low-prevalence countries is crucial (Potts).

(2) *How many surveys of seropositivity are needed, in order effectively to "get on with the job"?*

The main need is not for national seropositivity surveys (Piot). We do not need to distinguish between a seroprevalence rate of 2 percent versus one of 3 percent.

(3) *Why is AIDS spreading so rapidly through heterosexual intercourse in Africa, when this has not been the pattern elsewhere? What is the significance of cofactors, especially STDs, but also social cofactors?*

(4) *What are the implications of the subfertility issue, and how is this related to specific ethnic groups, or to specific geographical areas? Is subfertility accompanied by a high incidence of STDs?*

As many as 30 percent of TH patients in one study were childless (Good), indicating that this is a significant issue in at least some parts of Africa.

(5) *What is the relevance of "the matrilineal belt" for AIDS?*

This is a large area in Central and Eastern Africa where descent is traced through female links, and where there are distinctive social patterns of settlement, residence, inheritance, marriage and divorce, and relations between men and women. Some scholars claim that there is a higher instability in marriage, than in patrilineal societies.

(6) *What is the epidemiological significance of ethnicity in regard to sexuality. That is, to what extent do traditional knowledge, attitudes, and practices determine sexual behavior?*

There is evidence that cross-cutting factors are often more important--age, gender, occupation, income, education, religion, residence, etc. In any event, African cities are characterized by polyethnicity, even where there is one dominant group (e.g., Baganda in Kampala, Kikuyu in Nairobi) and ethnicity has many limitations as an explanatory factor.

(7) *Can we separate generalizations into major and minor forms of behavior?*

This would be a useful practical strategy, as it is usually possible to make general statements, indicating the mean or mode

and the range, even when precise quantification is not possible (Conant).

(8) *What will happen to the growing number of orphans, who lack both parents or even extended families to care for them?*

The government of Uganda has accepted responsibility for AIDS orphans and is assessing their needs (Ankrah).

(9) *Are elites more adversely affected, as some of our information suggests, or are they overrepresented in studies because they have better access to medical services?*

(10) *Have suicide rates increased because of AIDS?*

(11) *Is there evidence that "cults of affliction" are emerging as the number of people with AIDS increases, and if so, how can they be used positively?*

(12) *Will fear alter customary social behavior and lead to a rejection of people with AIDS, or will therapy management groups act as hospices where people with AIDS can die in a safe, humane, and caring environment?*

8. AFRICAN INVOLVEMENT

It is essential that Africans be involved at many different levels. AIDS will be with us a long time, and the earlier we involve local people the better. Africans know that they cannot depend on foreign expertise forever (Lamprey). They are already involved in AIDS education projects by the hundreds, despite all the problems raised at this workshop. They are getting on with the job. Our role should be to assist them through the provision of scarce resources.

(A) Professionals: Social Scientists and Medical Personnel

The SIDA-Zaire project employs three expatriate and 17 Zairean physicians, one of whom is National AIDS (SIDA) co-ordinator. This involvement and training of local professionals "will prove to be our best contribution" in the long-term struggle (Piot).

We need to incorporate local evaluation of programs. Experience in other domains, such as national-resource management, has shown that one effective type of local participation is in evaluating projects and programs, so that they can be fine-tuned to meet local needs.

It is important to strengthen local research capacity, so that African researchers and African institutions can undertake

more studies. Many African universities have well established departments of sociology (which often include social anthropology) and other relevant social sciences. It would be possible to recruit both senior and junior researchers. It is especially important to have some junior people, including graduate students, associated with research and intervention projects, so that a core of AIDS researchers can be trained.

(B) Traditional Health-Management Systems

We must find the middle road between a "technofix" that does not exist, and total social and behavioral change, which is not possible (Janzen). This middle road can be found, at least in part, by looking at local forms of therapy management. There are many indigenous therapy-management groups (TMGs), which can play a central role in the care of people with AIDS. Wherever there are caring and sanctioning communities, these can be directed and focused. TMGs will not be able to carry the full load of AIDS care, however, for not all individuals will be encompassed. Widows and divorcees, for example, may be left out. Sometimes these groups are activated only when an individual becomes ill, not before. Also, TMGs do not exist everywhere.

Therapy management varies according to the status of the person afflicted, and the resources that are available within the group. They may provide "escort service," diagnostic help (determining the nature of the disease), or establish the "cause" of the illness. They can marshal resources, including time, money, and vehicles, to care for the sick (Good, Feierman).

Increasingly, AIDS will become a rural as well as an urban problem. Formal government health services cannot look after all the people with AIDS, so there is an urgent need to involve families, lineages, therapy groups, and communities in their care (Rutayuga). The potential contribution of traditional healers should not be underestimated. Instruction of THs in oral-rehydration therapy and their subsequent use has been successful (Green). In Ghana, THs paid for a course covering herbal medicines, nutrition, water use, and hygiene. The course graduates then went on to train other healers in their newly acquired knowledge, thus accelerating the process of information distribution (Good, citing work of M. Warren).

(C) Governments

In dealing with African governments and officials, it is necessary to keep in mind that AIDS is a sensitive subject, and that many comments made by outsiders have been seen as gratuitously offensive, misleading, or false (see, for example, R. C. and R. J. Chirimuuta, AIDS, Africa and Racism, published by Bretby (UK) in 1987).

AIDS programs require cooperation from all government departments, not only health. We need to include not only formal and national institutions, but also local institutions (Packard). At the local level, NGOs (nongovernmental organizations) such as church or women's groups, are often important and effective.

While cooperation with government officials and institutions is essential, there is a danger that national committees may promote interventions of a bland and noncontroversial nature, which may not be cost effective--e.g., cleaning up the blood supply--rather than confront the sexual behaviors that are primarily responsible for the spread of the disease (Potts).

(D) Communities

There is a problem in defining communities; as A. F. Robertson wrote, African communities are like Chinese boxes--one inside the other. It is important to determine the level that is significant for collective action--if such a level exists. Among the Hausa of West Africa, for example, there is no tradition of collective action at the community level (Good).

We need to examine the social dynamics of local communities and determine which strategies are most likely to work. It is essential to work with local people, and to avoid a "top-down" approach (Good).

(9) OTHER RECOMMENDATIONS

We need to organize a workshop such as this in Africa, and encourage more African participation (Lampsey).

A center for AIDS in Africa should be established, to coordinate research, interventions, and training.

We must focus our efforts on a small number of effective strategies due to our very inadequate resources for dealing with the disease.

10. CONCLUSION

"The virus sets our time table." (Potts)

The most important specific recommendations and conclusions are:

- (1) We have limited resources, and cannot tackle everything.
- (2) It would be easy to be overwhelmed by the magnitude of the problem, or to get distracted by methodological or disciplinary boundaries, but we must make a start.
- (3) Any answers will be found in collaborative studies involving both biomedical and social science researchers.
- (4) We must act within both an immediate and a long-term time frame, as AIDS will be with us for many years.
- (5) We must strengthen local research capacity and primary health services.
- (6) We need to establish baseline data on patterns of sexuality, and explore other possible modes of transmission.
- (7) Interventions should be concentrated on high-risk populations (including both sex workers and their clients), taking care not to initiate any scapegoating.
- (8) The use of condoms and spermicides must be promoted, especially for people with multiple sex partners.
- (9) Innovative and appropriate educational programs need to be designed to reach specific groups rather than just general populations.
- (10) Major participation by Africans is essential, in research and intervention projects, and at the community level, through traditional as well as modern institutions.
- (11) The African capacity for adaptation and flexibility should be encouraged, so that Africans continue to participate actively in the fight against AIDS.

LIST OF PARTICIPANTS

Dr. Donald J. Adamchak
Dept. of Sociology
University of Zimbabwe
Harare, ZIMBABWE

Dr. Samuel K. Adeniyi-
Jones
National Institute of
Child Health and Human
Development
National Institutes of
Health
Bethesda, MD

Dr. Susan Allen
University of California
San Francisco General
Hospital
San Francisco, CA

Dr. Alden Almquist
Research Analyst for
Sub-Saharan Africa
Library of Congress
Washington, DC

Dr. E. Maxine Ankrah
Senior Lecturer
Department of Social
Work
Makerere University
Kampala, UGANDA

Dr. Kenneth Bart
Director of Health
U.S. Agency for
International
Development
Washington, DC

Dr. R. Palmer Beasley
Dean, School of Public
Health
University of Texas
Health Science Center
Houston, TX

Dr. Cliff Block
Office of Education
U.S. Agency for
International
Development
Washington, DC

Dr. John Bongaarts
Senior Associate
The Population Council
Center for Policy
Studies
New York, NY

Dr. David Brokensha
Institute for
Development
Anthropology
Binghamton, NY

Mr. Charles E. Buckler
Laboratory of Molecular
Biology
National Institute of
Allergy and Infectious
Diseases
National Institutes of
Health
Bethesda, MD

Dr. John Wilson Carswell
Public Health Officer,
AIDSTECH
Family Health
International
Durham, NC

Ms. Cathleen Church
Futures Group
Washington, DC

Ms. Lisa Collis
Africa Technical
Department
World Bank
Washington, DC

Dr. Francis Conant
Department of
Anthropology
Hunter College
New York, NY

Ms. Carol Dabbs
Office of Population
U.S. Agency for
International
Development
Washington, DC

Ms. Harriett Destler
Office of Population
U.S. Agency for
International
Development
Washington, DC

Dr. Roger Detels
UCLA School of Public
Health
Dept. of Epidemiology
Los Angeles, CA

Dr. Barbara O. de
Zalduondo
Harvard School of Public
Health
Boston, MA

Dr. Arwind Diwan
University of Hawaii
J.A. School of Medicine
Dept. of Tropical
Medicine
Honolulu, HI

Dr. Jerrold J. Ellner
Professor of Medicine
Director of Infectious
Diseases
University Hospitals
Cleveland, OH

Dr. Steven Feierman
Professor
Dept. of History
University of Wisconsin
Madison, WI

Dr. Douglas A. Feldman
AIDS Center of Queens
County, Inc.
Richmond Hill, NY

Dr. Harvey Fischman
Dept. of Epidemiology
Johns Hopkins School of
Hygiene and Public
Health
Baltimore, MD

Mr. Andy Fisher
Demographic Health
Surveys
Westinghouse Institute
for Resource
Development
8850 Stanford Blvd.
Suite 4000
Washington, DC

Dr. Claudia Fishman
Doremus Porter Novelli
Washington, DC

Mr. Steven Garfinkel
Research Triangle
Institute
Research Triangle Park
Durham, NC

Dr. Harold M. Ginzburg
Epidemiology Branch
National Institute of
Allergy and Infectious
Diseases
National Institutes of
Health
Bethesda, MD

Dr. Peter Glasner
Epidemiology Branch
National Institute of
Allergy and Infectious
Diseases
National Institutes of
Health
Bethesda, MD

Dr. Charles M. Good
Dept. of Geography
Virginia Polytechnic
Institute and State
University
Blacksburg, VA

Dr. Stephen Gortmaker
Harvard School of Public
Health
Dept. of Behavioral
Science
Boston, MA

Dr. Alma Gottlieb
Dept. of Anthropology
University of Illinois at
Urbana-Champaign
Urbana, IL

Dr. Mark Grabowsky
101 East Mt. Royal Ave.
#203
Baltimore, MD

Mr. Edward Greeley
U.S. Agency for
International
Development
Washington, DC

Dr. Edward Green
International Programs
John Short & Associates
Columbia, MD

Dr. Neal Halsey
Johns Hopkins School of
Hygiene and Public
Health
Baltimore, MD

Dr. Jeffrey Harris
Office of Health
U.S. Agency for
International
Development
Washington, DC

Mr. Michael Helquist
AIDSCOM
Academy for Educational
Development
Washington, DC

Dr. Mauricio Hernandez
Harvard School of Public
Health
Boston, MA

Mr. Robert Hollister
Research Triangle
Institute
Research Triangle Park
Durham, NC

Dr. Harry Holloway
Uniformed Services
University of the Health
Sciences
Dept. of Psychiatry
Bethesda, MD

Dr. Daniel F. Hoth
AIDS Program
National Institute of
Allergy and Infectious
Diseases
National Institutes of
Health
Bethesda, MD

Mr. Dale Huntington
Johns Hopkins School of
Hygiene and Public
Health
Dept. of Health Policy
and Management
Baltimore, MD

Dr. Roy Jacobstein
Office Population
U.S. Agency for
International
Development
Washington, DC

Dr. Barbara Janowitz
AIDSTECH
Family Health
International
Research Triangle Park
Durham, NC

Dr. John Janzen
Dept. of Anthropology
University of Kansas
Lawrence, KS

Dr. Robert T. Jensen
University of Texas
Health Science Center
Dept. of Family Practice
San Antonio, TX

Ms. Bekki Johnson
Health Services
Consultant
Martinez, CA

Dr. Pamela Johnson
U.S. Agency for
International
Development
Office of Health
Washington, DC

Dr. Warren Johnson
Division of International
Medicine
Cornell University
Medical College
New York, NY

Ms. Mary June
U.S. Agency for
International
Development
Washington, DC

Mr. Lenni Kangas
Office of Health
U.S. Agency for
International
Development
Washington, DC

Dr. Phyllis Kanki
Harvard School of Public
Health
Dept. of Cancer Biology
Boston, MA

Dr. Samuel L. Katz
Dept. of Pediatrics
Duke University Medical
Center
Durham, NC

Dr. Carl Kendall
School of Hygiene and
Public Health
Johns Hopkins University
Baltimore, MD

Mr. Craig K. Kennedy
School of Public Health
University of California
at Berkeley
Berkeley, CA

Dr. Gerald Keusch
New England Medical
Center
Division of Geographic
Medicine and Infectious
Diseases
Boston, MA

Ms. Mary Kilby
AIDSCOM Project
Doremus Porter Novelli
Washington, DC

Mr. Peter Kilmarx
Dartmouth Medical School
Hanover, NH

Dr. Alexander Kramer
Viral Epidemiology
Section
National Cancer
Institute
National Institutes of
Health
Bethesda, MD

Ms. Laurie Krieger
PATH/PIACT
1900 M Street, NW
Suite 720
Washington, DC 20036

Dr. Virginia Ktsanes
School of Public Health
Tulane University
New Orleans, LA

Prof. Jean La Fontaine
14 Addington Square
London SE5 7JZ ENGLAND

Dr. Peter R. Lamptey
AIDSTECH Project
Family Health
International
Research Triangle Park
Durham, NC

Mr. Bradshaw Langmaid
Bureau of Science and
Technology
U.S. Agency for
International
Development
Washington, DC

Dr. Melody Lin
Office of Protection from
Research Risks
National Institutes of
Health
Bethesda, MD

Mr. Walter Lockwood
Director of the Office
of International Health
Policy
Washington, DC

Dr. William Lyerly
African Bureau
U.S. Agency for
International
Development
Washington, DC

Dr. Fathia Mahmoud
Apt 222
4890 Battery Lane
Bethesda, MD

Dr. Glen Margo
AIDSCOM Project
Academy for Educational
Development
Washington, DC

Dr. C. K. Martin
University of Texas
Health Science Center
Dept. of Family Practice
San Antonio, TX

Dr. Kent Martin
Box 878
St. Francisville, LA

Dr. Carol MacCormack
London, School of
Hygiene and Tropical
Medicine
London, ENGLAND

Dr. Janet McGarth
Dept of Anthropology
Case Western Reserve
University
Cleveland, OH

Ms. Kathleen MacQueen
Institute for
Development
Anthropology
Binghamton, NY

Dr. Ed McSweegan
Office of International
Research
National Institutes of
Allergy and Infectious
Diseases
National Institutes of
Health
Bethesda, MD

Dr. Austin Moede Health Adviser for International Health Policy U.S. Dept. of State Washington, DC	Dr. Nancy Mueller Harvard School of Public Health Dept. of Epidemiology Boston, MA
Dr. Gary Merritt African Bureau U.S. Agency for International Development Washington, DC	Ms. Elizabeth Njeri Ngugi University of Nairobi Dept. of Community Health Nairobi, KENYA
Dr. Heather Miller Seabase Committee on AIDS Research National Academy of Sciences Washington, DC	Mr. Doug Nichols Family Health International Research Triangle Park. Durham, NC
Dr. Kirk D. Miller AIDS Program National Institute of Allergy and Infectious Diseases National Institutes of Health Bethesda, Md	Ms. Sara Organic AIDS Program National Institute of Allergy and Infectious Diseases National Institutes of Health Bethesda, MD
Ms. Sheila Mitchell AIDSTECH Family Health International Research Triangle Park Durham, NC	Dr. Kevin O'Reilly STD Research Branch Centers for Disease Control Atlanta, GA
Dr. John Moran Office of Medical Services Peace Corps Washington, DC	Dr. Randall Packard Dept. of History Tufts University Medford, MA
Ms. Patricia Moser Office of Population U.S. Agency for International Development Washington, DC	Dr. Peter Perine Division of Tropical Public Health Uniformed Services University of the Health Sciences Dept. of Preventive Medicine Bethesda, MD

Dr. Peter Piot
Institute of Tropical
Medicine
Antwerp, BELGIUM

Dr. Bob Pond
Misereor (W. Germany)
Martinez, CA

Dr. Malcolm Potts
Family Health
International
Research Triangle Park
Durham, NC

Dr. Moses Pounds
Population Information
Program
Johns Hopkins University
Baltimore, MD

Ms. Elizabeth Preble
AIDS Programme
UNICEF
New York, NY

Dr. Thomas C. Quinn
Laboratory of
Immunoregulation
National Institute of
Allergy and Institutes of
Health
Bethesda, MD

Dr. Priscilla Reining
American Association for
the Advancement of
Sciences
Washington, DC

Dr. William Reinke
Johns Hopkins School of
Hygiene and Public
Health Dept. of
International Health
Baltimore, MD

Dr. Andrea Ruff
Johns Hopkins School of
Hygiene and Public
Health
Dept. of International
Health
Baltimore, MD

Dr. John Rutyuga
P.O. Box 29074
Washington, DC

Dr. Alfred Saah
Johns Hopkins School of
Hygiene and Public
Health
Dept. of Epidemiology
Baltimore, MD

Ms. Stephanie Sagebiel
AIDSTECH
Family Health
International
Rosslyn, VA

Dr. Kenneth F. Schultz
Centers for Disease
Control
Center for Prevention
Atlanta, GA

Dr. Debra Schumann
Dept. of Anthropology
Case Western Reserve
University
Cleveland, OH

Dr. Robert McNair Scott
Walter Reed Army
Institute of Research
Washington, DC

Mr. Steve Smith
Development Through
Self-Reliance, Inc.
Columbia, MD

Dr. William Smith
AIDSCOM Project
Academy for Educational
Development
Washington, DC

Ms. Dianel L. Sondheimer
AIDS Program
National Institute of
Allergy and Infectious
Diseases
National Institutes of
Health
Bethesda, MD

Mr. Lewis Stess
Institute for
Development Anthropology
Binghamton, NY

Ms. Dace Stone
AIDSCOM Project
Academy for Educational
Development
Washington, DC

Mr. Nicholas Studzinski
Asia Near East Bureau
U.S. Agency for
International
Development
Washington, DC

Mr. Curtiss Swezy
AIDSCOM Project
Academy for Educational
Development
Washington, DC

Dr. Robert Tesh
Yale University School
of Medicine
Dept. of Epidemiology
and Public Health
New Haven, CT

Ms. Rikka Transgrud
Futures Group
Washington, DC

Dr. Beth Ungar
Division of Tropical
Public Health
Uniformed Services
University of the Health
Sciences
Bethesda, MD

Dr. Linda Valleroy
Office of Health
U.S. Agency for
International
Development
Washington, DC

Dr. Ann Van Dusen
Office of Health
U.S. Agency for
International
Development
Washington, DC

Dr. Martha Ward
University of New
Orleans
Dept. of Anthropology
New Orleans, LA

Ms. Sharon Weir
AIDSTECH Project
Family Health
International
Research Triangle Park
Durham, NC

Dr. Karl A. Western
Office of Tropical
Medicine and
International Research
National Institute of
Allergy and Infectious
Diseases
National Institutes of
Health
Bethesda, MD

Dr. Louise White
Department of History
Dalhousie University
Halifax, NS
CANADA

Dr. Stefan Wiktor
National Cancer
Institute
National Institutes of
Health
Bethesda, MD

Ms. Elizabeth Younger
AIDSCOM Consultant
Academy for Educational
Development
Washington, DC