*Names in italics refer to first authors of Abstracts, Papers and Presentations*

# HIV/AIDS communication facing African multilingualism
## Exploratory workshop

**University of Lausanne/16-20 November 2010**

Synthesis report[1]

# TABLE OF CONTENTS



[1] This synthesis owes much of its substance (i) to the detailed notes taken by the PhD reporting teams during the proceedings including the discussion rounds (1.A.iii, 1.C.iv); (ii) to the digests drafted by the two PhD working groups as a follow-up to the workshop; (iii) to the concluding statements drafted by the anglophone and francophone working groups, reflected in section 7. The pre-final version was read by Prof. Guéladio Cissé and Prof. Pascal Singy. Their comments and those received in reaction to a preliminary version distributed to the participants were integrated into this final version. – Thanks also to Dr. Martin Benjamin for proof-reading and commenting the preliminary English version. Authorial responsibility: Prof. Thomas Bearth, University of Zurich. *Contact:* thomas.bearth@flashcable.ch.

## 7. Recommendations/Follow-up

*7.1. Research*

*7.1.1. Recommendations by the working groups*

*7.1.2. Recommendations by the terminology task force*

*7.1.3. Research proposals for dealing with language/culture/gender barriers*

*7.1.4. Recommendations from the coordinators' desk*

*7.2. Training: working group recommendations*

*7.3. Recommendations for publication of workshop proceedings*

*7.4. Lobbying for recognition on research and public agendas*

*7.5. Topics left for future consideration.*

## 1. Overview

The fact that scientists from different disciplines as far apart as linguistics and health decide to take several days out of their heavy schedule to meet may be interpreted as being in itself a strong indicator of awareness of a common field of inquiry in need of attention, and of a perception of converging interests which call for cooperation across disciplinary boundaries. The purpose of the workshop devoted to "HIV/AIDS communication facing African multilingualism" was to translate this awareness into mutually interpretable descriptive and analytical language and into concrete proposals for cooperation. The first goal was reached to an extent that leaves no doubt about the usefulness and timeliness of the workshop, the second see 7 below. Hosted by the Section de Linguistique, University of Lausanne, it took place from 17 to 20 November 2010. It was funded by the Swiss National Science Foundation (grant IZ32Z0_133958), with participations from the NCCR North-South[2], the Swiss Centre of Scientific Research in Côte d'Ivoire (CSRS), PASRES (=Programme d'appui stratégique à la recherché scientifique en Côte d'Ivoire)[3], and from the following entities of the Faculty of Arts of the University of Lausanne: Dean of Faculty; Centre of Linguistics and Language Sciences; Section of Linguistics. It was implemented in scientific collaboration with the University Hospital Centre of the University of Lausanne (CHUV), the Swiss Tropical and Public Health Institute (Swiss TPH), Basle, the Swiss Centre of Scientific Research in Côte d'Ivoire (CSRS), and the Department of General Linguistics, University of Zurich.

Out of 24 participants, 13 were residents from Africa, 9 from Switzerland (including 3 African scholars/practitioners here), and 2 from Germany. 19 papers ranging from field experiences to theoretical contributions were presented by a total of 21 contributors. Age of participants ranged from under 30 years to over 70. 5 participants are PhD students, 4 of whom are currently engaged in research directly related to the workshop theme: 2 from Ivory Coast (supported by CSRS/PASRES), 2 from Lausanne, 1 from Zurich.

*Structure and program of the workshop*

A. The workshop was organized in such a way as to provide a balance of

(i) state-of-the-art input from complementary disciplinary angles on major issues;

(ii) participant reports reflecting regional differences and specificity as viewed through their research foci, with the aim of obtaining a multi-perspective view of the field;

(iii) involvement of junior researchers (PhDs) who were entrusted with the day-by-day reporting responsibility (see C iv);

(iv) optimization of intercommunication between Anglophone and francophone researchers in spite of limited individual bilingualism.

[2] Participation of B. Bonfoh & S. N'guessan.
[3] Participation of G. Singo.

B. *Three major event blocks* were designed to provide, in this order

(i) full input by participants as a means of providing broad contextualized background information on the main issue while addressing, in piecemeal fashion, specific issues important to them;

(ii) sufficient space for discussion and exploration ;

(iii) using input from B(i) and B(ii) to construct coherent *surveys of problem areas* and their interdependence; as well as proposing methods and solutions;

(iv) *synthesis of workshop results* based on the combined input from A(iii) and B(iii).

C. Organisation:

(I) Local infrastructure, public events & finances at local level: Remi Jolivet

(II) Programme (flow chart): Guéladio Cissé, Thomas Bearth

(III) Moderation: Guéladio Cissé, Ndoungou Salla Ba, Pascal Singy

(IV) Reporting: Guéladio Cissé, Mohomodou Houssouba; *PhD students:* Kibibi Amran (KA. English)), Per Baumann (PB, English); Sosthène N'guessan (NG, French), Geneviève Singo (SG, French).

## 2. The contours of a common field of observation and inquiry

### *2.1. HIV-AIDS prevention – a twofold challenge to communication*

> *On the one hand, without active participation of the local population in the process of HIV/AIDS communication – and this is in most areas of Africa possible only in local languages – there can be no sustainable understanding of the issue and accordingly no change of behavior.*
>
> *On the other hand, because of widespread linguistic and cultural taboos concerning sexuality and disease – especially across the gender and generation divides – local languages might be less suitable as a vehicle of communication than the former colonial languages, which allow a certain distance in discourse.*
>
> *Local and official (formerly colonial) languages may prove complementary by fulfilling different functions in HIV/AIDS communication. However, it must be emphasized that in almost all countries of Africa, full mastery of both a local and the official language is still the exception for a vast majority of the population.*
>
> Kibibi Amran/Per Baumann (PhD. students), Extract from summary report

A common view prevailed among participants that (i) HIV-AIDS prevention and management is a communicative problem to an extent and in a way which is not necessarily the case for health communication in general, and that (ii) this communicative problem is exacerbated by multilingualism which in turn is deeply entrenched in most parts of Africa. Intrinsically, talking about HIV-AIDS is subject to heavy constraints due to cultural attitudes, language taboo, and social stigmatization. Under the general heading of language divergence, three different sources of communicative inadequacy must be distinguished: (i) unequal distribution of linguistic competences resulting in deficient intelligibility, (ii) language attitudes (habitus, Bourdieu 1982:14): top down communicative settings correlated with asymmetrical

perception of status and public roles attributed to languages involved in the communicative process tend to reproduce and reinforce communicative dependency (e.g. on interpreting), fragmented intelligibility, and restrictions imposed on negotiating power; (iii) socially motivated prejudice (taboo, stigma) stands in the way of acceptance of the message(s) about AIDS prevention and management even if (or sometimes because!) its cognitive and social meanings are too well understood. While a number of contributions pointed to the cumulative effects of various "noise" factors (see 3.1 below, Figure 1), e.g. *Singo*, *Namyalo*, *Bwanali*, others, to the contrary, insisted that the problem is no longer primarily with intelligibility (i, ii) but with acceptability (iii) (*Amran*).

Yet access to appropriate and adequate information for individuals and populations concerned was generally recognized as the most indispensable prerequisite to change of behavior in ways which contribute to protect oneself and others (including one's own young children) from being infected, to live with AIDS according to standards made possible by medical progress, and to prevent the disease from spreading, and more generally, reduce its impact on society, or on specific risk groups. Conveying such information is at the heart of AIDS campaigns, media spots, seminars, collaborative learning programs, and also of much of doctor-patient interaction, as well as public health extension in the broadest sense.

There is further broad agreement that gaps in education, the gender divide, and certain beliefs may be major obstacles to the adoption of essentials of HIV-AIDS prevention (*N'guessan*/Cissé). The gender divide with its constraints on freedom of decision and action is partly responsible for the feminization of the pandemic observed in many parts of Africa.

### *2.2. Multilingualism – both a challenge and an asset to HIV-AIDS communication*

Recognizing socio-cultural factors as impediments to comprehension and acceptance is not enough. Processes of knowledge constitution depend heavily on the extent to which language resources are shared between providers of such information and its recipients. Where this is not the case, key audiences, particularly women, may still be by-passed and may be exposed to heightened risk due to uncertainty about risk factors. As one case study from Western Ivory Coast based on interviews conducted in the local language shows (*Singo*/*Bearth*), the latter in many cases still holds the place of the preferred or even unique resource suitable for processing new information in its integrality; and negotiating ensuing behavioral adjustment. The case study further suggests that, contrary to what selectively polyglot media policy implies, osmosis by hearsay alone is not a substitute for the appropriation of messages specifically targeted at local constituencies.

Yet the view portraying multilingualism as an obstacle to effective dissemination of relevant information, compounded by taboo and stigmatization as further factors of resistance, is counterbalanced by observations attesting that multilingualism can be an asset in breaking

the communicative deadlock caused by this latter obstacle. Multilingual settings offer additional resources for by-passing the taboo barrier by presenting patients (and public health agents by implication) with a choice between taboo vs. non-taboo linguistic repertoires in taboo-sensitive domains; these resources are evidently unavailable to monolingual audiences. Evidence of multilingualism as a resource for successful AIDS communication in sub-Saharan migration circles in Switzerland (*Bourquin/Singy*) is corroborated by comparable strategies in the Maghreb where debate on AIDS is strongly tabooed by religious leaders and where the Internet offers a zone of escape from these constraints – thanks to French which dominates the net, for "talking about taboos in one's mother tongue (Kabyl Berber in this case) is shameful" (*Tigziri*).

As was pointed out in the final discussion round, these observations corroborate results from the ongoing EU-sponsored DYLAN project <www.dylan-project.org> for a different region (Africa) and a different domain (health). Sporadic findings presented at the workshop (for which further corroboration is needed) provide evidence in support of the DYLAN key hypothesis, namely that multilingualism constitutes a significant added value to society, science and economy (Lüdi 2010) which could logically and usefully be extended to the domain of public health.

### *2.3. Diversity of multilingual environments*

African multilingualism has three main roots to which correspond several types of complementary role attributions between participating languages in terms of dominance, functionality, and official status:

1. diversity of ethnic composition of modern African nations which goes back to pre-colonial times and serves as a vector of identity, basis for claims to autochthony, superiority and inferiority, and as a repository of local knowledge, including interpretation of disease and healing;
2. the double linguistic inheritance resulting from acculturation of former colonial languages and their derivates, considered in late postcolonial Africa as part of the continent's socio-linguistic inheritance and, to the younger generation, as part of their identity (*Sow*, discussion). At the same time, the role which the African part of that inheritance is to play in developing the continent is under permanent review and currently being reclaimed (*Agyekum*, discussion). The view that the function of bridge language is shared between the former colonial languages and their derivates on the one hand, and major African languages on the other, is widely accepted, and its positive effect on health communication well established (e.g. for Akan, *Agyekum*);
3. Contemporaneous migration, illustrated e.g. from Uganda with numerous refugees' exolingual communities superimposed on endolingual multilingualism (*Namyalo*).

*2.4. L1 as default vs. subsidiary language in HIV-AIDS communication*

There is broad consensus that L1 (first language) is the preferred medium of basic knowledge-processing (as distinct from taboo by-pass) in matters of health, and HIV-AIDS in particular. The significance of this convergence of opinion in a multidisciplinary workshop is that the plea for taking into account language diversity is not, in the case at hand, based on language-centered arguments such as language maintenance, linguistic human rights or cultural diversity, but on the need for inclusive communication in a domain vital for individual wellbeing and for society's survival. Access through one's own language to relevant information – one could call it linguistic equity – is also claimed to be an essential missing link on the way to equity of access to free treatment (*N'guessan*/*Cissé*).

The convergence of statements by six researchers working in four different institutional, academic and socio-economic contexts in Ivory Coast as to the positive effect of a presumed incidence of an active national language strategy on AIDS prevalence reduction and risk exposure [++ default medium, + subsidiary medium] may be taken as representative:

| ***Ivory Coast*** | Necessity of L1 adoption as default or subsidiary communication tool | **Context** |
|---|---|---|
| *Sangaré* | ++ | National AIDS communication strategy |
| *Singo*/*Bearth* | ++ | Transmission and reconstitution of basic knowledge relating to AIDS in a remote rural area |
| *N'guessan*/*Cissé* | ++ | Linguistic equity as a correlate of equity of access to treatment |
| *Betsi*/*Cissé* | + | L1 as complementary to L2 (French) in a mixed linguistic peri-urban environment |

Table 1: L1 as a default or subsidiary medium in HIV-AIDS communication

There are important nuances to this, though. Successful communication on sensitive matters such as health care and HIV/AIDS crucially depends on its ability to reflect and integrate patterns of multilingualism and the perceived roles of languages within these patterns, as well as their relation to socio-economic status and internal social structure of target audiences. Linguistically mixed neighborhoods require different strategies for sensitization or mobilization: e.g French as bridge and decision-making language seconded by African home languages as subsidiary resources for ensuring inclusive participation (*Betsi*/*Cissé*). Construction of knowledge for community-based action in such cases is a linguistically hybrid process, as compared to what is required for linguistically homogeneous populations, where the construction of relevant knowledge depends on its reconstitution through information made available in the local language as its primary resource for community-level negotiation (*Singo*/*Bearth*). As a caveat against premature generalization we may add that the distinction

between linguistically hybrid and single community language-focused communication does not necessarily correlate with the distinction between urban and rural settings (cf. *Beck*'s study on a linguistically homogeneous interactional urban setting in Kenya).

## 3. Communication and knowledge construction in HIV-AIDS prevention

### *3.1. Model of communication – moving beyond the "transmission" legacy*

The linear model of communication originally proposed by Shannon and Weaver (1949) at the dawn of the present age of technology of communication – two entities (sender and receiver), connected by a physical support (channel) and a medium (code)[4], and transmission devices ensuring encoding and decoding – is still today considered as essential to any discussion of communication (*Sangaré*).

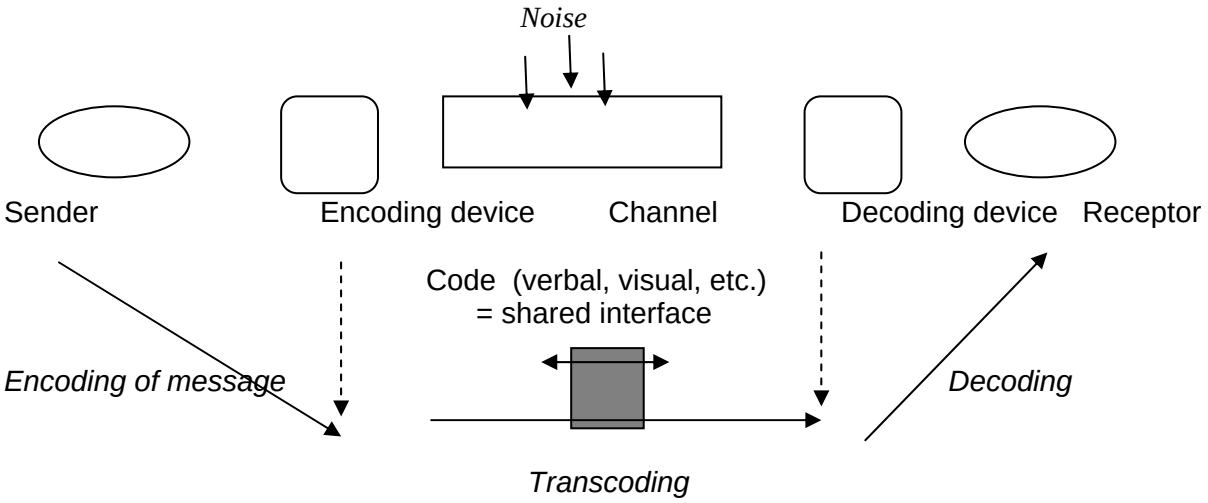


Figure 1. Linear model of communication (adapted from Shannon/Weaver 1949)

Its fundamental flaw is that it ignores meta-communication as a condition for verbal (or any symbolic) activity to be recognized as an act of communication in the first place, as a prerequisite to formal closure by which any kind of act is established as an instance of social interaction, and finally as a symbolic activity designed to produce an added value of meaning. Its second no less serious shortcoming is that, as a theoretical construct imposed on the broad context of communication aimed at knowledge production, under which HIV-AIDS and public health communication undoubtedly falls, it tends to equate the sender with the entity that knows, and as a correlate, to identify the receiver as the entity which lacks knowledge – thus interfering by theoretical a priori with the mere possibility of communication as a means of collaborative knowledge production, while excluding the receiver's potential as

[4] Added in Jakobson's model (Jakobson 1960:353), along with "context" as another distinct variable, it contributed to make the model more "human".

a co-producer. A principal reason why scholars and even practitioners fall back on the classical linear (or code or transmission) model seems to be that none of the currently available models (see Mucchielli 2008 and Wikipedia 2010a for overviews) addresses the specific problems of cross-language communication, and even less those engendered by a context deeply marked by language inequality (though imbalance of *social* relations may be addressed, see Wikipedia 2010b, Newsbery).

A host of insights relate to the dynamics of communication in different types of micro-settings which, as opposed to relatively stable macro-settings (represented by the language map of a country or region), leave room for inventiveness and innovation, more or less in pace with, or constrained by theoretical models (Meunier 1994, 1995). While methodologically diverse, their common objective is to make participation of individuals, groups, and society as a whole more effective in the fight against the disease at all levels of social integration and at all stages of intervention, from acceptance and diagnosis to ARV treatment and social rehabilitation.

A typology of micro-settings defined in terms of categories of audience design is proposed by *Sangaré*. She distinguishes interpersonal, group, mass as well as institutional communication. To these four categories, she adds traditional or community communication which, subject to local control, rules and conventions, constitutes a relevant category of its own that requires strategic adjustments which are even less dispensable in the delicate, taboo-ridden domain of HIV-AIDS communication. For her, the shift of perspective from the "sending pole" to the "receiving pole", while not implying a departure from the linear model which she explicitly maintains as theoretical reference, entails the inclusion of national languages in a national policy of AIDS communication. In the context of the prevailing policy of AIDS communication, it follows that, in order to fulfill its purpose, diversification of actors in the multi-sectorial approach promoted by the Ivorian Ministry in charge of the fight against AIDS needs to be supplemented by a "multi-directional" approach focusing on the receiver and conditions of the reception, including the latter's linguistic diversity, as much as on enlarging the sectorial scope of the outreach.

### *3.2. The place of language in communication for knowledge production*

One of the fallouts of the exploratory concept implemented in the workshop program is the fact that it offers productive time for plenary discussion, review, and synthesis. Various observations on the role of language in knowledge constitution led to put a joint effort into reformulating what is to be meant by "knowledge" and/or "understanding". Knowledge that counts as such includes knowledge about knowledge (knowing what and why one knows, in the vein of double-loop learning (Argyris & Schon 1974)), conversancy in parallel discourse (Beck, p.c.), the capacity to deal with argument and counter-argument in the particular field

to which a given piece of knowledge is applicable (*Singy*, and passim), and it includes a social dimension of understanding as a cultural distinctive of at least some African societies (*Bearth*). Such a pragmatic, reflexive and socially determined concept of knowledge has important consequences for the constitution and transmission of knowledge in multilingual contexts: (i) It will have to take into account, and preferably work through, the language in which people are most at ease arguing, which, particularly in Africa, is not always the language in which they had their formal education (if they had any); (ii) it obliges to relativize the current euphoria about spread of knowledge in HIV/AIDS matters in Africa, as do incidentally most of the case studies presented at the workshop; (iii) comprehension of what understanding means in a given society has some bearing on the much discussed question of the knowledge/behaviour gap (*Amran*).

It would seem that this strand of reflexion which mostly emerged from workshop discussions falls in line with a preoccupation of national and global institutions monitoring the current alleged progress of knowledge on the disease, its risks and ways to contain them. Thus in a critical discussion of what constitutes “comprehensive knowledge”, this term, used by the Tanzania Commission for AIDS (2008:26), not only includes argumentative knowledge but is defined by it, namely as double awareness of what is the case as against what is incorrectly supposed to be the case (see also UNAIDS 2009, p. 30, note 2).

While the shift of perspective to the receiver credibly serves the double purpose of ensuring optimal contextualization and improved compliance, it remains committed in practice to the linear model of communication based on the sender-receiver dichotomy which underlies the notion of “transmission”. Given the origin of this model in the mathematical and its dominant use in the technical sciences, it is remarkable that workshop contributions from participants with a background in natural sciences clearly prefer a more “human”, collaborative model of communication in its place, as the following perusal of contributions shows.

Drawing on broad professional experience, the Executive secretary of the national program for the fight against HIV-AIDS in Mauritania, Ndoungou Salla *Ba* (opening talk), says that it is the task of the providers of health services to learn the language of the patient. By implication, she suggests the inversion of the top down communication model by privileging a bottom-up approach to communication which, for diagnosis and treatment, gives epistemic priority to the affected person or group. By further implication, it places the medic, communicatively speaking, in the position of a learner. Where the conditions for full receiver language mastery are not fulfilled, inquiry into key terms through medically trained personnel conversant in the patient’s or advisee’s language is preferable to reliance on in situ translation which is fatally tied to top-down communication (*Ba*, p.c.). The same circular communicative logic leads to enlarge the “cast” of actors involved in the communication to include traditional communities and their leaders, sages, etc. (Needless to say, defining in

these terms a communicative approach to AIDS prevention and treatment in no way implies a syncretistic approach in medical terms.)

In discussion, *Bonfoh* draws attention to the need of mutual learning. It is important that specialists become conversant in their specialty in the language(s) in which they are born or were socialized (generally their own L1). This underscores the need to go beyond "receiver sensitivity" and "contextualization of the message" in the quest for a model of co-production for construction of the message and for knowledge-driven action in health communication.

The research NCCR North-South framework a priori favors an inclusive transdisciplinary approach, "considering academic and non-academic knowledge in the research process and valuing contributions of all stakeholders in the generation of knowledge" (*Bonfoh*). A case study on "Perception of health and illness among Kel Tamacheq", using the perception of tuberculosis as example, serves as litmus test demonstrating the added epistemic value of research through the local language (by a non-native) as opposed to research on the same topic done through translation (by a researcher with native background). "Deconstruction of language and representation" as a "new form of communication" rests, as *Bonfoh* observes with an eye on the linguists, on prior semantic research on indigenous taxonomies, etiologies, and diagnosis. (Linguist's remark: None of the latter is new to linguists, its neglect is a consequence of discredit thrown on it in the wake of anti-Whorfian universalism. It is time to reconsider some of these issues.)

*The fulcrum of HIV/AIDS Communication: transfer of knowledge in the interaction between experts and a target population must go both ways. Promising results in the fight against HIV/AIDS can only be expected when both sides can confirm.*

Kibibi Amran/Per Baumann (PhD. students), Extract from summary report

### *3.3. Discourse analysis as a means of understanding knowledge production*

How is relevant knowledge constructed or deconstructed through discourses involving key actors in the HIV-AIDS conscientiation process? Which discourse strategies and procedures are used by participants from different angles for which purposes? The two invited guests from Germany, both having several years of experience in specialized research in the field of HIV-AIDS communication in Africa to their credit, drew on the empirical mass of data from their field research in geographically and institutionally widely distant settings, to demonstrate the potential of linguistic, discourse and conversational analysis both as heuristics and as proof procedure for understanding how relevant knowledge is constructed across linguistic and, more pertinently, cultural barriers. Both contributions focus on the relevance of language data as a research tool with a view of formulating implications for effective

communication which in turn may or may not have implications for language as a communication tool in culturally heterogeneous environments.

Drawing on data from classroom interaction in French in the context of training of peer advisors on HIV-AIDS in Burkina Faso, *Drescher*, by observing e.g. textual reformulations, demonstrates the potential of discourse-analytical tools to formally identify traces of the local cultural discourse substrate, references to local representations of HIV-AIDS, and local strategies of coping. Trainees are thereby faced with a rhetorical dilemma: to evoke local perceptions – including their own – for the purposes of contextualization of the teaching they receive, while demonstrating adherence to global bio-medical discourse as the sole legitimate basis of constructing AIDS reality and knowledge recognized in the immediate didactic environment; they are shown to seek to resolve the dilemma by recourse to alternation between formally identifiable discourse templates, notably between epistemic and evidential modality. Such observed correlations must not only be read as a challenge to the conveners to deal with parallel discourse and “prejudice”, but to mitigate hegemonic bias inherent in international teaching environments and global discourse underpinning it, lest to risk to ultimately subvert its purpose. Follow-up discussion focused on the need for extending discourse analysis of this kind and finesse to matching samples from primary local discourses as a source of corroborative evidence.

In a conversation-analytical study of HIV-AIDS education targeted at disadvantaged youth in a slum neighborhood in Nairobi and conducted in Sheng, the locally dominant basilect of Swahili, *Beck* demonstrates the heuristic value of linguistic routines as indicators of acceptance and rejection of the core message which the prevention game in which they participate is supposed to convey. From this case study, mandated by a major German development agency for evaluation purposes, one may deduce that using the “right” language does not guarantee acceptance of the prevention message, but – the point *Beck* makes – provides cues for understanding the reasons for its rejection, and for discovering contestation of established power relations as the hidden meaning behind rejection.

### *3.4. Ownership of knowledge as the ultimate goal of HIV-AIDS communication*

The contributions summarized in the preceding sections raise the question, beyond the methodological issue of a heuristics of appropriation, construction and subversion of knowledge, of the ultimate purpose of HIV-AIDS communication. Issues of language as a tool for communication (*Ba*, *Betsi*, *Sangaré*, *Singo*), and of language *data* as a research tool (*Bonfoh*, *Drescher*, *Beck*), while interdependent (results from the latter may feed into the former, and vice versa), are not to be confounded. Both, however, are concerned with a common overarching goal and purpose defined in one contribution as "ownership of the message by the entire population characterized by cultural diversity" (*N'guessan*/*Cissé*).

The operational test of "ownership" applied to a body of knowledge is the latter's availability and accessibility when and where it is needed by a community and its members. "Sustainable knowledge", as it was called in the discussion, presupposes the capacity of local leadership and communities to cope with the challenge posed by the disease itself and the stigma attached to it without having to rely on, or wait for, onerous campaigns or costly special actions targeted at them for enabling them to do the right thing. On the ground, this overall goal – progressive emancipation from communicative dependency on external sources of information – fans off into three practical objectives:

(i) Empowerment in the sense of "ownership of knowledge" should be made the explicit goal of HIV-AIDS communication;

(ii) Mobilizing communicative resources locally available and accessible, prominently among them local languages used in the relevant communicative space, appears as a prerequisite to making "ownership of knowledge" effective to "the entire population" which uses these resources in their daily lives;

(iii) To the extent that "ownership of knowledge" required for fighting the disease (a) contributes to efficacious and permanent reduction of HIV-AIDS incidence in the local perimeter within its reach, (b) reduces the need for external intervention, it constitutes a significant factor of public health cost reduction on both counts; this justifies, in economic terms, modest investment into local language resources likely to translate into significant reduction of overall cost on a local, regional and national scale.

Recast in the categories of the communication model evoked above, these observations may allow some further clarification of the workshop's central topic. "Ownership of knowledge generally entitles the owner to transfer it to other contractors of the project or to third parties."[5] Even if we felt obliged to adopt the linear communication model and its assumption of a fundamental dichotomy between sender and receiver, looking at communication as a process leading to a change of an original state of lack of knowledge into a new state of

[5] http://www.ipr-helpdesk.org/documents/LimitsTransferOwnership_0000006311_00.xml.html <Help desk of European Research Council, FP6.>

control over knowledge, we are led to conclude that, as a result of successful communication (success being defined in terms of acquisition of ownership of knowledge), the original receiver has acquired properties that qualify him as sender: the model is so to speak validated and at the same time invalidated by its own internal logic. The principle of communicative sustainability (*Bearth*, opening talk) is seen to apply to health communication in an analogous way as that documented in detail with respect to local resilience towards ecological assets in the 2002-2007 Ivorian conflict (Bearth & Baya 2010). Put in operational terms, "communicative sustainability of an innovative message results from the substitution of an endogenous source to its original exogenous source" (www.lagsus.de/Project description).[6]

As a necessary caveat concerning the meaning of "ownership of knowledge" or, if we prefer, of "communicative sustainability" as the ultimate purpose of HIV-AIDS communication, we must stress the fact that emancipation from communicative dependency still leaves room for asymmetry of knowledge distribution between participants. By following through with the doctor's prescription, a patient may demonstrate his or her understanding of the latter as intended by the doctor, but this does not mean that he or she will have become a doctor by following medical advice. What sustainable knowledge implies is the capacity of local leadership and communities to deal with the challenge at reduced external cost, in their own cultural terms, and in consensual partnership with external instances still needed.

## 4. Terminology and ICT as metaresources for stabilizing knowledge across language divergence

### *4.1. Terminology – a luxury?*

> *[There is] lack of standardized HIV/AIDS terminology to*
> - *increase and consolidate knowledge about HIV/AIDS*
> - *bridge the gap between the elite and the common people.*
>
> *Extract from the summary of the Anglophone working group*

In dealing with health communication in the broader context of integration of marginalized societies into knowledge-based global society, a distinction needs to be made between

[6] On several counts, before and during the workshop, it was intimated that knowledge cannot be reduced to information (knowing what is the case) but must include competence to handle counter-discourse (knowing what is not the case and why; competence to deal with argument and to refute at least the most common misconceptions); see e.g. Bwanali's discussion of deficiency of knowledge in linguistic minorities in Malawi. In the context of evaluating spread of "knowledge" about HIV/AIDS which, beyond reduction of prevalence ascribed to progress of medical science, is considered to be the single most decisive factor in gauging the long-term efficacy of the fight against the disease, the way in which knowledge is defined makes a huge difference (UNAIDS 2009:30, note 2). By linking communication and knowledge, the dynamic and dialogic properties of knowledge relevant to HIV/AIDs and useful in the fight against it are brought to the foreground. Communicative sustainability (CS) adds a further dimension: knowledge is not seen primarily as being owned by the individual but as resulting from a drive within communities to achieve consensus. This in turn presupposes the dialogic process of knowledge appropriation.

production of knowledge in situated speech (doctor-patient; sensitization of collectives, training of health workers, and extension work of any kind) on the one hand, and coded knowledge on the other (Bindé 2005). The former is defined by negotiable parameters relevant to the setting in which it occurs, such as communicative profile (involvement of participants, attributions of rights and obligations, choice of media and language register, topic, content, and modes of reception). Coded knowledge, on the other hand, is associated with terminology or, more generally, with naming processes. Terminology, in a general sense, aims at creating a "stable interface between language, its speakers, and knowledge of a given domain" (Bearth, in press). Lexicography, on the other hand, is a representation not of object knowledge, but of knowledge about how language works. But as such it is also the default source for terminology.

Prejudice against the need for terminology in educationally and economically underprivileged societies is reflected in low priority in national and ONG policies and low allocation of funding. This dim view of the role of terminology is entirely mistaken; the fact that health terminology in languages spoken by predominantly less-resourced target audiences was prominently dealt with in 14 out of 19 papers read at the workshop, and moreover was the main subject in 6-7 of these, speaks in this respect for itself.

In multilingual settings, terminology constitutes a principal means of producing a mutually convertible knowledge base accessible to speakers of languages not naturally understandable to each other. It is thus a means of "empowering language" (*Bwanali*) by enabling it to express scientific and applied contents of an innovative nature. As a by-product, it was recognized (see inlay above) that access to terminology, and participation in the process of establishing it, may be a means of reducing social distance between educated elites and less privileged members of society at large. Phone-in broadcasts in the Akan language are a case in point – a regular feature of Radio *Afisem* operating from the campus of the University of Ghana since it was launched in the late 90ies. Mushrooming of this use of media in promoting linguistic equity together with domain-specific knowledge across the Akan speaking area is thought to have contributed significantly to reducing HIV prevalence in this country.

### *4.2. Methodological hurdles confronting research and application of terminology*

There was general agreement between participants that efforts to create terminologies in under-resourced languages are crucial for overcoming conceptual barriers which still keep a large proportion of populations in the dark regarding the nature of HIV-AIDS and how to prevent and treat it. There are several reasons why this is by no means an easy task:

(i) *Dependency on translation:* The translation of messages of prevention in the context of health extension tends to be unreliable because of the unavailability of confirmed

terminology. But terminology in turn depends on translation as it tends to be produced in an ad hoc manner as the need arises in attempting to formulate the message for heteroglossic audiences. The result may be that “different organizations use different translations. Thus AIDS communication becomes a source of confusion rather than of information” (*Namyalo*). –

(ii) Another recurrent problem is *lack of idiomaticity*: translators tend to copy dominant language templates instead of searching for natural dynamic equivalents in the target language (*Bwanali*, commenting AIDS information in Chichewa translated from English). The majority of discussants see the answer to these problems in the integration of specific communication modules in the training e.g. of health workers, in the promotion of professional carriers for translators in African languages, and in the institutional reinforcement of translation as part of the implementation of extension work.

In order to avoid the pitfalls linked to translation, a by-pass strategy was proposed, namely to “encourage production of messages in local languages”; the implication seems to be that terminology would filter out naturally from conversation about AIDS as practiced by the community (Anglophone reflexion group). Whatever is meant, the reasoning begs the question. While naturally occurring discourse constitutes a valuable resource, it does not replace active research on terminology.

(iii) *Conflict with target language usage and cultural tenets* (all papers): L1 terms proposed on account of straightforward equivalence with a source language term may clash with preexistent undesirable connotations or taboo. In response to this recurrent problem, a three step strategy has been devised (English PhD report):

- Develop glossaries of taboo terminologies related to HIV/AIDS ;
- Find alternative expressions (taboo avoidance techniques=TAT);
- Train traditional communicators through workshops.

(iv) *Acceptance and validation*: Harmonization between disciplines (e.g. between linguists and medical specialists of AIDS) is important (*Kihore*), but does not in itself guarantee dissemination and acceptance by user communities. It was noted that lack of acceptance of terms used by promoters may translate into rejection of their message.

(v) *Standardization*: Institutional backing of terminological work is also important. As a perusal of Swahili terms approved by the National Kiswahili Council (BAKITA) shows, official certification may be helpful for professional users. But the same example also shows that standardization is not tantamount to acceptance: innovative strategies are called for to gain broad acceptance by the community of potential users and by those most in need of it (*Kihore*).

*4.3. Popular nomenclature – an indispensable resource for dissemination*

At the conceptual level, there is a need for clarification of the difference between

1. Terminology and specialist "jargon" (*Kihore*)
2. Terminology and lexicology (see above)
3. Scientifically-based terminology (denotative) and local nomenclatures (evocative)
4. Emergent vs. scientific terminologies.

There is a need for clarification of the complementary roles of scientifically-based terminology (denotative) and local nomenclatures (evocative) as resources for knowledge constitution. With respect to the latter, one might be inclined to dismiss them as irrelevant as a valid source of working knowledge for AIDS communication. However, some evidence provided through the proceedings leads to a different conclusion. First, as already mentioned, in the context of HIV-AIDS communication, local strategies of naming the disease and phenomena related to it typically reveal taboo as well as emotional states and social attitudes. To quote one notorious example, a panoramic view of the evolution of popular talk and terminology over a period of 25 years is provided by Mutembei's monumental research on AIDS poetry in Tanzanian newspapers (Mutembei 2009). Gleanings from vocabulary used in discourse on AIDS, using techniques of euphemism, circumlocution, and paronymy, were shown in a number of workshop contributions to reveal local perspectives and shed light on ways of coping, avoidance and resistance (*Agyekum*, *Amran*, *Bwanali*, *Singo*).

Second, as confirmed by several contributors, popular terminology is characterized by its ingenuity in circumventing taboo and precisely for this reason constitutes a non negligible resource for resolving communicative dilemmas where e.g. bluntness in sexual matters would be an a priori motive for dismissing not only the tabooed term itself but the communicative effort as a whole.

Also, while popular talk is not generally regarded to be a valid resource for the dissemination of knowledge, the case of Niger Republic shows that endogenous terminology rooted in traditional value, precisely by virtue of its evocative power, may very well be the key to successful dissemination on a nation-wide scale (*Sow*). If the case of the Fulani herdsman's hat as an alias for the condom permits some extrapolation, one may infer from it that local terminologies, though not a priori coined with the explicit purpose of substituting professional jargon as a means of expressing systematic knowledge about AIDS, could turn out to be the missing link between professional and popular language, while at the same time offering a credible solution to the problem of dissemination. Contrasting the case of Niger with that of Algeria, both countries with strong adherence to Moslem faith (though Moslem state religion in the latter, not in the former), one finds that "euphemism" (the cover term routinely used to denote indirect naming strategies applied to the disease and its material and social corollaries) is ambivalent in terms of its consequences for the reception of the information it

carries by the community. While in Niger the hat metaphor has become the bridge for acceptance and popularizing of the object it represents, analogous indirectness in the Algerian case has become synonymous with rejection as emblems of moral decline of both the evil itself and the means of its prevention. The comparison offers an empirical basis for the hypothesis according to which, against a similar religious background as is the case of the two countries, the difference between rejection and acceptation owes more to the communicative strategy chosen than to the ideological background.

*4.4. The growing edge of terminology: collaborative lexicology and ICT*

In discussing cooperation between disciplines (*Kihore*), issues of codification and standardization (*Namyalo*), the role of media in dissemination (*Agyekum*, *Bwanali*) as well as translation (passim), it appears that the traditional division of labor between production and dissemination as two disjunct phases of implementation is still the dominant working model. It is obviously reminiscent of the sender-receiver dichotomy of the classical model of communication. The traditional division of labor was however challenged by two complementary presentations of collaborative approaches to lexicography and terminology (*Houssouba*, *Benjamin*). Both emanate from currently Swiss-based enterprises with strong roots respectively in Eastern Africa (www.kamusiproject.ch) and Mali (http://www.songhay.org), respectively, and more recent extensions into other parts of Africa. Collaborative lexicography/terminology, as understood in these working environments, is committed to (i) taking user input as a source of production, and (ii) ICT as a tool of dissemination. Procedures currently being tested include “a five step participatory methodology for terminology development that maximizes the likelihood that a term set will be accepted and used by a language community” (*Benjamin*), and routines for creative and controlled input from the grassroots as well as from the learned community at large. Another module provides for linking current terminological efforts in several African languages between them as well as to global databases.

Difficulties of funding were repeatedly mentioned as one main reason why progress of terminological work has been slow in most cases. In considering these one has to keep in mind that terminological work is generally considered to be an application and therefore lies outside the scope of funding geared towards fundamental research. On the other hand, it also has an academic aura to it that may explain the low priority it enjoys with development and health agencies’ funding schemes. To get better starting conditions, it is indispensable to redefine the scope of terminological work as to include (i) L1 as source of production, (ii) the Internet as source of dissemination, (iii) formal links with international terminology agencies. The recognition of such work being done in Africa as being in global public interest may give some leverage to requests in approaching international donor agencies.

To bring this point home, here is a quote from recent literature on sustainability:

> *One clear challenge is that the ability of scientists and leaders in receiving societies, especially in developing countries, to participate in the co-production of knowledge for sustainability depends fundamentally on leveling the playing field regarding access to what is currently known: especially the science that underlies technological innovation. How can local innovation leaders be expected to be equal partners in innovation if they are not equal partners in open access to S&T information?* (Wilbanks & Wilbanks 2010:1000)

## 5. Triadic communication, interpreting, and interpersonal aspects of communication

Relational aspects, particularly in the context of doctor-patient interaction, are among the most studied topics in the burgeoning literature on health communication. However, though rather common in migrant health care and even more so in public health services in African multilingual contexts, health communication under the conditions of unequal distribution of linguistic competences or lack of a shared language has received little attention so far. Presenting hypotheses and insights from SNF-supported studies in Switzerland on triadic communication in the context of HIV-AIDS care to a mostly African migrant audience (Singy & Guex 2008) and probing into their relevance to African contexts was therefore an important agenda point in the context of the workshop under review (*Bourquin/Singy*). As far as sub-Saharan Africa is concerned, it served mainly as a pointer to a neglected area of inquiry. Indeed, bemoaning the hazards of translation linking teams of scientists or specialists to local language audiences is a commonplace. Yet empirical studies which would offer, beyond anecdotes, tangible evidence for the discrepancy between the unwarranted trust into this time-honored and ubiquitous practice and its expected results, would identify causes for failure and distortion, as well as show possible improvements beyond more and better training, seem to be almost completely missing as far as AIDS communication in Africa is concerned. Yet, one may estimate that success and failure of almost every second health-related interaction hinges on precisely this very practice which defines the prototypical variety of triadic speech situation.

A key issue specific to this form of communication, according to the results from Swiss-based research, is *confidentiality* (*Bourquin/Singy*). Confidentiality, not faithfulness of the translation, is the big issue. This seems indeed to match concerns of African medical communication (*Ba*, for Mauritanian contexts); the probable reason why this aspect was not further pursued at the workshop is that it tends to be merged with issues of taboo and stigmatization.

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## 7. Recommendations/ Follow-up

### *7.1. Research*

*7.1.1. Recommendations by the working groups:*

i. Develop **tools for evaluating** the impact of communicative strategies on behavioral change in respect to AIDS.

ii. Multiply **opportunities for participatory negotiation of concepts, actions** and **research** between actors from the different disciplines, with the purpose of developing a **common language**.

iii. Reformulate **problems of health as community tasks via participatory diagnosis** involving community members and external agents/observers.

iv. Introduce strategies for coordinating **multi-level communication** on AIDS.

*Recommendations of a more general nature, not specifically related to communication:*

v. Develop preventive strategies specifically adapted to countries with low HIV-AIDS incidence in order to further reduce incidence and to obviate recrudescence;

vi. Strengthen co-operation with international organizations engaged in the fight against AIDS.

vii. Develop a new research proposal in which all can participate through interdisciplinary approach. (Anglophone working group)

*7.1.2. Recommendations by the **terminology task force** (= Anglophone work group):*

I. Solutions to terminology problems
   a. terminology ought to be taught in undergraduate and postgraduate education
   b. regional and international cooperation
   c. sharing of databases (Kamusi[7])
   d. dissemination in cooperation with media

II. Solution to taboo (three approaches which together form a “kit”)
   a. glossaries of taboo terminologies related to HIV-AIDS
   b. search for alternative expressions (taboo avoidance techniques)
   c. train traditional communicators

III. Solutions to multilingualism
   a. Encourage research on minority languages
   b. Multilingual tool of terminology development
   c. Multilingual glossaries in local languages

IV. Solutions to translation
   a. Strengten its position in specialized education
   b. Instituionalization (centers)

[7] The Internet Swahili Living Dictionary. See www.kamusiproject.org.

c. Professionalization
d. Circumvention of translation bottleneck by producing messages directly in LL

V. Solutions to multiculturalism
   a. HIV-AIDS communication must be culture-sensitive
   b. Promote cross-cultural studies

VI. Interdisciplinary cooperation
   a. Linguists should work with medical experts, etc.

VII. Religious groups
   a. Help with resources (?)
   b. Encourage dialogue.

*7.1.3. Research proposals for dealing efficiently with language/culture/gender barriers:*[8]

i. Research in linguistic anthropology focusing on "**cultural and linguistic interfaces** … in order to develop an effective HIV/AIDS communication model which can ignite behavior change";

ii. Research focusing on the **nexus between gender, language and communication**. This is a high priority because "what health message designers seem to consider as gender-based HIV/AIDS communication is based on casual observation";

iii. inquiry into ways of dealing with the gap between modern health communication and **cultural communication practices specific to each language community**.

iv. efforts for making increased use of people's everyday language as a means of improving their health condition and of empowering them to deal effectively with challenges of HIV/AIDS have as their correlate and prerequisite an active policy of **language development**. This includes the whole gamut of status and corpus planning as well as standardization and lexical expansion.

*7.1.4. Recommendations from the coordinators' desk:*

I. Integrate the **DYLAN perspective** (2.2) into future research: What are the positive aspects of language diversity in the African context of health care and health promotion? Is there a potential for turning multilingualism, usually considered to be a handicap to efficient transmission of health concepts and knowledge, into an asset rather than a liability? What are the conditions for this perspective being recognized and integrated into research, practice, policy, and funding?

II. Encourage and promote **solid empirical studies** permitting to relate communicative choices to long-term effects of health intervention, enabling policy makers to

[8] Proposal made by Dr. S. Namyalo, a workshop participant from Makerere University, Uganda, as part of her feedback to a preliminary version of this synthesis report. (Adapted TB)

compare, to measure and to evaluate outcomes in the light of their linguistic and communicative antecedents.

III. Supply **well-documented case studies** on cross-linguistic interaction, particularly in neglected domains such as interpreting and terminology transfer. This type of research must be inclusive so as to hit home with national/local decision-making bodies for its effect on local policy and practice, and with international research and governance for recognition and funding.

IV. Explore the **potential of ICT** for grassroots collaborative research through experiments and cooperation.

### *7.2. Training*[9]

I. Provide **training in communication** to medical personnel including doctors themselves.

II. Training in **cross-cultural research and terminology** should become a standard feature of advanced training in development sciences and applied disciplines as well as in linguistics itself.

III. Enable scientists to become comfortable in **expressing and discussing their specialist knowledge in their native languages**.

### *7.3. Recommendations for publication of workshop proceedings*

I. Open access synthesis on internet[10]

II. Papers presented at the workshop, or excerpts of such papers (online).

III. Article to be published in a specialized journal.

### *7.4. Lobbying for recognition on public and research agendas*

Subject matter for recommendations to be submitted to high level agencies, both national and international, was pointed out particularly in regard to sections 3.2, 3.4, and 4.1-4. The workshop has produced strongest possible arguments for the inclusion of local languages into HIV/AIDS prevention and management strategies, and for the importance of terminology. The paradox that Africa, home of greatest health hazards, is still left out from the global health databases must be communicated to high level instances in appropriate ways if changes in funding policy (which were repeatedly called for) are to come about. In regard to terminology issues, an active approach by national agencies towards the International Health Terminology Standards Development Organization (IHTSDO) should be envisioned.[11]

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[9] Proposals 1 and 2 emanate from the working groups, proposal 3 from a discussion round (B. Bonfoh).

[10] The present synthesis report will be accessible in its final approved version in both English and French on the site of the Swiss Centre of Scientific Research in Côte d'Ivoire (www.csrs.ci).

[11] See their membership statutes <http://www.ihtsdo.org/members>. A recently retreated member of the IHTSDO had announced his visit to the workshop but eventually did not turn up.

### *7.5. Topics for future consideration*

I. Homosexuality: the question of the appropriate approach to include homosexuals as a specific risk group into HIV/AIDS communication in Africa was raised during a discussion panel but not further pursued (except for its mention under euphemisms by *Tigziri* under practices proscribed by Algerian religious authorities).

II. Sexual vs. non-sexual transmission: Each category may require different strategies of communication, notably in terms of taboo; this question, too, was left to future agendas.