

*Part Two*

**The Dynamic of the Epidemic**



# Twenty Years of Intervention and Controversy

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## 1. Preamble

The story of AIDS can be written in hundreds of ways. Depending on whether one has lived with it in Lusaka or in Brussels, whether it is seen from a clinical point of view, from a demographic or even from a social point of view, from the viewpoint of someone who is infected with the disease, or from that of a mere observer. History is always a viewpoint and varies according to the way you perceive the world around you and your ability to place yourself within, as Fabrice del Dongo helplessly commented, at Waterloo. And it would be presumptuous to speak of it here without care. The periodisation proposed in this article describing reactions to the HIV epidemic covers three phases over a twenty year time span: this period needs to be seen as provisional, within the scope of contemporary history.

The remarks which follow are those of a player at international level, involved as a researcher from 1983 in several AIDS studies in Rwanda, then, from 1987, under the aegis of the World AIDS programme sponsored by the World Health Organization (WHO). When, ten years later, in 1996, the joint United Nations programme for the fight against AIDS (UNAIDS) began its activities, the author coordinated the programmes concerning prevention, research and evaluation, until relatively recently.

The story of an epidemic unfolds at several interwoven levels, local, national and international at the same time, following the rhythm of research progress, the ups and downs of international financing, the mobilization of activists from New York to Johannesburg. HIV is a modern phenomenon: it could only have multiplied in the twentieth century, a time when urbanization, mobility, migrations and international travel have all transformed the world into a vast connected network which has allowed a virus ensconced in the blood of a few people to contaminate more than 70 million in less than forty years.

## 2. Emergence of a new syndrome

The construction of the acquired immunodeficient syndrome (AIDS) came about gradually. The first clinical symptoms were initially described in June 1981 in Los Angeles, United States, in five men who had a rare form of pneumonia caused by a protozoon *Pneumocystis carinii*, with no known risk factors.<sup>1</sup> The new syndrome was seen as an ailment affecting only “marginal” and “deviant” groups described in the press by the term the 4H: homosexuals, heroin addicts, (intravenous drug addicts), hemophiliacs and Haitians. For several months, the latter group was suspected of having imported the epidemic into the United States. But from 1984-85 the virus responsible for the new syndrome was identified: the first tests which

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<sup>1</sup> “Pneumocystis pneumonia – Los Angeles”, *Morbidity and Mortality Weekly Report*, 30 (1981), 250-252.

enabled the identification of “healthy” carriers were developed; the main methods of transmission were described: sexual contact, blood and mother to child transmission.

Today it is difficult to recall the overwhelming fear of the 1984-86 period faced with the sudden scale of an epidemic which seemed to spread invisibly. In the United States, in a few months, thanks to tests, eight thousand infected people were identified in forty-four states and thousands in northern and southern Europe. All the continents registered their first cases; soon all countries did the same. The press looked for historical precedents and, inevitably, comparisons with epidemics of the plague in Europe caused the fears and need for protection of bygone ages to reappear. This reaction of panic amongst the general public can be explained by the discovery of carriers of the virus who had no obvious symptoms, by the uncertainty at the time of ways of transmission such as saliva or simple physical contact, by the fatal nature of AIDS and the powerlessness of medicine. Fundamentally, it was a reaction to the symbolism attached to the transmission of the disease: sex and blood, touchstone of all fears. Fear led to the social rejection of those who were affected, homophobia ensued and groups with at-risk behaviour were pilloried. Stigmatization and the rejection of infected people were made in the name of morals, religion and also race.

### *An “African” AIDS?*

The awareness of the existence of AIDS in sub-Saharan Africa arose from 1983 with the description of several cases amongst African patients who had been hospitalized in Belgium<sup>1</sup> and France. A few months later, the syndrome was described in the hospitals in Kigali, Rwanda and Kinshasa, Zaire<sup>2</sup>; then in Uganda under the name *slim disease*.<sup>3</sup>

Tests, which were later carried out on stored blood, confirmed the presence of the virus in central Africa from the end of the 1950s, both in rural and urban areas. But it is likely that the epidemic of the infectious AIDS virus, the human immunodeficient virus HIV, began towards the middle or end of the 1970s and then slowly spread through several continents amongst the most vulnerable populations.

When the epidemic was identified in Africa, the prevalence of HIV amongst the urban population in several central African capital cities was already high: in 1988 in Kigali 30% of the adults were infected; 60-80% of the prostitutes in Butare, the second city in Rwanda<sup>4</sup> and similar proportions of infection were seen amongst the prostitutes in Bujumbura, Lusaka and Nairobi. The epidemic appeared to be mild in rural milieus<sup>5</sup> except for the districts in the south of Uganda where the Tanzanian army had been stationed during the war against Amin Dada's regime.

In spite of the high level of the infection in urban areas in central Africa, the visibility of the epidemic remained extremely low. Many infected adult patients died in hospitals or at home from opportunistic diseases, such as diarrhoea or tuberculosis, associated with the virus. Overworked clinicians who did not have access to blood tests, were not inclined to disclose to the patients or to his/her family a diagnosis of a disease associated with sexual promiscuity.

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<sup>1</sup> N. Clumeck, F. Mascart-Lemone, J. de Maubeuge et al., « Acquired immune deficiency syndrome in Black Africans », *The Lancet*, 1 (1983), 642.

<sup>2</sup> P. Van de Perre, D. Rouvroy, P. Lepage et al., « Acquired Immunodeficiency syndrome in Rwanda », *The Lancet*, 2 (1984) p. 62-65 ; P. Piot, T.C. Quinn, H. Taelman et al., « Acquired immunodeficiency syndrome in a heterosexual population in Zaire », *ibid*, 65-69.

<sup>3</sup> D. Serwadda, R.D. Mugerwa, N.K. Sewankambo et al., “Slim disease: a new disease in Uganda and its association with HTLV-III”, *The Lancet*, 2 (1985), 849-852

<sup>4</sup> Ph. Van de Perre, N. Clumeck, M. Caraël et al., « Female prostitutes: a risk group for infection with HTLV-III », *The Lancet*, 2 (1985), 524-527.

<sup>5</sup> N. Nzilambi, K.M. De Cock, D.N. Forthal et al., « The prevalence of infection with HIV over a 10-year period in rural Zaire », *New England Journal of Medicine*, 318 (1988), 276-279.

During several stays in Uganda in 1984 and 1985 in the rural district of Masaka, I visited several villages where young adults were dying in fear and destitution. The villagers questioned themselves as to the origin of this new scourge which they associated with the upheavals provoked by civil war. They had already seen, by observing the families who were affected by the disease, that the infection was transmitted through heterosexual channels, sometimes from mother to child and not through simple contact.

The scientific world had not yet accepted the idea that HIV was transmitted heterosexually. The transmission of the virus from man to woman was recognized but not that of woman to man. In fact, in high income countries homosexuals represented the large majority of sick people who had been infected through sexual contact, and in the case of intravenous drug addicts who share syringes the majority are male. For many years, scientific evidence had to be collected and the dominating role played by other sexually transmitted diseases in the speeding-up of the transmission of the virus had to be demonstrated before the transmission<sup>1</sup> of the disease from woman to man was accepted and a stop put to the idea of an African AIDS, an idea associated with sub-Saharan Africa.

In fact, a debate had begun concerning the origin of this new virus – new viruses because HIV-2 had been discovered – and its genetic similarities with SIV in central African monkeys.<sup>2</sup> This scientific debate which was important for the future development of a vaccine, immediately caused northern countries to develop racial attitudes towards Africans and to offend the African intellectual elite. Threats to freedom were obvious: sections of public opinion demanded control measures at border posts for those who were HIV positive, compulsory tests for at risk groups and the isolation of those who had AIDS. Stigmatism was at a very high level.

### **3. A lengthy denial phase in Africa (1984-1988)**

The reactions of African governments to the HIV epidemic were shaped by this international context. The refusal to recognize the existence and the extent of the epidemic was demonstrated by both the authorities and the African elites including the great majority of the medical fraternity. AIDS became a political and cultural stake before being a health problem. Reactions of nationalistic pride were exacerbated by the debate on the African origin of the virus or on “African sexual promiscuity”. The African elites denounced AIDS as a foreign disease spread on the continent by white homosexuals, as an attempt to bring down the birth rate by imposing the use of condoms, as an attack associated with the puritanism of Christian sects in the face of African traditions such as polygamy.

#### ***Wait-and-see governments***

The majority of sub-Saharan African governments, with a few exceptions such as Uganda, Zaire, Zambia and Senegal, denied the reality of the epidemic for a long time or demonstrated a cynical scepticism, accepting international aid without really combating the virus. The infection which was associated in rich countries with homosexual behaviour, prostitution or intravenous drug usage seemed impossible in Africa. When local studies showed that the level of HIV infection was particularly high amongst blood donors, prostitutes, patients with STDs the majority of governments denounced the insults made to African culture, to their countries' reputation and their economy which often partially depended on tourism.

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<sup>1</sup> J. Kreiss, M. Caraël, A. Meheus, “The role of STDs in the transmission of HIV”, *Genitourinary Medicine*, 1 (1988), 1-2.

<sup>2</sup> V.M. Hirsch, R.A. Olmsted, M. Murphey-Corb, R.H. Purcell, P.R. Johnson, “An African primate lentivirus (SIVsm) closely related to HIV-2”, *Nature*, 339, (1989), 389-92.

Confronted with epidemiological facts which were more and more troubling, but often abstract and difficult to understand, the authorities denial took on several different forms: the refusal to accept the existence of a new syndrome; a policy of secrecy concerning the number of infections; accusations against the research teams most of which were foreign and unfamiliar with communication policies; denunciation of blood tests which were seen to be unreliable; suspicion concerning therapeutic procedures; promotion of miracle cures inspired by local research. This negative conformism in the face of an increasing number of sick and dying as well as the extraordinary passivity of Ministries of Health can be explained by the fact that the political and medical systems are cut off from the rest of society.

### *Societies in search of an answer to the new syndrome*

Amongst the local people, scepticism and disbelief in the face of a local epidemic had long been a characteristic of its presence. AIDS was seen as the distinctive disease of the Other, linked to foreigners: Whites, prostitutes, truck drivers, migrants and towns folk. The death rate due to AIDS was hidden by both doctors and family members which made the public awareness of the disease difficult. For these reasons, there were no specific demands or public pressure on the State or on health services.<sup>1</sup>

Where the mortality rate was high as a result of AIDS, the disease was diagnosed in the light of local beliefs and linked to other diseases like tuberculosis. In many ethnic African cultures, a fatal disease is never “natural” even if it has been brought on by a virus. Chronic illness or premature death are the penalties for having disobeyed prohibitions. In other cultures, witchcraft and malevolent acts explain premature adult death. In both cases, individual prevention is not of importance. “Messages” on faithfulness or the use of condoms remained formal and exterior to the culture: they were not assimilated at the level of sexual behaviour.<sup>2</sup>

Sexuality is the domain *par excellence* of rules and regulations, the prime area where nature and nurture are linked. It belongs to the world of impurity and filth. It is dangerous, an inexhaustible source of individual and social problems. Communication about sexuality is highly codified. Contrary to popular belief, sexuality is rarely spoken about in African society: even President Mandela, the best ambassador for the fight against AIDS, has never openly confronted it in his public addresses in South Africa.

The doctrine of predestination is also widely spread: it is the religious expression of the fact that in a world of rarity, success and failure, health and sickness, life and death are not dependant upon clever or preventative behaviour but on circumstances beyond individual control: “fate” is fashioned by higher powers, some known, others unknown.

Because of their diversity, all these factors specific to the African continent have undeniably contributed to slowing down changes in individual behaviour and to rigidifying consciences. They have also encouraged the isolation of the ill and the absence of communal reactions.

## **4. A belated and vertical global response (1989-1994)**

The WHO, the international organization in charge of epidemics, reacted belatedly as the result of an historic error in judgment on the part of Dr Halfdan T Mahler, director general at the time, who admitted to not having recognized the epidemic and universal character of the syndrome before 1986.

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<sup>1</sup> M. Caraël, “Le Sida en Afrique” in E. Hirsch (ed) *Le SIDA, Rumeurs et Faits* (Paris, Cerf, 1987), 53-66 ; M.D. Grmek, *Histoire du sida* (Paris, Payot, 1989).

<sup>2</sup> J. Benoist, A. Desclaux (eds), *Anthropologie et sida. Bilan et perspectives* (Paris, Karthala, 1996).

Then, very rapidly, in 1987, with the creation of the Global Programme for the Fight against AIDS (GPA, Global Programme on AIDS) modeled on the fight against smallpox, national programmes to fight against AIDS were set up and funds allocated to ministries of health. Priority was given to the African continent. By the end of 1989 in an effort without precedent, 160 countries had established, often in great haste, the basis of national programmes of struggle.<sup>1</sup> At the end of the year, for the very first time, an international summit devoted entirely to AIDS brought ministers of health together in London.

The philosophy behind the global programme and the conceptual framework of the battle against the epidemic defined by Jonathan Mann, the first director of GPA, was based on a few general principles: “Public health must be protected, the rights of man must be respected” and “education is the key to the prevention of AIDS; the transmission of HIV can be prevented by informed and responsible behaviour.”<sup>2</sup> The WHO had set up a strategy to fight against AIDS which can briefly be summarized as follows:

- Priority to be given to the threatened rights of infected persons in a context where coercion, compulsory tests and means of isolating the sick were multiplying. The main effect of these prohibitory policies was to drive at-risk people or groups underground, far from access to information and services, and to considerably limit preventative efforts.

- Stress on the all-important role of information, education, communication and the control of the sexual transmission of HIV by simple methods to reduce the risks: delay first sexual relations, limit the number of partners, develop a means of controlling STDs and the use of condoms.

- A rational model of protection against the infection, based on individual responsibility, which presupposes that those who are informed of the dangers of transmission of the virus would choose a life style that would protect them from the virus.

- A psycho-medical perception of social conditions which reflects a humanistic but simplified vision of real societies.

### *Successes in the North*

Public health authorities in high-income countries have stressed information, means of transmission of the virus and means of protection and services. With differing success rates, politically organized groups such as homosexuals in the United States, Australia and Western Europe have managed to obtain some access to financial resources and have organized programmes with specific aims.<sup>3</sup> Partnerships between health personnel, NGOs, and people infected or living with AIDS created a new militancy, fostered a political and media approach and maintained pressure on public authorities. Sex education was introduced into secondary schools and the use of condoms from the earliest sexual contact became widespread. The epidemic slowed down in rich countries, not only amongst homosexuals but also amongst intravenous drug addicts once it had been proved that sharing needles was dangerous.

However, the example of Eastern Europe reminded the world that social changes and socio-economic upheavals played an even more important role in the evolution of HIV epidemics than individual efforts of prevention. Whilst for more than ten years the HIV epidemic had remained constant at an extremely low level in the USSR, the fall of the wall

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<sup>1</sup> D. Tarantola, “Grande et Petite Histoire des Programmes SIDA”, *Le Journal du SIDA*, 86-87 (1996), 109-116.

<sup>2</sup> J. Mann, D.J. M. Tarantola, T. Netter (eds) *AIDS in the world. A global report* (Cambridge and London, Harvard University Press, 1992).

<sup>3</sup> Virginia Berridge, *AIDS in the UK. The making of policy, 1981-94* (Oxford, Oxford University Press, 1996); P. Kennis, B. Marin (eds) *Managing AIDS. Organizational response in six European countries* (Vienna, Ashgate, 1997); S. Cattacin, C. Panchaud, V. Tattini, *Les politiques de lutte contre leVIH/SIDA en Europe de l'Ouest* (Paris, Harmattan, 1997).

and the collapse of the system of values in the former Soviet Union brought about a rapid growth in the use of intravenous drugs and prostitution and a surge of HIV infection.<sup>1</sup>

### *A developmental crises context in sub-Saharan Africa*

Cultural and historical contexts view epidemics as having different dynamics and national responses must adapt themselves in order to be effective. The HIV epidemic in Africa appeared in a context of crisis for development models: increased socio-economic inequalities, chaotic urbanization, crises in rural areas, deterioration of exchange rates, increased external debt in twenty two countries out of forty-four. From the beginning of the 1980s, sub-Saharan Africa experienced a regression in all the developmental indices with the lowest socio-economic parameters in the world (levels of literacy, of schooling, infant mortality, life expectancy) and the most unfavourable level of social security cover (doctor/patient ratio, access to health services). Eighteen out of nineteen worldwide famines between 1975 and 1990 were African. Since the 1980s more than half of the African countries have experienced conflicts. The number of refugees and displaced persons was estimated at close to ten million. These crises and this structural deterioration were due to a persistent neo-colonial heritage and “bad governance” tainted with corruption. The programmes of structural adjustment that were set up to “purge” the economies often had devastating effects on the so called “non productive” social sectors such as education, health and social infrastructures.

### *Fragmented medical strategies for the struggle*

The establishment of national strategies to fight against AIDS was strongly influenced by this structural context where little attention was paid to public health and where the HIV epidemic was not seen as a priority. The major weaknesses in national reactions to the epidemic during this period can be pinpointed by a critical retrospective look-back:

- Direct intervention from technical advisors and foreign experts and taking charge of the battle by the WHO contributed in many cases to a national abrogation of responsibility which was facilitated by the low level of political involvement: president, government, parliament, local leaders without the odd civil or community organization taking over.
- Established under the guidance of the Ministries of Health, the national programmes to fight against AIDS inherited all the historical shortcomings of the health sector: weak budgets, rundown infrastructures, lack of personnel, concentration in urban areas, few primary care health facilities, partitioning of care, small projects, lack of priorities, stress on laboratories and individual care etc.
- The absence of a visible impact by AIDS in terms of mortality contributed to the epidemic being interpreted in terms of individual cases which were the concern of the Ministry of Health and the medical corps. The programmes against HIV/AIDS were seen as separate, vertical programmes with their own structures: the other sectors of the government did not feel involved.
- The model for intervention was based on the experience of the fight against other infectious diseases such as smallpox and diarrhea and stressed information, making condoms available and care.
- The conceptual framework – aimed at general and individual information – considerably underestimated the silence and prohibitions regarding sex. Education

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<sup>1</sup> L. Atlani, M. Caraël, J.B. Brunet et al., « Social change and HIV in the former USSR : the making of a new epidemic », *Social sciences and Medicine*, 50, (2000), 1547-1556.

retained a medical slant and did not count real experiences such as paid sex, informal sexual relations, multi partners, actual use of condoms etc.

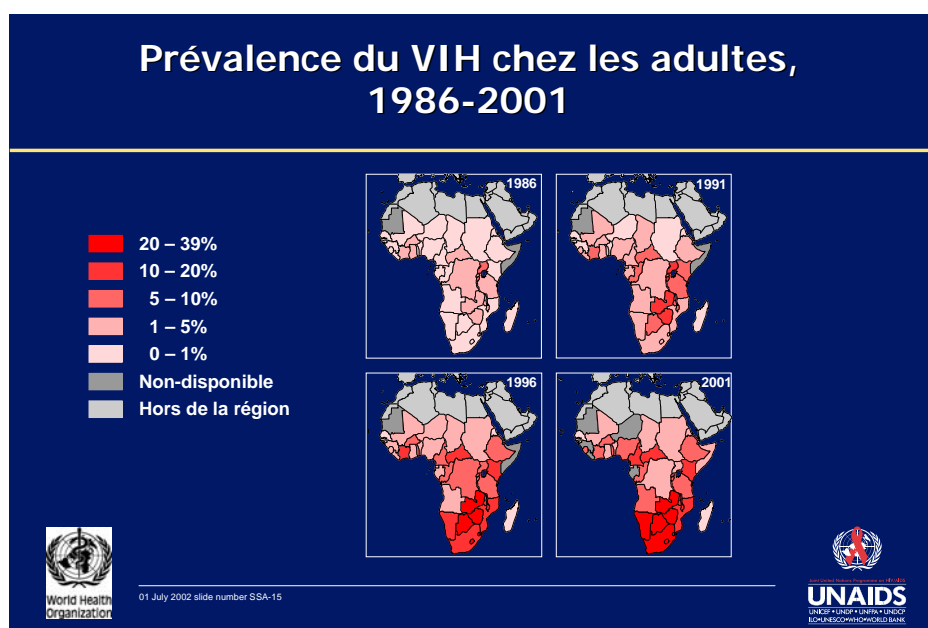
- Financial resources – external for the most part – aimed at medical and governmental prevention were not sufficient for an epidemic in full flood. In many countries, these resources were not used other than in laboratories and blood banks. They gradually dried up when it became clear that the epidemic in the North remained restricted and that the expenditure far outstripped the results obtained.

### *Expanding HIV epidemics*

During this time, the epidemic in sub-Saharan Africa continued to spread especially in the east and in the south, as much in urban areas as in rural milieus (figure 1). In 1986, with the exception of a pocket with high levels in the centre of Africa, the national levels of HIV were not, on average, higher than 5%. In 1991, ten countries had levels higher than 10%.

The phenomenon is global. In 1995, the WHO estimated that twenty-four million adults had been infected since the beginning of the epidemic, of whom sixteen million were in Africa. At least five million had died. From then on, AIDS has been the major cause of death amongst adults in cities in the USA, Europe and Africa.<sup>1</sup>

Figure 1 : Seroprevalence among adults in sub-Saharan Africa, 1986-2001



In the middle of the 1990s, Uganda was the only African country to demonstrate that it is possible to stem the epidemic. At first noticed among young people in an urban environment, the rate of decline of HIV became general. From 30% amongst adults in Kampala in 1992-93, it progressively declined to level off at less than 6% in 2004. This exemplary national case would contribute to modifying the perception of the epidemic by proving that HIV could be prevented if civil and political society involved themselves in an open and determined way.

<sup>1</sup> Global Programme on AIDS. *The current global situation of the HIV-AIDS pandemic* (Geneva, World Health Organisation, 1995).

The Ugandan example<sup>1</sup> and the different dynamics of the epidemic across continents have contributed to international recognition that there are different situations of vulnerability at regional and international level, and from one town to another. The failure of the majority of governmental responses to control the infection marks the end of a unique global strategic model linked to Ministries of Health and centered on individuals.

Moving from a model of psycho-social behaviour modification to a model of at-risk situations involves a paradigm change. The individual risk factors can explain who in the community is infected by the virus but not why this community has a higher level of HIV prevalence than others. Explaining why this is so requires an understanding of the cultural, social and economic factors of the epidemic at local level such as the relationship between men and women, the sexual practices, mobility, the presence of social and health services, participation in community activities and many other factors.<sup>2</sup> Economic precariousness and the absence of social support are factors that increase vulnerability at local level by limiting the individual's choice. Henceforth, any action at local level would involve the recognition of the critical role played by communities and associations in modifying the norms and behaviour such as commercialised sexual relationships.

The impact of AIDS on social, cultural and economic development became obvious. The fight against AIDS became a national priority in the countries which were the most affected; it had to concern itself with prevention as much as treatment or social support for affected communities and include all sectors of the community. It required that AIDS be seen as an obstacle to development and as a social and economic handicap and not only an illness.

### **A broader response at global level (1995 to the present day)**

It would have taken a long time to institute strategies and programmes of intervention against what one would call second generation HIV which were based on a broadened and multi-sector framework where governmental pleas would play an important role. At a global level, these changes took place in December 1995 when the WHO coordinated the struggle against AIDS and enforced the creation of a joint secretariat – UNAIDS – with five (shortly ten) United Nation agencies and the World Bank who were, in the future, supposed to unite their efforts in their respective fields so as to broaden the fight against AIDS at both a national and international level. It would take UNAIDS several years to convince the agencies and to impose a common strategy and a consistent sharing of responsibilities on them and it was only towards the end of the 1990s that this vision shared at central level began to be applied by the UN agencies at the level of different countries. The culture of competition and autonomy between agencies gradually made way for a plan of integrated work to support national action against the epidemic.

At the beginning of the 2000s, these changes in global planning and strategy were reflected at national level with the creation of national committees for the fight against AIDS (CNLS) controlled by the countries' highest authorities which replaced the old structures in the Ministries of Health. These committees consisted of representatives from the main ministries such as education, population planning and youth who were involved in the fight against AIDS as well as representatives from the private sector and civil society. The UN agencies and the main donors at local level were charged with coordinating their support with

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<sup>1</sup> G. Asimwe-Okiror, A.A. Opio, J. Musinguzi, E. Madraa, G. Tembo and M. Caraël, "Change in sexual behaviour and decline in HIV infection among young pregnant women in Urban Uganda", *AIDS*, 11 (1997), 1757-1763.

<sup>2</sup> M. Caraël, A. Buvé and K. Awusabo-Asore, "The making of HIV epidemics: What are the driving forces", *AIDS*, 11, Special issue on Africa, Supplement B (1997), 23-31.

the work of the CNLS within thematic groupings. Henceforth, stress was put on integration and on national coverage of programmes of prevention, counseling and health in order to rival the many micro-projects which were operating in isolation in some urban centres.

After a long period of indifference on the part of political and public opinion decision makers, the international community again mobilized itself at the highest level, spurred on by UNAIDS. From now on, AIDS would be discussed in meetings of ministers of finance, the G8, at the Davos forum as much as in those meetings where cancellation of the third world's debt, developmental crisis and security were discussed. In 2001, almost twenty years after its identification, the 189 member countries of the United Nations eventually devoted an extraordinary General Assembly to AIDS and undertook to implement an impressive series of measures to reduce the level of HIV in their respective countries between 2005 and 2010.

In rich countries, AIDS sufferers' generalized access to antiretroviral therapies (ART) resulted in a considerable reduction of the mortality rate brought about by the disease. Henceforth, in spite of the cumbersomeness of the treatment and resistance to ART, it became possible to live with AIDS. This clinical progress heightened the awareness of the differences in low revenue countries and particularly Africa where the majority of infected people lived. Differences that were due not so much to public health considerations as to the moral and ethical response to the scandal of the millions of publicised deaths amongst infected people.

The creation of a global fund to fight against malaria, tuberculosis and AIDS was a response to these demands. In 2004 a battle which had been going on for three years about the price of antiretrovirals and the conditions for fixing the prices resulted in a theoretic possibility of countries acquiring tritherapy at a price of US\$150-200 per person per annum compared to the \$1200 in 1998. Access to medications became possible in the South. The WHO began a "three by five" initiative so that three million AIDS sufferers could benefit from ART by the end of 2005.

### ***Increased financial resources***

At the same time mobilization for increasing financial resources for the prevention, treatment and social support began to bear fruit in spite of fears which had been expressed at the birth of UNAIDS.<sup>1</sup> Close on five billion dollars had been spent in 2003, half of what was needed to meet needs.<sup>2</sup> This increase in funding came about as a result of bi-lateral aid from rich countries, the increase in contributions of United Nations organizations as well as from national budgets. The total amount still represented only half of what was estimated to be necessary to develop effective programmes but it did allow for the launching of programmes on a national scale including the improvement of services and treatments.

### **Provisionary assessment**

The political involvement of African presidents and governments has only recently been asserted, with a few exceptions. National committees for the fight against AIDS – a new institutional creation – have taken the coordination of the fight away from the Ministry of Health. In future, apart from inter-ministerial committees, representatives from civil society and the private sector would be associated. The plan is to extend the programmes on a national scale and to decentralize to district level. It is still too early to judge of the success of

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<sup>1</sup> M.E. Gruénais "Les dispositifs de lutte contre le sida à l'heure d'ONU SIDA et la démocratisation" in C. Becker, J.-P. Dozon, C. Obbo and M. Toure (eds), *Vivre et penser le sida en Afrique. Experiencing and understanding AIDS in Africa* (Paris, Codesria, Karthala & IRD, 1999), 455-470.

<sup>2</sup> B. Swartlander, J. Stover, N. Walker et al "Resource needs for HIV/AIDS" *Science* 292, (2001) 2434-2436.

this broadened strategy and to gauge national responses. In some African countries such as Kenya, Rwanda, Ethiopia and Malawi surveillance of HIV has shown that there is some stabilization of the epidemic but this would appear to be more of a “natural” stabilization linked to the balance between deaths and new cases than growing success of the prevention programmes linked to a broadened conception. However, it is difficult to separate the two effects.

The conditions of a more effective fight on a national scale seem concerted but many weak points and uncertainties remain:

- Community involvement in prevention remains superficial although it appears that in the few countries where there has been country-wide success, this involvement has been absolutely necessary. Stigmatisation amongst the infected remains high. Many attempts at controlled educational programmes in Uganda, Tanzania and Zimbabwe have recently concluded that prevention programmes have hardly been effective although they were multi-faceted and included improvement of services, peer education, gender spread, entrenchment in local organisations. The reasons which have been given to explain these results are often the norms and prohibitions linked to sexual cultures, the lack of community involvement and fears associated with stigmatization.
- Could the expanded response which aimed at attacking the roots of the epidemic by diminishing the structural factors of vulnerability to HIV be translated into programmes which would lead to behavioural changes in matters of sexuality? In order to reduce the vulnerability of young girls to HIV it would be necessary to improve their level of education. But would this not bring about a risk reduction for young girls in a context of general poverty and of competition for a decent social status? Investment in the fight against poverty, the cancellation of debt in the poorest countries, inequalities between men and women and social capital seem necessary and justified for the control of the epidemic but, at the same time, the effects of globalization seem to create more disparities, to destroy local cultures and to reinforce inequalities. The growing exposure in the media and the new life styles which this encouraged, accelerated the break-down in traditional social norms which had limited sexual contact. The new context of possible access to treatment – still far in the future for the majority of African countries – could revitalize the prevention programmes but could also remedicalise the programmes and put a curb on the dynamism of the various associations, as has clearly happened in the rich countries where new infections are increasingly spreading. Many questions remain<sup>1</sup>.
- The most effective prevention strategies for avoiding infections has been evaluated and are widely known. However, at political, moral and religious levels they met with unbelievable resistance. Whether it is a question of risk reduction amongst intravenous drug addicts who share needles, the promotion of the use of condoms amongst prostitutes or preventative services for homosexuals, sex education at schools, innumerable obstacles prevent these strategies from being applied on a large scale and of having an impact on the population. The Bush administration which contributes generously to the fight against AIDS in Africa refuses to finance national programs for youth that would go beyond promoting sexual abstinence.

Over and above this chaotic research to find a combination of means to fight

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<sup>1</sup> J. Stover, N. Walker, G.P. Garnett et al., “Can we reverse the HIV/AIDS pandemic with an expanded response?”, *The Lancet*, 360 (2002), 73-77; Piot P and Carael M., *L'épidémie de sida et la mondialisation des risques* (Brussels, Labor, 2005).

against the epidemic, history will remember, apart from the terrible human suffering, the enormous demographic wound occasioned by AIDS with its procession of deaths, which has seen 15 years cut off life expectancy in those countries which are the most affected (figure 2). The demographic effects of this unparalleled mortality rate will be felt up to and beyond 2020 whatever future successes there might be. The extreme case of Botswana (figure 3) where the national level of HIV has reached 37% illustrates the drop in birth rates and the high level of death amongst adults.

History will also recall the curbs on development which have been brought about by the epidemic and, more generally, the inability of societies to organize themselves collectively by showing solidarity in controlling the spread of a sexually transmitted virus which, in a twenty year period, will have affected several scores of millions of people.

For those African countries where the HIV level is high, the story has barely begun. With eleven million orphans in 2003 and twenty million expected by 2010, an entire generation deprived of parents must face the future. This story has yet to be told.

*(translated from the French by Carole Beckett)*

Figure 2: Life expectancy and HIV seroprevalence in six countries from sub-Saharan Africa, 1950-2005

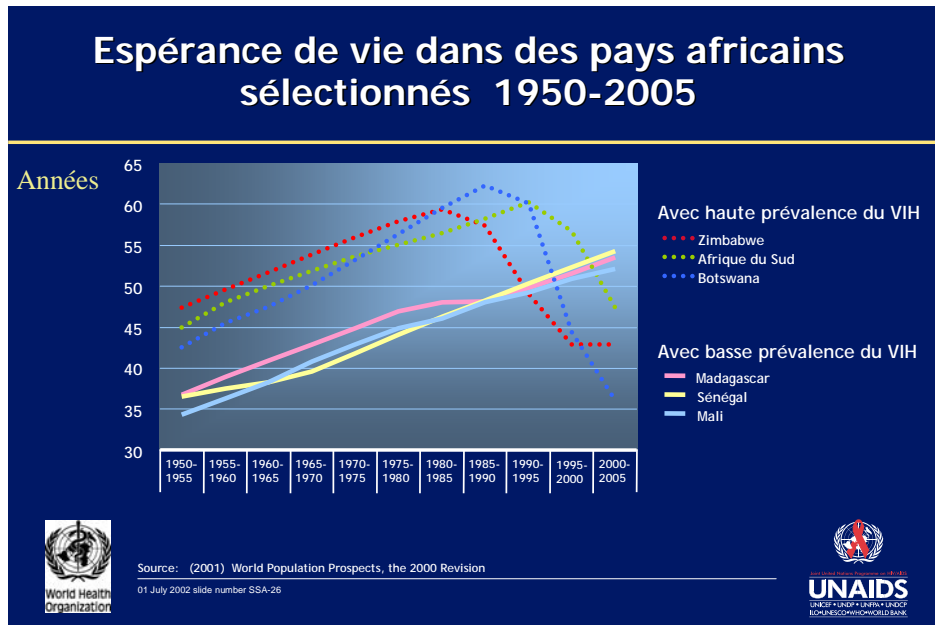


Figure 3: Projected population structure in Botswana in 2020, with and without AIDS mortality

