French policy on international cooperation in the fight against HIV/AIDS in developing countries
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>French policy on international cooperation in the fight against HIV/AIDS in developing countries</td>
<td>3</td>
</tr>
<tr>
<td>The HIV/AIDS pandemic: a tragedy</td>
<td>5</td>
</tr>
<tr>
<td>Moving on from observation of the facts to the definition of an international response</td>
<td>10</td>
</tr>
<tr>
<td>France in the global process</td>
<td>13</td>
</tr>
<tr>
<td>A strategy based on updated intervention</td>
<td>17</td>
</tr>
<tr>
<td>A commitment to be taken forward: more and better</td>
<td>20</td>
</tr>
<tr>
<td>Reference of operational frameworks</td>
<td>23</td>
</tr>
<tr>
<td>Safe blood transfusion</td>
<td>23</td>
</tr>
<tr>
<td>Voluntary testing and counselling</td>
<td>24</td>
</tr>
<tr>
<td>Prevention of Mother to Child Transmission of HIV (MTCT)</td>
<td>25</td>
</tr>
<tr>
<td>Access to medication</td>
<td>26</td>
</tr>
<tr>
<td>Screening and following up infected patients</td>
<td>27</td>
</tr>
<tr>
<td>Follow-up for patients suffering from severe immunodeficiency</td>
<td>28</td>
</tr>
<tr>
<td>Caring for the orphans</td>
<td>29</td>
</tr>
<tr>
<td>HIV/AIDS and the world of work</td>
<td>30</td>
</tr>
<tr>
<td>HIV/AIDS and rural communities</td>
<td>31</td>
</tr>
<tr>
<td>HIV/AIDS and the education sector</td>
<td>31</td>
</tr>
<tr>
<td>Solidarity and prevention</td>
<td>32</td>
</tr>
<tr>
<td>Community associations and the fight against HIV/AIDS</td>
<td>33</td>
</tr>
<tr>
<td>Long-term health care funding</td>
<td>34</td>
</tr>
<tr>
<td>And what about tomorrow?</td>
<td>35</td>
</tr>
<tr>
<td>Notes</td>
<td>36</td>
</tr>
</tbody>
</table>
The first cases of AIDS were identified in 1981 in the United States in male homosexuals. Two years later, cases were identified in Africa in heterosexual men and women. The world was thus alerted to the existence of a new and potentially terrible threat. At the end of 2001, over 40 million people were living with HIV; 25 million have already died of AIDS. “These deaths will not be the last – the worst is still to come”\(^1\).

**AIDS is every one’s problem**

“Today, what do we know, what do you yourself know about AIDS? Perhaps you thought it was a disease caught by other people, that the epidemic of fear was out of all proportion to the actual harm from the epidemic itself. Today we know that this long, exhausting disease, a burden psychologically, economically and socially difficult to cope with, is the problem of all of us”\(^2\).

**A question of respect and dignity**

“I want to give AIDS a human face. I want all those who work for this cause to be aware that I am not a statistic. I am a human being, a unique person like every one of those living with HIV”\(^3\).

**A future we must build together**

“The fundamental act which distinguishes AIDS from the other scourges is refusal. Faced with AIDS, individuals have found the courage to refuse to give in, to say ‘no’. Those who say ‘no’ have found the courage to organise to be more effective, to act. Solidarity – that is the keyword for our future”\(^4\).

**But what exactly is AIDS?**

“AIDS is neither the only fatal disease (many curable diseases are still that), nor the only transmissible one, nor the only disease to which stigma attaches. What sets it apart is the simple fact that it is the only disease to have all three of these characteristics at one and the same time, and the only one to drag the sufferer in the gutter to such a degree”\(^5\).

AIDS, or “Acquired Immunodeficiency Syndrome”, is characterised by the destruction by HIV, or “Human Immunodeficiency Virus”, of immune system cells that are crucial to the defence of the body against infections and tumours.

HIV is transmitted by:
- Vaginal and anal sexual contact;
- Injection of blood and blood derivatives from HIV infected individuals;
- Contaminated needles, syringes and other perforating instruments;
- Transmission of the virus from an infected mother to her unborn child during pregnancy, labour or breastfeeding.

When HIV infects a cell, it combines with the cell’s genetic material, where it can remain silent for several years. Most individuals infected with HIV can remain...
in apparent good health for years, or suffer only from benign medical conditions: such individuals are infected, but do not have AIDS. Those who test positive for HIV are both infected and infective: despite the fact that they are not actually ill, and seem to be in good health, they can transmit the virus to others.

After a period of time of varying length, usually about 10 years, immunodeficiency increases considerably and gradually causes the appearance of a group of serious diseases characteristic of AIDS.

At the present time, there is no effective vaccine capable of preventing HIV infection. Current treatments permit patients to survive for longer, but, although morbidity and mortality have been reduced by two-thirds in Europe and the USA after the introduction of multidrug therapies, AIDS remains a fatal disease. In the current state of our knowledge, combating the disease means preventing infection and where this is not possible, prolonging and improving the period of survival of patients.
The HIV/AIDS pandemic: a tragedy

“AIDS is far from being simply a medical problem. AIDS is far from being simply a national problem. The AIDS crisis is far from over” (6).

Despite the efforts of the international community – and despite the fact that the incidence of HIV tends to stabilise in Sub-Saharan Africa (7) – the overall situation continues to worsen, leading to a real crisis in development which is further deepening the gap between rich and poor nations.

From a public health issue handled at national level when it first appeared, AIDS has become a global crisis for development. It is also on the way to becoming a major political crisis which could compromise international relations if the response from the international community does not match the scale of the challenge.

AIDS is a demographic disaster...

Over 40 million people are living with HIV/AIDS at the present time. Of these, 2.7 million are children under the age of 15. The cumulative total for deaths since the disease first appeared is estimated at almost 25 million. This situation is devastating, in the worst affected countries, where the reduction in the labour force can in some cases be as high as one-fifth of the working population, to the prospect of a reshaped age pyramid and major imbalance between the numbers of working adults and the numbers of dependants.

Sub-Saharan Africa alone has 28.1 million infected individuals and 21 of the countries where the seroprevalence of HIV is highest. A quarter of all adults are infected in Botswana, Zimbabwe and Namibia and over 10% in at least 10 other countries. With nearly 70% of the total number of infected individuals, Sub-Saharan Africa is therefore bearing the heaviest HIV infection and AIDS burden. AIDS is now the most common cause of death in this region: most infected individuals will die within ten years, joining the 14 million Africans already swept away by the epidemic. Today, the probability that a child born in Zambia or Zimbabwe will die of AIDS is greater than 50%. According to United States Census Bureau projections, in Botswana, South Africa and Zimbabwe, the...
AIDS is a social tragedy

One dramatic consequence of the pandemic is the erosion of the progress made in life expectancy at birth and infant survival over the last few decades.

In Botswana, life expectancy at birth will halve over the next 10 to 12 years, falling from 65 to 33 years, a fact due entirely to HIV/AIDS. This will cause the rapid loss of advances in development made at the cost of great sacrifice, especially where literacy and health care are concerned.

Women, proportionally more of whom are infected and at younger and younger ages, are the first victims: in Africa, 12 to 13 women are infected, for just 10 men (10). On average, they infect their very young children in one third of all pregnancies, and their levels of fertility are declining significantly.

Of the 10 countries with the largest numbers of infected children worldwide, 9 are in Sub-Saharan
Africa; in 1999, over 500,000 newborns contracted HIV from their mother.

It is currently estimated that over 13 million children have been orphaned by AIDS and this figure is expected to rise to 40 million by 2010. Most are in Sub-Saharan Africa and account, in some countries, for more than 10% of all children. Such children are obliged to cater for their own needs, and may even have to assume adult responsibilities in the home, which they are more likely in fact to leave, or lose, are particularly vulnerable where access to health care and education is concerned. They are exposed to risks of extreme poverty, social exclusion and marginalisation, along with all the accompanying dangers. Also, because of AIDS, in many countries the number of street children has significantly risen. This problem will become particularly acute in the near future.

Independently of differences of culture and country, the extended African family and the community traditionally provided for the needs of such children. The unprecedented scale of the problem which now exists, modern life and its associated individualistic tendencies, plus social and economic pressure, development of geographical mobility and urbanisation, the high costs generated by the provision of modern services (education, health, etc.), have all eroded, or deeply undermined, this traditional system, whose mechanisms for solidarity are now barely functional (11).

AIDS is a multifaceted economic threat…

…that affects production in both public and private sectors (12)

AIDS leaves in its wake destroyed families, a diminished labour force, and by the same token development prospects that are either totally frozen or severely compromised. By hitting hardest the most active age groups, the HIV/AIDS pandemic acts as a strong brake on growth. The World Bank considers that beyond a level of prevalence of 8% among adults, each further percentage point reduces growth by 0.4 of a percentage point.

Although the major negative macroeconomic impact of the retroviral pandemic now hardly needs demonstrating, its effects on businesses in terms of:
• loss of qualified staff,
• lower productivity due to absenteeism and unavoidable replacements by staff who are often less experienced,
• higher recruiting and training costs,
• higher health expenditure,
are no less real despite the fact that they are not yet completely evident for all.

…and that no longer spares rural areas (13)

It is not an exaggeration to say that AIDS is now above all a rural issue in most developing countries badly affected by the pandemic. AIDS is making more rapid inroads there than in towns and cities, rural populations are less prepared to cope with it, and they bear much of the cost of HIV/AIDS. It has been
demonstrated in Zimbabwe that the death from AIDS of a family breadwinner will reduce the household’s maize production by 61% in community areas carrying on small-scale crop-growing and, in Ivory Coast, the health care provided to a planter costs between a quarter and a half of the annual income of the holding, in many cases leading the families concerned to decapitalise by selling off their livestock and agricultural equipment. AIDS therefore constitutes a grave threat to the security of food supplies.

…that hits education hard

An efficient educational system is a core component in the fight against poverty and successful achievement of sustainable human development: such systems are heavily undermined in countries with a high level of prevalence of HIV/AIDS infection, where the teaching profession is particularly severely affected, and where their pupils, faced with the disease, are exposed to the risk of voluntary or involuntary, temporary or permanent exclusion from schooling. In South Africa, AIDS is now the most common cause of death among teachers: 20% of teachers in Natal and 16% in the other provinces are affected by the virus.

An efficient educational system is also a core component in building an effective response to the HIV epidemic. Partly because of the disorganisation caused by the pandemic, the system has failed to some extent: young people in training or school, who are in principle the best informed, have been hardest hit by the infection.

…that is causing profound destabilisation in the health system

A five-point rise in prevalence will increase demand for health care by 25%, urban hospital bed occupancy specifically due to AIDS may therefore be as high as 50% to 80% (Ivory Coast, Burundi, Zambia, Zimbabwe) and at the same time, deaths of health care providers have increased by a factor of 13 in 10 years (Zimbabwe). In this way, a quarter (Zimbabwe), or even two-thirds (Rwanda) of the health budget can end up being spent on the treatment of sufferers, and this does not take into account the cost of the substantial increase in the numbers of cases of tuberculosis, the infection most frequently associated with AIDS. The resources which must be devoted in this way to health care because of AIDS considerably compromise funding for other programmes offering good cost/efficiency ratios: for this reason, it has become virtually impossible to even hope to achieve in the most affected countries the development targets set in the health domain.

About 14 000 new HIV infections a day in 2001

- More than 95% are in developing countries
- About 2 000 are in children under 15 years of age
- About 12 000 are in persons aged 15 to 49 years, of whom:
  — 50% are women
  — over 50% are 15-24 years old

Source: UNAIDS - OMS.
All in all, because AIDS decimates the available labour force, undermines and impoverishes families, destroys the bedrock of community organisation and renders fragile the social fabric, this disease, through its structure-destroying impact on the economic and social system, is seriously compromising development in the countries that are most affected, notably in Africa.

AIDS is also a political threat

Due to its demographic, economic and social impact, AIDS may compromise the political situation in the countries that are hardest hit, even destabilising regimes in power. The increase in poverty, precarious living conditions and social exclusion in societies that are already vulnerable is a sword of Damocles hanging over the heads of national political authorities. The prospect, in the countries worst affected, that in the space of a decade nearly one quarter of the adult population will disappear will lead to human bloodletting on a scale unprecedented in modern history.

For this reason, AIDS may have an impact on regional geopolitical balance. The demographic decline and its economic and social consequences, such as the high level of prevalence in certain population segments, especially the armed forces, could substantially weaken certain countries currently emerging as regional powers.

In addition, the explosion of the pandemic in certain areas of the world due to the modes of disease transmission, sundry population flows and increased travelling, is a threat for all countries in the world.

Lastly, the gap between the situation in the North where patients enjoy a high level of access to tritherapy and the South where numbers of patients are deprived of access to health care is not sustainable and could lead to major worsening of the international relationships when the massive mortality indicated by current statistics actually comes to pass.

“A decade ago, HIV/AIDS was regarded primarily as a serious health crisis. Today, it is clear that AIDS is a development crisis, and in some parts of the world is rapidly becoming a security crisis too. AIDS is unique in its devastating impact on the social, economic and demographic underpinnings of development.”

Estimated number of people living with HIV/AIDS by region, 1980 to 1999
“We live at a turning point in human history. AIDS spotlights all that is strong and weak in humanity: our vulnerability and fears, as well as our strength and compassion, especially for those more vulnerable, less able, or poorer than ourselves.”

After more than a decade of combat against this epidemic, initial denial has been acknowledged:

“Bearing public witness has a real impact on people who can no longer say that AIDS doesn’t exist.”

But much remains to be done, particularly in the crucial area of the protection of basic human rights, particularly for the most vulnerable groups, women and children:

“We should put a symbol on their papers and gather them all together to stop them spreading it. We should deport foreigners who are infected as well.”

“Right from the morning of the death and up to the burial, we were the target of every imaginable insult, every imaginable accusation from our father’s side of the family. Worst of all, our mother was accused of having stolen her husband’s property and killing him. They harassed us to make us leave the family home, in spite of the fact that it is ours.”

“My in-laws spread rumours to drive me away from the area. They took away my children and all my furniture. I was lawfully married.”

Given the uncertainty surrounding the likelihood in the near future of an effective vaccine to prevent the disease, given the difficulties encountered by the majority in gaining access to special therapeutic treatments, given the extremely multifaceted nature of the catastrophe facing us, one without precedent in the recent history of humankind, and in light of the apparently inexorable spread of the
pandemic, any illusions as to the possibility of bringing it rapidly under control have gradually faded. It is for this reason that the international community has had to organise to deal with the threat. Besides bilateral interventions, its political response is chiefly institutional and based on the definition of strategies and the management of multilateral UN funds for the fight against AIDS, funds entrusted in 1987 to the care of the world health supervisory organisation via WHO/GPA, the Global Programme on AIDS, now known as UNAIDS, the joint United Nations programme on HIV/AIDS set up in 1996 to make possible a coordinated and broader response to the scourge:

“It became apparent that a joint programme bringing together the institutions of the United Nations with mutually complementary competencies and mandates was necessary in view of the urgency and scale of the epidemic, its deep social, economic and cultural roots, the taboos and hypocrisy surrounding the issue of HIV and the manner of its transmission, the discrimination and violation of human rights faced by infected individuals and those under threat of infection” (24).

During the year 2000, general awareness of the threat made important strides. The United Nations Security Council, which had never addressed any public health issue in its 55 years of history, met on three separate occasions in the space of a single year to discuss the problem of AIDS. The General Assembly convened also a special session on this topic in June 2001. The G8 meeting in Okinawa in July 2000 also addressed to AIDS and gave clear commitments to strengthen the international response. Finally, in September 2000 after the European Commission organised an international round table to speed up action on HIV/AIDS, malaria and tuberculosis, the Development Council adopted on 10 November 2000 a resolution centring on the best use of health and development policies, cost reduction for health care and increased efforts in the area of research on the production of new drugs and on social aspects of communicable diseases. France supported all these initiatives and has played a substantial role in the emergence of the debate in the international political arena. Its response is also technical in nature. Originally focused chiefly on prevention and counselling, it has gradually evolved towards a more integrated approach including access to treatments. It is indeed an illusion to think that any policy of prevention can yield results if it is not combined with hope of recovery through treatment. This approach supported by France during the CISMA (Abidjan, 1997) was the starting point of a constant and resolute combat by the French authorities to have the international community recognise the right to access to multitherapies of AIDS patients in countries of the South.

The keys to understanding this global vision were clearly set out by UNAIDS:

“15 years of action against the epidemic have generated important insights into effective responses. While international political, financial and technical support are important, lowering incidence and mitigating the epidemic’s impacts must be a nationally driven agenda. National responses require the persistent engagement of government, with a single, powerful national AIDS plan; social openness, increasing the visibility of the epidemic and countering stigma; social
policies that address core vulnerabilities; the engagement of all sectors (not just health); a recognition of the synergy between prevention and care; support to community participation; and targeting interventions to those who are most vulnerable, including young people before they become sexually active”.  

Finally, its response is financial. AIDS can be handled effectively using preventive and therapeutic programmes if, and this is the challenge for the world, concerted effort by the international community can be mobilised to fight it. The reason for this is that the struggle against HIV/AIDS, and more generally against the major infectious diseases, cannot make significant headway without an exceptional level of support from that community, offered in a spirit of solidarity.

Without underestimating the difficulty of putting precise figures on the cost of the fight, and the resulting divergence in the estimates given, very major levels of funding can be envisaged in the short term, and France argues that “developing countries should use the room for budgetary manoeuvre provided by the debt initiative to implement, as part of poverty reduction strategy programmes, actions to combat AIDS” (Prague Declaration by the ministry of Economic Affairs, Finance and Industry, September 2000). The target of mobilising US$10 billion by the international community, put forward by the French delegation at the Prague meeting, has had a favourable reception, especially from World Bank management. In spite of the mobilisation of resources, the major problem will be how to employ these funds judiciously not just for a single disease but for the entire social and health care system, which must be consolidated if we are to hope to take efficient and long-lasting action.

In addition, it is no less true that despite a real willingness to reach a consensus, differences of view still prevail among the various actors in the fight against HIV/AIDS. The strategies for action of each partner, whether bilateral or multilateral, public or private, are often governed by their own imperatives. This is why considering a coordinated action by development partners, on the basis of national public health strategies whose policy directions are defined by the actors themselves, remains a goal yet to be attained.
France in the global process

A long-standing French commitment...

One fundamental characteristic of French action in the fight against HIV/AIDS is its resolute commitment to its own sufferers from the very beginning of the epidemic, a commitment it was strongly urged and driven to make by lobbying from community-based associations. This has radically changed the way that society and the medical community see and act in relation to the disease and its victims. Daniel Defert, who initiated the AIDES association, wrote, as early as 1984, in a seminal text: “...I knew that AIDS was an issue that could not for long be confined to the status of a medical problem...” and, arguing that the “sharing of medical knowledge... ownership of medical knowledge...” by those suffering from the condition, puts the individual, the community, at the very heart of the structure as a participant impossible to ignore: “the community will soon be the best informed group on problems relating to the immune system...” (26).

It is against this background that the French government’s programme in support of the combat against HIV/AIDS in the developing nations also started up very early, in 1985. The first epidemiological surveys, conducted on samples of the general population in Central Africa, enabled an initial measure of the scale and gravity of the problem, an assessment of its geographical distribution and its main aspects, and the implementation of the first tools for effective surveillance of what was at that time no more than an epidemic. An emergency programme was launched to provide screening kits to blood banks and transfusion units in partner countries and to develop special information, education and communication (IEC) actions as part of national programmes against the disease put gradually into place with WHO encouragement.

The spread of the pandemic outside the main urban centres and the growing awareness on the part of the governments of partner countries in Africa of the increasingly drastic health-related, economic, social and cultural impact that AIDS was having on their national development, led them to ask for even more active French involvement in assisting them. Thus, as early as July 1993 in Abidjan, Ivory Coast, the French government affirmed its determination to intensify its effort in the fight against AIDS and to make this one of its priority programmes.

This engagement, confirmed in December 1994 in Paris at the Summit devoted to the combat against AIDS, resulted in a significant increase in the budget and human resources mobilised, which were concentrated on a small number of particularly severely affected countries, most of them in French-speaking black Africa. The Paris Summit also made clear, as it did for all the signatory countries, the overall...
strategic context of the intervention of the French government in relation to a number of essential points: “To protect and to promote, by means of a legal and social environment, the rights of individuals, and notably individuals living with HIV/AIDS and those most exposed to risk of infection; to involve fully in the action taken the government authorities, non-governmental organisations, community-based associations and those living with HIV/AIDS; to act to ensure that the law guarantees individuals living with HIV/AIDS equal protection in terms of access to health care, employment, education, freedom of movement, housing and social welfare.”

On the basis of the conclusions reached in the external evaluation of the programmes to fight HIV/AIDS over the decade from 1987 to 1997, the efforts made by the French government to help developing countries represented, on a full year basis, excluding multilateral commitments, an average of euros 12.2 million in total actual expenditure, including technical assistance, which accounted for virtually a quarter of all resources devoted to the health domain. This financial effort was split between projects as such, 62% of the total, and technical assistance (35%), with the remainder being devoted to non-project study grants, intervention funding from decentralised government bodies to diplomatic posts, and co-funding by the French Ministry of Foreign Affairs of projects supported by French Organisations for International Solidarity and NGOs.

Comparison of amounts (in M€) involved in programmes against communicable diseases, 1994-1997

<table>
<thead>
<tr>
<th>Disease</th>
<th>Amount (M€)</th>
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<tr>
<td>Onchocerciasis</td>
<td>14.8</td>
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<tr>
<td>Malaria</td>
<td>6.8</td>
</tr>
<tr>
<td>African human trypanosomiasis</td>
<td>3</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>2.3</td>
</tr>
<tr>
<td>Blinding and blindness-causing diseases, excluding onchocerciasis</td>
<td>1.8</td>
</tr>
<tr>
<td>Schistosomiasis</td>
<td>1.22</td>
</tr>
<tr>
<td>Blindness and blindness-causing diseases, excluding onchocerciasis</td>
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In the two-year period 2000/2001, 45 projects supporting the combat against HIV/AIDS based on a specific approach or making the intervention part of an integrated public health project and/or field research project, are currently being conducted or actively studied in 28 countries in the so-called Priority Zone of Solidarity (including 8 non-French-speaking countries) and all Caribbean countries, the total amount involved being over euros 30.5 million, as evaluated over the duration of the projects or programmes.

At the same time, 300 technical assistants in the health organisation deployed externally, almost two-thirds are involved for part or all of their time in the combat against HIV/AIDS (30 devote all their activity to this and 15 at least three-quarters of their working time).
### Actions currently ongoing or in preparation for 2000/2001 (euros millions)

<table>
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<tr>
<th>COUNTRIES (Bilateral Projects)</th>
<th>Special HIV/AIDS projects</th>
<th>Integrated public health programmes</th>
<th>TOTAL</th>
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<tr>
<td></td>
<td></td>
<td>Total</td>
<td>including HIV/AIDS</td>
</tr>
<tr>
<td>Angola</td>
<td>1.22</td>
<td>1.22</td>
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<tr>
<td>Benin</td>
<td>1.83</td>
<td>Total</td>
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<tr>
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<tr>
<td>Zimbabwe</td>
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### Public interest projects

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### Mobilising programmes

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### UNAIDS

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* Projects currently in preparation.

Source: MAE.
A strategy based on updated intervention

Over the last decade, the French cooperation strategy in supporting the fight against HIV/AIDS in developing countries has evolved through the addition of a series of new measures. The topics and approaches initially prioritised (Information Education Communication, safe transfusion, involvement of civil society, etc.) have never been set aside, while others have been added (voluntary and anonymous screening, reduction of incidence of mother-child transmission of HIV, access to special medication, etc.). So much so, in fact, that French overseas cooperation has addressed virtually the entire range of ways of combating the disease, and over time it has undeniably acquired expertise mediated by the excellence of its extensive technical assistance organisation.

The priority assigned since the mid-1980s to the fight against HIV/AIDS has been sustained and stepped up in the context of the recent overhaul of French overseas aid. The governmental HIV/AIDS programme is based around five strategic goals:

1/ The prioritisation, within the limits set by general policy directions defined internationally, of a regional approach taking into account national and local diversity. The search for synergy through regional intervention projects and/or stronger partnerships with the whole range of bilateral and multilateral players, and the consolidation of North/South and South/South networks of community-based associations are highlighted as productive strategies.

2 - Increasing the effectiveness of the combat through holistic understanding of the issue; this is because it is illusory to think that it is possible to supply sustainable solutions by separating prevention and care, or by not taking account of the whole range of determinants contributing to the appearance and spread of the infection, as well as to the seriousness of its consequences.

- Holistic in medical term terms by including in the care process all aspects relating to information, prevention, health care and assistance to those affected, putting sexual transmission into a broader context, with a view to enabling both couples and individuals to act as responsible parents and to express their sexuality without risk, taking care to ensure that the fight against HIV/AIDS is conducted in a way that not only avoids compromise to other programmes, but strengthens them;

- Holistic in extra-medical terms by taking into account the complexity of the infection’s social, cultural, religious, economic, political and legal implications. Respect for the rights of those infected and otherwise affected is affirmed and defended in relation to access to health care, employment and education or training, as well as in the area of property ownership and the family, and the duty of solidarity with regard to infected individuals. Close
attention is paid to vulnerable individuals and groups, and the victims of discrimination, especially women, young girls, and children in general.

3 - Involvement of non-governmental partners and infected individuals in defining and implementing programmes at all levels.

4 - Development of applied research in developing countries in the context of genuine North/South partnerships, and in strict adherence to international ethical rules.

5 - The consolidation of achievements, which entails support over the medium and long terms; making achievements durable, which entails the integration of programmes against the disease into the whole infrastructure of the health and welfare sector with a view to strengthening the national health system.

Developments in the French Cooperation intervention strategy:

- At first, the French Cooperation supported the provision of availability of anti-retroviral drugs (ARV), notably through the ITSF, the International Therapeutic Solidarity Fund.

"We have no right to accept that there should now be two ways of fighting AIDS: treating sufferers in the developed countries, and simply preventing infection in the South /.../ We must do all in our power to ensure that the benefit of the new treatments is extended to deprived populations in Africa and elsewhere in the world." (Jacques Chirac, Abidjan, 1997)

The ITSF, most of whose budget is funded by France, has made it possible to initiate five pilot projects in Ivory Coast, Senegal, Morocco, South Africa and Benin.

The ITSF
The ITSF is an initiative launched at Abidjan in 1997 by the President of the French Republic and the French Secretary of State for Health. Its main goal was to assist those countries that wish it to organise access to treatment techniques for HIV patients using an approach that prioritises the reduction of mother/child transmission of HIV and that provides HIV/AIDS care for mothers, children and, as far as is feasible, the partner and/or the family unit. Such an approach did not rule out the other ITSF core target, which was to ensure access to antiretroviral drugs for pre-identified patients in the overall context of a continuum of care. This had to be done in a spirit of partnership, taken forward in cooperation with the national authorities and bilateral overseas cooperation organisations, international institutions, public or private foundations and the private sector.

- Nowadays, the French Cooperation strengthens the attention paid to the organisation of health systems and services, adopting a holistic, integrated and decentralised approach leading to greater efficiency in the provision of care and sustainable access to health care of high quality at all levels in national welfare and health systems.

- Gradual expansion of action to include the whole of the Priority Zone of Solidarity.

The larger part of this strategy is implemented by two major special directorates in the Ministry of Foreign
Affairs: the Development and Technical Cooperation Directorate (DDCT), along with the Scientific, University and Research Cooperation Directorate (DCSUR).

While acting within this overall strategic context, the MCNG – Mission pour la coopération non gouvernementale, Mission for Non Governmental Cooperation – acts to provide co-funding for programmes of more limited scope, usually targeted on health care organisations or limited geographical areas, actions proposed by local government bodies and/or French NGOs and Organisations for International Solidarity.

For its part, the Ministry of Health, acting in its international capacity, develops actions benefiting migrants, placing great emphasis on improving the organisation of health care in the French West Indies / Guiana region, involving experts in the fight against HIV/AIDS in the Caribbean region and co-financing the ITSF.

In developed countries, it is hospital responsibility to ensure the control of health care for infected individuals. Therefore, hospital teams have acquired a deep longstanding and recognized experience. That is the reason why France launched, in partnership with other European countries (Luxembourg, Spain, Italy), the ESTHER programme standing for « Together for a Hospital Networking Partnership against AIDS » which places hospital at the root of the cooperation in the area of access to treatment, by developing twinings between hospital centres of countries of the North and health centres of countries of the South.

Where the AFD Group – Agence Française de Développement / French Development Agency – is concerned, it has been agreed that endeavours will be made to reduce the risk of HIV/AIDS in all the projects and programmes it funds. It will thus integrate into project aid specific components for the combat against the disease, with the action taken at local level in projects or programmes becoming fully meaningful by forming part of a broader, nationwide, programme of support.
A commitment to be taken forward:
more and better

The changed scientific context brought about by therapeutic advances in the most developed countries, the new political situation, expressed notably in the high level of demand for access to such treatments coming from leaders in the countries of the South, the worsening of the social and economic situation that will be caused by dramatic growth in the numbers of HIV infected persons, deaths and orphaned children, as well as the extension of the scope of the Priority Zone of Solidarity, are all leading the French government, taking into account its updated strategy for intervention now embodied in a frame document on international overseas cooperation policy, to reorganise its action around the following:

1) An expansion of the resources allocated to the combat against AIDS, especially in financial terms,
2) Improved interfacing of bilateral action with the other main bilateral and multilateral donors.

This effort should make it possible, taking into consideration the conclusions and recommendations of the external evaluation of the programmes to combat HIV/AIDS conducted by French overseas cooperation over the last decade, to develop the six following guidelines:

1) In the broader context of the fight to reduce poverty and to reduce the various forms of vulnerability, to mobilise all ministerial departments to increase the resources deployed in favour of the countries of the South, and to introduce an “anti-HIV/AIDS” component into projects designed for sectors other than health or social development, in particular in the fields of education and rural development;
2) To derive full benefit from achievements in the various international summits and to this end, to support implementation of their recommendations, whether these come from the United Nations, the European Union, or the G8. Intervention, possibly in conjunction with other external, bilateral or multilateral partners, will emphasise the acknowledged expertise of French technical assistance.

In this spirit, France in partnership with UNAIDS and WHO, organized on December 1, 2001, in Paris, a meeting of experts at higher level who drew up a «Declaration for a framework for action: improving access to HIV/AIDS care in developing countries». 
3) A stepping up of multilateral support, particularly in connection with the International Partnership against HIV/AIDS in Africa, operating under the aegis of UNAIDS for which a grant agreement has recently been implemented.

4) Step by step development, over the medium term, for all countries in the Priority Zone of Solidarity, actions will be developed with the aim of organising national welfare and health systems to allow them to provide holistic care for the HIV/AIDS infection, including, if possible, and depending on the context, access to all required therapeutic techniques. Although it is possible to offer a very inclusive framework and a multisectoral, cross-category view of such action, the objective is nevertheless not to seek to cover in each country the entire range of possible components of the fight against HIV, but rather, very pragmatically, working to complement, and in synergy with the community of development partners, to provide assistance in domains not addressed although they are crucial to setting up an effective health system. Working within the national strategic planning process is very much in line with this approach.

The strategic planning process
The HIV/AIDS pandemic is in fact a combination of complex epidemics driven by various factors linked to human behaviour, economics and society. The diversity of the engines behind these epidemics, combined with the need to use scarce resources as efficiently as possible, makes it necessary to use "strategic planning" which, defined under the national responsibility of the country, includes the following phases:

1. A map of the HIV/AIDS is drawn up and an understanding reached of the local epidemic's characteristics by identifying all the factors driving HIV propagation. The strengths and weaknesses of the national response are analysed.
2. A plan of action is defined to match the desired response and to make best use of the limited resources of the country concerned.

To accomplish this, France will continue to offer its support more particularly in those domains where it has demonstrated that it possesses acknowledged expertise, ranging from safe transfusion, voluntary testing and counselling, prevention of mother-child HIV transmission and access to drugs, to screening and follow-up for infected individuals or those suffering from severe immunodeficiency. France will also be developing, also using targeted technical datasheets, and in conjunction with the specialist agencies of the United Nations (ILO, UNDP, UNFPA, UNICEF), its expertise in crucial sectors that are still insufficiently explored, ranging from care for orphans, intervention in the world of work, in the rural community or the education sector, to issues of solidarity and prevention or their relationship with community-based associations combating HIV/AIDS, increased involvement of these specific actors in development allowing enhancement of the capacity for action and expanded structure-promoting flows, combined with encouragement for innovative capabilities.

5) For countries recently integrated into the Priority Zone of Solidarity, a regional approach needs to be encouraged by supporting inter-state bodies (SADC, CAREC, etc.).
6) The development is necessary over the medium term, in partnership with the countries of the South and with strong emphasis on training, of a comprehensive programme of operationally-targeted research specifically covering the main issues relating to the implementation of the concept of holistic, integrated and decentralised care:

- An evaluation of high-risk situations and behaviour, identification and validation of appropriate response components.
- Reinforcement of information and health management systems enabling situations to be better evaluated, their development to be monitored, and their determinants to be identified and analysed.
- The adaptation/validation of the concept of holistic, integrated and decentralised care in the specific context of mobile population groups.
- Support for the definition and implementation of strategies and organisation for supporting individuals living with HIV, socio-economic and social behaviour impact studies.
- Evaluation of the factors limiting national drug policies on access to generic and essential drugs.
- Support for the implementation of the Trade Related Aspects of Intellectual Property Rights (TRIPS).
- Support for national policies for screening for infection and reinforcement of the capacities of primary reference test laboratories; improvement of screening techniques in anonymous screening centres and blood transfusion units, support for the creation of a quality control laboratory for French-speaking Africa.
- Improvement of hospital hygiene in order to develop the fight to reduce accidental and hospital-borne infections.
- Improvement of knowledge on the natural history of the disease
- Analysis of the situation of AIDS orphans and strategies for caring for such children.
- Analysis of the situation of socially excluded and marginalised individuals and strategies for caring for them.

Fundamental research will go on helping to fund the French National AIDS Research Agency (ANRS) and in particular its “coordinated action No. 12” (AC12) whose main objective is “to promote and organise research on AIDS throughout the Priority Zone of Solidarity” and beyond research to support anti-AIDS programmes in developing countries including at the level of therapeutic treatment.

ANRS key research areas in the developing world are the biodiversity of the HIV viruses found throughout the world, the clinical trials aimed at reducing mother-child transmission and preventing the emergence of opportunistic diseases, antiretroviral trials, surveillance of resistance to antiretrovirals, socio-anthropological studies aimed at better understanding the reasons for the spread of HIV in developing countries, accessibility of specific health care, the economic burden of the disease and of treatments.
It is said that between 5% and 10% of the total number of cases of HIV infection worldwide are due to blood transfusion or the use of contaminated blood products. The importance of this risk factor obliges governments to set up an effective public blood transfusion service to meet national needs for transfusion and blood products.

Assuming that a national blood transfusion service does exist, four factors need to be taken into consideration in order to improve the blood product safety. They are:

- The collection of blood and the selection of donors. Blood donors are a scarce resource that is currently irreplaceable and unpredictable. If availability of this resource is to be ensured, the general population must be informed and made aware of the issues, and must be motivated if low-risk donors are to be recruited, selected and their loyalty ensured in a system where payment for blood donations is prohibited;

- Qualification of the blood donated, which involves careful clinical selection supplemented by standardised biological screening for the main agents responsible for infections transmissible through transfusion;

- Preparation of products to eliminate all bacterial risk through the imperative application of quality control and assurance procedures in all facilities;

- Distribution of the products and training for decision-makers, this being an essential factor in limiting numbers of non-essential transfusions.
To know is to be empowered

The HIV epidemic is driven by sexual relations between infected individuals and non-infected partners. When the serological status of the two partners is unknown – and at least nine-tenths of all seropositive individuals worldwide do not know that they are infected – the only safe options are sexual relations not involving penetration or sexual relations with the protection of a condom.

However, the condom is not without disadvantages, especially in the context of stable relationships when pregnancy is a desired outcome or when it is difficult for one of the partners to suggest the use of a condom spontaneously. For many couples and individuals in Africa, where the rates of prevalence of HIV are high, knowledge of their serological status would broaden the range of options for HIV prevention.

Screening policy must be based on a voluntary choice by individuals, with anonymity and/or strict confidentiality being an absolute imperative.

The approach to testing should provide for counselling prior to the procedure, the test itself, followed by a consultation at which the results are given, enabling work to be done on prevention or the individual helped to obtain proper care. This voluntary test and counselling process and the departments operating it are an essential link in the chain of measures providing greater assurance of prevention and support in the area of HIV/AIDS infection. The effectiveness of this approach has been attested by the following:

- positive changes in the sexual behaviour of men and women,
- prevention of transmission of HIV and other sexually transmitted infections (STIs),
- prevention of the transmission of HIV from mother to child,
- more practical access for infected individuals to medical care,
- an improvement in general public health through appropriate nutritional advice,
- the provision of psychological, spiritual, social, legal and financial support,
- possible extension of the benefits to the family unit and friends and relatives.

Despite their satisfactory cost efficiency, such services nevertheless remain underdeveloped in many of the countries hardest hit by the pandemic. If the situation is to be improved, support must be provided for genuine national coverage by voluntary testing and screening centres whose efficiency would be enhanced by the following:

- informing the general population on such centres and the benefits they offer,
- improving the quality of the services (appropriate infrastructure, satisfactory technical facilities, competent and helpful staff, guaranteed confidentiality, increased psychological support, and so on),
- back up with activities aimed at mitigating stigma and discrimination,
- increased attention to particularly vulnerable groups whose needs and legitimate demands should be better known,
- inclusion of specific actions to improve the organisation’s cost efficiency,
- broader access to screening in non-specialist welfare and health facilities.
Major breakthroughs in the development of effective and affordable actions permitting reductions in the level of risk of HIV transmission and better provision of effective care for those suffering from severe immunodeficiency, mean that a reduction in MCT must be in the forefront of current concerns.

It is now possible to develop an overall approach to the issue involving the implementation of a strategy of prevention of mother to child transmission and care for HIV/AIDS infection for women, their children, and to some extent their partners and/or family unit. Such a programme must be able to offer, in the context of services related to reproductive health and pregnancy, a complete and coherent range of measures for prevention, health care and follow-up both upstream and downstream of the provision of medical care per se, and notably pre- and post-test counselling providing a context for access to information on serological status, addressing the issue of sexual transmission of HIV and the STIs (screening, prevention, treatment), prevention of vertical transmission of HIV by means of short courses of ARV drugs, provision of breast milk substitutes, medical follow-up and satisfactory care for opportunistic infections and, where necessary, specific antiretroviral treatments, plus individual psychological and welfare support.

However, in agreeing to screening, pregnant women run the major risk of discovering that they are seropositive at a crucial, destabilising moment in their lives and at a time when they are particularly vulnerable. In the final analysis, such women will be responsible, usually quite alone, for coping with a number of major difficulties: pregnancy, high-risk pregnancy, appropriation and psychological acceptance of her new status, the decision to minimise the risks of transmitting the virus to her child or not, potential guilt feelings, and the announcement of her status to her partner, as well as to family and friends.

We must continue to defend the right of women to information on their serological status and the concept of integrating the screening option into a package comprising a minimum of prenatal medical services, despite the problems raised. Giving women this knowledge is certainly to give them the tools they need for their empowerment, but it will also destabilise them if they are not assisted by the provision of an environment based on responsible medical, socio-cultural and community association services.

Designing this type of intervention therefore involves all the questions linked to the overall HIV/AIDS issue, but it also requires broader consideration to be given to gender. This in turn requires prior reflection based around the social and cultural determinants of the world in which women in developing countries exist, one of the major characteristics of which is major variation from country to country. In this context more than any other, there is a need for field research.
Improving access to treatment for AIDS in developing countries raises further issues:

- the integration of care for those living with HIV/AIDS into the general health system,
- improvement of health systems which are usually incapable of coping with the problem posed by the prevalence of the disease, to enable diagnosis, care and follow-up for patients,
- improvement of drug procurement and distribution channels,
- reduction of the cost of the drugs as paid by patients, moving in the direction of a desirable match between price and their capacity to pay, adopting an approach based on argument and negotiation in favour of “tiered prices” for therapeutic techniques,
- efficient distribution of international aid.

If access to high-quality, affordable treatment is to be ensured for the majority of the population, the following will be necessary:

- a national list of essential drugs drawn up strictly on the basis of their cost effectiveness in the light of the local epidemiology,
- optimisation of therapeutic strategies in caring for AIDS patients,
- regulations that are relevant and implemented for the official approval of products and quality assurance at all points in the supply chain,
- improved information on the factors determining the cost of the drugs and their variants according to each country concerned, throughout the chain from purchase from the manufacturer to administration to the patient,
- identification of the possible economically rational options, whether public or private, national or international, that will permit, given local circumstances, real influence to be exerted on cost determinants,
- evaluation, applying economic, budgetary, legal and practical criteria, of the feasibility and effectiveness of the various options,
- expansion of available financial resources, calling for both national and international contributions against the background of a genuine and worldwide “mobilisation of society”.

Access to medication
The ongoing development of the pandemic, combined with new possibilities in the area of drug-based prevention and access to specific and non-specific therapeutic techniques, are leading to the organisation of the fight around a strategy involving optimisation of screening policy and enabling effective access to diagnosis.

This kind of approach, which supplements the whole range of preventive strategies, and notably the extension of safe transfusion to all hospitals and transfusion facilities, entails the adoption of the following as overall objectives:

- Improvement of access to diagnosis in order to begin caring for HIV patients under the best possible conditions and to encourage preventive behaviour patterns during the period of major viral spread,
- Facilitation of access to holistic care for infected individuals,
- Help in the adoption of individual strategies for avoidance of reinfection risk and the long-term maintenance of prevention-focused behaviour.

The adoption of such objectives requires the following:

- Information to the general population, starting with those most vulnerable to the risk, depending on local circumstances,
- Development of national coverage by test and screening centres to facilitate, in addition, access to prevention and care for diseases transmissible by sexual contact and blood, from which HIV is inseparable. Such national coverage would make it possible to approach individuals and groups that are particularly at risk,
- Ensuring that the opportunistic diseases associated with AIDS, mainly tuberculosis, are actually diagnosed and treated at an affordable cost and as close as possible to the place in which the patient is living, at home or in medical or welfare facilities suited to the issues raised by what is a chronic condition with major social and economic dimensions and against the background of continuous growth in the numbers of cases detected,
- Guarantees of access to high-quality medical examination, which presupposes the following:
  - Definition and validation of simplified screening and patient follow-up strategies,
  - Standardisation of test procedures (sensitivity, specificity, simplicity of application, use-by dates, ease of reading, packaging, price, etc.),
  - Guaranteeing a reliable chain of supply for reagents,
  - Guaranteeing internal/external quality control for the laboratories.
- Definition of the role of community-based associations for persons living with HIV and support for the fight against HIV/AIDS in the general context of the organisation for monitoring the infection, and provision of support for such associations in the execution of the tasks allotted to them.
Access to specific therapeutic techniques has radically changed the strategy for caring for patients suffering from severe immunodeficiency. Such access is potentially available to all countries in the short term, including developing countries. This entails a redefinition of the role of the hospital and taking the full measure of the medical and social dimension of an issue now generally agreed to be fundamental. The aim must be to provide outpatient care within a care continuum ranging from the patient’s home to specialist facilities of reference, and including all the resources most closely matching the economic and socio-cultural environment of the patient.

Access to ARV drugs will be all the easier for the least developed nations if a certain number of issues can be resolved:

- Improvement in the selection of ARVs and effective drugs for opportunistic diseases and associated conditions,
- Organisation and reinforcement of procurement and distribution systems,
- Improved affordability for all treatment components,
- Evaluation of the benefits and feasibility of local production and of measures allowing generic drugs import.

Inadequate treatment encourages the appearance of resistance that will impede the effectiveness of treatment; it is essential, irrespective of the country concerned, as soon as immediately effective treatment is made available, to create the right conditions for correct and sustained observance of protocols with a view to treatment over the very long term. If this is to be successful, it must be possible to offer patients assistance allowing the building of voluntary adherence to treatment courses. Civil society, and more specifically associations of persons living with HIV and NGOs promoting the combat against HIV/AIDS, obviously have a full role to play here, which needs to be clarified and assisted technically, logistically and financially.

Lastly, such provision of care is inseparable from a high level of vigilance in terms of ethics and law and the need to take account of the broader context of the fight against stigma and discrimination.

Follow-up for patients suffering from severe immunodeficiency

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Lastly, such provision of care is inseparable from a high level of vigilance in terms of ethics and law and the need to take account of the broader context of the fight against stigma and discrimination.
Independently of differences of culture and country, the extended African family and the community traditionally provided for the needs of such children. The unprecedented scale of the problem which now exists, modern life and its associated individualistic tendencies, plus social and economic pressure, development of geographical mobility and urbanisation, the high costs generated by the provision of modern services (education, health, etc.), have all eroded, or deeply undermined, this traditional system, whose mechanisms for solidarity are now increasingly ineffective.

It remains however the case that any sustainable solution to the problem must inevitably involve the family and/or the community, through either the biological family or a foster family, allowing the child to satisfy its basic needs in terms of housing, food and social integration. Institutional welfare care should be considered only as a temporary solution while awaiting the identification of a suitable placement option, although specialist institutions, as a possible interface in the community organisation, has a key role to play in terms of organisation, training, support, coordination and evaluation in such a system.

The definition of a national policy for the protection of children and their rights, especially in terms of preservation of family property, access to health care, to education and professional training, alongside the definition of policy on the new rights granted foster families, all fall within the remit of the government authorities, who must reinforce the existing safety nets or, where they are lacking, design and set up effective mechanisms. The implementation of these, with all its financial implications, is largely the responsibility of central and local government.

National and international mutual help and solidarity should make it possible to mobilise resources needed to support community initiatives and effort, supplementing the capabilities of public bodies.

Cumulative number of children estimated to have been orphaned by AIDS at age 14 or younger at the end of 1999

<table>
<thead>
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<th>Region</th>
<th>Number</th>
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<tbody>
<tr>
<td>North America</td>
<td>70,000</td>
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<tr>
<td>Caribbean</td>
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<td>Latin America</td>
<td>110,000</td>
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<tr>
<td>Western Europe</td>
<td>9,000</td>
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<tr>
<td>North Africa and Middle East</td>
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<tr>
<td>Sub-Saharan Africa</td>
<td>12.1 million</td>
</tr>
<tr>
<td>Eastern Europe &amp; Central Asia</td>
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<td>East Asia and Pacific</td>
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<tr>
<td>South &amp; Southeast Asia</td>
<td>850</td>
</tr>
<tr>
<td>Australia &amp; New Zealand</td>
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<tr>
<td>Total</td>
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Although the major negative macroeconomic impact of the retroviral pandemic now hardly needs demonstrating, its effects on the corporate sector in terms of:

- loss of qualified staff,
- lower productivity due to absenteeism and unavoidable replacements by staff who are often less experienced,
- higher recruiting and training costs,
- higher health expenditure,
are not yet completely self-evident for all.

Involving employers in the fight against HIV/AIDS in the workplace does not imply that the government authorities should be freed of their duty to put in place a legal framework ensuring equality, protection of the rights of infected individuals, and elimination of discrimination based on serological status.

Involving employers in the combat against HIV/AIDS in the workplace should result in the setting up on site of comprehensive and sustainable programmes including the following, within the limits set by strict adherence to the rules of confidentiality, in conjunction with the responsible government authorities, and subject to the framework provided by national policies to fight HIV/AIDS:

- Continuous information and training suitable for all the workforce, including the provision of condoms,
- Promotion of easier access to voluntary screening, counselling and support services for employees and their families,
- Diagnosis, treatment and care for STIs contracted by employees and their sexual partners, provided either in the company itself or by external agencies,
- Easier access to therapeutic techniques for opportunistic infections and ARVs, depending on national policies,
- Modification of job profiles to match the residual work capacity of infected individuals.

While the financial cost to companies should not be underestimated, especially if antiretroviral drugs are provided, the benefits from this initiative will, in some respects, be of a different kind (a strong welfare image for the workforce and in the country, limitation of the loss of investment in human resources, better organisation of replacements for lost workers) but fully as important.
It is no exaggeration to say that AIDS is now above all a rural issue in most developing countries badly affected by the pandemic. AIDS is now making more rapid inroads there than in urban areas, rural populations are less prepared to cope with it, and much of the cost of HIV/AIDS is borne by the rural community. We must therefore bear in mind that AIDS constitutes a grave threat to the security of food supplies.

This is why there is an imperative need to include a component for the fight against HIV/AIDS in all interventions in support of rural development.

An efficient educational system is a core component in the combat against poverty and in successful achievement of sustainable human development: such systems are heavily undermined in countries with a high level of prevalence of HIV/AIDS infection, where the teaching profession is particularly severely affected, and where their pupils, faced with this disease, the problem of orphaned children, voluntary or involuntary exclusion and marginalisation, demands new ways of organisation for education and training.

An efficient educational system is also a core component in building an effective response to the HIV epidemic. This system has failed to some extent: young people in training or school, who are in principle the best informed, have paid, however, a very heavy toll for the infection.

In view of the urgent nature of the epidemic, educational institutions must reorganise on the basis of a forward-looking evaluation of the following:

- The consequential effects in human, social and financial terms on the quantity and quality of educational services,
- The availability and qualifications of teachers,
- The reaction of families and communities to the impact of HIV,
- The ongoing development of the situations and needs of children and students not in school, excluded from school or receiving inadequate schooling.

Given the urgency of the epidemic, the educational sector must provide relevant solutions for young people, who must be considered in their various situations with respect to schooling, beginning sexual activity very early in their lives, faced with social practices and constraints which do not match the messages encouraging “responsible behaviour”. This probably requires a cultural change in order to allow young people – and the community – to invest time and energy in all the domains where they can make a contribution to their education. It is essential to adjust the culture of education to the needs of young people living side by side in a world affected by HIV and AIDS.
Over and above its impact on public health, the pandemic poses a dual economic and social threat, with a high capacity to undermine the structure of the traditional types of social organisation prevailing in developing countries.

In addition to medical responses as such, this situation requires shock treatment in which account must imperatively be taken of the social dimension of the problem, security of employment and decent income levels, as well as social solidarity and inclusion. Alongside the fight to reduce poverty and precarious living conditions, this being the general framework suited to providing an effective and sustainable response to the issues involved, there is undoubtedly a need to rely on the community – insofar as it still survives – on households and/or on NGOs and community-based organisations, in order to find an effective answer taking the following into account:

- The need to compensate for families' reduced working capacity,
- The possibility of generating activities capable of maintaining/increasing income,
- Provision of support for children and orphans.

This must obviously not free central government, in conjunction with its external partners, from its duties in terms of the following:

- Development of overall production of goods and ensuring the wide availability of essential services: education, health, hygiene and the environment, access to credit,
- Improvements to the funding of the health system and, in particular the implementation of welfare schemes guaranteeing solidarity, this being an absolute prerequisite for reducing social exclusion,
- Promotion of the effectiveness of NGOs and community-based organisations by reinforcing their skills for the definition, planning, management and evaluation of action,
- Protection of the rights of infected or affected individuals in terms of access to health care, the right to work and the rights of the family, paying special attention to the most vulnerable groups, especially women and children.

Social prevention of the consequences, seen from the point of view of solidarity, must be considered in synergy with prevention as such of the HIV/AIDS infection and other STIs, the most effective strategy for which would seem to involve peer education, which has the greatest power to modify knowledge, attitudes, practices and, by the same token, high-risk behaviour.
The expertise of community associations in the area of community involvement...

In the countries of the North, the HIV/AIDS epidemic has caused an upheaval, under pressure from associations of infected individuals, in the philosophy underlying the operation of health systems, which have as a rule concerned themselves little with the situation of the sufferer in the community. As key actors in the combat against prejudice, and as catalysts for the mobilisation of civil society against the epidemic, associations of individuals living with HIV have gradually caused medical practice to change and have helped bring about a radical modification in the carer/patient relationship as well as in the perception of the disease. In this way, associations against AIDS have acquired genuine expertise in the field of community involvement; their participation in research, preventive actions, development of treatment methods and provision of patient backup during treatment is acknowledged to be a public health policy component that is impossible to ignore.

...the basis for North/South inter-association cooperation to be developed...

The experience acquired by the associations in the countries of the North makes them prime partners for cooperation with associations against AIDS in the countries of the South. In developing countries, public health systems still too often fail, incapable of providing the right care for HIV/AIDS patients. The best emerging responses for reduction of the risks linked to HIV and general provision of care, are those offered by local associations which, on the basis of the involvement of affected individuals, intervene, or even offer their own counselling services for voluntary, anonymous screening, medical follow-up and access to care and therapeutic treatment of high quality and low cost.

...further in the context of the arrival of antiretroviral treatments

With the arrival of antiretroviral treatment techniques in developing countries, it is of fundamental importance that inter-association cooperation between North and South be strengthened in order to:

- facilitate the sharing of experience, develop transfer and add value to new skills in informing and supporting affected individuals,
- develop arguments for generalised access to effective therapeutic techniques,
- ensure concerted action to protect the rights of sufferers,
- contribute resources for counselling and training in the essential domains of health and community development: reinforcement of the management skills of associations, reduction of risk, a family-focused approach to the provision of care, reduction of the economic vulnerability of affected individuals, assistance in treatment compliance.

In the spirit and according to the philosophy underlying the Paris Summit, it is a priority to assist community associations in both the North and the South, to support inter-association networking between North and South, and to facilitate the emergence of South/South networks.
Despite the fact that health funding is a topic of growing importance in the intervention strategies of all development partners, the specific issue of financial provision for AIDS sufferers, while it is indeed addressed in both general terms and from the point of view of its theoretical cost, has led to virtually no definite proposals for solutions at national level, especially in countries where prevalence is high. There is nevertheless a consensus on the fact that national health systems, as currently constituted, will not be able to cope in most cases.

Where the funding of the operation of health services is concerned, the overall lack of resources is obvious, even if it is compounded by low efficiency: for this reason current reflection on health funding has two main thrusts. The task must be to increase the share of resources devoted to health by combining different sources of finance and putting mechanisms in place to reduce waste. Consideration of risk mutualisation favours horizontal solidarity limited by subscribers’ ability to pay, having regard to the financial requirement. There is a risk that provision of care for severely affected patients may bankrupt these recently created and consequently vulnerable systems. The way forward usually chosen is therefore rather to cover a limited number of identified risks, among which AIDS and its consequences are generally not included.

At the present time, AIDS patients, who make frequent use of health services when suffering from opportunistic conditions, are dealt with under the common health regime. Some countries have set up in public health facilities stocks of drugs reserved for patients with AIDS. The distribution of such drugs remains unreliable and to a large extent inadequate to meet needs.

It is therefore urgent to examine on a broad basis the consequences of AIDS for the organisation and the funding of health systems. The fight against HIV/AIDS, and more generally against the main infectious diseases, cannot make significant progress without exceptional levels of support from the international community, provided in a spirit of solidarity. While there are prospects of very substantial finance in the relatively short term (HIPC Initiative, poverty reduction strategy papers, etc.), it still remains the case that the major problem that will arise, and which is far from having found a solution, is that of how to employ such funds rationally, not simply for a single disease, but for the whole health and welfare system needing consolidation. To accomplish this, preparatory work on funds raising, on the political commitment of local governments to reorganisation of their health and welfare systems and the organisation and coordination of the employment of financial resources, are imperative to propose feasible and sustainable solutions.
And what about tomorrow?

From a situation of denial, indifference or intolerance, contempt, rejection, marginalisation and exclusion, AIDS has now become in France – thanks to the commitment, self-sacrifice, determination and perseverance of a few particularly militant actors and patients, unpaid workers, members of community associations, health professionals, administrators and political authorities – a disease that is almost like any other, for which care is provided like any other. The epidemic has revealed and amplified malfunctions in the health system as a whole, and thanks to civil society and its determination in combating the disease, the “human dimension” \(^{(34)}\) or “human face” \(^{(35)}\) of AIDS has in the end been restored.

France, loyal to its fundamental values, intends to convince the whole world of this human dimension. That is the true meaning of its engagement in favour of the most deprived nations.

However, the opening of the eyes to others that AIDS makes possible, must apply irrespective of the illness involved. It is self-evident that much remains to be done.

We are witnessing – and it is a good thing – the increasing worldwide institutionalisation of the management of this pandemic. There may be an increasingly pressing risk, or perhaps temptation, in the broad process now crystallising, of forgetting the lessons of history, of reducing the fight against HIV/AIDS to one against an “ordinary” disease, of handing over power to technology, and technocracy, thereby forgetting the human dimension we had eventually rediscovered.

Let us continue to be vigilant.
Notes

(1) Peter Piot, Executive Director, UNAIDS, October 1999.
(3) Donald de Gagné, Persons with AIDS, a not-for-profit association, 5th International conference on AIDS, Montreal, 1989.
(5) M. Verboud, 1996.
(7) Update on the AIDS epidemic. December 2001. UNAIDS/01.75F.
(8) id.
(10) UNAIDS 1999.
(11) AIDS orphans; answers from the front line in Eastern and Southern Africa. UNICEF 1999.
(14) HIV/AIDS: a threat to food security and the rural world. FAO . TC/I/X87/13F/1/11.00/1000.
(19) Young man of 25, Bouaké, Ivory Coast, in: Faire face ensemble.
(20) Woman living with HIV/AIDS, Centre SAS, Bouaké, Ivory Coast, in: Faire face ensemble.
(22) Child who has lost its father; mother monitored by SAS Centre, Bouaké, Ivory Coast.
(23) Widow, SAS Centre, Bouaké, Ivory Coast.
(29) PM, French contribution accounts for 25% of the European Commission and EDF budget for development.
(30) The Priority Zone of Solidarity is defined as the area in which official assistance, deployed in a selective and targeted manner, can produce a significant impact and contribute to the harmonious development of institutions, society and the economy. It comprises countries that are among the least developed in terms of income, and with which France intends to build strong relations based on partnership, in a context of solidarity and sustainable development.