

# Strengthening U.S.-French Collaboration on HIV/AIDS in Africa

A Conference Organized by the  
Center for Strategic and International Studies  
and the Brookings Institution

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## Acknowledgments

CSIS and the Brookings Institution wish to thank the German Marshall Fund of the United States for its generous grant in support of the December 2001 conference, summarized in this report. In particular we are grateful to William Antholis, director of studies, and Stephen Grand, director of programs.

We thank the conference panelists, for taking the time and effort to share their insight and expertise on HIV/AIDS in Africa and opportunities for U.S.-French collaboration. That this report is longer than most conference proceedings attests to the depth and thoughtfulness of the presentations summarized.

We would also like to single out for special thanks Ambassador Richard Holbrooke of the Council on Foreign Relations and Dr. Helene Gayle of the Bill and Melinda Gates Foundation for cochairing the conference and provoking a lively and constructive discussion.

We are grateful to David Throup, senior associate of the CSIS Africa Program, who served as conference rapporteur, and to Jennifer Cooke, deputy director of the CSIS Africa Program, for editing the proceedings.

Finally we would like to thank Justin Vaisse, instructor with the Institute of Political Studies of Paris and a Brookings Institution affiliated scholar, for identifying and bringing to the conference a range of outstanding French official and academic participants, and Bridget Alway, senior research assistant with the Brookings Institution's Center on the United States and France, for handling the conference logistics so ably.

# Strengthening U.S.-French Collaboration on HIV/AIDS in Africa

## Summary

On December 3, 2001, the Africa Program of the Center for Strategic and International Studies (CSIS) and the Brookings Institution's Center on the United States and France (CUSF) hosted a conference on strengthening U.S.-French collaboration on HIV/AIDS in Africa. CUSF director Philip Gordon and CSIS Africa Program director J. Stephen Morrison welcomed participants and outlined the purpose of the conference: to identify new opportunities for active collaboration between France and the United States in combating HIV/AIDS in Africa. The conference was funded by the U.S. German Marshall Fund and is part of an ongoing two-year CSIS Task Force on HIV/AIDS, funded by the Bill and Melinda Gates Foundation and the Catherine Marron Foundation. Discussions focused on four key areas: the importance of HIV/AIDS to U.S. and French foreign policy and security assessments; the disease's likely destabilizing impact on African states; the role of the Global Fund to Fight AIDS, TB, and Malaria; and the need for closer collaboration among U.S., French, and African researchers, policymakers, and program implementers.

The conference revealed a number of areas where additional efforts to collaborate in the multilateral arena and the bilateral relationship can significantly improve leverage to effect positive change. In all of these areas, participants emphasized that African participation and collaboration is key.

## Public Diplomacy

Both the United States and France should work to encourage African leaders to play a catalytic role in combating the pandemic and to strengthen African ownership of the campaign against HIV/AIDS.

Debates over the structure, leadership, and focus of the Global Fund will likely persist, but the United States and France, as key players in the fund and in the international community, should continue to seek common ground and set a tone of collegiality, not competition.

## Bilateral Dialogue and Cooperation

Closer consultations among donor governments are needed as they devise policies on HIV/AIDS, to ensure complementarity and capitalize on comparative advantages.

The European Union has agreed to work together to reduce prices for antiretrovirals; a joint approach with the United States could reduce prices for essential medicines and medical products even further.

Both France and the United States are cognizant of the critical impacts that HIV/AIDS is having on African economies and development goals; on critical infrastructures including health systems, educational systems, and family networks; on political legitimacy (in the case of South Africa); and on the broader North-South dialogue. The United States and France should not limit cooperation in Africa to prevention, care, and treatment of HIV/AIDS. Concerted efforts to stem and mitigate the pandemic should be only a starting point for longer-term collaboration on a range of economic, political, and security fronts.

## Programmatic Collaboration

France has proposed an ambitious “hospital-twinning” scheme to strengthen African health systems, build human capacity, and reduce the cost of drugs and equipment. The United States should consider a similar “twinning” model, and although it need not be identical to the French proposal, it can build on some of its key strengths.

In-country program implementers should seek out opportunities to collaborate. Higher-level incentives, as well as institutional arrangements, such as memoranda of agreement, may be helpful in this regard. Implementing agencies should share more information about their policies, strategies, priorities, programs, partnerships, and lessons learned. U.S. and French embassies in recipient countries can play a catalyzing and convening function in this regard.

The United States and France should develop collaborative efforts on research, ethics, access to treatment, and large-scale trials, as well as programs. In selected countries, the United States and France might consider co-funding projects or programs. There are some advantages to parallel in-country research projects, but closer collaboration, particularly at the development stage, can produce better results.

In many African countries, military personnel are particularly at risk, and in some cases military and peacekeeping forces have become an important vector for the disease. The French military is more deeply involved on the medical front than is the United States, and the latter should devise military-to-military training programs on health, modeled after the International Military Education and Training (IMET) human rights program. Consultation with the French would be helpful in this regard, and the Africa Center for Strategic Studies should begin a dialogue with its French counterpart.

## Scientific Research

The U.S. National Institutes of Health, the French National Agency for AIDS Research (ANRS), and the Institut Pasteur, all of which have extensive networks in Africa, are currently collaborating on the clinical development of candidate vaccines. There are numerous opportunities for additional research. There will be many possible candidates in five years for Phase III vaccine trials, which will be a key area for U.S.-French collaboration—joint studies at the interagency levels are needed now, well in advance of these trials.

Further exchanges of French and U.S. researchers should be encouraged, as should joint efforts to improve the knowledge and capacities of local laboratories and African researchers.

## Venues for Enhanced Collaboration

The United States and France might begin, with a few selected countries in Africa, to make a concerted effort to ratchet up collaboration among program implementers, researchers, embassies, and institutions. Côte d'Ivoire, Senegal, South Africa, and Kenya may be good candidates. Another possible venue for greater collaboration is through regional organizations like the Southern African Development Community (SADC) and the Common Market for East and Southern Africa (COMESA).

Although not in Africa, Haiti is suffering acutely from the HIV/AIDS pandemic and would be a good candidate for enhanced U.S.-French cooperation. Haiti's health infrastructure is in shambles and the political situation uncertain, yet some pilot projects, including small-scale antiretroviral distribution programs, may hold some promise for success. The Harvard School of Public Health is active there, and two French hospitals have volunteered to work in Haiti as part of the French "hospital-twinning" scheme.

CSIS will continue to explore areas of potential collaboration and will hold smaller, more narrowly focused, follow-on meetings. Potential topics include: exploring how to operationalize a "twinning" project in the U.S. context; enhancing military-to-military action on HIV/AIDS; galvanizing greater participation on HIV/AIDS by the French and U.S. corporate sectors; and exploring options for procurement of essential medicines and medical products.

## Panel I: The Importance of HIV/AIDS in U.S. and French Foreign Policy

*Chaired by Ambassador Richard Holbrooke, counselor, Council on Foreign Relations*

**AMBASSADOR RICHARD HOLBROOKE.** Ambassador Richard Holbrooke explained that France has been singled out because of its enormous importance in Africa, the current epicenter of the crisis. Although U.S.-French relations are close, the two countries frequently misunderstand each other because of stylistic differences, and consequently the strength of the alliance is not always appreciated.

The HIV/AIDS pandemic has gained increasing attention in the last two years and is one of the few issues—apart from international terrorism—to remain prominent in the public eye after September 11. Yet in the disease’s 20-year history, the international community has been slow to respond. Mathilde Krim’s 1983 predictions—which went largely unheeded at the time—are now being realized. The disease is now spreading primarily through heterosexual contact, and most explosively where there is the greatest denial. Drugs are still not being distributed in many of the countries most acutely affected. The Bush administration places a high priority on the threat, based on statements by Secretary of State Colin Powell and Under Secretary of State for Global Affairs Paula Dobriansky. HIV/AIDS is now very near the top of the worldwide agenda, yet still not enough is being done in a war against the world’s greatest health crisis in 600 years. It is uncertain, for example, whether attitudes in U.S. embassies have changed sufficiently to make the war on AIDS a priority.

After September 11, the foremost international priority of the United States has been the war on terrorism. But the international community must not forget AIDS. With economic globalization and the movement of people from Africa to Europe, the Caribbean to North America, and from Eastern Europe into the European Union, the source of the disease must be attacked in each country, and a combination of education and prevention, treatment and research must be vigorously pursued. So far, prevention campaigns have not been very effective—even in Uganda, which has been praised for its education and prevention efforts, anti-AIDS billboards remain far too euphemistic. There must be an unflinching dedication to providing effective prevention messages as well as addressing related factors like gender inequality. Holbrooke commended recent *New York Times* articles about AIDS in South Africa that laid out the acute vulnerability of women. Prime Minister Makonde of Mozambique—the only example of a prime minister who is a gynecologist—has pointed out that most ethnic groups in his country do not have a phrase to describe HIV/AIDS and that it is known as “the disease of women.” The war against AIDS will be lost, Holbrooke warned, if such myths persist. It is a cruel irony that women teaching AIDS prevention in South Africa are themselves unable to practice safe sex.

There is no room in the war against AIDS for political nicety. The United Nations, for example, has made no real effort to educate its peacekeeping forces about the disease—with dire consequences. In Cambodia in the early 1990s, UN troops became a significant vector in spreading the disease. One concrete step would be for the UN Peacekeeping Office to add HIV/AIDS education and prevention to their mandate. Progress has been too slow.

In his position as president and CEO of the Global Business Council on HIV/AIDS, Holbrooke is urging international corporations to play a major role in tackling the problem. Corporations are less circumscribed than governments and have a real economic interest in this issue. The UN Foundation, the Gates Foundation, and the Soros Foundation are all actively involved in fighting HIV/AIDS, but apart from Coca-Cola (which has 100,000 employees in Africa), Viacom-MTV, Daimler-Chrysler, and Unilever, the business community has not to date played a major role. The Global Business Council seeks French corporate participation.

**PAULA DOBRIANSKY.** Paula Dobriansky, U.S. under secretary of state for global affairs, praised CSIS and Brookings for sponsoring the meeting and stressed the importance of closer U.S.-French collaboration. Recognizing that AIDS devastates countries that are least equipped to mount an effective response, there is an urgent need for a coordinated global commitment from governments, corporations, foundations, and nongovernmental organizations.

The U.S. government has made HIV/AIDS a high priority. President Bush was the first leader to pledge financial support to the Global Fund to Fight AIDS, TB, and Malaria, making an initial contribution of \$200 million with more to follow. The secretary of state and the secretary of health and human services jointly chair the U.S. Cabinet Task Force on HIV/AIDS, signaling the importance the administration attaches to this issue. It is important to recognize that congressional support for the campaign is also critical. In terms of U.S. foreign policy, on December 1, World AIDS Day, the State Department held videoconferences with a number of U.S. embassies to discuss the issue, and in May 2001, Secretary Powell stressed the importance of anti-AIDS efforts during his trip to Mali, South Africa, Kenya, and Uganda. All U.S. diplomatic posts in Africa have received cables stressing the importance of the Global Fund and emphasizing the significance of the HIV/AIDS issue. The United States participated in the UN special session on HIV/AIDS in June 2001 and has appointed Deputy Assistant Secretary of State for International Health Affairs Dr. Jack Chow to lead the U.S. delegation to Brussels to work with the Transitional Working Group of the Global Fund. Secretary Powell met Dr. Chrispus Kyonga, recently appointed head of the fund's Transitional Working Group, when Kyonga visited Washington in November.

Africa is disproportionately burdened with the AIDS pandemic. UNAIDS reports that 25 million people have died from the disease, which is now the world's fourth-largest killer. In sub-Saharan Africa, where 3 million have died from the disease this year, AIDS is already the main cause of death among those

aged 15–49. Worldwide, some 8,000 die from the disease every day, of whom 6,300 are Africans. Sixteen of the 25 worst-affected countries are in Africa, where, it is predicted, 5 million more people will be infected next year. Approximately 70 percent of the world’s total HIV-positive population and 80 percent of the world’s HIV-positive children live in Africa. By 2010, it is predicted that there will be 42 million AIDS orphans in Africa. While the disease is wreaking havoc in Africa, it is also spreading alarmingly in Eastern Europe, Russia, the Caribbean, and Central Asia, where it will seriously affect overall social, economic, and political stability. It is clear that there is an indirect, but nonetheless real, relationship between the spread of the disease and political instability. For example, the incidence of child mortality, an indicator for quality of life, closely correlates with state turmoil.

HIV/AIDS undermines development, in part because the most economically productive members of society, aged 15–49, account for the majority of all new HIV infections. Its effects are devastating. One quarter of Ugandan households contain AIDS orphans, and the disease is a contributing factor to the growing number of child soldiers in Africa. AIDS flourishes in closed societies and stigmatizes those affected. Uganda, Senegal, and Thailand have done well in combating the disease, shining a light on AIDS by developing national strategies to confront stigma and by emphasizing prevention.

In December 2001, the main U.S. effort was centered on the Transitional Working Group of the Global Fund. The EU summit and the G-8 meeting in Genoa both strongly supported the establishment of the Global Fund and aimed to have it up and running in early January 2002—a target that was met. By the end of 2001, some \$1.7 billion had been committed to the fund, but groundwork continues, and the fund is still in a very preliminary phase. Most of the discussions so far on the fund have been procedural, but it is essential to develop agreed-on, equitable procedures. The emphasis will soon switch to examining prospective programs. The United States stresses the need for a broad-based, flexible approach and warns against prejudging the outcome.

Responding to a question on who, if anyone, in the administration was coordinating the work against AIDS at the U.S. Agency for International Development (USAID), Centers for Disease Control (CDC), and the various bilateral programs, Dobriansky acknowledged that it would take time to create the State Department’s lead office and to change the organization’s culture. Dr. Chow joined as deputy assistant secretary in early September, and his first priority was to lead the U.S. team to the transitional working group. A cabinet-level task force has been established, including representatives of USAID and the National Institutes of Health (NIH), to coordinate U.S. efforts to develop an integrated approach. A subgroup is examining the USAID and Department of Health and Human Services (HHS) programs as part of an ongoing effort to develop new approaches. The United States does not want the Global Fund to supersede existing bilateral agreements.

**MICHEL FOUCHER.** Michel Foucher, director of policy planning in the French Ministry of Foreign Affairs, noted that in French policy circles, there is increasing aversion to “old-fashioned interference” in Africa and a growing sense that Africans must assume their own responsibilities. Nevertheless, Foucher emphasized, there is an urgent need for greater concrete collaboration on HIV/AIDS among those Western countries that have shown an abiding interest in Africa—notably the United States, France, and the United Kingdom. Franco-American consultations on Africa in July 2001 identified five strategic issues: (1) support for economic growth, (2) cooperation on conflict resolution and regional peacekeeping, (3) institution building, (4) development of civil society, and (5) strengthening the health sector. These five interrelated issues are part of France’s overall policy in Africa, and AIDS will have profound consequences in each.

The French government has been engaged in the fight against HIV/AIDS in Africa since 1985, when the first epidemiological surveys were undertaken in Central Africa. France now has 500 health professionals working in Africa. French nongovernmental organizations (NGOs) are mobilized, and there is widespread recognition of the devastating impacts of HIV/AIDS. AIDS is a social tragedy and an economic threat that is destroying decades of development. Experts predict that the South African Treasury will lose some 10 million working days (20 percent of the total) and 30 percent of GNP by 2015. The economy will be set back some 8 to 10 years. Some of South Africa’s political leaders are in denial, but the legacy of apartheid and reliance on migrant labor make South Africa highly vulnerable and may destroy its position as a “useful power” in the region. Other challenges in Africa are the possibility of peacekeeping forces spreading the disease, emerging power vacuums, and collapsing development frameworks.

Drug therapies are produced and available to people living with AIDS in the north, but in the south—where HIV/AIDS is most rapidly spreading—those infected are being denied effective treatment and care. The French government seeks to ensure greater access to antiretroviral drugs. France supported U.S. efforts to highlight the impact of AIDS in the UN Security Council in January and at the UN General Assembly Special Session on AIDS, held in June 2001. Between 1987 and 1997, the equivalent of 100 million euros were devoted to fighting HIV/AIDS, financing 45 projects in 28 countries, and making AIDS a priority “zone of solidarity.” In addition, France is working with a number of local NGOs and has begun rethinking its strategy. It seeks to conduct its own actions within a broader international framework, to develop integrated programs of prevention and care, to work with NGO partners and those infected, to encourage applied research in north-south partnerships, and to structure health systems to provide a comprehensive approach to the disease. The French government is increasing its financial commitment to HIV/AIDS and has promised 150 million euros over the next three years to the Global Fund.

France supports a comprehensive approach, integrating prevention and care, and providing access to antiretrovirals. Médecins sans Frontières is distributing antiretrovirals in Kayalitsha, a township on the Cape Flats in South Africa, and

the French government is encouraging partnerships between hospitals in the north and south. The establishment and launch of the Global Fund will be the main task for 2002. France believes that some 70 percent of the fund's allocations should go to Africa, the poorest continent with the highest prevalence. The fund has raised expectations, and these must be met. The north has to deliver, mobilize support, and finance access to care.

While in Washington for the December 3 conference, the French minister of health, Bernard Kouchner, met with the U.S. secretary of health and human services, Tommy Thompson, to devise a common strategy. France gives greater emphasis to the provision of access to care and treatment than does the United States, which concentrates primarily on prevention. The French government believes the Global Fund should concentrate most of its resources on HIV/AIDS, malaria, and tuberculosis. The Nordic countries and the United Kingdom favor a more general approach that stresses education and development. France considers that these tasks could be performed by other agencies and that the Global Fund should be more tightly focused on health issues, more narrowly defined.

France, like the United States, has a number of "old-fashioned" ambassadors who are not fully engaged in fighting HIV/AIDS. In time, they will adapt. The French minister of cooperation, Charles Josselin, sponsored a joint conference of the private sector and French ambassadors in Africa in August 2001 to change thinking and integrate the war against AIDS into diplomats' mandate. It takes time, however, to establish close collaboration at the local level. Minister Josselin is committed to the issue and had met with Ambassador Holbrooke to encourage more French companies to join the Global Business Council.

**GEORGE MOOSE.** George Moose, former U.S. ambassador to the United Nations in Geneva and former assistant secretary of state for Africa, recalled that during his time as assistant secretary, the United States and France were often seen as being in competition in Africa. In fact, there are more than enough challenges and opportunities in Africa to occupy both countries. At the operational level there was a sense of competition, and this affected discourse on HIV/AIDS. Moose experienced this in 1989 when as U.S. ambassador to Senegal he attended a conference on AIDS. Differences centered on the appropriate balance between treatment and prevention, and the debate between Minister Kouchner and former U.S. secretary of health and human services Donna Shalala focused on the wisdom of providing antiretrovirals to Africa. The French insisted on including treatment as part of any anti-AIDS strategy, while the United States was reluctant, fearing the staggering cost implications.

Both countries agree, however, that the anchor of any program is prevention. Tough decisions will have to be taken when implementing treatment programs to ensure that they do not discriminate between rich and poor, between rural and urban residents, and to ensure that they do not create increased resistance to the disease. A comprehensive strategy is needed, integrating prevention, care, and treatment; hopefully, policies will converge. Establishing practical Franco-American cooperation and surmounting the different institutional cultures will be

difficult. France and the United States have the most capacity and interest in Africa and, consequently, have a profound obligation to work together against AIDS. Collaboration should not be undermined by competition. Both countries have seen their influence in Africa decline following the end of the Cold War, and at the same time, the continent is lapsing into chaos as rebel warlords threaten to make many countries ungovernable. International criminal organizations, such as Al Qaeda, pose a threat, as does the breakdown of the social order in West Africa. AIDS and other diseases are spreading, undermining the fabric of society. It is important that France and the United States make the war against AIDS a priority issue and that they identify ways to exercise leadership and develop collaboration. The war against international terrorism must not push all other issues off the agenda.

## **Panel II: French and U.S. Perspectives on the Stability Implications of HIV/AIDS in Africa**

*Chaired by Helene Gayle, senior adviser on HIV/AIDS, Gates Foundation, and former director of the CDC Center on HIV, STD, and TB Prevention*

**DAVID GORDON.** David Gordon, national intelligence officer for economics and global issues at the National Intelligence Council, emphasized how starkly AIDS threatens the world's population and way of life. The infection curve is rising steeply in Eastern Europe and Asia, and AIDS has already killed more people than the wars of the twentieth century or the Black Death of 1347. Projections indicate the situation will get much worse. By 2010, life expectancy in Africa will have fallen to the levels of the early twentieth century, and there is a risk of a downward spiral that will overwhelm adaptive capacities, weaken human capital by killing teachers, entrepreneurs, and other leaders, and seriously erode the strength of many states. AIDS is closely linked with political instability, but with the possible exception of southern Africa, it is an indirect cause of conflict and unlikely to become a direct cause.

It is difficult to disentangle causal factors, but several long-term implications can be envisaged. AIDS will increase poverty as many breadwinners die, producing large-scale immiseration; if current trends continue, Africa will soon return to the poverty levels of the early colonial period. In addition to the economic consequences of death and morbidity for families, increasing numbers of AIDS orphans will contribute to the disintegration of traditional family and social bonds. When HIV prevalence rises to over 15 percent, the extended family structure begins to collapse, leaving massive numbers of orphans with no one to care for them. At the same time, acquiring weapons is easy, and their costs are falling. Drug traffickers, armed rebels, and terrorists may take advantage of vulnerable youths, producing more and more crime. Education patterns will be disrupted with the deaths of large numbers of teachers, as school children stay home to care for sick family members, and as rising family health expenses or the death of the breadwinner makes school fees unaffordable. Education, Gordon

emphasized, is the key to uplifting individuals and countries and there is a need for more research on the linkages between education, growth, and development. AIDS will also undermine Africa's fragile but active civic organizations, destroying the advances of the last two decades, while improvements in democratization and good governance achieved in the last decade will be at risk.

Studies by the World Bank and Harvard University suggest that HIV/AIDS begins to have a macroeconomic impact when the prevalence rate reaches 3–5 percent. At 10–15 percent prevalence, African economies are estimated to lose 0.5 percent of GDP per annum, which will have a devastating cumulative impact over 10 or 15 years. AIDS may also erode political stability, which is highly correlated with integration into the international economy. Africa is already marginalized in the globalization process, and AIDS makes its integration into the world economy even less attainable. AIDS is already deterring investment in South Africa, for example. Africa may face increasing conflict over access to power, as well as financial constraints resulting from scarce resources and limited budgets. Governments will face crucial choices on AIDS spending versus other essential expenditures on economic investment and social services, with important budgetary implications.

**DIDIER FASSIN.** Didier Fassin, director of African studies and professor of anthropology at the University of Paris XIII, has researched the political anthropology of the AIDS epidemic in South Africa. President Mbeki, in his letter to President Clinton in April 2000, tried to explain his government's position on AIDS, drawing attention to the heterosexual transmission of the disease in Africa and calling for solutions specific to the African context. Mbeki invited a panel of scientists and their critics to consider the etiology of the disease prior to devising policies. Coinciding with the declaration at the international AIDS conference in Durban, in which 5,000 researchers restated the basic facts of AIDS, Mbeki's speech to the delegates ignited an international controversy that eroded the legitimacy of the president and his government, dividing the tripartite alliance between the ruling African National Congress (ANC), the South African Communist Party, and the Congress of South African Trade Unions (COSATU). Both the Communist Party and the trade unions have distanced themselves from Mbeki, and rumors have circulated of conspiracies against the president, with some factions demanding his dismissal.

President Mbeki's opinions, however, have wide support in South Africa and have deepened the divide between whites and blacks and exacerbated suspicions between Africa and the West. Distrust of Western power is a consistent theme in South African political discourse and has made the fight against HIV/AIDS that much more difficult. This dispute has important repercussions for Africa's stability and for the international campaign against AIDS. During the apartheid era, aided by comparative economic sophistication, South Africa achieved substantial integration into the global market. Yet, the country has also experienced a uniquely rapid progression of AIDS from a 1 percent incidence in 1990 to 20 percent by 2000, with over 4 million people infected out of a population of 42 million. It provides a startling example of the epidemiological

crisis in southern Africa, posing a tremendous health care burden with severe economic and human consequences.

As with tuberculosis, there are three significant factors contributing to the spread of HIV/AIDS in Africa: social inequality, the high incidence of sexual violence, and high population mobility due to migrant labor and war. This epidemiological configuration is ideal for the rapid spread of HIV. Moreover, HIV/AIDS has generated unprecedented political and intellectual discord—particularly in South Africa where controversies emerged over local treatments in 1997, the South African government’s withholding of antiretroviral drugs that prevent mother-child transmission, and in 1998 and 1999 over the potentially toxic effects of AZT. Elsewhere, there have been disputes about the African origins of the disease and judgments about African promiscuity. In the Democratic Republic of Congo, Cameroon, Kenya, Côte d’Ivoire, and elsewhere these controversies have highlighted Africans’ suspicion of the West, leading to denunciations of AIDS as biological warfare or the result of ill-considered immunization programs. These controversies have had four common features, which Fassin termed the “political configuration” of AIDS controversies: confusion between science and politics, a racial interpretation, belief in a Western conspiracy during the Cold War, and manifestations of scientific nationalism.

African ruling elites are directly affected by HIV/AIDS, and many are dying. African armies have an extremely high incidence—over 70 percent in some battalions—and the incidence of HIV/AIDS is a serious problem among African peacekeepers in Sierra Leone and Burundi. Doctors, nurses, teachers, policemen, and workers in many other vital public sectors are seriously affected, with high rates of absenteeism and problems of replacement. The economic consequences of the disease on health care and social security systems will be profound, leading to major declines in productivity. In addition, people with AIDS will be isolated and discriminated against. The disease will create large numbers of orphans and intensify xenophobia and attacks on immigrants, perhaps even leading to pogroms.

The South African debate highlights two key issues: denial and mistrust. Denial underlies virtually all political debates and discussions among elites about the country’s future health programs. Denial about the causal links of the disease and about its severity is not limited to the African elite, however. Rather, it is a common reaction among people confronted by an intolerable situation—what can be called “the social space of denial.” Between 1990 and 2010, life expectancy in South Africa will fall more than 20 years from 62 to 41 (and to 36 years in Natal). Prevention and treatment will have little effect in the short term. South Africans wonder how this disaster can have happened just as apartheid ended and indeed whether it is a consequence of freedom recovered.

Such thinking inevitably leads to mistrust of whites and the West. Health data, drugs, and policies are all seen as coming from the West, and there is a tendency to believe in conspiracies and plots. Antiretroviral drugs, for example, are denounced as toxic products, and rumors abound of biological agents, such as

anthrax, being used to kill black leaders. Many perceive HIV/AIDS prevention as a new way to control blacks and stigmatize them as promiscuous and dangerous. Such thinking has a long history in Africa, dating back to the outbreak of the bubonic plague in 1900, which was used to justify urban segregation in South Africa under the Public Health Act, and in Dakar in 1912. Western experts too frequently fail to recognize the importance of the past and the social and historical roots of African suspicions of AIDS and the West. The disruption of families was commonplace under apartheid and now AIDS appears as an even more catastrophic scourge, “as if nothing ever happened” according to graffiti on a Johannesburg wall. Understanding this history is essential—not to justify or provide reparations for the past—but to suggest interpretations of the present and to effect meaningful change.

The West needs to find new ways to cooperate with African countries, recognizing that conceptualizing AIDS in terms of poverty or biology are not mutually exclusive. Western policymakers need to avoid over-simplifying the epidemic and promote dialogue with African intellectuals and policymakers who face intense national and international constraints and have little domestic support. There is ample room for collaboration. African leaders are thinking about an African “renaissance” and are proposing an African initiative for economic integration. The West should encourage African leaders to grapple with AIDS. After September 11, the United States enjoys new military, moral, and political leadership. It should recognize the sovereignty of African states and the competence of their leaders and use U.S. leadership to promote greater collaboration.

**CHRISTOPHER FOMUNYOH.** Christopher Fomunyoh, senior associate for Africa, National Democratic Institute for International Affairs, stressed that AIDS provides a major challenge to governance. In many African countries, the state is central in formulating health policies and allocating resources at the national level, and is, moreover, the caretaker of last resort for victims. The state also has primary responsibility for determining the environment in which civil society operates and can raise awareness for education and prevention. But many African states lack legitimacy. How positive a role can they play? The South African case highlights the dilemma. Is this case an exception, given that country’s unique history? The governments of Botswana, Senegal, and Uganda have undertaken concrete measures, suggesting that the more legitimate the government, the more likely it is to develop a comprehensive anti-AIDS strategy. In contrast, failed states provide a breeding ground for worsening AIDS crises, while autocratic states remain in denial and have not addressed the problem. Corruption also prevents appropriate resource allocation. Many African leaders have failed in their pedagogic role to explain what needs to be done. Only effective governance and unquestionable democratic legitimacy will enable African states to fight the spread of HIV/AIDS. The United States and France need their African allies to play the lead role but will also need to consider how to integrate this in a program of closer U.S.-French collaboration.

## Discussion

Participants focused on the high incidence of HIV/AIDS among African militaries and the need for African leadership. The military has been an important vector for the disease, particularly when soldiers return to civilian life, and it is therefore crucial to introduce AIDS education within demobilization programs. HIV/AIDS will undoubtedly weaken African armies, and there is a danger that internal conflicts may intensify, while the risk of state-state conflict would diminish. High HIV incidence among militaries has multiple implications, including increased military expenditures, erosion of command structures, and declining troop morale. It is important to consider the context in which militaries are operating. In the Great Lakes, Angola, and Guinea, conflict is very violent and leads to rapid sexual transmission. In peaceful cities with large army bases, the process of transmission is very different, with the power and prestige of soldiers attracting young girls. Soldiers should be designated a high-risk group. The United States and France have both devoted considerable bilateral attention to African militaries—this is a promising area of potential future collaboration. The United States has some modest programs addressing this issue, but the Africa Center for Strategic Studies should begin a dialogue with its French counterpart. The French military, for example, is more deeply involved on the medical front than the United States. Perhaps the U.S. military should devise military-to-military training program on health, modeled after the IMET human rights program.

The HIV/AIDS pandemic has the potential to destabilize governments politically. On the political side, the controversy over AIDS in South Africa has dramatically deflated the legitimacy of the ANC government, and there are other instances of failed leadership looming. Here again, diplomacy can play a key role. On the other hand, Fassin observed, intense debate in South Africa and the diminishing legitimacy of the government are, in fact, signs of burgeoning democracy. Such a debate could not take place in Zimbabwe or the Democratic Republic of Congo. The decentralization of political power in South Africa in 1994 has given provincial governments considerable autonomy, and they may in fact be able to side-step national policy. It is very likely, Fassin predicted, that attitudes among officials in South Africa will change as a result of the democratic process.

Opinions diverged on the importance of popular participation. In West Africa and parts of southern Africa, AIDS and health committees have sprung up with the support of international programs, but they are not necessarily representative of the public and tend to follow the agencies of the state. In South Africa, by contrast, there has been a real civil society mobilization. NGOs are active, campaigning against the drug industry and the South African government's policies. And although they have much greater autonomy than in many countries, we should not exaggerate what these associations can do.

One participant noted that although civil society and NGOs can help raise awareness about the pandemic, the state still has a vital role to play. Only the state can allocate and maximize resources. The fight against HIV/AIDS must be channeled through a country-led process. Existing programs bring together a

consortium of NGOs, but it is vital to foster government support. Public diplomacy is essential in this regard, and the United States and France should emphasize in all their bilateral exchanges with African states that the battle against AIDS is a priority. Currently, the problem drastically exceeds African states' capabilities. But it is essential to secure African leadership and ownership. The West should work to enable African leaders to demonstrate their commitment. U.S.-French collaboration should in fact be a three-way collaboration among the United States, France, and African countries.

## **Luncheon Roundtable: French and U.S. Perspectives on the Global Fund to Fight AIDS, TB, and Malaria**

*Chaired by Helene Gayle, senior adviser on HIV/AIDS, Gates Foundation, and former director of the CDC Center on HIV, STD, and TB Prevention*

**SCOTT EVERTZ.** Scott Evertz, director of the White House Office on National AIDS Policy, said that France and the United States have an opportunity to build a new relationship and need to move forward on a common agenda. U.S. bilateral assistance will continue, and the Global Fund—to which the Bush administration remains firmly committed—will soon be operating. The present U.S. contribution to the fund is only a down payment. Discussions are already beginning on the 2003 budget, and more resources will be provided. Evertz reaffirmed the need to devise a comprehensive prevention, care, and treatment program as soon as possible, and emphasized that prevention is impossible without care and treatment.

**BERNARD KOUCHNER.** Bernard Kouchner, French minister of health, a medical doctor and founder of Médecins sans Frontières, served as the UN administrator in Kosovo from 1999 until January 2001, and has long been a proponent of greater collaboration on health issues. Minister Kouchner began by pointing out that HIV/AIDS is the worst epidemic that the world has ever faced and will have vast human, economic, and strategic consequences. September 11 was a world tragedy and has demonstrated the need to develop a comprehensive approach to the Third World. Although funding in the West has increased, with an emphasis on early-warning systems and bioterrorism, there will nevertheless be a strain on health ministries' budgets.

Among France's top priorities in combating HIV/AIDS in Africa is increasing access to treatment. France has offered access to treatment to several African countries, particularly relatively inexpensive drugs to prevent mother-to-child transmission. It is important, Kouchner emphasized, to provide adequate information to those infected, treat them like human beings, and enable them to take their future into their own hands. The West should recognize that access to care is a key incentive for testing and a key asset for prevention. Research remains an important feature of French efforts, and France is still pushing for the development of a vaccine.

Drugs must be available, and so must properly functioning health care systems. These need not necessarily be the same as those in the West: equity should be a long-term objective, not an immediate imperative, since it is impossible to treat 40 million sufferers in the short term. Improvements in treatment will take time—in France, for example, it took many years before there was universal access to antibiotics. But there is nevertheless a responsibility to address this global issue. France is starting joint projects linking hospitals in France and Africa. This “hospital-twinning” scheme has three complementary aims: (1) to reduce the cost of drugs, (2) to demonstrate financial solidarity in helping to cover the cost of fighting AIDS, TB, and malaria, and (3) to strengthen national health systems in Africa. This twinning strategy is not a complete solution but a tool that will exchange staff and provide training opportunities, equipment, and access to drugs.

France also financially supports the Global Fund. Along with Spain, Italy, Luxembourg, Switzerland, and Portugal, France favors a pragmatic approach and seeks to provide access to antiretrovirals in an effective manner. This means strengthening African health services, hospitals, and clinics, and bringing drugs to the community level in collaboration with local NGOs. France is keenly aware of the dangers of viral resistance. Pilot programs will be developed first to investigate local needs. Community organizations must be involved in the design and implementation of programs before national campaigns are launched. Programs will spur treatment, provide information, and transfer knowledge, technology, and experience. The long-term objective is to improve health care systems, an essential future requirement. The first step is to provide access to care, through a decentralized approach that avoids creating a new bureaucracy.

With regards to the Global Fund, it is vital that not all its funds go to prevention and health care development but that a small part be spent on access to treatment. Perhaps 80 percent could go to infrastructure and prevention and 20 percent to treatment.

It is not a moral failing to treat one person before universal treatment is available. The international community should start work in perhaps 10 countries, improving and expanding the process month by month under African direction. This is not a form of colonial therapy—both the medical and policy direction should be determined by Africans. There will be problems of financial and scientific auditing. The strategy should start in hospitals, as it did in France itself, and issues of financial and scientific oversight should be resolved. If France can begin such a program in 10 countries, in collaboration with the United States, it will give hope to the rest of the world. Information is part of prevention, and the program offers a window of hope and access to treatment, even if it is not immediately available to everyone.

## Discussion

Helene Gayle observed that both France and the United States wanted to see the Global Fund operating soon and are seeking to link care with prevention. But are we were expecting too much of the fund? What would constitute success?

Minister Kouchner replied that there are always difficulties at the beginning of a big project. Certainly, there are many problems surrounding the fund, and debates over its structure and leadership will persist. But if the United States and France are willing to work together, there is a strong likelihood of success. The concept of the Global Fund is completely new. In the 1950s the World Health Organization (WHO) launched the global fight against smallpox, and all countries have faced serious plague epidemics before appropriate drugs were available. But now, there are no real technical limits—only financial limits. Kouchner observed that he was pleased by the French response to the Global Fund, which has demonstrated a global concern for all people in the world. A new concept is emerging of “patients without borders,” an ideal perhaps not achievable today but the day after tomorrow.

One participant raised the case of Haiti, which has been sorely neglected in international AIDS efforts. Overall, Haiti’s HIV prevalence rate is 5 percent, but in some regions it is as high as 25 percent, and among pregnant women some studies suggest a rate of 40 percent. Nevertheless, USAID funds to Haiti are being cut by 50 percent because the United States is at odds with the Haitian government. The United States should recognize the severity of Haiti’s HIV/AIDS problem and demonstrate a new commitment to that country. Dr. Gayle observed that USAID and CDC had contemplated intervening with additional resources in Haiti as part of the CDC’s Global AIDS Program. Haiti would be a good candidate for Franco-American collaboration. The CDC will launch an HIV Preventive Care Program soon, but the Haitian Ministry of Health is not a credible partner. The program will promote surveillance, voluntary counseling and testing, and studies of mother-child transmission. Haiti’s health system, however, is in a very weak state, and we must consider what structures are needed to mount an effective response.

Minister Kouchner emphasized that Third World societies do not need the same health care structures as exist in the West, merely a minimum commitment of cooperation. Huge hospitals are not required, but political involvement most definitely is. Kouchner, who has undertaken some 20 missions to Haiti, described it as practically hopeless, close to impossible, and one of the most difficult places to work. However, the Harvard School of Public Health has demonstrated that even without doctors it is possible to provide basic clinical treatment to Haitians. Of the 500 French hospitals that have volunteered to twin with Third World institutions, of which 40 were selected by the French Health Ministry, two have chosen to work in Haiti. Hope is not a prerequisite for action.

Stephen Morrison supported the idea of the hospital twinning project. It had high potential for building domestic support in the United States, but the U.S. system was less unified and less interested in international issues than France and at present is preoccupied by bioterrorism and homeland defense. Americans will require proof that the twinning model can be made to work.

Kouchner considered that a new pharmaceutical market for antibioterrorism drugs was developing. Anthony Fauci, director of the National Institute for

Allergy and Infectious Diseases at the National Institutes of Health, has offered to collaborate on bioterrorism and HIV/AIDS. U.S.-French collaboration could reduce the price of antibiotics. Bioterrorism is a new threat, and so more money is now available. The events of September 11 did not make us weaker but rather stronger and better prepared to answer bioattacks. We must work together against bioterrorism and pool our experience to provide for the poor with HIV/AIDS.

One participant raised the issue of drug procurement by the Global Fund and access to generic drugs. Scott Evertz acknowledged that drug procurement is one area of potential collaboration, but it is not clear “how quickly we can get there.” Generic drugs and pricing are still under discussion. The price of antibiotics has fallen rapidly, and the same might happen to AIDS drugs. France and the United States are in broad agreement, Minister Kouchner suggested. The 15 countries of the European Union have agreed to work together to reduce the price for drugs, and a joint approach with the United States will reduce prices even further. This is an historic step, the first emergence of a public health issue that is not included in the European Treaty. This agreement on research, management, and procurement, however, is “only the whisper of a beginning.”

### **Panel III: Opportunities for U.S.-French Programmatic Collaboration**

*Chaired by J. Stephen Morrison, director, CSIS Africa Program and HIV/AIDS Task Force*

**PAUL DELAY.** Paul Delay, chief of the HIV/AIDS Division of USAID, noted that despite the higher profile of his office it still only has a staff of 13. Nevertheless, it is the leading arm for U.S. bilateral assistance to 50 countries, with a priority focus on 20. USAID’s development perspective both enhances and limits its responses. It is concerned with cost-effective public health strategies aimed at helping large numbers of people. Its prevention activities are often relatively simple: supporting child survival through immunization programs, the provision of Vitamin A, bed nets to combat malaria, and oral rehydration salts for diarrhea. Its normal expenditure per treatment ranges from 25 cents to \$300 for TB therapy.

HIV/AIDS has multiple dimensions and synergies. It requires a comprehensive response, including prevention, care, treatment, and provision for the care of orphans. Care and treatment cannot be neglected, and should be part of a continuum with prevention. They enhance prevention, reduce the stigma of the disease, prolong parenthood, and lessen the risk of a secondary TB pandemic. Treatment, however, won’t stop the pandemic. It is clear from the experience of the United States, France, and Brazil that treatment alone does not retard the spread of the disease. Successful treatment, moreover, can encourage complacency: same-sex transmission has doubled in the last three years. We should develop common targets, aiming to reduce the incidence of HIV among 15–24 year olds by 50 percent in high-prevalence countries by 2007 and to maintain it below 1 percent in low-prevalence countries. USAID aims to ensure that 25 percent of HIV-infected mothers have access to interventions, to provide

basic care to 25 percent, and support 25 percent of those affected. Prevention measures include steps to improve blood safety, to reduce the stigma of the disease, and to market condoms. Care and mitigation measures include psychosocial support and care for AIDS orphans. It is essential to collaborate against AIDS, even more than in earlier campaigns against smallpox and polio.

Programmatic collaboration among donors, however, remains elusive. Donors do not focus on specific responses, and in effect, all bilateral donors try to do everything, with little consideration for concentration or comparative advantage. As a result, it is difficult to develop complementary activities. There is, for example, a considerable overlap between the work of USAID and the CDC. Donors, moreover, have different policies. The United States is unenthusiastic about the provision of antiretrovirals. They have different geographic concentrations, which make it even more difficult to synchronize. The United States and the World Bank, for example, have attempted to collaborate on sexually transmitted diseases, but delays in procurement have rendered training useless. There is a lack of systems for collaboration even in specific countries, let alone globally. Collaboration requires a dedicated staff, determined to make it work. The Global Fund may produce more effective structures, but equally it might make matters worse. We should all recognize, however, that we will fail if we do not make collaboration work. In five years' time the world's attention will have turned elsewhere.

**STEFAN WIKTOR.** Stefan Wiktor, chief of the Surveillance and Infrastructure Development Branch, Global AIDS Program, Centers for Disease Control and Prevention, also stressed the need for successful collaboration. He pointed to the CDC's Global AIDS Program that began two years ago. There are now programs in 24 countries, with a total U.S. staff of 40. This has been a new direction for the CDC—the first time that it has directly implemented its own program, starting from the ground floor. Two principles have been learned. First, each program needs to be designed to meet the individual country's needs and has to be decentralized in order to work with the local government and other donors. Second, the programs have to be synergistic and collaborative, bringing together donors and local governments at four levels:

- ◆ At the in-country level, there is a need for collaboration between staff with common approaches. The CDC and Britain's Department for International Development (DFID) have worked well with Nigerians in a sero-prevalence survey. In Côte d'Ivoire there is close collaboration between the CDC, USAID, and Ivoiriens.
- ◆ At the international level, staff should be assigned to international organizations, such as UNICEF, UNAIDS, and WHO in order to devise a common approach on such issues as antiretrovirals.
- ◆ On research, closer collaboration is required between the CDC and ANRS. Such collaboration has not, to date, really developed.

- ◆ Finally, there needs to be dialogue and close consultations between governments as they devise policies to combat AIDS.

Wiktor judged that the research and government policy levels were the most difficult. Discussing his own experience in Abidjan, he observed that the CDC's research facility in Côte d'Ivoire has been primarily concerned with research and is only now beginning to develop programs. Collaboration has not been particularly successful, and the French and U.S. teams have run parallel research projects. This has had certain benefits, but closer collaboration at the development stage would have produced better results. Collaboration, Wiktor argued, cannot be developed in the field—the focus is too narrow and the sense of ownership too great. Different funding cycles and administrative barriers impose further obstacles. Research collaboration has to be worked out at the agency level and common projects devised. Research collaboration nevertheless shows some signs of improvement. There is common work on vaccine development and on policies in the Côte d'Ivoire, and the International Therapeutic Solidarity Fund has been inaugurated in Abidjan.

Programmatic collaboration is easier than joint research. Issues of ownership are less intense, but, as with research collaboration, to be successful cooperation needs to be facilitated and encouraged at a higher level.

The United States and France should develop collaboration on research, ethics, access to treatment, and large-scale trials, as well as programs. Many unanswered questions remain on such issues as mother-child transmission. Franco-American collaboration on vaccine research and testing would be useful, as would a common platform for operational research on HIV interventions.

**ANNE DUX.** Anne Dux, senior adviser to the minister for cooperation, French Ministry of Foreign Affairs, lamented that discussions on cooperation stopped a year ago. French overseas development spending was \$4.22 billion in 2000 or 0.33 percent of French GNP. France has 71 priority zones of collaboration, centered on Africa, the Middle East, and Indochina. The strategic guidelines for projects and programs seek to formulate a comprehensive approach, providing information, prevention, care, support, and treatment. This integrated strategy combines extra-medical work on social and cultural questions, by fostering respect for those who are HIV-infected and promoting local centers to help those with AIDS, especially homosexuals and prostitutes. Second, it seeks to work with NGOs and the infected in devising programs; to provide access to antiretrovirals; to promote research in north-south partnerships; and to consolidate achievements by improving the general health structure.

France currently has bilateral programs in 28 countries and is sponsoring 45 projects, designed to fit into national programs. Projects include the development of anonymous testing, strengthening the care capacity of countries in advance of the provision of antiretrovirals, supporting community organizations, providing psychosocial support and treatment assistance and, through French contributions to the European Development Fund, providing out-patient care in alliance with local health clinics, centers, and hospitals.

Multicountry projects also seek to strengthen local NGOs and south-south collaboration. France is supporting 50 associations in 16 countries and various integrated projects, such as the International Therapeutic Solidarity Fund, launched in Abidjan in 1997. France is working with the French and Kenyan Red Cross Associations and Médecins sans Frontières programs in three East African countries, aiming to transfer international technologies to local NGOs over a three-year period. Research on prevention and mother-to-child transmission is underway in the Côte d'Ivoire and South Africa, and antiretroviral treatment programs in Senegal, Côte d'Ivoire, Benin, and Morocco. France also supports multilateral projects through the European Union Program Act as part of its commitment to poverty reduction from 2001 to 2006 and sponsors UNAIDS international partnership against AIDS in Africa.

Some 350 health technical assistants, two-thirds of them working on AIDS, are currently on the ground in Africa. France would like to expand its hospital networking as part of its contribution to the Global Fund. It is working through the International Labor Organization to sponsor prevention programs, is helping French companies provide treatment, and is targeting AIDS in the workplace and in education by working with UNESCO to mobilize teachers in the fight against the disease.

Franco-American collaboration in the past has encountered problems, but both countries can collaborate more closely on research and care in developing countries. The United States and France should also collaborate at the political level to improve the UN system. The two countries, however, have different procedures and financial cycles, and France places more emphasis on treatment, while the United States emphasizes prevention. France has attempted to raise the consciousness of its embassies, and EU ambassadors meet once a month to discuss the issue, but as yet, no concrete proposals have emerged.

**PETER LAMPTEY.** Peter Lamptey, executive vice president and chief operating officer, HIV/AIDS Prevention and Care Programs, Family Health International, outlined the work that his organization was undertaking in 50 countries at a cost of approximately \$500,000 per country. None of these programs provides antiretroviral drugs. U.S.-French collaboration can have a much more comprehensive impact. The implementing agencies at country level, financed by France and the United States, should share more information about their policies, strategies, priorities, programs, and partnerships. Guidelines for collaboration are needed at all levels. Joint funding and strategies can be developed in selected countries. Nepal provides a model of collaboration, employing Family Health International to manage all programs and strategies. But drastic changes are needed in donor culture from thinking about "our money" and "our programs" to emphasizing the needs of the target countries. All donors need to change their attitudes and collaborate with each other, with international partners, and with local organizations.

## Discussion

There was some debate on how to foster greater programmatic collaboration. According to some participants, higher-level incentives may be helpful in pushing greater in-country collaboration ahead. Others argued that collaboration can only be established by individuals rather than by instructions from the top. Another view was that instead of mandating collaboration or waiting for spontaneous collaboration to develop, it might be possible to establish structures to encourage long-term collaboration. In Abidjan, the CDC has worked with Belgium's Institute for Tropical Medicine on sexually transmitted diseases, and they have also undertaken collaborative work in the Democratic Republic of Congo. They had prepared a memorandum of agreement between the two institutions to allow personal and grass-roots collaboration. Also in Côte d'Ivoire, there is close collaboration between the CDC, local organizations, and the Ivoirien Ministry of Health. Several Health Ministry employees work in the CDC-supported laboratory, and research protocols have all been approved by the ministry. Such collaboration is essential to meet the priorities of the host government.

The Global Fund may enhance collaboration since cofunding requires built-in collaboration. On the other hand, although cofunding does force collaboration, it is difficult to track finances and apportion accountability. The Global Fund may provide a means to get around that, but more weight should be given to public-private collaboration in-country across the three diseases. Perhaps a way should be found to enable USAID to cofund projects. France has cofunded projects with the UN but never with a foreign agency. It may be possible to strengthen UNAIDS and similar organizations. Ted Turner's \$1-billion donation, for example, is intended to encourage UN agencies to work more closely together, promoting greater collaboration within the UN family. Both parallel and cofunding initiatives are welcome. Another possible venue for greater collaboration is through regional bodies like the Common Market for East and Southern Africa (COMESA) and the Southern African Development Community (SADC).

The costs of failing to work together will never be known—for example, how many parallel or redundant programs will be financed. Ambassadors possess a certain leeway and should be encouraged to sponsor greater collaboration. But currently such collaboration is not a high priority on either side.

## Panel IV: Scientific Research

*Chaired by Philip Gordon, director, Brookings Institution Center on the United States and France*

**ANTHONY FAUCI.** Anthony Fauci, director of the National Institute for Allergy and Infectious Disease, National Institutes of Health, outlined U.S. spending on HIV/AIDS. Efforts to fight the pandemic in 2002 will receive \$2.5 billion or 12 percent of the total NIH budget (some 52 percent of the spending on allergy and infectious diseases), compared to 0 in 1982. Some \$26.1 million (1 percent) of

this is to be spent on Africa. Spending on international AIDS has grown dramatically since 1988 and in 2002 will amount to \$154.1 million on direct projects under the Global AIDS Research Plan. NIH is undertaking work in 845 sites, of which 108 are in Africa (in 30 countries), promoting both training and research. The Comprehensive International Program of Research on AIDS (CIPRA) is implementing a comprehensive prevention and treatment agenda and is seeking to enhance local health infrastructures that can be sustained in the long term. It will emulate the very successful malaria research center in Bamako. Nevirapine is being used in trials in Uganda and seven vaccine/prevention trials are already underway, with two more due to start soon. Work is also being conducted on infrastructure development for vaccine trials in South Africa, Malawi, Tanzania, Uganda, Zambia, and Zimbabwe, and immunology laboratories are being established in Uganda and South Africa.

NIH is planning talks with French colleagues on the treatment of people with AIDS. Antiretroviral drugs have been approved, but problems remain over their availability and the use of generic drugs. AZT, for example, costs \$12,000 per patient per annum and in the United States has resulted in a fall in the number of AIDS deaths. Questions, nevertheless, remain over such issues as the quality of life, toxicities, viral reservoirs, the emergence of resistance, and about the cost and right to access. It is vital to devise research programs on a country-to-country and scientist-to-scientist basis to develop screening techniques, therapies, and research on toxicities and the effects of antiretroviral treatments on other diseases and on those suffering from malnutrition.

Therapy has to be associated with prevention and with existing infrastructures to combat malaria and TB. Work is required to improve the health infrastructure, and to train health workers in HIV-testing, but programs must have substance, providing value to the country where the research is being undertaken, have local support, and be sustainable. NIH also considers ethical requirements, including the value and scientific validity of the research, fair subject selection, the risk-benefit ratio, the need for independent review procedures, and consent and respect for the enrolled subjects. The United States is focusing on mother-to-child transmission, behavioral modification, and vaccine research, on which \$356.6 million will be spent in 2002. Basic research requires clinical evaluation and the implementation of field tests in close collaboration with pharmaceutical companies. Trials on monkeys have demonstrated nonprogression of the disease and a lower viral load.

NIH is collaborating with French researchers in the Central African Republic, Senegal, Cameroon, and Gabon, and is working directly with the French National Agency for AIDS Research (ANRS) and the Institut Pasteur on the clinical development of candidate vaccines; there are numerous opportunities for additional research. Both the NIH and the Institut Pasteur have extensive networks in Africa and could collaborate on and coordinate projects.

**MICHEL KAZATCHKINE.** Michel Kazatchkine, director of ANRS, outlined its \$45-million budget in 2001 (this excludes salaries, amounting to approximately

another \$100 million) for research on preventive vaccines. He observed that France and the United States are far from realizing the full potential of collaboration. Collaboration, however, should be not simply between French and U.S. scientists, but must include African colleagues.

More work is also required on sociobehavioral issues and on the economic impact of AIDS in the developing world. ANRS is sponsoring 61 projects in 20 countries (49 of which are in Africa) and 15 multisite programs. Twelve new projects have been approved as of November 2001. These cost \$6.5 million per annum or \$15 million including salaries. The main projects are in Abidjan, Dakar, Bobo-Dioulasso (where it is sponsoring women's NGOs), Ho Chi Minh City, Phnom Penh, and Rio de Janeiro. Research is underway in Burundi, Cameroon, Chile, the Central African Republic, Congo, Egypt, Gabon, Haiti, and India, among other countries. The research involves multidisciplinary partnerships with in-country investigators and includes both clinical tests and sociobehavioral investigations. The programs also aim to improve the knowledge and capacity of local laboratories, to improve the host countries' clinical capabilities, and to train African researchers.

It is vital to ensure the full participation of the host country and to integrate research and implementation; the Ministry of Cooperation and France's overseas embassies play an important role. The programs involve a two-year consultative process, during which the ethical issues involved are considered. They are reviewed by scientific peer groups in the target country. The committees are fully independent and carefully scrutinize the projects. All programs are reviewed by these local committees, not by a French ethical committee.

In Abidjan, ANRS is undertaking peripartum interventions to enhance the prevention of mother-to-child transmission; postpartum interventions discouraging breast-feeding; following children from mothers who have received antiretroviral treatment; long-term follow-up of cotrinnoxazole trials; and a random cohort of exposed infected women (in collaboration with the CDC); encouraging changes in behavior, sexuality and attitudes to breast-feeding; a pre-vaccinal behavior cohort; and evaluating the UNAIDS drug access initiative (with the CDC in Côte d'Ivoire) and antiretroviral implementation.

ANRS has also undertaken studies of clinical antiretroviral therapy in Africa. It is vital to learn the best regimen to provide the infrastructure for local health-care delivery. In Dakar, several hundred patients are involved in tests as part of a program to devise low-cost alternative techniques for monitoring the therapy. Work is underway in Burkina Faso, Côte d'Ivoire, Mali, Senegal, and Togo to devise alternative techniques to cytofluorometry (an automated separation and analysis technique for cells or chromosomes of specific fluorescent markers) for the enumeration of CD4+ and plasma viral load. ANRS is also investigating the cost of intervention with antiretrovirals in Brazil and is monitoring the prices of antiretrovirals in Africa (in collaboration with UNAIDS) to investigate price determinants. It is also undertaking an economic evaluation of UNAIDS Drugs Access Initiative in the Côte d'Ivoire and of antiretroviral treatment in Senegal.

ANRS's West African laboratories are testing the molecular epidemiology of HIV. ANRS is also sponsoring behavioral studies and vaccine trials in Abidjan, Rio de Janeiro, and Phnom Penh. Phases I and II of the trials will start in the last quarter of 2002. International cooperation will be required for Phase III. So far there has been little discussion of the criteria required to move to Phase III trials. There will be many possible candidates in five years time, and this will be a key area for U.S.-French collaboration in Africa.

Kazatchkine encouraged further exchanges of French and U.S. researchers and called for joint clinical trials, as well as improved on-site collaboration in Abidjan, Dakar, and Phnom Penh, where the opportunities for collaboration are unrealized. ANRS and NIH may hold joint Phase I and Phase II vaccine trials through the HIV Vaccine Trials Network and ANRS, replacing a culture of competition with one of collaboration in preparation for Phase III trials of preventive vaccines. He emphasized the need for a plan for joint studies at interagency levels in advance of such Phase III trials.

**LUC MONTAGNIER.** Luc Montagnier, head of the Department of AIDS and Retroviruses, Institut Pasteur, and president of the World Foundation for AIDS Research and Prevention, stressed the importance of basic research where a great deal more work is required. AIDS is a very complex disease with no cure. The World Foundation for AIDS Research and Prevention is fostering research centers in Africa. Montagnier emphasized the importance of integrating prevention, education, research, and treatment. Pilot centers should be developed and the model extended through Franco-American collaboration. Antiretroviral treatment was necessary for Africans, but it would not be sufficient. It will help restore the immune system after six months, reduce the viral load, and perhaps enable vaccination against the virus. Antioxidants could restore the immune system, and therefore we should aim at short, aggressive, antiretroviral treatments, which should be followed with more accessible treatments. It is also vital to improve the follow-up structure for patients in Africa, which must be done with the full collaboration of African governments and researchers.

**KASSIM SIDIBE.** Kassim Sidibe, epidemic intelligence service officer, Centers for Disease Control and Prevention, and former director of the National AIDS Control Program in Côte d'Ivoire, described the HIV research that has been underway in the Côte d'Ivoire for the past 15 years. It began with descriptive studies to determine the importance and dynamic of the epidemic. Then, in collaboration with the CDC, moved over the last five years to clinical trials on mother-to-child transmission among hospitalized pregnant women and outpatients with TB. Both France and the United States have played a leading role in AIDS research in the Côte d'Ivoire.

Studies are underway on the prevention of opportunistic infections, such as TB, and syndromic treatments of sexually transmitted diseases, and the prevention of mother-to-child transmission using antiretrovirals. A simplified regimen has worked best, requiring interventions on a limited scale. It must be remembered, however, that the research environment is very different from the health care

environment. The core study has involved 200 women and 3 physicians and nurses, whereas overall in Côte d'Ivoire there is only 1 physician for every 5,000 women. Trained personnel are in short supply, and health care facilities, as elsewhere in Africa, are in poor condition. The country has a very weak health infrastructure, and it is impossible directly to implement research findings. Strategies should be developed to implement existing interventions, not new research, and to achieve a minimum upgrade of the present health care system.

### Discussion

One participant noted that the World AIDS Foundation provides an implementation tool and a useful model for the Global Fund. The foundation provides small amounts of money to address implementation problems and training. It has, in fact, trained significant numbers of investigators. It is vital to target the development of research infrastructures in developing countries. Researchers are good at molecular biology but are less successful at scaling up programs for implementation, although it is important to link research with implementation. Research should not delay action on implementation, but implementation must also be carefully evaluated.

One participant questioned the criteria employed for competitive proposals for prevention and vaccine research. Most involve collaboration with U.S. institutions and are limited to five years. Longer-term projects, lasting 20 to 50 years, are required. The Comprehensive International Program for Research on AIDS must address the problem of sustainability. It is important to provide support to host institutions, including ministries of health, to sustain research and to train health care staff through cost-effective interventions in the local setting, and to devise strategies for sustained operational research.

## Conference Agenda

### France and the United States: Strengthening Collaboration on HIV/AIDS in Africa

A conference organized by the  
Center for Strategic and International Studies and the  
Brookings Institution Center on the United States and France  
funded by the  
German Marshall Fund of the United States

Brookings Institution  
1775 Massachusetts Avenue, N.W.  
Washington, D.C.

December 3, 2001

#### *Conference chairs*

Richard Holbrooke, Counselor, Council on Foreign Relations  
Helene Gayle, Senior Adviser for HIV/AIDS, Bill and Melinda Gates Foundation

#### *Welcoming remarks*

8:45 a.m.–9:00 a.m.

Richard Holbrooke, Counselor, Council on Foreign Relations  
J. Stephen Morrison, Director, CSIS Africa Program  
Philip Gordon, Director, Brookings Institution Center on the United States and  
France

#### *Panel I: Global Issues: The Importance of AIDS in U.S. and French Foreign Policy*

9:00 a.m.–10:30 a.m.

Paula Dobriansky, Undersecretary of State for Global Affairs, U.S. Department of  
State

Michel Foucher, Director of Policy Planning, French Ministry of Foreign Affairs  
Discussant: George Moose, Senior Fellow, Ralph Bunche International Affairs  
Center, Howard University; formerly U.S. Representative to the European  
Office of the United Nations and Assistant Secretary for African Affairs

10:30 a.m.–10:45 a.m. Break

*Panel II: Comparative Perspectives on the Stability Implications of AIDS in Africa*

10:45 a.m.–12:15 p.m.

David Gordon, National Intelligence Officer for Economics and Global Issues,  
National Intelligence Council

Didier Fassin, Professor, University of Paris XIII

Discussant: Chris Fomunyoh, Senior Associate for Africa, National Democratic  
Institute for International Affairs

12:15 p.m.–12:30 p.m. Break

*Luncheon Roundtable: French and U.S. Perspectives on the Global Fund to Fight AIDS, TB, and Malaria*

12:30 p.m.–2:00 p.m.

Bernard Kouchner, French Minister of Health

Scott Evertz, Director, White House Office on National AIDS policy

*Panel III: Programmatic Collaboration*

2:00 p.m.–3:15 p.m.

Paul Delay, Chief, HIV/AIDS Division, U.S. Agency for International  
Development

Stefan Wiktor, Chief, Surveillance and Infrastructure Development Branch,  
Global AIDS Program, Centers for Disease Control and Prevention

Anne Dux, Senior Adviser to the Minister for Cooperation, French Ministry of  
Foreign Affairs

Discussant: Dr. Peter Lamptey, Executive Vice President/COO, HIV/AIDS  
Prevention and Care Programs, Family Health International

3:15 p.m.–3:30 p.m. Break

*Panel IV: Scientific Research*

3:30 p.m.–4:45 p.m.

Anthony Fauci, Director, National Institute for Allergy and Infectious Disease,  
National Institutes of Health

Michel Kazatchkine, Director, French National Agency for AIDS Research

Discussants: Luc Montagnier, Head, Department of AIDS and Retroviruses,  
Institut Pasteur, and President, World Foundation for AIDS Research and  
Prevention; and Kassim Sidibe, Epidemic Intelligence Service Officer,  
Centers for Disease Control and Prevention, and former Director of the  
National AIDS Control Program, Côte d'Ivoire

4:45 p.m.–5:00 p.m. Wrap up

J. Stephen Morrison, Director, CSIS Africa Program

Philip Gordon, Director, Brookings Institution Center on the United States and  
France