The HIV War in Africa
How the battle was fought
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Background

- Alma Ata declaration in 1978
  - Health inequalities are unacceptable
  - Right/duty of people to participate in health care
  - Multi-sector participation
  - Relies on health workers
  - Better use of resources
  - Cultural sensitivity
The discovery of AIDS

- Homosexuals in San Francisco - 1981
- Bila Kapita in Kinshasa recognized symptoms in Kaposi Sarcoma in 1975
- African cases seen in France and Belgium
- Montagnier discovered HIV in 1983
Early responses: observations

- McCormick, Piot and others went to Kinshasa
- In November ’83 held a meeting at Mama Yemo to discuss doom and gloom after analysis of 38 patients
- Too much media hype, for 4 years stopped by Mobutu>Projet SIDA led by Jonathan Mann
The spread of HIV

- Bangui: multiple partners, cases seen in 1982 and confirmed in 1983
- Brazzaville: similar to Kinshasa
- Spread via the Lake Victoria basin to Rwanda and Burundi (TB)
- West of Lake Victoria into Uganda and Tanzania
- Kenya: Mombassa, Nairobi, Nyanza
The spread of HIV - south

- Northern Malawi - Karonga district (bordering Tanzania and Zambia)
- Livingstone: Zambia’s border (Sth) with Zimbabwe
- Manicaland: Zambia’s eastern border with Botswana
- ZM: Beitbrigde >RSA and Mutare> Mozambique
The spread of HIV - West

- More gradual and less complete than EAST and SOUTH: mainly HIV-2
- Cote d’Ivoire: HIV-1 met HIV-2
- Spread westward towards Senegal (limited epidemic) and eastward to Nigeria (delayed epidemic)
Early responses: Bangui criteria

- Initial test results comforted the opinion with high false sero-prevalence rates.
- Since tests were expensive, there were special clinical criteria: Bangui criteria, thus most Africans were infected.
- Women equally as infected as men-heterosexual transmission.
Early responses: Discrimination

- Homosexuals
- Haemophiliacs
- Haitians,
- HAfricans,
  - Thus
- Rejection by African governments almost “en bloc”.
Global Responses 1

- Based on the Western response model designed to counter epidemics in stigmatised but articulate minorities of homosexuals and injecting drug users
- Design: avoid discrimination, abandon high risk behaviour, collaborate in caring for the infected, educate the wider public to avoid infection
Global responses-2

- WHO was slow to respond to the HIV epidemic leaving the rich countries to do their thing
  - In Nov 1983, its priorities were safeguarding blood supplies and alerting homosexuals, its priority being PHC
- Mahler: AIDS obscured Africa’s real problems, malaria etc., and HFA
Global Response: 3

- Jan 1986: EB “AIDS is becoming a major public health concern” and urged the DG to “cooperate with member states in the development of national programmes”
- March 1986 AFRO to states: start NAC, epidemiological assessment, surveillance, expand lab and start public education programme.
Global response - 4

- May 1986 - WHA urged the creation of a body for WHO’s assistance
- Creation of a Special (later, Global) Programme on AIDS headed by J Mann
- GPA objectives: screen blood, train staff, public education, combat discrimination
GPA- Jonathan Mann

- 1986-1990: by June 1988, 151 countries had sought WHO assistance, 106 had short term plans
- MTP: more representative NAC, sentinel surveillance and high risk approach - condoms to CSW
- Budget: 0 in 1986; 30m 1987; 82m 1990
- 1991: funding slumped for the first time, Mann had left
GPA- 1991-1996

- Merson new director
- Whole structure of GPA under attack, NAC hardly met, in 1995 USAID channelled 87% of its funds to Kenya thru NGOs
- Period of deepest disillusionment
- Creation of UNAIDS in 1996
UNAIDS

• Joint United Nations Programme on AIDS
• Coordination of international action against the epidemic in January 2006
• AIDS to be seen as a multi-sectoral development problem
• People’s vulnerability has social and economic roots often including marginalisation, poverty and women’s subordinate status
• Impact of UNAIDS
When all think alike, no one is thinking very much.

Walter Lippmann
National Responses-1

- Slow to grasp the scale of the crisis: weak regimes, more immediate problems, threat to national dignity
- When they did eventually react, strategies were ill adapted to their contexts
- Battled with freedom of PLHIV/AIDS: to quarantine or not to quarantine (Moi)
- Public denial (Mobutu)
National responses-2

- Most positive responses were from Uganda, “To not be open about AIDS is just ignorant”, Museveni and Senegal (Abdou Diouf)
- ZIM: first 3rd world country to adopt a policy to screen all blood before transfusion in 1985
- NAC in all countries following GPA plans
National responses-3

- Most successful in Senegal and Uganda
- Senegal: prevented a generalised epidemic, prevalence < 1%, good STD control, CSW registered, male circumcision universal
- Uganda: Frank admission of scale of problem in 1986, proper funding 20m USD, health education, school syllabus 1987, blood screening, care, condom use?, surveillance, epi research
National responses-4

• Late programmes: Gambia 1992, Chad 1994
• Interrupted programmes: Nigeria, Ethiopia - civil conflicts or military interventions
• Delays between plans: Botswana (4 years)
• Lack of political will: Tanzania
• Discontinuity in directors: Cameroon (8 between ’85&’99)
National responses - 5

- Policy failure: Nigeria (no funding because oil rich)
- Bottoms up policy: RSA, once legalised in Feb. 1990, the ANC organised a conference in April in Maputo > National AIDS Convention of SA formed in 1992 to draft a national strategy. Plan of July 1994 cost 256 m vs. 31-36 currently. Appended was the real PHC approach plan: prevention, health system & discrimination
National responses- 5

- Compulsory testing: health delivery staff were divided on the issue since they worked under non-protective conditions; the policies of VCT meant that people needed to know their status to benefit from help.
Never mistake motion for action.

Ernest Hemingway
Local reactions to programs 1

- Too late to change course of the epidemic
- No effective drugs, or vaccines
- Difficulty understanding transmission of the virus
- Blame others: prostitutes, homosexuals, blacks etc.
- Fear of the unknown
Local reactions to programs 2

- Denials: Fela Ransome Kuti who died of AIDS in 1997
- Absence of sense of personal risk
- Less willing to be tested because of fatality
- Domestic violence
- Desperation among infected and affected
Local reactions to programs-3

• Africa has a cure!:  
  - Traditional healers: Kofi Drobo II (Ghana) claimed to have treated 60 patients; Yawanina Nanyonga (Uganda) therapeutic mud  
  - Prayers: Deo Balabyekubo (Kampala), Prophet Temitope Balogun Joshua (Lagos) heals hundreds of patients every Wednesday
Local reactions to programs-4

• Biomedicine:
  - MM1- Egypt and DR Congo
  - Mariandina- Uganda
  - Vahnivax- Cameroon
  - Kemron, Pearl Omega-Kenya
  - AKB- Tanzania
  - Herbiron-Tisaferon- Zambia
  - Virodene- RSA
  - Vaccine: Jeremiah Abalaka, Nigeria- cured >900
Local reactions to programs-5

• The causation of disease:
  – Biomedical view: the HIV
  – Moralistic view: focuses on why the epidemic occurred attributed to witchcraft, customs (wife inheritance) or to human immorality. Muslims and the Catholics oppose the use of the condom, life skills; “western” doctors oppose the recognition of traditional healers
Local reaction to programs-6

- NGOs and care
  - Proliferation, 600 in Uganda by ’92, >2000 by 2003
  - TASO, 1987, first indigenous NGO in Africa: Noerine Kaleeba & Elly Katabira, teach them “live positively”
  - Senegal: 1995, National HIV/AIDS Alliance
  - Zambia: Copperbelt Health Education Project CHEP
NGO’s

- NACWOLA - National Community of Women Living with AIDS - Beatrice Were
- SWAA (1988, Stockholm) - national networks
- Women, youths, CSW, carers, micro-credit
If you are going through hell, keep going.

Sir Winston Churchill
AIDS a chronic disease

- Beyond shame
- Deterioration of the social “safety net”
- From ambulatory to home based care- TASO to community-based home-care programmes, see WAMATATA in Tanzania, Catholic AIDS Action in Namibia- later in francophone countries
- Problems with acute pain
- ARVs
Antiretrovirals-1

• AZT, azidothymidine, 1964 to stop cancer cells replicating but too many side effects (Burroughs Wellcome)
• Tested in 1985 and licensed in 1991 at $3,000: absolute barrier
• 1994: AZT useful in PMTCT, by 68% ($1,000 per case), and given in the last month reduced by 51%.
• RT inhibitor Nevirapine, tried in Uganda in 1999 reduced MTCT by 48% at $4 per case of the drug.
Antiretrovirals-2

- MTCT-Nevirapine had side effects, did not combine well with TB drugs, rapidly provoked resistant mutations: however came to be widely used in poor countries
- What about the mothers?
- 1999: BOT started a nationwide PMTCT with AZT, 34% in 2002, Uganda, only 5% in 2002
- In 2003: only 10% cover in AFRO
Antiretrovirals-3

• RSA - conflict in the use of ARV. Vancouver 1996 results and local research and 75% reduction of AZT costs did not convince government. Stopped trial sites in Oct 1998.
• Role of NAPWA and TAC
• March 2001- Pretoria High Court ruled in favour of MTCT to all
• March 2003: most provinces were complying
Antiretrovirals-4

- 1996: discovery of protease inhibitors and use in HAART
- 1998: Geneva conference-proof of effectiveness
- 2001: Cipla, an Indian generic company offered to sell triple therapy at $350 per person per year. Simplification of regimen
- June 2001: Special Session of UN General Assembly created GFATM, the Global Fund- 10bn
- Jan 2003: PEPFAR- 15 bn/ 5 y
- 2004: 550 m/y for vaccine
Antiretrovirals-5

• Barcelona conference in July 2002: WHO 3 by 5 campaign
• Needed to be preceded by VCT (vs. mandatory - Brigadier David Chiweza in Zimbabwe)
• Jan 2002: BOT: Africa’s first national ARV project - AIDS isn’t me!
• Sept 2004: Uganda treating some 40% of those needing it! - preparation, delegation, Infectious Diseases Institute
• Nigeria, RSA, etc
AIDS Vaccine-1

- 1984: estimated at 2 years
- 1991: Montagnier – 5 years
- 2001: J Cohen- “one of the most formidable challenges ever assigned to health sciences”

Problems
- Effective immune response
- Speed of mutation of virus
- Many viral subtypes
AIDS Vaccine-2

- No animal model
- Little incentive to invest in the developed world
- 1999: Uganda conducted first trial to demonstrate feasibility-RD Mugerwa, P Kaleebu and others BMJ
- 2003: RSA initial trials
- 2004: Kenya trial-ineffectiveness of vaccine
- 2004: 30 candidates no promise, 22 still on trial
African Aids Vaccine Program

- Nairobi- 14 June 2000: Nairobi declaration: An African appeal for an Aids vaccine
- Third AAVP forum- 2005
- Milestones:
  - 2004: candidate vaccines
  - 2006: at least one ph III start
  - 2007: specific plans
  - 2009: at least one ph III completed
- Trials in BOT, B FASO, CI, ETH, GHANA, NIE, RWA, RSA
2006 estimates HIV/AIDS

People living with HIV/AIDS
39.5 (34.1-47.1)

Adults living with HIV/AIDS
37.2 (32.1-44.5)

Women living with HIV/AIDS
17.7 (15.1-20.9)

Children living with HIV/AIDS
2.3 (1.7-3.5)

People newly infected with HIV 4.3 (3.6-6.6)
Global trend of HIV/AIDS

- 1990-2005
I have not failed. I’ve just found 10,000 ways that won’t work.

Thomas Edison
Why is progress slow?

- Distractions - origin of HIV
- Weak health infrastructure
  - Poor data
  - Poor disease surveillance
  - Research structures
- Human resources crisis
  - Quantity and quality
  - Training: epidemiology, public health
- Governance
Origin of AIDS-1

• 1959: Leopoldville- blood specimens for malaria. 672 tested in 1984, 1 positive
• Luc Montagnier- American in 1952 with Pneumocystis carinii pneumonia: also Canadian in 1958 and American in 1959
• 1966: Norwegian seaman who visited Douala in 1961-2, wife and child
• AIDS existed but rare in the 1950s
Origin of AIDS-2

Did HIV originate from Equatorial Africa? Three reasons:

• HIV results from transmission to human beings of related SIV, re. influenza.
• The difficulty of transmission of HIV
• HIV weakens the immune system therefore- opportunistic infections such as TB: may mask HIV
The history of HIV is still unfolding before our eyes.

Do we have the eyes to see and the courage to take the required action?
Those who do not learn from history are doomed to repeat it.

Santana ya
Say, what did we learn?

Asante sana!