AIDS AND AFRICA
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The death drums, played nightly after the news in Uganda sent a chill of fear through the people. For a period these funeral drums were used to tell them what would happen if they made love to someone new without using protection. HIV would get them - AIDS would kill them.

The picture of AIDS in Africa over the past eight years has been one of unremitting horror. The World Health Organisation describes subsaharan Africa as having the highest rates of HIV infection in the world - an estimated 1 in 40 adults - and predicts that by the end of the century there will be half a million deaths a year.

Academic articles like these by Professor Roy Anderson in the UK are currently stating that AIDS will bring about a decrease in population in a few decades and this will lead to political disturbances in the continent of Africa.

The heterosexual transmission of AIDS through unprotected sex is blamed for the spread of HIV and AIDS. Health education now teaches school children of the dangers of sex without a condom.

Boy whispering: "A condom is a small rubber bag. Everything coming from a man's penis runs into this little bag."

Uganda, struggling to rebuild itself after two decades of civil war. A country that can only afford under a dollar a year per person in health care, opened its arms wide to international AID agencies. But the ensuing flow of often exaggerated AIDS statistics that emerged from a multitude of western research projects has backfired.

Dr. James Makumbi (Minister of Health, Uganda): "I am concerned about the interpretation of the picture of AIDS in Uganada, and this is unfortunately arising from our strategy of coming out and speaking openly about this disease, where some contries have preferred not to publish the actual situation."

Dr. Sam Okware (Deputy Director Medical Services, AIDS and Communicable Diseases): "I think there has been of late a lot of exaggeration about the extent to which AIDS is affecting Africa and Uganda in particular. I think one of the reasons is that we have been very open. We were the first African country to come out very openly with a programme and this has somehow been misunderstood by some people from the European countries, especially uninformed press that this is the epicentre of AIDS. I don't think that's the problem. I don't think that this is the epicentre of AIDS."

Badru Semmanda: "People are trying to make a way of living out of this. You know, they think that if they publicise it and they exaggerate it, they might win sympathy of the

international community and will get aid, or rather get assistance from the - we need assistance but not with the - I mean, not through bluffing people are dying at the rate which is not true."

Dr. Harvey Bialy: "From both my literature review and my personal experience over most of the AIDS - so called AIDS centres in Africa, I can find absolutely no believable persuasive evidence that Africa is in the midst of a new epidemic of infectious immunodeficiency."

So is there an AIDS epidemic? If not, how is it people are being misdiagnosed ?

This is the village of Rakai, described as the epicentre of the AIDS epidemic. Villages like this we are told have been wiped out by the disease. And AIDS is said to have started here, going on, to infect the whole world.

Najemba is a typical victim of the AIDS panic. People think she has AIDS although no one has ever tested her blood. Like so many thousands, she is an AIDS case without any evidence. She is struggling to survive but that is just as likely to be because she is starving, living off scraps from her brother.

Gerald: "I can hardly feed myself according to the salary that I get. That means I'm running poverty. That's why you see me sleeping in such a thatched house which is not good for my life. So now my worries is poverty first. Secondly I lack food. Thirdly we don't get good water. We don't get medicine. We don't get - let me say something that keep someone alive."

Gerald, his sister and his family are locked into a cycle of poverty, acute food shortage, dirty water and disease. In Africa, there are few places where HIV tests are available. But on the basis of her symptoms alone, Najemba still qualifies for an official AIDS diagnosis. She has suffered combined symptoms of fever and diarrhoea for over a month and she's had a dry cough.

Question: "How do you feel?"

Najemba: "I don't feel too bad but what I lack is things to drink."

Question: "Do you think you have AIDS?"

Najemba: "I can't be sure because the partners I've had are fine."

When we first met Najemba two months earlier she had such bad infections on her leg she couldn't walk at all. There was no way she could possibly afford any antibiotics so we left her some money for medicines and the leg infections have almost dried up.

The fact that Najemba hasn't been able to pay her rent combined with the belief that she has AIDS means she is now being forced out of her homein the village. In her fragile condition she has been trying to build a makeshift shelter in a malaria infested banana grove. She has in fact been building her own tomb. If Najemba dies her death will be blamed on AIDS but the real cause is more likely to be the destitute living conditions in

the Rakai.

In Najemba's village the total breakdown of the health and medical services is only too apparent. We visited the local hospital in this so-called epicentre of AIDS and found a sorry scene. Not a single AIDS patient only an empty ward. No nurses, no doctors only one tiny baby suffering from malaria convulsions surrounded by her silent family. We then found the only member of staff who got up from her sick bed to speak to us.

Namuburu Maxensia: "I work as a midwife. And I also help in the treatment of other patients."

Question: "How do you feel?"

Namuburu Maxensia: "Now I am sick."

Question: "What do you have?"

Namuburu Maxensia: "Malaria...."

Lack of staff and medicines at these local hospitals and dispensaries has meant that sick people simply stay in their own homes. But, Nurse Maxensia did agree to show us the medicines cabinet stocked with some drugs supplied free under the World Health Organisation Essential Drugs Programme - however under a new cost-sharing scheme villagers are now asked to pay a fixed rate for them which for most means going without.

Namuburu Maxensia: "Some don't even come. Before we put up that system we used to have a lot of patients here. For one day...one fifty out-patients without counting the inpatients."

Question: "But now?"

Namuburu Maxensia: "But now we get few."

Question: "Because they can't afford to buy?"

Namuburu Maxensia: "They can't afford to pay."

Our journey through Uganda took us through the Rakai region to the town of Kyotera. We travelled with Ugandan radio journalist Sam Mulondo who has been covering AIDS stories both in his country and in Europe. Here it seems that the fear of AIDS is having as great an effect as AIDS itself.

Sam Mulando: "'People are dying psychologically and the active cells, scientists call it active cells, or something, psychological death. Many are dying because of that. Somebody gets simple malaria, they fear to go to the doctor, to see a doctor, just because they will be branded with this clinical case as an AIDS or HIV. People are just left at home, they don't go for any treatment whatsoever. Any slight infection, people don't go to hospital. In addition to this area lacking proper medical care facilities, people are worried about the water they drink. They don't have treated water, t-piped water, it's only from the springs, well which is contaminated as it rains all sorts of, you know, contamination, goes into the

springs and well, they simple pick that water through these jerrycans, plastic things, take home. Most of them they don't boil that water, they just drink it."

At Uganda's capital, Kampala, Mulago Hospital's long tradition of excellence in tropical medicine has made it a focal point for AIDS research programmes. Here as in all African countries HIV tests are too expensive for general use. AIDS is diagnosed through guidelines laid down by the World Health organisation known as the 'Bangui clinical case definition.' To qualify for AIDS someone must have a combination of symptoms like persistent diarrhoea and fever for a month and a dry cough. The trouble is that many of these symptoms are indistinguishable from those of old established diseases like TB and malaria.

The Ugandan Ministry of Health did not allow us access to film patients inside their hospitals. They were concerned about patient privacy and the projection of too many negative images in the West. But we were able to speak freely to the doctors.

At Old Mulago Hospital, Dr. Martin Okot-Nwang is in charge of the TB wards. He is concerned about the way TB and AIDS statistics are being wrongly reported. TB is a disease that occurs where there is poverty, malnutrition and lack of medicines. Conditions all rife in today's Uganda. Figures have doubled recently in these wards.

Dr. Martin Okot-Nwang: "We have just recently undergone through a series of wars in this country, and this has led to a breakdown in our health services. It's not unknown that following war famine increases do occur, particularly in infectious diseases or communicable diseases, of which TB is one of them."

The rise in TB cases in Africa has led some scientists to speculate that the HIV virus is making some people more susceptible to the disease but it is hard to find any evidence for this. What IS documented is that flaws in the clinical case definition, that is the combination of symptoms used for diagnosing AIDS without an HIV test, have meant that many TB cases have mistakenly been called AIDS.

Dr.Martin Okot-Nwang: "A patient who has TB and is HIV positive would appear exactly the same as a patient who has TB and is HIV negative. Clinically both patients could present with long fever, both patients present with loss of weight, marked loss of weight, both patients who actually present with a prolonged cough, and in both cases the cough could equally be productive. Now therefore clinically I cannot differentiate with the two. Even when I look at the blood I may find some similarities between the two groups."

In the past TB of the lung or pulmonary TB was not considered a disease that qualified as AIDS by the US Centres for Disease Control but it was added to their list in January this year.

Dr. Martin Okot-Nwang: "I think if they include pulmonary tuberculosis as an AIDS defining case then all the TBs in Africa will - almost all the TBs in Africa - will be AIDS."

The danger in calling all TB cases AIDS means that money badly needed for the treatment and cure of TB is being diverted into preventing the spread of HIV.

Dr. David Serwadda: "I think that there is to - there is a lot of attention that has been paid

to HIV and to the detriment of many other diseases. And as less and less money becomes available, these diseases themselves could become a public health hazard. Malaria we are seeing a resurgence of malaria."

Dr. Betty Mpeka: "Malaria is quite a big problem in Uganda. It's the commonest disease in all parts of the country and it's the commonest outpatient problem in all health units in this country."

Question: "Is it curable?"

Dr. Betty Mpeka: "Very much so. It's very curable. The drugs are available. Chloroquine, which is still the cheapest is still effective."

Question: "Are you able to supply the medicines that are really needed?"

Dr. Betty Mpeka: "The, the supplies of medicines are not actually adequate in most health units."

Question: "Are you worried, etc..."

Dr. James Makumbi: "That's a very important point. We have periodically emphasised that research of any kind, not only AIDS should have a component of patient care, while we do agree that there should be a change in behaviour, and that's a very important strategy. But it would be ridiculous to leave people to die of tuberculosis."

Question: "Are you able to persuade the foreign agencies to provide funding for medication or are they reluctant?"

Dr. James Makumbi: "There has been little compliance on the side of actual patient care. We are having a lot of problems."

Our search for the best documented data on HIV and AIDS took us across Africa from East to West 3000 miles to Cote d'Ivoire. It's capital, Abidjan has been chosen by many international agencies to further research into HIV.

A stable political environment, well developed health services infrastructure, meeting place of different cultures and busy tourist trade have made it a useful centre for research projects.

Professor Kassi Manlan is Cote d'Ivoire's Director General for Health and Social Services.

Dr.Kassi Manlan: "The situation concerning HIV infection and AIDS in Cote d'Ivoire is the most serious in all of West Africa, as we come sixth amongst all sub-Saharan countries and we are in first place in West Africa in terms of prevalence."

In Abidjan epidemiologist Dr. Kevin De Cock heads a two million dollar a year AIDS reseach project funded by the US Centres for disease control or CDC. He is convinced that there is a mounting AIDS epidemic.

Dr.Kevin de Cock: "The problem is actually it is undermeasured. If you don't measure how

changes in - how patterns of mortality, for example, are changing, you know. We've looked at it in Abidjan and they've changed extraordinarily since the AIDS epidemic. With a tremendous increase in death. In premature death. This is an epidemic of historical importance. It is an epidemic that going to last for decades, it may last more than a century."

Prophecies of doom for Africa should perhaps be judged against similar predictions that have long been made of an AIDS catastrophe in the West. Predictions we now know to be greatly inflated. The committee appointed by the UK government in 1988 predicted UK AIDS figures for '92 that were over double what they turned out to be. In fact the only scientist who has consistently predicted almost exactly the right figures for the UK is Professor Gordon Stewart.

Dr. Gordon Stewart: "Now, because those predictions are so erroneous, and because the methods used by and large are the same, I find it very hard to understand why they place such confidence in those estimates for Africa, even though the confidence limits are wide. I mean at one extreme they'll say a very small number, the other extreme a very large number, and saying that it's not easy in between to decide what's going to happen, but that makes it all the more important to avoid making those statements about - the sense of doom about whole populations being exterminated. I can't see at the moment that we have justification for saying this."

Dr. Havey Bialy who has lived and worked in Africa is deeply sceptical of any current AIDS claims about the continent.

Dr.Harvey Bialy: "Those claims are just that. They are based on no real evidence whatsoever. In fact, the evidence could not really exist because mortality figures for the continent of Africa have never been kept as matters of record by the governments, even within hospitals. These figures are extraordinarily difficult to come by."

One group that is being closely observed is the prostitutes of Abidjan. Research shows a much higher incidence of HIV than in the rest of the population. Some of the women have been falling seriously ill and some have died. But prostitution often goes hand in hand with hard drugs and Abidjan's recent tourist boom has helped finance an escalating drugs problem.

As yet there is no useful evidence as to whether the prostitutes are dying of HIV infection or drug addiction. Cote D'Ivoire Committee for the Fight Against AIDS has just started a project amongst prostitutes.

Dr. Kouame Kale: "Yes, in this field it's true we have a big drugs problem. We have to be very careful not to upset the sensitive work that we are doing with this group."

Question: "They smoke cocaine and heroin don't they? They smoke it?"

Dr. Kouame Kale: "Hashish is the most widely smoked drug. Cocaine has been introduced into the country more and more. Heroin is very tightly controlled, but, you know, it difficult to completely regulate this area."

Many prostitutes like Alice from Ghana are not convinced that it is sexually transmitted

HIV that is killing them. They believe it is the drug addicts amongst them who are dying. Like the story of a Liberian friend who was diagnosed with AIDS or SIDA as the French call it.

Alice: "Drug, she took drugs too much."

Question: "So what happened?"

Alice: "Er..."

Question: "She was sick?"

Alice: "Yes, if she smoke the drug, didn't job. No job."

Question: "So, she went to the hospital."

Alice: "Yeah."

Question: "And then what happened?"

Alice: "They no have medicines, she died, for them."

Question: "She died? Why did she have no medicine?"

Alice: "No have money."

Question: "No money?"

Alice: "No money."

Question: "So she died?"

Alice: "Yeah."

Question: "And was that SIDA do you think?"

Alice: "No."

Question: "What was it?"

Alice: "Well say the SIDA, the doctor come tell it's SIDA. It's not SIDA."

Question: "You don't think it was SIDA?"

Alice: "No, no, no..."

Question: "What do you think it was?"

Alice: "Drugs."

Dr. Harvey Bialy: "These girls are consuming hard drugs in a smokeable form - namely, heroin and cocaine, in vilely adulterated versions for the first time in the history of Africa. And these drugs began to make their way into Abidjan in 1985-'86. They are epidemic amongst certain classes of prostitutes right now, and these are the only girls that are getting sick. It looks like AIDS because these girls are wasted both because of the direct effect of the drugs and because they use what little money they have on drugs, rather than on food."

Investment in AIDS research in Abidjan has led to extensive testing for HIV. Projects like this one at a maternity clinic in Koumassi have shown a greater incidence of HIV in Africa than in the West. But what they do not seem to be showing so far is a frequent progression to AIDS. That is only the first of the puzzles.

80% of the HIV positive mothers at this clinic are perfectly well. Jeanette, for example, who is visiting the clinic today for a regular check up and blood test for her baby, Ann.

Dr. Severin Sibailly: "Generally speaking the two women we have just seen this morning are asymptomatic. They have no signs of AIDS, but the problem is, we don't know when they were infected. But what puzzles us is the fact that many of the women who are classed as negative fulfill, the definitions for AIDS."

The study's director Dr. Georgette Adjorlolo has noticed that in the HIV positive group there are marked differences in progression to AIDS.

Dr. Geogette Adjorlolo: "I have no doubt that the HIV virus is the cause of AIDS. But we are seeing differences in progression to AIDS, and these observations lead me to think that it's not only HIV - but certain co-factors that accelerate the onset of the disease - and maybe other factors such as nutrition, and concurrent infections."

Dr. Kassi Manlan: "The virus is only a co-factor. One can perhaps say that progression to AIDS is not inevitable - that many people may encounter the human immunodeficiency virus, some will get AIDS, and others will not. One must therefore consider that there are several factors which we have to identify to improve our understanding of the disease and also to improve the way in which we wish to fight against it."

The more research funding that is put into Africa the greater the anomalies that emerge. Does HIV need triggers to turn into AIDS ? Can you have AIDS without HIV ? Can you live with HIV and not get AIDS ? Our search took us on to Cameroon.

The Seventh International African AIDS Conference held in Yaounde, Cameroon. Here the emphasis is almost exclusively on controlling AIDS by controlling the sexual spread of HIV. The conference attracted over two thousand delegates from all over the world.

Although AIDS was first diagnosed in the United States in the early eighties, many still look to Africa for the origin of the disease, blaming the African green monkey and African sexual practices. But, as more is understood about the disease the western model of AIDS seems to have less and less in common with AIDS in Africa. In the West, 90% of its victims are male; in Africa nearly half of the diagnosed cases are women.

Blaming Africa for AIDS caused puzzlement at first and then outright anger amongst many

Africans.

Richard Chirimuuta: "There were many many examples but one example is that African gave their children dead monkeys to play with as toys and there was all this nonsense about how promiscuous Africans were than, any other humans. I mean, I could go on and on. I mean and that African believe that the only cure for AIDS was to sleep with virgins and this is why AIDS was so widespread in Africa. Most of them were all based on racism or racist preconceptions of Africans. The allegations really that Africans were more promiscuous than the rest of the human race were unfounded. They didn't make any sense scientifically. In fact when they sent teams of researchers, sociologists, anthropologists to Africa, they were amazed that Africans were actually much more conservative in their sexual practices."

A focal point of the conference was the need to change sexual practices and how to encourage the use of condoms.

Tita Gwenjemg: "You see there is the tank. This is the tank where the sperm will remain after ejaculation. You hold like this. And gently it goes down, make sure this one you press the tank gently. And there it is."

The Cameroun conference was a grand affair, drawing together all the national and international dignitaries of the AIDS round.

But behind the scenes a French charity worker called Philippe Krynen was photocopying his protest pamphlets down the road - pamphlets critical of the AIDS hype he has experienced in Africa. He is angry at the way exaggerated figures for the prevalence of HIV in his area of Tanzania are causing distress and even death in his communities, so he decided to test an entire village and called a press conference here in Cameroun to announce the results.

Philippe Krynen: "We got a whole village coming forward to volunteer to know - you know what ? To know if they are going to die. What is important is to see that these declared cases of deaths from AIDS have not increased. In this village particularly since two years."

We went to visit Philippe across the Ugandan border into the Kagera region of Tanzania. Philippe was waiting for us across the border. He is director of Partage, a French charity that supports, through individual sponsorship, orphan children in this remote region. Orphan in this part of Africa means a person under 18 who has lost one or both parents. It can also refer to children with special needs. Philippe travels constantly and has noticed that the number of so-called AIDS deaths is diminishing in this area.

Philippe Krynen: "We see that the casualties because of AIDS with the diseases which are called AIDS here which are similar to the symptoms of AIDS, they are less and less since now two years."

Philippe and his wife Evelyne have based themselves in Bukoba a once prosperous town on the edge of Lake Victoria that has fallen out of political favour over the years and is suffering increasing poverty and neglect. Here Partage provides medical care, schooling and support to children in fifteen villages spread over a vast region spanning over 1000

square miles. So great has been the fear of AIDS in this community that Philippe has found it difficult to generate community support for the orphan children.

Philippe Krynen: "How can you ask people who believe they are going to die tomorrow, how can you ask them to look into the future which are the children. They give up, they don't invest. They don't want to come to work in northern Kagera because they think that they are going to die of AIDS, or to contract it."

HIV awareness campaigns have been particularly successful in this region leading most people to believe they could be infected. Philippe decided to get at the facts. First he asked all of his 160 workers if they would volunteer for confirmed HIV tests. He found 5% were positive. Then a whole village of 842 people volunteered. He found 13.8% were positive. These figures are higher than estimates for the number of HIV positives in the West, which are less than 1%, but substantially lower than previous estimates for this region of Tanzania.

Philippe Krynen: "This is the first time in Africa that a village has volunteered as a whole to be tested for a deathful disease. That everybody has got his results and that the truth has been five times lower than the figures given by the World Health Organisation of the AIDS control programmes."

Rebuilding the shattered confidence and morale in this region has required dedicated follow-up.

Lucy is an orphan who was working as one of Philippe's trainees. She became ill with repeated infections and lost over 20 pounds in weight. Most people thought she had AIDS.

Lucy: "I was very ill at home when Mr. Philippe came to the village Mwambele led him to my house. Mr. Philippe was worried and took me to hospital."

Philippe discovered that Lucy had been diagnosed as HIV positive in an unconfirmed screening test. He and his wife decided to support Lucy and help her regain her position in the community. They moved her out of her small hut and built a new house for her.

Philippe Krynen: "And slowly in four five months time, Lucy started top recover, to put weight. Supplemented with vitamins, supplemented with food, with a better salary. And because she had put weight again, and she had been freed of skin diseases, her friends started to look at her differently. Not putting her on a side and not being afraid of her. Because they started to question if really she had AIDS or not. It's very seldom you see people who have been stigmatised with AIDS, who are not dying a few months later. So, Lucy was one of the first persons who, because we didn't support the AIDS tag on her, recovered and was proof to the community that you can recover for - from such episodes."

Lucy: "I am strong and I'm back to my old weight. So, I can do any work I'm faced with."

Question: "What would you like to see happen?"

Lucy: "I hope to have children."

In three successive tests Lucy has now been found to be HIV negative. She is just one

example of the mass of flawed HIV statistics that bedevil Africa. Her unconfirmed screening test would have been included in the official reported figures for HIV positives.

Dr. Harvey Bialy: "Some of these tests are so non-specific that 80 - 90% of the positives that are picked up are false positives. They're reacting to antibodies that are not HIV specific. And when one realises that these tests are being pushed in a context in which we have to test as many people as possible, the inevitable outcome is that Africa - the figures for numbers of HIV infections in Africa will become wildly exaggerated and feed into a very, very deadly self-fulfilling prophesy."

According to official figures, over a period of 8 years in the United States there's been a relatively stable estimate of 1 million HIV positive people. The total number of reported AIDS cases is 250,000. In subsaharan Africa, as testing has increased, the estimated HIV positive total has risen to six million people (six times the US figures). But the total number of reported AIDS cases is only 129,000 - (half the US figure).

The disparity between HIV and AIDS here and in the West is dramatic but the single most obvious fact about AIDS and HIV statistics in Africa is that they are unreliable and virtually useless in charting the course of AIDS. HIV figures are flawed because the tests are unreliable, giving too many false positives.

And identifying AIDS through the Bangui case definition, by looking for a combination of several symptoms, is also flawed because so many other diseases get swept into the net.

Does the African experience of AIDS help our understanding of AIDS in the West ? One who thinks it does is molecular biologist Professor Peter Duesberg. He has argued for six years that HIV is not the cause of AIDS. In leading science journals he develops his view that HIV is no more than a passenger or hitchhiker that's around, like other bugs, when people are at risk - a bug that's dormant rather than fatal. And he points to one anomaly in particular in Africa's statistics that he believes supports his theory - more than two thousand documented cases of AIDS without HIV.

Many of these cases come from Dr. Kevin de Cock's studies in Abidjan'a three main hospitals. There over one third of cases NOT qualifying as AIDS under the Bangui definition of symptoms were HIV positive and one third of cases which DID qualify as AIDS were HIV negative. How does Dr. de Cock explain the cases in his study which have been diagnosed as AIDS cases but when tested have been found not to have HIV ?

Dr. Kevin de Cock: "If we're talking about AIDS we should perhaps scrap that word and talk about HIV disease. Alright. It's very clear what is HIV disease. Now it is not surprising that the constellation of symptoms, signs, and indeed, opportunistic infections, occasionally - occasionally occur in people without HIV infection."

Dr. Harvey Bialy: "There are thousands of documented cases from the Third World, from Africa in particular, of clinically reportable AIDS in which HIV testing has been done and found to be negative. I think it's amongst the strongest arguments that HIV is irrelevant to the development of AIDS in at least some cases if not all cases."

Dr. de Cock maintains that those HIV negative cases may have looked like AIDS but they were simply conditions which were drawn into the net when collecting numbers of patients

for resarch purposes and not for patient care.

Question: "These 2400 cases were called AIDS, for all intents and purposes, in all the literature. And yet you're saying they shouldn't have been called AIDS. But they were identical to AIDS. So, are you saying..."

Dr. Kevin de Cock: "But they were HIV negative."

Question: "So, are you saying there have been 2400 misdiagnoses?"

Dr. Kevin de Cock: "Are you talking about - we're talking about the quality of surveillance data."

Question: "The documented cases of full blown AIDS which, when tested, were HIV negative."

Dr. Kevin de Cock: "Well then they're not AIDS cases. They're not AIDS in the way we talk about HIV disease."

Question: "But they were called AIDS in the documents. They were called clinical case definition Bangui AIDS. Do you see?"

Dr. Kevin de Cock: "Of course I see. Any case definition particularly one which is clinically based is not going to be perfect."

Dr. Harvey Bialy: "When one has clinically identical pictures one with HIV antibodies, one without HIV anti-bodies - to call one AIDS and one not AIDS is patent absurdity. This is irrefutable proof that HIV is not necessary for the presence of AIDS, except by definition."

In Uganda's the external debt now stands at $ 570 million. The interest payments on these debts amount to twice the total annual health budget, which is about half of one per cent of the Gross Domestic Product.

There is a crying need to call on health funding from outside - the trouble is HIV prevention is swallowing most of it up. In 1992 Uganda's total budget for malaria treatment and control was less than $ 57,000 yet foreign funding for AIDS was over $6 million dollars.

However well intentioned, AIDS funders also have their own agendas. The American government's aid agency US AID's genuine desire to help prevent the spread of HIV by funding counselling and condom distribution coincides with its declared interest in population control. It's investment in HIV prevention is huge.

Helene Gayle: "In the next five years AID plans to devote hopefully as much as $ 400 million for prevention activities worldwide. Much of that will go to Africa to help develop larger, more comprehensive and integrated programmes that we hope will be able to show to the world that you can make an impact on behavior change and we can make an impact on slowing down the spread of HIV transmission."

Question: "There has been some criticism that US AID's policy in Africa of distributing condoms suits US AID's policy for population control and this is worrying some African spokespeople. What is your view?"

Helene Gayle: "AID has always had a very strong emphasis on population. But condoms have never been, the contraceptive of choice for population programmes and so condom use in population programmes has not been particularly successful."

Dr. James Makumbi: "We have about - more than 700 non-government organisations, operating in the AIDS field in Uganda. This raises a lot of concern, because a few of them are doing a very good job. But a good number of them, my ministry is not aware of what they're actually doing, and there is no way of evaluating them. Unfortunately a good number of them do rush in, collect data, and go away with it, and the next we hear about it is when it is being printed in journals, and we have not had any imput and some of this work has been done in very limited areas, not reflecting the rest of the country."

At Mulago Hospital senior lecturer, Dr. David Serwadda is not at all happy with the wayresearch projects have been conducted in Uganda, and in 1990 published his criticisms of western researchers in *The Lancet*.

Dr. David Serwadda: "I'm concerned about who is setting the priority. Two, the main results who - the implications of the results, how applicable are they and how relevant they are to our environment. And three the training during the course of the execution of the research - to train the local individuals so that at the end of the research, there is some local manpower that is trained to be able to carry on independent research."

Dr. Serwadda has told us he keeps an open mind as to whether HIV is the cause of AIDS and is conducting his own research in the Rakai District with a team from Mulago Hospital. Contrary to previous reports, he has found a lower than expected incidence of HIV - at 12.6%. Almost the same as Philippe Krynen's findings in the neighbouring region of Tanzania. Another of his projects involves following up, one hundred 'discordant' couples where one partner is HIV positive and the other negative.

Dr. David Serwadda: "The results of the study so far shows that in only five pairs have both individuals become positive. This was a pleasant surprise because I had expected a much higher set of conversions."

Question: "Which means?"

Dr. David Serwadda: "Which means both couples becoming positive over a two year period."

If HIV were one day found not to be the cause of AIDS then the consequences for Africa and Africans of following the HIV hypothesis would have been grave indeed.

Dr. Martin Okot-Nwang: "What keeps a man energetic and keeps them doing what they do is their hope for the future. But once you tell me that I am HIV positive then you have given me this message that you are going to die, and therefore I have no energy for the future."

In spite of everything, life and love goes on in Uganda and even those who believe HIV does play a role in AIDS have strong messages of hope for the future.

Dr. Sam Okware: "You see the majority of our people here are children who are below the age of 19, and these are more than 50 percent and they're all negative, most of them are negative. If you look at the seropositivity, incidents or prevalence of AIDS cases here in this country you'll find that not more than six percent of the general population is affected. Now six percent leaves 94 percent of the population completely able to perform what should have been done by the rest of the population. So, I don't think AIDS really in the long run will completely mutilate and disintegrate Africa." *

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