Some elements for an history of STDs and AIDS in Senegal

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Historians still recall the fright aroused in Europe by a certain shattering new disease that broke out suddenly during the Charles VIII expedition to Italy, late in the 15th century, in a troubled context of war and loosening moral standards amidst the armies of France and Spain around the Kingdom of Napoli. It was so "new" then that there was no name known to identify it. The French people called it the "Napoli disease" and Italians the "French disease". When demobilized and back home, Charles VIII's mercenaries who were natives of many countries, went spreading it generously throughout Europe. The prestige of the Italian Renaissance contributed largely to popularizing the denomination *morbus gallicus* and its alleged American origin which, though controversial, will find advocates throughout centuries in an ever revived and open debate [1] . French medical practitioners suggested other denominations: venereal disease or "great pox". Girolamo Fracastoro was first to propose the term "syphilis" [2] which was to be accepted only by the end of the 18th century — the commonest term used until then, by doctors as well as ordinary people, was "great pox".

However that may be, it is interesting to note how much syphilis has, from the very beginning, been branded "the other's disease, the foreigner's disease", as evidenced by its various denominations and the long lasting controversy over its American origin. What then about the representation of this peculiar, devilish, contagious, venereal disease, a few centuries later, within the special context of colonial confrontation? In 1897, the libertarian press, playing with words, ironically referred to the so-called civilizing mission of French soldiers in Madagascar as "syphilization in Madagascar" [3]. This phillipic was echoing the famous saying attributed to Kraft-

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1 Claude Quétel, *Le mal de Naples. Histoire de la syphilis*, (Paris: Séghers, 1986); Jon Arrizabalaga, "Syphilis" (VIII.134) in Kenneth F. Kiple, ed., *The Cambridge World History of Human Disease*, (Cambridge: Cambridge UP), pp1025-1033; O. Dutour, G. Palfi, J. Bareto, J.P. Brun, eds, *L'origine de la syphilis en Europe avant ou après 1493?/The origin of syphilis in Europe before or after 1493?* (Toulon/Paris: Centre archéologique du Var/Editions Errance, 1994).

2 This disciple of Copernic at Padua University entitled his book — published in 1530 — *Syphilis sive morbus gallicus* , which was translated into French in 1753 under the title *Syphilis ou le mal vénérien. Poème latin de JérômeFracastor* [Syphilis or the venereal disease. Latin Poem by Jerome Fracastor]. (Quétel, *Le mal de Naples*, p68).

3 *LePèrePeinard*, 28 Nov.-5 Dec., 1897, quoted by Alain Corbin, *Les filles de noce. Misère et prostitution (19e siècle)*, (Paris: Aubier Montaigne, 1978, Flammarion, 1982), p401. It should be noted that some experimental "syphilization" was attempted in the mid-19th century by Auzias Turenne (1844) who issued several publications on

Ebing, i.e.: "civilisation is syphilization". The eminent German professor [4] was an illustrious representative of a fin de siècle Europe marked by an obsessive fear of civilisation taints that included alcoholism and syphilis regarded as "social scourges" [5] , while the Old World was launching colonial conquest ventures viewed by some as bearing regenerative potentials [6] .

Whereas European wayfarers had been travelling along the West African coast for many years — first and for quite long trading human beings, then for "legitimate" trade that laid the path for colonisation — it was not before the 19th century that long term settlement prospects materialised with the establishment, in Senegal, of permanent administrative structures. An Order dated 5 November 1830 made the French common law enforceable in the colony. Through a specific so-called "assimilation" policy, the French institutional and administrative model was applied in part of the colony, i.e. territories under direct administration. Hence, four communes with full rights were created — Saint-Louis and Gorée (1872) [7], Rufisque (1880) and Dakar (1887) before the establishment, in 1895, of a federation of West African territories named *Afrique Occidentale Française* (AOF). The AOF natives were the French colonial "subjects" — as opposed to the "orginaires" of the above mentionned communes who were granted French citizenship — were ruled by so-called indigenous laws (*Code de l'Indigénat*).

The awareness of venereal diseases and proof of its existence started fairly early in urban areas. Initially with reference to two specific groups: prostitutes and the military. In September 1882, the Internal Affairs Clerk (*Commis de l'intérieur*) acting as head officer informed the civil physician in Saint-Louis that "in view of the considerable number of venereal disease cases in town, serious measures should be taken and loose girls sent regularly to the hospital for check up" (letter n°621). The doctor was hence requested to examine carefully those girls and keep those in the hospital that would present suspect signs, until they were totally recovered. Full cooperation with the Administrator was expected from him, as well as a status report on prostitution in Saint-Louis [8] In his reply dated 28 September, Dr Duchoud indicated that:

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the matter, over some thirty years. The experimentation consisted in repeatedly inoculating the same individual with soft chancre until a negative reaction or the expected curative effect are obtained. This syphilis "immunization"has been dropped and is now just one of many vain attempts at preventing the disease (see J. Rollet "Syphilisation" in Dechambre, ed., *Dictionnaire encyclopédique des sciences médicales*, [Paris: Asselin & Cie, Masson, 3e série, Q-Z, tome XIV, Sym.-Sys. 1884], pp678-691).

4 His book *Psychopathia sexualis* published in 1886 was translated into French in 1892.

5 See, in particular, chap11 "Tuberculosis, syphilis et cancer de 1880 à 1940" by Olivier Faure, *Histoire sociale de la médecine (XVIIIe-XXe siècles)*, (Paris: Anthropos, 1994), pp199-220, and the analyses by Claudine Herzlich and Janine Pierret, *Malades d'hier, malades d'aujourd'hui. De la mort collective au devoir de guérison*, (Paris: Payot, 1991); Quétel, *Le mal de Naples* (1986); Alain Corbin, "Le péril vénérien au début du siècle: prophylaxie sanitaire et prophylaxie morale", *Recherches*, 1977, déc., n°29; A. Corbin, *Les filles de noce* (1978) .

6 See Raoul Girardet, *L'idée coloniale en France de 1871 à 1962* (Paris: La Table Ronde, 1972).

7 The Order dated 10 August 1872, promulgated in Senegal on 20 September 1872, established, in the colony, municipal institutions similar to those in France (with counsellors elected by universal suffrage). But Gorée and Saint-Louis had municipal status since 1848, with a mayor appointed by the Governor.

8 Archives Nationales du Sénégal (ANS), série H (Santé) H42.

"authorised prostitution in Saint-Louis did not include brothels. Girls were not subjected to weekly consultations. Prostitute register directly with the police. On my arrival there were ten to twelve of such girls registered. Three of them have died, one is in prison, another one is suffering from typhus, in the hospital. The police list has been given to the hospital staff so that they will report any absences from regular consultations. As for underground prostitution, the most dangerous form — which exists according to rumours — the police are in a better position to provide the most accurate information. Certainly, common and hereditary syphilis are very prevalent and considered to be normal by people who declare they have without any shame and often without basis. Out of an average 600 newborns per year, about 60 die. This figure is twice that in France and it is unfortunate that general treatment which needs to be of a long duration, is unaffordable due to exageratedly high drug prices" [9].

On the day before, i.e. 27 September, the Police Superintendent informed the Internal Affairs Officer, in his correspondence n°35, that he had just

"ordered women whose behaviour is notably unhealthy to be taken to the hospital for a detailed examination" [10].

In a letter dated 8 June 1897, the AOF Governor General informed the Internal Affairs Director of high prevalence of venereal diseases among military troops based in Saint-Louis and Dakar, and requested municipalities to undertake surveillance in this regard [11]. A few days later, the Governor of Senegal stated that:

"... the conditions under which prostitution was occuring in Senegal made preventive measures such as those implemented in European cities not applicable. For, it is not in the streets that such actions take place which would have facilitated surveillance by vice squads who could then keep records on those indulging in such an activity. As for controlling prostitution in brothels, it is easier to imagine than to actually establish, because those ready to undertake such commerce are yet to be located, since no such request has been reported so far. The attempt made some years ago at Ndar Toute [12] was not successful but some local entrepreneurs are likely to take it over. The Public Administration can not achieve efficient surveillance unless cases of infected women and brothels where infection is detected are reported. If military officials could provide such information — which should be easy since a number of their soldiers have had hazardous contacts — police could then track down women thus reported and necessary steps could be taken to cure them" [13].

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9 ANS, H42.
10 ANS, H42.
11 ANS, H46.
12 A fishermen's district in the city of Saint-Louis, located on the so-called "Langue de Barbarie" (a sandy littoral band at the mouth of Senegal River) separate from the city-centre which is on the island.
13 ANS, H42: letter n149, 19 June 1897 to the AOF Governor General.

During the same month, Colonel Pujol, the Senegal troops Commander-in-chief, informed the AOF Governor General of the sanitary measures taken against venereal diseases (letter n°995) and wrote to the Internal Affairs Director — 1 July 1897 — about a native soldier in the Saint-Louis garrison suffering from a venereal disease [14].

The first overall picture of the venereal disease problem in the colonial territories was given at the beginning of the Century, by an Inspector General in charge of health in the colonies. After he reviewed various medical reports received from 1890 onwards, at the Ministry for Colonies, Inspector Kermorgant noted that, for quite some time, colonies were standing as high risk sites for venereal diseases. He recalled the 1888's measures taken by the Ministry for Shipping and Colonies in order to prevent "importation" of such diseases into France. Those measures focused on the military and prostitutes. He further noted that doctors emphasized more diseases specific to tropical countries. Yet medical reports from colonies convinced him of the need to protect the colonies against diseases from abroad, despite the difficulties in taking preventive steps that were often not easy to implement due to the Governors' fear of alienating populations they governed or confronting elected assemblies in the four communes. He observed that, in Senegal — where prostitution was neither regulated nor controlled — venereal diseases were quite frequent. Blennorhagia common among the military was found in its acute form among newly arrived Europeans and in its chronic form among black soldiers. In 1898, those diseases accounted for 177 out of 1,000 days of treatment for Europeans and 270,2 out of 1,000 days for natives (hospital statistics). He concluded that venereal affections were highly prevalent, especially when considering that 90% of natives admitted to the hospital for other affections also had chronic urethritis and almost all of them had syphilis [15]. However, according to the same author's data, some years later — in 1905 and 1906 — AOF and New Caledonia ranked last among French colonies as far as prevalence of venereal infections among European military was concerned, with 11.4 per 1,000 population syphilis cases, 17.5 per 1,000 blennorhagia cases and 53.6 per 1,000 for all venereal diseases put together. Yet, morbidity among native troops was about one third of the corresponding rate among European soldiers; which the author explains by the fact that: natives being authorised to live in couples, had less opportunity of becoming infected than Europeans, and also being assigned to geographically remote positions without doctors, they often escaped medical examination and reporting [16].

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14 ANS, H46.

15 A. Kermorgant, "Aperçu sur les maladies vénériennes dans les colonies françaises," *Annales d'Hygiènes et de Médecine coloniales*, 1903, **6**, p435.

16 A. Kermorgant, "Maladies endémiques, épidémiques et contagieuses dans les colonies françaises en 1906,"*Annales d'Hygiènes et de Médecine coloniales*, 1908, **11**, pp379-80.

In addition to this interest in assessing the scope of public health problems arising from these affections, there were new concerns about sanitation in this century. Subsequent to the establishment of an administrative authority over the whole country, there was a pressing need for more physicians. Hence, in a report to the AOF Governor General, Dr Rangé — Inspector of civil health services — proposed training young physicians who would be appointed in pacified centres and provide medical assistance to native populations. The 8 February 1905 Order instituted AMI (*Assistance Médicale Indigène,* [medical assistance to natives]) following the detection of the poor health conditions and dreadful mortality that prevailed among native populations in African provinces [17]. Governor General Roume prescribed, in his circular letter dated 12 April 1905 [18], a survey of the causes of mortality and their prevention — notably among children. The survey was to be conducted in each colony. The civil health service inspection report [19] indicated excessively high mortality due to two major types of diseases: 1) ordinary diseases caused by poverty, poor hygiene, dirt (tuberculosis ranking first, followed by syphilis and alcoholism); 2) diseases that were specific to those countries, i.e. endemic beriberi, leprosy, trypanosomiasis, malaria, and epidemic cerebrospinal meningitis, typhoid fever, smallpox. It is in the context of interest in these so called misery diseases — which was new in colonies — that venereal diseases were dealth with. The promotion of the "trio" of tuberculosis, syphilis and alcoholism to the rank of "social scourges" [20] by European hygenists towards the end of the 19th Century based on a convergence of social fears and statistical observations, was taken up by high level health authorities who were haunted by the fear of depopulation shared by French doctors and hygenists at the turn of century and accentuated by the obsession of public authorities with demographic issues (1893 and 1902 laws) [20b].

Gallay's report indicated that it was impossible to state definitely the number of syphilis cases (p 20) but it gave some general contrasted (or even contradictory) features regarding the disease forms, its geographic distribution and side-effects. It also stated that secondary and tertiary attacks accounted for half of the consultations in county clinics — especially in Podor and on stopover points along the River and railway — where demands for potassium iodide often overwhelmed the scanty budgets; animist populations in Southern colonies (Ivory Coast, Dahomey) seemed less

17 Henry Gallay, *Trois années d'Assistance médicale aux indigènes et de lutte contre la variole. 1905, 1906, 1907,* (Paris: Emile Larose, 1909), p13.
18 Circular letter drafted by Civil Health Service Inspector Rangé.
19 Report prepared by Gallay, Rangé's successor (reproduced in H. Gallay, *Trois années d'Assistance médicale...,* 1909, pp14-45).
20 see Faure, *Histoire sociale de la médecine* , pp.199-220; Herzlich and Pierret, *Malades d'hier, malades d'aujourd'hui,* pp193-211.
20b 15 July 1893 Law on Free of Charge medical assistance (*Bulletin des Lois,* 1893; n°1583, p841), 15 February 1902 Law on Public Health Preservation (*Journal Officiel,* 19 Février 1902, p1173).

affected than islamic people of the North [21], but were more affected by the consequences of alcoholism; the greatest concerns raised by syphilis related to its incidence on child mortality, abortion, premature labour and child mental deficiency, which it increased. The author also elaborated the ways and means of preventing depopulation and recommended the creation of an autonomous vaccination service and a corps of native medical assistants which were established through the Order dated 7 January 1906 [22].

The context of First World War was to aggravate this demographic obsession due to a combination of factors, i.e. the poor health of young natives which became more apparent during the massive recruiting process of black troops at the beginning of the war, the high demographic cost of the conflict, and the urgent need for man-power to develop the colonies which led the "colonial party" to launch an active campaign for the development or promotion of the so-called "colonial réservoir" [23]. This strong trend turned into a large "development" programme of which Albert Sarraut was one of the keenest defenders [24]. The natives' health issue in the war aftermath was clearly connected to that of labour shortage and was thus expressed in terms of production: "the native race had to be developed qualitatively and quantitatively" [25]. Then came a radical change in the doctrine of action; "currative medical assistance had to give way to social preventive medecine" (Ministerial circular dated 10 December 1924). This change was supported by a considerable increase in medical staff. The circulaire dated 12 April 1921 (Merlin) and confirmed by the one dated 12 March 1924 (Carde) emphasized the social role to be played by native auxillaries and the need to increase their number and encourage midwives to visit native families, in a sustained effort to improve child health and advocate hygiene. Carde's 15 February 1926 circulaire gaves specific instructions in the objectives and means to implement it [26]. The 5 March 1927 one relates to the first results recorded and provides some supplementary guidelines. The 1 August 1930 one focuses on infant protection and workers health.

During the interwar years — a period marked by an obsessive fear of syphilis [27]— the picture of the threat of venereal disease became thicker and more complex in colonial medical reporting.

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21 A common view that Africa has been infected through the double influence of Europeans and Islam (see Henri Baudet, *Extension actuelle de la syphilis dans les pays de nouvelle colonisation*, (Paris, Legrand, 1936, MD thesis).
22 *Bulletin Administratif du Sénégal*, 1906,1, pp54 and 59.
23 Christophe Bonneuil, *Des savants pour l'Empire. La structuration des recherches scientifiques coloniales au temps de la "mise en valeur des colonies françaises" 1917-1945*, (Paris: ORSTOM, 1991).
24 Albert Sarraut, *La mise en valeur des colonies*, (Paris, Payot, 1923); appointed at the Ministry of Colonies in January 1920, Sarraut will stay there for over four years.
25 Governor Carde's slogan "faire du noir" [produce Blackies], will be relayed throughout years, by administrators. Michel Leiris in his journal of the Dakar-Djibouti ethnography mission notes on 14 July 1931 [French National Feest, in Tonkoto a gloomy sub-prefecture of French Soudan]: "After the distribution of small presents, the administrator closing the ceremony, had the following statement translated, after he read it very loudly in French: 'Now, you will go to bed and work to get babies! Because when there are a lot of babies, there is a lot of income tax!' [...] The interpreter repeated faithfully the formula and everybody went away light-hearted" (M. Leiris, *L'Afrique fantôme*, (Paris, Gallimard, 1934, in *Miroir de l'Afrique*, [Paris: Gallimard, Quarto, 1996], p148).
26 *Journal Officiel du Sénégal*, 1926, 1318, p193.
27 Quétel, *Le mal de Naples*, p238.

The ever present demographic concern led to a closer retrospective look at data on stillbirth rates and infant mortality recorded in health facilities between 1890 and the early 1920s [28]. Thiroux (1923) compared these to the more recent data on the ravages of congenital syphilis given by Hata [29] such as abortions and infant mortality among Japanese women with a positive Wassermann reaction without clinical signs of syphilis. Several child affections among native populations and more specifically athrepsia, was a sequela of congenital syphilis as evidenced by blood tests, and "the superiority of 'sulfasenol' treatment over vegetable soups" [30] was confirmed. Relative immunity of Africans to venereal syphilis as suggested by Jeanselme (1904) and the possible diagnosis errors were major issues [31]. The assumed immunity seemed to be based on the mildness of symptoms or on the fact that the African adult was relatively resilient to malaria as compared to the White population for whom malaria associated syphilis was extremely virulent [32]. Fournier [33] referred to this combination as "exotic syphilis" the extreme malignancy of which is due to the association of malaria as demonstrated by strict etiological analysis. Thiroux [34] notes on the contrary that if African adults were not very sensitive, their children were hardly affected by malaria [35] which — he stresses — has a major effect on the virulence of syphilis.

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28 See Maurice Nogué, "Note sur le fonctionnement de la polyclinique de l'Hôpital indigène de décembre 1918 à juillet 1919," *Bulletin de la Société médico-chirurgicale française de l'Ouest africain*, 1919, **1**(3):28-33 ; Heckenroth, "Quelques considérations démographiques sur Dakar," *Bulletin de la Société médico-chirurgicale française de l'Ouest africain*, 1920, **2**(5):132-141.

29 in *Revue Internationale d'Hygiène Publique* 1921, p368.

30 André Thiroux, "Les maladies vénériennes dans les colonies françaises,"*Bulletin de l'Office international d'Hygiène publique*, 1923, p195.

31 Thiroux, "Les maladies vénériennes..." 1923 ; Hermant, "Les maladies transmissibles observées dans les colonies françaises et territoires sous mandat pendant l'années 1928,"*Annales de Médecine et de Pharmacie coloniales*, 1931, **29**:5-139.

32 A. Kermorgant, "Aperçu sur les maladies vénériennes dans les colonies françaises,"*Annales d'Hygiènes et de Médecine coloniales*, 1903, **6**:428-460.

33 Alfred Fournier, *Traité de la syphilis*, (Paris, Rueff, 1906) p.841. Fournier is one of the leading figures in syphiligraphy in France (hailed by Léon Daudet as "the first syphiligrapher of his time and probalby of all times"). Herald of the crusade against the venereal disease his numerous works are authoritative on the subject since 1857. He founded in 1901 the French Association for Sanitary and Moral Prevention. He is also the father of dispensaries (community clinics) and elaborated the idea that the disease was not threatening only those exported to it, stressed the number of "underserved" contaminations among women and children (see Quétel, "L'ère de Fournier", in *Le mal de Naple*, pp165-169).

34 A. Thiroux, "Les maladies vénériennes ...," 1923, p195.

35 The malaria patients ratio, established following the Koch method based on the percentage of infected children, was 60 to 70% in Senegal in the early century (A. Thiroux and d'Anfreville, *Le paludisme au Sénégal pendant les années 1905, 1906*. [Paris: Baillière et fils, 1908]).

With more appropriate arrangements gradually put in place — institute of prevention [36], institute of social hygene [37], community clinics, and specialist consultations [38] — the natives were followed more closely and the diseases detected through new scientific methods. Hence the "deceitful" and "sly" nature of the endemic [39] was better understood. Certain ethnic groups like the Fulani and Tukulor, were almost totally syphilized and some doctors stated that eighty per cent of the population of Dakar were infected [40]. The problem's scope did not dwindle with the passing years, though results of treatment were rather positive; reporters delighted in underscoring the quick curative action of arsenical medications that were overriding the other interwar anti-syphilis drugs, due to their easy administration and ready acceptance by natives [41].

Therapeutic options had of course evolved since the medical instructions of 1876 regarding posts without doctors [42] which recommended use of there a mixture of copaiba and cubeb, local emolient baths, zinc sulphate injections, lead acetate and calomel. The soda salt from arsenic acid (*atoxyl*) that Thomas and Brein (Liverpool) proved effective for trypanosomiases [43], in 1905, was soon to be also used by French practitioners to treat syphilis in West Africa. Bargy at Gaoua, Sudan (1908), reports 32 cases of syphilis (6 primary, 17 secondary and 9 tertiary) which were

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36 An advisory committee on venereal diseases in the colonies was set up in 1929 at the "Institut Prophylactique" (existing since 1916) where Marcel Léger was appointed after several years spent as head of the Pasteur Institute in Dakar. Cazanove presented to this committee his report on "syphilis control at the Port of Dakar" (Frank Cazanove, "Les enseignements de deux années de lutte anti-vénérienne au Port de Dakar," *Archives de l'Institut prophylactique*, 1933, **5**(1):32-42).

37 Opened in 1921, it comprises 6 departments including an anti-venereal one. In 1927, some 87,723 consultations were effected (Lhuerre, "Notes sur le fonctinnement de l'institut d'hygiène sociale de Dakar," *Bulletin de la Société de Pathoogie exotique*, 1928, **21**(4):329-334).

38 Since 1919 an anti-venereal clinic and consultation annexed to the natives maternity ward, in Dakar was operating on mornings (Kerneis, "Fonctionnement de la maternité indigène de Dakar," *Bull. Soc. méd.-chir. Ouest-afr.*, 1921, **2**(4):107-118). A Health station was created in 1926 at Dakar Port with a syphilimetry laboratory, in compliance with the Brussels International Arrangements (1st December 1924), to provide care to merchant navy men suffering from STDs. Its testing and care services will be gradually extended to the fluctuating population of the port vicinity and natives in Dakar city-centre and Medina (a separate ward was set up for women only). Mercurial pills recommended by Dr Vernes, that were easy to take and without side-effects, locally manufactured from a formula transmitted by Marcel Léger, were very sucessful among natives (Cazanove, "Les enseignements de deux années de lutte anti-vénérienne au Port de Dakar," 1933). Blood testing was developing at the syphilimetry laboratory (Hôpital Principal). The Pasteur Institute in Dakar used Bordet-Wassermann's reaction to test blood serum and cerebrospinal fluid (Marqué, "Les maladies transmissibles dans les colonies françaises et territoires sous mandat pendant l'années 1931," *Ann. Méd. Pharm. col.*, 1933, **31**:123-323).

39 Marcel Léger, "Coup d'œil d'ensemble sur la syphilis dans nos colonies," *Conférence de la défense sociale contre la syphilis*, (Nancy: Procès-Verbaux de la conférence, 1928), pp53-56.

40 M. Léger, *ibidem*.

41 Hermant, "Les maladies transmissibles ... pendant l'année 1928," *Ann. Méd. Pharm. col.*, 1931, **29**:5-139; Grosfillez, "Les principales maladies observées dans les colonies françaises et territoires sous mandat pendant l'année 1932," *Ann. Méd. Pharm. col.*, 1934, **32**:153-268.

42 ANS H 38, manuscript, 24 p.

43 The pathogenic agent in human trypanosomiasis has similarities with *Treponema pallidum* — syphilis treponema — then discovered. Trypanosomiasis was a major public health concern in AEF and, in some AOF territories, which led to the establishment of a specific control device that made Dr Jamot so famous (see Jean-Pierre, Dozon, "Quand les Pastoriens traquaient la maladie du sommeil," *Sciences sociales et Santé*, 1985, **3**:27-56, J.P. Dozon, "D'un tombeau l'autre," *Cahiers d'Etudes africaines*, 1991, **31**(1/2):135-157.

rapidly and successfully treated [44]. Injections of Van Swieten liquor, and mercury, were used in alternance. Bargy reported the constant, rapid and successful results of this new specific treatment for the "great pox", the absence of local accidents (frequent with mercury injections), and its painlessness. Yet, he recommended not giving more than 4 grams because this drug was a poison. Due to its toxicity, its usage was to be abandonned and some other products proposed. Erlich (Francfort) developed an organic arsenical preparation injected intraveinously: "606" (or *Salvarsan*, an arsphenamine) modified into "914" (*Néo-Salvarsan*, novarsphenamine) whch was easier to use [45]. In 1921, Sazerac and Lavaditi discovered the treponemocide property of bismuth. With arsenical medications and bismuth, doctors claimed they could defeat the disease [46]. A Health service inspection report to the Governor General, dated 1st August 1922 [47], recommending prevention measures, suggested: 1) for abortive or curative treatment of primary syphilis, use mercury salts, arsenic or bismuth in community clinics, maternity wards, examination rooms for prostitutes, or hospitals, in the absence of arsphenamineswhich have a more powerful action of bleaching but cost a lot. 2) for tertiary lesions, iodide was suggested in association with mercurial medications. Since it was very expensive and needed to be used at righ doses and a prolonged course, iodide was to be administered, in priority, for mixed iodided treatment of pregnant women and young children with hereditary-syphilis [48]. As for mercury salts, they were to be generously distributed to patients. Budgetary constraints were still bitterly felt, with regard to the increasing demand for arsenical products by population who were appreciative of the successful results of these injections [49]. In the context of global economic crisis, bismuth and mercury-based medications were to be given priority again [50].

However, the prospects introduced up by the new therapeutic possibilities [51] were countered by ever renewed multicarious difficulties probably related to the medical community's constant incrimination of people's attitude as if they wanted to exculpate themselves from their helplessness.

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44 Apparently to patients' great satisfaction, "Wonderful your injections!" as an infantryman from Soudan exclaimed in December 1907 in face of the rapid and spectaculor result of Dr Bargy's injection treatment (Bargy, "L'Atoxyl dans le traitement de la syphilis en Afrique occidentale," *Ann. Hyg. Méd. col.*, 1908, **11**, pp618-19).

45 "914" has apparently been very popular in the Senegal River Basin, according to Abdoul Sow, a Hapulaar investigator (Tukulor ethnic group), personal communication, February 1996.

46 Quétel, *Le mal de Naples*, p179.

47 ANS H 130

48 In the mid-20s *"Stovarsol"* tablets were introduced as a specific treatment of pian in Ivory Coast where the affection was widespread. This treatment soon appeared as the most advisable sterilisation system for heavily infected communities. It was particularly sucessful, as evidenced by populations's increasing demand. It thus became a policy instrument ; from 25 kg in 1926, its intake went up to 150 kg in 1929 (Anonymous, *Les Services de l'Assistance Médicale Indigène en Afrique Occidentale Française*, [Paris: Agence économique de l'AOF, 1931]).

49 ANS H186 Letter to the Governor of Senegal, from the files of the Medical Assistance Department.

50 Ledentu, "Les maladies transmissibles observées dans les colonies françaises et territoires sous mandat pendant l'année 1933," *Ann. Méd. Pharm. col.*, 1935, p765.

51 The Malaria therapy suggested by Wagner von Jauregg since 1917 (which won him the Noble Prize in 1927) did not seem to be actually applied in the African context where, as we have seen, there were few cases of general paresis, tabes and neuro-syphilis. Yet, there were records in Dakar, of several strains sent to Sainte Anne Hospital in Paris for malariatherapy of French mental patients.

They denounced natives' "unbelievable lack of privacy", "excessive copulation" [52] ; patients' indifference to blennorhagia and primary syphilis manifestations [53]. Virtually all authors stressed — as a compulsory refrain — the "natives' incredible carelessness" about the disease and its treatment, when they were not leniently echoing popular beliefs and prejudices according to which blennorhagia would give males special ability to procreate due to the penis's special erethism — entailed by urethral irritation [54]. The infection was also believed to make the semen "thicker" [55]. According to another prejudice, sexual intercourse with a virgin cures stubborn blennorhagia [56]. Colonial confidence in the civilising mission consisting of promoting and improving natives health conditions was often shattered by the tough realities in the field where there were doubts diagnoses. For instance, after the era of symptom-based diagnosis, the Wassermann reaction revealed that the disease's scope was larger than ever suspected [57]. It seemed to be even more so, with the advent of large scale studies conducted and the greater reliability of communications [58] but also because prevention was complicated by the frequently overlooked sequellae of blennorhagia, as well as late or incomplete treatments [59]. Arsenical medications were also attached [60] ; their quick action, easy administration and acceptance by patients prompted intensive use though often not long enough to more than merely mask symptoms. It gradually became apparent that neither clinical observation nor laboratory tests could definitely establish whether recovery was effective. Hence the strategy was to gain flexibility; control efforts tended towards the identification and treatment of the virus-hosting site, for syphilis at least [61]. But the necessarily limited action of institutes of hygiene or "anti-venereal" clinics, was to be supplemented in rural practice by polyvalent medications at sufficiently high dosages to ensure long lasting sterilisation more compatible with patients' degree of impatience. The global crisis context coupled with repeated warnings — from Marcel Léger in particular — about the risks involved in inadequate arsenical, prescriptions prompted a renewed preference for bismuth and mercury-based drugs. Individual treatment with sublimate pills were to be left to patients only under exceptional conditions. Results from dermato-venereology consultations in town were improved with regular blood testing and prevention and oriented home

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52 H. Gallay, *Trois années d'Assistance médicale aux indigènes* , 1909

53 G. Ledentu, "Les maladies transmissibles observées... pendant l'année 1933," *Ann. Méd. Pharm. col.*, 1935, **33**: 552-816; G. Ledentu and M. Peltier, "Les maladies transmissibles observées... pendant l'année 1935", *Ann. Méd. Pharm. col.*, 1937, **35**:748-1335.

54 Thiroux, "Les maladies vénériennes dans les colonies françaises," 1923, p206.

55 Ledentu, "Les maladies transmissibles observées ... pendant l'année 1933," 1935, p781

56 *ibidem.*

57 Thiroux, "Les maladies vénériennes dans les colonies françaises," 1923.

58 Hermant, "Les maladies transmissibles ... pendant l'année 1928," 1931.

59 Ledentu, "Les maladies transmissibles observées ... pendant l'année 1929,"*Ann. Méd. Pharm. col.*, 1931, **29**:661-851.

60 Grosfillez, "Les principales maladies observées dans les colonies françaises et territoires sous mandat pendant l'année 1932," 1934. Authors insist on the importance of early and long duration treatment. Some of them were also aware of the limitations of medical facilities treatment capacities in face of an increasing demand of care (Marqué, "Les maladies transmissibles ... pendant l'année 1931," 1933).

61 G. Ledentu, "Les maladies transmissibles observées ... pendant l'année 1933,"*Ann. Méd. Pharm. col.*, 1935.

visits conducted by nurses [62]. In 1932, a special place for consultation was opened in Sor (suburb of Saint-Louis). External treatment with washing (in blennorhagia) had a chance of succeeding only in a restricted category of disciplined and well informed patients (referred to as "evolved" [*évolués*] in colonial ideological discourse). For other patients, *Gonacrine* injections were successfully used. But over the entire range of therapy, there was no product that had a genuinely massive action.

With the advent of antibiotics (penicilline was introduced in 1943) a new era started. In the early 50s, *Extencilline* allowed mass treatment with one low-cost injection. Meanwhile, major changes occurred with Jamot's doctrine instituted when he was appointed Head of the Permanent Mission for the Prevention of Trypanosomiasis. Jamot initiated "mobile medicine" which started in 1926, in Cameroon and reached AOF in 1932. The Independent General Service for Sleeping Sickness (SGAMS/*Service Général Autonome de la Maladie du Sommeil*) was thus created in 1939 with biochemistry and entomology laboratories. A Nurses-Training School was also set up in Bobo-Dioulasso to organise control activities throughout AOF divided into sectors. Mobile preventive medicine largely employing trained native staff and taking laboratories to rural areas was thus born. From June 1944, following the Brazzaville Conference, the SGAMS became the General Mobile Hygiene and Preventive Service (SGHMP/*Service Général d'Hygiène Mobile et de Prophylaxie*) covering several major endemic deseases including syphilis *(bejel)*. The importance of such a service was to be fully realized only after 1949, with the creation of a mobile groups conducting investigations in the Sahelian areas of Niger (Djerma-Songhai lands) and Senegal River Valley (Podor). The SGHMP hence included Treponematoses. In 1955 [63] mass campaigns were extended to other treponematoses *(pian)* in forest areas. In 1957, intensive control activities were conducted under international guidance and using international means; i.e intensive use of depot penicillin [64].

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62 In 1933, some 25,734 syphilis patients were under treatment in health care delivery units, against 19,042 in 1932. An average of 17 injections per patients was delivered in 1933, against 9 in 1932 (Ledentu, *ibidem*, 1935).

63 As recommended by several international conferences, the most important one being the Enugu one (Nigeria, November 1955). International pressure on colonial powers was getting heavier during that period; asking for a greater concern about improving the welfare of populations under their rule. The Hot Spring conference (May-June 1943) committed them to take care of malnutrition (a large scale survey for an anthropological study of AOF native populations was conducted over 30 months under the leadership of Colonel Dr Leon Pales. See L. Pales, *Rapport N°1, Sénégal*, (Dakar, Direction générale de la santé publique, 1946), L. Pales, *Le bilan de la mission anthropologique de l'AOF (janvier 1946-août 1948)*, (Dakar: Gouvernement de l'AOF, 1948), Michael Worboys, "The discovery of colonial malnutrition between the wars", (in David Arnold, ed., *Imperial medicine and indigenous societies*, Manchester & New York: Manchester UP, 1988:208-225), etc. As acknowledged by A. Basset, it is only in 1958, further to Anglo-saxon works in Uganda and in Bechuana land reserves, that the French "great" endemia department with Richet started research on endemic syphilis in West Africa (A. Basset ("Tréponématoses en Afrique de l'ouest", *Afrique médicale*, 1966, 5:37-40). This affection was so far apparently confused with congenital syphilis.

64 Financially autonomous, the SGHMP was funded from the general AOF budget (± one billion in 1958). A 258 million CFA FIDES fund provided for programmes to be implemented in 1956-57 and 250 millions in 57-58, brought international organisations (UNICEF) to grant important assistance for mass campaigns (268 millions CFA

Research works on various aspects of the treponematoses problem increased, with a special attention paid to the diagnosis of congenital syphilis [65]. The importance of pian became a clear indicator of social changes and progress in health education and was more of a social issue than a medical one [66]. Gradually, a focus endemic syphilis [67] was to be clearly identified in Senegal, mostly affecting the Fulani nomad people's grazing lands [68]. Treponematoses prevalence rates among various sedentary populations previoulsy overlooked, were being assessed among the Bedik people in East Senegal [69], and the Serer around the groundnut growing area [70]. Epidemiological data based on patients' records at the "Institut d'Hygiène Sociale" provided information for both urban dwellers [71] and some rural ones [72]. The annoyingly high frequency of positive blood tests that remained positive after treatment was a major concern. For it raised the

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in 1957). Such campaigns were undertaken simultaneously to massive anti-pian campaigns with international assistance, in The Gambia, Liberia, Ghana, Nigeria (see Pierre Richet, *Le Service Commun de lutte contre les Grandes Endémies de l'Afrique occidentale française, Rapport d'activité depuis sa création*, 1958 [Dakar: ANS], 111 p. mimeo.; Makhone Douta Seck, *Le Service de Lutte des Grandes Endémies du Sénégal*, [Dakar, Thèse de médecine, 1968).

65 Jean Sénécal, René Souvestre, "A propos du diagnostic de la syphilis congénitale chez le nourisson africain," *Bulletin et Mémoire de l'Ecole de Médecine de Dakar*, 1952-53, **1**:113-117; J. Sénécal, G. Trapet and R. Souvestre, "Etude de la sérologie dans la syphilis congénitale en Afrique," *Semaine des hôpitaux*, 1952-53, **29**(64):3263-3270; J. Sénécal, H. Dupin, R. Souvestre, "Le diagnostic précoce de la syphilis congénitale," *Bulletin médical*, 1954, **10**:251-257; R. Souvestre, *A propos du diagnostic de la syphilis congénitale chez le nourrisson dakarois*, (Bordeaux: imprimerie moderne de Guyenne, thèse de médecine, 1953) ; Monique Castets, *Sérologie de la syphilis et protidémie chez les Africains de Dakar*, (Paris: Librairie Arnette, thèse de médecine, 1958).

66 M.A. Vaucel, "Le pian dans les territoires africains français," *Bull. Org. mond. Santé/World Hth Org.*, 1953, **8**:183-204. Pian annual prevalence rate in AOF was 4%, with a downward trend from Ivory Coast (huperendemicity area) up to Sahelian territories (0.1% in Senegal) in hypoendemicity areas.

67 Just suspected until the early 60s, its existence had not yet been confirmed in Senegal. It does not appear on WHO maps by Guthe and Willcox (*Chron. OMS* , 1954, **8**(2/3):42).

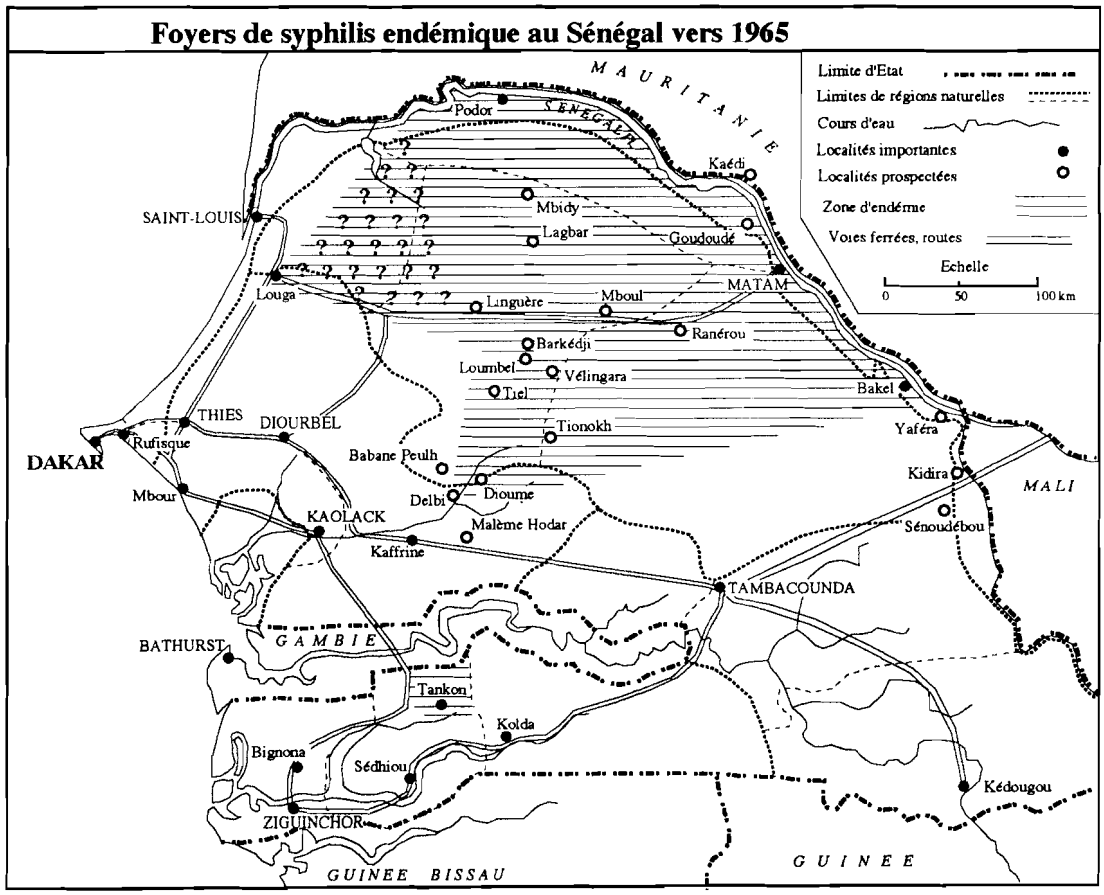
68 A. Basset, H. Boiron, P. Brès, M. Castets, M. Basset and E.N. Moyen, "A propos du foyer sénégalais de syphilis endémique", *Bull. Soc. Path. Exot.*, 1963, **56**(2):173-181 ; A. Basset, J. Malleville, I. Faye, "Nouvelle enquête sur la syphilis endémique au Sénégal. Etude clinique et épidémiologique. Etude sérologique, isolement d'une souche de tréponème," *Bull. Soc. Path. Exot.*, 1969, **62**(6):1017-1034 ; A. Basset, J. Malleville, J. Malgras, Y. Privat, I. Faye, M. Basset, E. Heid, H. Rusher and Ermolieff, "Nouvelle enquête sur un foyer de tréponématose en Casamance (Sénégal)," *Bull. Soc. Path. Exot.*, 1972, **65**(1):66-78 ; H. Boiron, A. Basset, I. Faye, A. Debroise and M. Mallet, "Etude des limites du foyer sénégalais de syphilis endémique," *Bull. Soc. méd. d'Afr. noire de langue française*, 1965, **10**:408-411.

69 P. Cicera, C. Bouloux and J. Gomila, "La fréquence des tréponématoses chez les Bedik du Sénégal," *Bull. Soc. Path. Exot.*, 1970, **63**(6):666-675.

70 J. Linhard, R. Baylet, G. Diebolt and S. Diop, "Prévalence sérologique des trépnématoses dans deux populations sérèr," *Bull. Soc. Path. Exot.*, 1973, **66**(6):701-706.

71 H. Bah, E. Maffre, R. Baylet, J. Wone, Ch. Gueye, "Maladies vénériennes suivies à l'Institut d'Hygiène Sociale de Dakar. Aspects épidémiologiques 1956-1964," *Bull. Soc. méd. Afr. noire de langue française*, 1965, **10**:230-236.

72 In a report on hygiene and health, prepared for the first development plan of the Senegalese government, Dr Anne Laurentin highlighted all the shortcomings related to the actual awareness of the epidemiological impact of the various treponematoses in several rural areas. She became famous with her work on the incidence of venereal diseases on the decrease in Black African countries birth rates (Upper Volta, now Burkina faso and Central African Republic) (Anonymous [ss dir Anne Laurentin], *Rapport Hygiène-Santé*, 2 vol. 1960 (Rapport enquête CINAM-ORANA 1959-60, ANS bi I 4° 160), A. Retel-Laurentin, *Causes de l'infécondité dans la Volta noire.* (Paris: PUF, 1979), A. Retel-Laurentin, *Un pays à la dérive. Une société en régression démographique. Les Nzakara de l'est africain.* (Paris: J.-P. Delarge, 1979) ; P. Peretti, R. Michel, "Bilan de dix ans de dépistage sérologique et de traitements des tréponématoses au Secteur des Grandes Endémies de M'Bour (Sénégal)," *Bulletin de la Société médicale d'Afrique Noire de Langue française*, 1971, **16**(2):201-206.



Dressée à partir des cartes publiées in Basset et al. (1963 : 176) et Boiron et al. (1965 : 410)

difficult issue of differential diagnosis, given the existing interrelationship between endemic syphilis, congenital syphilis and the latent forms [73], and the limited reliability of serological reactions which brings up questions about a possible abusive use of qualitative serology with terrible administrative consequences for some workers and the social injustice it carries for international labour migration [74]. An increasing number of elements tend to substantiate the unicity of the treponematoses [75].

Although we do agree — at least on its main principles — with the analysis suggested by Megan Vaughan [76] on the British colonial view of the syphilis epidemics in Baganda-land (Uganda), at the beginning of the century, and the colonial efforts to overcome it, we still feel that, colonial views on certain issues are not identical. In Francophone West Africa, the Christian missionaries' lobby on the matter, for instance, had a lesser impact in countries heavily marked by Islamic. Church-State separation applied in the context of colonial administration to readily anti-clerical components, would indeed highlight the slight socio-moralising connotation embedded in papers dealing with sexually transmitted diseases. Prejudices in colonial medical circles were stigmatised —in lay terms — the populations's indifference or carelessness rather than viewing it as immorality. The oldest texts indeed incriminated "excessive copulating" which translates into obsessive fear of morbid copulation [77] common in that period marked by the fears of degeneration of mankind deriving from some popularized darwinism. Alain Corbin [78] stresses how in the continuous dialogue between medicine and society, medical staff and their discourse (the heredito-syphilis theory for instance) just translate into scientific language the collective fantasies of their times. In this respect, colonial doctors' prejudices and attitudes are not different at all from those of their counterparts in Europe, made up of contempt and fear towards lower classes, towards the "people" regarded as immature.

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73 H. Boiron, A. Boisset, M. Basset, M Castets, "Contribution à l'étude de la syphilis au Sénégal," *Bull. Soc. Path. Exot.*, 1962, **55**(1):98-116 ; A. Basset, "Tréponématoses en Afrique de l'ouest," *Afrique médicale*, 1966, **5**:37-40 ; S. Dauchy and R. Baylet, "Réflexion sur les problèmes posés par la positivité de la sérologie tréponémique en Afrique de l'Ouest," *Médecine d'Afrique Noire*, 1972, **19**(11):843-848.

74 G. Niel, M. Gentilini, "Sérologie tréponémique des travailleurs de l'Ouest africain transplantés (A propos de 1.000 examens en immunofluorescence et en floculation de Kline)," *Bull. Soc. Path. Exot.*, 1970, **63**(2):180-194 ; S. Dauchy and R. Baylet, "La syphilis: évaluation de l'importance accordée à cette maladie dans les dispensaires au Sénégal," *Médecine d'Afrique Noire*, 1972, **19**(8-9): 655-658.

75 A. Basset, H. Boiron, P. Brès, M. Castets, M. Basset and E.N. Moyen, "A propos du foyer sénégalais de syphilis endémique," *Bull. Soc. Path. Exot.*, 1963, **56**(2):173-181 ; A. Basset, J. Maleville, J. Malgras, Y. Privat, I. Faye, M. Basset, E. Heid, H. Rusher and Ermolieff, "Nouvelle enquête sur un foyer de tréponématose en Casamance (Sénégal)," *Bull. Soc. Path. Exot.*, 1972, **65**(1):66-70.

76 Megan Vaughan, "Syphilis and sexuality: the limits of colonial medical power," in *Curing their Ills. Colonial Power and African Illness* (Stanford: Stanford UP, 1991), pp129-154 ; M. Vaughan, "Syphilis and colonial East and Central Africa: the social construction of an epidemic," in Terence Ranger and Paul Slack, eds, *Epidemics and Ideas. Essays on historical perception of pestilence.* (Cambridge : Cambridge UP, 1992), pp269-302.

77 The role of sexuality and venereal overindulgence in the disease transmission is not relevant to syphilis only but also to tuberculosis, the so-called social diseases (in its classical association with alcohol).

78 "L'hérédosyphilis ou l'impossible rédemption", *Romantisme*, 1981: 131-149.

The history of prostitution in Senegal is still to be constructed. Archive material on the issue are rather scarce, thus showing how the regularist system, or "French system" [79], found it difficult to operate here more than anywhere else. The regularist project — first designed by Parent-Duchâtelet (1836) [80] — considered prostitution management as a "matter of refuse collection", maintaining order and decency on public ways and places. Prostitution is not an offence per se since criminal law only condemns public indecent exposure and offence against public decency (Art. 334). Prostitutes are therefore subject to neither police nor magistrate's courts, but only to municipal regulations and administrative authority with its correlate arbitrariness. We have seen the difficulties faced by public authorities in trying to regulate prostitution and to find managers for identified brothels which would be thus easily controllable; despite some hygenists wish in suggesting the establishment of a vice squad that would collaborate with the preventive medical service [81]. Whereas European prostitution seems to be under control [82], its native counterpart escapes virtually all control. Lhuerre deplores the fact that the vice squad does not apply to native and half-breed prostitutes in the 13 January 1926 Order's provisions. Another colonial practice that was to contribute to restricting prostitutes from beeing referred to health facilities, was the so-called "*prendre mousso*" (to take a native woman in the French Soudan colonial jargon). Military doctors tacitly encouraged this practice among male colonial staff, believing that it would guarantee sanitary safety. African companions were supposed to "entertain, care, dispel boredom and thus prevent Europeans from indulging in alcoholism and sexual depravity that were unfortunately so frequent under hot climates" [83]. But, since the colonial transformations almost exclusively called for male labour thus entailing large-scale migrations, indigenous prostitution developed. Another characteristic of modern prostitution in Africa, is that organised procuring seldom exists [84].

79 Corbin, *Les fillesde noce*, 1978.
80 Dr Parent-Duchâtelet, *De la prostitution dans la ville de Paris, considérée sous le rapport de l'hygiène publique, de la morale et de l'administration*, (Paris, 1836).
81 H. Lhuerre, "Notes sur le fonctionnement de l'institut d'hygiène sociale de Dakar", *Bull. Soc. Pathol. Exot.*, 1928, **21**, 4:329-334; and "Sur la prostitution à Dakar", *Bull. Soc. Pathol. Exot.*, 1928, **21**, 9:703-707.
82 5 brothels were registered in Dakar, in 1942 (regular visits, periodical blood tests, long lasting treatments) and 70 native prostitutes were reportedly admitted in hospital the same year (ANS 1 H29 sous-dossier 1 - Venereal diseases in AOF between 1938 and 1943).
83 Francis Simonis, "Splendeur et misère des *moussos*. Les compagnes africaines des Européens du cercle de Ségou au Mali (1890-1962)" in Catherine Coquery-Vidrovitch, éd., *Histoire africaine au Xxe siècle. Sociétés - Villes - Cultures*, (Paris, L'Harmattan/UA Tiers-Monde-Afrique Paris VII/CNRS, 1993), p209.
84 Catherine Coquery-Vidrovitch, "La prostitution : de la femme libre au sida" in *Les Africaines. Histoire des femmes d'Afrique noire du XIXe au Xxe siècle*, (Paris, Desjonquères, 1994) pp189-206.

The AIDS era

In Senegal, like in many other African countries, AIDS occurred with the emergence, resurgence or steadfastness of major health problems: malarial forms resistant to conventional drugs, cholera which reappears after some 80 years of silence, cerebrospinal meningitis, tuberculosis, malnutrition, diarrheal diseases. There is often a discrepancy between degree of specialist awareness of the problem's existence and scope, and the layman's common social awareness. Initial reactions are denial, hiding or use of a discourse minimizing the disease existence and seriousness. An analysis of such reactions highlights the opposition of rationales evoked by the various actors, and the differing and competing types of discourses on the epidemic [85]. Before 1986, the Senegalese media were giving information on the epidemic's development elsewhere in the world and in other African countries while the local scientists were actively involved in research works on the human and simian retroviruses, and played an active part in the discovery of HIV-II [86]. Yet the presence of the infection in the country was still not announced. By mid-1986, the first cases were reported and considered as of "foreign" origin.

Structures were however rapidly established. Senegalese scientists participating in research and abreast of the epidemic's spread in the world and in Africa, were convinced of the need to promote prevention. The media and common discourse persist in overlooking the presence of the disease and its impact. The epidemics management policy remains deeply marked by STDs control models; HIV infection and AIDS being viewed as "social diseases" similar to STDs. A National Multidisciplinary Committee for AIDS Prevention (CNPS: Comité National pluridisciplinaire de Prévention du Sida) was created in 1988. Hosted at the Institut d'Hygiène Sociale, the Committee has a more or less conscious perception of AIDS as a "social disease" which makes it focus preventive measures differently from those regarding other affections that are more difficult to implement. However, two medical units are playing a key-role, i.e, the Bacteriology/Virology Laboratory (effecting blood testing and epidemiological follow-up) and the Infectious Diseases Ward of Fann's University Teaching Hospital (for clinical studies and patient treatment).

The CNPS encourages "control" and research and leaves a large action-oriented share to NGOs and other associations. Epidemiological surveillance, testing (in blood collection units) and medical care are combined. Both "prevention" and "control" have their advocates within the CNPS which

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85 Didier Fassin and Jean-Pierre Dozon, "Les Etats africains à l'épreuve du SIDA," *Politique africaine*, 1989, 32:79-85; J.P. Dozon and D. Fassin, "Raison épidémiologique et raison d'Etat. Les enjeux socio-politiques du SIDA en Afrique," *Sciences Sociales et Santé*, 1989, **7**(1):21-36; Gilles Bibeau, "L'Afrique, terre imaginaire du sida. La subversion du discours scientifique par le jeu des fantasmes," *Anthropologie et Sociétés*, 1991, **15**(2-3):125-147; Gill Seidel, "The competing discourses of HIV/AIDS in Sub-Saharan Africa: discourses of rights and empowerment vs discourses of control and exclusion," *Social Science and Medicine*, 1993, **36**(3):175-194.

86 Publication, in 1985, on the identification of HIV-II to which Prof. Souleymane Mboup was associated; Doctoral thesis by F. Dieng Samb (1986) which, according to the media, relates the identification in Senegal of an "non-pathogenic virus".

has been expanded while keeping its autonomy. Its leading members have been there since its inception, despite several reshufflings of the cabinet. Its guidelines and actions are highly appreciated by foreign organisations supporting National AIDS Control Programmes.

Some assessment of people's awareness has been attempted ever since the first cases were reported. In 1989, a study was conducted on the population of Dakar and its suburbs, as well as a standardized KAB [87] survey initiated at WHO's request. But findings are kept confidential. Studies using more sophisticated methodologies and implemented in selected rural areas revealed that the latter were very little affected by HIV infections (Saloum region [88]; Casamance [89]; Sine [90]; Kolda [91]). Studies further indicated how little rural populations were aware of AIDS and provided more elements on their perception of STDs. There is heretofore no indepth study on the most affected regions, which would have permetted following the evolution of awareness and assess the impact of past and recent initiatives for prevention and education. In 1992-93, "EDS-II" largely confirmed the relative scarcity — at the national level — of knowledge about AIDS, its modes of transmission and methods of prevention [92].

Yet, academic works are developing, especially in the medical field with some 200 doctoral thesies on HIV, AIDS, STDs at the Faculty of Medecine and Pharmacy (90% of which were submitted since 1986); presentations on AIDS at international meetings published in journals [93]; sustained participation in international research on HIV specially on HIV-II; and facilitation of regional and continental training courses regularly organised in Dakar since 1993.

One of the CNPS's main tasks has been to follow the evolution of the pandemic in Senegal, through data collected by the sero-epdidemiological surveillance group. Sentinel surveillance on six target groups (blood donors, pregnant women, prostitutes, men with STDs, hospital patients, TB patients) initially restricted to four towns has been extended to six. It also now includes

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87 Knowledge, Attitudes, Beliefs, Practices.

88 Mariam de Loenzien, Alpha Wade, Yves Charbit, Souleymane Mboup, "Attitudes de la population rurale face à la maladie et au sida", in Y. Charbit and Salif Ndiaye, eds, *La population du Sénégal*, (Dakar/Paris: DPS/CERPAA, 1995) pp435-466

89 G.Pison, B. Le Guenno, E. Lagarde, C. Enel, C. Seck, "Seasonal migration: a risk factor for HIV infection in rural Senegal," *J. Acquir. immun. Defic. Syndr.*, 1993, **6**(2):196-200.

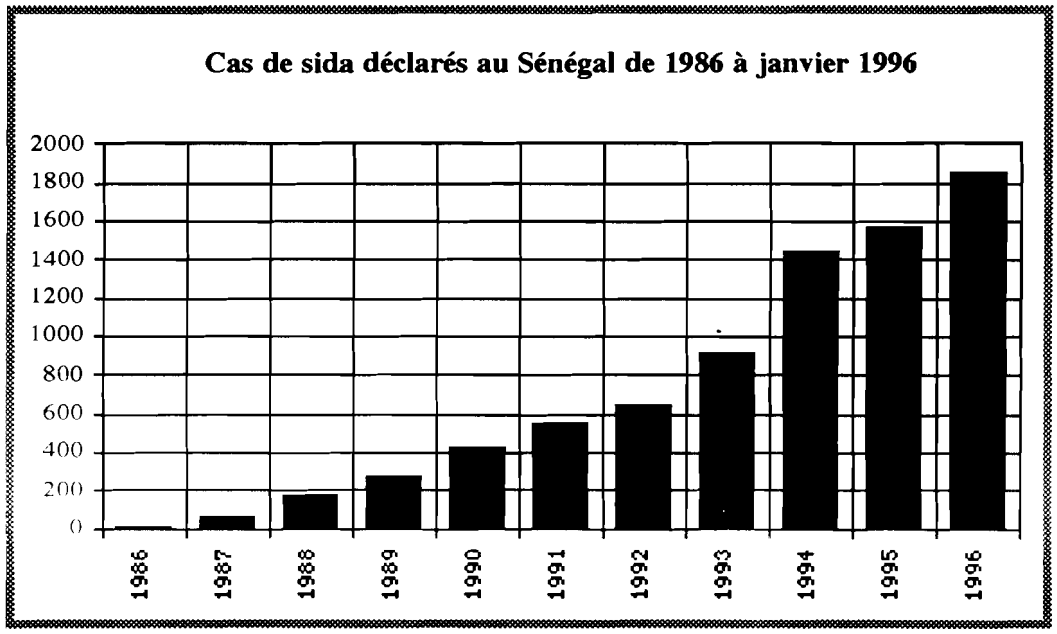
90 Charles Becker, *Etude anthropologique sur les migrations, la nuptialité et les comportements sexuels chez les Sereer du Sénégal*, (Rapport ANRS 1990, 4 fasc., 1991), "Facteurs de risque du SIDA liés aux migrations et aux comportements sexuels: une étude en milieu rural sénégalais", paper presented at Conférence Internationale sur le SIDA en Afrique, Dakar, 16-19 Dec. 1991).

91 Mame Birane Ibrahima Camara, *Etude socio-culturelle des MST dans la région de Kolda (Casamance)*, (Dakar, Université, thèse de médecine, 1991), 123 p.

92 Salif Ndiaye and Mohamed Ayad, "Maladies sexuellement transmissibles et sida", in Salif Ndiaye, Papa Demba Diouf and Mohamed Ndiaye, *Enquête démographique et de santé au Séngal (EDS-II) 1992/93*. (Dakar/Calverton, DPS/Macro International, 1994), pp161-170.

93 cf. Michel and Christine Etchepare, *Sida en Afrique. Bilan d'une décennie. Analyse par pays*, (Dakar, Enda, 1993) 301 p.

surveillance on other STDs, notably syphilis. Forecasts have been made [94] and give grounds for the optimism of public health authorities with an estimated prevalence rate lower than 1% among the adult population. Cases reporting is still limited as shown on the graph indicating 1,846 cumulated cases since 1986; for 1993, the estimated figures were 54,042 HIV positive people and 3468 AIDS patients [95]; in 1994 the estimated adjusted seroprevalence rate for the general population over 15 years of age was 0.95% or 36,485 including 23,969 men and the cumulated number of deaths is 8,188 [96].



Information generally relates to epidemiological, virological, medico-clinical and treatment aspects. Whereas very few data are available on the social ones, except for sexual behaviour [97] and migration [98], prevention among specific groups: *dimba* and *lawbe* women [99]. Urban areas are

94 *Bull. épidemiol.* HIV, 5, 1994.
95 *Bull. épidemiol.* HIV, 4, 1993: 31.
96 *Bull. épidemiol.* HIV, 5,1994: 34.
97 Michel Garenne, Charles Becker and Rosario Cardenas, "Heterogeneity, life cycle and the potential demographic impact of AIDS in a rural area of Africa," in Tim Dyson, ed., *Sexual behaviour and networking: anthropological and socio-cultural studies on the transmission of HIV*, (Liège: Dreouaux-Ordina, 1992) pp269-282; Catherine Enel and Gilles Pison, "Sexual relations in the rural area of Mlomp (Casamance, Senegal)", Tim Dyson, ed., *Sexual behaviour and networking*, (Liège: Dreouaux-Ordina, 1992) pp249-267.
98 Emmanuel Lagarde, Gilles Pison, Bernard Le Guenno, Catherine Enel, Cheikh Seck, *Les facteurs de risque de l'infection à VIH2 dans une région rurale au Sénégal*, (Paris: INED-Museum d'Histoire Naturelle, 1992) 41 p (+ 29 p annexes).
99 Cheikh Ibrahima Niang, "The Dimba of Senegal: A support for women", *Reproductive Health Matters*, 1994, 4:39-45; C.I. Niang, "Sociocultural factors favoring HIV infection and the integration of traditional women's association in AIDS prevention strategies in Kolda, Senegal," Washington DC, ICRW (International Center for Research on Women), May 1994, 5p. Studies conducted in the Kolda region among therapist women groupings *(dimba)* and in Kaolack among *lawbe* women who have special knowledge on sexuality, tended to involve in prevention actions, people reputed for their traditional knowledge.

largely prefered whereas data on rural ones are scattered and concern Casamance, the Kedougou area [100], Sine [101] and the Senegal River area where migrations towards Northern countries and interafrican ones are correlated to the presence of HIV-I [102].

A review of media publications shows a slow evolution in the social perception of AIDS and reveals the reluctancy long shared by the general public and newsmen. Newspapers started reporting on AIDS as a problem to Senegal only in 1986. Earlier brief articles located the disease elsewhere, thus conveying and disseminating very negative views on the disease and its patients, rejecting the idea of its African origin by emphasizing the virus' first identification and high prevalence in USA and Europe. Following reports of the first cases, papers included both new and recurring topics often reporting denial reactions similar to those recorded elsewhere in Africa. They also made reference to other specific concerns, since the epidemiological situation was regarded as less alarming. The contents of these related to the epidemiological situation as well as to actors and their responses to the epidemics.

Since the very first cases — considered as imported — there are regular accounts of the role played by migrants and other high "risk groups" (prostitutes, drug addicts, homosexuals). When reference is made to "risky behaviours", this is often just a language contrivance that cannot conceal the assumed relationship of AIDS to certain social groups. Designating migrants from a given region or an ethnic group as the vectors of epidemics, constitutes an obstacle to prevention. AIDS has often been compared by politicians and newsmen, to other fatal diseases like malaria, with an intent to highlight other health priorities.

There is a large discrepancy between the active involvement of Senegalese scientists in international research work (since 1986 when a second AIDS virus was identified in Senegal), with several publications on its characteristics issued over the past ten years and the common understanding of the epidemics and its scope, which even intellectuals find difficult to aprehend. This is particularly reflected in the abundance of conclusions from scientific meeting and insistance by local scientists, as compared to the scarcity of data on the spread of the epidemic and the problems it raises for health care systems and African societies. Nevertheless, already in 1986,

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100 B. Le Guenno, G. Pison, C; Enel, E. Lagarde, C. Seck, "HIV-2 seroprevalence in three rural regions of Senegal: low levels and heterogeneous distribution," *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 1992, **86**: 301-302

101 P. Lemardeley, A. Diallo, A. Gueye, E. Sarr, C. Becker, S. Mboup and J.L. Rey, "Evaluation des risques de MST et d'infection par VIH en zone rurale sénégalaise (1991)," *Cahiers Santé*, 1995, **5**(1):43-48.

102 Fadel Kane, Michel Alary, Ibra Ndoye, Awa M. Coll, Souleymane Mboup, Aïssatou Guèye, Phyllis J. Kani, Jean R. Joly, "Temporary expatriation is related to HIV-1 infection in rural Senegal", *AIDS*, 1993, **7**(9):1261-1265.

research authorities who are actively involved in CNPS activities, focused more on education and prevention rather than record the expected achievements.

Health authorities often claim vehemently an illusive control over the epidemics, using epidemiological statistics. Such claims are paralleled with the shyness of non-medical circles reflections on the pandemic due to their reluctancy to talking about health-related social issues and especially those raised by AIDS.

The possible role of traditional healers and their pharmacopea in STDs and AIDS prevention and management is seldom dealt with and has so far just given rise to a brief specific debate, thus highlighting old oppositions, journalists' little interest in traditional medecine's possible contribution, and its definite rejection by certain doctors. Whereas an active cooperation between the modern and traditional health care systems have been underscored as desirable, normal and ineluctable for a significant impact on STDs and AIDS spread in Africa [103], reflexion on this issue is still insufficient in Senegal and has not yet led to the development of collaborative approaches [104].

The publicity given to events organised by associations or in outlying regions are part of the strategies devised by various groups suggesting varying solutions and cautiously advising the use of condoms. Moral and religious leaders who stood long back from debates and actions, have recently become involved. The causes and modalities of that new committment promoted by AIDSCAP an active international organisation-would require further analysis.

Prevention is not easy to implement, due to the atmosphere of denial surrounding the epidemic. Prostitutes ("Risk group") — targeted prevention for instance, presents some shortcomings. Besides, there is a real difficulty in devising specific messages to the other groups. Despite some experiments conducted over the past years in three towns and in the most heavily affected regions,

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103 Edward Green, *AIDS and STDs in Africa. Bridging the Gap Between Traditional Healing and Modern Medicine*. (Boulder, San Francisco, Oxford,Pietermaritzburg: Westview Press, University of Natal Press, 1994), xi-276p.

104 The issue of the ambivalent relationship of the two care delivery systems in Senegal deserves a specific historical study. While the interest in traditional medecine seems rather shy at first sight, there have been early publications, by colonial doctors and pharmacists, on those issues, even in the *JO du Sénégal* (Official gazette) which, at the turning century, welcomed that type of information. In his outstanding book on Senegalese traditional pharmacopeia, Joseph Kerharo (*La pharmacopée sénégalaise traditionnelle. Plantes médicales et toxiques*, Paris, Vigot, 1974, 1011p.) makes an inventory of and describes about one hundred plants commonly used in STDs treatment. He further proposes a historical approach to research work on medicinal plants and flora, and their therapeutical use in indigenous medecine. Colonial doctors have hower had negative attitude towards traditional healers they called quacks. Variolisation as practiced by native populations was turned down and stigmatised by health authorities. In the 50s, children's deliberate inoculation with a pale treponema among certain groups was mentionned with reference to the high syphilis prevalence rates among such groups (A. Basset, "Tréponématoses en Afrique de l'ouest," *Afrique médicale*, 1966, **5**:37-40). This has nevertheless not been confirmed in Senegal.

very few programs are directed to youngsters (apprentices, workers of varying status, pupils, students).

Reflections on ethical and legal aspects are not well developed, although the CNPS includes a sub-committee specialised in such issues which was established fairly early. This is related to the low prevalence rate recorded in the country and the epidemics' virtual invisibility. Current debates in more severely stricken countries, about drug trials, testing, confidentiality, rights of people with HIV, etc, have had not much development here. It should however be noted that a national team has been formed and it participated in the Dakar Consultation (June 1994) that formalised the establishment of the African network on "Ethics, Law and HIV" and adopted a Declaration starting ten basic principles [105]. The development of associations of people with HIV seems to be partly hindered by a desire for discretion (a will to keep secret the identity of infected individuals) in a context of low prevalence and fear of stigmatisation.

The Senegalese community has been unequally confronted with the HIV infection (depending on the regions) but also less rapidly as compared to other African countries [106]. The management model of the epidemic is considered to explain its slower rate of spread, but other factors (e.g religious, moral, social factors) are also cited to more or less convincingly. Like everywhere else, the community's perception of AIDS was initially narrow — and remains so for a large majority — before the disease became visible and a directly noticeable reality. Denial reactions are still frequent. In regions that seem least affected, most people are not aware of AIDS and even deny its very existence. In the absence of a genuine knowledge of.the infection, promoting discussion might just lead to refusing to believe in this very special "disease" that might be serious and frequent for others. Such discussions might disseminate diverse representations of this ailment, its origin and modes of transmission.

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105 UNDP, *African Network on Ethics Law and HIV.* Proceedings of the Intercountry Consultation, Dakar, Senegal, 27 June-1 July, 1994. (Dakar: UNDP, 1995), xiv-220p.["Senegalese Country Paper", pp149-155]

106 Jeanne-Marie Amat-Roze, "Dynamique de l'infection à VIH et du sida en Afrique noire" in Actes du VIe colloque Histoire au Présent. François Olivier Touati,éd., *Maladies, médecines et sociétés. Approches historiques pourle présent.* Paris, L'Harmatta/Histoire au présent, 1993, Tome I:86-103 ; J.M. Amat-Roze, "Les inégalités géographiques de l'infection à VIH et du sida en Afrique sud-saharienne," *Social Science and Medicine*, 1993, **36**(10):1247-1256 ; Gérard Rémy, "L'espace épidémiologique de l'infection par le virus del'immunodéficience humaine VIH-2 en Afrique sud-saharienne," *Médecine tropicale*, 1993, **53**(4):511-516; G. Rémy, "Image géographique des infections à VIH en Afrique de l'Ouest.Faits et interrogations," *Médecine d'Afrique Noire*, 1993, **40**(1):15-21; , G. Rémy, "Image géographique des infections à VIH en Afrique de l'Ouest.Faits et interrogations. II. Epidémiologie géographique des infections dans la population générale," *Médecine d'Afrique Noire*, 1993, **40**(2):81-86; G. Rémy, "Image géographique des infections à VIH en Afrique de l'Ouest.Faits et interrogations. III. Dynamique socio-spaciale des infections à VIH," *Médecine d'Afrique Noire*, 1993, **40**(3):161-164.

The history of STDs, health policies and conceptions implemented by colonial rulers, highlights an often ambiguous relationship between demographic themes (population growth and health for the development of colonies) and sanitary ones that are recurring in venereal diseases control. Some practices are constant, particularly those pertaining to the status of these diseases long considered as "social scourges" and stigmatized as such. As they jeopardized the desired population growth and were more difficult to control than other diseases, they were classified as separate and specifically dealt with very much like AIDS today.

Like for other compulsory reportable diseases, the "struggle" against STDs has been marked, since the end of last century, by its internationalisation and the desire to control and eradicate them under the supervision of doctors. Recent campaigns for controlling the rapid population growth are also conducted at international levels, with similar methods. In both cases, contradictions appear within communities where authorities want to implement voluntary actions and health programmes without taking into account consideration the various social actors and schools of thought.