A History of Sexually Transmitted Diseases and AIDS in Senegal: Difficulties in Accounting for Social Logics in Health Policy

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Historians still recall the fear aroused in Europe late in the fifteenth century by a certain cataclysmic new disease that broke out near the Kingdom of Naples. It emerged suddenly amid the armies of France and Spain during Charles VIII's expedition to Italy in a troubled context of war and loosening moral standards. It was so new then that there was no name to identify it. The French called it the Neapolitan disease and Italians the French disease. Upon returning to their homes after demobilization, Charles VIII's mercenaries — who were natives of many countries — spread the disease widely throughout Europe. The prestige of the Italian Renaissance contributed largely to popularizing the name *necrosis gallicus* for this new scourge and its alleged American origin (which, although controversial, has found advocates throughout the centuries in an ongoing and open-ended debate). French medical practitioners suggested other nomenclature: venereal disease or great pox. Girolamo Fracastoro was the first to propose the name syphilis, which gained wide acceptance only at the end of the eighteenth century; the term most commonly used by doctors and lay people until then was “great pox.”

However that may be, it is interesting to note how much syphilis has been, from the very beginning, branded the other's disease or the foreigner's disease. How, then, was this peculiar, devilish, contagious, venereal disease represented a few centuries later within the special context of colonial confrontation between Europeans and Africans? In 1897 the libertarian press, playing with words, ironically referred to the so-called civilizing mission of French soldiers in Madagascar as promoting “syphilization in Madagascar.” This philippic echoed the famous saying attributed to Krafft-Ebing, “civilization is syphilization.” The eminent German professor was an illustrious representative of a *fin de siècle* Europe garked by an obsessive fear of the taints of civilization. These taints included alcoholism and syphilis, which were regarded as "social scourges." It was precisely during this time that the Old World was launching its colonial conquests. This enterprise was perceived by some propagandists as presenting opportunities for the regeneration of a failing nation still in the throes of the trauma of defeat in the 1870 war with Germany.

European wayfarers had been travelling along the West African coast for many years, at first (and for quite a long time) trading human beings and later for legitimate trade that paved the way for colonization. It was not until the nineteenth century that long-term settlement prospects materialized with the establishment in Senegal of permanent administrative structures. An order dated November 5, 1830, made the French common law enforceable in that colony. Through a specific so-called assimilation policy, the French institutional and administrative model was applied in the parts of Senegal under direct administration. Hence, four communes with full rights were created in this way: Saint Louis and Goree (1872), Rufisque (1880), and Dakar (1887). All of these communes were founded before the establishment in 1895 of a federation of West African territories named *Afrique Occidentale Française* (AOF). Natives of the AOF were French colonial subjects and ruled by so-called indigenous laws. The European residents of the communes, in contrast, were *originaux* and were granted French citizenship. Although our purpose in this chapter is to focus on Senegal, we shall also consider other territories under French colonial rule in West Africa. This is appropriate because, after the far-reaching reorganization of the AOF from 1902 to 1905, medical and sanitary policy was elaborated at the federal level for the whole group of West African colonies until independence in 1960.

**AWARENESS OF VENEREAL DISEASES**

Awareness of venereal diseases and proof of their existence in the AOF started fairly early in urban areas with initial reference to two specific groups: prostitutes and the military. In September 1882, the internal affairs officer, acting as head officer, informed the civil physician in Saint-Louis (capital of Senegal), "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." The doctor was requested to examine those "girls" carefully and to keep in hospital those who presented with questionable signs until they were totally recovered. Full cooperation with the administrator was expected from the physician, who
was also to prepare a status report on prostitution in Saint-Louis. In his reply, dated September 28, Duchoud indicated that:

Authorized prostitution in Saint-Louis did not include brothels. Girls were not subjected to weekly consultations. Prostitutes registered 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, and another one is in hospital suffering from typhus. 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 rumors — 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 it without any shame and often without basis. Out of an average of 600 newborns per year, about 60 die. This figure is twice that in France and it is unfortunate that general treatment that needs to be of a long duration is unaffordable due to exaggeratedly high drug prices.

On the preceding day, September 27, the police superintendent of Saint-Louis informed the internal affairs officer that he had "ordered women whose behavior is notably unhealthy to be taken to the hospital for a detailed examination." In a letter dated June 8, 1897, the AOF governor general informed the internal affairs director of a high prevalence of venereal diseases among military troops based in Saint-Louis and Dakar and requested all municipalities to undertake surveillance in this regard. A few days later, the governor of Senegal stated:

The conditions under which prostitution was occurring in Senegal made preventive measures such as those implemented in European cities impracticable. For it is not in the streets that such actions take place that 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, and no such request has been reported so far. The attempt made to establish a brothel some years ago at Ndai Toute was not successful but some local entrepreneurs are likely to take it over. The Public Administration cannot 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.

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 and wrote to the internal affairs director on July 1, 1897, about an African soldier in the Saint-Louis garrison suffering from a venereal disease.
concerns about sanitation. After the establishment of administrative authority over the whole country (Senegal and other territories of AOF), there was a pressing need for more physicians to respond to the needs of the increasing population under colonial rule. Physicians were also needed to treat colonial personnel and to confront the diverse disease ecologies of an expanding colonial domain. In a report to the AOF governor general, Rangé, inspector of civil health services, proposed training young physicians who would be posted to pacified areas and provide medical assistance to African populations. An order dated February 8, 1905, instituted Medical Assistance to Natives after poor health conditions and dreadful mortality were revealed among populations of West Africa. In a circular dated April 12, 1905, Governor General Ernest Roume ordered that surveys be conducted in each colony of AOF in order to determine the causes of mortality and how they might be prevented, particularly among children. The resulting civil health service inspection report indicated excessively high mortality because of two major types of diseases: ordinary diseases caused by poverty, poor hygiene, and "dirt" (tuberculosis ranked first, followed by syphilis and alcoholism) and diseases that were presented to be specific to those countries at that time (endemic beriberi, leprosy, trypanosomiasis, malaria, and epidemic cerebrospinal meningitis, typhoid fever, and smallpox).

Venereal diseases were dealt with in the context of an interest in these so-called diseases of misery — an interest that was new in the colonies. Such an approach may sound like a sociological perspective. More precisely, the general point of view of the report reflects the deep influence of the new perspective introduced in France by the hygienists on health matters at the end of the nineteenth century. The promotion of the trio of tuberculosis, syphilis, and alcoholism to the rank of "social scourges" by European hygienists was based on a convergence of social fears and statistical observations. These theories came about in the context of urbanization and industrialization characterized by unhealthy living conditions and promiscuity — conditions denounced in the first studies in medical geography and sociology. This era was also characterized by the influence of Social Darwinism. Among the elite, Social Darwinism comforted the fear of human degeneration, which was thought to be the inevitable result of the abuses in the popular classes, such as venereal disease and alcohol abuse. Hygienists of this period were also fascinated by the use of statistics, despite their doubtful and deceptive nature at the time. During this period the French government became haunted by the fear of depopulation and passed two major modern laws on gratuitous medical assistance (1893) and on public health preservation (1902). High-level health authorities in both the metropolitan ministry offices and in the West African colonies adopted a similar perspective.

In his report Gallay indicated that it was impossible to state definitely the number of syphilis cases in AOF. He did, however, give some general (and sometimes contradictory) information about forms of the disease, its geographic distribution, and its sequelae. For example, he observed that secondary and tertiary attacks accounted for half of the consultations in county clinics, especially in Podor (on the bank of Senegal River), at the trade points along the river, and along the railway running from Saint-Louis to Dakar. Demand for potassium iodide in these locations often overwhelmed the scanty budgets and supplies. The Animist populations in the Southern colonies of Ivory Coast and Dahomey seemed less affected by syphilis than the Islamic peoples of the North, but were more affected by the consequences of increasing alcoholism. The greatest concerns raised by syphilis among these populations in the minds of colonial sanitation authorities related to its effects on child mortality, abortion, premature childbirth, and child mental deficiency. To prevent the depopulation of the colonies, Gallay recommended the creation of an autonomous smallpox vaccine service to be staffed by a corps of native medical assistants. This was accomplished in the order dated January 7, 1906.

**WORLD WAR I AND THE DEMOGRAPHIC OBSESSION**

World War I heightened this demographic obsession because of such factors as the poor health of young Africans, which became more apparent during the massive process of recruiting black troops at the beginning of the war. Furthermore, the high demographic cost of the conflict exacerbated the urgent need for manpower to develop the colonies and prompted the colonial party to launch an active campaign for the development or promotion of so-called "colonial reservoirs." This strong trend in metropolitan public opinion turned into a large development program of which Albert Sarraut was one of the keenest defenders. Sarraut emphasized the role that the colonies could play in increasing the greatness of France after World War I. He argued that the colonies had a threefold purpose of serving France: to increase its population and give it greater manpower, to make a financial contribution to the nation, and to supply France with the raw materials it needed.

**The Inter-War Years**

In the aftermath of the war, the native health issue in AOF was clearly connected to concerns about labor shortage and, thus, was expressed in terms of (re)production, "the native race had to be developed qualitatively and quantitatively." Governor Cardé's slogan, "faire du noir" ("produce 'Blackies'), was relayed over the years by the administrators. In his journal.
Several childhood afflictions among native populations in West Africa a positive Wassermann reaction (but without clinical signs of syphilis). The ever-present demographic concern led to a close retrospective look at data on stillbirth rates recorded in health facilities in Dakar between 1890 and 1930, focuses on infant protection and worker health. Therapeutic options had, of course, evolved greatly since the medical instructions of 1876 issued for posts without doctors. These old recommendations included the use of a mixture of copaiba and cubeb (local emollient baths), zinc sulfate injections, lead acetate, and calomel. However, at the beginning of the twentieth century the soda salt from arsentic acid (atoxyl) that Thomas and Breinl in Liverpool proved effective for treating trypanosomiasis in 1905 was used by French practitioners to treat syphilis in West Africa. In 1908 Bargy at Gaoua, Sudan, reported 32 cases of syphilis (6 primary, 17 secondary, and 9 tertiary) that were rapidly and successfully treated using this method, apparently to the patients' great satisfaction. Injections of Van Swieten liquor and mercury were used alternatively in the cure of a same person. Bargy reported the constant, rapid, and successful results of this new specific treatment for the great pox and the absence of medical complications (common with mercury injections). It was also painless. However, he recommended not giving more than 4 grams because this drug was a poison. Because of its toxicity, its usage was abandoned and some other products proposed.

New Specialized Facilities and Medicines

With more appropriate specialized institutions and facilities gradually put in place — Institut Prophylactique, Institut d'Hygiène Sociale, community clinics, and specialist consultants — Africans were followed more closely and their diseases detected through new scientific methods. Hence the deceitful and sly nature of the epidemic among them was better understood. A new conviction that "Certain ethnic groups like the Fulani and Tukulor, were almost all infected with syphilis" appeared in the medical reports, and some doctors stated that "eighty percent of the population of Dakar were infected." The scope of the problem did not dwindle with the passing years, although results of treatment were generally positive; reporters delighted in underscoring the quick curative action of arsenical medications.

Several childhood afflictions among native populations in West Africa and more specifically athrepsia (marasmus) were sequelae of congenital syphilis (such as abortions and infant mortality) given by Hata for Japanese women with syphilis and more complex in colonial medical reporting. This change was supported by a considerable increase in medical staff. The circular of Governor General Merlin dated April 12, 1921, confirmed by a circular of Governor General Carde dated March 12, 1924, emphasized the social role to be played by African auxiliaries. The circulars spoke of the need to increase the numbers of auxiliaries and to encourage midwives to visit African families in a sustained effort to improve child health and to advocate hygiene. Carde's circular of February 15, 1926, gave specific instructions about these objectives and the means by which to implement them. A circular of March 5, 1927, relates the first results recorded from these activities and provides some supplementary guidelines to their implementation. The circular of August 1, 1930, focuses on infant protection and worker health. The inter-war years were marked by a substantial fear of syphilis by French medical administrative authorities in both France and AOF. During this time the picture of the threat of venereal disease became denser and more complex in colonial medical reporting. The ever-present demographic concern led to a close retrospective look at data on stillbirth rates and infant mortality recorded in health facilities in Dakar between 1890 and the early 1920s. In 1923 Thiroux compared these figures from Senegal to more recent data on the ravages of congenital syphilis (such as abortions and infant mortality) given by Hata for Japanese women with a positive Wassermann reaction (but without clinical signs of syphilis). Several childhood afflictions among native populations in West Africa and more specifically athrepsia (marasmus) were sequelae of congenital syphilis as evidenced by blood tests, and "the superiority of sulfasenel treatment over vegetable soups [that is, a nutritious diet]" was confirmed. The relative immunity of Africans to venereal syphilis as suggested by Jeanselme in 1904 and possible diagnosis errors were major issues. The assumed immunity of Africans 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 seen to be extremely virulent. Fournier referred to this combination of diseases as "exotic syphilis." The extreme malignancy of exotic syphilis in Europeans was thought to be due to co-infection with malaria, as demonstrated by thorough etiological analysis of blood slides. Thiroux noted on the contrary that if African adults were not very sensitive, their children were hardly affected by malaria, which, he stressed, had a major effect on the virulence of syphilis.
incredible carelessness about the disease. In particular, it suggested that native or curative treatment of primary syphilis at community clinics, venereal wards, examination rooms for prostitutes, or hospitals provided through the use of mercury salts, arsenic, or bismuth. These were more powerful bleaching effect (easing of the symptoms), were quite expensive. For tertiary lesions, the report suggested the use of iodide in association with mercurial medications. Iodide was very expensive and required high doses in a prolonged course of treatment. Thus, its use in a mixed iodide treatment was prioritized for pregnant women and young children with hereditary syphilis. On the contrary mercury salts were to be distributed generously to patients. Budgetary constraints were still bitterly felt as demand increased for arsenical products within a population that was appreciative of the successful results of injections. In the context of global economic crisis during the 1930s, bismuth- and mercury-based medications were to be given priority once again.

**Difficulties and Blaming Africans’ Attitudes**

However, the hopeful prospects introduced by the new therapeutic possibilities were thwarted by constant difficulties in implementation in the field among African populations. The medical community constantly implicated African attitudes as the root of the problem. It was as if the physicians wanted to exculpate themselves from their helplessness by blaming their patients. They denounced the “natives’ unbelievable lack of privacy,” “excessive copulation,” and their patients’ indifference to blennorrhagia and the symptoms of primary syphilis. When physicians were not busy excoriating Africans for their sexual behavior, they were complacent pointing to popular local beliefs and prejudices according to which blennorrhagia was held to give males special procreative abilities. This was thought to be because of the special erethism of the penis in association with mercurial medications. Iodide was very expensive and required high doses in a prolonged course of treatment. Thus, its use in a mixed iodide treatment was prioritized for pregnant women and young children with hereditary syphilis. On the contrary mercury salts were to be distributed generously to patients. Budgetary constraints were still bitterly felt as demand increased for arsenical products within a population that was appreciative of the successful results of injections. In the context of global economic crisis during the 1930s, bismuth- and mercury-based medications were to be given priority once again.

Colonial confidence in the civilizing mission of promoting and improving the health conditions of Africans was often shattered by the harsh realities in the field where diagnosis was difficult. For instance, after the era of symptom-based diagnosis, the Wassermann reaction (discovered in the first decade of the twentieth century) revealed that the scope of syphilis infection was larger than ever suspected. It seemed to be even more so with the advent of large scale big yards in Senegal and West African colonies and the significant labor migrations they produced. Railways and the new road networks also indirectly contributed to the expansion of STDs in AOF. Furthermore, prevention was complicated by the frequently overlooked sequelae of blennorrhagia and by late or incomplete treatment. Arsenical medications were also attacked. Although their quick action, easy administration, and acceptance by patients prompted intensive use, they were often not used long enough to do more than merely mask symptoms. It gradually became apparent that neither clinical observation nor laboratory tests could definitively establish whether recovery was complete. Hence, the health service’s strategy was to emphasize a reorientation to pathogen-focused control efforts, for syphilis at least, that stressed identification and treatment.

The limited reach of the institutes of hygiene or anti-veneréal clinics situated in urban areas was to be supplemented in rural practice by the administration of polyvalent medications at sufficiently high dosages to ensure long-lasting cure of the infection. This practice accommodated the common impatience with long-term treatment among African populations. The context of global economic crisis in the 1930s coupled with repeated warnings — from Marcel Léger in particular — about the risks of relapsed infection from inadequate treatment with arsenical prescriptions prompted a renewed preference for bismuth- and mercury-based drugs. Treatment with sublimate pills was to be left to patients only under exceptional conditions. Treatment at dermatovenereology clinics in towns was improved through regular blood testing and prevention-oriented home visits conducted by nurses. In 1932 a special place for STD consultation was opened in Sor, a suburb of Saint-Louis. External treatment of blennorrhagia by repeatedly applying washing conducted in sanitary facilities had a chance of succeeding only in a restricted category of disciplined and well-informed patients (referred to as evolved in colonial ideological discourse). For other more resistive patients, gonococic infections were successfully used. The African population was favorably impressed by injections and its yearning to be cured in one single consultation. However, over the entire range of therapy, there was no product that was genuinely effective for the masses.

**THE NEW ERA OF ANTIBIOTICS**

The advent of antibiotics, starting with the introduction of penicillin in 1943, began a new era in the biomedical treatment of STDs. In the early 1950s extencillin allowed mass treatment with one single low-cost injection. It was a true revolution. Meanwhile, major changes were made to the doctrine instituted by Jamot when he was head of the Permanent Mission for the Prevention of Trypanosomiasis. Jamot had initiated mobil
Independent General Service for Sleeping Sickness was created in 1939 with biochemistry and entomology laboratories. A nursing school was also set up in Bobo-Dioulasso to organize control activities throughout AOF (which was divided into sectors). Mobile preventive medicine employed trained African staff who took laboratories to rural areas. Following the Brazzaville Conference in June 1944, the Independent General Service for Sleeping Sickness became the General Mobile Hygiene and Preventive Service and was concerned with several major endemic diseases including yaws (bejel, a variant of endemic, non-venereal syphilis). The importance of such a service was to be fully realized only after 1949, with the formation of a mobile group conducting investigations in the Sahelian areas of Niger (in Djerma-Songhai lands) and Senegal River Valley (in Podor). The General Mobile Hygiene and Preventive Service thus included treponematoses. In 1955 mass campaigns were extended to other treponematoses (pian, or yaws) in forest areas. In 1957 intensive control activities were conducted under international guidance and using international means, such as the intensive use of slow-release penicillin.

Problems of Differential Diagnosis among Treponematoses in the 1950s

Research on various aspects of the treponematoses problem increased, with special attention paid to the diagnosis of congenital syphilis. The importance of pian became a clear indicator of social changes and progress in health education and hygiene and was more of a social issue than a medical one. Gradually, a focus endemic syphilis was clearly identified in Senegal, mostly affecting the Fulani nomad people's grazing lands. Treponematoses prevalence rates among various sedentary populations that were previously overlooked were being assessed among the Bedik people in East Senegal and the Serer around the groundnut growing area. Epidemiological data based on patient records at the Institut d'Hygiène Sociale provided information about syphilis for both urban dwellers and some rural ones (Figure 4.1).

The disturbingly high frequency of positive blood tests that remained positive after treatment was a major concern. This raised the difficult issue of differential diagnosis between endemic syphilis, congenital syphilis, and the latent forms and emphasized the limited reliability of serological reactions. It also may have had direct administrative consequences for some African workers and constituted a social injustice if used in rejecting for international labor migration African candidates coming from regions with (sometimes unknown) focus of endemic syphilis. Western medicine has enormous difficulties in establishing scientific criteria for differential diagnosis between venereal syphilis and
medicine in 1926 in Cameroon and in 1932 in AOF. The Independent General Service for Sleeping Sickness was created in 1939 with biochemistry and entomology laboratories. A nursing school was also set up in Bobo-Dioulasso to organize control activities throughout AOF (which was divided into sectors). Mobile preventive medicine employed trained African staff who took laboratories to rural areas. Following the Brazzaville Conference in June 1944, the Independent General Service for Sleeping Sickness became the General Mobile Hygiene and Preventive Service and was concerned with several major endemic diseases including trypanosomiasis (bejel, a variant of endemic, non-venereal syphilis). The importance of such a service was to be fully realized only after 1949, with the creation of a mobile group conducting investigations in the Sahelian areas of Niger (in Djerma-Songhai lands) and Senegal River Valley (in Podor). The General Mobile Hygiene and Preventive Service thus included treponematoses. In 1955 mass campaigns were extended to other treponematoses (pinta, or yaws) in forest areas. In 1957 intensive control activities were conducted under international guidance and using international means, such as the intensive use of slow-release penicillin.

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other remaining human treponematoses. An increasing number of elements tend to substantiate the unity of the parasite (Treponema pallidum) in the on-going and open-ended debate between the partisans of a unitarian concept of treponematoses and the defenders of a plurality of germs.

Although we do see similarities between the AOF case — at least on its main principles — and the analysis by Megan Vaughan of British colonial views of the syphilis epidemic in Baganda-land (Uganda) at the beginning of the century and of the colonial efforts to overcome it, British and French colonial views on certain issues were not identical. In francophone West Africa, for instance, the Christian missionary lobby had a lesser impact on sexual matters in countries that were heavily involved in Islamic culture. The church-state separation that occurred in French political life at the beginning of the twentieth century (1904) soon applied in the colonial administration’s context with deeply anti-clerical components. This is highlighted in the slight socio-moralizing tone of colonial papers dealing with STDs. Prejudices in colonial medical circles as reflected in medical reports stigmatized — in lay terms — the African population’s indifference or carelessness in the face of STDs rather than viewing the issue as one of African immorality. The oldest texts did, however, stigmatize Africans for “excessively copulating.” This obsessive fear of morbid copulation was common in that period of the twentieth century marked by the fears of degeneration of humankind. These fears derived from popularized ideas of Social Darwinism. The French historian Alain Corbin stresses how in the continuous dialogue between medicine and society, medical staff and their discourse (the hereditary syphilis theory, for instance) merely translated the collective fantasies of their times into scientific language. In this respect, the prejudices and attitudes of colonial doctors toward African populations were not so different from those of their counterparts in Europe at the time who held a mixture of contempt and fear toward the European lower classes, another category of people who were regarded as immature.

**Prostitution**

The history of prostitution in Senegal is still to be constructed. Archival materials on the issue are rather scarce, thus showing how the regularizing system, or French system, found it more difficult to operate in this domain than anywhere else. The regularist project — first designed by Parent-Duchâtelet — considered the management of prostitution as a “matter of refuse collection,” of maintaining order and decency along public ways and in public places. Prostitution was not an offense per se, because criminal law only condemned public indecent exposure as an offense against public decency (Code pénal, Article 334). Prostitutes were, therefore, not subject to police or magistrates’ courts, but only to local municipal regulations and administrative authority (which tended to be arbitrary in terms of enforcement).

There are many examples of the difficulties faced by the public authorities in the AOF trying to regulate prostitution and in finding managers for identified brothels that were supposed to be easily controllable under regulation. Some hygienists, however, suggested the establishment of a vice squad that would collaborate with the preventive medical service. Whereas European prostitution seemed to be under control its native counterpart escaped virtually all control. Lhuere deplored the fact that the vice squad did not apply to African and mulatto prostitutes in the provisions of the order of January 13, 1926. The colonial practice of “prendre mousso” (“to take a native woman,” in the colonial jargon of French Sudan) also contributed to restricting prostitutes from being referred to health facilities. 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 in hot climates.” However, because the transformations of the African social and economic order called almost exclusively for male labor, large-scale migrations ensued and indigenous prostitution developed. Another characteristic of modern prostitution in much of Africa is that organized procuring seldom exists.

**The AIDS Era in Senegal**

In Senegal, as in many other African countries, AIDS occurred with the emergence, resurgence, or persistence of other major health problems: the resistance of malaria to conventional drugs, the reappearance of cholera after some 80 years of silence, and the persistence of cerebrospinal meningitis, tuberculosis, malnutrition, and diarrhoeal diseases. There is often a discrepancy between degree of medical awareness of a problem’s existence and scope and the layman’s social awareness. Initial lay reactions to AIDS include denial or the use of a discourse minimizing the existence and seriousness of the disease. An analysis of such reactions highlights the opposite rationales invoked by the various actors and their differing and competing discourses about the epidemic. Before 1986 the Senegalese media were giving information on the epidemic’s development elsewhere in the world and in other African countries at the same time that local scientists were actively involved in research on human and simian retroviruses. In 1985–86 these scientists played an active part in the discovery of HIV-II. Yet the presence of the infection in the country has still not been announced. By mid-1986, though, the first cases were reported and were considered to be of foreign origin.
The National AIDS Prevention Program

Structures for confronting the epidemic were rapidly established, however. The Senegalese scientists who were participating in research and who kept abreast of the epidemic’s spread in Africa and elsewhere around the world were convinced of the need to promote prevention. Yet the media and those engaged in common discourse persisted in overlooking the presence of the disease and its impact. The policy for managing the epidemic remains deeply marked by previous STD control models; HIV infection and AIDS are viewed as social diseases similar to other STDs. A National Multidisciplinary Committee for AIDS Prevention (Comité National Pluridisciplinaire de Prévention du Sida [CNPS]) was created in 1988. Located at the Institut d’Hygiène Sociale, the committee has a more or less conscious perception of AIDS as a social disease inspired by the pattern of STDs that makes it focus on preventive specific human measures more difficult to implement than those regarding other transmitted infections. However, two medical units are playing a key role: the Bacteriology/Virology Laboratory, which conducts blood testing of STDs and AIDS and epidemiological follow-up of these diseases, and the Infectious Diseases Ward of Fan’s University Teaching Hospital, which conducts clinical studies and carries out patient treatment.

The CNPS encourages control and research and leaves a large action-oriented share of prevention work to nongovernmental organizations and other associations. Epidemiological surveillance, testing in blood collection units, and medical care are combined under the CNPS’s authority. Both prevention and control have their advocates within the CNPS, which has been expanded while keeping its autonomy from the Ministry for Health. The leading members of CNPS have held their posts since its inception, despite frequent reshuffling within the ministry. Its guidelines and actions have been praised in international conferences by such foreign organizations as the World Health Organization and the United Nations AIDS Organization, which support national AIDS control programs.

Assessments of awareness of HIV/AIDS have been attempted 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 knowledge, attitudes, beliefs, and practices survey initiated at the request of the World Health Organization. However, findings concerning Senegal have not been published; the reasons for this are unknown. Studies using more sophisticated methodologies and implemented in selected rural areas revealed that the regions of Kaolack, Ziguinchor, Fatick, and Kolda were very little affected by HIV. These studies provided a better picture of rural perceptions of STDs and indicated that rural populations were not well aware of AIDS. There has heretofore been no in-depth study on the most affected regions (Saint-Louis, Louga, Diourbel, Thiès, and Tambacounda), which would have allowed the evolution of awareness to be followed, and the impact of past and recent initiatives for prevention and education to be assessed. In 1992–93 a demographic and health survey largely confirmed the relative scarcity at the national level of knowledge about AIDS, its modes of transmission, and methods of prevention. Yet, academic work on HIV/AIDS is developing, especially in medical field. There have been some 200 doctoral theses on HIV, AIDS, and STDs at the Faculty of Medicine and Pharmacy of the University of Dakar (90 percent of which have been submitted since 1986). Preser- on AIDS at international meetings; publications in journals; training in international conferences on AIDS at international conferences; and facilitation of regional and continent-wide training courses organized regularly in Dakar since 1993.

Epidemiological Data

One of the CNPS’s main tasks has been to follow the evolution of pandemic in Senegal through data collected by the sero-epidemiological surveillance group. Sentinel surveillance for AIDS only, on six to groups (blood donors, pregnant women, prostitutes, men with STDs, hospital patients, and tuberculosis patients) was initially restricted to towns but was extended to six in 1992. It also now includes surveillance on other STDs, notably syphilis. In addition, forecasts have been made that give grounds for optimism on the part of public health authorities with an estimated prevalence rate lower than 1 percent among the population. Case reporting is still limited. As Figure 4.2 indicates, there were 1,846 cumulative cases between 1986 and January 1996. For 1995 estimated figures were 54,042 HIV positive people and 3,468 A patients. In 1994 the estimated adjusted seroprevalence rate for the rural population over 15 years of age was 0.95 percent with an estimated figure of 54,042 people and 3,468 patients. In 1995 the estimated adjusted seroprevalence rate for the rural population over 15 years of age was 0.95 percent with an estimated figure of 54,042 people and 3,468 patients. The cumulative number of deaths was thought to be 8,188.

The information available on HIV/AIDS in Senegal generally relates to epidemiological, virological, clinical, and treatment issues. Few data available on the social issues, with the exception of sexual behavior migration, and prevention efforts among Dimba and Lawre women. There has been more research in urban than rural areas. Data on locations are scattered and primarily concern Casamance, the Kédougou area, Sine, and the Senegal River area where migration to our both within and outside of Africa has been correlated to the present situation.

A review of media reports shows a slow evolution in the social perception of AIDS and reveals the reluctance to confront the epidemic long delayed by the general public and news media. Newspapers started reporting
AIDS as a problem in Senegal only in 1986. Earlier, brief articles located the disease elsewhere and conveyed very negative views on the disease and those afflicted with it. These reports rejected the idea of an African origin for HIV by emphasizing that the virus was first identified and reached high prevalence in the United States and Europe. Following official reports of the first cases in Senegal in 1986, newspaper coverage included both new and recurring topics, often reporting reactions of denial similar to those recorded elsewhere in Africa. Because the epidemiological situation was regarded as less alarming than in other African countries, the journalists made reference to specific concerns. They stressed the need for more scientific studies and more preventive action, but they did not refer to the therapeutic activities and other counseling and support activities by biomedical staff and nongovernmental organizations.

Since the very first cases — considered as imported — there are regular accounts of the role played by migrants and other high risk group (prostitutes, drug addicts, homosexuals) in spreading the epidemic. Reference to risky behaviors is often just euphemistic talk that does not 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. Furthermore, AIDS has often been compared by politicians and newsmen to other fatal diseases like malaria with an intent to highlight that there were other health priorities aside from HIV.

There has been a large gap between the active involvement of Senegalese scientists in international research work and the common understanding of this complex epidemic and its scope, which even the Senegalese intellectuals find difficult to comprehend. This is particularly reflected in the abundance of accounts of scientific meetings and th emphasis on the role played by Senegalese scientists, as compared to the scarcity of data on the spread of the epidemic in Africa and the problem it raises for health care systems and African societies. Nevertheless, 1986 research authorities who were actively involved in CNPS activities focused more on education and prevention, but the results were less important than the expected achievements. Using epidemiological statistics, health authorities have often vehemently claimed an illusory controversy over epidemics — not only AIDS but also cholera and yellow fever. At the same time their claims are met with reluctance from non-medical circles to talk about health-related social issues (especially those raised by AIDS and shyness about offering reflections on the pandemic).
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people with HIV seems to be partly hindered by a desire to keep secret the identity of infected individuals in a context of low prevalence and fear of stigmatization.

The Senegalese community has been unequally confronted with the HIV epidemic from region to region, and the infection has spread less rapidly than in other African countries. The model by which the epidemic has been managed is considered by CNPS and UNAIDS authorities to explain this slower rate of spread; but other factors including religious, moral, and social factors are also thought to contribute. As everywhere else, the community’s perception of AIDS was initially limited and before the disease became visible and a directly noticeable reality. For a large majority it remains so, and denial is still frequent. In areas 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 based on experience, popular discourses about AIDS, such as traditional African representations associated with evil, disease, and misfortune, may just express a personal denial to believe in this very special disease that is a serious and frequent occurrence for others. Such public discourses may disseminate and reactivate a lot of traditional representations associated with evil, its origins, and modes of transmission. These profoundly grounded representations, largely shared, do not facilitate the acceptance of a modern medical message in the absence of genuinely effective medicine and appropriate counseling and support.

PROVISIONAL CONCLUSION

The history of STDs, health policies, and conceptions implemented by colonial rulers highlights an often ambiguous relationship between the demographic themes of concern over population growth and health for the development of colonies and the theme of sanitation that has been recurring in venereal disease control programs. Some practices are constant, particularly those pertaining to the status of the diseases long considered as social scourges and stigmatized as such. Because they jeopardized the population growth desired by the colonial administration and were more difficult to control than other diseases, they were classified as separate from other kinds of afflictions and were dealt with very much as AIDS is today.

Recent historical research on West African demographic evolution during the last century underlines the interactions between the four parameters constituting the demographic regime: fertility, nuptiality, migrations, and mortality. This approach put forward the study of mortality (subsequently study of attached morbidity), because this parameter lies at the confluence of demography and health. Mortality often reflects sanitary crises or progress, as it appears through demographic and health statistics. This
This chapter was written in May 1994.

Nevertheless, it may be recognized that, as in the cases of other compulsorily reportable diseases, the struggle against STDs has been marked, given to epidemics and endemics, which were targeted first by the sanitary measures, especially vaccination programs, may have had a real impact on the course of demographic development in reducing mortality since the 1930s. However, the precise consequences of the measures against STDs in the decrease of mortality cannot be defined with any certainty, but were probably limited insofar as the concerned diseases — contrary to what colonial doctors thought and wrote — seemed not so widespread in Senegal in the past. Priority was broadly given to epidemics and endemics, which were targeted first by the sanitary measures. A wide field of investigations remains open on themes and questions scantily raised in this contribution about social, economic, and political factors related to health, reproductive health, and mortality.

NOTES


2. Quétel, Le mal de Naples, p. 68. This disciple of Copernicus at Padua University entitled his book — published in 1530 — Syphilis sine morbus gallicus. The volume was translated into French in 1753 under the title Syphilis ou le nouvel Hercule. Poème latin de Jérôme Fracastor (Syphilis or the venereal disease. Latin poem by Jerome Fracastor).

3. Le Père Peinard, November 28-December 5, 1897, quoted by Alain Corbin, Les filles de noces. Misère et prostitution (19e siècle), (Paris: Aubier Montaigne, 1978 p. 401. It should be noted that some experimental syphilization was attempted in the mid-nineteenth century by Aziz Turenne (1844), who issued several publications on the matter over some 30 years. The experimentation consisted in repeatedly inoculating the same individual with soft chancre until a negative reaction or the expected curative effect was obtained. This syphilis "immunization has been dropped and is now just one of many vain attempts at preventing this disease (see J. Rollet, "Syphilisation," in Dictionnaire encyclopédique des sciences médicales, vol. 14, edited by Dechambre [Paris: Asselin and Cie, Masson, 1884], p. 678-91).

4. His book Psychopathia sexualis published in 1856 was translated into French in 1892.


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


8. ANS, H42.

9. Ibid.

10. ANS, H42, letter no. 35.

11. ANS, H46.

12. ANS, H46.

13. Ndèr Toute is a fishermen’s district in the city of Saint-Louis located on a sandy littoral band at the mouth of Senegal River called "Langue de Barbarie" and separate from the city center, which is on an island.

14. ANS, H42, letter no. 149, June 19, 1897, to the AOF governor general.

15. ANS, H46, letter no. 999.


17. These measures were taken in answer to a wish expressed by the Académie de Médecine.


19. A. Kermorgant, "Maladies endémiques, épizootiques et contagieuses..."
Syphilis. Public health policy for many years and reached a very large part of the population in the countryside as well as in the cities. Important data on its activities, its force.


Andre Thirow, "Les maladies vénériennes dans les colonies françaises," pp. 59. The Independent Service of the Vaccine represented a major and even a prioritizing investment in the colonial health policy for many years and reached a very large part of the population in the countryside as well as in the cities. Important data on its activities, its forceful methods, the various reactions from the populations, and its effects are available in the archives and in medical journals from the colonial period. (cf. René Collignon and Charles Becker, Setent and population en Sénégalie des origines à 1960. Bibliographie annotée, [Paris: INED, 1989], pp. 85-109, 305-7).


Albert Sarraut, La mise en valeur des colonies (Paris: Payot, 1923). Appointed at the Ministry of Colonies in January 1920, Sarraut stayed for more than four years.


Quétel, Le mal de Naples, p. 238.


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38. Kermorgant, "Aperçu sur les maladies vénériennes."

39. Alfred Fournier, Traité de la syphilis (Paris, Ruef, 1906), p. 841. Fournier was one of the leading figures in syphilology in France and was hailed by Léo Daudet as "the first syphilographer of his time and probably of all times." Hered of the crusade against this venereal disease, his numerous works since 1857 at authoritative on the subject. In 1901 he founded the French Association for Sanitary and Medical Prevention. He was also the father of dispensaries (community clinics), elaborated the idea that the disease was not threatening just those who passed it on, and stressed the number of underdiagnosed infections among women and children (see Quétel, "L’ère de Fournier," in Le mal de Naples, pp. 165-9).


41. The ratio of malaria patients (determined using Koch’s method based on the percentage of infected children) was 60-70 percent in Senegal early in the century (André Thiroux and L. d’Anfreville, Le paludisme au Sénégal pendant les années 1905, 1906 [Paris: Baillière et fils, 1908], p. 59).

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

43. Opened in 1921, the Institute of Social Hygiene comprises six departments including an anti-venerale one. In 1927 some 87,723 consultations were made (H. Lhuirre, "Notes sur le fonctionnement de l’institut d’hygiène sociale d’Afrique," Bulletin de la Société de Pathologie Exotique 21 (1928): 329-34).

44. After 1919 in Dakar an anti-venereal clinic and consultation service annexed to the native maternity ward operated in the mornings (J. Kerneis, "Fonctionnement de la maternité indigène de Dakar," Bulletin de la Société médico-chirurgicale française de l’Ouest africain 2 (1921): 107-18). In 1926, in compliance with the Brussels International Arrangements of December 1, 1924, a health station was created with a syphilis laboratory at Dakar Port. It was charged with providing care to merchant navy men suffering from STDs. Its testing and care services were gradually extended to the fluctuating population of the port vicinity and to natives in Dakar city center and Medina, a separate ward that was set up exclusively for women. Mercurial pills recommended by Dr. Vernes were manufactured locally from a formula provided by Marcel Léger. The pills were easy to take, were without side effects, and were very popular among African (Cazanove, "Les enseignements"). Blood testing was being developed at the syphilis laboratory at Hôpital Principal. The Institut Pasteur in Dakar used Boel-Del-Wassermann’s reaction to test blood serum and cerebrospinal fluid (Marquis Quétel, "Les maladies transmissibles dans les colonies françaises et territoires sous mandat pendant l’année 1933," Annales de Médecine et de Pharmacie coloniales 31 (1933): 123-323).

45. Marcel Léger, Conférence de la défense sociale contre la syphilis (Nancy: Proebs-Verbaux de la conférence, 1928), pp. 53-56.

46. Ibid.

47. Hermant, "Les maladies transmissibles"; Grosfillez, "Les principales
Les maladies observées dans les colonies françaises et territoires sous mandat pendant l'année 1933,
48. ANS, H.188, "Instructions médicales pour les postes n'ayant pas de médecin," manuscript, p. 241f.
49. The pathogenic agent in human trypanosomiasis has similarities with
Trypanosoma pallidum — Syphilis treponema — that had also been discovered in 1905. Trypanosomiasis was a major public health concern in British East Africa in some AOF territories. This led to the establishment of a specific control device that made Jamot famous (see Jean-Pierre Dozon, "Quand les Pasteurians écartaient la maladie du sommeil," Sciences sociales et Santé 3 (1985): 25-56; Jean-Pierre Dozon, "D’un tombeau l’autre," Cahiers d’Études africaines 31 (1991): 135-57.
51. 914 has apparently been very popular in the Senegal River basin, according to Abdoul Sow, a Halpulaar investigator of the Tukulor ethnic group, personal communication, February 1996.
52. Quélet, Le mal de Naples, p. 179.
53. ANS, H.130.
54. In the mid-1920s stovarosal tablets were introduced as a specific treatment of plan in Ivory Coast where the infection was widespread. This treatment soon appeared as the most advisable treatment technique for heavily infected communities. Its success was evidenced by the local population'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].
55. ANS, H.186, letter to the governor of Senegal, from the files of the Medical Assistance Department.
57. The malaria therapy suggested by Wagner von Jauregg in 1917 (for which he won the Nobel Prize in 1927) does not seem to have been applied in the African context where, as we have seen, there were few cases of general parasi, tabs, and neuro-syphilis. There were, however, records in Dakar of several strains of malaria sent to Sainte-Anne Hospital in Paris for malaria therapy of French mental patients.
58. Gallay, Trois années d’Assistance médicale.
62. Ibid.
63. Thiroux, "Les maladies vénériennes."
64. Hermant, "Les maladies transmissibles."

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66. Groth, "Les principaux maladies observées." Authors at the time insisted on the importance of early and prolonged treatment. Some of them were also aware of the limitations of treatment capacities of medical facilities in the face of increasing demands for care (Marqué, "Les maladies transmissibles").
68. Marcel Léger was correspondent of Académie des Sciences Coloniales. Medical officer of the Corps de Santé Colonial, he created the Institut de Biologie de l’AOF in Dakar (1920) that became Institut Pasteur de l’AOF in 1924. He pursued scientific investigations on syphilis diagnosis and initiated many colonial physicians to the new techniques of diagnosis and treatments they applied in the African colonies.
69. In 1933 25,734 syphilitic patients were under treatment in health care delivery units, as opposed to 19,042 in 1932. An average of 17 injections per patient was delivered in 1933, as opposed to 9 per patient in 1932 (Ledentu, "Les maladies transmissibles," p. 765).
70. This recommendation came from several international conferences, the most important being the one held in Enugu, Nigeria in November 1955. International pressure on colonial powers to show a greater concern about improving the welfare of populations under their rule was growing during that period. The Hot Springs 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 a period of 30 months under the leadership of Colonel Dr. Pales. See Léon Pâles, Rapport No. 1, Sénégal (Dakar: Direction générale de la santé publique, 1946); Léon Pâles, Le bilan de la mission anthropologique de l’AOF (January-1946-août 1948) (Dakar: Gouvernement de l’AOF, 1948); Michael Worboys, "The Discovery of Colonial Malnutrition between the Wars," in Imperial Medicine and Indigenous Societies, edited by David Arnold (Manchester: Manchester University Press, 1998); pp. 208-25.
71. Financially autonomous, the General Mobile Hygiene and Preventive Service was funded from the general AOF budget (about 1 billion F CFA in 1957). (US$1 - 600 F CFA.) A 258 million F CFA fund provided for programs to be implemented in 1956-57 and 250 million in 1957-58 prompted international organizations, such as UNICEF, to grant important assistance for mass campaigns (266 million F CFA in 1957). Such campaigns were undertaken simultaneously with massive anti-yaws campaigns launched with international assistance, in The Gambia, Liberia, Ghana, and Nigeria (see Pierre Richet, Le Service Commum de lutte contre les Grandes Endémies de l’Afrique occidentale française. Rapport d’activité depuis sa création [Dakar: ANS, 1958], 111 pp. mimeo.; Makbone Doua Seck, Le Service de Lutte des Grandes Endémies du Sénégal, MD Thesis, (Dakar, 1968).
Senegal


90. As acknowledged by A. Basset, it is only in 1958, further to Anglo-Saxon works in Uganda and in Bechuanaland reserves, that the French great endemics’ department (Service des Grandes Endémies) with Richet started research on


The issue of the ambivalent relationship of the two care delivery systems in Senegal deserves a specific historical study. Although the interest in traditional medicine seemed rather timid at first, there were early publications by colonial doctors and pharmacists on the topic — even in the Journal Officiel du Sénégal (the royal gazette) which at the turn of the century welcomed this type of information. In his outstanding book on Senegalese traditional pharmacopoeia, Joseph Ker Latta (La pharmacopée sénégalaise traditionnelle. Plantes médicinales et toxiques [Paris: Paul Geffroy, 1974]) makes an inventory of and describes about 100 plants commonly used in STD treatment. He further proposes a historical approach to research on medicinal plants and flora and their therapeutic uses in indigenous medicine. Colonial doctors, however, had a negative attitude toward traditional healers, whom they considered quacks. Vaccination (vaccination) as practiced by native populations was put down and stigmatized by the colonial health authorities. In the 1950s, the deliberate inoculation of children of certain groups (nomadic Fulas in Niger region) with Treponema pallidum was mentioned with reference to the high syphilis prevalence rates among those populations (Basset, “Tréponématoses en Afrique de l’ouest,” p. 38). This has nevertheless not been confirmed in Senegal.

AIDS Control and Prevention Project was founded by the United States Agency for International Development and implemented by Family Health International since August 1991. AIDS Control and Prevention Senegal is based in CNIS, and its interventions in Senegal (as in other countries) were built on three strategies: communicating, improving treatment and prevention of other STDs, and increasing access to and correct use of condoms. Seidel, “The Competing Discourses of HIV/AIDS in Sub-Saharan Africa”; Green, AIDS and STDs in Africa.


HISTORIES OF SEXUALLY TRANSMITTED DISEASES AND HIV/AIDS IN SUB-SAHARAN AFRICA

Edited by
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