Introduction

Yes, there is a better way! The battle against AIDS can be won, this I know, not because of any sudden personal revelation, but because of impressive, little-known successes among communities and countries in Africa and Asia that I have worked with who have been able to cope with the epidemic of AIDS and hold it at bay.

When people, when communities assume personal responsibility for their health, they far surpass the efforts of health services and international institutions in combating an urgent health problem. Thirty years of experience in public health service in Africa and Asia have taught me that there is an actual “social vaccine” that grows out of these successful campaigns of the people against an epidemic like AIDS.

I have been able to witness these successes first hand, thanks to my work in Zaire and other African countries and my extraordinary experiences with my friends in Thailand and in conjunction with my work with the United Nations.

So, I invite you to come along with me and share these many extraordinary encounters as well as the harsh realities of my experiences. In this way, you will, I hope, come to share my conviction that there is a better, more effective, more humane way, to respond to the AIDS epidemic.
A Taste for Africa

It’s the day of the final examination in surgery at the Catholic University of Louvain when, in June of 1972, I finished my doctorate in medicine. At the end of the examination Professor Joseph Kestens turned toward me and showed me my grade—it wasn’t bad!

He said to me, “So, Lamboray, it’s obvious: you are going to do internal medicine?”

“No.”

“Oh, surgery maybe?”

“No, not surgery.”

“Okay, pediatrics, then?”

“No, sir, I’m not going to do pediatrics.”

“Well, what in the world are you going to do now?” he asked.

“I’m going to leave for the Congo. I’d like to work with dispensaries, setting up outpatient facilities.”

Kestens could not have been more surprised. He burst out laughing and slapped his thighs.
“It’s no more foolish than trying to transplant livers,” I said, rather disloyally, for that was his specialty.

I was fond of Professor Kestens and I believe the feeling was mutual, mutual enough in any case for him to want to pursue our conversation. That day my choice had evidently piqued his curiosity: why in the devil would a medical student with so many fine opportunities want to leave for Africa?

In the course of the graduation reception that ended the day, I talked with him about my two trips to the Congo and how they had aroused my compassion.

“I love Africa and the African people,” I said. “I am happy down there. Besides, I love medicine, but what attracts me even more is enabling the Congolese to practice health care in adequate conditions. Which, all too often, is not the case.”

For those around me the reasons for my choice remained nevertheless obscure, and the word vocation kept coming back again and again. “Why would you want to go to the Congo? Is it a vocation?” my friends asked me. Others, more cynical, didn’t hesitate to suggest that I wanted to practice on Africans before coming back to operate on Belgians.

No, I didn’t feel that I had a calling, a vocation. My choice seemed to me much simpler: I felt that I would be happy down there. So why stay in Belgium?

As for the idea of honing my skills on Africans, I used it in my own way years later during a dinner party in Kinshasa at the home of Mr. Lelièvre-Damit, the minister-counselor representing the Belgian Development Agency.
We were sitting around the table in a very beautiful mansion; a servant in a white jacket passed the plates. Toward the end of the meal the minister’s wife considerately asked me about my family.

“You have a daughter? Where was she born?”

“At Bree,” I replied.

“But what in the world were you doing in Flemish Belgium?” (Her husband was a true-blue Fleming.)

“Madame, I was doing my residency in surgery: I wanted to practice on the Flemish before operating on the Congolese!”

I can still hear the thundering laughter of the very jovial Mr. Lelièvre-Damit. . . And I can still see his wife, her spoon frozen in space between her mouth and her dessert, and then slowly putting down her spoon.

I met my fiancée in medical school. By chance, she was also attracted by Africa, for she had been born there in Leopoldville, now Kinshasa. Her father, Charles Liétaer, a doctor himself, had left for the Congo right after the war in 1946. He spent his entire career there and in 1970 was practicing in Mbuji-Mayi in the Kasai, where he was the chief medical officer of the large diamond mining company, the Bakwanga Mines. He invited us to spend our summer vacation in the Kasai.

I developed a tremendous admiration for my future father-in-law: as a doctor, as a man with a dry, caustic sense of humor, and as a great tennis player. He was extremely modest, and only years later did we learn of his heroic behavior in the 1960s during the
civil war between the Luluas and the Balubas: in spite of the raging battles he was right there on the roads evacuating the dead and caring for the wounded.

At his funeral services I tried to sum up his life simply: “Papy loved to talk about Africa and Africans. He talked about them non-judgmentally, with great respect and with a dash of his special humor.” His example, his wonderful willingness to talk, have marked and inspired me.

Mbujimayi, the diamond capital of the Congo, is a mining town of some 300,000 inhabitants in the middle of a savannah, invaded with high growth during the rainy season. In the region there are lions, rarely seen but very much present (I can still see the mark of five claws on the plump buttocks of a Congolese lady), civet-cats, genets, and other small savannah animals. Not to mention the crocodiles who regularly find their victims among the diamond “diggers,” those men who excavate the Mbujimayi riverbed. For diamonds are at the very center of the economic life of the Kasai. History has proved, and will continue to prove, that diamonds are also at the center of political life.

My fiancée and I began with a month’s vacation in a very post-colonial milieu: beautiful villas of the high executives of the mine, tennis matches at the club, swimming in Lake Mukamba. The workers quarters, comparable to those one sees in Europe, ran along one side of the residential area. On the other side, there was a Congolese city made up of people drawn by the opportunities of the mine, Baluba refugees from Western Kasai, and later from the Katanga. A flourishing commerce developed, for there were numerous clandestine “diggers” searching the diamond concession for stones. The
security services were constantly hunting down these “diggers” with night patrols and
search expeditions in Hovercraft over the river. What a world!

Vacation, to be sure, but I took advantage of being there to make contact with the
local medical establishment, notably at Disele Hospital, ten kilometers from Mbuji-mayi,
where I would begin practicing medicine, not without some difficulty, a few years later.
It’s an extraordinary place: this Fomulac hospital—the Fondation médicale de
l’Université de Louvain au Congo—was built, as a result of an error by geologists right in
the middle of a diamond mine! The building sits enthroned on a kind of peninsula at the
center of a gigantic hole in the mine. One reaches the hospital by a narrow strip of land.
The whole site is surrounded by barbed wire to keep out “diggers”, and one needs a
special permit to get in. I found out that some nights, diggers pursued by the security
patrols, climb over the barbed wire fences and hide in the hospital where with the
benevolent complicity of the nurses, they slip into unoccupied beds. When the patrol
arrives, they find only patients!

At Disele we were able to be present at a few minor operations. I became so
friendly with Justin Malaba, chief nurse in the operating room, that one evening he
invited me to his house in the workers camp to have a glass of beer and to meet his
family.

Later on that would be held against me by the chief medical officer when I came
to work at Disele. “Doctors should not go drink beer with staff. It is simply not done!”

While my fiancée went back to Belgium, I stayed on to spend a month with a
doctor whose decisions, options, and behavior would have an impact on me and reinforce
my own aspirations. Dr. Jacques Courtejoie, a forty-year-old bachelor at that time, was in charge of a scheutistes¹ fathers’ mission hospital at Kangu in Mayumbe in the Bas-Congo. He was passionate about health education. The rooms in his house had been transformed into workshops where, with the help of the young people in the region, he put together “image boxes,” large paper panels, each series of which would be packed in a box with the marvelous tropical tree aromas of the forests of Mayumbe. Distributed all over the country, and later in a large part of Africa, these image boxes brought health education to rural populations. For example, drawings and stories illustrated the dangers of fecal matter, why it was necessary to use toilets or latrines, steps to be taken to avoid the ancylostoma parasite (a worm that penetrates the skin and sucks blood), and all sorts of hygiene advice.

Jacques Courtejoie sacrificed his personal comfort to this work: design workshops took over his living room and what should have been his bedroom. His bed was pushed into a corner of the room.

Tirelessly, with his young team helping him, he worked on developing new stories, then on a series of remarkable books on nursing, sexuality, and so forth.

During my stay, he communicated to me his sense of egalitarian contact, of sharing the life of the Congolese, of setting aside the segregation inherited from colonial times.

¹ The more than 1000 Scheut or CICM Missionaries live and work in 23 countries throughout Africa, Asia, North and South America, and Europe. The acronym CICM stands for Congregation of the Immaculate Heart of Mary (in Latin: Congregatio Immaculati Cordis Mariæ). The name Scheut refers to a suburb of Brussels, Belgium where Father Theophile Verbiest, a Belgian diocesan priest, founded the Missionary Institute in 1982.
Around us, the Mayumbe region is superb with its hills of red earth covered in immense trees: the limba that looked a hundred meters tall, the bushier kambala. . .

The large brick buildings of the mission are earth colored.

Every morning I assisted Father Jacques who said Mass in twelve minutes. He claims he holds the speed record among the Scheutistes.

I spent my days in the operating room, as the second assistant, under the protective wing of Mr. Auguste, the head nurse of the operating room. Jacques Courtejoie took me along on his rounds, barefoot in his sandals, the sides of his white coat fanning open over his shorts.

One evening I was invited to a reception in honor of a nurse who is getting married. There I made a new and enchanting discovery: African dances. My debut in the Congolese rumba was pretty awkward, and my partner, a midwife at the hospital, kept her eyes lowered the entire time, which led me to believe that my awkwardness bothered her. But when I consulted Mr. Auguste, he reassured me by revealing something of the local codes: “Doctor, if a woman, while she is dancing, looks you in the eye, that means that the coast is clear!”

The return to Kinshasa where I was to board a plane for Brussels afforded me more learning experiences. I was traveling with a young nun named Sister Féliciane Malela. A scheutiste father drove us to Boma where we took a motorboat to Matadi, which marked the end of the navigable part of the river. Beyond that point began the grand rapids in which the television personality, Philippe de Dieuleveult, disappeared
with six of his colleagues on August 6 of 1985. Boma is a city with plenty of character: the Congo River is broad, sprinkled with islands. On the other side is Angola.

In Boma you can see the touching cemetery where are buried the remains of so many young missionaries, cut down by malaria or yellow fever only a few weeks after their arrival in Africa. You can also see there the hollow baobab tree where Stanley had a door installed in order to imprison slackers.

The motorboat sped up the “majestic river,” as it would be called later in the national anthem, La Zaïroise. On the river banks the baobab trees cross branches with enormous borassus palms whose huge fruits look like soccer balls and pose a threat to the heads of passersby!

We were the only passengers in the motorboat. Sister Féliciane, very pretty, was dressed in an elegant pagne (sarong wrap skirt), for the sisters insisted on asserting their African identity. The jolly crew, of course, had a great time joking about us. “You’re pulling our leg, she’s not a nun! She is too pretty and too well dressed. She’s your wife!”

We arrived at Matadi, its port stuck into the mountainside. The city, built on a rock, is a veritable furnace. At the convent of the Sisters of Charity of Ghent, the administrative staff was European nuns. They served me a meal, alone, in a room reserved for drivers. Sister Féliciane was shocked and pained, for this attitude is so contrary to African hospitality. She cried about it and let them know that she could not see the relationship between the chill of this welcome and the evangelical message. Two worlds meet. . .
From this first stay in Africa I returned with three strengthened convictions:

It’s there that I want to go as soon as I finish my studies.

My vision of my future profession goes beyond the simple practice of medicine.

I refuse to take part in the social systems inherited from the colonial period.

My second stay in Africa was much longer, and more involved professionally since my fiancée and I left in 1971 to do our final stage of the doctorate in medicine in the Congo, which became Zaïre that same year.

We were about to get married, but at Louvain the head of internships responsible for relations with the Université Lovanium of Kinshasa told us, without batting an eye: “You can’t get married because there is no married couples housing at Lovanium. So, I want you to continue your engagement and live in celibacy. Give a good example of Christian morality to your friends, who truly need an example.”

So there we were, both interns, each one living in a separate dormitory. It was first and foremost a chance for an intensive apprenticeship in medicine. Just before we arrived, President Joseph-Désiré Mobutu had sent all the Congolese students to the army for a few weeks to put them on the ideological straight and narrow. This meant that at the hospital, besides the permanent personnel, there remained only foreign students: Nigerians, Sudanese, Cameroonian, Burundian, and Belgians. For six weeks we were on duty every other day. I fell asleep anywhere and everywhere. But it was a period of enormous practical experience. I birthed a hundred or so babies. I assisted at open-heart operations and benefited from experiences backed by high quality teaching.
It was also the period where I encountered for the first time traditional medicine, for which, over the years, I had ample opportunity to develop a great deal of respect.

One day while make the rounds in the pediatric ward, Professor André Debroise stopped us in front of an infant brought to the hospital by his grandmother, for he was an orphan. After examining the baby, the professor turned to my fellow intern and me and asked:

“Do you two have any questions?”

“Uh. . .no.”

“Well, think a minute: the baby is an orphan. Therefore, one could wonder how he is going to survive, who is going to nurse him.”

Then turning toward the old grandmother, the professor asked:

“Are you the one who is nursing the baby?”

“Of course,” she said.

We burst out laughing: how could a toothless old woman nurse a baby? The professor gently corrected us: “You boobies! Before laughing, you ought to examine this woman.” And he turned toward her.

“Maman, raise your blouse.”

The woman raised her blouse, exposing two very long breasts.

“Squeeze the nipples a little,” the professor added.

Fascinated, we watched drops of milk fall from those old breasts!

“Maman,” he continued, “When did you stop having your periods?”

She burst out laughing.
“Doctor, really, how do you expect me to remember? That was so long ago.
When I was young!”

I then learned that traditional doctors make a certain concoction of roots and bark to bring back lactation. They don’t have many opportunities to make it because when a woman dies in childbirth, there is almost always some woman in the family nursing a baby. This question will be raised again some years later when the ravages of AIDS will leave behind so many little orphans.

Some years later, as chief medical officer in the Bas-Zaïre, I worked regularly, at his request, with a great traditional medicine doctor, Mbala Samba. He confirmed the story of the nursing grandmother, pointing out that it takes him two or three days to bring on lactation with a woman still having her periods and a good two weeks with a woman who has passed menopause.

But, getting back to the beginning of my discovery of Africa. We socialized a great deal with our Zairian colleagues. We resumed our friendship with Bernadette, whom we had met two years previously in Mbuji-Mayi and her fiancé, Jean-Marie. With them we traveled up to the Zongo falls. Bernadette invited us into her family. We also spent many wild evenings dancing in the bar of the medical student center that we baptized “the thick smear,” the name of a technique used to diagnose malaria! What great fun, what joie de vivre! We danced to the music of the great Zairian singers of that time: Franco, Rochereau—always the Congolese rumba, but also the mutuashi, a Balubas dance, moving in a circle, very suggestive for a European. As for our Zairian friends, they didn’t think when they danced: they just danced!
It was during that period that President Mobutu launched his authenticity movement. The Congo became Zaïre. From one day to the next, everything changed and people laughed and joked about it:

“You’re not a Congolese any more, you’re zairois!”

“No, I’m not. I’m Zaïre rien?”

The national anthem *Debout Congolais* was replaced by *La Zairoise* that the students sang every morning as the flag was raised. The use of Christian first names was forbidden. Joseph Mobutu became Mobutu Sese Seko Kuku Ngbendu Waza Banga. From that time forward Bernadette’s name became Madiya and Jean-Marie’s Mbuyi.

Men could no longer wear ties, and a new suit was created, the *abacost*, a Maoist kind of jacket requiring neither a shirt nor a tie.

It was also a time of repression. The government entered into a conflict with the Catholic Church, which as far back as 1969 had denounced “the dictatorial tendencies of the regime.” One night someone came to spy on our prayer group: could we be plotting against the government?

But life continued almost as before on our university campus. From the summit of Mount Amba that we called “the inspired hill” it dominated the city of Kinshasa. Modern buildings, up-to-date technological equipment, a superb chapel in the style of Le Corbusier, and Olympic-size swimming pool—it was a magnificent place. But all the same it was a ghetto, and I was attracted by the native quarter qui spread out at the foot of the hill, the Ngaba area. I formed a friendship with Anne Bumbulu, a young patient in

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2 A note from the translator: A play on words. “I am a Zaïre – nothing”
the pediatric department who suffered from diabetes and who was soon going back to her home in Ngaba. One day I went walking there in order to find a dispensary where Anne could be treated. Going from dispensary to dispensary, I discovered a place full of misery, ignorance, and exploitation only a kilometer from our ultra-modern hospital!

There was nothing: a syringe, three phials, and a few needles that were obviously used on everyone. That day I decided that instead of isolating myself in a hospital, I would go into the villages and the native quarters and reorganize health care.

An incident that could have turned into a tragedy definitely convinced me of the necessity of speaking the language of the country. While driving across the Ngaba quarter, I noticed, in the middle of the road in front of me, a shape that looked like a cloth sack. But as I passed alongside it, I realized that it was a young woman, stretched out unconscious. I stopped and walked toward her to see how I could help her. At that moment, a mob came down from the hills, and people started to yell: “There’s been an accident! This white man has killed that girl!”

Fortunately, I understood enough Lingala to realize that the situation was becoming threatening. The mob came closer. I turned to face them, and to everyone’s surprise, I yelled: “Tika makelele!” which means, “shut up, get quiet!” I added that the girl was still alive and that I was going to take her to the hospital. Her father approached me at that point and said that he would help me. The mob quieted down.

Language is a sine qua non prerequisite in making contact with the people, in gaining their confidence, of living among them. My progress in Lingala would eventually enable me to negotiate a dowry for a Canadian friend engaged to a young
Zairian woman. This young doctor, serving an internship with us, fell in love with a student nurse (today they live in Canada). After he decided to ask for her hand, I accompanied him to his future father-in-law’s house where, in Lingala, I negotiated the dowry. I insist that the young lady is worth not two cases of beer, but only one, that three suits for the father is too much, that a kerosene lamp for each member of the family is exaggerated and so forth. We spent the whole night at it, and one and all, on both sides, had a great time!

Some years later in the Bas-Zaire, the use of Kikongo and its proverbs proved essential in health committee meetings, but let’s not get ahead of ourselves.

We made our decision: we would come back to Zaire and I would work on improving the health care system. But it was equally clear to me that to be able to do this, I had to establish as far as my colleagues were concerned my credibility in two fields: surgery and public health. I devoted the coming year on just that.

Our internship completed, we went back to Belgium. For a year I practiced surgery as an assistant in Bree Hospital while attending classes for a special degree in public health three times a week at Louvain. I studied under Professor Michel Lechat, who remains for me today a master, the ideal teacher, capable of articulating basic concepts derived from practical experience. Never have I forgotten his method, and it has always informed my own work.

The ministry of Belgian volunteer services accepted my candidacy: I would soon be sent to Zaire, to Mbujiemayi, exactly where in 1970 I had made my first visit to the Congo, invited by Charles Liétaer, who two years later would become my father-in-law.
I still had a few months left to garner all I could from the teaching of Professor Lechat, to listen to him talk about Zaire, where he had worked for several years in a leprosarium on the banks of the Congo River.

And a few weeks left to appreciate his common sense. I still recall his remark when I gave him a draft of a program for fighting onchocerciasis, a disease that leads to blindness.

“Lamboray, what you have done is perfect on an academic level. . .you are certainly going to go about it differently when you get down there.”
From the very first days, I felt that things were not going to go well.

The Belgian Development Agency assigned me to Disele, that odd Kasai hospital built in the middle of a diamond mine. My appointment letter clearly indicated that I was there to organize a network of dispensaries in the bush surrounding the hospital.

So, as soon as I arrived, I asked the chief medical officer, a Spaniard, permission to go into the bush to meet those who run the dispensaries as well as those who are treated there. His answer astonished me:

“No. It’s out of the question. As of today, you are to head the internal medicine section. You are on duty at all times. Besides the hospital, the only place you are authorized to go to is the mining company club. There you’ll find a pool, a bar, and a cinema. That ought to be enough for you.”

“...”

So, there I was stuck in the hospital night and day. It was a shock. I didn’t come to Africa for that!

Moreover, I soon discovered to my dismay the kind of medicine that was practiced in Disele.

The first principle was distrust: for lack of dispensaries worthy of the name, the 300,000 inhabitants of the region had to go to the hospital for benign ailments. The second principle was that a doctor must see every patient since an African nurse clearly was not capable of making a diagnosis.

The result of these principles was hasty practices.

In the hospital’s big consultation room, several doctors, their backs to the wall, sat behind a long table. The patients entered through a door on the left, waited behind a screen during the consultation in progress, presented themselves to the doctors, and left by the door on the right.

Marcel Ilunga, the nurse/interpreter, stood near the doctors. At the end of each consultation, he yelled, “Next!” then, with some solemnity, he presented the problem: “... hasn’t had a bowel movement for a week...; ...bitten by a snake; ...chronic cough”, etc.
The patient stood in front of the doctors. In less than a minute, one of them examined him, indicated a treatment, and called for the next patient.

One day, one of my colleagues asked the nurse:

“So, Marcel, what’s the matter with that one?”

“He has severe back pains.”

The doctor asked the patient.

“Pull up your shirt.”

The patient obeyed.

“Turn around.”

The doctor felt along the patient’s backbone a minute or two.

Marcel said, “His urine specimen is normal.”

“No more sexual relations for two weeks,” thundered the doctor. “Next!”

And turning toward me, he said, “These people get laid night and day, they have to learn to control themselves.”

A woman came out from behind the screen (accompanied by two members of her family).

Marcel Ilunga declared: “This woman can’t get her tongue back into her mouth.”

It was clearly a case of hysteria, which is very common when the dry season wind blows.

The woman stood there, her tongue hanging out, stiff as a piece of leather. My neighboring colleague stood up and said to her: “Turn around.” Scarcely had she obeyed, when he let fly an authoritative kick to her rear! The woman went “Hah” and pulled in her tongue.

“You see?” he said, darting a glance at me, “She is cured. Next!”

As for me, it was clear that I had to get out of Disele, the sooner the better.

I asked for reassignment. I got sick with hepatitis, and I have stay in bed. Before going to spend a month convalescing in Belgium, I learned of my assignment to Kisantu, in the Bas-Zaire, where I had done an internship right before coming to Disele. My internship had gone well, and the chief medical officer, Michel Jancloes, who had been assigned to Dakar, thought of me to replace him.

I left Disele with the satisfaction of having known how to say “no.” No, to the order to confine myself to a role that cut me off from any action on the ground.
While convalescing in Belgium, I had another opportunity to make my goals absolutely clear. While visiting the Saint-Pierre Hospital, where I had taken my exams, I ran into the head of internal medicine, Professor Frans Lavenne.

“Ah, Monsieur Lamboray. So you’ve come back from Africa?”

“No. I’m here only temporarily.”

“It’s about time that you got down to serious work. Don’t tell me that you’re going back to the Congo?”

“Of course, I am!”

Evidently, for this professor the organization of dispensaries was not serious work, for, with good results on examinations, one could obtain from one day to the next a post as assistant in the internal medicine department. But I once and for all turned my back on that life.

Today I realize how important these refusals have been. Where did they come from? They are not entirely rational but rather intuitive.

A conversation at my house with Professor Lechat, my mentor in public health and an important professor of nutrition with the World Health Organization, led me to clarify these vague feelings.

“While we are on the subject of Africa and Africans,” the professor said, “We have to recognize, all the same, that we are clearly more rational that they.”

Spontaneously, I shot back: “I don’t understand what you are saying, Professor. Rational? Have your major life decisions been rational? Did you choose your wife in a rational manner? And your profession? I don’t understand what you are saying!”

Little by little, I adopted a principle: I will find my bearings in life using as a compass an intuitive sense of future happiness.

The very good road that leads to Kisantu winds between the high hills of the waterfalls area. It crosses a wooded region that has become savannah land from overexploitation of the forests. We are in the Bas-Zaïre, between Kinshasa and the coast, about 120 kilometers from the capital. In the villages that we cross, the houses are made of puddled clay walls with straw or tin roofs. Some papaya and mango trees
grow nearby. Around the houses the earth is swept clean, the grass cut to keep snakes away. Here and there, you can see the buildings of one of the numerous missions.

It's beautiful. But the road is a high-risk place where loaded down trucks, their springs flattened out, swaying around curves, whiz by at top speed. Up on top of a load of manioc, passengers hold onto the rails tightly and duck their heads under low branches. The shoulders of the road are scattered with the skeletons of cars, vans, and trucks, mute witnesses to numerous wrecks.

Approaching Kisantu the land slopes toward the river Inkisi, “the place of fetishes.” There, in the nineteenth century after being converted by the Jesuits, the natives threw their fetishes into the river and gave themselves to Christ.

Inkisi is a town of 45,000 inhabitants, with bars, prostitutes, and shops owned by Zairians and Portuguese. At the top of a hill the brick cathedral sits enthroned alongside the gigantic bishop’s palace. The hospital is located on the hill next to it. Up there is where we are going to live.

You get there by crossing a large park planted with mango and palm trees and gigantic Lagerstroemia with blue flowers. At the end of the park pavilions with 400 beds are reached by a beautiful central walkway bordered with borassus palms (watch out for your head!) and by lateral walkways of cement with tin roofs.

On the right the nuns’ convent, and farther on, the nursing school.

I arrived there with my wife, pregnant with our second child, our oldest just a year old.

Our house faced the hospital; a superb house with a high roof that insulated it from the blistering heat and its covered terrace, a baraza that completely surrounded it.

My colleagues and the hospital personnel gave us a magnificent welcome.

Thus began years of happiness.

Kisantu Hospital has a constellation of fifty-odd small dispensaries located in the villages of the Madimba zone, a territory diagonally about 200 kilometers.

At the hospital I found a team of Belgian doctors: Philippe Cornet, Michel Nyst, and Mimi Gerniers. Doctors Katende, Kiswi, Luyeye and so many others would join us.
Mimi Gerniers, a pediatrician, in Kisantu and later in Kinshasa, did me the immense favor of channeling my enthusiasm. I would always be able to count on her to transform my visions into feasible actions!

As soon as I arrived, I proposed a new system to my colleagues: I would take my turn on duty at the hospital, which would give them some relief, and they would participate in the development of the health services zone by supervising the dispensaries with me.

At that time, international health services tended toward a multiplication of “village health officers.” To these community agents we gave a nursing unit after an abbreviated training. This agent had neither the means nor the training to do much: he had barely enough to make a salt-sugar solution to treat a patient suffering from diarrhea or give medication for malaria... He had neither a mini-laboratory nor the means to give patients an injection. As soon as the medical problem went beyond what every family ought to be able to do alone, the patient had to go to the hospital.

I said to myself that Zaire could do much better by working not from a group of agents but from nurses trained and mentored by the hospital team. The experience of Michel Jancloes, my predecessor at Sadi Kinsanga, put me on the right track. This village is situated at 105 kilometers from Kisantu, in other words two to five hours of trails according to the season. Before leaving for Dakar, he took me there in one of the hospital’s Land Rovers.

That visit was all-important.

The Sadi Kinsanga dispensary was not in the charge of a village agent but of Kondo Pambu Yemba, a man holding a diploma as a nurse’s aide, a man who demonstrated extraordinary human and medical qualities.

In this village Konde created a health committee that each month discusses health problems in the area. Each of some fifteen nearby villages is represented on the committee by its chief and by a “mama bongisa”, which means “maman straightens things out.” The mama bongisa serves as intermediary between her own village and the nurse. She is the one who inspects the latrines, who makes sure that each patch of land next to the houses is hoed to keep snakes away, she who reminds women of the prenatal consultation day, she who brings the children to be vaccinated, who visits the family of an undernourished child, and so forth.
In Sadi Kinsanga I realized the extraordinary quality of the relations established between Konde and the committee. Konde’s respect for the villagers manifested itself in an exceptional courtesy.

There is cooperation and absolute trust on each side.

But there were more surprises: in the course of a committee meeting, in the straw hut set aside for that purpose, I discovered a major public health teaching tool in Africa: the health song!

That day emphasis was placed on the necessity of using latrines—instead of defecating around the village. And all of a sudden the thirty members of the committee start to dance and sing in Kikongo, not without a certain mischievousness:

*Munganga eh, munganga eh*  
*Eh munganga*  
*Sadila mu na kabinet*  
*Sadila mu na kabinet*  
Doctor, doctor, defecate in the toilets!

Then, soon they sang:


Several members of the group are in turn called upon to join in. They have to mime the gestures of defecating, dancing all the while. Everything is done with full-throated good humor!

. . .and they continue:

*eh betu kulu* (all of us) *Sadila mu na kabinet.* . .

They finish the study of this issue by pulling out one of the famous “image boxes” of Dr. Courtejoie, whom I met during my vacation in the Bas-Congo in 1970, the illustrated boards explaining the risks of bad hygiene et indicating how to build latrines correctly.

The members of the committee repeat the song in each of their villages. And as the months go by I see the impact of this teaching: everything is remarkably clean in these rural hamlets. You could eat on the ground! Spring water is collected in a hard-sided construction with a built-in filter. The water is perfectly safe to drink. I never drink any other.

Konde, the craftsman of this success, sets the example: at his house, meals are always served on an immaculate tablecloth. His wife, *Mama na* that she is a model for the women in the village. All her
neighbors imitate her in the morning when she sweeps around her house; and as custom dictates, she
doesn’t speak a word to anyone before going to wash herself at the water pump.

Konde, in addition, displays a rare clinical sense. By a subtle question he knows how to redirect
my clinical examination to one or another symptom that could have escaped me.

In short, there existed in Sadi Kinsanga an entirely different health model than that of the village
agent, doubtless fine as far as it goes but ultimately lacking in overall medical instruction. We therefore
decided to spread the Sadi Kinsanga health model throughout the Madimba zone and to improve it.

A few months after my arrival in Kisantu, Professor Ngwete, the Minister of Health, invited me to
Kinshasa to participate in the work of a commission set up to reform the Zairian health system.

I knew Professor Ngwete well: this small man, his eyes sparkling with intelligence, taught me
tropical medicine during my first year as an intern in Kinshasa, well before his entering the government. It
is he, too, who sent me from Kisantu to Kasongo, at the expense of the Zairian government, in order to
learn about the principles of health zones.

The commission set up an ambitious project and the Minister sent out a call for anyone with even
the most minimal diploma in public health: which came down to five people—two Zairians, a Colombian,
and two Belgians.

Soon the scope of our undertaking became clear. In order to develop and improve close-
at-hand medical care in a country four times the size of France, we had to make a choice: either village
health agents offering a simple brief examination before sending the patient to a hospital, or small health
centers staffed by competent nurses who could provide genuine care when hospitalization was not
necessary. The commission recommended this second option, following the model developed initially by
the Institute of Tropical Medicine in Antwerp at Kasongo in the northeast of the country, then set in place
by my predecessor in Sadi Kinsanga.

Although we did not know it then, the basic formulas we articulated would later be followed in
most of the rest of Africa.

Here are the basic principles: First of all, we aimed toward an improvement in the range of
treatments. At that time, even in Sadi Kinsanga, in the case of fever, for example, the nurse had
instructions to give anti-malarial medication. If the fever did not drop within three days, the patient was to be sent to a hospital.

Essentially, we modified this approach by substituting other guidelines: in the case of fever, here are the procedures to follow in order to rule out serious illnesses other than malaria. If the nurse finds other symptoms, the patient is to be sent that very day to the hospital. Otherwise, aspirin and nivaquin are to be given and the patient cared for on the spot.

This plan of course was predicated on the rigorous preparation of nurses and the formulation of precise instructions regarding preventive (vaccination, nutrition, hygiene) and curative measures.

The other principles involved the participation of communities in the management of the health centers and finally the harmonizing the work of the government with the health facilities of the religious missions. Competition was over. If a mission offered a health facility, a hospital, large dispensary, or a small health center, in a given sector, the government would not set up another one. Cooperation: in each zone, the network center was the hospital, whether public or private. The health centers were attached to it.

I spent eleven years carrying out this reform with my colleagues, with the nurses, and the inhabitants of the rural health zone of Madimba and later in Kinshasa. A growing network of medical officers worked throughout the country.

Many years later, I have confirmed, with such emotion, that what we put into place has held up against the destruction of the civil wars that have torn Zaire apart. I am convinced, even today, that this eventuality is in large measure due to an attitude, to one key word: trust!

To set up this new system, the doctors of Kisantu and three supervising nurses followed the work of some fifty health centers organized in three geographic sectors called “circles.”

From the outset, we established one inviolable principle: the entire system cannot function unless, in a systematic fashion, we did not express and give proof of total trust in our nursing personnel.

Up to that time, the doctor making the rounds of the centers examined all the patients present at the time he passed through. With our reforms the doctor assisted the work of the nurse and talked over cases with him or her. The only patients he examined were those whom the nurse thought he should see. In this way, he made clear his confidence in the nurse and the nurse’s excellent work.
Moreover, we gave the nurses financial and therapeutic assistance that they had never had before, such as drugs, microscopes, the wherewithal to make injections, and so forth. And we trained them.

The nurses received the instructions and the procedures to follow for each preventive and curative treatment. In addition, we brought together in Kisantu every three weeks the fifteen or so nurses from each “circle” for two days of training.

We presented and discussed new ways of improving the quality of the nursing and...we had great parties! The parties were important, for there we share experiences and the health and hygiene songs. In the evenings, after dinner, we shoved the tables aside, and one after the other the nurses offered a new song—it was almost a competition! All the songs were taken back to the villages. Through them women learn that their child should be vaccinated a three, four, five, and eight months; they learn how to take steps to avoid mosquitoes, etc.

During the long hours traveling in the Land Rover from one health center to the other we sang these health songs until I thought we would lose our voices.

At the same time, the logistics moved ahead: henceforth, the nurses were entrusted with streptomycin and other anti-tubercular drugs, for we had trained them to examine the Koch bacillus under a microscope. And they had the authority, when they found the tuberculosis bacillus, to begin treatment of the patient that very day and to continue treatment at the center.

When in the course of a training seminar I announced the news about streptomycin, Makitu Samba, one of the senior nurses, stood up and solemnly declared:

“Doctor, I’ve been a nurse since 1947. I started with the nuns at Kimvula (and then he digresses into a resumé of his career). Doctor, never has anyone allowed me to possess streptomycin! They always distrusted me, thinking that I would sell the streptomycin to guys with the clap! Well, since you have shown me such trust, I solemnly swear, in the name of all those nurses assembled here, that you will never see a gram of streptomycin disappear.”

Once again, trust. From that point forward, the three supervising nurses were responsible for the delivery and the sale of drugs in the centers. Each month they brought back to the hospital pharmacy, managed by Sister Laetitia, sums of money representing ten, even twenty times, their own salaries. So
much money! That really bothered Sister. One day she came into my office while I was working with
Konde, who had become one of the three supervisors.

“Doctor,” she said, “You’re crazy to trust these supervising nurses!”

“What makes you say that, Sister Laetitia?”

“Why, don’t you see: all that money that they are collecting? You just wait, one of these days
they are going to steal you blind!”

I was furious. How could this nun (remarkably devoted and very courageous) say such a thing to
me, especially in the presence of Konde?

“Get out, Sister!” I said.

And I took her arm and led her to the door.

Konde was looking at me, his eyes round.

“Doctor, you shouldn’t have done that! “

“What?” I asked Konde, “She insults you, and you say I shouldn’t throw her out of my office?”

“All right, doctor, but, all the same, you didn’t have to take her by the scruff of the neck and throw
her out.”

Not one of the supervising nurses ever stole a cent.

In each health committee the management was placed under the control of the villagers by the
representative of the health committees (the village chiefs and the mama bongisa). That included the work
as well as the behavior of the nurse, as we will see, and financial auditing. Up until that time the nurses
priced consultations and medications according to what they thought the patient could pay: “For you that
will be this much, Mrs. Doe” and, of course, certain nurses got something out of it. So, in order to put an
end to these practices, we started a system of a lump sum payments: one price for children, on price for
adults which included consultation and drugs, no matter which drugs, and this enormously simplified the
financial management of the centers. At the same time, we asked for and obtained from the Ministry of
Health a raise in the nurses’ salaries. The situation improved immediately.

Of course, the entire system had to be economically viable. So, we realized that one important
problem arose from a certain benefit: in the state hospitals and health centers, civil servants have the right
to free drugs.
I went to see Dr. Samba, the chief medical officer of the district.

“Doctor, in order for us to balance our accounts,” I said, “I intend to do away with free drugs for civil servants in the Madimba zone. Will you back me up?”

“Colleague”—that delightful man still calls me colleague—“if I take such a step today, I will be in prison tomorrow. But it’s your role as a volunteer to change things, and to permit change. Go ahead, you are not going to risk anything.”

As time went by, I discovered that the role of a foreign volunteer is no longer a technical role, for these countries have mastered the techniques. They have doctors, engineers, etc. Don’t we find doctors from Africa or from the countries of the Middle East in European hospitals? The role of the volunteer is to stimulate, to permit change, to bring it along.

From year to year the network of our health zone grew stronger. And we witnessed a double evolution. The health care improved: a few hours from the market of any village in the bush, tuberculosis, malaria could be treated, a difficult pregnancy diagnosed and children vaccinated.

The health service and the inhabitants worked together better and better. And in a way unimaginable in Europe. That interaction—or its absence—will take on considerable importance ten years later when I will be confronted with the AIDS epidemic in Africa and Asia.

Little by little, there emerged a vision of health care very different from the classic vision in which experts embody the know-how and are therefore the legitimate “owners” of medical power.

The health committees naturally worked in earnest concert with the nurse and the doctors, but they made clear, in various ways, that they were co-owners of medical power. It was their health!

And if they were not happy with the nurse—or, on the other hand, if they were highly satisfied—they knew how to let me know.

One day in Kimayulu, when I got down from the Land Rover with Konde, it was clear that something was wrong. Mboma, the nurse, looked glum, the village chiefs greeted me but I felt that they were preoccupied. After my rounds at the health center, I joined the members of the committee in the grass hut. As usual the meeting began with the national anthem, “La Zairoise.”

*Zairian in newfound peace,*
*A united people, we are Zairian*
*Let’s move forward, proud and full of dignity*
*A great people, a people free forever.*
Then followed the party slogans:

*Long live the People’s Revolutionary Movement, MPR, let’s open our eyes!*

Then came “our” health song (and I could finally join the chorus):

*Bu tukala mu na nrtama, tumona mpasi zingi, sante ka I kala ko (twice) oh la sante!*

*La sante tolongele, malongi matu-longanga*

*Tulunda ye tusadila, mpe tulonga mu na bana, Oh la sante!*

*Landa (the head of the line)*

*Landa nioka landa (the head of the line)*

*Nkatu!*

*Oh, la sante!*

*La sante tulangele. . .*

*In the past we suffered a lot, our health was bad, oh, health!*

*We are taking care of our health, we are learning lessons.*

*We are learning and practicing these lessons and teaching them to our children. Oh, health!*  

*Let us be clean!*

*Let us have tapeworms…NO! (all make a huge gesture of refusal)*

*Oh, health!*

The meeting could now begin.

Someone spoke in the name of the chief, for the chief always speaks last, and told . . . a story about a trucker!

“In the village, Doctor, we had trouble selling our agricultural products. The wholesalers in Kinshasa were eating us up. So we took up a collection and bought an old truck so that we could take our produce to market directly. Since we didn’t have a driver, we had to hire one from a neighboring village. In the beginning he gave us complete satisfaction: the fruits, vegetable, and manioc were delivered on time and sold very well. We were making good profits! Then things began to deteriorate: it took a lot of coaxing, pushing and shoving to get the driver to leave on time, the load arrived late at market, and our commerce was jeopardized. So, Doctor, tell us: who is the boss? The owner of the truck or the driver?”

I asked for a break in the meeting. Konde, my driver, and the few members of the Kisantu team who had come with me that day followed me to one side. They confirmed what I feared: we had a real
problem with Mboma, the nurse. In the beginning everything went well but now he thinks he’s the chief.
So who is the owner, who is responsible for our health, the villagers were asking: the nurse or the community?

The meeting resumed, and I took up the parable of the trucker, insisting on mutual cooperation.

Once the meeting was over, Konde stayed a little while in the village to iron out the details.

This kind of incident led us to reexamine the idea of “community participation.” It was generally understood as the participants’ contribution to the functioning of the health services by paying for a part of the treatments, the work of villagers, their collaboration with the nurse—all that in the context of a vast program defined by national and international initiatives. But we see that in this case the population is not simply acting as an obedient partner in these services but as an owner, as a participant in his health and as a co-employer of the nurse. The population wants to take charge of him. Such is the translation of the story about the truck.

At a few hours of track from Kimayulu, the villagers in Kindundu had to confront an entirely different situation.

In this village we had installed a young nurse, Kinkela, to raise the small old dispensary to the status of a genuine health center. Shortly after his arrival, the number of monthly consultations soared from 27 to 200. Kinkele is a young man with a rigorous medical background and a thorough respect for his patients, an authentic Konde student.

A year after his arrival, Konde and I spent the night in Kindundu. The following day, in the Land Rover, I exclaimed enthusiastically:

“Kindundu is a fantastic place, and Kinkela is doing wonderful work.”

“Yes, Doctor, you’re right, but as for me, I did not sleep all night.”

“And why not?”

“There is a terrible problem. Seven girls in the village say that they are pregnant by Kinkela. So, we’ve been discussing this all night long, and the villagers asked me to give you a message.”

“So, what’s the message?”

“Well, here it is: Doctor, don’t worry about this problem! We’ll take care of it. Kinkela is a wonderful nurse, and the villagers are very anxious that he not be transferred.”
Afterwards I learned that the villagers don’t want to throw any stones at Kinkela. The fathers of the village admit that they encouraged their daughters to go prepare meals for this handsome young man who would make a terrific son-in-law.

The following month, one of my medical colleagues returned to Kindundu for the health committee meeting. They decided to listen to the young girls. There are only four now, not seven. The first, questioned about her relations with Kinkela, gives a date that disqualifies her: the nurse was at that time traveling away from the village. The second reaffirmed that she was indeed pregnant by Kinkela but she very definitely did not want to marry him. So there remained only two. Two? The villagers quickly found a solution: Kinkela could marry both at the same time: one would become an assistant at the health center; the other would take care of the house. Everyone was thus satisfied.

Different cultures account for the answers to questions from men, women, and communities, but aren’t the questions the same? That being so, can’t one bring men together on fundamental questions, whatever the culture?

That question will become all-important when AIDS breaks out. For the time being, the African vision of sickness, life, and death raises this question for me again and again.

In the evenings, in the villages where I stayed overnight in the course of my rounds for the opening or for the rehabilitation of a health center, there was always a party! Everybody was there, seated in a circle: for 50 to 300 persons. Men and women, young and old. We spent the evening together, around a fire, with drums and tom-toms. And almost systematically, we put on the “Health Theater,” a play repeated again and again a thousand times, with all kinds of variations on themes such as vaccination, infant malnutrition, family planning, etc.

The basic scenario remained unchanged: a child is sick. The parents are worried and go to the nganga, the wizard, to explain the illness.

His face and body whitened with chalk, his torso bare, covered with amulets, the nganga interrogates the spirits by casting knucklebones or by studying the entrails of a slaughtered chicken. He called on the ancestors, the drums thundered! Then he gave the parents the reason for the illness, which was always tied to the behavior of a third person. For example, your child has a bloated stomach (le
kwashiorkor) because someone in the family has had sexual relations with someone in his clan. . . Among the Bakongo, actually, sexual relations between cousins on the maternal side, even very distant, comes close to being incest and is strictly forbidden.

To calm the spirits, the nganga begins more incantations, receives a goat from the parents, and sends them back home.

But the actors, the village people, show that the child is still sick.

And then, just by chance, the nurse happens by, examines the child, and tells the parents that the baby is very undernourished. Everyone goes to the health center where the nurse prescribes a porridge made from peanuts. The baby is cured! General rejoicing! To conclude the play, the nurse declares: “Let’s abandon the old ways, let’s follow, unfailingly, the way to health.” Curtain falls, the dances start up, the party continues.

I am very cautious about this kind of teaching and still ambivalent about the dual referential brought into play: that of Africa, and that of Europe. And I think of this exchange, reported by my predecessor, Michel Jancloes:

“Doctor, why does my husband have tuberculosis?”

“Because there exists a bacteria, a tiny little insect invisible to the eye, that floats in the air and that your husband breathed in, that’s called BK (Koch Bacillus).

“But whey did this BK go into my husband’s lungs?”

The Bantu has an answer to “why.” He finds the explanation in a violation of the rules of the proper functioning of society. The illness of a child or of a young adult is explained not by his own behavior but rather by that of someone else in the community who for example has broken a sexual taboo, or has cast a spell on the sick person. Correcting the evil done by the third party effects the cure. The white man, on the other hand, usually answers with a “how.” Even though the Church is obliged to assure us of a “why.”

I witnessed this when my mother, gravely ill with cancer, was dying at home. She was very well acquainted with Father Ryan, the spiritual director of the American college, at the Catholic University of Louvain, and he came to visit her often. After one of these visits, as he was leaving the house, my father asked him why his wife was dying of cancer.
“Why. . .for her sins,” he said.

“Come now, Father Ryan! She has sinned no more than the next person.”

“That’s true: her malady also comes from the sins of others.”

Why do we get sick; why do we die prematurely? I urged the nurses: don’t contradict too harshly the explanations of the nganga with medical science, be subtle, it is not a simple matter.

We have never got to the bottom of this ambiguity, and to this day, I still do not know whether we can reconcile these two systems of thought. And I think that for us Westerners, who have made such progress in discovering “how”, the “why” remains a profound mystery.
III

In the Suburbs of Kinshasa

“Doctor, you have been requisitioned to take part in the fight against cholera in Kinshasa. Please report to Dr. Kalisa Ruti without delay.

The time was July 1979. My family had left for vacation in Belgium with the understanding that I would join them in August. This urgent message from the Ministry of Health radically changed my plans.

Cholera! One of the plagues of poor countries! The epidemic broke out in the east of the country. Soon it swung from the basin of the Nile to that of the Congo. Cities fell victim one after the other. Deaths were counted in the hundreds. The epidemic spread rapidly toward the south. Kinshasa was threatened.

I left immediately for the capital where two colleagues awaited me whose great professional and human qualities I rapidly appreciated: Kalisa Ruti, the director of the national vaccination program and responsible for the battle against cholera in the entire country; and Ngwala Ndambi with whom I would form a team during the five months of that battle.
The stakes were considerable, for if the epidemic spread to Kinshasa, the city would be facing a veritable health catastrophe. It was therefore urgent that we put into place an epidemic surveillance system and a network of rehydration centers all over the city, ready to be put into use should the epidemic hit.

By bringing together Peace Corps volunteers and by calling upon the existing medical networks in the Salvation Army, the Kimbanguist, Catholic, and Protestant churches, private enterprises, we sectioned the city with fifteen diagnostic and rehydration centers, placed under the supervision of nurses and doctors.

Under the leadership of Dr. Ngwala, we constituted a small team that got together every day at five o’clock in the morning before going out into the city to organize, set up and equip these rehydration centers. We drew up instructions for treatment that indicated specifically the importance of oral rehydration (rather than intravenous), the amounts to be given hourly, etc.

The health services of Kinshasa were completely unprepared, and all our logistics came from OXFAM, the great humanitarian organization that chartered a Boeing and performed an enormous feat in getting materials and products to us within a few days.

I entrusted the management of this operation to two young Peace Corps volunteers, Jim and Melanie. I can still see Melanie giving her orders to Zairian soldiers in a huge GMC truck, who carried off to the fifteen rehydration centers, needles, bleach, beds with holes under which buckets could be placed to catch the stools of patients, etc.

Even before we could do anything, the first cases broke out, the first deaths were announced at Kikimi, a section of the city where 100,000 people were totally deprived of any medical care! I had heard the story—one story among a hundred like it—of the
calvary of a man, arriving exhausted and abominably filthy, at the health center run by nuns after having carried his wife on his back for several kilometers. The lack of health proper health care in the suburbs of the capital was appalling.

From July to November we coped with the epidemic. When it stopped, our records showed that 232 patients had been admitted to our centers. Fourteen of them died, all of them in the centers supervised by doctors. Unlike the nurses who had followed to the letter the treatment instructions, the doctors gave their patients very little to drink, wrongly choosing instead intravenous rehydration. I remember one patient who had drunk 32 liters of fluids in 48 hours: “Doctor,” he said, “that sugar and salt water solution, it’s as delicious as champagne!”

In the course of these months of intense work we were able to measure the abyss that separated the city of Kinshasa from the Kisantu region as far as health care was concerned. By chance, it was at this time that the Zairian authorities figured out the relevance of health centers in our experience in Kisantu—to such an extent that they asked the Belgian development agency to which I belonged, to transfer me to the capital to try to work out the same system, which I would do two years later.

I benefited greatly from the friendship that would from that point onward attach me to Ngwala and also to Kalisa Ruti, whose courage and leadership abilities I greatly appreciated.

A powerful, brawny man, Kalisa Ruti was a true patriot, totally open to the cooperation with Belgium whenever it benefited his country. I sometimes say that for that man who was the linchpin of health reform in Zaire, I would walk through fire. We worked and often put our heads together, for instance, regarding his national vaccination
program. That program allowed us to move an important step forward in our small rural health centers. While the initial plan envisaged vaccination campaigns carried out by mobile teams, crisscrossing the country, I convinced Kalisa of the impossibility of arriving at a satisfactory coverage of a country so vast: a hundred teams would be necessary to do the job!

“Instead, let’s entrust the responsibility for vaccinations to the small health centers,” I said. He agreed and proposed that we collaborate on forming twelve district medical officers.

As a preliminary step, Kalisa sent to Kisantu a mission charged with evaluating the merits of Kisantu as a training ground for those medical officers. The mission was made up with colleagues from the WHO, the Centers for Disease Control in Atlanta, and the Centre français international de l’Enfance.

Anxious to grab the opportunity, I welcomed the first trainees far from the temptations of the city in a convent in Ngidinga, which at night was guarded by six Rhodesian Ridgebacks, South African watch-dogs. No way to slip out every night to party in the bars!

For me the stakes in this seminary were huge: would I be able to convince these colleagues about community participation, about the trust one can and should place in the nursing personnel, and the means that one can and should place at their disposition?

To this question was quickly added another, for one of the organizers, Pierre Daveloose, from the Institute of Tropical Medicine in Antwerp, proposed visiting the health centers to make sure that the principles promoted by the institute as applied in Kasongo were indeed respected in the centers.
I therefore took these dozen colleagues on a tour of our health centers, all the while wondering, not without considerable anxiety, if we did indeed respect those principles—integration, continuity, globality—that our team in Kisantu had never articulated.

Integration: Each encounter between the nurse and the patient should be an opportunity for an entire review of what is appropriate medical advice for that person. A consultation resulting from a fever, for example, can end with advice on family planning.

Continuity: We can no longer get away with the usual, “That imbecile has stopped taking his medicine again.” It is up to the center to make sure that the treatment is sustained. If, for example, a patient with tuberculosis doesn’t show up at the center for his appointment, steps are taken right away to get him back to the center.

Universality: The nurse places himself in the dynamic of the patient and not vice versa. The needs of the patient, not the priorities of the nurse, determine the choice of location and times of treatment. What are his professional constraints? Where would he be best surrounded by his family, etc.

The twelve colleagues came back to Ngidinga delighted and convinced: the centers respected the principles, simply because the nurses had absorbed the role we had assigned them in the community. Because they felt responsible for bringing health services to each person in their zone, they easily absorbed these principles.

My twelve colleagues would from that time on become part of an informal network that would spread this approach to health services throughout the country. In the course of the following years, several hundred Zairian doctors were trained in this same plan.
We were now in 1981. My years in Kisantu were coming to a close. I asked leave to spend a year in the United States to obtain a Master’s degree in Public Health at Johns Hopkins in Baltimore before taking up my new post in Kinshasa.

Before leaving the Bas-Zaire, I undertook a final round of three weeks along the trails to say goodbye to the nurses, the chiefs, and the *mama bongisa* of fifty health committees, and all the villagers who had taught me so much and with whom I had known such happiness. Those were three weeks of celebration! Everywhere, we danced! Here, sacred musical instruments were brought out, hollowed out of elephant tusks, there, they reminded me of noteworthy moments during those years. To my astonishment, they never cited, in these commemorations, the progress in health care, though it was considerable, but rather details of my own personal behavior:

“Doctor, we remember the day you arrived at the health committee, late as usual, and so as not to interrupt the discussion, you sat down on the trunk of that tree over there!”

“Doctor, we remember the evening you arrived soaking wet and covered with mud, during the rainy season. You had had to cut a way through the trail for the Land Rover with a machete. You were exhausted but smiling!”

In an old truck we carried away from Kisantu all that we would need to live in Kinshasa on our return from the United States: our trunks, but also our chickens and rabbits (we always had twenty or so that we were raising) and even our precious compost! We moved into one of the houses of Camp Mimosa, a small residential area planted with avocados, papayas, and palm trees, at the bottom of Mont Ngaliema,
Mobutu’s place of residence. It was a beautiful spot, slightly outside the city, where we could hear the rumble of the rapids of the Congo River.

When our neighbors, Zairian cadres and Europeans, saw our truck and its homely load, they expected to see a Zairian family moving in!

Among our new neighbors were Dr. Miatudila, whom I would find again later at the World Bank, and my dear Dr. Ngwala with whom I would once again share adventures.

On my return from the United States in 1982, Ngwala and I were indeed named co-directors of a project entitled “Health for All-Kinshasa”. The objective was clear: we were to set up health zones in the city made up of small centers maintained by the population.

With a team of Belgian cadres (among them Mimi Gerniers) and Zairians, we began with a part of the city completely without resources: Kikimi, exactly where cholera had broken out. This vast urban zone near the airport is planted on a sandy terrain where four-wheel drive is absolutely necessary because not one street is paved. There is neither running water nor a sewer system. People dig wells for water.

In order to bring health services into this stricken place, we needed help.

Naturally, we turned to our partners during the cholera epidemic: the Ministry of Health, the Salvation Army, the Kimbanguiste Church, the network of parishes in the city of Kinshasa, the Church of Christ (the Protestant confederation), and certain private enterprises. . . .

With these institutions, separated as they were by different beliefs, we created a network based not on competition but on solidarity and complementarity. Together we
drew up treatment instructions: everything was organized, written down, both for preventive and curative treatments and for administrative procedures. Whether a mother came with her baby to a Protestant or a Kimbanguiste dispensary, she received exactly the same treatment, the same medication. It was a revolution!

That was an experience that enriches me to this very day: proposing an ambitious and inspiring project that called upon the best in all the participants. Because we appreciated the abilities of our Zairian associates, they were able to build and maintain a health system that benefited the people without filling the pockets of anyone. And all this was possible even in a predatory state like Zaire during the Mobutu era.

As in Kisantu, the involvement of the communities was capital. Here, the streets replace the villages, but the social structure remains the same. There is always a reigning chief in each little quartier and a *mama bongisa* in each street. With them, we constituted health committees, just as in a rural milieu.

In order to be continuously present to listen to them, to be in contact with them, we lodged in Kikimi once a week in a rented house, naturally with neither water nor electricity. In the evenings, we talked with the chiefs of the quartiers about establishing new centers.

The health committees took up their positions. Every three months, these committees met with the nurse to evaluate the health status of the population based on seventy-five criteria! This kind of active participation allowed us to anticipate health problems. In this way the health zone of Kikimi launched a huge vaccination program after detecting a slight increase in the number of the cases of measles—and thus the health committees avoided the hecatombs of previous epidemics.
“We have had some deaths from the measles, Doctor,” one of the chiefs confided to me, “But much fewer than in times past.”

“How do you know?” I asked.

“Well, in the past, during the measles epidemic, there were so many deaths that families could share renting a truck to take the bodies to the cemetery. Now, transporting the body to the cemetery costs a family dearly: the fatal cases are so rare that a family can’t find anyone to rent a truck with them.”

We trained our doctors harshly, obliging them to live in the house in Kikimi so that they would experience first-hand the realities of urban life.

Those four years in the city were as exciting as my years in the country in Kisantu! The zone health system proved as effective in the city as in the bush. The small health centers, maintained and supervised by the people, brought a level of health care never before reached.

I was able to spread these ideas to the highest level; from then on, I could take the “elevator.” I frequently spent my entire days in the most miserable quartiers, and the beginning of the evening in ministerial offices.

Dr. Kalisa, who had directed the fight against cholera, was now the chief of staff at the Ministry of Health. Together, we developed a network of allies—Zairian, Belgian, American—who in Kinshasa and in countries around the world promote national health reform. And we got results. When, for example, the political advisor to President Mobutu asked Dr. Tshibasu, the Minister of Health: What can the president announce in the inaugural address of his new seven-year term?” The minister could answer without hesitation: “The official adoption of health zones!” And he explained how they work: the
creation of small centers, the training of nurses, instructions, working with the people, etc.

“Oh, come now, Dr. Tshibasu, you must be talking about an experiment in West Africa, or in Kenya, but not here in our Zaire!”

“Gentlemen, this system is functioning in 60% of the country, and I invite you to come find out for yourself right here in Kinshasa.”

Without delay, a special team from the presidential security arrived in Kikimi to verify what the minister had said. They spent the day there, questioning everyone: doctors, nurses, men, women.

The conclusion was clear: “Congratulations! What you have done is terrific. . . and we understand why you have kept quiet: because clearly you undermine the personal interests of doctors. They would never have allowed you in the fancy downtown quartiers!”

And Mobutu gave his blessing to a health policy for the entire country that is still today in effect for the Democratic Republic of the Congo. It has survived the civil war—notably in Kikimi here the fighting left many dead, but no one touched the health centers.

But a blessing is not entirely sufficient: we still had to fight for official, administrative recognition for these health zones, which had de facto become autonomous public interest entities whose resources were controlled by an administrative council. Which bothered certain regional health inspectors tempted to take their cut from the revenues.
We developed within that predatory state a system that escaped systematic exploitation. Certain highly placed individuals were well aware of this. Their attitudes reflected both courage and fatalism.

Witness the interview Kalisa Ruti and I had with the chief of staff of the Prime Minister, at that time Kengo Wa Dondo. Kalisa asked me to accompany him. He presented his request for the Zairian government to finance the animation teams in the health zones. After three refusals, the chief of staff, exasperated, turned to me.

“Doctor Lamboray, explain to Doctor Kalisa that the health of the Zairian people is too important to be entrusted to the Zairian government! Let the government take care of ONATRA (the river transport office) and destroy it; let the Zairian government destroy the Office of Public Works; let it destroy its national airline, but NOT the health of our people!”

Two years later, the cabinet changed. I found myself with that giant Mushobekwa, the Minister of Health, a former ambassador of Zaire to China, a jurist who in the past led the youth in the party.

“Doctor Lamboray,” he said to me, “Don’t take me for a fool! I see very well what you are doing with your little Zairian friends and the others, what you are doing with these health zones: you are separating all that from the government.”

He fell silent, looked at me for a while, then with a sly smile, he added: “Keep on!”

Yes, I salute the courage of those people, right in the middle of a full-blown period of radicalization, at a time when the presidential purse equaled the national budget.
But I also realized, little by little, that the countries of the North could also learn from Zaire.

One day the Belgian ambassador called me: a doctor from Mons wished to accompany me to see how the health zone functioned in an urban milieu. I gladly agreed and I took this colleague to Kikimi, where we had created our first center. There we found Kinkela, the nurse with two wives who had come to help us transpose the model of our rural health centers.

That day Kinkela was leading a training session for eight *mama bongisa* from the neighboring streets. Everyone was there, in a thatched hut, in front of the center. There were of course children and a few chickens. They sang and then began the topic of the day. “Today,” Kinkela explained, “I am going to show you what to do at home when your child has a fever. This will enable you to decide whether you can treat the child yourself or, on the contrary, if you need to take him immediately to the health center or to the hospital.”

And he explained, in precise detail, all the steps: start at the top, examine the baby’s fontanel, look for stiffness in the neck, listen to the rhythm of the baby’s breathing, examine the stomach, etc. If none of the signs is positive, don’t worry: give him a cold bath, make him take some aspirin at such and such dosage, or nivaquin at such and such a dosage. . .”

Suddenly, at my side, I heard a sob!

I turn and it’s my colleague from Mons who was crying!

“What’s the matter?” I asked.
“It’s crazy to see that. . .in Belgium I was censured by the Medical Board for having tried exactly the same thing with the mothers of my patients: I wanted to teach them to examine their babies to find out if there was an emergency or if they could, without risk, give the medicine themselves. And I was censured.”

Development or underdevelopment? The meaning of these words was beginning to lose its clarity.

The health zones functioned from then on in Kinshasa. And in 60% of the rural and urban health zones, throughout the country, the comprehensive vaccination program now approached that of the European countries. Everything was going really well! Really? No. Because AIDS was already there. And I was totally unaware of the extent of the threat. . .

However, as early as 1983, Peter Piot, a specialist in medical biology at the Institut de Médecine Tropicale d’Anvers, came to Kinshasa. In Brussels he had been asked to examine patients who presented the same symptoms as American homosexuals and Haitians. They had a disease that had just been named “Acquired immunodeficiency syndrome” (AIDS) in the United States and “syndrome d’immunodéficience acquise” (SIDA) in France. Now, these patients in Brussels, African or European, came from Zaire. Piot deduced that AIDS must be present in Africa and he organized a visit to Kinshasa with Joe McCormick of the CDC, the Centers for Disease Control in Atlanta, an international authority on the question.

At Mama Yemo Hospital, the largest in the city, what a shock: Piot discovered—and revealed to the doctors—that an enormous percentage of the beds, 40%? 50%? was occupied by patients with AIDS!
Dr. Piot went immediately to the Minister of Health, Dr. Tshibasu.

“Minister, Mama Yemo Hospital is full of patients with AIDS. Can we organize an information meeting for the personnel?”

“Of course, do it right away, I will give the necessary orders.”

Doctors, nurses, assistants were therefore convoked to the large auditorium of the hospital. To the surprise of Piot, the minister had in addition summoned national radio and television crews. Piot’s report on the presence of AIDS, its nature, its gravity, was therefore communicated throughout the country.

I want to stop for a moment and comment on the political courage of Tshibasu. While so many politicians would deny or minimized the presence of AIDS in their country, for fear of damaging the country’s image, or through cowardice, Tshibasu did not hesitate. Afterwards, I asked him this question.

“Weren’t you afraid that by informing the country—and as a consequence the world—about the development of AIDS in Kinshasa, that the image of Zaire would be damaged, and that the country would then be fingered (which actually is what later happened)?”

“No, I didn’t hesitate a moment. The health of our people is too important.”

In reporting this dialogue today, I hope to compensate as much as possible for the injustice to Tshibasu, whose courage no one has ever commended. For too many people “nothing good can come out of Zaire.”

At the cabinet meeting the day after Piot’s report, there was electricity in the air.

“Tshibasu, what kind of stunt are you pulling now? Do you want to forbid us to screw?”
So we had that visit, that discovery, but AIDS as far as I was concerned, was just one more sexually transmitted disease (STD), and was only a small part of what I had been doing for years in public health. The basic work of the health zones was not oriented toward one particular disease, but toward keeping people alive, toward mother and child: prenatal consultations, vaccination, etc. In the centers there existed no protocol for treatment of STD, which was considered a secondary problem.

Moreover, contrary to conventional wisdom, the prevalence of AIDS remained relatively low in Zaire for several years until the arrival of foreign armies.

Fifteen years later while on a trip to Kinshasa, Kinkela told me: “Doctor, we have an epidemic of pregnancies here. We can’t do anything with the twelve or thirteen year old girls because the Zimbabweans pay in dollars—and they don’t use condoms.” I was boiling mad, because I bet that the majority of the soldiers were HIV positive.

We were not yet in 1986, but we were beginning to see people dying around us.

In Kisantu, the director of the center for agricultural training died of a mysterious diarrhea.

In Kinshasa our friend Myriam, a theater and film actress, was HIV positive. A tall, beautiful, intelligent woman, the mother of two pretty little girls, we once celebrated the New Year with her by dancing all night long until eight in the morning to the music of the Zaiko Langa Langa orchestra. She was the last person we visited before leaving Zaire. That day on our way to the airport, we stopped at the Ngaliema clinic. Myriam was there, skeletal. She died a few months later.

Yes, AIDS was there, but I did not appreciate the scope of its threat.
I had other things on my mind. For some time I had realized that my principle that I stay in a place so long as I am happy there was reaching an end. I thought I had accomplished the work that led me to leave Belgium thirteen years before. Moreover, I felt that I occupied a position, notably vis-à-vis the political authorities that was beginning to bother my colleagues. We were no longer in the situation of 1973, when the entire country could count only two or three Zairian doctors with degrees in public health: a group of very high quality now existed.

The time had come to leave if I didn’t want to become some sort of dinosaur of public health, a mandarin whom one would not dare contradict!

I had two possibilities: a post in Bamako with the WHO, the other in Washington with the World Bank.

In the course of our last vacation in Europe, while we were driving from the Cote d’Azur to Belgium, I took advantage of a stop in a village in Burgundy to go by myself into a small church. I wanted to be quiet, to be able to reflect on the choice I had to make. When I came out, I had made my decision: the work at the World Bank would definitely be more difficult, but if I could put across my convictions there, I could make more of a difference. So, we would go as a family to Washington.

Before leaving Kinshasa, I asked for a final meeting with the Minister of Health at the time, Professor Ngandu Kabeya. I wanted to thank him.

“If I’ve been offered a post at the World Bank, it’s thanks to what I have learned in working with your people. I have learned to practice medicine, of course, but much more than that: in the most remote villages, in the most destitute places, I have discovered the capacity of people to take charge, to take care of their own health. I am
leaving all the stronger for their blessing: Go, pierce the heart of the lion, pierce the leopard, and come back when you need to renew your strength.”

At Kisantu, then later in Kinshasa, I discovered that with faith and determination one could build upon a localized experience to influence national policy. And I began to dream that the same could prove true on the level of a great international institution.

I took away from Zaire, like so many gifts, a joie de vivre, a sense of humor, and a fighting spirit that still delight me even to this day.

I left for Washington, feeling strengthened by unique experience and filled with convictions. . .without in the slightest suspecting what awaited me.
IV

Tensions at the World Bank

It was very cold that fourth of January 1987 when I arrived in Washington with my wife and our four children, at that time aged thirteen, eleven, nine, and seven years. The blizzard that welcomed us put a definitive end to our years in Africa. After our initial installation near Rock Creek Park, we moved to Bethesda, on the outskirts of the city. In a quartier dubbed the “French ghetto”, were located the French school and numerous francophone families. We were just outside Washington, but I could ride my bicycle to the Bank, rolling along the canal that parallels the Potomac River. One evening on the towpath, I almost hit a roebuck, and one of my colleagues broke his collarbone braking to avoid hitting a beaver! Yes, nature was all around, and sometimes it was a blessing to be able to stop there to reflect, to sum up.

But more often than not I simply took the metro to the Farragut North station. A ten-minute walk past the White House and another three minutes to get to the World Bank and only a couple of minutes more to the International Monetary Fund close by.

It is not by chance that the World Bank is located on the doorstep of the presidency of the United States, at the heart of an enormous concentration of power. And it is not neutral.

We were very far indeed from the health centers of Kisantu and the squalid quartiers of Kinshasa, far from Konde the model nurse, from Dr. Ngwala, from the *mama bongisa*, from all my friends... Yet it was thanks to them that I had come to bring to fruition the experience gained in Zaire.

At the Bank everything is done to ease the new arrivals’ adaptation to life in Washington. They evaluate and improve the capacity of each to speak and write English; they advise about the purchase or the rental of a house; they provide contacts so that spouses can quickly form social relationships.

The Bank thinks of everything, and I appreciated that.

Nonetheless, at the end of a welcoming seminar to which all the fifty or so of the latest recruits were convoked, I seriously thought of packing my whole family back to Belgium!
In the large auditorium where we were assembled, the atmosphere was rather stiff. Each one felt the weight on his shoulders of the responsibility of world development and in his heart an awareness of belonging to the best institution in the world.

An important dignitary of the institution stepped up to the lectern. To me, God knows why, he looked like an Argentinean general! Gray hair, haughty bearing, loud of speech, he began to explain to us the course set out by the Bank for the year 1987.

Astounded, I heard him proclaim that development would come about through “structural adjustment.” His speech followed in a straight line the Reagan politics of the time: all developing countries are poor because they have allowed their administration to grow in an uncontrolled fashion. There are too many civil servants. Too many national enterprises suck the blood from these countries and prevent them from investing in their own development. Reduce public spending, and development will take off as if by magic!

Naturally I am aware of the need to control public expenses, but can the battle against poverty and development be reduced to the simple matter of the how many people work in the ministries? Where is the individual in these speeches?

And where are the interlocutors, our partners in development work: the governments? Not a word was said about the different regimes with which we would have to work. Can one deal in the same manner with the predatory Zaire of Mobutu as with a government like Tanzania, much more benevolent toward its citizens?

The meeting had no sooner ended than one question plagued me: what was I doing there? I came to help the development of people, and what I was presented with was a narrowly financial vision.

The Bank, happily, soon revealed other riches to me. But for a few days I envisaged having to recognize that I had made a mistake in direction and that the only thing to do would be to take my family back to Belgium—or look for another job.

I eventually came round however to my point of departure: it would certainly be difficult to influence health policies in such an institution in the light of my African experience, but the high stakes deserved the effort. I would stay.
In the course of the weeks and months that followed, I became well acquainted with this enormous institution that employs 10,000 people in the world, 8,000 of whom are in Washington. I learned about how it functions, about its missions, and its history.

The World Bank is one of the great institutions of the United Nations. It was created in 1944 at the international conference of Bretton Woods, at the same time as the International Monetary Fund, and today numbers 184 member states. Its role consists of reducing the inequalities between poor countries and rich countries, and the task is immense: more than a billion human beings have less than one euro a day to live on; more than one woman dies every minute in childbirth, all around the world. . .

The World Bank permits “developing” countries to make progress in health care, education, economy, thanks to loans that are granted them by the intermediary of two “teller windows” manned by the same personnel.

The International Bank for Reconstruction and Development offers first category countries loans at a more favorable rate of interest and length of repayment than private banks.

The International Association of Development allows the second category, countries with lower revenues, to benefit from no-interest loans with long-term reimbursement, and even, for the past few years, gifts in certain cases like the battle against AIDS. Forty member nations, the richest, replenish every four years the resources necessary for the funding of the projects undertaken by IAD.

In addition, the Bank has to maintain itself: it pays its personnel with the interest paid by the debtor countries. It is therefore absolutely necessary that it make loans.

In the course of the following years I discovered how this obvious economic necessity sometimes brought about hasty or debatable decisions and choices.

But, for the time being, I began to work at the heart of the technical department for Africa where the experts advise, clarify and sustain different project financed by the Bank in that part of the world. In the beginning, I was the only doctor. Unlike my colleagues I chose to advise and assist in a broad range of projects in Africa rather than directing only a few. I chose influence rather than control.

And during the six years that followed, I devoted myself to two enormous projects: the development of public health systems in African countries and the mobilization of the Bank in the fight against AIDS.
What a change in my life! From then on, no more taking a hand in the work myself: I had only to use my brains, my word, and my writing style for thousands of documents, reports, assessments, notes, and memoranda to put forth ideas and make decisions. Now, I find I’m not comfortable with this kind of writing, and the apprenticeship is laborious.

On the other hand, I quickly sense the tensions between the mission advertised by the Bank (struggle against poverty in all its forms) and the pressure to wrap up projects as rapidly and as cheaply as possible.

Finally, there was the enormity of the work: when, in that first year, I added up the demands for expertise that accumulated on my desk, I totaled 120 weeks for twelve months! Public health and AIDS summoned me to the four corners of Africa.

To fulfill all these demands, there was only one solution: I traveled like crazy. In general, a functionary of the Bank cannot be obliged to travel more than 90 days a year, 120 if necessary, with the functionary’s agreement. In 1988 I spent 166 on mission. That is, more than five months absent on some ten trips. Most took me through New York, Brussels, Paris and Geneva, to embark for two to four African countries where I would stay for varying lengths of time, from one day to three weeks.

And I liked it! I have never grown tired of contemplating the desert or a tropical forest from the window of an airplane. Jet lag eventually posed no problem, so long as I stuck to my almost sacrosanct principle: in a plane, I eat, I drink, I sleep. It’s one of the rare places where one can still be tranquil, far from emails and phone calls.

In the summer of 1987 the Bank team responsible for the health system in Mali invited me to join them to evaluate the results of an important undertaking that they had been supporting for two years and to prepare a new stage of development. It involved, no more and no less, the development of a public health system and a water supply system.

So I found myself in Bamako, on the banks of the Niger River with its magnificent sunsets. The city seemed really small compared with Kinshasa: at the time the airport had only a few small buildings. The immigration officers were installed in modest laminated stalls. At the hotel you ran into rats from time to time in the hallways. You said a prayer when you stepped into the elevator.
Sanousi Konate, the Malian in charge of the project, welcomed me and presented me with a list of appointments: all in different ministries and NGO’s! I put off the invitation, asking to first take a look at what was being done. And so pretty soon I was rocking along on a train on the Bamako-Dakar line, en route to Kita, the headquarters of one of the three sectors—down there they say “circles”—where a first program, sponsored by the Bank, for improving the health system was underway.

The chief medical officer of the Cercle provided me with the basic information: the proportion of people vaccinated, the people who came for medical treatment, the women in prenatal visits, the consumptives under treatment, in short, the basic indicators in public health. And we studied the information together.

A few days later, in Bamako, the World Bank team met with the Minister of Health to discuss the implementation of the second phase, which would take in the entire country.

The stakes were therefore very high. The Inspector General of health in Mali presided over the meeting that included all the authorities in the ministry, the local representatives of the Bank, and those in charge of the first phase.

After the introduction, the Inspector General turned to me, “the expert from the World Bank just back from the site.”

“Doctor Lamboray, would you give us your impression of what we have accomplished in two years with the World Bank loan?”

“Sir, your country has drawn down a loan of 15 million dollars to complete this program of ‘health and water supply.’ As far as the water supply is concerned, the progress is clear. But as far as the health system is concerned, this loan, in my opinion, has brought no improvement to the general population. Of course, personnel have been trained, new buildings have been constructed, supplies have been bought, and all this is not negligible. But the people have not changed their way of using the health services, they do not use them more often and do not get better treatment, they are not healthier than before. The people do not seem to have invested themselves in the project.”

There were no protests from those present. The Inspector General even murmured to his neighbor (he confided later to me): “The worst of it is that this toubab is right!”
I appreciated the integrity of my Malian counterparts: they willingly accepted a cogent argument based on facts without fear of jeopardizing their situation. I concluded my remarks by saying that it would be a long undertaking, that it was well worth pursuing, but that the basic premises ought to be reviewed.

I then began a close and fruitful collaboration with three people for whom I have the greatest respect: a young twenty-seven year old woman doctor, Fatoumata Nafo, destined for a brilliant future; another doctor, Fairi Togola, and Aliou Sylla, a specialist in community development.

The contribution of the latter was valuable because in order to develop health centers and get them off the ground, we were going to ask the country people to create and manage, in common with several villages, a small health center. It was a new step, and it bothered the old regional doctor of Kayes.

“Lamboray, this policy is very interesting, but it’s shooting for the moon!”

“How is that?”

“Listen to me: I come from Kita. In my native village, there are wells. Well, it is out of the question that women from the neighboring village come get water there. Even if they were dying of thirst, they wouldn’t be given any water. It’s not their well!”

“Are you really that separated from village to village,” I asked.

“Yes, it’s like that. . .and now you are asking these two villages to construct a health center together! I agree, but you ought to know what a cultural leap that demands of us.”

Fatoumata Nafo and her team were convinced. They started to work to clarify their plans and the means that they judged necessary to equip the entire country with health centers. Charged with following the progress of this work for the Bank, I went regularly to Bamako to consult with them. It was an enterprise of great breadth, the expansion throughout a country of the principles I had discovered in Zaire and that others were putting into practice around the world.

Finally, in 1990, everything was ready, and I presented the request worked out with the Malians at a very formal meeting of “evaluation” at the Bank. This meeting took place in a room in the J Building in Washington, where the services working with Africa are located.

The atmosphere was quasi-liturgic. In such circumstances the Bank displays itself with its ceremonial, its dignitaries and its high priests: the director of the Africa technical department, the division chief, the economist, the advisor of the vice-president of the Bank for Africa, the team that worked out the
project, the procurement specialist, various technical advisers. . . . All these eminent personages will give their point of view, and that will influence the definitive approval of the project. Millions of dollars are at stake.

The Malians, in their request, were clear. Long discussions and our work together had given them a precise and consensual vision of their project: they thought that the quasi-totality of the “circles” in the country ought to benefit from the funds from the Bank, but only on one condition: that each one of them first prove his ability to create the first health center and get it to work: vaccination of children, women’s assiduity in prenatal visits, participation of the local population, up to 50%, in the expense and work required for the construction of the center, the health committee, etc.!

In Washington, before the meeting, several colleagues warned me: “You are crazy to present this matter, Lamboray! The Malians will never be able to do all that by themselves.”

This skepticism was expressed during the meeting, but finally the meeting concluded with a partial approval: “We are starting from the hypothesis that only half of the circles will be able to meet the conditions that the Malians themselves have pointed out in order to benefit for the loan.”

The Bank therefore released 80 million dollars assembled with the participation of the European Union and with several governments: France, Belgium, Germany, Switzerland.

Two years later, in Bamako, all the participants were reunited for a review meeting in the premises of WHO. Fatoumata Nafo was then thirty-one years old. Placed in charge of the project, it was she who managed, with absolute integrity, the 80 million dollars. When she began to speak, we were all struck by the extreme gravity of her expression. What had happened? What catastrophe, what failure was she going to announce? Her first words only increased the concern.

“We have a very great problem. I don’t know how to present our difficulty to you. Do you recall that condition requiring that the circles must first prove their ability to create a health center before they could profit from the program funds? Well, here is the result of our inspections: all the circles in the country meet that requirement!”

The hall exploded with enthusiasm. “Terrific, Dr. Nafo, there is no problem, speed up the paying-out, we will back you up!”
Why did the plan work, in spite of all the difficulties—and especially the old cultural habits? Because the Malians took the time to “own” this project whose impact on public health would be confirmed ten years later.

“Ownership.” Capital idea!

Nafo and the members of her team did not take over a technocratic schema “key in hand” conceived by an international institution. They debated, argued on every level: ministry, province, districts, circles. They took the time to analyze, to plan, to explain, to debate, to convince. They involved the populations concerned. This project became their thing. For my part, I had the Bank play a role as stimulant, catalyst, support. The moneylenders agreed to play the game. UNICEF provided the necessary technical assistance. And it succeeded.

My supervision rounds on the ground confirmed it.

In the course of one of them, I went to Selinkenye, west southwest of Bamako, a village where the health center serves 5,000 people and which one reaches by crossing the savannah, now and then skirting fields of sorghum, millet, and corn.

With me in the jeep was Reiko Niimi, a Japanese colleague who belonged to my team and Abdel El Abassi, the UNICEF health representative in Mali.

The members of the health committee welcomed us. How handsome they were! The men in their ample boubous, the women in lace, their braided hair decorated with small white cowrie shells. A man used to figures, a former taxi driver from Bangui, conscientiously kept the receipts and medications inventory up to date.

There was enormous satisfaction in Selinkenye: they had passed from a situation in which a nurse sold for his own profit drugs that he managed to get his hands on here and there, to a system managed and supervised by the people. The quality of health care had considerably improved. Selinkenye offered a genuine medical step before going to a hospital.

We continued our tour beyond Kenieba, near the Guinean border, in the heart of a forest where monkeys watched us go by with astonishment, for vehicles were rare on the trail! Finally, we came to a village. Right in the middle stood a very large round hut of puddled clay with a straw roof. It was the health center.
There, too, everything functioned remarkably well and when, later in the day, I talked with the village chief, he confided in me.

“You know, since independence, we have asked ourselves whether we were Guineans or Malians.”

“And do you have the answer?”

“Yes. Since we built this health center, with the help of Bamako, we know that we are Malians!”

While the jeep bumped along the trail on the way back, I reflected on some findings that have become for me convictions.

An ambitious and enthusiastic project can bring together and mobilize formidable energies: the Malian authorities, UNICEF, the Bank, everyone cooperated marvelously.

People have a greater ability to take charge of their health care than those who govern them and the “experts from cold countries” believe.

Every grand design begins on a local level. There is no short cut. Democracy takes root in the villages, in the quartiers or else it is just talk.

In Washington my successive division chiefs trusted me, supported me, and I am infinitely grateful to them.

The apparatchiks did not have the same attitude. I rapidly recognized the existence of two categories of people among my colleagues. For some, the social missions of the Bank, the reduction of poverty, those are merely the underpinnings of their career. Their most important client is not the country to which they are supposed to help but the hierarchical chief who holds the key to their promotion. Their strategy consists of finishing up rapidly, therefore cheaply, projects that please the moneylenders and other administrators of the Bank, without too much worry about the genuine achievement on the ground. Those people follow all the fashions of the powers-that-be and say only what is expected of them. In such a world, reality counts for very little.

Others, on the contrary, stick faithfully to the missions of the Bank, sometimes at the risk of their career. They assume the chronic tension between the necessity to make loans to country—otherwise the Bank could not survive—and that of lending only very knowledgeably. Their convictions help them confront this daily dilemma. With such people, I can form long-term alliances, strategic alliances.
One of these men is Steen Jørgensen, a Dane, seven feet tall, the brilliant son of peasants, recruited by the Bank as a “young professional” among thousands of candidates. Steen was responsible for a health project in Zambia, and he asked me to come work with him there.

So here I was on my way to Lusaka with Steen and Reiko.

The capital of Zambia, the former Northern Rhodesia, still bears traces of the British colonial empire: at the airport, everything is perfectly clean, the uniforms are impeccable, it works, it’s kept up. In the former British colonies, the law is so ever present—unlike its almost total absence in Zaire—that it can become stifling.

The Zambians wanted to improve their health system whose infrastructure, however, was already impressive. I noticed that in the small town where I arrived, at 100 kilometers from the capital. At the hospital they even had an ultra-modern kitchen to prepare the patients’ meals.

But everything was broken, not working! They had not been able to repair anything. There was no petrol to run the refrigerators where the vaccines were stored.

A few days later, I was in the office of the Minister of Health, in Lusaka. Three or four colleagues from the Bank, the minister and the members of his cabinet had come together to ask a simple question with complex answers: how to improve health in Zambia?

“Doctor,” said the minister after a few minutes, “You are not saying anything. What is your first impression?”

Without preamble, I recounted a little story that I had prepared in anticipation of the question.

“Sir, a rich, business family owned a splendid white Cadillac that the whole village admired. It probably burned a lot of gas, but that was okay, right? Because business was good and money was pouring in. One day, however, business slowed down, profits dwindled. Costly repairs to the Cadillac were spaced out; they could wait a while. But the financial situation continued to deteriorate to such an extent that the father brought together his children: ‘I would like to ask your advice,’ he said to them. Lately, we have had a hard time maintaining our magnificent Cadillac, but today it is difficult buying gas to run it. So, what do you think: should we call on our uncles and ask them for financial aid? Or should we instead buy a Toyota, which consumes a lot less and which would give us the same service?’”
All the members of the cabinet burst out laughing. “Excellent, doctor, excellent! That’s exactly our situation.”

The essential was said.

The Zambians then with our help carried out an impressive job of starting from scratch and bringing their entire health system down to a realistic level. From the smallest dispensary at the university hospital, all the missions were redefined: how many people in a center? What treatment protocols? In which cases is an x-ray necessary? Who should be sent to the hospital? Who can be treated locally? With which drugs, which laboratory examinations? Etc.

This work in Zambia marked a turning point in the history of health development, because, once again, we incited the Zambians to formulate a plan together which would be theirs and not that of such and such an international organization. That was a major change, for at the time, the cooperation services of rich countries tended to hold this sort of discourse with the countries of Africa:

“Our country is entirely disposed to help you in your development. As you know we are very competent in hospital construction, in vaccination campaigns, etc. Hand over a province to us and we will concentrate our aid there, send you our best teams.”

As a result, the province in question receives more aid than all the rest of the country. Impressive progress is made, but everything collapses the day the foreign aid workers leave.

In addition, since different rich countries adopt their own approach in various provinces, throughout the country there are as many health policies as there are cooperation programs. The pattern is the same in most poor countries.

In Mali, in Zambia, and in many other countries in the course of these six years, I helped the authorities to formulate their own project in which outside moneylenders were invited to participate. That became the policy basis of development. Thus, I translated my conviction according to which the role of international institutions consisted not of imposing their expertise and solutions, but of helping countries to find theirs and to put them into practice.

In Washington, during this time, my family gradually adapted to the expatriate milieu in which we lived. We happily joined the French-Belgian-American-African network that formed, little by little, in Bethesda, mainly around the French “parish.” We were lucky: our neighbors—Dave and Monica, Bob and...
Helen, Jean-Pierre and Marie-France—welcomed us very warmly. Today we cannot pass through Washington without a little neighborhood reunion.

On the other hand, we measured the price of these friendships when we were invited to dinners with the milieu of the World Bank, the embassies, and the IMF. I still remember one dinner in the course of which the woman seated next to my wife turned to her and asked:

“And you, Madame, what do you do?”

“I work at home.”

“Ah? And what do you do there?”

“I’m raising our four children.”

Without adding a word, the woman turned slowly, ostentatiously to talk with the guest on her right. Since my wife could offer her nothing through her contacts or her professional experience, she did not count at all. That was not the only sad experience.

We were in a society where the ultimate reference is power or money.

Happily, those were not the criteria of my chief of division, Ishrat Husain, an Indian woman about fifty years old. She believed in the missions of the Bank and entrusted me with an ambitious task that was for me an opportunity and a challenge: the conception of a general orientation document for improving the health of Africa.

It would be called Better Health in Africa.

Two people, one of whom was a former American diplomat, were to help me write it, for I had not yet mastered all my deficiencies in that area.

We worked like crazy and six months later, we submitted the first version to the Bank.

Our document contained two messages very out of sync with customary Bank positions:

—People and not governments create health. Governments and their services merely provide a favorable technical environment.

—Every country possesses, in its midst, the experience necessary for improving the health of its people. And it can do it, provided that it knows how to learn from that experience.

A series of positive examples, drawn from Zaire and West Africa, supported these statements.
This work forced me to recognize a key fact: positive experience is rarely described and communicated. Those who work in the field rarely write. And it is a serious problem, for those who write rarely venture into the field. Now, it is what the latter write that influences policies. As a result, experience, which is so vital, is hardly ever taken into account when decisions are made. The reaction of an adviser to the vice-president for Africa confirmed this for me.

“Your document is very interesting, Jean-Louis, but I have never heard anyone speak so positively of Africa as you describe it!”

So we were told to moderate the optimism in the report, which we did: without, however, cutting out of the document its basic message.

When Better Health in Africa was published, in 15,000 copies, I was not even cited as the co-author! The Bank mediator whom I consulted advised me to drop the matter: “Don’t fight over it, Jean-Louis. The technical advisers always get knocked out by the apparatchiks.” I agreed with her. The important thing was to spread the word, to get these ideas, born in Zaire, developed and tested in Mali and Zambia, adopted by all the African ministers of health at the Bamako conference the preceding year.

It was a real victory.

Not without confrontations. I experienced the considerable and sometimes negative power of money, personal ambition, of the technocracy, of the bureaucracy, and of academe.

The pressures were still more extensive in the endeavor to which I was devoting more and more energy: the battle against AIDS.
AIDS spread with frightening speed during the years I spent at the World Bank, from 1987 to 1995.

During my trips to Africa, there were thousands of constant reminders of it.

In Lusaka, Zambia, the mayor of the city had to make a decision to burn the dead—which is never done in that part of the world—because there was no more room in the cemeteries.

In Abidjan, the group at the reception desk at the Hotel Ivoire gradually shrank, cut down by the disease.

In Washington, an announcement heard over the radio devastated me: the Zairian singer Franco had died of AIDS. Franco...I can still see him, powerful, full of health, in his nightclub in Kinshasa, while we danced to his wonderful music. I had to walk around the neighborhood to calm my tears before going to fetch my daughter from her drawing lesson.

The figures are impressive: in 1995, it was estimated that nearly twenty million people in the world were living with HIV positive, the AIDS virus.

But when I arrived at the Bank, eight years earlier, the infection was still only a small red spot on the map of Africa: the south of Uganda, the east of Tanzania, Rwanda, Burundi, the east of Zaire. And it was only when my superior, Ishrat Husain, asked me in January 1987 to work specifically on the disease that I became fully aware of the gravity of the threat.

“Jean-Louis, since you come from Zaire and you have a hand in several African operations, try to formulate some recommendations about AIDS in Africa.”

Since I was not a specialist in HIV, my first step was to inform myself: I asked Peter Piot, at that time professor at the Institut de Médecine Tropicale in Antwerp (and whose trips to Kinshasa I
remembered) and Professor Pierre Viens, at the Université Laval in Canada, to join in helping me to be clear-sighted and to understand.

Peter immediately informed me of the characteristics of the epidemic: AIDS is 100% fatal. Its incubation period can last from eight to ten years. It is transmitted particularly fast in groups already afflicted with STD, sexually transmitted diseases, which means that male homosexuals are especially vulnerable to these infections. On learning all this, thanks to Peter, I finally realized the enormity of the menace. But around me at the Bank, my colleagues to whom I spoke of the urgent need to act considered me a madman!

“Lamboray, what’s the matter with you? Okay, there is AIDS, but there are also malaria, tuberculosis, diarrhea, and so forth.”

“Listen, this is different: AIDS represents a gigantic danger for Africa and for the world. The Bank ought to act right away,” I said.

“You’re asking us to get to work on a potential disaster while we are busy working on current disasters.”

With AIDS the pattern is too often the same: the first reflex is to deny it. But with denial, at every level, lives are lost.

What recommendations could be made for Africa? Peter Piot, Pierre Viens and I worked from our knowledge, our respective experiences, and the data that we collected. And we defined four means of taking action:

—Inform the public
—Treat STD
—Distribute condoms
—Take action in the regions where STD is widespread since we knew that where STD spreads, AIDS will spread all the more rapidly.

In addition these regions had to be identified.

Now, when we tried to draw up a map of STD in Africa, we had to acknowledge that the data did not exist, except in the Cameroon. For twenty years, all public health activity had focused on infant and
maternal mortality. STD, considered a marginal problem, was hardly ever studied or placed in the statistics.

In spite of this lack of information, we began to mobilize the attention of the Bank. Beginning in 1987 the Bank supported the special program to fight AIDS put in place by the WHO and directed by Jonathan Mann. This American doctor from the Centers for Disease Control in Atlanta carried out the first studies on AIDS in Kinshasa following the visit of Peter Piot.

Programs, exclusively preventive, were gradually put into place, beginning with Uganda, Rwanda, Kenya, Tanzania, and Ethiopia.

The finalization of our document progressed. I left for Geneva to submit the first version of it to Jonathan Mann. While I was explaining the contents of our work, Jonathan stopped me suddenly with this question, a priori very astonishing:

“Jean-Louis, you think that AIDS is an STD, a sexually transmitted disease?”

“Yes, but it can also be transmitted by blood.”

“Of course,” I said, “But nonetheless it is an STD, for example, like syphilis: no one disputes the sexually transmittable character of it even though this disease can also be transmitted by blood.”

And I had a hard time—I no longer know whether I was able to write about it in the document—getting a specific admission that AIDS is a sexually transmitted disease!

Jonathan died in a plane crash, and I was not able to explore with him the reasons for his reservations. But I believe I perceive what they were.

Perhaps he was afraid that the moneylenders, the rich countries habitually solicited by the Bank, would hesitate to finance a battle against a “sexually transmitted disease.” Malaria and enfant diarrhea were much better for their image.

Perhaps Jonathan was also thinking of the debate initiated and fed by the American gay community.

After years of struggle, gays in the United States had obtained recognition of their rights. It was a considerable victory against the discriminations from which they had only too often suffered.
In any case, the gay community did not wish to become the object of yet more discrimination and they feared this would be the case if AIDS were officially recognized as an STD. For in the United States contact tracing is practiced. A doctor who diagnoses an STD in a patient is entitled to ask him: “I want to see the person with whom you have had sexual relations. It’s a matter of public health. That person has to see a doctor and get treatment.”

In certain states health officials are even required to trace the network of transmission.

AIDS remains to this day an exception in the United States and in numerous countries.

A debatable exception? You be the judge: a colleague at the World Bank told me of his imminent marriage in California. Before appearing before the justice of the peace, she and her future husband had to provide a medical certificate asserting that neither had syphilis. But—in the name of civil liberties—nothing of the sort would be asked for AIDS! Later, my Thai colleagues would tell me of their ambition of making AIDS a disease like any other. And what if the international community had taken this point of view rather than making AIDS an exception?

These debates did not prevent us from moving forward. With three of my colleagues from the Bank—Jacques Baudouy, project task manager and his superiors, Alain Colliou and Paul Isenman—we shared the same conviction: the effects of AIDS represented such a risk for development that it was necessary to help the affected countries eradicate the plague. The Bank must throw all its weight into this effort.

Thanks to their determination, we set up a first loan of 10 million dollars to Zaire in 1988 to help fight the epidemic. Other countries soon followed.

Our recommendations about AIDS in Africa were ready. We had only to get them officially approved. Paul Isenman, acting vice-president, called me:

“We are convoked to present the document to the president of the World Bank!”

So there I was en route to the holy of holies, at the very top of the main building of the Bank. The twenty-five or so people who made up the president’s council were seated around the heavy oak table in big leather and wood armchairs.

Our work was very well received.

“Bravo, it’s terrific, very clear. Do you have the approval of WHO?”
“Yes. Absolutely.”

“Very good.”

At that point the African administrators of the council spoke up:

“Sir, why is your document specifically oriented toward Africa?”

“In the technical department for Africa where I work, we have ascertained that the epidemic today is developing particularly on that continent, which does not mean that it is not going to spread elsewhere.”

“Well, we think that this document should be presented with a world perspective and not just African.”

We were a long way from the courage of the Zairian minister Tshibasu, whose primary concern was to inform his countrymen. These administrators really did not want to recognize that Africa was confronted with AIDS, that homosexual disease!

The document was not published. But that did not change the aim of the Bank. The vice-president was convinced of the accuracy of our views. Soon we contributed financially to the WHO program to support the African countries that added an AIDS component to their health programs.

Those were baby steps in the fight against AIDS. It was a period full of questions. I remember my own hesitations: we were going to provide information, distribute condoms, preach fidelity and abstinence. And these were the costs involved in the development of such services. Very good. Nonetheless, I felt confusedly that we ought to do more, go beyond that. But how?

It was also a great period of controversy. The first involved condoms.

Ishrat Husain, like many others, was very skeptical.

“You mean to tell me that Africans are going to use condoms? While they refuse to do so in the context of our family planning programs. According to them, making love with a condom is like eating a piece of candy in its wrapper!”

“Yes, but the situation is different. In one case, it’s a question of accepting a diminution of pleasure to avoid procreation; in the other, it’s to avoid death.”

Actually, in Africa, the campaign for the use of condoms was a success. The quality of social marketing, entrusted to a specialized company PSI (Population Service International) had a lot to do with it: after a market study, great attention was given to the packaging, to the image, and to the publicity. In
Kinshasa the condom brand was “Prudence.” The leopard on the packaging expressed strength combined with prudence. Elsewhere, other cultural and visual codes were used.

Another controversy involved the demographic impact of AIDS: we could not say, and especially we could not write in any Bank document, that the disease could reverse demographic growth in Africa. For if the idea spread that AIDS “is doing the work” in decimating populations, what countries would accept financing more programs in family planning put in place with the help of the Bank.

These debates and these reservations prevented us from defining general guidelines and getting them accepted by the Bank. Programs were launched.

I felt I had done my work. In 1990 I recruited an American colleague to work with the AIDS dossier and I rejoined Janet de Mérode, in charge of policy and strategy for population, health and nutrition activities for the Bank. I was acting advisor for health, for the post was temporarily vacant.

I thought I had disengaged myself from the AIDS dossier. On the contrary, it would soon occupy all my time and plunge me into the heart of a veritable inferno, for the epidemic was also wreaking havoc, in another fashion, in the very heart of the United Nations.

Two United Nations agencies were engaged in an important polemic: WHO, which by and large endorsed our recommendations (information, condoms, surveillance of STD), and UNDP, the United Nations Development Program), which insisted: “Careful, you are ignoring the less obvious causes of the epidemic—the status of women, the inequality of the sexes, poverty. . .not counting all entirely intimate and personal aspects brought into play by AIDS.”

The director of WHO, Halfdan T. Mahler, was open to cooperation with UNDP. Beginning in 1987 during a meeting I was attending, he said to his director of the AIDS program, Jonathan Mann: “Jon, this problem is much too big for us! The epidemic is going to explode in our face. Let’s join the UNDP.”

Mann and his entourage reluctantly joined this cooperation. Some, at WHO, saw in the fight against AIDS such a very good opportunity to refurbish their image, rather tarnished by their fight against malaria, that they scarcely wanted to share the glory to come.

Other agencies in the United Nations also set forth their competence in handling the problem, and we witnessed a disturbing battle for funding. Helen Gayle, head of AIDS at USAID, the State Department branch of development, deplored this situation:
“Every day, people come to tell me that their agency is better than the next one in fighting against 
AI9/17/10. Everyone claims to be right: WHO, UNDP, UNICEF, and each one says: “You should give us 
the credits.”

In African countries, the results of these conflicts were disastrous. The authorities didn’t know 
which way to turn: WHO approached the Minister of Health; the UNDP the Minister of Planning, etc. and 
each one boasted his competences and his program. It was a Tower of Babel.

Aware of this cacophony, the general assembly of WHO recommended that its general director 
study the creation of a joint program under the participation of six United Nations agencies: WHO, the 
World Bank, the UNDP, UNICEF, UNFPA, and UNESCO.

Meetings were organized in New York with representative of the six agencies. I represented the 
World Bank. Our mission was to follow up the recommendations of the general assembly of WHO and 
therefore study the creation of one single organization.

But in the course of these first meetings, AIDS, and even less the victims of AIDS, never came up 
for discussion. Structures were the only theme taken up. We discussed endlessly whether this common 
program ought to be conceived on extensive structures involving technical personnel, or on the contrary on 
a basic structure that would coordinate agency personnel, etc.

After a few weeks, the Secretary General of the United Nations, Bouros Boutros-Ghali, received 
the six agency chiefs, one of whom naturally was the representative of the World Bank. The first order of 
business of this summit meeting was the projected program to fight AIDS.

I was in Laos at the time—and the colleague with whom I was working on AIDS called me from 
Washington, to ask me to send her the contents of a document in preparation, a brief destined for our 
president, Lewis Preston. We pointed out to him what in our opinion ought to be the essential thrust of our 
intervention: at that stage, during the first meetings, there was no need to commit the Bank in a common 
program, for all the discussions revolved around structures, and not around fundamental questions.

I immediately called the representative of the Bank in New York, Wali Haddad, a Lebanese:

“Wali, what happened during that famous meeting with Boutros Ghali?”

“I’ve no idea. Only the agency heads and the head of the AIDS program of WHO participated.”
“But we were very surprised: what the head of WHO has announced doesn’t correspond to the document submitted to the president of the Bank.”

“You gave him a written document?”

“Yes.”

“Did you get any feedback from the president after the meeting?”

“No.”

“Then you can be sure that he followed your recommendations to the letter and you can continue to work in that direction.”

On the basis of that conversation, our vice-president signed the letter of denial that we proposed, addressed to each of the five other agencies: the World Bank would not participate yet in the joint effort. The Bank would take part in a united program only after an in-depth discussion of the conditions of work of the new program in countries and especially after AIDS had finally been addressed!

I distributed that letter to each of the representatives of the agencies at the meeting of the six. The participants read it in a deathly silence.

An elderly doctor from UNDP finally broke the silence by turning to me:

“Young man, do you know what you are doing? You are defying five heads of agencies in the United Nations!”

“Sir, if that is what I have to do, I am doing it.”

A veritable storm broke out. I underwent pressure from all sides, orchestrated by WHO, to force the Bank to rejoin the other agencies without further discussion.

The American administrator of the Bank called me:

“Doctor Lamboray?”

“Yes.”

“I am the Administrator of the Bank for the United States.”

“Delighted to know you, Sir.”

“Tell me, the Under-Secretary (in other words, the number two of the State Department) gave me a report on you after his return from Geneva. It appears that you oppose the working in concert of different agencies of the United Nations. You want the Bank to go it alone.”
“You can interpret it like that, but here is the situation. . . .”

My explanations appeased him somewhat. But other people interfered.

My friend Pascal Chevit, scientific adviser at the French embassy called me:

“Jean-Louis, things are heating up!”

“What’s happening?”

“I was just on the phone with the Quai d’Orsay.”

“So, what did they want?”

“They want me to give you a sound thrashing. I had to explain to them that you are Belgian and that we have no power over you!”

Midnight. The telephone rings. A friend:

“I have just left a meeting with Boutros-Ghali. I was on a conference call with the Director General of WHO, who was calling from Palestine. And I heard the latter, in the course of the conversation, say to Boutros Boutros-Ghali: “We absolutely have to get rid of this small fry Lamboray, who is keeping us from making progress.”

Fortunately, two important senior officers from the Bank and WHO soon met. They knew each other and talked unemotionally. They were my director, Janet de Mérode and Alia Hammad, who was a member of the staff of the director of WHO. Alia understood Janet’s explanations and approved the basic reasons for my attitude. The storm died down, then stopped. I really had had my feet to the fire!

That episode inspired me with absolute respect for the Bank and its directors. During all that battle, the point of view of the hierarchy was unambiguous:

“Jean-Louis, you are in charge of the dossier. What you say is common sense. We will follow your recommendations.”

The situation therefore began to loosen up.

Mike Merson, in charge of the AIDS program at WHO took a first step: all right, let’s move forward; let’s begin by talking about AIDS.

The commission of six met again in New York. I was in charge of preparing this meeting with a colleague from UNDP, Elisabeth Reid, an Australian, very sensitive to the human dimension of the question, for she was personally affected by the disease. . . .
In common accord, we decided two things:

— Begin the meeting by reminding the participants of our common responsibility regarding this disease and the countries afflicted with it.

— Try to bring the group together by proposing a clear-cut rule of behavior: we commit ourselves to reporting the remarks exchanged during our meetings, whether oral or in reports, exactly as we would if the person we are citing were sitting next to us.

It is necessary to point out that, at the time, no one would risk speaking out in meetings anymore, for everything that was said was immediately used to pull the blanket toward such and such an agency. If, for example, someone asserted that AIDS is a development issue, the people from UNDP, the United Nations Development Program used this statement to say that the money ought to go to them. If someone proposed that, above all else, condoms ought to be distributed, WHO immediately claimed the leadership of operations, etc.

My colleagues accepted this line of conduct and that relaxed the atmosphere somewhat.

During the second part of the meeting, in the afternoon, Elisabeth asked only one thing of the participants: that each recount a personal experience related to AIDS. We went around the table and shared our stories. The atmosphere was no longer the same, and I seized the opportunity to propose that our next meeting take place in Zambia. In that way we would talk about AIDS and strategies not in an abstract and technocratic way but by being directly confronted with the problem in an affected country.

I called my friend, the Zambian Minister of Health.

“Can you organize a meeting on AIDS for representatives of the six agencies of the United Nations?”

“No problem, Jean-Louis, we will be happy to be their hosts.”

In the following month we were in Lusaka. I insisted that we make a community visit before beginning our work, properly so called, and, we had hardly got there when two minibuses took us to a village severely hit by AIDS, not far from the city.

And there we were on beaten earth, surrounded by huts. There were men, women, and children present. Several of them were clearly gravely ill with AIDS. Chairs were put out under the mango trees. A few hens and goats ambled about, nibbling and scratching for food. A discussion started up.
What happened then in this little African village would change the attitude of six agencies of the United Nations! And all that in a very simple way: from the questions that we asked of these people seated around us, with their miseries, their courage, their life.

There came a moment, for example, when Elisabeth Reid from UNDP, asked a question related to condoms, the “spear-head of WHO.”

“Have you thought about systematically using condoms and not using them only to have a baby?”

And then Mike Merson from WHO, whose first concern ought logically be related to medicine, asked how the village would survive economically with all the sick people, all the deaths... Points of view crossed.

We were headed in the right direction! I felt that if we continued to expose ourselves in this way to actual conditions, we would succeed in creating this famous joint program on healthy premises.

But the challenges were not over. The following day, during our first work meeting, at the Intercontinental Hotel in Lusaka, our Zambian friends broke into the conversation:

“AIDS doesn’t just concern our sexual conduct. It also concerns your unbearable bureaucratic conduct, you, the agencies of the United Nations. How do you expect us to attack such a problem in an effective way with your impossible regulations? For the least little soft drink served at the end of a village meeting, we have to provide you with documents justifying it! We are buried in red tape and administrative procedures.”

In Lusaka, the debate opened up in all directions, in all their multiple aspects. Every one admitted that the questions were more complex than the analyses done in the air-conditioned offices of New York and Geneva. We could then begin to discuss the methods and means of this new joint, sponsored program that would be called UNAIDS.

Back in Washington, I informed my superiors that the conditions posed by the Bank for participating in the new program had been met.

The latter was officially adopted in the course of a meeting of ECOSOC, the counterpart of the United Nations Security Council for economic and social affairs. UNAIDS, whose director would be Peter Piot, was mandated to coordinate the actions of the United Nations in combating AIDS in the world, to put
an end to the absurd competition between agencies and to make sure that the management of resources would be efficient.

While waiting for the launching of UNAIDS, which began in January 1996, I continued my missions in Africa. It was a means of getting a real feel for the dimensions of the fight against the virus: the participation of people living with HIV in the measures taken to combat the epidemic.

I met for the first time the man who introduced me to this idea in front of the fabulous Victoria Falls, at Livingstone in Zambia, near the border with Zimbabwe.

Roland Msiska, the Zambian head of the fight against AIDS, invited me there to a meeting of his staff. I took advantage of a break to go admire the famous waterfall.

A young man stood there, contemplating the falls. To my astonishment, he looked at me and said, “How beautiful it is!” Such expressions (?) are unusual in Africa where the sharing of an aesthetic experience is rare.

The following day, I saw this young man, Winston Zulu, enter the room where the meeting was taking place. The organizers wanted to hear his testimony because he was one of the first in the country to declare publicly that he was living with HIV. He belonged to a worldwide network of HIV positive people, a network begun in the United States and in France, notably.

The following year, in June 1994, Winston Zulu participated in a summit meeting in Paris on AIDS. Before all the ministers of health assembled, he spoke in the name of the network:

“We, those living with HIV, we are not the problem. We can become of a part of the solution!”

The future would prove him abundantly correct, but how much time would pass before this idea would be heard again: Invite the people living with AIDS into the fight. And therefore begin to know and support them.

I had hoped to influence the work of the summit in this direction by drafting a document with the Canadian journalist Donald de Gagné, at that time president of the network “Global Network of People with HIV/AIDS,” the worldwide organization of people living with HIV.

Our idea was supported in this way: in that year 1994, nearly twenty million people lived with the virus. Six billion human beings lived without the virus.
In order to stop the transmission of the virus everyone ought to behave in the same way because everyone is concerned. But in order for transmission to take place, an HIV positive must encounter an HIV negative. We therefore proposed putting the prevention money on the eleven million HIV positives, rather than dispersing it over general populations. Aim for a real impact on the HIV positive. Tell them—and prove to them—you belong to society, we are doing everything to treat you, to hold on to your place, your work. And you, you can fulfill your part in the battle against this epidemic by living positively.

I sent this document to WHO, hoping that it would supplement the statement of the ministers of health, in Paris, pointing out the support of the organization of individuals living with HIV.

WHO classified the document “no follow-up, case closed” because, I was told, of its “fascist” character.

What! they said at WHO, who is this guy who proposes that HIV individuals come forward and make themselves known? That’s a violation of civil liberties.

That day, we very probably just missed an historical opportunity.

The red spot spread out over Africa. The Ivory Coast was engulfed. The epidemic spread toward the south in a dramatic fashion. It reached Asia. A serious hotbed developed in Thailand, others broke out in India, Indonesia, China. . .

All this was well-known; the statistics were available. However, when I warned the countries: “Watch out, the epidemic has not yet hit you very hard, but you already have STD, and that’s the forerunner of AIDS.” Most of them had the same response: “Doctor, we understand your agitation. You have lived a long time in Zaire where everything is in trouble. But, here, we are different.”

Or else, according to the country: “Come now, Doctor, this is the Philippines, we are Catholics. . . here in Niger, we are Muslims. . . In our country, Doctor, there are no homosexuals. . . .”

Very rarely did I encounter the courage or the lucidity of Zaire, so unjustly maligned. Even in a country like Madagascar, where, while there in 1991, I ascertained a gigantic number of STD, the authorities declared themselves safe from AIDS. “No, come now! Not in our country.”

Ten years had to pass before the president of Madagascar himself declared that it was time for them to take their heads out of the sand: AIDS was threatening to jeopardized the development of the
country. In ten years of doing nothing, Madagascar went from one person infected per 10,000 to one in 100. And if they did nothing at all, tomorrow, there would be one in five!

The epidemic galloped across the world. Leaving the airport in Lusaka, I saw that the taxi driver taking me into town was rail thin. He constantly leaned out the window to cough.

Another one. . .

At the travel agency, seeing the red ribbon on my jacket lapel, the woman behind the counter, said to me:

“Ah, you work with AIDS? I belong to the club.”

“The club?”

“Yes, the widows club. We’re all widows here. Our husbands died of AIDS.”

In Nairobi, the immigration officers at the airport were younger and younger. All the old ones had disappeared.

In Washington, an African delegation arrived to negotiate a loan with the Bank. Less than a year later, when a colleague arrived in the country for a first supervisory visit, two-thirds of the members of the delegation were dead.

At the Yokohama conference in 1994, Roland Msiska, head of the national program in Zambia, used this poignant statement to define the impact of the epidemic in his country: “In our country the cemeteries are busier than the markets!”

We were at that point when I left for Bangkok, where revelation and hope awaited me.
VI

On the Frontline of AIDS in Thailand

Who could have made me believe that I would leave Washington for Thailand? Who could have made me believe that I would agree to concentrate all my energy on one single disease, given that I had always worked to develop health care systems, and refused to work on programs addressing a single public health issue.

Nonetheless, that is exactly what happened during the course of the year 1995, under the pressure of events that, by chance, turned my life upside down.

The first event came at the end of 1994: my situation as senior health advisor to the World Bank came to an end. I had held this post in the interim while awaiting a recruitment that had just been concluded. So I had to find another assignment.

The other event was the transition toward UNAIDS and the opening, by the Bank and WHO, of an office in Bangkok in June 1995, that would soon become the relay of UNAIDS in Asia.

For me, it was another time for decisions! Decisions illuminated by all the experience acquired in the course of eight years spent at the Bank and by an awareness that AIDS calls into play so many parameters: medical, sociological, economic, psychological, etc. that it opens up an entirely new vision of public health. That idea inspired me to plunge into the UNAIDS undertaking. I submitted my candidacy, and it was accepted.

I had had scarcely any experience in Asia, outside of a few isolated missions.

So, in the course of the winter of 1994-1995, a colleague from UNDP invited me to an exploratory trip that took us to Vietnam, China, Burma (today Myanmar), and Thailand. The objective was to determine the main resources of these countries in coping with AIDS and the support that UNAIDS would soon be able to give them. But I was also expecting from this trip information and insight on that part of the world whose realities I would soon be forced to confront and whose codes I would soon have to decipher.
It was a period when communist countries like Vietnam and China were beginning to open up a market economy. And we were quite impressed by the impact of that revolution on people’s minds and the questions that it raised, including questions about HIV.

For decades, these planned economy States had tackled social problems by attacking those who were the vectors—or the victims. Therefore, prostitutes were prosecuted; drug addicts were imprisoned, etc. Once citizens became economic agents, encouraged to take initiatives, what would happen in the social scheme of things? That was a huge subject of inquiry in these two countries. We were witnesses to it in the course of our visits there.

In Vietnam the Minister of Social Evils tracked down prostitutes and had them put in prison. At the same time, the national Program combating AIDS tried to educate these same prostitutes so that they would carry the prevention message. One day, these women would be encouraged to promote the use of condoms among their prostitute friends, and the next day, they would get themselves arrested for possessing condoms, a sure sign that they were prostitutes!

In China, in Yunnan, Dr. Yee was in charge of family planning and of tracking the epidemic of AIDS in the city of Kunming. He exposed his questions to us by taking the example of the policy of births: the State attributed to each village a certain number of “procreation licenses,” in other words, the authorization to create a specific number of babies. The village would meet to discuss the authorization to determine which couples would have the right to conceive a child that year. But these same people, so structured in the most intimate aspect of their lives, were now authorized to take initiatives in economic and commercial matters. Would it be possible to maintain these centralized and repressive systems in the social and family domains while the economy was being liberalized?

While in Kunming, we were astounded by the volume of the prostitution. It was much more obvious than in Bangkok, where it is a highly developed activity. Here in Kunming hairdressers served as go-betweens. Clearly, the public was well aware of this connection, but when I talked about it with Dr. Lee, who was in charge of AIDS, and ought to be keenly aware of what was going on in prostitution, he claimed to be quite surprised.
“No, I did know that hairdressers were mixed up in this business. . .you understand, I work with the epidemiological bases of AIDS, so my life revolves around my home and my office. I don’t pay any attention to what is going on in the streets!”

Contrasts. Contradictions: In Vietnam, in Hanoi, defying the hair-raising bicycle and motorbike traffic, we rented two mobylettes so that we could get outside the city a little. There was a Catholic church in a nearby village. There we found no worshippers but instead a few people living on the edge of absolute poverty. They were the parents of the priest and their children.

Thirty kilometers further, a radical change of scene: in a garishly new golf club, we were welcomed by a gorgeous hostess wearing a dress split up to the top of her thighs. Money flowed like water.

In Rangoon, in Burma, we were shown, with great pride, a home for the rehabilitation of prostitutes. These women, we were assured, would discover the redemptive value of work in doing the laundry for luxury hotels—for a miserably low salary. In a corner of the main room, an iron cage where one cannot stand up waited for the rebellious and recalcitrant. In answer to my question about the cage, our guide said that it was there “for discipline problems.” Sad and depressed, we spoke for a few minutes with a superb Burmese woman of twenty-two, sent away from Japan where she was a “sex worker” when her employer learned that she was HIV positive.

Everything there was so different from Africa! And one question haunted me: Would what I was going to learn in Thailand help me sustain my African friends in the fight against AIDS?

During one of my last trips to Zambia, I asked my friend Roland Msiska, head of the national program for AIDS, that question. I can still hear his prophetic response:

“We are letting you leave for Asia, Jean-Louis. You will come back stronger!”

Off to Asia, then! I left Washington for Bangkok in June 1995.

Very quickly, I became fascinated by that city, even though housing speculation has disfigured it. The lovely canals have been filled in to make streets; many streets have been made dead ends to force the inhabitants to pass through main commercial areas. The pollution is terrible and the traffic a nightmare, for the enormous downtown expressway project has not been completed.
From the apartment we rented on the fourteenth floor of a high rise built on a private street, the view of the city with its contrasts was superb: on eye level, the ultramodern high rises, unfortunately constructed with no regard for urban planning, and down below, miserable little houses where women wash their laundry in huge cauldrons in the front yard and chickens scratch in the bare earth.

But I love this city and especially its inhabitants, for their gentleness, their kindness, their grace.

For UNAIDS, I had to start everything from zero: I had to find premises, form a team, define our objectives, make contacts, get myself acquainted with national and regional realities. But on this last point I confirmed once again that these realities do not always count in the culture of large institutions.

Coming from Washington, I went by the office of WHO in Geneva, to which I was attached until the end of the year. I was immediately asked about my “plan of action”! I protested that I had first to get informed about the different aspects of the epidemic in that part of the world, and with the different players. I put off my answer for six months. That did not improve my image with the bureaucracy of WHO, a stalwart enforcer of a priori controls. I was a long way from the climate of trust at the World Bank.

In Bangkok my first contact with the UN agencies was likewise somewhat strained. The creation of UNAIDS had upset the settled habits of the agencies. It was therefore not surprising that the local head of WHO, Brian Doberstyn, welcomed me rather coolly in the beginning.

The regional office of WHO in New Delhi, on the other hand, gave me a helping hand in sending to me S.P. Ahuja, an Indian, who had behind him a long career in public administration. He put into place my logistics: documentation, file cards, account books.

In addition, André Boland was of priceless help to me. André spoke and wrote Thai fluently. He had arrived in Thailand as a young priest in a Belgian missionary order shortly after the Second World War.

Secretary of the Thai episcopal conference, he definitely had a brilliant ecclesiastical career ahead of him, but eventually he could no longer endure this clergy, which he described to me as “rich, hieratical, and condescending toward the faithful.” Two events confirmed his decision to leave the priesthood: the position of the Church on contraception, and more importantly, the complete lack of critical response of the bishops during the bloody repression of a student revolt.
André received from Rome his “reduction to lay status” and became a French teacher. His bishop, with whom he had remained on good terms, soon celebrated his marriage with Boonsong. They live today in a house with superb red wood planks that they had built in Bangkonthi, the native village of Boonsong, 80 kilometers to the southwest of Bangkok.

André served as my interpreter and facilitated our progress. It was a meeting of great significance in more than one way, for he had an intimate knowledge of Thai society. It was a great friendship as well, for we had much in common.

“When I saw you arrive,” he confided to me years later, “I thought you were going to work the way they do in the large organizations: think up vast programs, call in experts, etc. But I saw you begin by meeting people touched by HIV: the personnel of health centers, prostitutes, and sick people. You didn’t work according to abstract principles but from the people themselves, according to their lives, their questions, their needs. And that struck me. I would have wished so much that priests would do the same!”

My plan of action gradually defined itself: I wanted this UNAIDS office in Bangkok to bring together an international team from Southeast Asia whose objectives would be analysis and advice that would enable the sharing of experience among all those concerned by HIV.

Without delay, I set out to accomplish this last goal, for the sharing of experience to my mind was clearly fundamental to the battle in which we were engaged.

Two years earlier, I had met Tim France. This English biologist, married to an Irish woman, was then the head of the documentation center of WHO in Geneva. With him I discussed the possibility of open exchanges through email which I had experimented with in Washington. We were at the very beginning of Internet use.

“What people are living through, in different countries affected by AIDS,” I said to Tim, “represents tremendous learning potential. If we could begin sharing experiences through email, it would be great!”

Tim was very interested. His office received fifty letters a day concerning AIDS. And Tim realized that the answers to the questions posed, more often than not, were to be found in one of these fifty letters.
“Maybe we cannot help these people,” he said to me later, “But they can help each other immensely. It’s up to us to put them into contact.”

His post at the documentation center of WHO did not warm to this idea, and from then on, Tim thought about leaving Geneva and its offices to go into the field to meet finally the people for whom he had been working for several years: those people living with the virus, the sick people and those who surrounded them.

Three hundred letters applying for work “in Asia and the Pacific” brought him only a few answers. But Tim was truly determined. He resigned from WHO and left to try his luck in Bangkok where we were.

When I offered him a position putting into place a forum on the Internet open to all those touched by AIDS, he accepted with enthusiasm.

As of 1996 we created the site: SeaAids (South-East Asia AIDS). Within a few months, 600 individuals came together on this forum, one of the first in the world on AIDS. The correspondents could not only exchange information and experiences, but they could also ask for advice and download all aspects of the documentation of WHO in Geneva. It was a revolution, an immense success with millions of pages exchanged in two years.

From everywhere, requests came to the forum. One day, it was the health authorities in Vietnam: “Could you help us estimate the number of condoms we would need for the entire country?”

Another day, an ordinary individual:

“I am sick with AIDS and I am leaving for a trip to Japan. Could you tell me what precautions to take, and where I can go for help if I have a problem?”

SeaAids became a veritable loudspeaker about AIDS. The NGOs and the governments of the region are connected through it.

Unexpected connections fell into place.

In an airport I met a Frenchwoman who worked with an NGO in Da Nang in Vietnam. After learning what I did in Bangkok, she asked me:

“Are you the one who started SeaAids? We get it.”

“But how?”
“The Vietnamese authorities download the messages, translate them into Vietnamese and then transmit them to us.”

The forum also became a place for debate: a professor from San Francisco pleaded ardently in favor of a much more vigorous offer of testing for HIV. Others exchanged information on the availability of medicine, their cost, etc.

My idea of a trans-Asiatic office became clearer. I wanted to make AIDS the order of the day in the different commissions of ASEAN, which is somewhat equivalent to the European Union in that part of the world. The epidemic actually knows no borders, and it is present in many dossiers studied by ASEAN: clandestine immigration, the smuggling of laborers, drugs, prostitution, border activities, the media… There are multiple interactions between these countries. UNAIDS could stimulate their awareness of the epidemic and the steps to be taken. In order to accomplish these objectives, I recommended that an Asiatic head the team.

I started groups working on this objective in Bangkok, and of course I pursued my contacts in Thailand.

With a consultant from my team, Seri Pongpit, I went to the north of the country which had excited a lot of talk in Bangkok because the sector of Chiang Mai, Phayao and Chiang Rai were literally devastated by AIDS. At Phayao, if one goes back a few years, the rate of infection among young men aged twenty-one reached 20%! It was also very high among the very numerous young women who were sex workers in the many brothels of the cities and surrounding areas, not counting the number of those who left for Bangkok, and even for foreign countries, to practice their trade.

But I learned that since 1992 the trends had reversed. In that region means had been found to push back the epidemic. It was therefore a trip not to be missed.

Seri Pongpit had a lot of experience in rural development. He had also worked in the north, with the social integration of individuals living with AIDS. In Chiang Mai, he introduced me to his network, namely to Ajarn Sanaan, a Protestant pastor of the Church of Christ. Ajarn Sanaan was one of the very first to have welcomed and supported individuals living with HIV. There I met a man whose testimony immediately impressed me.
A former executive in a private security firm, thin, distinguished, Prasaert was then about forty years old. His wife was HIV positive. Their only child would soon die...

And Prasaert confided his story to me:

“In this part of the country, Dr. Lamboray, there was a frightening number of sick with AIDS at the beginning of the 1990s. And everyone knew that they were going to die. As an executive, I witnessed this agony: one of my employees was HIV positive. This man was eaten up with despair. Shunted aside by his colleagues and his family, he could no longer live a life worthy of the name. His own brother, also ill, died rapidly.

With friends we began to reflect: what to do, how to support these people who were sometimes hounded out of their work, becoming an embarrassment, even a shame in their village? How to reintegrate them into society, make them respected?

And then I discovered that I, too, was HIV positive!

And instead of withdrawing into myself like my employee, I talked with my pastor, with doctors. All of whom gave me advice and information about the best way to react and how to take care of myself. That helped me and I wanted to share with others.

During my visits with individuals infected with HIV, or already sick with AIDS, I discovered that their greatest problem was not related to health. Rejected, isolated, marginalized, these people need, above all else, to be respected as human beings to be able to live in society.”

Prasaert knew what the anxiety preceding the test meant, then the overwhelming despair that learning the results can bring. He could speak to those going through that ordeal because he knew. Next to the San Sai Hospital, in close collaboration with the hospital personnel, he created in a small house the Association Clear Skies, a hospitality and support center. Each day, he listened to and advised those who wished it, before and after the test. Individuals could spend the day at the center, playing cards, getting a massage, getting psychological support, learning to meditate, and finding various information. Prasaert also played a role in neighboring villages: at their request or at the request of their families, he visited the homes of people infected with HIV, he stimulated the beginning of dialogue, of conversations, of reflections on AIDS in families and in villages.
Several associations of individuals living with HIV were active in the north of Thailand. During that first trip into the area, I realized the importance of their role in the fight against the epidemic. After years of fear, of rejection, and discrimination, the afflicted were little by little acquiring recognition. In 1995 the Prime Minister himself received them at Chiang Mai on the occasion of a regional meeting on AIDS. And he heard a speech whose wisdom commanded respect:

“Mr. Prime Minister, we realize that the State cannot furnish free of charge triple therapy, for the price of this treatment is prohibitive (at the time 12,000 dollars per person per year!). But we have learned that the transmission of HIV to newborns can be slowed if antiretroviral drugs are given to HIV positive pregnant women. And that, we ask you to do.”

At that moment the words of my friend Winston Zulu, down there at the foot of Victoria Falls, echoed in my ears: “We, the people living with HIV, we are a part of the solution.”

In the north of Thailand I was beginning to realize that it was incredibly true.

Back in Bangkok, I took up again my activities and my family life.

My wife had rejoined me, with our youngest son, now aged seventeen. Our three other children, university students, stayed in Belgium. We had taken our son away from his group of friends in Washington, and he had to mourn his years in America. But, little by little, he adopted the city where he was infinitely freer in his movements than in the United States, for Bangkok is much safer than the American capital. Here, for example, in perfect safety, he could take a tuk tuk to go see his friends from the Lycée français; he could play basketball without risk in a park with young Thais whom he had just met, unthinkable things in Washington.

My wife worked regularly in the nearby Immigration Detention Center with foreigners without legal status: without visas, without passports. The volunteer team that she joined was very international: a Philippine woman doctor, a French Jesuit priest, a few Frenchwomen, a Vietnamese, another Belgian. Among others, my wife took care of Congolese, quite forsaken, for their closest embassy was in Peking and Tokyo.

After Kisantu, Kinshasa, Washington, we found our markers, and we discovered as the months passed by, the facets, the social codes, the way of life and thought in this magnificent country. So many cliché or simplistic ideas float around on Thailand and the Thai people, whose most beautiful character
traits are rarely mentioned. I was able to do so quite spontaneously, during a dinner party when the wife of a colleague at WHO asked me:

“What strikes you in this country?”

Without hesitating, I answered:

“Their thoughtfulness! The quality of the caring that these people have for each other. It’s simply extraordinary.”

And a hundred, a thousand times afterwards, I could confirm that answer.

I could have added—among others—the deference, the gigantic respect for the king.

Few men in the world, I think, are the object of such consideration. It corresponds to that of Bhumibol Adulyadej for his people, which has been manifested, since his accession to the throne, by multiple trips to the most remote sections of the country and by his incessant interventions in favor of the well being of the Thais. The king is the source of thousands of projects destined to improve the life of his citizens, in particular, the lives of the poorest.

The fervor of this relationship peaked the day of his seventieth birthday.

That day, Brian Doberstyn, the representative of WHO, invited us to his beautiful wood house on the banks of the river Chao Praya. From the terrace we could see the king pass, descending, following tradition, the river in the royal barge to go to the magnificent temple of Wat Arun.

As we stood on the terrace in the company of the staff of the WHO office in Bangkok, we heard in the distance the sound of drums matching the rhythm of the rowers of the king’s barge. And soon the royal fleet swept under our eyes. Twenty-odd large pirogues with glowing red decorations opened the way. The rowers were superb in their red, blue and gold uniforms. This spectacle from another age was incredibly majestic.

The royal barge finally came near, and we witnessed, for just an instant, a scene whose magic I will never forget.

It was the rainy season, the weather was variable. The royal escort and the king’s barge passed in front of us, in the sunshine, and—twenty meters behind—the rain was following the king!

When we exclaimed incredulously, the Thais present on the terrace answered calmly: “But it’s normal, it’s the blessing of the king!”
The idea of sharing experiences stayed with me. I invited a half dozen people from different countries in Asia to Chiang Mai to talk about their life with AIDS. There was a senator from the Philippines, a doctor, and other individuals living with the virus. It was our first attempt to share experiences and to learn from them. But we were not entirely satisfied: we did not see how we could get from personal anecdotes to useful knowledge. The idea was there and it preoccupied us, but we did not have a technique. Not yet.

The maturation of the idea took an unexpected direction. In June 1996 the head of the UNAIDS office in Bangkok was announced, bringing forthwith official recognition of the existence of this office. Our Thai consultant, Seri Pongpit, replaced me.

A formal meeting was organized in Chiang Mai to study the progress of the fight against AIDS in that region in the north of the country. Peter Piot, now director of UNAIDS, came from Geneva to preside over the meeting, where he was to announce the nomination of Seri. All the regional heads of UNAIDS came, as well as representatives from the United Nations, numerous Thai executives in the health services and NGOs. . .

Seri Pongpit took me aside.

“Jean-Louis, we are friends, but I must tell you that your remaining in the UNAIDS team is impossible because both of us are losing face.”

We went outside to talk; I was still hoping to find a solution that would allow me to keep participating in the work. It was impossible. So an announcement had to be made that I was dismissed from my post and that in addition I was leaving the team that I had put together.

I urged Peter Piot to be clear:

“Peter, you’ve made your decision? Why not announce it? I’m just part of the collateral damage, that’s all. . . .”

A few minutes later, to general astonishment, Peter announced my departure from the team. People came up to me saying:

“This is impossible, it makes no sense!”
When I got up to speak, I gave a speech offering my full, unconditional support to my successor. Later, I realized how much this attitude earned me the support and the sympathy of the Thais, and also of Brian Doberstyn, the representative of WHO in Bangkok. Our friendship was born that day.

That rather dramatic meeting also marked another milestone. I made the acquaintance of someone who would teach me a great deal: Usa Duongsa. With her husband, she taught at the School of Education in Chiang Mai. Both had worked on questions of women’s rights, child labor, and prostitution. With their students they frequented villages and village people to find out what made these communities vulnerable and what weakened them: the immigration of men to Bangkok, the departure of young women to become sex workers. They had witnessed the number of young women coming back to the village sick. They brought AIDS with them.

When I met her, Usa was in charge of the network AIDSNET that grouped the NGOs of the north. She impressed me by the clarity of her analysis. I was far from suspecting the quality of the friendly relationship, both personal and professional, that would be established between us.

For the time being, let’s look at the facts: I was without a job! What was I going to do?

At the end of the Chiang Mai meeting, I spoke about it with Peter Piot, and he said:

“You sometimes say, Jean-Louis, that health services should be able to pass the AIDS test. What do you mean by that?”

“That those in charges of these services ought to learn from AIDS in order to develop their own operation.”

“Why don’t you pursue that? Why not study what they are doing here, apparently with success, to fight AIDS, to see if some key lessons can be learned in the interests of health services in general.”

I was immediately intrigued.

My activities at the head of the Bangkok team ended officially at the end of December. I therefore had a few months to turn around, get organized, and find a way to land on my feet. I studied several possibilities and finally, I accepted the invitation of Dr. Sanguan—to whom I owe a huge debt of gratitude—who had a high office in the ministry of Health. He directed a pilot project to reform health services in Thailand, and he offered me a place on his team, where, he assured me, my experience and
competence in public health would be greatly appreciated. Later I learned that he had also acted out of sympathy, so that I would not be left in the lurch.

So, I arrived with my personnel dossier under my arm, my computer in my hand, in front of the ministry of Health, six big white buildings that looked like cruise ships. With great pleasure I found there Pierre Daveloose, a faithful friend in this delicate transition period. On the seventh floor I was assigned a corner in a large room where thirty-odd people were working. I had about two square meters, a table, a chair, and a telephone.

Vince, my driver, was devastated.

“Doctor, what has happened to you? You, an expert! You are going to work there?”

And thus began a new period of happiness.

Plunged in the middle of Dr. Sanguan’s team, I witnessed a delicate and constant attention to other people. People asked about how others were feeling, they passed around little cakes. “Doctor, have you tasted this fruit? Doctor, can you come lunch with us?”

Dr. Sanguan’s project consisted of improving the efficiency of the health services in Thailand, beginning in a very concrete fashion in several provinces, one of which was Phayao.

Phayao and its region were among the most affected by HIV in Asia, but the battle against the disease had made notable progress.

With Sanguan, we proposed that we draw on the lessons learned in the province of Phayao in its battle against AIDS to inspire the reform of the health services.

“Let’s go together to Phayao,” Sanguan said to me, “to find Dr. Petshri Sirinirund. She is the provincial director of health. Everyone at the ministry talks about the extraordinary work that has been done in the action center against AIDS that she has created. Let’s offer to work with her to elucidate and formulate that experiment, which has been so positive.”

I almost had my hand on the key to the treasure.
The Revelations of Phayao

The serene beauty of Phayao stole over me little by little as I approached the city, after a three-hour journey on the road from Chiang Mai. The majestic mountains of Doi Mae Jai that extend all the way into Burma rose up in the background. When we left them, a few kilometers across rice fields led to the city with its numerous wooden houses built along the lake. On the bank a temple spread out its terraces. Fishermen in pirogues cast their nets. A supreme tranquility often drew me there in the evening to watch the rare beauty of the sunsets.

Dr. Petshri Sirinirund, a woman of medium height with eyes sparkling with intelligence behind her thick lenses, welcomed me to the Health Office of the province of Phayao. Right away, I appreciated her strong personality and her direct way of thinking and expressing herself.

After having proposed my desire to learn from the actions undertaken against AIDS in that province so that the entire health system could profit from it, I said:

“Could we look at what you have learned from your success?”

Her response was emphatic:

“Dr. Lamboray, if you want to work with us, you will have to avoid talking about ‘success’ in Phayao. There is no success here. It’s true that the prevalence of HIV has dropped from 20 to 5% among the young conscripts and in similar proportions in pregnant women, but 5% is still too much. And then, the problem remains: AIDS is still here.

What we are most proud of is not these results but the important progress we have made in the social integration of people living with HIV.”
“You mean that discrimination against them has diminished?” I asked.

“It has not disappeared, but today these people can participate in marriages, in funerals, in all social activities, without being given a second look. Their children are no longer shunned in schools as they formerly were.

But we are even prouder of the fact that in each province, each village group, each “Tambon” or commune is busy trying to find out how to protect themselves against HIV and AIDS. People are taking concrete steps to solve the problem. That is what you ought to take into account. Welcome to Phayao!”

This speech delighted me. From our first contact Dr. Petshri reinforced my conviction acquired in the course of my years in Zaire and a conviction I defended sometimes with difficulty at the World Bank: people themselves are the first participants in health care.

As far as AIDS was concerned, the implications of this account would be considerable.

For a year I divided my time between Phayao and Bangkok.

All my work boiled down to three questions:

“Is all this progress against AIDS real?”

“How were these results achieved?”

“What lessons can we draw from them to improve health services in general and the battle against AIDS in particular? In Thailand and elsewhere.”

Dr. Petshri put into action a remarkable team to get the answers to my questions. My alter ego was Dr. Aree Tanbanjong, on first meeting a severe woman who intimidated me a little. Could we get along? Soon my worries disappeared, giving way to a great complicity. I had an assistant and interpreter named Phuk, a young woman who had lived ten years in New York and whose Brooklyn accent enchanted me. Suwat, the economist on the team, followed the statistical
The course of the epidemic and rapidly revealed qualities and aptitudes that far surpassed the analysis of numbers. The masterly hand of a nurse, Saowanee, managed our organization.

I was installed in an air-conditioned office, and during the first weeks, I stayed in a hotel.

The grand investigation began. With difficulty.

To my eternal question, “What are the elements, what are the secrets of the progress that you have achieved here?” the team did not find an answer. Several meetings, very formal, for in Thailand, hierarchy is very much respected, brought disappointing results. Visibly, this “expert” who wanted to listen to them instead of telling them how to work threw off my colleagues.

In an attempt to relax the situation, I invited the team to a restaurant. We were seated around a table without any regard for hierarchical order, for Dr. Petshri and Dr. Aree were not there. We ate, we drank, we laughed. . .and suddenly we began to talk freely! This meal created a dynamic. That day we began truly to work as equals.

As Lord Browne of Madingley, director general of British Petroleum, once said: “The exchange between peers must take place outside any hierarchy that constrains the truth.”

To give our study all possible credibility, we put together three teams of Thais from Bangkok whose mission would be to pass through a fine tooth comb the account of the actions undertaken against AIDS in the province: a team of epidemiologists whose role would be the devil’s advocate, to analyze all the results with a critical and skeptical eye, a team of economists and an anthropologist.

This battle plan in place, I began to get in touch with the field. The statistical evidence was one thing, but I was convinced that what was not measurable—the ability of people to mobilize and to change their attitudes—was in our situation of capital importance. Therefore, I had to see, to listen, to understand, and to meet people, situations, and their culture.
Suwat, our economist, was in this respect an exceptional guide. With him, one could stop the car at the corner of a street, knock on any door of any house, and talk simply with its inhabitants. These questions, always respectful, assured us of a trusting reception and led to an understanding of people’s lives and their relationship to health services, and to the disease.

But one day, he invited me to his house, and that first visit opened up a new path for me.

“Dr. Lamboray, I invite you to Suwatland, the house of nature and of life!”

In his Toyota pick-up truck he took me outside the city, to the edge of the national park of Doi Luang. In the distance on a wooded crest one could see the temple complex of Wat Analayo and a 15-meter high statue of Buddha. At the foot of the first mountains, Suwat had constructed a superb house in wood, scarcely raised off the ground. Next to it, a modest building with a straw roof served as his temple. Further on, a small lake in which I would swim.

The evening found us in the middle of a discussion. Suwat got up: “In the evening I am in the habit of meditating. If you like, you can accompany me.”

So there the two of us were, seated on mats facing a statue of Buddha with a magnificent smile. Suwat turned to me, and, in his very rudimentary English, gave me a resumé of Buddhism.

“You know, Buddha was a man, not a god. He was a prince. He got fed up with the life he led and withdrew to meditate, and then when he returned to society, he formulated a few principles (something like the last eight commandments of the Decalogue). I believe that if one follows them, one is happy. So, I propose to you a little exercise in meditation: pay attention to your breathing while counting to ten without being distracted.”

I tried. And I had to keep trying several times before getting to ten.

“Dr. Lamboray, Buddha said: try. His teachings work for me, but that doesn’t mean that they will work for you. If that’s the case, fine. Otherwise, it’s no big deal, don’t insist.”
That evening I thought about Thai pragmatism, about Buddhist pragmatism. And a tension, a conflict suddenly within: what a contrast between Suwat’s simple remarks and the homilies I had listened to since earliest childhood. Here I heard, “Try, see what works. . .there is one thing one can be sure of: the existence of suffering and the pursuit of happiness. And here are a few paths to get there.” And over there, men interpret ex cathedra, without any dialogue, a given truth come down from heaven.

This tension was reinforced a few weeks later as I as driving to Chiang Mai with a young woman from Phayao, who had to go there for some errands. On the trees in the forest, big, bright yellow billboards bearing inscriptions in Thai hung thirty meters in the air.

“What’s written on them?” I asked.

“Those are Protestant slogans: ‘God died for you, God suffered for you, God loves you.’

“And what do you think about that?”

“I’m familiar with all that: my parents sent me to study with the nuns because their school is the best in the region. But all those words about God, they’re for Christians, they’re not for us, we don’t need them.”

That conversation marked me, just as my evenings at Suwat’s house did. For the first time I met a people who seemed not to need transcendence, even if that did not exclude superstition. And that day, a belief, anchored in my being since childhood, was called into question: that of a god whom one could approach like another person.

I have since pursued my spiritual quest. It has led me to meet Thich Nhaht Hahn¹. I found in his description of the Plum Village, the village where he resides, the same light that

¹ A Vietnamese Zen Buddhist monk, a refugee in Dordogne after the end of the war in Vietnam. www.plumvillage.org
bathes Suwatland. I practiced meditating there in 2002. It allowed me to control my emotions better, which was no small achievement during the trials that I was going through at that time.

But let’s not get ahead of ourselves. Let’s get back to Phayao. Our investigation made progress. The head of the epidemiology team came from Bangkok several times with five collaborators to go over all the documentation with a fine toothcomb. Finally the team presented its work:

“You asked me to go over all the results with a critical eye. I give up! I can truly say that the figures we have there, the drop in the prevalence of AIDS are exact. There is no doubt that considerable progress has been made in Phayao.”

The facts were indeed there. It remained for us to understand them.

With the anthropologist I spent an entire weekend in a village. While she was in a discussion with the village chief, she motioned for me to come listen to what was being said.

“Chief, your wife has come back from a trip. Where has she been?”

“Ah, she worked as a prostitute in Frankfurt.”

“And that woman over there?”

“She worked in Japan.”

In this village as in many of those in the province, many women had been prostitutes in Bangkok or abroad. They come back to the village, get married, and thenceforth lead a worthy and respected life.

I knew, from my first year in Bangkok, that prostitution in Thailand was for many an activity and not a status. Married women prostituted themselves for a time in order to achieve a specific financial goal—paying back a debt, buying consumer goods—then would go back home. Girls, especially, did this, for in Thai society of the north, the girl must help her family.
Communities condemned those who prostituted themselves less than those who did not help their parents. At worst, they would say, “She’s a bad woman but a good daughter.”

In the north of the country before the spread of AIDS, prostitution was a veritable industry. Recruiting agents for brothels in Bangkok then lived in beautiful villas in the city. They canvassed the villages and talked parents into giving them their daughters, according to precise contract terms, on payment of lavish, staggering sums.

The rise of materialism aggravated this trend. More than poor families, those who had started to taste consumerism looked for new ways of getting money. They helped papa, but to do what? Not always for vital spending: to change his car, to build a more substantial house.

At the post office in Phayao, the operator informed me that the international telephone traffic mostly involved calls between sex workers who had gone abroad and their families.

Revenue from this activity also came from local clientele. Before the arrival of AIDS the province of Phayao counted 77 brothels. The frequenting of sex workers by single men was quite acceptable. Visits by numerous married men were widespread.

But at the beginning of the 1990s, one young man in five was infected by the virus. Soon the young women who came back from Bangkok, Frankfurt, or Tokyo were more and more often sick and emaciated. A wave of deaths among young men and women swept over the province. Mortality rates became higher than birth rates.

In a few years, the population and the health services reacted. An NGO organized trips to Bangkok so that parents could see the life that their daughters led there. Recruiting agents were less and less tolerated. The frequenting of sex workers was in free fall: the number of brothels fell from 77 to 7 in three years. While at one time it seemed ridiculous to use a condom in those places, now it seemed stupid not to use them.
How to account for such progress in Thailand and not in Africa? That question came back to haunt me when the sight of the huge trees along the road to Chiang Mai reminded me of faraway Zaire.

Regularly, I questioned Dr. Petshri:

“How did you reverse the trend, what have you discovered?”

As the months went by, she gave me pieces of the answer.

One of them was the radical change in the attitude of public health personnel in their counseling. In order to explain it to me, Dr. Petshri evoked family planning consultations:

“When a woman, or, in the best of cases, a couple, comes to ask for advice about family planning, the doctor or the nurse who conducts the consultation analyzes the request according to a set of criteria and can then says: ‘Given your age, the number of children you would like to have, etc., the method I would advise for you is . . . ’ (A contraceptive injection, the insertion of a loop, the use of a condom, or the pill). In other words, the doctor or the nurse takes into consideration the situation of the client, but he is the one who announces the solution to be adopted. He has the answer in his possession.

With AIDS, the nature of the counseling changed radically: all that we tried to do was to help people decide for themselves. Take the example of a young couple that comes for the prenuptial visit, strongly recommended by the health services.

The nurse meets with them:

‘Are you ready to take the test for AIDS?’

‘Yes, yes, we are quite ready.’

‘But have you discussed with each other all the possibilities?’

‘What possibilities?’
‘Well, in a couple, the woman can be HIV positive and the man negative, or vice versa; the two can be HIV positive, or neither one. There are then four sides to the question. Have you discussed what you would do is one of these turns out to be the case?’

If they have not considered these possibilities, the nurse advises them to take the time to talk it over before coming back for the test, for their subsequent attitude will to a large extent depend on their awareness.

Notice that the nurse does not decide. She does not say, for example, ‘If the test is positive, I advise you not to get marry.’ She puts them in the position to make a decision. Including that of acting in a way for both to remain HIV negative if they still are.”

That amounted to a total change in medical practices, a reversal of power. The decision passed from the doctor to the individual, to the couple, or even to the community when a village began to discuss the factors of vulnerability to AIDS (seasonal immigration, prostitution, etc.).

“Another factor determining the work accomplished in Phayao,” Dr. Petshri explained to me, “regards the health personnel itself. At the beginning of the epidemic, the personnel were extremely disturbed. Doctors and nurses feared so much for their own health and felt so helpless in front of patients that they handled them badly. The first thing that we had to do was to show, to demonstrate that we were taking care of our personnel, of their safety. They had to be assured that we were doing everything possible to protect them from the risk of accidental infection.”

That concern for personnel went even further.

One evening, Phuk, my assistant, came back to the office, radiant.

“Doctor, I’ve come from an extraordinary conversation with Nong Kran.”

I knew the nurse Nong Kran very well: her mother kept a stall in the rice paddies, right next to the place where I often went to eat a plate of noodles in the evening.
But I didn’t know her story.

At the beginning of the 1990s, Phuk told me, Nong Kran found herself confronted with a wave of young people who were dying of AIDS like flies. That situation and her helplessness became intolerable. In the evenings, she would go home in a bad mood, quarrel with her husband, and push her children around. And she would drink. The following day she would arrive at work extremely irritable. She rebuffed her patients by telling them that she could not do anything for them anyway.

Nong Kran was not the only nurse to endure these tensions. Dr. Petshri realized this and she organized a workshop whose objective was not to pass along orders or to teach such and such a technique, but to help nurses and aides come to terms with AIDS. For a week, Nong Kran recounted, we were invited to reflect on AIDS in our personal life, as a spouse, a parent, a lover, or a child. The order of the day was “Understand yourself, then you will be able to understand others.”

For the nursing aides participating in the workshop, that basically meant addressing these questions: Am I at risk? Are there circumstances in my life when I take risks? And if I do, how do I react? Should I take the test? Should I use a condom? Am I sure of my husband, of my wife? Should we take the test together? I have never talked about AIDS with my thirteen-year-old daughter, is it time that I do it? etc. For Nong Kran, as for her colleagues, this work was decisive. She no longer rebuffed her patients, because AIDS no longer caused her anxiety.

To live nearer the inhabitants of Phayao, to get to know them better, to understand what made them act and react, I decided to leave the hotel and the city and to lodge in a village. My friends, Suwat and Phuk, went hunting and finally found me a vacant house that the owner was ready to sell me for 200 dollars.
“That’s really cheap, that house! How is it possible?” I asked.

“There is a slight problem. . .the lady who lived there had AIDS, she couldn’t stand it anymore and she committed suicide. So the house is ban phi, a haunted house and nobody wants to live there. But you are European and maybe that won’t bother you?”

So we left to look at the house, several kilometers from the city, beyond the lake, in the direction of the mountain. One gets there after crossing several villages. At a curve in the road, suddenly there it was in the middle of tamarind, papaya, and banana trees. It was a very ordinary plank structure, raised on six concrete pillars. A tile roof, no glass windows, only shutters. A bedroom, a living-dining room, a shower and bathroom area. The location was marvelously peaceful. Without hesitating, I said to Suwat:

“It’s fine, I’ll take it, and when I leave, it will be yours” (I bought the house and not the land because a foreigner cannot own land in Thailand).

We made the acquaintance of my neighbor, Phon, a saleswoman in Phayao. She lived in a similar house, fifty meters from mine, with her mother and her husband. They had three cows, some cocks, and a mango orchard. With her and the nurse Saowanee, we left for the city to buy my furniture: a mattress, six big cushions, and a low table. Later, I would complete my furnishings with an armchair. There was also a refrigerator and a gas ring. That was all.

And there I spent evenings of supreme calm. Early in the morning I heard carts drawn by bullocks pass by, their bamboo bells ringing, the birds singing.

Sometimes, coming home from work, I went to spend a few minutes at Phon’s house. Another neighbor, the official singer of the province, would join us. Phon would prepare a little something to eat, there was rice alcohol, and I brought beer. The singer struck up very old
melodies of the Thai culture, and I contributed a few old songs in French. They really liked *Mon Dieu, que je suis à mon aise quand j’ai ma belle auprès de moi!*

In the distance, very high up on the wooded crest, a flash of bright light in the setting sun signaled the presence of a pagoda built by hand by Suwat and his friends.

I returned regularly to Bangkok to work with Dr. Sanguan. I rejoined my wife, who stayed behind in the capital because of her work with the Detention Center.

But the essential part of my life, during that third year in Thailand, took place in Phayao, immersed in the fruitful solitude of that house, among the rice paddies and the tamarind trees.

Suwat brought me a statue of Buddha about 20 centimeters high with a magnificent smile.

“Dr. Lamboray, I made this Buddha myself. I give it to you. With him in the house nothing bad can happen to you!”

Suwat lived alone…but very much surrounded by friends, for his house, his “Suwatland,” was a center of hospitality, of meditation, of prayer for all the people he welcomed to his house: those ill with AIDS thrown out of their homes, a young woman mentally handicapped, an old woman who served as his housekeeper, monks who came for a change of scene. . . The village folk loved him and respected him. With the gifts that they gave him, he constructed over the years three lovely little temples where one could go to meditate.

Suwat went to bed around nine o’clock, and he got up two or three times in the night to meditate and then went back to sleep. Often he spent the end of the night on a bench on the bank of the lake, listening to nature, the frogs, and the wind in the wooden bells whose secret the old people in the village know. . .

“Do you ever think of getting married, Suwat?” I asked.
“Oh, no, you know, I meditate.”

With all the collected information, I began to draft a report that would be the result of that year of work. Throughout these months I discussed AIDS with Dr. Aree, who helped me penetrate the heart of the subject. She was for me an interpreter of the facts. I drafted the report in English, and we discussed it line by line, with the greatest mutual respect.

One day I asked her:

“To sum it all up, what is the main factor in the progress achieved here? What is the main thing you have learned in your fight against AIDS?”

“Dr. Lamboray, one day you said to me: this battle is waged in the bedroom and not in health centers. Well, that is precisely what we have learned. But it took us a long time to learn it. We launched a campaign against AIDS in this part of the country with the same mentality as a general leading his troops into battle. That’s the way we eradicated smallpox: we shot our patients—literally, since we made our injections with vaccine guns, guns with compressed air that inject vaccine into the arms of people. So we used people as our targets and smallpox disappeared. We entered the battle against AIDS in the same spirit, without thinking too much about it. We fired information at people, about condoms, about drugs, thinking that this problem would disappear, too. But that wasn’t enough. What made the difference in fighting off AIDS did not come from us, the health services, but from our people, from men in particular, who one day said to themselves: ‘It’s just not worth it, let’s stop, let’s change our attitude.’ That was the basic element without which we could not have reversed the trend. It was beginning with this change in people’s attitude that the actions of the health services, the information campaigns, the counseling, etc. became productive.”
How to formulate these scattered ingredients of success, or at least of progress? I felt an urgent need to do so: the battle against AIDS in the world begins with a dynamic vision of a necessary utopia, of a possible victory. Each one does his part with a certain fatalism or a very good conscience, working with all his might to fill the barrel of the Danaides.

I am convinced that, in order to mobilize people, communities, health services and international organizations, a common objective must be formulated and a vision of a possible success. One must believe, the pertinence must be demonstrated, one must say it, otherwise strength dissipates, those who were cool or skeptical become downright frozen, and the power and money tighten up. I confided in a few friends and collaborators.

One day, three of them, three people of different nationalities and cultures, came into my office, all excited. They were Dr. Aree, Masami Fujita, a Japanese who came to carry out a development project for his country, and a Frenchwoman, Agnès Soucat, an economist and a doctor, who worked with me in the UNAIDS organization.

“Jean-Louis, we perhaps have a formulation for what could be a victory over AIDS, the groundwork for success. We certainly cannot totally suppress the disease, but today victory lies in ‘competence.’ The capacity for a community, a village, a province, a country, to continue to develop in a world where AIDS exists. And that’s the situation, one can see it here, where each element of the social body—the family, the community—makes it their problem, takes it into account, discusses it, examines how to come to terms with it, decides on solutions, and changes behavior.

The idea of “AIDS competence” dates from that day, and the future would show how it holds the key to progress. Far beyond Thailand.

Our report was ready. I sent it, among others, to the direction of UNAIDS for validation.
Shortly thereafter, during a visit to Geneva, the assistant to the director came to me:

“Jean-Louis, the director asked me to give your report back to you. He did not read it because he does not read any documents that are not directed solely to him.”

I put all my faith in that work, we worked on it an entire year, we elaborated a message that could have a major impact in the battle against AIDS in the world, it’s the fruit of a mandate financed by UNAIDS and the director does not even take the time to read it. I just couldn’t take it! In front of the assistant I burst into sobs.

But I got a hold on myself quickly: my superior in UNAIDS, Awa Marie Coll-Seek, had always supported me and encouraged me since my arrival in Thailand. She authorized the publication of the report and gave me the means in the course of the following years to draw from it some genuine tools for work.

In Thailand the reception was just the opposite. Fifteen officers from the ministry of health and from various NGOs flew into Bangkok especially to attend an official meeting in which the report was accepted with very great satisfaction. It established a reference point for both the battle against AIDS and the reform of the health services.

My stay in Thailand was reaching an end. Those years in that country were, thanks to my Thai friends, years of revelation.

Those revelations were about AIDS.

Those were the people who were at the center of the reply, of the “answer” to AIDS; they were the ones who made up the answer. Any progress, any hope of progress begins by communication in couples, in families, in communities, the health services, and by the end of discrimination towards infected individuals. Information, condoms, money are necessary elements of the struggle, but they can never substitute for what people themselves do. What
worked in Phayao was a combination of the two. The encounter, the confident communication between a population well served by its pragmatism and health services that have radically changed their own attitude, passing from dictates to advice.

The question of AIDS is therefore social before being medical. It is an economic question as well: there is a direct link between the evolution of the epidemic and, namely, the education of girls, prostitution, and the creation of local jobs that slow immigration to the cities, etc. etc. We analyzed these different factors.

The report was published by UNAIDS in April 2000².

Those years in Thailand also brought me revelations of a spiritual nature: the development of Nong Kran and so many others, the friendship with Suwat demonstrated to me the twin ways of interior peace and compassion.

“What is really different in Thailand?”

My Congolese friend Miatudila of the World Bank, a man of great culture, a doctor, theologian and philosopher, asked me this question during one of my trips to Washington.

“Miat, you know the second commandment?”

“Of course. Thou shalt love thy neighbor as thyself.”

“Well, what is different in Thailand is the “as thyself.” I have the impression that my entire upbringing has emphasized, “love thy neighbor” and that in Thailand I discovered the real meaning of “as thyself.”

I left Thailand, missing a part of my heart and haunted by several questions:

—Are international institutions capable of following the journey accomplished by the health services of Phayao, this journey already pursued by the nurses of the health committees of

² From Crisis to Opportunity: HIV and Health-Care Reform in Phayao, UNAIDS, April 2000
Kisantu: working with individuals, supporting their strengths instead of selling them readymade programs based on their weaknesses?

—How to stimulate in other countries, in Africa in particular, the reflex that leads people to say, “That’s not worth the effort, the game is not worth the candle, let’s behave in another way.”

—How to share experience so that it is not reduced to bare information?

—Can one share experience from one culture to another? Isn’t the progress made in Thailand due to their pragmatism and to Buddhism? And if so, what is possible in Thailand would not work elsewhere.

I don’t think so.

When I went to say goodbye to the very wise Dr Prawase in Bangkok, our conversation confirmed my faith.

“Professor Prawase, how is it possible that individuals from such different cultures as you and I can be so in agreement on the means to fight AIDS?”

“Beyond our cultures, Dr. Lamboray, we start from the same point: respect for the human being. If we start there, the response is universal, even if it uses different cultural tools.”

A first harvest was over. I needed the means to share it. I would go on to spend six years forging the tools, sometimes against time and tides, with an ever increasing group of traveling companions.
“Jean-Louis, you’re a controversial guy here in Geneva. Many negative things are circulating about you.”

“Really?”

“I wanted to form my own opinion. I got information about you, in Africa. You have my entire confidence!”

I will never forget my first conversation with Awa Marie Coll-Seck, the director of the Research and Strategy department of UNAIDS. She was my ranking superior in Geneva who supervised my mission in Thailand. On my return it was with great pleasure that I saw this Senegalese woman, an eminent doctor and scientist. At 47 years old, Awa had a brilliant career behind her. Professor at the Faculty of Medicine in Dakar, she has more than fifty publications on AIDS, with which she has had practical experience in her country.

A very modest woman, Awa never mentioned her kinship with Leopold Sedar Senghor, her grandfather. She is a person with great integrity, solid, right thinking. She reconciles two systems of reference: she doesn’t have “one foot in a Boeing and the other in a pirogue”, but both feet on the ground.

Awa supports my vision of things: in the battle against AIDS, it’s individuals who can in their private life begin to tip the scales in the right direction. The progress against the epidemic passes by a local and effective appropriation of the problem and actions to undertake. That path ought to be well trodden and promoted.

Awa demonstrated courage in supporting me, for the separation between me and the UNAIDS management grew deeper every day. Once while passing through Geneva, I suggested to Peter Piot that UNAIDS get more involved in doing everything possible for the “responses” to AIDS. And he answered: “Jean-Louis, you don’t understand anything about UNAIDS! It’s not an NGO. We don’t have anything to do with the field.”
And for years the involvement of UNAIDS was limited to cooperation between the agencies of the United Nations and to the development of strategic national plans.

So, Awa supported me. She assigned me to examine the elements of what I would thenceforth call “the local response” to AIDS.

“Local” response rather than “community” response, for if the effective response comes, for example, for the inhabitants of such and such a village, it comes also from the quality of their relationship with the providers of local services: nurses, doctors, agricultural extension workers, teachers, etc.

Often, at the end of the day, I had long talks with Awa. She called me her “adviser.” I have gratitude and respect for her.

So, there I was posted to Geneva. To spread the teaching of Phayao, to amplify them, to enrich them, I threw myself heart and soul into the work of meetings, apprenticeship, information, and exchange. All of this on two planes of action: on the one hand, the African countries, Thailand and later Brazil, on the other hand, international conferences. The latter arena is important, for it is in these conferences that a new spurt of energy or a new orientation can take place and that new alliances can be formed. And the occasions were frequent because a worldwide conference was organized every other year and an African conference the other year.

Thus for the first time, in 1999, at the African conference in Lusaka in Zambia, I began to serve as a witness of the effectiveness of the response to AIDS noted in Phayao.

In the audience one man listened to me with particular interest. Our paths had crossed ten years earlier during a similar conference in Arusha in Tanzania. This time, our trajectories would become parallel and so close that they would often become one. Ian Campbell is an Australian, about fifty years old, whose ascetic look is illuminated by a rare intensity of expression.

At the time of our first meeting in Arusha he was the director of a Salvation Army hospital in Chikankata in the Gwembe valley in Zambia. The AIDS question had emerged in his environment in a dramatic fashion: the chief of a neighboring village appeared at the hospital one day, overwhelmed. He said that his son, ill with AIDS, was living alone in his hut in the middle of the village, abandoned by everyone. And this son has just committed suicide by setting fire to his hut. He died there, in the middle of the village, from the silence and abandonment of his own people.
The chief was overwhelmed with sorrow and shame. He asked Ian and his team: “Help us to talk about AIDS among ourselves. We cannot continue like this. But we can’t talk about it all alone.”

From that day forward, what had been a secret and shameful domain of such and such a family became a responsibility shared by the entire village. Finally, people began to talk to each other, to get informed, to reflect on the risks, on situations, on attitudes. As the years passed, Ian’s team was asked hundreds of times to help such and such a village in . . . coming to terms with the problem!

Ian therefore turned to international agencies to request some funds to carry out the work in some depth, to go to visit people, villages, to promote awareness and changes in behavior. No luck.

“At the time,” he complained, “AIDS was considered by governments and the United Nations as a problem that the health services could resolve in the same way as smallpox. We at the Salvation Army were convinced that this disease, because it was sexually transmissible, had its roots in intimacy and culture, and that its solution was well beyond an ordinary health program.”

When I met Ian again in Lusaka, ten years later in 1999, our two experiences came together and reinforced each other: AIDS could be combated by creating an environment which allowed people to respond to it in the workplace and in their homes. That is the “local response,” and it ought to be the basis, the point of departure, of any action, of any local, national and international program.

In order to consolidate this message, to verify that it did indeed have universal value and to promote it, I began to travel like mad. Everywhere examples and counter-examples confirmed the teaching of Phayao and the experiences of the Salvation Army in Zambia.

Counter-example in Tanzania in the Mbeya region. During a visit in that sector I met a nurse who had carried out to the letter all the directives of a program supported by Germany.

“Doctor, I’ve done all that should be done: I have informed people, I’ve offered them condoms, I’ve told them where they can take the test, what medicine to take for opportunistic illnesses.

“And so, how has the epidemic evolved?” I asked.

“People are continuing to die like flies!” And he burst out laughing!

“People die and you find that hilarious?”

“Doctor, when the action takes place, I’m not there!”
Everything possible had been poured into that village, but there had been no preliminary
ownership of the issue and of its solution. They had sown without plowing. And they found themselves
with 15% of the population contaminated.

Information does not suffice, and it gives the dangerous illusion of having done all that is
necessary. It was sadly true in Mbeya with this zealous and fatalist nurse; it was also the case in the
Cameroon in a sector situated between Douala and Yaoundé where I went with colleagues from the World
Bank. We wanted to find out the impact of a program of information on AIDS provided by agricultural
extension workers to hundreds of thousands of households. We followed one of them in a village to find
out the effects of his previous passage. A part of the population waited for us in a hangar. Rapidly, we
entered into the heart of the subject.

“Well, what have you decided to do as a result of this information campaign?”

“Now that we are informed, we inform others. We tell them: ‘Careful, there is AIDS here and it is
transmitted in the following way. In order not to get it, there is fidelity, abstinence, or a condom.’”

“And that’s all?”

“Yes, what else can we do?”

In vain we tried to learn more, but with no results!

But finally a woman stood up.

“I think that our friends here want to make us understand that we ourselves are taking risks with
this disease. We ought perhaps to discuss among ourselves what situations put us at risk, and what we
might do to avoid them!”

She immediately put forth a first suggestion.

“In the old days women went to wash themselves in the river in the morning and the men in the
evening. But now we are all together in the middle of the afternoon. Who here is going to pretend that
seeing us all naked doesn’t give us ideas? Isn’t it time that we went back to our old ways so as not to be
too tempted?”

That was the trigger. Everybody started talking. They got together in groups, men, women,
young girls and young boys, to identify the risk situations and the means of avoiding them. Soon the
women came back.
“Listen, let’s be honest. Everybody says that the place of temptation, the place where we risk getting AIDS is the bar. But in the bar, whom do you meet? Us, the women in the village! So, could we all agree to say that from now on we will use condoms?”

The men cried out in indignation.

“You women don’t understand anything: a condom in a brothel, okay, but not in the village!”

The discussion was launched, the people were starting to own the issue!

When people talk truthfully, when they honestly become aware of the gravity of the threat, of their responsibility, everything can change, little habits or even secular traditions.

Dr. Tarimo, a Tanzanian doctor, former director of health systems at WHO, told me how things had evolved in a district in his native country. As a result of who knows what awareness, all the active voices of the community got together: women, young and old, spiritual and political leaders, etc. Everyone was there and calm.

“We are dying likes flies in our villages; it’s unbearable, we’ve got to do something.”

But what? In discussing what in their life favored the spread of the epidemic, these people realised this: “Many people are dying here. We therefore observe many periods of mourning. Now, according to tradition, during the thirty days of mourning, love is free. It’s clear that we are transmitting the virus during the mourning period.” They decided therefore to change that secular tradition: the mourning period was reduced from thirty to three days!

Elsewhere, while tradition requires that in the process of mourning her husband, a widow have sexual relations with her brother-in-law, she today merely sits down symbolically on his knees.

But such examples, even if they increase, still remain too isolated. And in Africa, as of this date, only Uganda has succeeded in reversing the trend, in lowering the incidence of HIV infection.

Even there we can see that in the beginning, there was also the word. In this case that of the president of Uganda, Yoweri Museveni himself.

Museveni realized the enormity of the threat in the course of a conversation with Fidel Castro during a meeting of non-aligned countries in 1986. Castro in effect told him: “My good man, you are in a dramatic situation. We are training in Cuba a group of sixty superior officers for your army who had to
take a test for AIDS. Eighteen of them are HIV positive. If you do nothing, your army is going to be decimated.”

Museveni did not wait for the aid and programs of international institutions. He addressed his people directly on the radio.

“We have succeeded in chasing the dictator Obote from power. Today a new enemy has come forward. It’s called AIDS and we are going to conquer it also.”

Not only did the president recognize the problem, but also he instilled in his people the courage to confront it; he told them that they were capable of doing it.

Other Ugandans then dared to speak up. One of them, the singer Philly Lutaya had AIDS. Knowing that he was going to die, he dedicated the rest of his life to warning his compatriots. He sang about AIDS, filled stadiums, went to schools. His song, *Alone and Frightened*, is a poignant invitation to open, to care for each other, to share.

Today in Uganda 3,000 organizations are concerned with AIDS, and there exist eight associations of people living with HIV. When the Ugandan minister of Education speaks about AIDS to the board of UNESCO, he doesn’t talk about it in an abstract way as a “health issue”: he does not hesitate to talk about his own brothers and sisters who have died from it.

The effects of speaking out about AIDS are impressive: the American journal *Science* recently pointed out that the prevalence of AIDS had diminished by 70% in ten years in Uganda, basically thanks to word of mouth.

And, in Thailand, this movement got started before the creation of UNAIDS.

What a contrast with neighboring Kenya! In that country and in so many others where the prevalence is quite high, the explanation given for the deaths is not AIDS: “He was cursed.” The traditional explanation of the cause of the disease serves as an alibi; it allows them to avoid examining the real causes of the illness and acting.

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On the other hand, talking about the disease allows exchange, lucidity, and in their wake, action, the ability to react, and competence. And the competence in confronting AIDS is extraordinary because it is contagious!

An anthropologist confirmed this while carrying out a study in several African countries and in India. She discovered that in those places where people had begun to talk to each other, to say, “We are going to work on AIDS. After all, we have managed to survive other disasters. Once again, we are going to react.” In those places, a sharing of the experience takes place horizontally: women talk about it in the market, young people in their sports club, pastors discuss it with others. Our anthropologist came to the conclusion that, in an underdeveloped rural area—with dirt roads, little or no electricity, etc—this exchange of experience spreads out into a circle of around thirty kilometers.

These informal dialogues are the authentic dialogues, those that throw up the very first stones in the barrier against the epidemic!

This idea has to be absorbed, and it is not easy for the technocrats of humanitarian aid to admit it.

How to stimulate the awareness by each community of AIDS as our problem? Tools do exist. To begin with, in Thailand and in Tanzania, by mapping. The idea is to have the inhabitants draw up a map of the village or of the quarter where each one indicates the risky places, the places that encourage sexual relations. The gathering is divided into four groups: women, men, girls, boys. When each has drawn his map, they come back together. . .and it’s always a moment of great surprise because each group has identified different places! For men it’s the bar, there that they meet girls; for women it’s the path back from the water source outside the village; for the young people it’s the festivals, marriages, funerals; it’s the meetings of the parish chorus, the toilets at school, even the “private lessons” that the teacher imposes on young girls in exchange for a good grade.

The mapping immediately arouses an intense discussion. The silence is broken. And this exercise has the advantage of being able to be put into practice anywhere, in a city, a village, on any continent, in any culture, on any kind of surface: a sheet of paper, a picture, a sandy floor.

It leads people who do it to make decisions.

Thus in a village in Tanzania, near Lake Victoria, the discussion revealed that a part of the problem came from the mobile cinema: regularly, a man arrived with his motor bike, installed a white sheet
on the village square, and projected pornographic films, for a fee. “That business arouses the young people so much that after leaving the showing, behind the bushes...” Immediately, they decided to forbid the showing of pornographic films to young people under twenty-one years old.

In Tanzania UNICEF proposed theatre courses for young people to teach them to portray on the stage various aspects of life in their village. One day the subject was AIDS. The young people did their investigation and, in front of everyone, displayed what risk situations were occurring in that village.

During one of the shows, a woman stood up, very angry.

“What are you talking about, you young people, it’s not like that at all here!”

“Listen, lady, we are from the village and we have done our own checking.”

“No, those things don’t happen here, people don’t act like that here. And besides, who has told you our secrets?”

Through thousands of venues likes this, the debate begins, the ability of communities to confront AIDS develops, and the prevention programs become effective.

Nonetheless, once awareness begins, institutions must follow up and give communities the means to act.

Now, that calls into question an entire approach, an entire process. We had a difficult experience with this in the province of Gaoua in Burkina Faso.

Pierre Mpele, a former head of the battle against AIDS in the republic of Congo-Brazzaville, was sent to Gaoua by UNAIDS for a technical problem. I convinced him to take advantage of his trip to mobilize all social groups in Gaoua, and to facilitate the elaboration of a plan of action based on their systematic analysis of the causes of AIDS in their region.

Pierre accomplished a marvelous work: the young people, the women, the religious and political leaders, the health services, the teachers, everyone was mobilized. They put into place a plan coordinated by the mayor of Gaoua. The young people, for example, made plans to distribute condoms on bicycle in the villages; they set forth the creation of jobs to slow emigration to the big cities. It was terrific!

Pierre, for his part, secured promises of funding from international organizations of different countries.
This business seemed to be off to such a good start that on the eve of the world conference on AIDS in Durban in 2000, I urged a high ranking officer of the World Bank, Hans Binswanger, to go to Gaoua. Hans is an internationally known specialist in agricultural development. Himself living with AIDS, he discovered the extent of the problem in Africa while attending a conference on AIDS in Geneva in 1998. Since then, we have worked together. With a rare energy Hans joined his experience with the disease with that of community development to shake up the Bank.

Hans chartered a helicopter and took an entire delegation to witness the success of the operation in Gaoua.

Scarcely had he arrived, when the population started booing him! “You have betrayed us. For months we have prepared everything, we have mobilized people, we have got them to discuss, to talk about risks, to envisage changes in attitudes that would slow the epidemic. You promised to finance the follow-up actions: availability of tests, delivery of condoms, etc. And we have not received a penny! Your red tape is such that there is always a paper missing that would free up the funds. People feel duped. It’s shameful!”

Hans arrived in Durban.

“Jean-Louis, your experiment in Gaoua, it’s a catastrophe! Nothing is working down there! Can I report about it to the conference?”

“Of course.”

Hans publicly denounced the entanglements of the international aid system. And he did much more: he relaunched the program, convinced donors and his own financial institution to streamline their process. A part of the funds from the World Bank went directly to Gaoua and the villages instead of passing through the governmental bureaucracy. This was a great first.

With the action of Pierre Mpele relayed by that of Hans Binswanger, we realized the effects of an essential work, that of the “facilitator.” The facilitator stimulates awareness. Instead of arriving with a readymade plan, designed to overcome the weaknesses of a community, he on the contrary come to support and to sustain these forces. In addition, he puts everyone in contact: populations, public services, financial backers.
Ian Campbell was present at that meaningful world conference in Durban in 2000. His Salvation Army teams had ten years’ experience in facilitating action.

In Thailand Usa started the movement. I renewed my contact with that faculty member at the University of Chiang Mai, for more than ten years a member of the national council fighting AIDS. And I supported the setting up of the team with a methodology of apprenticeship in the fight against the epidemic, based on local responses in the north of the country. That was the beginning of a very fruitful collaboration.

A facilitation team consisted of a half-dozen people: representatives from NGOs, members of the local health services, and foreign aid workers. These teams’ main function was to respond to invitations from the communes, villages, to discuss AIDS, the local situation, and the actions taken here and there. The team was enriched by each of these experiences, reflected on them for their own purposes, and passed them along in their successive contacts. In addition, the different representatives of NGOs or of administrations that were there stopped acting like competitors and acquired a common vision of the battle against the epidemic.

But in certain countries the authorities don’t want such a plan. They intend to keep control. Now, if the population takes initiatives in this domain, they want to take over in others. Ian tells me of this awful remark of someone responsible for action against AIDS in Malawi: “Let them die. If they don’t die, they’ll keep asking for more!”

In Geneva a consultant who spent a day at UNAIDS finally told us: “After all, your problem is simple: the epidemic will decline when the competence, the capacity of people to respond effectively to AIDS increases faster than the virus.”

This is our conviction: with AIDS the mechanisms of biological defense are deficient; but there is an answer to that: the social immune defense.

For their part, the Thai say: “There is not yet a biological vaccine, but we can develop a social vaccine.” And they demonstrated that they know how to do it.

How to spread these convictions and these processes on the scale of not only an entire country but also from one continent to another?
In the corridors of the Durban conference, I met an old Swedish friend, Urban Johnson, regional
director of UNICEF, based in Nairobi. He shared my questions.

“Go see what is happening in Phayao in Thailand,” I said to him, “and we’ll talk about it again.”

He went there and came back so convinced that the following year, we organized a visit to Chiang
Mai for four African countries: Zambia, Malawi, Tanzania, and Uganda.

For this trip to Thailand we took along local political, administrative, religious leaders, and
individuals living with AIDS, representatives of NGOs, members of national commissions involved in the
battle against AIDS, making a total of thirty odd people from different counties.

During the first two days of the trip, all these people were welcomed into local homes, into Thai
families from Chiang Mao, Phayao, and Chiang Rai. Several of them had a sick person in the house or an
HIV positive person. The Africans spent two nights there, discussing with their hosts, the village, the
quarter, and they saw the implication of individuals living with HIV in social life. For some of them, it was
a revelation. The Thais, for their part, discovered with interest how the Africans had been able to involve
young people in certain African countries.

Soon the climate of this encounter surpassed by far the classic confines of a study trip.
Everyone—Africans, Europeans, Asiatics—felt drawn together by a tremendous common hope, by a faith
in man, to such an extent that one of my French colleagues, Luc Barrière-Constantin confided in me:
“Jean-Louis, in the house jargon, they would call this a technical meeting, but in fact it’s more a meeting of
a spiritual kind.”

The end of the week came, the time to say goodbye. At the end of our last meeting, we
grouped ourselves into two circles. The Thais formed the outer circle and the Africans the inner. They faced each
other and slowly turned in the opposite direction so that each one could say goodbye to each other.

And at that moment, everyone wept.

Then, Dr. Moses Sichone, head of the battle against AIDS in the UNICEF office in Nairobi,
spoke: “You Thais have inspired us so much and given us such energy and hope that we invite you to
come to see what we have done in a year.” And the following year the Thais went to Africa.

The week therefore ended marvelously. It almost ended with a drama. Among the Ugandans was
Sandra, a tiny energetic little woman, ill with AIDS. In the middle of the trip she suddenly became very ill,
experiencing respiratory problems, and we took her to the hospital of Chiang Mai, where they diagnosed a Cryptococcus infection, an opportunistic illness. Her condition was so alarming that we thought she was close to death. But when I went to visit her in her room the following morning, I found her smiling radiantly. “Doctor, the people here are so nice, the nursing so attentive that I am already feeling better!” And she got over it!

A few months later I saw her again in Kampala. With charming levity, she declared: “Doctor, thanks for saving my life! You know, I am a married woman now. I married a man living with HIV. Since we are both Catholic, we have told the priest that we are going to use condoms to avoid reinfections, and he has agreed to marry us all the same. And then, my resistance, which had fallen to 30 CD4 (a measure of immune resistance; below 200 is bad) has gone up to 300 CD4.”

As far as she was concerned, there was no doubt: the reconquest of her system was tied to the quality of the welcome and the nursing that she had received in Chaing Mai.

In Geneva during the summer of 2001 Awa left us, called back to Senegal by President Wade, newly elected, who named her minister of Health.

At that time I was named head of development of technical systems at UNAIDS and that new position put me in a situation of proposing a strategy. Two main ideas guided me:

First, I maintained that UNAIDS ought not to be satisfied with coordinating the fight against the epidemic of the different agencies of the United Nations and with supporting the conception of strategic plans. I asked that everything that encouraged the capture and sharing of experience and the stimulation of community appropriation be integrated into our missions.

Next, I proposed that from then on we take into consideration not only the information provided by traditional experts (doctors, economists, etc) but also the experience of people in the field: the widows who help each other in Zimbabwe, the imams of Uganda, the monks of Thailand, the pastors and the priests of such and such countries, the associations of people living with HIV.

In Geneva these proposals were received with reticence. Never were they studied seriously.

UNAIDS therefore dragged its feet. I had the consolation of seeing the World Bank, on the other hand, move ahead, questioning certain aspects of its functioning: thenceforth, from 40% to 50% of the financing granted for such and such a project in the battle against AIDS would go directly to the
communities: to districts, village groups. Four hundred million dollars were thus made available for
decentralized action. In addition, for the poorest countries, the World Bank no longer financed these
programs with loans but with donations, which had never been done before.

But, in the meantime, international cohesion confronting AIDS was deteriorating: UNAIDS had
not been able to pull all its efforts together by proposing a common vision of progress and victory.

Consequently, there resulted a hasty and sometimes unhealthy emergence of a crowd of initiatives:
under the pressure of demagogic speeches, the G8 created a worldwide fund for malaria, tuberculosis and
AIDS, funds which entered into direct competition with the World Bank, created and administered by the
same countries.

The United States, though a promoter of this new fund as well as the principal administrator of the
Bank, created its own presidential Fund! It was once again a free-for-all, a situation similar to the one that
had led to the creation of UNAIDS.

In the poor countries receiving exterior aid, those in charge spend considerable time managing
their relations with the different funds, which means that much time and energy lost for action in the field.

Nonetheless, I obstinately followed my own path, comforted by the informal network, now
worldwide, which knitted a framework on this vision of things: the individual, HIV positive or not, is the
point of departure of any effective response to AIDS.

Henceforth, the message began to circulate among Thailand, numerous countries in Africa, and in
Brazil.

And then, and I am proud of this, for it was a wall that I contributed to tearing down, the
international community revised its position on the question of the treatment of patients.

For years, the commonly held position was to fund prevention to the maximum, but to leave the
financing of treatment to the concerned countries, as for any other disease.

That meant ignoring the voices of people living with HIV who said, from Bangkok to San
Francisco: “We can be active participants in the battle. Give us the means of taking care of ourselves, of
reintegrating with society. We are a part of the response.” It meant ignoring the voices of those like Ian
Campbell who, leaning on experience, demonstrated to what extent those patients who were respected, well
cared for, and not alone could become agents of prevention.
That idea finally reached acceptance. But there again, money did not suffice. Even for nursing care, if there was not first a basic discussion, the appropriation of the problem by the individuals concerned, by the communities, action was not effective. There is no shortage of examples:

In the Cameroon, the government offered anti-retroviral medications free to members of the electric company personnel. Less than 20% of those sick took them. The others refused: “No, that’s a white disease, I don’t have it.”

In Botswana, where we supported a program of distribution of AZT to HIV positive pregnant women (taken at 8 months, AZT reduces the risk of transmission of the virus to the infant from 30% to 10% approximately), the authorities refused community involvement in their program. “Useless: our health services offer test and medication, that’s enough.” As a result, the program took years to get started.

In South Africa, the big companies—Daimler Chrysler, Anglo-American and others—offered treatment and anti-retrovirals free for their workers and often their close relatives. Less than 30% of those sick requested them.

And what kind of sex life do those have who don’t request them?

What can be done to open the dam of silence there where it persists, how can international institutions be made to pass from the idea of control (which is always an illusion) to that of support, of influence and continuous learning?

I feel that we are missing a tool to make effective the sharing of experience, of creating a climate, in communities of all sizes as well as in international institutions, favorable not only to pasteurized expertise but also to continuous learning.

Those thoughts filled my mind when I boarded a Sabena plane in Brussels heading for Washington. In my satchel I had a book entitled Learning to Fly (Apprendre à Voler)! Once I buckled my seatbelt and, contrary to all my principles (in an airplane I eat, I drink, I sleep!) I began to read that book which has nothing to do with flying airplanes.
When the wheels of the Boeing 747 touched down at J. F. Kennedy, I had finished reading *Learning to Fly*. And I was carried away! In that book I discovered how, in the depths of a company, an entirely new logic for the continual sharing of knowledge was perfected, by counting on those who face problems in the field, and not on the work of experts shut up in their offices.

And that company, which staked its development on the continual exchange of experience among its employees is an enormous multinational: British Petroleum (BP), 100 units of production and distribution, 100,000 collaborators in the world! The authors of *Learning to Fly*, two Englishmen, Chris Collison and Geoff Parcell exposed the concrete methods that allow people to learn from each other before, during, and after action.

I absolutely have to meet these people!

Their approach actually resonated in an extraordinary way with what I had been trying to develop for months: a tool that leads communities—villages, quarters, cities, NGOs, etc.—to determine their capacity to respond to AIDS and to enrich their mutual experiences.

A few weeks and a few email exchanges later, one of the two authors, Geoff Parcell, aware of our interest in their work, arrived from London to give us a day of his
time. I explained to him what some of us in UNAIDS were trying to do: collecting
experience, already acquired or in the process, sharing it, and drawing on it for a greater
competence in fighting the epidemic.

I also revealed to Geoff our difficulties: the management of UNAIDS gave
priority to the organization of existing knowledge by the creation of information banks
solely made up of the work of duly certified experts.

Geoff was immediately on pitch. He told us that BP had put the idea of the
traditional expert back in the closet. To the members of the expert team based in London,
it gave the choice between a return to the field or a . . .trip to the competition! And if, in
London, there remains a central service for the sharing of information between the 100
unities of the company, its role is essentially that of a matrimonial agency: someone is
looking for a solution to such and such a problem? Someone else has dealt with the
problem; it puts the two together.

That process has made possible extremely important progress in productivity. In
the introduction to Learning to Fly Lord Browne, the executive director of BP, cites the
example of a Norwegian engineer in the company, Marton Haga, who, by using the
equipment of oil well drilling in a certain way, realized a saving of 300,000 dollars. That
ingineer explained what he had done on the company intranet. Shortly afterwards, one of
his colleagues in Trinidad adopted that technique with the same success.

The strategy of BP as a whole, stressed Geoff, was henceforth based on
connecting the individual, what he or she did, and no longer on such and such an expert.
In fact, expertise had become a vital business, harmonized with experience.

The day ended.
“Geoff, would you like to come to work with us?”

“Yes. That would interest me enormously. I know that this approach to know-how has made a lot of money for BP. I didn’t realize that it could save human lives!”

“So, what should we do now?”

“Write to Lord Browne.”

Full of hope, I rushed to the head of the Director in charge of managing knowledge at UNAIDS to tell her how much we could profit from such methods. But she maintained the priorities that we faulted (create information banks based only on traditional expertise) and expressed her doubts about the possibility of adapting methods from the private sector for an agency of the United Nations.

This time, I had had it! I felt more and more trapped and paralyzed at UNAIDS. One night I confided in a friend, a political advisor of the director.

“I can’t deal with this burdensome bureaucracy anymore. Now I have to have four signatures to leave on a trip! I can’t hire a consultant without having someone assure me that the projected work, planned to be completed in eighteen days, could have been completed in sixteen. . . it’s becoming impossible. And especially, I have concluded that those in charge are resisting the idea of sharing knowledge that I am trying to promote.”

“Jean-Louis, don’t wear yourself out dreaming of UNAIDS as you would like it to be. Get organized some other way. . .”

That conversation took place on a Friday evening. On Monday morning I called Marcel Boisard, the executive director of Unitar, a training and research program of the United Nations that depends directly from the Secretary General, Koffi Anan.
“Mr. Boisard, I have something to propose to you. Can we lunch?”

“Of course. The Creux de Genthod, does that suit you?”

“Perfectly.”

In that bay of Lake Leman, near Geneva, one of course enjoys perch from the lake.

By the time the waiter had brought them to us, we had already settled the business!

“I feel,” I said to Marcel Boisard, “that we have today an extraordinary opportunity to contribute in a very real way to the battle against AIDS. Individuals, communities, countries have a genuine savoir-faire. They have been able to push back the epidemic and to put into place a ‘social vaccine.’ A certain number of us here in Geneva and in the world want to facilitate the collection of this savoir-faire and to patronize the sharing of it.”

And I briefly outlined to him the fruit of these last years and the quality of the network that upheld this thesis: Usa, Ian Campbell and so many others, the contact with Geoff Parcell, my projects. . .

“What you are saying interests me, and you are welcome at Unitar.”

Michel Sidibe, who had replaced Awa at UNAIDS, supported my transfer.

Shortly afterwards, the two directors of UNAIDS and Unitar created a joint program, “The AIDS Competence Program,” based at Unitar that I would direct. We were now in October 2002. At the same time they sent a two-paragraph letter to Lord Browne asking him to release Geoff Parcell for a year in Geneva. . .all expenses paid by BP!
And BP accepted! “Here is a request that we cannot refuse, no matter what it costs the company. You have Geoff Parcell for a year.”

Geoff called me in Geneva at the beginning of 2003.

“Jean-Louis, I don’t know anything about AIDS, how are we going to do this?”

“We’re going to Thailand. There you will learn the basics.”

And his very first day of work for UNAIDS took place in the Swissair plane that took us both to Bangkok.

In Chiang Mai, we met Usa Duongsa, the university professor so involved in the battle against AIDS, Ian Campbell and some of his colleagues from the Salvation Army. They had come together to prepare the launching of a national facilitating team.

I could not have found listeners more interested in Geoff’s work. So, the first evening we gathered around him in the lobby of the hotel. Each one wanted to know how in the world the management of knowledge in British Petroleum could contribute to the fight against AIDS!

Geoff explained to us first that on the instigation of his team the management of BP asked each of its 100 units to do a self-evaluation on twenty-six practices whose mastery should lead them to excellence. That concerns all the fields: technique, commercial, management, etc. Are they good in one field? Weak in another?

Then, on his laptop computer, set up on a low table in the lobby, he showed us a schema on which appeared the results of these self-evaluations.

A blue line crossed this diagram. It illustrated the difference between those who had the highest levels and the lowest. One could therefore see immediately, practice by
practice, where the strengths and weaknesses were and, which groups could have the most productive exchanges.

Ian Campbell seemed to be struck by a sudden illumination.

“That blue line, that zone of sharing and enrichment, that’s the river of life!”

And he showed us the logo of the Salvation Army documents on AIDS where these words have been used for more than ten years:

“Finding hope in the river of life”

Usa asked us—Geoff, Ian, and me—to agree to a sharing of experience. At that time at the faculty of Education in Chiang Mai, she was leading a group composed of policemen, social workers, and human resources directors, and she wanted us to articulate for them when lay at the heart of our conviction, the very basis of our action, for each of us in our fields.

Three very different fields actually: the Salvation Army is a Christian association; BP is a multinational, and UNAIDS/Unitar an agency of the United Nations.

Therefore, as each of us took our turn to speak, we realized with utter surprise that, even if the words were different, we were all three saying the same thing! At the heart of our practices, of our functions, of the vision that we had of our profession, the central value was the respect of the individual and our faith in his capacity to act!

That day an adventure began, a wellspring tapped. It seemed to us that we were witnessing the confluence of three rivers. An African proverb came to mind: “In the beginning, the river flows slowly with many meanderings, but when the meanderings come together nothing can stop their flood.”
And Ian Campbell cited this passage from Psalm 46: “It is a river whose arms gladdens the city of God.”

We felt that in uniting our efforts, our experience, we were going to be able to make things move forward and release knowledge in order to better combat AIDS.

Back in Geneva my little team at Unitar started to work with Geoff immediately.

Our idea was to propose rapidly to every community concerned (a village, a health service, a city, the team of an NGO, etc.) a tool of self-evaluation that would permit it to know where it stands regarding AIDS, what are its strengths, its weaknesses, and thus:

— Encourage, facilitate awareness, and the appropriation of the problem.
— Stimulate action to develop its competence to combat AIDS.
— Give an element of comparison with other communities and bring about the exchange of savoir-faire and experiences.

We simplified the BP Tool and kept a graph on which five levels of competence allowed the community to see where it stands on each of the following points:

— The recognition and acceptance of the epidemic and its consequences.
— The integration of individuals living with HIV into social life.
— The community’s handling of the situation.
— Action taken to reduce the community’s vulnerability to AIDS.
— The capacity to learn and transfer lessons
— The evaluation of the changes achieved.
— The adaptation of the response to the evolution of the situation.
—The work methods.

—The mobilization of resources.

On each of these points, a community can situate itself, take stock, for example, of its vulnerability and specifically identify it: the immigration of young bachelors to the city, the ignorance of certain risks. . .

The following month a first canvas was ready. We took it to Thailand and Kenya to test it out. By May it was sufficiently refined for us to judge it operational for a year.

Our means of conveying information were modest: the tool of self-evaluation was available on the website created at Unitar; it was also available to 650 people enrolled in our global electronic discussion group.

To launch the movement we organized small training groups in self-evaluation and in learning from local action in five countries: Thailand, Uganda, Zambia, Guinea, and Brazil. But soon it became a flood. We witnessed a veritable explosion in demands!

Here is one email among a hundred others:

“Sir, I can find that tool only in English; can you give me a French version so that I can use it in Gabon?”

In Zambia Geoff and Marlou de Rouw, head of our information network, used the self-evaluation graph with a group made up of heads of NGOs, of national functionaries, and agents from the United Nations. They all did the exercise to see where their own organization stood in relation to the epidemic: was their organization doing what it should? Was it capable of pursuing its mission in an effective manner?
The result left them astonished: “When a question arose, we were used to waiting for the expert in Washington or in Geneva. . .we didn’t realize that we had, right here, so much expertise to share!”

In Uganda eight organizations of people living with HIV did their self-evaluation. One of them stood out as the most competent. Others soon came to consult it: How do you do that? We aren’t that good yet; help us. . .and the best realized, after hearing the questions they were asked, that they had also a vast field of progress ahead of them.

In Brazil twelve cities came together in Curitiba to familiarize themselves with the tool of self-evaluation. Attending were Sao Paulo, 12 million inhabitants and Manacapuru, 80,000 inhabitants, a city in the Amazon situated hours by boat from Manaos. At the end of the meeting, the representative from Sao Paulo gave a summing up:

“In the beginning we said to ourselves that we had nothing to learn from the representative of Manacapuru, that little city in the jungle. . .then we realized that we also have our own jungle of concrete and that their experience taught us a lot.”

In October 2003, less than a year after the arrival of Geoff, we invited to Lyon fourteen cities to see what wealth of exchange was possible between rich and poor cities, cities with high and low prevalence of HIV.

Eleven responded positively: Ouagadougou, Parma, Mumbai, Barcelona, Durban, Bangkok, Jinja (Uganda), Goteborg, Simferopol (Ukraine), Kinshasa—and Lyon. Each city was asked to proceed with its self-evaluation before coming.

Each presented its results, its questions and requests.
For example, Lyon wanted to get the diagnosis of the HIV infection much sooner, because half of the individuals who came to take the test in the detection center already had AIDS. That had obvious consequences for their own health but also for public health since these people didn’t know their condition for years and therefore ran a tremendous risk of infecting others.

At the end of the meeting a member of the delegation from Burkina Faso, president of the truckers association in his country, offered the most useful suggestion for the improvement of detection. We were deep into experience-expertise! Ties were created; groups from three cities committed themselves to work together. The tool of self-evaluation was unanimously appreciated. All planned to distribute it, to translate it, and adapt it if necessary to such and such an aspect of the local culture.

The delegation from Parma realized with some embarrassment that it was the only one not counting among its members an individual living with HIV and that that fact revealed the absence of dialogue between the municipality and its people. Ouagadougou and Jinja explained to them the way in which they had established a process to initiate such dialogue.

Port of Spain wanted to launch a program making retrovirals available. Curitiba had already done it and offered to help them do it, etc.

And above all, the cities felt themselves reenergized to fight against the epidemic.

One determining element explained the productiveness of that meeting of cities in Lyon: we totally abandoned the idea of “developed country-underdeveloped country.”

To present oneself, to consider oneself as a “developed” country, blocks, from the start,
any real possibility of learning. Besides, one can hope that every city is “developing”, and we saw that all can learn from others.

The tool of self-evaluation showed its effectiveness under the paneling of city hall in Lyon, but it functioned just as well under the palaver tree in a village in Africa. Each can pick it up and use it.

A medical colleague from Kinshasa discovered it on our Internet site, he downloaded it, printed the document and showed it to the heads of an NGO: “Suppose we tried to do this in the quarter?” And they got together on a square under a mango tree. Their result was not among the highest but they said to themselves: “It’s great, it’s the first time that we have such a dialogue on our ability to respond to AIDS in the quarter, and that we see clearly where we can make progress.”

The government of Madagascar called us: “We have a plan to combat the epidemic, a group of experts from different agencies from the United Nations, NGOs, etc., and even millions of dollars available, but we do not know how to begin or what to do.”

I left with Luc Barrière-Constantin, a colleague from UNAIDS, for Antananarivo to spend a week with fourteen heads of Malagasy districts. We went into the field to help communes do their self-evaluation. People were disturbed: they believed that we had come to bring them money, or to give them a lecture, and all that we wanted was to discuss AIDS such as it figured in their community. But when the discussion got started, they were won over—and sometimes startled by their own ignorance of the problem
The Malagasy authorities were convinced: beginning with the following week they used the tool of self-evaluation in a province where the political authorities, up until then, had denied the reality of the epidemic.

Still more astonishing: we had the team of the local office of UNICEF do the evaluation work. *A priori*, these people are particularly competent and sensitive to AIDS.

However, it appeared that they had never had a real dialogue personally involving each of them. One of the women on the team exposed the long road to be run when she suddenly declared:

“**I can assure you that if I were HIV positive, I would definitely not tell you!”**

“But why?”

“Because I know very well that you would ostracize me, that I would be the object of general discrimination!”

Specific questions, never formulated, came out:

“We want to know the procedure to follow if one of us learns that he or she is HIV positive. And, by the way, where can one take the test?”

“We want the mediator in our bureau to be very well informed about AIDS so that we can confide in him if we ourselves or someone from our family is touched by AIDS.”

At the end of that meeting, the team decided to discuss the implications of AIDS with all the local collaborators of UNICEF, department by department.

It goes without saying that this example demonstrates neatly that those who traditionally have the knowledge, such as this UNICEF team, are concerned in the same way as anyone else.
Whoever one may be—farmer, doctor, executive of an NGO, politician, functionary of the United Nations, nun, truck driver, prostitute—AIDS concerns all of us, eventually as a professional, always as an individual.

A few years before, I made every effort to send this message to the bishops of West Africa. Meeting in conclave in Conakry, they asked UNAIDS to send someone to speak about the epidemic. So there I was, the only lay person among all those bishops. The envelope in which they gave me to the key of my room was addressed to “Monsignor Lamboray!”

When in the course of my exposé I tackled the question of competence, I felt their interest, for competence is not limited merely to the use of a condom: it takes into account attitudes—fidelity, financial problems, a less promiscuous sex life, etc.

Some bishops questioned me however about the condom, with arguments more technical than theological.

“In any event, the condom is not totally trustworthy, it can break if it has been left too long in the sun, and it can slip. . .”

“Monsignors, let us not confuse the condom in practice with fidelity in theory. Accidents happen with condoms, I agree. But I think I know that accidents happen with fidelity also.”

One question allowed me to evoke a subject dear to my heart.

“Doctor, you have said that we have to come to terms with AIDS. What did you mean by that?”

I answered by telling a story whose scenario is perfectly plausible in Africa.
“The doctor of a Catholic mission in the bush goes to the capital each week in his car to get the medication he needs for his patients. The journey is long and, on each of these trips, the doctor is obliged to spend the night in the city. As the months go by, he meets a charming young girl, Isabelle, who becomes his girlfriend. Once a month, therefore, our doctor spends the night with Isabelle. The day comes when, on the long return journey, he says to himself, “Good lord, I have once again made love to Isabelle without a condom, and I don’t have any idea how she spends the twenty-nine other nights between each of my trips. And what if I have caught that dreadful disease?”

“The following day during consultations he sees an emaciated young woman arrive. Very quickly, it’s clear: she has AIDS. The doctor thinks of Isabelle. Seized with a terrible anguish, he cannot even bear the sight of his patient. He sends her away harshly. ‘Go home, I can’t do anything for you.’”

I then look the bishops in the eyes, and I ask them:

“You understand, Monsignors?”

Some of them blanch. All of them have understood.

It is very important that every person implicated in the struggle against AIDS come to terms with the disease and is not eaten up by a more or less repressed anguish. Because then that person becomes irrational; he externalizes the disease, he makes of it a technical affair to be talked about like any other technical problem. One can very well—and there are multiple examples in the NGOs, in the international institutions, health services, churches—talk about AIDS as one would talk about truck transport or drilling for water.
Thus at UNAIDS it was no longer a question of AIDS and the way in which it concerns us.

How to make institutions evolve, when they are too inclined to approach profoundly human questions in a technocratic manner?

That was one of my topics of conversation and of reflection with Dr. Prawase Wasi. During each of my trips to Thailand, I made sure that I have time for conversation with that man who enjoys in his country considerable respect and great moral influence. From a very modest background, his father was a bamboo cutter then grocer in a village in the west. Dr. Prawase was an outstanding student and was counted among the greatest hematologists of that time. But he was also a servant of his people: he devoted himself entirely to the teaching of medicine and to the improvement of the health system in Thailand, refusing even to take charge of a lucrative private clinic in order to devote all his time to the public good. His interventions, profoundly marked by Buddhist compassion, were clearly challenges to Thai society and the authorities. We were once again in Bangkok in December 2004.

“Dr. Prawase, during our last meeting, we were talking about competence in confronting AIDS, which ought to spread faster than the virus. . .”

“Yes, that is truly the objective we need to pursue.”

“In order to do that, don’t you think that the future is the interconnection of teams who, in the field, learn from action and experience? If these teams and all the people concerned form relationships, notably through Internet, wouldn’t one discover an architecture of humanity that would resemble that of the human brain?”
“I have always thought that. That’s where the future of the world lies. We have in effect dreamed of an interconnected world where local apprenticeship will emerge in politics because it will be the product of the interaction of different groups, situated in different places in the world and active in different fields. From this process could come an orientation of human societies very different from the present rule, based on power and money.”

“But how to bring about such a transformation in all these structures, governments, international organisms, principally oriented toward acquisition and the maintenance of power?”

“There is only one single way, only one means of doing it: immersion in communities. Have leaders enter into a relationship, into an interaction with people. And let leaders be inspired by that experience.

And he gave me the example of the group of agricultural extension workers in Thailand who, for decades, conceived of their work as the imposition on uneducated peasants of methods and rules conceived by the central administration. The frustration was enormous on both sides. The advisers said: “Those peasants are idiots.” And the peasants thought, “Those guys are not bringing us anything.”

“We have totally changed this relationship by suggesting that the advisers begin every encounter by sitting down with the farmers and asking them quite simply to talk about their genealogy, their origins and of their relations with them. That simple question restored the dignity of the peasants and changed the opinion that the advisers had of them. In restoring the dignity of the individual, we released a positive spiral that led to the indispensable social change and the institutional transformations.”
These words of hope, were they sufficient, were they powerful enough to face the enormity of the task? In this middle of the year 2004, forty million people in the world live with HIV. Certainly, they die less quickly in places where anti-retrovirals are used. Certainly, the idolatry of money has been beaten back by countries that henceforth produced medications at prices infinitely lower than those in rich countries. But the dam has not yet cracked, this dam that keeps us from seeing the river of life flow.

This dam is the mortifying silence of those who today obstinately keep quiet about the progress and the victories whose example could reverse the situation. And why this silence? Fear of losing their power, and sometimes their markets.

So, would discouragement and fatalism prevail?

On the contrary. We have within reach a formidable promise of progress. Throughout the world disinterested and intelligent men and women are weaving a new intelligence. Still more effort and the dam that is already cracking will give way. If it does, it is my firm conviction, we can in the ten years to come, reverse the course of the epidemic and save millions of lives.

But that requires radical choices.
Victory within Reach?

The epidemic spread over the countries of Eastern Europe and in China. It continued its ravages in numerous countries of Africa. In addition, there where it has been contained, the evil crouches at the door. Those who give up, such as this nurse in Zambia who last year, overwhelmed by so many deaths, spoke to me of “pruning.”

Nonetheless, I say it here with emphasis: this is not the time to be discouraged but to renew action. Countries have succeeded in turning back the tide, others can do it. And we can all participate in this reconquest: country people and city dwellers, agents of health services and NGOs working in the field, associations of people living with HIV, political leaders, functionaries of the United Nations.

AIDS is not a distant problem; it continues to concern all continents, all countries. We all have a role to play; we can make things move.

But it is true that one must choose.

Choose to back those who win: promote ways of staying positive, the awareness of each one, the patient appropriation of the problem by communities, the interaction of these latter, and local health services, of donor support to the local and regional level, the continuous collection and sharing of experience, the placing of every person and organization concerned in contact, the creation of collective knowledge, constantly enriched. ..
To choose the truth over demagoguery. The battle against AIDS is not just a question of money, not just a medical question. Money and medical action are obviously indispensable, but from the beginning salvation does not depend on the budgetary decisions of the White House nor of the strategic plans of the United Nations. That battle is won first in the bedrooms, in the brothels and behind bushes, in the conscience of people, whether they are infected or not, who one day say: “I will stop acting like that, it’s not worth it. I will stop risky conduct.”

To choose to care for, to integrate into social life people living with HIV. Through elemental compassion, by socio-economic care also, but also because they play a major role in the expansion of or the arresting of the epidemic.

To choose to stop being one of those who act for people but with them.

Very concretely, that means:

—Support the creation and the functioning, in all countries, of teams who draw lessons from local experience and make organization and collectivities profit from it.

—Distribute broadly the training of self-evaluation, for this tool stimulates awareness and change in behavior.

—Distribute the ingredients of the “social vaccine” in combating AIDS by favoring the exchange of savoir-faire thanks to the Internet.

Those are the elements of an engine that will turn tomorrow full speed if donors allocate even only 1% of their credit to this approach.

But all this supposes a preliminary choice, still more radical. To accuse it of naïveté or of simplicity is just another excuse to avoid it: it is necessary to choose the
central value on which all action is based: the respect for the individual or idolatry of money.

It is necessary also to choose between permanent apprenticeship and the power of mere academic savoir.

And to put an end to a perversity: it is much easier for an international aid organization to pretend to make up for the weaknesses of a country than to come to sustain its strengths. It appears more effective, in order to conserve its power, to guard its savoir jealously rather than to give rise to new savoir by working with the people to whom it is addressed.

Are institutions ready to let themselves be challenged by the lessons learned from progress?

AIDS will never be conquered without a profound questioning of the approach of large organizations. The World Bank has made progress in that direction.

Finally, it is necessary to choose to expose oneself to the unexpected, the unbelievable, and the inconceivable.

“Many social assumptions separate and divide, create rejects,” said Usa during my last trip to Chiang Mai: sex, beliefs, religions, ethnicity, sexual orientation, money, class, politics, cast… To confront AIDS we have had to cross all that, all sort of limits, or frontiers. . . and Thailand is coming out of that ordeal better than before!”

Yes, the inconceivable: from the sharing of that ordeal men come away freer and stronger. Isn’t this really what we felt, with astonishing joy, at the end of those meetings in Nairobi, Chiang Mai, Lyon, Curitiba?

The road is long that leads us to this place of radical choices.
For me, the road passed through a hundred paths in Africa, America, and Asia, on which I crossed a thousand faces. Those of women and men with whom I have shared and learned so much. I have not been able to cite all those whose experience has nourished me for fear of weighing down the narrative and I evoke here only a few of them: Dr. Courtejoie and his image boxes, Konde the model nurse of Kisantu, the courageous minister Tshibasu, the *mama bongisa* of the quarters and villages, Awa Coll-Seck in Geneva, Hans Binswanger of the World Bank, all the friends of Thailand: Drs. Petshri and Aree, Suwat, Usa, my neighbor Phon, the nurse Nong Kran, Dr. Prawase, André Boland, the pastor Sanaan; and then Ian Campbell, Geoff Parcell and so many others. . . Hans, Prasaert, Winston, Sandra, all those patients committed to actions of solidarity; those prostitutes and transvestites standing together with their peers, those truck drivers, ministers, bishops, imams and monks, those people from Brazil, Zambia, Madagascar and so many countries. All those dead whose memory I carry with me. The thousands of correspondents who, throughout the world, weave today the network of competence in the face of AIDS and will do so even more tomorrow.

Forty million people infected in the world…

Yes, we are right in the middle of a drama. But today we are full of hope.

For the road is short toward a possible reversal of the tendency.

I maintain that the battle can be won, that victory is within reach. Strengthened by the lessons drawn from countries where progress has been made in a spectacular fashion, I have the conviction that international institutions, and most particularly UNAIDS can today create a dynamic of the victory and give countries the means of
achieving it. Will they have the courage and the political will to do it? To succeed, they must change their opinion, their approach. And institutions do not change by themselves.

The battle will not be won without you. Without each of you, wherever you may be.

Think first of yourself, of your own behavior, of those near to you. Spread the message in your familial, professional, religious, and cultural environment. Challenge those who govern, nurse, inform, and counsel. Let’s join together!

All of us, let us take up the relay from the singer Philly Lutaya, whose voice still resounds in the stadiums of Uganda:

*With open hearts, let’s stand up and speak out to the world*

*We’ll save some lives, save the children of the world.*

Let us stand up and open our hearts to the world.

We will save some lives; we will save the children of the world!

Paris, Manigod, Phayao, Geneva
June, 2004