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Issue: December 2006
Journal: *Perspectives on Politics*



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Written in Blood: AIDS Prevention and the Politics of Failure in France

Michael J. Bosia

After 25 years, there is a broad though sometimes superficial awareness of state responses to HIV/AIDS in the global South, where the spread of disease is said to be fueled by inept or failed states, those so poor or whose officials are so indifferent that they lack public health services or even a minimal health care infrastructure. But this narrative ignores the failed responses among states struck in the first wave of the pandemic in the early 1980s.¹ In the long run, generally between 1986 and 1990, the industrialized democracies where a new illness was first identified did implement comprehensive disease prevention, blood safety, and treatment and care regimes specifically targeting AIDS; in the short run, these same countries struggled over—and more often than not failed to implement—appropriate measures to stem the spread of the epidemic. And in the long run, tens of thousands contracted HIV and died.

These failures in HIV prevention are clearest and most striking with regard to blood safety, though they are not unique to this domain. Less than two years after the diagnoses of the first cases, some epidemiologists noted with near certainty that AIDS was at least partially the result of an unidentified blood-borne pathogen similar to the hepatitis B virus. With no known culprit, they still recommended a variety of screening procedures to safeguard blood transfusions and pharmaceutical products drawn from whole blood that were used to treat hemophilia. Nevertheless, state officials universally ignored or minimized such warnings: the French and others even hesitated to mandate an HIV screening test when it became available in early 1985, and was recommended by most experts. After testing was implemented, both the United States and France refused to recall blood products already

acquired by hemophiliacs that were almost certain to be tainted.

How can we account for government failure to adopt early and effective prevention programs? Taking France as one exemplary case, we can see that absolute state capacity measured by the ability to act on new challenges at a time of global change is not sufficiently explanatory.² Instead, I suggest that “capacity perceptions” and misconceptions about HIV/AIDS were and are more important in inhibiting many governments from acting proactively. By capacity perceptions, I mean a shared understanding among state officials and those close to them about the appropriate possible measures the state could take, given a mix of other pressing policy priorities. In the early 1980s, AIDS arrived after international economic crisis spurred government attention to austerity, reductions in social welfare, and the profitability of key industries. By misconceptions, I call attention to the intersection of AIDS with marginalized populations and the characterization of behaviors that seemed to place some at greater risk for the disease. This intersection shaped popular and even many scientific theories rationalizing the apparently higher rate of AIDS among the marginalized. Neither were state officials immune to these misconceptions. Looking to the French failure to act early and forcefully when faced with an AIDS-related crisis in blood safety, I outline a decision-making process doubly informed, on one hand, by the pressure of other issues given priority, and on the other, by the misconception that AIDS, especially in its most deadly form, would confine itself to certain homosexual men.

Focusing on perceptions and misconceptions in the first round of state mobilizations will help us better understand how middle states—those with some measure of capacity readily apparent or demonstrable by the ability to generate and enforce new policy—can either fail or succeed in stemming the spread of HIV and limiting mortality. It is clear that institutional deprivation and international pressures do place some states in a position of failure absent the intercession of international institutions. From another perspective, Lieberman and Gauri look internally to argue

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that too much state centralization impedes the improvisation of community-based prevention and treatment efforts at the local level, and they add that a cohesive national community with less rigid social boundaries helps explain the success of some states in responding to HIV/AIDS.³ My approach suggests that state failure to prevent the spread of HIV should be considered both in terms of internal factors and in relation to global economic pressures. Importantly, I point to *capacity* as a relative constraint and *community* as conditioned by specific beliefs about sexuality, difference, and AIDS. While many states of the middle rank face a variety of capacity-related issues, both internal in terms of institutions and external in the form of pressures to adopt structural reform or accept international market conditions, when we look at the first states to confront AIDS, we can see more clearly how such constraints in fact reflect a perception of capacity that limits action regardless of institutional centralization. Adding in misconceptions about the disease, in ways that are particular to the intersection of domestic and international politics in each state, we can see when AIDS becomes a less than pressing issue measured against the perception of constraint despite a cohesive national community and despite some complicity on the part of community-based organizations in these decisions.

France, with its strong national political community, new government open to issues important to gay men and lesbians, highly adaptable bureaucracy, and respected scientific community, appeared to be among the best positioned countries, able and probably willing to respond to the crisis when the first cases were diagnosed in 1981. François Mitterrand and his Socialist Party had just dominated presidential and legislative elections, winning the presidency and a strong majority in the National Assembly to govern in coalition with the weakened but still powerful French Communist Party. The new government promised the traditional growth-oriented policies of the left while engaging with the 1968 generation's concern for a new politics based on decentralization, participatory democracy, and sexual and gender "liberation." Two years after Margaret Thatcher swept a more radical right to power in Britain, and a year after Ronald Reagan brought neoliberals and Christian evangelicals into the American administration, it appeared that the French electorate had awakened a different force in government when it was most needed—at the dawn of the AIDS pandemic.

Nevertheless, early French AIDS prevention policy was a failure. While increasingly preoccupied with an economic crisis, financial reform, and the profitability of key industries, state officials did not adopt mandatory screening of blood donors, failed to authorize or require mechanisms to purify donations of whole blood nor to recall blood products known to contain HIV, delayed the testing of blood donations for months, and allowed tainted blood to be given to hemophiliacs already living with HIV.

Nor did they implement either targeted or generalized prevention programs, or repeal a ban on condom advertising. As a result, the French rate of HIV infection is among the highest in Europe, closer in epidemiology to the American epidemic, despite an initially slower proliferation of the virus within populations at risk. French hemophiliacs alive in the early 1980s, who used treatments produced from whole blood, were at the time more likely than any population other than their American counterparts to be HIV positive or to have died as a result of AIDS. In an unusual turn of events, French activists actually compelled prosecutors to bring a former Prime Minister and two of his colleagues to trial on charges of involuntary homicide after blood system administrators were convicted in 1992 for their own failure to stem the spread of AIDS.⁴

In the following sections, I examine the capacity perceptions and the misconceptions about the disease that lead to the French failure to stop blood-related AIDS. First, I reconstruct decision-making in the first years of the epidemic and later justifications. The evidence suggests that austerity, financial reform, and market positioning came to trump concerns over the threat of AIDS, so that the leadership of one of the strongest states could actually consider themselves constrained in terms of both resources and policy options available for the public health fight. Next, we see how misconceptions about the threat AIDS posed to specific populations—through its association with homosexuality and the United States—enabled the French to minimize the danger of blood borne AIDS; they considered French blood and healthy heterosexuals less susceptible to the disease. Because the first relates to the ability to respond, and the second to the need, the combination would determine the nature and scope of early measures to secure the safety of the blood supply.

Capacity Perception and Blood Safety

Three years into his presidency, Mitterrand placed his Socialist government under the leadership of his protégé, Laurent Fabius, a graduate of the prestigious *École Nationale d'Administration* and the youngest person ever appointed prime minister. Fabius was charged with reversing the growth-oriented policies of the old left and instituting what were viewed as necessary financial reforms and liberalization in the face of a changing international economic environment.⁵ Deregulation of the state-led finance sector began and corporate financing freed up so that international capital would again be available, the franc would stabilize, and French firms could compete on the international market. State spending was reduced under what the French call *rigueur* and what Anglo-Americans know as austerity, deficit reduction, or limited government. Soon, governments of the left and the right would fully or partially privatize public corporations including

banks, pharmaceuticals, and manufacturers, and the stock market or *bourse* would expand.⁶ Just as previously sacrosanct social services were beginning to face a new challenge from AIDS, the state seemed to be dismantling itself and incorporating into public services those market pressures that discourage the inefficient or unprofitable protection of marginalized groups, and transferring to private interests key aspects of the health care system such as the development and manufacturing of medical technology and drugs to enhance global competitiveness. This dynamic juncture of AIDS, austerity, and market imperatives shaped the perception of the state's capacity to act and so structured the prioritization of policies.

The AIDS crisis was well documented when the government appointed Michel Garretta to be director of the French blood system, called the CNTS or Centre National de Transfusion Sanguine, in October 1984. With the new fiscal priorities, the blood agency was a prime target for reorganization, with a budget deficit estimated at 4 million francs at late as 1985.⁷ However, austerity was not the only concern. French officials also favored key industries against foreign competition in an increasingly global market. Though it was notoriously poorly run and financially insecure, the blood agency held promise: managed well, it might return to economic health if not downright profitability (still prohibited by law) through the development of blood-related medical treatments, products, and technologies for a pharmaceuticals industry at the time dominated by American, German, and Swiss firms. A doctor and trained administrator, Garretta was charged with turning the ailing organization around to challenge the better-established competition and become self-financing. He would first have to reorganize the agency to control spending, and then find the appropriate structures to enable the French industry to compete.

At the same time, Garretta was up against the mounting evidence that AIDS was passed through blood, evidence that included the isolation of the suspected virus by French and American researchers. Indeed, public health officials in both countries early in the pandemic reported the first cases of AIDS among patients with no other risk factor than blood transfusion or use of hemophilia-related blood products. While the American Centers for Disease Control issued warnings about the need to secure the blood supply, some French researches advised the immediate introduction of a new heating technology to cleanse blood products of HIV and hepatitis B, a warning widely repeated at the International Conference on AIDS in Atlanta during April 1985. That same spring, an internal audit at the CNTS indicated that virtually all the stocks of blood products in Paris destined for hemophiliacs showed evidence of contamination with the newly identified virus.

With financial restraint shaping the perception of the state's capacity to adopt new policies, officials at all levels delayed. Though Jacques Roux, Director General of Health,

in 1983 issued an advisory to blood supply administrators suggesting that collection centers screen out all donors at risk for AIDS, he never followed up to demand its implementation and the advisory was never enforced. At the CNTS, with no French heat purification technology proven and available, Garretta refused to import costly heat-treated blood products or heating technology from the United States or Austria. The CNTS also saved money by ordering the use of all contaminated stocks primarily for the treatment of hemophiliacs who already indicated infection with HIV. Despite the warnings about widespread contamination of blood and the now international recommendation that all products be heated, as late as June 1985 Garretta convinced the members of the Association française des hémophiles (AFH) to scale back their request for the introduction of heated products to "as soon as possible" instead of immediately.

Moreover, financial concerns dovetailed with mercantilist ones to favor the pharmaceutical industry over proactive AIDS prevention, as market imperatives were allowed to define how the state should prioritize its response. Director General Roux wrote to Garretta to advise that the CNTS wait to approve any imported heating products or technologies until it was determined that procedures developed at a center in Lille could not meet domestic needs.⁸ As to a proposal from the Austrian firm Immuno to export heat treating technology to France, Roux later explained that its goal was to penetrate the French market and disadvantage the local competition. He cites testimony from the director of development at CNTS: "The negotiations between CNTS and Immuno did not proceed on the basis of a real partnership. . . I sensed that Immuno wanted to obtain . . . a dominant commercial position in the French market."⁹ As a result, the availability of heated and purified products was delayed for months. Because heating would not be reimbursed by the government until September 1985 after officials failed to establish a joint agreement with Austria's Immuno, the procedure could not be implemented by the financially strapped CTNS. In September, the government delayed any potentially costly limits on the use of nonheated products until the following month.

At the same time, French and American companies were requesting French patents for HIV-testing products, competing for shares in a worldwide market estimated at the time to be worth at least \$100 million.¹⁰ The test introduced by the American firm Abbott was ready for use months in advance of that of the French being developed by Diagnostics Pasteur, the for-profit arm of the research agency Institut Pasteur. Such a test could have prevented countless infections among hemophiliacs who had not yet used tainted blood products and among transfusion recipients if a patent had been approved soon after the application was submitted by Abbot in February. In the spring of 1985, Prime Minister Fabius's interministerial cabinet

decided to delay licensing of the American test in order to give the French company time to introduce its version. François Gros, scientific advisor to Fabius and a former director of Institut Pasteur, warned the Prime Minister's chief counselor of the "risk" that the Abbott test would "inundate the French market," adding that the possible use of the Abbott test by French agencies would be "very questionable." A handwritten note responds "Scandalous. This will be corrected, happily."¹¹ Roux concurred, later noting that Abbott threatened a monopoly in the market, not because of a superior product, but instead based on its "fallacious propaganda."¹² Other medical experts demanded an early announcement of testing, but it was not until July 1985 that Fabius ordered the systematic use of the Pasteur test to begin on August 1.

Forestalling new expenditures and domestic competition, Garretta now turned to positioning the CNTS in a global economic environment increasingly structured by market imperatives. A reorganization had begun in 1984 with the establishment of the public agency's first private commercial arm, S.C. Ing, which focused on new technologies associated with the growing blood industry. The network of firms grew with Bio-Transfusion in 1986, Holding transfusion sanguine européenne in 1988, and Novacell in 1989. Finally, the CNTS established Espace-Vie in 1990. Presided over by Garretta, this firm was almost wholly owned by the Fondation nationale de transfusion sanguine, the research umbrella for the CNTS. Its aim was the commercialization of new blood products. At the same time, Garretta established key relationships with American firms to ease the acquisition of technology and market new products, sitting on the board of Haemonetics, which provided medical equipment to CNTS, and setting up a joint association with Medarex to develop and market new blood products.¹³

While the decisions made before and in 1985 resulted in hundreds, and ultimately thousands, of new cases of AIDS and HIV, Garretta's restructuring also failed to open markets for new products, produce the profits envisioned, or resolve the system's fiscal problems. However, little more than a year before Garretta was brought to trial in 1992 for his failure to halt the distribution of tainted blood, a new Socialist government approved his transformation of the CNTS as an "ethical" project. "It is an original solution," Minister of Health Bruno Durieux wrote, "giving the Foundation the means necessary to adapt to this new environment while marrying ethical concerns and economic performance."¹⁴

In his 1999 trial, former Prime Minister Fabius claimed he always deferred to the authority of his ministers and other officials, including Garretta. He said he ordered universal blood testing when presented with the need, and throughout his tenure adhered to the recommendations of the doctors and researchers focusing on AIDS. Fabius particularly notes that at a June 1985 meeting, Garretta

not only misinformed hemophiliacs, but also the government. For his part, Garretta defended his actions by turning the table on the ministers. He could note that he called on the government to "take their responsibility for this grave problem," which would require the Prime Minister to change budgetary policy to reflect the new circumstances and make funding available to cover purified blood products.¹⁵ Garretta argued, as a bureaucrat, he could only implement the policies adopted by higher authorities. Without action from the government to suppress tainted products, reimburse the use of heated treatments, and recall unheated products already in homes across the country, the CNTS had no choice but to make due with the treatments available and implement the government's ongoing desire to reduce costs and improve competitiveness. Garretta argued that he could not act *except* with a change in government policy recognizing blood safety as a priority, reflecting the perception of limited capacity prevalent in the government, while Fabius insisted that he could not act *except* on the advice of the experts.

The Politics of Misconception

AIDS challenges communities and populations that are already marginalized from national and sometimes local social and political power.¹⁶ While it is accurate in some contexts to argue that state officials minimized the danger or pursued ineffective and discriminatory measures because they were motivated by intolerance of gay men, this argument is not sustainable in France. Indeed, the Socialist and Communist government elected in 1981 came to power promising the integration of gay men and lesbians in public life. Moreover, the extreme right wing National Front, which emerged on the national scene in 1983, did not speak about homosexuality before 1985 or about AIDS before 1986. As a result, the politics of misconception reflects not simply the association of AIDS with male homosexuality, but the context and specificity of this association. AIDS, in its early incarnation in France, was an American disease, inextricably linked with beliefs about the sexual excesses of American gays and the emphasis on profit in American business that the French still considered socially suspect. This misconception would shape the discussion of who was at risk for AIDS and the assessment of the disease as a life threatening illness, so that some would be considered relatively safe from infection or death. State officials could thus minimize the threat AIDS posed to the blood supply in general and the threat that the disease posed to hemophiliacs and transfusion recipients specifically.

Reports of a new "gay cancer" in 1981 singled out "Americanized" French gay men and began the association of AIDS with the United States generally and in particular New York. This *cancer gay new yorkais*, as it was often called, was the product of gay practices popular in

the Village but rare in France, and in fact the earliest reporting in *Le Monde* included statistics indicating that the majority of French men with AIDS had recently traveled to the Big Apple, or, as another claimed, nearly all incidents of AIDS in France were “imported.” In a series of articles in the summer of 1983, *Le Matin* in Paris cited “the famous AIDS ‘Made in America’” (“Made in America” appears in English in the text)¹⁷ and profiled a respected physician who claimed, “Everyone knows that French homosexuals visit New York in huge numbers. It seems to me clear that the disease will make its appearance in Paris at the center of this population.”¹⁸ The physician argued that AIDS originated in New York and from there, made its way to Africa. Thus, French homosexuals became dangerous by virtue of their association with Americans. Only a few weeks later on Bastille Day, in an article devoted to AIDS, *Le Matin* questioned the sexual and political practices of American gays, calling them “a community that publicly defends its desire,”¹⁹ and in a previous article had quoted a French homosexual who said he would not hesitate to have sex with an American.²⁰

This early reporting on the disease drew from medical theories that considered AIDS an immune dysfunction caused by the sexual excesses of its gay male victims.²¹ As it became clear that AIDS was caused by a blood-borne pathogen, doctors had to reinterpret the link between AIDS and some gay male sexual practices, so that a new hypothesis claimed the manifestations of illness resulted from a new virus that was able to take advantage of an immune system weakened by sexual excess and drug abuse.

Relative concern for the safety of the blood supply was shaped primarily by misconceptions about the danger posed by AIDS-tainted blood from the United States. Early in the pandemic, media attention and expert opinion focused on the for-profit blood system in the United States just as they were focusing on American gay male sexual practices. Reports explained that blood was collected at clinics in urban neighborhoods where AIDS hit hardest, and according to *Le Matin*, which explored the risk of AIDS in the blood supply, “American donors, who sell their blood, are often the donors ‘at risk’ [for AIDS]” because of drug use or multiple sexual partners. To drive this point home, the report claimed that AIDS began as “a strange disease in the homosexual milieu of New York and San Francisco.”²² In contrast, the blood system in France was a semi-public operation predicated on three basic principles: a network of voluntary donors and a prohibition of payments, where nearly all blood was drawn within France, and profiting in blood or blood products was forbidden by law.²³ Blood donations and distribution had such a weighty role in French culture that donations were voluntarily drawn from those incarcerated in prisons as a means of encouraging their reintegration into society. French reports were correct in that American blood collections relied on both reimbursed and volunteer donations, and

that the pharmaceutical industry frequently made use of collection centers or programs that targeted those who would become at risk for AIDS. Nevertheless, volunteer drives in both countries included at-risk gay men and the prison blood drives in France, though voluntary and pursued for socially meaningful reasons, were themselves highly questionable given the incarceration of intravenous drug users.

Because of these misconceptions, some doctors, ministers, bureaucrats, and the public so strongly believed in the integrity of this system that, even as AIDS began to touch recipients of blood donations and blood products and international experts began to call for blood safety measures, the French often pointed with confidence to the three pillars of the French system as a guarantee.²⁴ So it is no surprise that the government’s first action to protect the blood supply was to ban the importation of American blood and blood products.²⁵ This proved a dubious policy choice as American companies began to make purified blood products available well before their French competitors.

In this context, then, it was not unusual for the some doctors within the small network treating hemophiliacs—organized under the auspices of the CNTS—to reassure their patients, the Association française des hémophiles, and the government that blood products were safe, or that hemophiliacs with AIDS, as opposed to gay men, were generally healthy and so the disease was not terminal. “We had absolute confidence in our doctors,” Edmond Luc Henry, who became head of the AFH, explains.²⁶ “And this mysterious epidemic seemed to touch people whose lifestyles were, to me, radically foreign.”²⁷ Joëlle Bouchet, the mother of a hemophiliac who would later bring charges against the government, first trusted the doctors when she heard her son had the virus and they told her he would be fine.²⁸ One 1985 report, signed by the country’s leading AIDS experts, predicted, “The indication of a positive test result is not a valuable prognostication. . . . Less than 10 out of 100 seropositive individuals will manifest illness after 3 to 5 years.”²⁹ For many doctors and state officials, then, it followed logically that if homosexuals were more at risk because of presumed behaviors, then hemophiliacs were less at risk for illness even after being exposed to HIV.

Indeed, it is optimistic advice from a segment of the medical and scientific community—and the misconceptions that underlies it—that supports the government’s defense, constructed as it was on theories about the different manifestations of the disease in gay men and hemophiliacs. As officials later argued, “medicine is not an exact science.”³⁰ The policy response, however failed by the number of people infected with HIV through blood and blood products, was admittedly based on misinformation about the nature of AIDS. Nevertheless, it is not simply scientific uncertainty, but misconceptions about the nature of the disease that, grafted upon attitudes about homosexual

behavior, supported the overly optimistic assessments. Situated between the constraints they identified and their misconceptions, officials could claim that they did not know any better. They were also unwilling to weigh the uncertainty of the more optimistic advice against the threat posed by the less sanguine scenario proposed by some experts or the measures they advocated both at home and at international meetings. In effect, the scientific debate comforted them as they felt buffeted by economic crisis and new financial constraints. They were reassured by the misconception of AIDS as an American “gay cancer.”

Conclusions

French officials still assert that they did everything necessary or conceivable, no matter how minimal their response nor how great the extent of HIV infection in France. Instead of a more comprehensive mobilization in the face of a health crisis, they mobilized the considerable resources of a wealthy state to fight a crisis they considered more pressing and more long term: the restructuring of the French economy so French industry could better compete with their American counterparts in the global marketplace. Their concern for AIDS, then, was first colored by their concern for the relationship of AIDS to their economic choices within a changing international environment. Next, policy became a product of how officials assessed risk through the prevalent misconceptions that enabled them to delay or minimize programs that might have prevented the spread of HIV, certainly in the blood supply but also by implication for other populations at risk.

Other articles in this symposium show that when governments with some measure of capacity have responded, it has been partially because those who were affected by the pandemic took upon themselves the responsibility for mobilizing prevention and care. It also results from a political leadership recognizing the nature of the epidemic and believing that government has the capacity to act. San Francisco developed early and effective programs in conjunction with community-based efforts, while New York’s mayor at the time, facing the repercussions of near bankruptcy only a few years before, was accused by gay and lesbian activists of ignoring the epidemic. In 1985, California even went beyond United States and French efforts to secure the state’s blood supply in approving a new \$5 million program, despite the Republican governor’s emphasis on austerity.

At the dawn of the second quarter century of AIDS, we can note that the failure of advanced industrial democracies to respond quickly to HIV/AIDS has been repeated in many of the hardest hit societies. In some cases, this is because state institutions were or are so weak, resources so lacking, and international pressures so measurably constraining that the state had or has few options. In other

cases, focusing on the relationship between domestic misconceptions related to the pandemic and perceptions of external constraints related to neoliberal reforms, not only across regions but across the chronology of the pandemic, clarifies more complex motivations. These perceptions of constraint and misconceptions about the disease are not absolute; instead, they vary dramatically, in ways that shape decision-making across a broad range of states having some capacity to act. Such states are not destined for failure.

Notes

- 1 The distinction between first- and second-wave countries is in many ways academic. AIDS was first diagnosed in the United States, and soon after in France as well as other industrialized democracies. But later studies of the disease demonstrated that it was already present in countries where—for political or practical reasons—it would not be diagnosed until later in the decade. This lag in “impact” is mirrored in a policy development lag even among those countries that have acted forcefully. But it can also be an empirical distinction, where the collapse of previous institutions, as is the case in Russia, has facilitated the spread of AIDS. Garrett, for example, knits together her focus on failed opportunities in the global South with a rather extensive wave theory. Garrett, 2005.
- 2 For the study of AIDS prevention, Tilly provides a useful definition of state capacity in terms of the degree of control a government can exercise “over changes in the conditions of persons, activities, and resources” under the government’s territorial jurisdiction. Tilly 2000.
- 3 Gauri and Lieberman 2004.
- 4 On the response of activists, see Bosia 2005.
- 5 Loriaux 1991.
- 6 Bauer 1988; Loriaux 2002.
- 7 L’avenir incertain du business du sang, *Le Figaro*, November 1, 1991.
- 8 Roux 1995.
- 9 *Ibid.*, 203.
- 10 *Wall Street Journal*, July 6, 1984, cited in Patton 1985, 32.
- 11 Quoted in Bernard Seytre, Sept mois des décisions administratives, *Libération*, February 8, 1994.
- 12 *Ibid.*, 202.
- 13 At the same time, Garretta benefited financially from his position on the boards of these various enterprises through direct compensation and stock options, which activists and plaintiffs judged to have tainted his decision-making.
- 14 Quoted in Lucien Degoy, Le Duo Garretta-Durieux, *L’Humanité*, November 12, 1991.

- 15 Florence Couret and Marianne Gomez. "Hémophiles: Histoire d'une contamination," *La Croix*, September 11, 1991.
- 16 See, for example, Patton 1990; Cohen 1999.
- 17 Frédéric Ploquin, A Paris dans une boîte homo, *Le Matin*, June 20, 1983. Geniéve Latour, Sida: La Nouvelle Peste, *Révolution*, July 14, 1983, which said that "AIDS was born" in the United States; *Le Monde*, Soixante-dix cas de Sida en France, July 31–August 1, 1983, noting that more than 75 percent of those with AIDS in France had visited New York at least once. In 1984, Dr. Jacques Leibowitch, one of the first involved in the response to AIDS, published a book called "Un virus étrange venu d'ailleurs" ("A Strange Virus from Somewhere Else," though when published in English, the title was translated as "A Strange Virus of Unknown Origins"). *Le Figaro* in 1984 argued that in the first two years of AIDS, "all, or almost all, the cases in France were imported," Dr. Monique Vigy, L'inquiétant Sida, *Le Figaro* August 10, 1984, emphasis added.
- 18 Maurice Szafran, Le Dr. Leibowitch: 'La France sera frappée comme les Etats-Unis,' *Le Matin*, June 18–19, 1983.
- 19 Antoine Pingaud, L'amour, la mort, et le Sida, *Le Matin*, July 14, 1983. Pingaud was described as a journalist with the gay magazine *Gai Pied*.
- 20 Ploquin, A Paris dans une boîte homo.
- 21 Lawrence K. Altman, New homosexual disorder worries health officials, *The New York Times*, May 11, 1982; AIDS—the mysterious illness, MacNeil/Lehrer NewsHour, August 26, 1982 (Education Broadcasting and GWETA); Robin Marantz Henig, AIDS: A new disease's deadly odyssey, *The New York Times*, February 6, 1983; Fermeture des arrières salles dans dix bars pour homosexuels, *Le Monde*, March 5, 1985; Les homosexuels français et le Sida, *Le Monde*, November 9, 1985. Dr. Claude Lejeune, then president of the *Association des médecins gais*, warned about "vagabondage sexuel." Eric Conan, Les homosexuels français et l'effet Sida, *Libération*, October 20/21, 1984.
- 22 Marie-Ange d'Adler, Transfusion sanguines: la peur du sida, *Le Matin*, June 17, 1983.
- 23 Steffan 1999.
- 24 Koupernik 1995.
- 25 Lawrence K. Altman, M.D. Concern over Aids grows internationally," *The New York Times*, May 24, 1983: C1. Dr. Bijan Safai, chief of dermatology, Memorial Sloan-Kettering Cancer Center, quoted on the MacNeil/Lehrer NewsHour, original airdate August 26, 1982 (Educational Broadcasting and GWETA, 1982).
- 26 Personal interview, November 14, 2001.
- 27 Henry, 1992: 78.
- 28 Personal interview, November 17, 2001.
- 29 Quoted in parliamentary debate. Comptes Rendus: Débats Parlementaire, Assemblée Nationale (Paris: Direction des Journaux Officiels, December 16, 1992).
- 30 Ibid.

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