Slim Disease and the Science of Silence:

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This paper focuses on the earliest epidemiological and other scientific studies of HIV/AIDS (or ‘slim disease’ as it was first colloquially known in Central Africa). This literature tentatively raised but very quickly dismissed the possibility of same-sex transmission of HIV. I examine how precisely African men who have sex with men but do not identify as gay or bisexual were written out of the investigation between 1983 and 1988 and how in this way ostensibly objective science served to reaffirm old ethnographic stereotypes about ‘African sexuality’. It contrasts the supposed ‘heterosexual African AIDS’ with more recent research and donor pressures upon African states that reverses this erasure of same-sex sexuality and calls for sexual minority rights. Without suggesting a direct link, this history does raise concerns about the politics of knowledge production in a period that was characterised by deeply unpopular, Western-backed transitions to neoliberal structural adjustment regimes.

I. INTRODUCTION

In 2009 The Lancet, one of the world’s most respected medical journals, published a literature review that suggested men who have sex with men (MSM) were a more significant at-risk population for HIV in Africa south of the Sahara than had previously been assumed, accounting for perhaps as much as 20% of all new infections.¹ This was followed soon after by a World Bank publication that argued for programmes specifically targeting MSM with a range of public health and education interventions, including in countries where same-sex acts are illegal.² That report had particular praise for South African and Kenyan leadership on the issues and was frank in its condemnation of

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2. Chris Beyrer et al., The Global HIV Epidemics Among Men Who Have Sex With Men (2011). This report, I should note, is global in its analysis and recommendations. No other region of the world than Africa had such a long and profound period of non-recognition of the role of MSM in HIV infection, but similar issues are widely encountered in the Global South. For the World Health Organisation (WHO) position on what constitutes best practices, see WHO, PREVENTION AND TREATMENT OF HIV AND OTHER SEXUALLY TRANSMITTED INFECTIONS AMONG MEN WHO HAVE SEX WITH MEN AND TRANSGENDER POPULATIONS (2009).
homophobic laws and policies elsewhere on the continent for health, human rights and narrowly economic reasons. Among other things, providing explicit sexuality education, lubricated condoms, and antiretroviral therapy to MSM makes good economic sense, according to the authors. Several powerful donors have since taken up the cause to promote sexual minority rights in Africa, notwithstanding the accusation that this amounts to Western cultural imperialism over ostensibly African values.  

This ‘discovery’ of sexual minorities in Africa is interesting in at least three ways: First, it comes a remarkable twenty-five years after HIV/AIDS was first recognised as an epidemic in the region. Throughout almost that whole time, isolated publications, fitful research, documentary films and a mixed bag of activist literature on and by MSM, WSW (women who have sex with women), and LGBTI (lesbian, gay, bisexual, trans and intersex people) had been appearing. That literature (including film and other forms) was generally ignored or regarded as insignificant to understanding both the epidemiology of HIV and wider initiatives to develop a health-promoting culture of human rights. Well into the new century, important publications aimed at health care professionals continued to deny the existence of same-sex transmission of HIV in ‘black Africa’, while others offered homophobic prescriptions for the suppression or containment of homosexuality; just to be safe.² The Lancet article by Smith et al thus represents a noteworthy

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3. I examine this change in approach, and its implications for African sexual rights associations, in Marc Epprecht, Advancing the Right to Sexual Orientation and "Erotic Justice" in Africa Through Public Health Strategies, 111 (443) Afr. Affairs 223–43 (2012); See also Marc Epprecht, Sexuality And Social Justice In Africa: Rethinking Homophobia And Forging Resistance (2013); Marc Epprecht, Heterosexual Africa?: The History of An Idea From the Age of Exploration to the Age of AIDS (2008), [from which this article is adapted, with permission]; See also Carl Alan Johnson, Off the Map: How HIV/AIDS Programming Is Failing Same-Sex Practicing People in Africa (2007).


5. HIV/AIDS in SOUTH AFRICA (S.S. Abdool Karim & Q. Abdool Karim eds., 2005). In this case, two of South Africa’s leading medical professionals in the field not only studiously avoid the topic throughout nearly 600 pages of their self-described ‘authoritative’ text, they also reproduce a UNAIDS map that indicates Africa south of the Sahara as having only one significant mode of transmission of the virus, heterosexual vaginal intercourse. For instances of homophobic prescription in an otherwise reputable academic publication, see Human Sexuality In Africa: Beyond Reproduction (Eleanor Maticka-Tyndale et al. eds., 2007).
intellectual breakthrough that is contributing to the belated adoption of best practices for education and prevention directed at one of Africa’s most at-risk populations.

Second, the West is commonly accused of promoting a specific form of gay culture and identity through ‘queer imperialism’, not merely in Africa but throughout the Global South. That identity is typically characterised as individualistic and consumer-oriented if not hedonistic and thus at odds with romanticised notions of communal African values. Yet here is a case where Western scientists, donor agencies and even gay rights activists in the West to some degree colluded for decades to repress or deny some of the most important aspects of gay identity formation (education, health outreach, formal rights for sexual minorities). This calls into question the notion that there is any consistency or coherence to Western cultural imperialism around sexuality.

Third, the World Bank and Western donors were among the greatest advocates of neoliberal structural adjustment programmes in Africa, as elsewhere in the Global South. These programmes largely coincided with, and are widely thought to have fuelled, the HIV/AIDS pandemic. I do not want to suggest any direct link between the scientific research on HIV/AIDS and the ‘Washington consensus’ on economic policy. Alex De Waal, however, has provocatively argued that the AIDS crisis was effectively managed, if not cynically exploited, by African states and their Western backers to maintain their legitimacy through a period of intensely unpopular economic reforms. The absence of any discussion of the impacts and legacy of structural adjustment in Beyrer et al also recalls James Ferguson’s critique of the World Bank as an “anti-politics machine,” making inconvenient evidence disappear when necessary in order to justify loans or other development initiatives that bind Africa to the hegemonic system. Was the erasure of same-sex sexuality in the scientific discourse really a coincidence with the promotion of neoliberal reforms? Could the donors’ present embrace of sexual minority rights be

7. World Bank, Accelerated Development in Sub-Saharan Africa: An Agenda For Action (1981). The World Bank’s delineation of its structural adjustment plans for Africa was published in the previous year that a mysterious new disease was reported in Los Angeles; its agenda was in place in over 40 African countries by the end of the decade.
consonant with that management process as quasi- or non-democratic regimes today continue to be beholden to neoliberal ideology, and as on-paper economic growth masks deepening inequalities?

The latter questions are much too big to be able to answer in this article. At the very least, however, it could be helpful to examine the factors that contributed to diverse actors such as scientists, politicians, and economists all producing the resounding and enduring silence on same-sex sexuality from which they are now emerging. Anthropologist Michael Herzfeld has coined the term "cultural intimacy" to capture this sense of shared, often unconscious stereotyping among people with otherwise quite divergent views or professional commitments to empirical accuracy.\(^{11}\) The term, and the specific history from Africa which I want to discuss, has relevance anywhere that expert consensus is used to advocate policy without being subjected to rigorous, interdisciplinary critique.

The cultural intimacy, silence or blind spot in the science of HIV/AIDS in Africa is not surprising at one level and it is not my intention to cast aspersions on the scientists who found themselves faced with a looming health and developmental catastrophe in the mid-1980s. The first scientists to engage the issue did not see any obvious gay 'scenes' when they arrived in Kampala, Kigali, Kinshasa and so forth. The predominant clade or genetic variation of HIV was different in Africa than among gay men in the West, while scientific studies from the pre-HIV/AIDS era also overwhelmingly denied or minimised the existence of same-sex sexuality in Africa.\(^{12}\)

Yet the silence is surprising at several other levels, including the sheer size of the ignored population intuitively at risk. Not even counting non-disclosing homosexuals and bisexuals, by the late 1980s there were more than half a million men in prisons and uncounted millions of children living on the street across the continent, very high risk environments as attested by Gear and Ngubeni and Lockhart, for example.\(^{13}\) Moreover, even a casual eye must note how rapidly orthodoxy was established in the HIV/AIDS science and how cursory was the research to test inherited

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assumptions about African sexuality. As I will discuss below, scarcely two years and a handful of questionable empirical studies passed between the first tentative acknowledgment that an AIDS-like disease was present in Africa and definitive statements that homosexual transmission did not merit investigation (which is to say, funding). Those definitive statements came before the first significant ‘Knowledge, Attitudes, Beliefs and Practices’ surveys interviewed Africans about their actually-existing (as opposed to ideologically desired) sexuality.\textsuperscript{14} Also striking is how disinterested Smith \textit{et al}\textsuperscript{15} and Beyrer \textit{et al}\textsuperscript{16} are in analysing the making of this orthodoxy. It seems to have just happened with no need for blame or critical self-reflection.

This article interrogates the construction of silence around same-sex sexuality in the HIV/AIDS science in Africa. The assumption is that if we are to make our interventions effective it surely helps to acknowledge, reflect upon and hopefully avoid errors that came before. I begin by setting the context of pre-HIV biomedical interventions around Africans' sexual health, and changing attitudes toward (or knowledge about) same-sex sexuality rooted in the colonial and apartheid experiences, something which virtually none of the early HIV/AIDS investigators acknowledged. I proceed by closely analysing the methods, unspoken assumptions, and language of the major research contributions at the onset of the epidemic in the leading, English-medium scientific journals. The focus is on a short but critical moment in time, from 1983, when the first alert about the new disease among black Africans was specifically directed to medical practitioners in Africa,\textsuperscript{17} up to 1988. In the latter year, Ugandan and South African medical professionals with the backing of their respective governments adopted comprehensive – except for MSM – strategies to contain HIV/AIDS.\textsuperscript{18} How exactly was that blind spot, entrenched in the concept of a distinctively heterosexual ‘African AIDS’, established with such assurance?

The conclusion draws attention to key studies conducted since the late 1990s that have challenged this orthodoxy. Of course, care and cultural sensitivity will need to be exercised in all future interventions and the various political risks carefully assessed in each instance. But these


\textsuperscript{15} Smith \textit{et al.}, supra note 1.

\textsuperscript{16} Beyrer \textit{et al.}, supra note 2.

\textsuperscript{17} A.P. Fleming, \textit{HTLV: Try Africa, 321} (8314) \textit{The Lancet} 69 (1983).

studies demonstrate that truly comprehensive and rigorously scientific approaches to sexuality are possible in Africa regardless of cultural or political rhetoric around same-sex issues and that the exaggerated silences enjoined from the mid-1980s can—indeed must, in good conscience—now be broken. This puts me firmly in agreement with current World Bank and other international prescriptions for sexual minority rights in Africa. The history examined here nonetheless alerts us to the art of forgetfulness in Western donor discourse that is so conducive to a broader package of neoliberal programmes and practices. That broad neoliberal package, with its well-documented tendencies to exacerbate income inequalities, fuel commercial sex work and provide fodder for populist demagogues or fundamentalist religious movements, undermines the very quest for human rights and sexual health that the specific attention to sexual minority rights otherwise promotes.19

II. CONTEXT: SEXUAL HEALTH UNDER COLONIALISM AND APARTHEID

From the perspective of the early Christian missionaries and colonial officials in Africa, traditional patriarchal societies there were morally suspect or repugnant.20 However, to the extent that they maintained control over the rambunctious sexuality of young people and young women in particular, they could be admired and indeed, supported. It was also widely noted and admired by European observers that most African societies appeared not to tolerate exceptions to heterosexual norms.21 The disruptions caused by colonialism and racial capitalism,

19 Kaoma Kapya, Globalizing the Culture Wars: U.S. Conservatives, African Churches, and Homophobia (2009); Kaoma Kapya, Colonizing African Values: How the U.S. Christian Right Is Transforming Sexual Politics in Africa (2016). Again, there is a vast scholarship that substantiates these points but let me simply direct readers to one Zambian researcher who connects the rise of neo-conservative politics in the United States to the aggressive export of homophobic ideologies to Africa in conjunction with intensifying neoliberal economic discipline, Uganda being ‘ground zero’ in the current struggles.


however, rapidly broke those traditional mores and controls down. By the late nineteenth century, the sexual health of Africans had consequently emerged as a significant concern to colonial administrations and their corporate and other allies.

The unchecked spread of sexually transmitted infections, above all syphilis, was not just a humanitarian crisis. Syphilis prior to the late 1940s was effectively incurable. It frequently resulted in insanity and a horrible, humiliating death, including for wives infected by their husbands with all that implied for stable family life. There were material and political implications to the disease as well. Even less debilitating infections like gonorrhoea undermined the viability of a cheap African labour force in that the resultant sickness and absenteeism imposed significant costs on industry and infrastructural development. The existence of sexually transmitted diseases on such a scale also exposed to public debate the sordid underpinnings of the so-called civilising mission. The male migrant labour system, the legal and institutional apparatus erected to minimise women's and children's presence in towns, infertility, and the proliferation of female prostitution (to use the language of the time) that often flowed from these policies, brought condemnation of colonialism from critics as wide-ranging as Christian missionaries, African chiefs, and the Comintern.

Colonial medical interventions to address the crisis often did put humanitarian concerns to the fore. Funding and personnel, however, were never remotely adequate to the task. Moreover, often operating under extremely primitive laboratory conditions and in the face of unfamiliar tropical diseases, European medical interventions almost inescapably drew upon poor or flatly wrong empirical research. The extent of the syphilis epidemic around the turn of the century notably appears to have been hugely exaggerated due to confusion between the very similar spirochetes of syphilis and yaws, the latter disease being endemic in much of Africa and non-sexually transmitted.22 Medical interventions around sexual health further suffered from high levels of morally normative language and presumptions. Indeed the majority of the early heath care providers were missionaries or lay-Christian

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22. Karen Jochemson, Sexually Transmitted Diseases in Nineteenth and Twentieth Century South Africa, in History of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa 218-9 (Philip W. Setel et al. eds., 1999). The scale of the error can be inferred from missionary claims of a rate of syphilis infection of 75-80% among Basotho and Ndebele men in 1906.
doctors and nurses. Their understanding of sexuality was profoundly coloured by the vocation that had brought them to Africa in the first place: convert 'barbarous' or 'lascivious' Africans to a model of 'civilised' gender relations and sexuality such as they idealised about their own societies. Disease in this way became a rhetorical crowbar to pry Africans away from customary practices and understandings of puberty transitions, courtship, marriage, and even specific sexual acts. To reconstruct Africans' sexuality in this way was to lay the foundation for the rise of a 'respectable' African middle class (assimilés or assimilados in the French and Portuguese colonies).

In practical terms, what this meant was that medical interventions purportedly on behalf of Africans' sexual health were frequently punitive, deeply humiliating for the recipients and either useless or actually counter-productive to preventing the spread of diseases. The practice that the Shona people of modern Zimbabwe termed chibura was one of the more notorious examples: compulsory vaginal examinations of women in town, sometimes with male African police constables in attendance, followed by deportation back to the rural areas if they were found to have an infection. In other settings, men who did not report symptoms for treatment faced a prison sentence or were fired and deported to rural homes if discovered. And discovered they would be, since many of the large employers subjected their contract African labourers to mandatory genital and anal examinations as a pre-condition for employment or re-employment after every short-term contract.

The colonial medical establishment through the first half of the twentieth century also de facto supported the view that male-male sexuality among Africans either did not exist or was not a potential health concern. Some doctors may have simply accepted the prevailing wisdom about Africans' supposedly primitive heterosexual nature and not even considered homosexuality as a possibility. Others may have felt a similarly misplaced confidence in the progress of 'respectability' or assimilation. This view acknowledged the existence of certain homosexual-like rites or relationships in traditional culture but felt (as the anthropologists' African informants assured them) that such practices

25. Epprecht (2008), supra note 3 (examining psychiatrists' views on these issues).
had become moribund before the march of Christian civilisation. Yet at the same time, medical professionals were unquestionably aware of new forms of MSM appearing in non-traditional settings like migrant labour camps and same-sex boarding schools. Doctors were often called as witnesses in criminal cases of indecent assault or sodomy, for example. That medical health officials did not write more about such situational sex probably reflects the fact that it was not perceived as a public health concern. Male-male sex may even, not to be admitted in public, have been regarded as a public health good.27

How could European men from societies that otherwise criminalised and scorned homosexuality have construed MSM among Africans as a relatively desirable behaviour? The simple answer is that anally transmitted sexual infections were almost never observed in the dominant forms of MSM practiced by African men and indeed the men themselves claimed that anal sex was not allowed according to the prevailing etiquette. Rather, in a strictly hierarchal relationship the ‘husband’ would emit between the legs of the ‘wife’.28 The participants in these relationships for the most part clearly were not turning into ‘real homosexuals’ to disturb social decorum. Male-male thigh sex or masturbation was meanwhile an obviously less risky activity than penetrative sex in male-female prostitution in the context of the times. As a discreet, temporary expedient it helped to preserve men’s marriages to women and social stability back home in the rural areas, not to mention protecting white women from the assumed scourge that might result from unrequited black male lusts (so-called ‘Black Peril’). Male-male sexuality associated with long-distance porterage, prisons, mine hostels and other modern institutions was thus somewhat embarrassing to

27. Charles Van Onselen, *Chibaru: African Mine Labour in Southern Rhodesia, 1900-33* (1976). He was the first historian to make this case, subsequently developed by Moodie with Ndatshe, and Harries among others, with reference to a series of South African government commissions of enquiry from 1906 onwards.
28. Louis F. Freed, *The Problem of European Prostitution in Johannesburg: A Sociological Survey* (1949). These claims about male-male sexual etiquette may have been overstated and there is evidence from later periods that anal sex was more widely practiced than the ‘rules’ admitted. The first systematic attempt to determine the numbers of African men engaging in penetrative male-male sex in an urban context, notably, was reported in 1949. Dr. Louis Freed found that 19 out of his sample of 211 syphilis patients had an anal infection, suggesting that no less than 9% of African men in Johannesburg were engaged in receptive homosexual anal sex, or just about double the rate he found among white men in the same study. See Louis Freed, Letter to Dr P. de Vos, 19 Dec. 1950 (on file with William Cullen Library, University of Witwatersrand, Johannesburg A1212) (where he is citing research for his book). See Gear & Ngubeni, * supra* note 14 on this topic as seen by men in the post-apartheid South African prison system.
colonial health officials but could be tolerated or even tacitly condoned as the lesser of several evils.

Public health not being at risk and moral education being largely in the hands of the missionaries, colonial states thus made scant movement on this issue beyond guarding against obvious breaches of the peace and public decency. The first noteworthy health intervention that I was able to uncover was not until the late 1930s or early 40s. In that instance, the South African government lent its support to an International Red Cross initiative to teach African working class men the health benefits of abstinence, self-repression and/or self-masturbation. The pamphlet they circulated to men on the mines in southern Africa was principally concerned with averting sexually transmitted infections acquired by the men from female prostitutes, again to use the language of the times. However, it also vigorously denounced homosexuality ("This unnatural act, repulsive to all healthy-minded men, must be strenuously opposed and eradicated"). It underscored this point by anchoring itself in reference both to modern medical science and to the ethnography of (presumed) ancient African cultures. Indeed, without noticing any contradiction with its masturbation advice for grown men, the authors swathed themselves under the mantle of respect for African traditions: "Tribal Laws of the Bantu provided drastic penalties for sexual irregularities."

This is not to make homophobic and racist Europeans the centre of attention. On the contrary, African religious leaders, political activists and intellectuals all played supportive and sometimes leading roles in constructing an ideology of African sexuality that served their social and political agendas in the rapidly changing environment. Knowledge about 'shameful' or 'emasculating' practices such as sex in prisons or for money was suppressed in this discourse, particularly as the struggle against European colonialism heated up. By the 1960s, drawing upon eclectic sources including European ethnographies, Frantz Fanon's revolutionary thought, and Christian scriptures, African nationalist ideologues and politicians asserted a distinctive form of homophobia that presented steadfast African heterosexuality in opposition to dangerous, morally corrosive outside influences. As Tanzania's first president put

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29. **RED CROSS SOCIETY, SEX HYGIENE AND VENEREAL DISEASE** (South African Department of Public Health, GES 2268 60/38L). The following quotations are taken from this pamphlet, no exact date of publication provided.

it in justifying his preference to criminalise homosexuality as long back as 1973, he was “amazed” by then liberal European attitudes on the issue: “I can’t even begin to talk about it.”

III. A Research Question Is Posed – And Answered

The above history needs to be borne in mind if we are to understand people’s responses to three shocking discoveries over the course of 1983-84. First, was the discovery that HIV/AIDS had already become deeply entrenched in Central Africa before the first cases were even identified. By the time doctors arrived in the Rakai district of Uganda, whole villages had been depopulated by ‘slim disease’ while people reported having been aware of the mysterious killer from at least three or four years before. Among select groups tested elsewhere in the region such as female sex workers and male truck drivers, rates in 1984 were found to be in the double digits – and in some cases a majority of the sample – barely months after the first confirmations of HIV infection.

Second, was the discovery that men and women in Central Africa were almost equally infected. Since its first tentative identification in North America in 1981, the new disease had been primarily associated with gay or bisexual men. The equal ratio between men and women in Central Africa thus suggested a very different and far more dangerous pattern from Europe and North America. As one of the first World Health Organisation studies found, 90% of the African AIDS patients did not belong to any of the then known risk groups. This meant that rather than a potentially self-limiting epidemic among relatively small minorities, Africa might be facing a catastrophic pandemic in the majority population.

31. Chris Dunton, Face to Face, in Unspoken Facts: A HISTORY OF HOMOSEXUALITIES IN AFRICA (Epprecht ed., 2008). That section of the interview of Nyerere by East German journalist Hubert Fichte was cut from the published version in 1974, presumably to protect fellow socialist Nyerere from embarrassment. It exists only in an unpublished transcript in private hands. An imaginative recreation of a similar interview between fictional characters can be found in Dunton’s piece.

32. See Edward Hooper, SLIM: A REPORTER’S OWN STORY OF AIDS IN EAST AFRICA (1990) (for a first-hand account of the outbreak and political reactions in Uganda); For overviews of these discoveries and people’s responses, see AIDS IN CONTEXT: SPECIAL ISSUE OF AFRICAN STUDIES, 64 (1) (Peter Delius & Liz Walker eds., 2002); Joseph R. Oppong & Ekeziel Kalipeni, PERCEPTIONS AND MISPERCEPTIONS OF AIDS IN AFRICA, in HIV/AIDS IN AFRICA: BEYOND EPIDEMIOLOGY 47-57 (E. Kalipeni et al. eds., 2004); John Iliffe, The African AIDS Epidemic: A History (2006). These and the following analysis draw upon English-language publications but a glance over key publications in French suggests that the same points can be made of the scholarship in that language. See Carale, et al., supra note 16; Gilles Bibeau, L’Africaine, terre imaginaire du Sida: La subversion du discours scientifique par le jeu des fantasmes., 15 (2-3) ANTHROPOLOGIQUE ET SOCIETES 125-148 (1991); Becker et al., supra note 9; Daniel Vangheemere, SIDA ET SEXUALITE EN AFRIQUE (2000); L’EPIDEMIE DU SIDA EN AFRIQUE SUBSAHARIENNE: REGARDS HISTORIENS (Philippe Denis & Charles Becker eds., 2006).

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Third, was the discovery that HIV appeared to be a genetic adaptation of simian immunodeficiency virus from ape to human hosts. As if stigma and AIDS-phobia were not already complicating political responses to AIDS in the West, racists there immediately seized upon the new evidence to slur Africans with bestiality accusations. Even otherwise sober media made comments that fuelled an existing popular perception of Africa and Africans as a source of disease, moral depravity and a looming threat to the West.

Conscious of the political uproar and moral panic that HIV/AIDS was causing in the West but likewise horrified at the prospect of an uncontrollable pandemic in Africa, the first scientists to venture its existence in Africa tried to be as calmly objective as possible in publishing their findings. The very first published letter to alert medical professionals that AIDS was present among blacks in Africa referred to a married Zairian woman and concluded, simply, that “AIDS is not restricted to homosexuals and drug-users.”34 Thereafter, as studies began to report an almost equal number of black women as men testing positive for HIV or showing AIDS symptoms, researchers first posed the research question in wondering terms (for example: “Is there something unusual about the sexual mores of Kinshasa”35). They then carefully tested their logic. The evident absence of risk groups as then understood in the West could only mean three things. Either African AIDS was a different disease from what appeared in the West, that it was being spread to women through needles infected in the health care system, or that it was being spread through heterosexual intercourse among Africans.

The first possibility was quickly ruled out by genetic analysis (although, significantly, different clades in Africa compared to the U.S. and Europe suggested a different epidemiology than through male-male intercourse). The second hypothesis took a bit longer but, notwithstanding the oft-shambolic state of health care systems in Central Africa, infected needles were soon also ruled out as a major mode of transmission. This left heterosexual intercourse, which could be through vaginal, oral or anal sex. I query the methodology of specific studies below but in short they all quickly ruled out both oral and anal sex: when interviewed, African patients and healthy controls alike virtually all often strenuously denied any sexual practice other than vaginal intercourse. African informants did not seem to mind admitting to multiple partners in that activity, however. On the contrary, Africans in the most affected areas like

Rakai themselves intuitively connected the disease with the breakdown of traditional mores that had valued (and enforced) sexual restraint. Many rued the new disease as metaphysical payback for their self-admitted decline in sexual morality, evidenced by multiple, concurrent heterosexual partners.36

Several studies over 1984-5 appeared to corroborate that view by demonstrating a close co-relation between vaginal intercourse with multiple heterosexual partners and HIV infection. Hardly more than a year after the first cautious alert, therefore, scientists posited—and then began unambiguously to assert—that men’s frequent use of female prostitutes and the prostitutes’ “highly promiscuous” behaviour were the key variables in the spread of the disease.37 Van de Perre et al added that living in the city and having a “reasonable standard of living” (which enabled promiscuity compared to those who lived in rural poverty) were probable other risk factors.

But could it be possible that some of the men who infected their female partners had been initially infected by other men? There was obviously no openly gay presence in the cities first affected by HIV/AIDS. The earliest studies in the Zaire (Congo), Rwanda and Uganda nonetheless did tentatively enquire around the possibility of covert homosexual or bisexual activity. In some cases, they left the question open. The pioneering article by Van de Perre, for example, did not exclude the possibility that one of the men in their study may have had homosexual contacts during his three previous years in prison.38 Mostly, however, male African informants vigorously denied it and their interlocutors saw no reason either to dispute them, to re-ask the question in more subtle ways or to refer to the ethnography for a second opinion. The fact that Europeans who had contracted HIV in Africa also claimed only heterosexual encounters confirmed the pattern.39


38. Van de Perre et al., supra note 42, at 65.

Summing up the evidence after the first two tumultuous years, a key article published in *The Lancet* in 1986 thus concluded: “The sex ratio of cases does not support homosexual distribution and, furthermore, most Africans, both male and female, adamantly deny homosexual activity.”\(^{40}\)

The predominantly heterosexual nature of transmission was further definitively asserted in *Science* magazine the same year by four of the top medical scientists in the field. Despite citing some tantalising evidence to the contrary (a WHO survey of Africans in Europe), Quinn, Mann, Curran and Piot set the dominant tone for the next two decades by not even listing homosexual intercourse as a mode of transmission in Africa.\(^{41}\) Occasional calls for caution and more careful research notwithstanding, the consensus was so strong that by 1988, it typically did not require a footnote to back or qualify. When Botha *et al* described the first two cases of South African women with AIDS, for example, they did not include a single citation to back their flat claim about “heterosexual promiscuity” in Africa.\(^{42}\) Writing in 1989, Hooper suggested that scientists who had left the door open to homosexual or bisexual transmission in their early publications quickly regretted or distanced themselves from that early caution.\(^{43}\)

Then, with Caldwell, Caldwell and Quiggin’s sprawling and influential synthesis of the research that asserted an “alternative civilization” with respect to African sexuality, same-sex sexuality almost entirely disappeared as an object of scientific enquiry for close to the next decade.\(^{44}\)

The first systematic ‘Knowledge, Attitudes, Beliefs and Practices’ (KABP) surveys came soon after this certainty about heterosexual transmission was expressed, further consolidating the orthodox view.\(^{45}\) These surveys were conducted by the Global Programme on AIDS of the World Health Organisation beginning in 1988. By 1991, collaborative international and local research teams had completed surveys in 18 African countries with sample sizes ranging from 1600 to 3000 informants. The summary of the findings reported all kinds of intimate details about sexual activity outside of marriage and traditional relations as revealed by African men and women, including mean age of first intercourse, how many partners...
on average, frequency of 'casual sex' and condom use, risk awareness and much more. Same-sex sexuality does not merit a single mention, even to be denied or footnoted as insignificant/unknown.

National HIV/AIDS control programmes or committees began to be put in place around this time in line with this scientific consensus. Without a cure or vaccine, this meant that attention focused first on securing the blood supply by proper screening and safe transfusions. Next came national prevention and education initiatives. With a few notable exceptions (such as the deportation of Malawian mine workers from South Africa in 198346), these generally adhered to the WHO's recommended best practices. These recognised the important role of secrecy and taboo in abetting unsafe sexual practices and advocated developing an approach to sex education that used frank language to alert people to the issues.47 In keeping with the scientific orthodoxy, however, frank language in the African interventions almost never spoke frankly about or even conceded the possibility of African MSM. On the contrary, national AIDS campaigns focused virtually exclusively on reducing high-risk heterosexual contacts by promoting the use of condoms and a reduced number and frequency of sexual partners: “zero grazing” (meaning, no casual heterosexual intercourse outside of heterosexual marriage) as the catchphrase of Uganda’s relatively successful initiative put it in the late 1980s.48

Yet, as logical and persuasive as this orthodoxy may have seemed at the time, it was evidently ineffective in addressing the public health crisis. With the major exceptions of Senegal, where adult prevalence of HIV/AIDS was kept below 1% and in Uganda where seroprevalence actually decreased in the 1990s, the disease confounded each and every national AIDS programme until very recently, nowhere more so than in southern Africa. Adult prevalence shot up from 0.7% in South Africa in 1990 to nearly 25% in a decade and as high as the 37.5% in KwaZulu-Natal and neighbouring countries by the early 2000s.49 No serious observers doubted that heterosexual intercourse remained at the heart of the disaster and that every effort needed to be made to empower girls

47. Jonathan Mann, The Impact of Homophobia and Other Social Biases on AIDS (1995). Mann was the first and highly influential director of the WHO Global AIDS Programme. This booklet is a popular summation of its human rights approach to HIV/AIDS, See also WHO, supra note 2.
48. Hooper, supra note 37.
49. Abdool Karim & Abdool Karim (eds.), supra note 5, at 56. Estimates here are based on antenatal clinic attendees, a contentious means to measure prevalence. Recent revised calculations do bring estimates lower but still represent a stunning incidence over a short period of time.
and young women to protect themselves. Unquestionably many factors contributed to the failure to achieve that objective in the aspired way. But one has to wonder, did an understanding of sexuality education that stubbornly did not allow talk about the full range of human sexuality, add to the mystery/ disaster?

IV. THE MAKING OF AFRICAN AIDS

In retrospect, the consensus about the non-existence or insignificance of homosexuality and bisexuality to the struggle against HIV/ AIDS in Africa surprises, not only for the unscientific rush to generalise about a vast place based on extremely limited research samples, but also for ignoring anomalies in the readily available documentary record. Even South Africans – coming from a country with an established gay rights movement, a dense and relatively richly-supported research environment, and a long history of public acknowledgement of African MSM in male-only hostels (indeed, an explicit, if not lurid account of male-male anal sex was published on the cusp of the epidemic in that country50) – seemed incapable of connecting the dots. The very first comprehensive overview of HIV/ AIDS in South Africa epitomised this. Ijsselmaiden et al warned that densely populated single-sex dwellings were among the “social and economic factors intrinsic to our society which may enhance the impact of HIV infection.”51 The danger was not, however, because of the type of activity described by Mark Mathabane (group man-boy penetrative sex). Rather, male-only hostels in Ijsselmaiden’s analysis were dangerous because they gave rise to heterosexual prostitution and promiscuity in the surrounding neighbourhoods.

Presuming the professionism of the scientists involved, how can we understand such oversights in the basic research? Overt homophobia among doctors and scientists themselves does not appear to have been a factor, although an implicit fear of being abused or ousted by unsympathetic or hostile health care providers almost certainly drove MSM underground or to misrepresent their sexuality to health researchers.52 Rather than overt homophobia, however, naïveté and heterosexual logic were ubiquitous in the early AIDS research in Africa. For example, a commonplace false assumption was that if a man was married

50. Mathabane, supra note 4.
to a woman or went to female sex workers, then he was heterosexual: end of story. That category was assumed to be stable enough over time not to require further investigation. The doctors who reported the first Zairian woman with AIDS thus did not think it necessary to establish the sexual history of her (assumed exclusively heterosexual) husband. We know only that he was not a drug user but have no idea whether he had ever had unprotected sex with a man. Similar studies of men who admitted to going to female sex workers assumed that this admission alone established their 100 per cent heterosexual credentials. The first two reported cases of South African women with HIV/AIDS also simply noted that they had engaged in prostitution in one case and co-habited with a Malawian migrant labourer in the other. The men's sexual history was not questioned on the assumption that they must have been exclusively and permanently heterosexual, since they had engaged in this one known case in sex with a woman.

Efforts to establish whether African men's sexual histories were more complicated than appearances might suggest followed a clear pattern. Either the pertinent question of sexual history was not asked at all or it was expressed in a way that unintentionally elicited negative responses. The first report of a black man in South Africa with apparent AIDS symptoms, for example, simply noted that "sexual orientation was unknown," implying that no one asked about it. Note the use of the passive voice to obscure the research gaffe, an almost standard feature of the writing. The twenty healthy Rwandan men against whom Van de Perre et al. controlled their prodromal AIDS patients also "were not known to be drug abusers or homosexuals or bisexuals."

As for the early cases turning up in Europe, mostly from francophone Central Africa, we are left to assume that sexual histories were established through interviews in French. That language, however, like English, did not convey much subtlety in capturing nuances of meaning or avoiding pejorative associations. Media coverage of some of the behavioural extremes in the gay subculture in San Francisco and New York unquestionably had an effect of reinforcing those pejorative

53. Offenstadt et al., supra note 39.
54. Botha et al., supra note 48, at 132-4; See also S. F. Lyons et al., Sero-epidemiology of HTLV-III Antibody in Southern Africa, 67 S. Afr. Med. J. 961-962 (1985) for a similar assumption in defining the control group against which 'homosexuals' were measured.
56. Van de Perre et al., supra note 42.
57. Clumeck et al., supra note 42; Quinn et al., supra note 38.
associations, including in Africa, where the press frequently picked up stories from the international news services that shed ‘the West’ in a mocking light.58

Meanwhile, no mention was made of what, if any, indigenous terms were used to translate ‘homosexual’ and ‘bisexual’ in interviews and on the questionnaires administered to Africans. On the contrary, readers are led to assume that these concepts are trans-historical, stable, and self-explanatory, unaffected by choice of language. An important case in point was a report written in English by Dr. Fred Kigozi based on thirty-minute interviews with forty-eight Ugandan hospital patients. This was the very first study to attempt to determine sexual behaviour in Uganda in a more or less scientific manner (Kigozi was a professional psychologist). Kigozi did not identify the language used in the interviews, although it was likely mostly luGanda. Yet luGanda, like many indigenous languages in Africa, does not contain words that directly translate as ‘homosexuality’, ‘oral’ or ‘anal sex’. That being the case, it is unclear how all informants were able to have “adamantly denied any experience” of those very things.59 That normative assumptions may have worked their way into the interviews through translation is suggested by subsequent studies that drew upon Kigozi’s work, including the bluntly titled report “HIV infection through normal heterosexual contact in Uganda.”60

Many of the most widely cited articles in the emerging canon demonstrated obliviousness to the power of language in other ways. Van de Perre et al, for example, interviewed 26 patients with AIDS symptoms at the Centre Hospitalier de Kigali.61 Interviews were conducted in Kinyarwanda only “when necessary,” suggesting that French was the default language. The ability to capture nuance and subtlety on such a delicate topic is also put in doubt by the methodology described in a follow-up study by Van de Perre et al.62 This involved administering a baseline questionnaire to 33 women (passive voice, again) “who were understood to be prostitutes,” 25 men getting treatment for sexually transmitted infections who admitted to going to a prostitute at least once in the previous three months and a control group of 60 women and men who denied being or using prostitutes. No details are given about the Rwandan investigator other than his name (Elie Nzabihimana, the

58. SHIPTS, supra note 45; EPPERSCHT (2008), supra note 3.
61. Van de Perre et al., supra note 42.
only Rwandan out of the listed authors). But, one has to wonder, how would Rwandans who secretively engaged in stigmatised practices have responded to a series of highly personal questions in a public space (the state hospital)? The reliability of answers is further called into question given the (unacknowledged) fact that the Rwandan state in the mid-1980s was an ethnic dictatorship with a long history of repressive government facilitated by Belgium, whence came most of the doctors conducting the research.

A sense of reluctance or even duplicity in African informants' responses to this line of research comes through in one of the first serious studies of MSM in African prisons. The discrepancy between what the men admitted about themselves (3.8% engaged in penile-anal sex while in prison) and what they estimated about their co-prisoners (nearly 60% felt many or almost all were involved in such sex) is so pronounced that it suggests a distorting effect in the question or questioners themselves.

That 3.8% bears an eerie similarity to the figures Van de Perre et al determined of their Rwandan informants who admitted to anything other than vaginal intercourse.

A possible analogy might be discerned in the Haitian experience around this same time. In the 1970s, Haiti had been a destination of choice for white U.S. and German gay sex tourists (who may in fact have introduced HIV to the island). When Haitians in New York were identified later the next year as one of the four so-called risk groups, researchers rushed to Haiti to find out why. The first comprehensive study done there indicated that 'bisexuality' was indeed the most important risk factor among AIDS patients, cited by 38-50% of the sick Haitian men surveyed up to 1983. The men themselves did not necessarily identify as homosexual or even bisexual but claimed to have engaged in sex with foreign tourists for the money not pleasure. Nevertheless, the government immediately responded by criminalising homosexual activity and making it punishable by six months in prison, plus six months so-called rehabilitation. Known or suspected foreign homosexual tourists were deported. Not unexpectedly, as social opprobrium of Haitian men who had sex with men grew, the number of Haitian AIDS patients...

who willingly admitted to such behaviour dropped precipitously. By the time the next systematic survey of risk behaviours took place in 1986, admitted ‘bisexuality’ had dropped from up to half to only 10% of all cases of HIV infection.67

Researchers in Africa unfortunately do not appear to have paid much attention to Haiti. Nor did they appear to reflect upon evidence coming out of the West and from white South Africans that indicated serious problems with the stability of the categories of homosexual, bisexual, and heterosexual. An urgent letter to the South African Medical Journal in 1988 was a breakthrough in that respect. It reported in almost panicky terms a case of an HIV-positive white gay man who made it his practice to seduce men who regarded themselves as heterosexual.68 The author of the letter did not identify the race of the young partners who ‘liked showing off their virility,’ leaving readers to assume that they were white as well. His key point, however, was that doctors and AIDS educators needed to be aware that a little alcohol, some flattery and some pornography seemed to be all that was needed to destabilise supposedly exclusive heterosexuality. This alert passed without subsequent comment let alone substantive follow-up research in the journal.

Also apparent in the early studies were fundamental misunderstandings around the meaning of the word ‘sex’. European, U.S. and white South African researchers overwhelmingly predominated the production of knowledge about HIV/AIDS in the early years and evidently brought to bear upon their research culturally specific assumptions about what exactly ‘sex’ was. Freud had been hugely influential in that regard with his notion of ‘polymorphous perversity,’ that is, the idea that humans experience sexuality in many ways, perhaps through all parts of the body irrespective of such details as penetration, orgasm or fertilisation.69 Scientists and public health officials who encountered the ‘gay plague’, as AIDS was often characterised when it first appeared in the U.S., confirmed the appropriateness of understanding sex in such a broad way. The range of combinations, partners and activities among gay men in San Francisco and New York that were revealed to wide audiences at that time made any other approach untenable, as indeed the World Health Organisation very quickly advocated.70 By contrast, we now know

67. FARMER, supra note 72.
69. WULF SACHS, BLACK HAMLET: THE MIND OF THE BLACK NEGRO REVEALED BY PSYCHOANALYSIS (1937) Among a truly vast scholarship on Freud’s theories about sexuality, Sachs is notable as one of the first serious attempts to apply them to an African subject, with mixed results.
70. SHELBY, supra note 45; WHO, supra note 2.
that this broad understanding of ‘sex’ was not historically widely shared in African cultures. An important article (in retrospect, that is, as it went virtually unnoticed at the time) that alerted HIV/ AIDS researchers to this disjunction was Anne-Marie Jeay’s deconstruction of Malian ways to connote what she as a European would unambiguously regard as sex acts (such as mutual masturbation and maybe more). These included equivalents of *reposer le corps* (relaxing the body), *se détendre* (loosen up), *bien-être* (well-being) and ‘massage’.71

Later studies from Lesotho and Tanzania similarly revealed a common understanding that sex was procreation-minded, penis-to-vagina penetration only. Other activities involving genitals and orgasm did not necessarily fall within that definition but had their own distinct terms or euphemisms.72 Cameroonian sociologist Charles Guobogou has also argued that traditional cultures in his country enabled widespread “pseudo-homosexuality” and “sex games,” including female-female masturbation. These took place as symbolic acts, rites or play without at all compromising the meaning of ‘sex’, which remained in the popular imagination as an act that took place between men and women leading to children.73 This would have made it possible for a man who had had penetrative anal sex or mutual masturbation with men to respond ‘No’ in all honesty when asked: Have you ever had sex with a male?

In the rush to pronounce homosexuality a non-issue, cautionary notes about such possible cross-cultural research problems were generally ignored. A letter published by doctors Nancy Padian and J. Pickering in the *Journal of American Medical Association*, for example, wondered if the rarity of Africans who admitted to bisexual or homosexual contacts “could be based in fact, but could also reflect cultural or methodological biases in the interviewing technique [. . .] low African ratios could be explained by a higher proportion of bisexual compared to homosexual men in Africa than in the United States.”74 As with Knobel’s worries about the instability of sexuality in self-identified heterosexual men, no response or rebuttal to Padian and Pickering’s point was ever published in this or any other of the major academic journals.

Keeping cultural dissonance in mind and recalling that Central Africa was heavily evangelised by the Roman Catholic Church which attached

71. Jeay, supra note 4, at 66.
huge moral stigma to homosexuality and bisexuality, it is almost amazing that some Africans actually did admit to behaviour in those terms. This makes the fact that they subsequently disappeared from the analysis all the more curious. In an article on African AIDS patients in Europe, 1981-85, for example, Jean Sonnet and H. Taclman noted that one out of 42 patients in their study admitted to 'homosexuality', that is, about 2.5% of the total. The WHO study noted above found even more. Out of 117 African patients in Europe who were tested in the first nine months of 1986, 5% were found to have contracted HIV through homosexual or bisexual transmission and a further 1% either that way or through intravenous drug injection. These figures are very low compared to the epidemic in Europe and the U.S. But they can more usefully be compared to what Alfred Kinsey found in U.S. men back in the pre-gay rights days (that is, 4% admitting to 'homosexuality' as a predominant orientation in the late 1940s).

It could be argued that this 5-6% of HIV positive Africans living in Europe had been corrupted and infected by homosexual Europeans. A possible exception to the use of the former colonial languages in interviews about sexual history, however, hints at something else. This reference appeared in the first substantive study of 'slim disease' to come out of Uganda (1985). Its findings were based in part upon interviews with fifteen Tanzanian traders who were suspected of having introduced HIV into the most heavily affected region of the country. As usual, the authors of the study did not think it important to identify or reflect upon the language they used in their interviews. In this case, however, we can safely surmise it was kiSwahili, the historical lingua franca of trade and cross-border traffic throughout much of east Africa. KiSwahili is also one of the few major African-languages that possess a vocabulary distinguishing individual types of sexual preference without necessarily suggesting an immoral agenda or exotic influence. That might explain why, if indeed, they were asked in kiSwahili, the traders 'admitted to both heterosexual and homosexual contacts.'

76. Quinn et al., supra note 38.
77. See KINSEY INSTITUTE FOR RESEARCH IN SEX, GENDER, AND REPRODUCTION, http://www.kinseyinstitute.org/ (last visited Sep. 22, 2013). Statistics on sexual practices, orientation, identity and more are closely followed by the Kinsey Institute for Research on Sex, Gender and Reproduction, upon which I have relied.
Serwadda et al. did not break down the fifteen interviews to determine how frequent and to what kind of homosexual contacts this admission referred. The more germane number from my perspective, however, is zero. That is, while the Serwadda et al. article was subsequently widely cited as a pioneering work of scholarship on the emerging pandemic, this particular clause of that particular sentence was not once reiterated or pursued by systematic research into hidden male-male sexual practices. A subsequent article purporting to synthesize research on the “social context” of HIV in Uganda pointedly does not mention it even to contest or to discredit the claim.80

How then did the tentative conclusion that homosexuality was insignificant so quickly solidify into taken-for-granted fact? To be blunt, the repetitive citation of a handful of crude investigations to the exclusion of contradictory evidence played a big role. Quinn, Mann, Curran and Piot were thus incorrect when they claimed that “multiple studies performed in Africa by both national and international experts in sexually transmitted diseases” had definitively ruled out the possibility of male-male transmission.81 In fact, the studies they cited typically referred only to each other’s assertions rather than to any original and culturally sensitive research on the topic. One of the very first descriptive articles of cases appearing among blacks in South Africa, for example, baldly stated that “homosexuality is not a factor.”82 This was not drawn from interviews with South African men or local studies. Rather, Sprackel et al supported their claim about black men in South Africa with a footnote to a single study of female prostitutes from Zaire. The authoritative proclamation of the heterosexual nature of ‘African AIDS’ in the South African Medical Journal83 offered the most commonplace references to Rwanda, Zaire and Uganda as proof, including Serwadda et al. (1985) whose data, as noted above, actually made a contradictory point about the existence of male-male sexuality.84

Quinn et al. provide one of the more sobering illustrations of that incestuous tendency. They back their statement that “African AIDS

80. Adeokun et al., Social Context of HIV Infection in Uganda, 5 (2) Health Transition Rev. Supplement 1-26 (1995); Hooper, supra note 37, at 347, is the only direct reference I have found to Serwadda et al. claim, although even he did not take it very seriously at the time. Dr. Wilson Carswell, by contrast, believed that MSM was taking place in boarding schools, seminars, prisons, and perhaps among long-distance truckers but “attempts to engage locally based social scientists (based in Makerere University) in AIDS research of any kind, let alone on MSM] were largely unsuccessful at that time.” (Communication dated Jan. 26th, 2007, on file with author).
81. Quinn et al., supra note 38.
83. J. Stelmuiden et al., supra note 58, at 456.
84. Serwadda et al., supra note 88.
patients rarely report a history of homosexual activity,” with three footnotes which all refer to works that draw largely upon the research of the co-authors themselves.\(^85\) One reference to co-author James W. Curran (an expert on the U.S. epidemic) is especially weak. The cited article by him refers to Africa in but a single sentence that asserts heterosexual transmission only. That claim is backed by a footnote citing Curran’s co-authors Piot and Mann plus the famous Van de Perre et al article on Kigali prostitutes.\(^86\) Besides the obvious huge difference between ‘rarely report’ and ‘actually do’, this is a remarkably empty substantiation.

This question cries out for some good oral history which I have not been able to do up to now. I did, however, interview Dr. Julie Dyer, the former Medical Officer of Health in what is today one of Africa’s most heavily infected cities (Pietermaritzburg, South Africa). Dr. Dyer got her introduction to the field in Uganda during the mid-80s. She was but one of many in an expanding cohort of medical professionals tackling the crisis and, as a woman, is not representative of the majority. However, her recollections about the learning process from the time seem to fit the pattern described so far:

_Marc Epprecht (ME):_ How did you come to understand that male-male transmission was not an issue among black people in Africa?

_Julie Dyer (JD):_ As a medical student in Liverpool most of our discussions focussed on Uganda and Kenya and the truck drivers/prostitutes culture as a vector of the disease. I had been in the region before, hitchhiking around. And I got a feel for that scene where the men just hung around and had prostitutes or girlfriends at every stop.

_ME: But did you know that there had been an article published in The Lancet in 1985 that referred to _traders_ in Uganda who admitted to both heterosexual and homosexual sex?_

_JD: I don’t remember that. Heterosexual transmission made a lot of sense, it was logical to assume. Why would men need to go with men or boys when there were so many women readily available?_

_ME: They say some people don’t necessarily differentiate that seriously._

_JD: Well, we never really even considered that possibility. And there was a difference in the type of the virus from what homosexuals were getting in the U.S., no.\(^87\)

\(^{85}\) Quinn et al., _supra_ note 38.


\(^{87}\) Julie Dyer, Medical Officer of Health for Pietermaritzburg/ Msunduzi (South Africa, 1994-
Compounding this accumulating logic was the problem of disciplinary blinkers. Among contributors to the major scientific journals, such blinkers appeared to rule out consulting non-scientists for backgrounds or historical and cultural contexts (such as the history of sexual health interventions and ethical abuses under colonial rule and apartheid discussed above). Most noticeable is the almost systematic tendency to overlook or ignore the pertinent ethnography. Indeed, it was not until September 1985, two years into the crisis, that any of the scientists noted above referred to the ethnography at all. Even in that case, the effort was clearly not to find out if there might be hidden practices or discourses around same-sex sexuality that complicated getting an honest answer to bald questions about male-male or anal sex. Rather, in citing an anthropologist, Van de Perre et al did so primarily to justify their methodologically unusual decision not to have controlled for marital status in their tests for HIV infection. That single anthropologist demonstrated to their satisfaction that all women of the ages in question in Central Africa were heterosexually active regardless of their marital status (hence no control group was needed).

Lack of interest in anthropological or historical research into sexuality in Rwanda enabled Van de Perre and subsequent researchers to take their patients’ (and their African collaborators’) claims of no homosexual or bisexual activity at face value. But had they at the very least read Jacques Maquet’s classic anthropological study of Rwanda, they would have had to have been more careful. Based on two years of field work carried out in 1949-51, Maquet found that: “Homosexuality was widespread among Tutsi and Hutu young men,” and “common” among Tutsi elites. Indeed, Rwanda’s king was removed from office by the Belgians in 1930 under allegation of homosexual immorality.

Beyond Rwanda, moreover, anthropologists, historians and other social scientists were by this time starting to reveal significant male-male sexual subcultures that existed side by side or were hidden within

88. Van de Perre et al., supra note 69.
90. Vangroenwegehe, supra note 37, at 446. One hesitates to trust one ethnographer but on this issue the same finding could be adduced from J.M.M. Van de Burg’s study of neighbouring (ethnically- and culturally-similar) Burundi (Van de Burg 1904, cited in Vangroenwegehe’s piece), which documents no less than seven different terms for ‘homosexuality’ or ‘hermaphrodite’. D. A. Feldman et al., Public Awareness of AIDS in Rwanda, 24 Soc. Sci. & Med. 97-100 (1987). It was also subsequently suggested in an overlooked (or harshly criticised) survey from 1987; See des Forges, supra note 70. The allegations against King Musinga are discussed in the des Forges piece.
the heterosexual norms. Tanner had broached the topic of prison sex in Uganda, for example, Hanry in Guinée high schools, and van Onselen (1976) in the industrial compounds around mines in colonial Zimbabwe. An open secret was starting to be outed to those who chose to listen. As Mathabane later reflected on his own experience: "Little did I know then that what I vowed to keep secret until I died was actually an everyday occurrence known to every adult in Alexandra." Every adult except, it seems, visiting epidemiologists.

Researchers in Central Africa meanwhile had little interest in what the premier English-language medical journal published in Africa had to say and understandably so. Indeed, the South African Medical Journal contributed almost nothing of relevance to the rest of the continent until the very end of the 1980s. For the first two years from its initial mention of the existence of the new disease (interestingly, in an editorial written in Afrikaans, not English), the journal characterised the disease as an almost exclusively white male homosexual phenomenon. Prior to 1985, it made almost exclusive reference only to studies from the United States and Europe. Travel to the United States was cited as a key risk factor in these early articles. On the surface, this appeared to be empirically justified, given that the first deaths attributed to AIDS closely matched the profile. However, the journal's lack of interest in Africa continued even after the first report of a possible case of a black South African man with AIDS. Ras et al (1984) made no mention of the emerging material from Central Africa about heterosexual transmission but continued to contextualise AIDS in South Africa with studies from the West. To be sure "black men and women in contact with carriers from Central Africa" were eventually identified as one of the risk groups in South Africa. But then nothing at all (!) was published on HIV and AIDS among black Africans in the journal in the next two years. As late as 1987, the South African Department of National Health and Population Development based its predictions entirely on the U.S. epidemiology, notwithstanding the presence in South Africa of hundreds of thousands of Africans from north of the Limpopo. This

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92. Mathabane, supra note 4, at 74.
95. Hayes et al., supra note 62 (referring to a case dating back to March 1982).
96. Isaac & Miller, supra note 59, at 329.
myopia allowed it to counsel a highly misleading complacency just as the epidemic began to transform. An editorial later that year for the first time used the term “African AIDS” in distinction to Western AIDS and warned that it could become a major public health disaster for the country. But it pointedly did not mention homosexuality or bisexuality as possible factors in its epidemiology among blacks. Rather, it deferred to the orthodoxy on this topic already established by reference to the single study from Zambia.

An element of self-censorship – conscious or unconscious – may have contributed to the gathering consensus. This can be traced back to an apparently unsuspected obstacle encountered in the initial research project: Africans’ memories of colonialism, and in particular of its punitive and paternalistic sexual health campaigns and associated rhetoric. Suspicions by African leaders of a Western conspiracy to dredge up old colonial slanders about ‘African sexuality’ were evident from the earliest days of the epidemic. Inflammatory, apocalyptic language in some Western media almost seemed intended to pull the rug out from under very fragile economies right across the continent, whether AIDS had been identified in a country or not. The fact that the very first learned conference on ‘AIDS in Africa’ was held in the capital city of one of the most reviled former colonial powers (Brussels, November 1985), and that more than nine out of ten of the participants at that conference were non-African probably did not help with these appearances. The impression created was that many of the delegates regarded Africa as a single country and that the history of racism or colonialism was not pertinent to the issue. Both assumptions were insulting if not infuriating views to African leaders that prompted a sharply defensive reaction.

That reaction did not at first explicitly extend to homophobic responses, which really only began in the early 1990s. Rather, the reaction manifested itself primarily in accusations of racism against

101. Hooper, supra note 37 is also valuable for his insights into the personalities (and competing egos) of the scientists involved.
Western researchers, in African officials’ denial or huge understatement of the looming crisis and in bureaucratic or police harassment and obstructionism towards the research. Wilson Carswell, co-author of several of the pioneering reports and articles on the Uganda epidemic, for example, was the target of an apparent death threat and deportation for his work. On the academic front, Chirimuuta and Chirimuuta (1987) delivered a withering polemic about racism in Western research and reporting about AIDS in Africa in language that read as a blanket condemnation of the whole project and as an appeal for Africans to resist Western scientists’ education and prevention advice.

Western researchers and activists faced a real dilemma in this context: to speak the truth as they saw it and to probe into painful and sometimes embarrassing matters or to calm the reaction by underplaying select controversial aspects of the disease. The absence of effective and cooperative government significantly exacerbated such dilemmas as it implied dependence upon civil society groups both to disseminate HIV prevention information and to get researchers into affected communities. Yet in the African countries most affected by HIV/AIDS in the mid-1980s, civil society scarcely existed beyond church, mosque and elders. Uganda had barely begun its recovery from the devastation of the dictatorship, invasion, economic collapse and civil war, the latter still very much alive in the north of the country. Rwanda and Burundi had brutal dictatorships with institutionalised links to the stridently homophobic Catholic church. Zaire was a ‘kleptocracy’ teetering on the verge of collapse while Kenya groaned under the deeply corrupt and ethnically divisive regime of Daniel Arap Moi. With the exception of Rwanda, all of these countries made homosexuality illegal, with punishments inherited from the colonial regimes extending up to fourteen years in prison in Kenya’s case. Popular sensitivities under such conditions could preclude frank interventions on HIV/AIDS in general, let alone on homosexuality. According to John Iliffe, even Nelson Mandela in South Africa felt compelled to retreat into silence from an attempted ‘bold’ discussion of HIV/AIDS in response to popular disapproval amongst his rural audiences in 1991.

It needs to be stressed here that this was also a time of great economic insecurity as various forms of African socialism and state-centred

105. Iliffe, supra note 37, at 67.
development came crashing down. They did so both under the weight of
their own internal contradictions and the not-so-gentle ministrations of
the World Bank, the International Monetary Fund, and other Western
donors. Beginning with Ghana in 1983 and culminating in Zimbabwe
in 1991, virtually all African states fell in line with the new neoliberal
mantra of structural adjustment, often with devastating impacts upon
health care, education, employment, and currency values.106

An insight into the kind of difficulties the political and economic
environment created for the conduct of research is provided by Dr. Dyer
in her interview with me. As the epidemic in South Africa moved into
the general population in the late 1980s, a virtual civil war prevailed in parts
of the country. Direct repression by the apartheid state constituted a big
part of this but violence was also intense between black supporters of
the main liberation groups (United Democratic Front, African National
Congress) and supporters of “tribal” movements like the Zulu-based
Inkatha. The political schism was reflected in social divides as well, with
the UDF and ANC strongest in the townships (where settled families
lived) and Inkatha strongest in the rural areas and the male-only hostels
(for migrant labourers). Dyer remembers the effect that the violence and
these schisms had on the free flow of ideas about public health in a place
that was popularly notorious for male-male sexuality:

We visited one of the big hostels in 1988 as part of our course learning
about hygiene and social conditions. Ten thousand men lived there in
bunk-beds. I suppose if it were England, we would have asked. But
here we never discussed the possibility or the risks of homosexual
transmission of HIV. We didn’t even consider it. Instead, the focus
was on female prostitutes who were either just outside the hostels or
sometimes right inside. There was very little control at the time. There
was so much lawlessness and violence that we actually feared to ask
sensitive questions, even afterwards in privacy to our teacher.107

In this fraught context, foreign researchers and donors were under
enormous pressure to enlist the leadership of strategic political allies
in Africa. Downplaying the most sensitive and seemingly tangential
issues was an obvious gambit. The Caldwell et al article may be seen in

106. Marc Epprecht, Investing in Amnesia, or, Fantasy and Forgetfulness in the World Bank
Approach to Health Care Reform in sub-Saharan Africa, 31 (3) J. Of DEVELOPING AREAS
337-356 (April 1997) offers a wide-ranging discussion of the scholarship on the impacts of
structural adjustment on African health care systems, with a critique of the World Bank’s own
highly selective scholarship on the issue.
107. Julie Dyer, Medical Officer of Health for Pietermaritzburg/Msunduzi (South Africa, 1994-
2005), Interview with Marc Epprecht in Pietermaritzburg, South Africa, June 19, 2006.
this light. Its primary goal was to fill the glaring gap of ethnographic context through a monumental survey of historical writings on sexuality in Africa. Rather than echo the often blatant racism of that early literature, however, the Caldewells and Quiggan brought to bear a sympathetic view toward Africans whose culture, they argued, had been grievously misrepresented by the earlier prudish and racist Europeans. Ironically, in doing so the authors entirely avoided the sensitive issue of same-sex sexuality. No doubt this won them respect and readers in important places but it also invited a generation of researchers not to bother double-checking what the ethnography actually had to say on this topic.

The first indisputable success in winning a major political ally to the anti-AIDS struggle was Yoweri Museveni who came to power in Uganda late in 1986. High officials in both the previous regime and in Museveni’s revolutionary government had amply made their displeasure known at supposedly racist Western researchers. Museveni himself, however, showed willingness to listen carefully to scientific opinion and eventually, in 1988, moved decisively to muster civil society in line with scientific advice. He was able to do that in part because his radical politics were balanced by a social conservatism that appealed to the Christian ministers and Muslim imams who comprised the backbone of Uganda’s attenuated civil society. Museveni’s social conservatism did not at the time extend to the public expression of homophobic sentiments which he only revealed in speeches in the late 1990s. But it is hard to imagine that Western researchers did not intuit his (and his powerful wife Janet’s) implicit homophobic streaks in their views on family and monogamy. Censoring themselves on the topic of same-sex sexuality, or making unduly strong claims about the non-existence of male-male sexual transmission in Africa, must have made a lot of sense in the effort to keep a critical African ally on board against those who would obstruct the research entirely.

There was, of course, a group of people who knew better and who might have spoken out against the gambit: out gay rights activists in South Africa. They did not and retrospective admissions of self-censorship are in fact starting to come forth to explain their strategic silence at that time. As noted earlier, HIV/AIDS first appeared in that country among gay

108. Caldwell et al., supra note 50.
109. Hooper, supra note 37; Putzel, supra note 100.
110. Dr. Carswell tacitly admitted as much in an email exchange with me. On Museveni’s political skills on the HIV file, see de Waal, supra note 10; Kapya, supra note 21 on the role of U.S. conservatives in Uganda.
white men. Its epidemiology seemed to conform to that of the U.S. and Western Europe and it met with much the same official callousness and homophobia. Indeed, as late as 1987 the South African director general of the Department of Health cynically suggested that his government had the interests of the African majority at heart by not supporting the gay community’s initiatives: “Homosexuality is not accepted by the majority of the population,” and homosexuals were hence invited to die if they chose to continue in their lifestyle.111

The instinct to keep a low profile in this context was encouraged by a tendency among LGBTI activists in the West to seize upon (or co-opt) ‘heterosexual African AIDS’, in their own struggles against homophobia and AIDS-phobia in the West. Heterosexual African AIDS, with loyal wives, schoolgirls, and infants in the role of principal victims of infection, made it hard to blame the disease on a despised sexual minority. The trope hence helped create political space in the West for mainstream leaders to commit to fight the disease.112 White South Africans, a deeply suspect group in the West by this time because of their association with apartheid, were hardly welcomed to disrupt such a useful narrative even had they been inclined to do so.113

That said, white gay rights activists did take their own initiatives to inform themselves of the disease and to organise education for prevention within their communities. As early as 1984, the Cape Town branch of the Gay Association of South Africa established an AIDS Action Group, the first HIV/AIDS association to be formed on the continent.114 But tensions around race within the South African gay scene frustrated efforts to bring non-whites into the movement. Black LGBTI and white activists who stressed anti-racism over anti-homophobia politics took their struggles elsewhere and actively sought to distance themselves from the existing white-dominated scene, including the anti-HIV initiatives. Jackie Achmat, one of the first black intellectuals to come out as gay and as HIV positive, suggests that this was at least partially a conscious decision. Downplaying their homosexuality helped to win them credibility first in the wider anti-apartheid struggle and then, post-1994, in the majority population affected by HIV/AIDS. Compared to the West, he notes how:

111. Jochelson, supra note 26, at 235.
113. See SEX AND POLITICS IN SOUTH AFRICA (Neville Hoad et. al. eds., 2005) on the racial politics of gay rights movements in relation to the global community in the mid-1980s.
114. Pegge, supra note 4.
In Southern Africa, the taboos were stronger, the economic and social power and influence of the LGBTI community weaker. And it was further weakened by the moral failure of the white lesbian and gay community, with very few exceptions to speak against apartheid and racism. So, when the HIV/AIDS epidemic hit our shores, we all scrambled against direct association with our LGBTI communities. We feared association with the racist LGBTI communities and we wanted to protect the broader LGBTI community from discrimination. We did not actively campaign for the direct needs of especially vulnerable communities — the gay community, sex workers, prisoners, women, children, substance users and so on. We dissociated HIV/AIDS from the LGBTI communities as sources of infection to reduce discrimination and danger [by African populist reaction] very effectively but we failed to identify our own real physical and social vulnerability.\textsuperscript{115}

V. CONCLUSION: A NEW PARADIGM EMERGES

By the late 1990s and early 2000s, the non-existence of homosexuality in Africa was so firmly entrenched in mainstream AIDS discourse that it did not require explanation. As Achmat describes, even black LGBTI activists focused their attention on the presumed heterosexual majority to the neglect of their own specific needs. And yet, even as heterosexual African AIDS was being asserted with such confidence, the dogma was already beginning to unravel. The successes of the gay rights movement in South Africa in the early 1990s and the subsequent emergence of smaller associations elsewhere in Africa first made African LGBTI visible. They also precipitated a flurry of demagogic attacks on gays and lesbians by African leaders. By so dramatically raising public debate and by so implausibly linking African LGBTI to Western gay imperialist conspiracies, these attacks stimulated new research into same-sex practices in Africa. They also stimulated interventions by or about African LGBTI in countries where public discussion of the issue had hitherto been almost non-existent.\textsuperscript{116} At the same time, a whole generation of orphans and the impacts of prolonged, wrenching structural adjustment programmes made pre-existing problems of high risk sex clearer than they had been in the mid-1980s: street children, sex work/tourism, a crisis of overcrowding and underfunding in the prison system and pervasive masculine unemployment and alienation.\textsuperscript{117}

\textsuperscript{115} Zackie Achmat (Personal Communication dated 3 August, 2006, on file with author).
\textsuperscript{116} Niels Teunis, *Homosexuality in Dakar: Is the Bed the Heart of a Sexual Subculture?*, 1 (2) J. of Gay, Lesbian & Bisexual Identity 153-169 (1996); P. Brooks & L. Bocafut (dirs.), *Woum Cheri* (1998) for example, from Senegal and Ivory Coast, respectively.
\textsuperscript{117} Becker et al., *supra* note 9; Margrethe Silberschmidt, *AIDS, Sexuality and Gender in Africa*.
These developments coincided with pharmaceutical triumphs such as the discovery of anti-retroviral therapy, and education campaigns in the West that by the late 1990s had succeeded in containing or turning back HIV/AIDS prevalence among homosexual and bisexual men. Indeed gay rights activists riding in part on the strength of their victories in the struggle against HIV/AIDS scored enormous legal, political and social victories in the West, including the right to marry, to receive child custody and to hold high political office. While homophobia remains a significant issue to HIV/AIDS activists in the West, by the 1990s it was no longer a central or dominating concern compared to harm reduction for intravenous drug users and systemic racism against marginalised communities where HIV has become increasingly concentrated. The political value of ‘heterosexual African AIDS’ to Western activists fairly quickly diminished as a result. The hesitancy to raise the profile of sexual minorities in Africa diminished along with it and a new generation of researchers stepped forward to tackle ‘taboo’ sexual topics. Ranjani and Kudrat, notably, were first to document the existence of kanyenga or ‘comfort sex’ among male street children in the central Tanzania city of Mwanza.\footnote{Rakesh Ranjani & Mustafa Kudrat, The Varieties of Sexual Experience of the Street Children of Muanza, Tanzania, in Learning About Sexuality: A Practical Beginning 301-323 (Sondra Zeidenstein & Kirsten Moore eds., 1996).} In a follow up study, Chris Lockhart found that because the boys regarded self-masturbation as a sign of “real homosexuality” (to be despised), kanyenga (including penetrative anal sex) was their preferred means to perform heterosexual normalcy to their peers. Since 100% of the boys subsequently moved from predominantly kanyenga activities to heterosexual relations with girlfriends, kanyenga represented “a critical bridge for the transmission of HIV/AIDS between the general population and the population of street boys.”\footnote{Lockhart, supra note 14, at 307.}

Research has also begun to trickle in from West Africa. A team based out of the University of Dakar produced a report that identified a significant subculture of MSM at high risk of both homophobic intolerance/violence and of infection by HIV and other sexually transmitted diseases.\footnote{Chellah Ibrahim Niang et al., ‘It’s Raining Stones’: Stigma, Violence, and HIV Vulnerability Among Men Who Have Sex With Men in Dakar, Senegal, 5 (6) CULTURE, HEALTH & SEXUALITY 499-512 (2003).} In another study, Dr. Dela Attipoe of the National AIDS/STI Control Programme, Accra, found that Ghanian youth were actively being drawn into MSM activities, in part because of the belief

Collective Strategies and Struggles in Tanzania and Zambia, 56 SOC. SCI. & MED. 425-427 (2003) offers an insightful examination of the link between masculine disempowerment and AIDS.
that anal sex is safer than vaginal sex. While HIV transmission was not necessarily clearly demonstrated in the male-male sex, other sexually transmitted infections were, with big implications for the women with whom they also slept. Indeed, nearly half the informants identified as bisexual but even those who considered themselves gay often had girlfriends to conceal their secret. As one informant put it: "I like to have both vaginal and anal sex because two ways are better than one and people will not suspect what is going on."¹²¹

By now, the floodgates have opened and huge quantitative surveys, sensitive ethnographic work and oral histories have begun to come out of countries and urban townships where non-normative sexuality is highly stigmatised: Nigeria, Cameroon, Mali, Gambia, Ethiopia, Uganda and more.¹²² Moreover, whereas Europeans and North Americans had significantly predominated as researchers in this field, young African scholars are now taking the lead. Such studies have not yet demolished the orthodoxy of 'No homosexuality in Africa', nor do they assert homosexuality as a major factor in the epidemiology of HIV/AIDS. Nonetheless, they demonstrate that research into hidden same-sex practices both can be done and that Africans are among those who understand the need, and possess the skills, to do it.

Such research has been markedly slow in coming compared to other regions of the world. As we have seen, many factors have contributed to that tardiness and the unscientific over-eagerness of scientists to accept each other's naive enquiry and uncritical repetition of 'heterosexual African AIDS' as a definitive fact. We can be generous about this. Above all, it was empirically correct that African women were at higher risk of HIV through heterosexual transmission than anywhere else in the world yet encountered. With the need to move urgently to address that fact in the face of desperate shortages of resources, it made sense not to overspend energy on what probably looked like a research dead-end


or minor footnote. Issues that today seem obvious and critical, such as street children or the collapse of funding for public institutions like prisons, were not yet imaginable on the scale that was to come. Cutting short methodologically difficult enquiry into same-sex sexuality can be understood in part as a kind of research triage in a situation of grave danger for the heterosexual majority. For African LGBTI, the risks of adding the terrible stigma of AIDS to existing homophobias against them amply warranted keeping heads down and, in many cases, fooling themselves that their hidden sexual lives were ‘not really’ sexual.

Clearly this ‘cultural intimacy’ among a diverse group of scientists, political, religious and other leaders and LGBTI activists both in Africa and the West is no longer defensible and indeed it is almost certainly contributing to the present sexual health crisis where it persists. The shared desire by diverse authors and informants to enable a politically expedient untruth (no homosexuality in Africa) can no longer be sustained in the face of accumulating evidence to the contrary. If the World Bank can now attach costs to it in dollar terms, then you know it is time to act.123 In acting, however, whether to develop sexual health education and HIV/ AIDS prevention and treatment, address human rights violations or encourage development in line with conventional economic theory, we need to be aware of the history of the debates that came before. The role of science in side-stepping debate by silencing knowledge about same-sex sexuality in Africa during a formative period of HIV/ AIDS policies is an important piece of the puzzle. If a truly comprehensive approach to fighting HIV/ AIDS is to be achieved, then we need to acknowledge the full range of human sexuality and how this relates to broader transformations in the political economy in explicit terms and to learn from how and why so much of that knowledge became submerged in the early research process.

123. Beyrer et al., supra note 2.