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Not So 'Gay' After All - Constructing (Homo)sexuality in AIDS Research in the South African Medical Journal, 1980-1990

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Not So 'Gay' After All – Constructing (Homo)sexuality in AIDS Research in the *South African Medical Journal*, 1980–1990[1]

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Abstract

Throughout the 1980s, the medical narrative of AIDS was linked to sexuality – specifically homosexuality. The first article in the *South African Medical Journal (SAMJ)* to report on a rise in immune deficiency related deaths was titled 'Immuniteitstekort en Homoseksualiteit' (Immune Deficiency and Homosexuality). The sexuality represented in the 'objective' scientific/ medical journal that the *SAMJ* claimed to be, referred to a constructed white, male homosexuality that was commonly contrasted to a constructed white, male heterosexuality (an absent referent) imbued and influenced by the conservative racial, moral, and gendered discourses of apartheid South Africa. In the 'public' forum of the *SAMJ*, some medical practitioners created a stereotype of 'male homosexuality', represented it as 'abnormal' and 'promiscuous', and constructed 'the homosexual' as an (unscientific) research category. The resultant discourse around AIDS categorised it primarily as a syndrome of the 'deviant few', rather than a shared public health problem. Examining the discourse around homosexuality allows a glimpse into the inherently subjective nature of scientific research. It also reveals the concerns, interests and beliefs of a specific group of medical professionals creating 'scientific facts', and divulges as much about constructions of 'white', male 'heterosexuality' as it does about 'white' male 'homosexuality'.

Keywords: South Africa; AIDS; HIV; sexuality; homosexuality; scientific bias; social history medicine

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Introduction

Before HIV had been identified, or AIDS formally named, the *South African Medical Journal* (*SAMJ*) informed the medical professionals that make up its readership of a number of deaths that had occurred in the USA and UK which were specifically linked to immune deficiencies.[2] The *Journal* revealed that virulent forms of usually treatable illnesses were proving fatal, predominantly, but not exclusively, among homosexual men.

Reporting on cases well beyond the African continent, the article began the process of unscientifically equating AIDS with male homosexuality and 'black Africa'.[3] Over the following decade, and beyond, in the pages of a self-styled 'apolitical' medical journal interested in the transmission of 'objective' scientific information, unnecessary and unscientific distinctions were drawn between both illnesses, and the people who experienced them.

In a society where the activities of most professionals involved in medical research very rarely addressed the commonalities of the human condition, an entirely predictable discourse emerged around AIDS. This discourse categorised it as a syndrome of the 'deviant few', rather than the 'normal majority', and therefore not a shared problem that needed to be addressed for the 'common good'.

At the start of an epidemic spread predominantly via sex, it was not male sexual activity in South Africa that was investigated to determine the relationship between men, sex and AIDS, it was 'homosexuality' and homosexual activities. As a result, research in AIDS in South Africa, as in the United States and United Kingdom, was clouded and coloured by conscious and unconscious assumptions about, and views of, sexuality, sexual activity and sexual orientation. Concomitant assumptions about 'race' and gender fed into, and off, these assumptions and had a direct impact on the creation of knowledge about AIDS that would move beyond the printed text and impact on people's lives and deaths. While a substantial body of literature exists to show this in relation to the UK and US, in South Africa, Louis Grundlingh has begun research into this field.[4]

Grundlingh has demonstrated that varying degrees of homophobia prevailed within the South African state, among most churches, sectors of the general population and medical professionals.[5]

2. Editorial, 'Immuniteitstekort en homoseksualiteit' (Immune Deficiency and Homosexuality) *SAMJ*, 61, 9 (27 February 1982), 298 (my translation of title).
3. *Ibid.*
4. For Grundlingh's work see L. Grundlingh, 'The Nature and Development of HIV/AIDS Historiography', *Acta Academica*, 29, 2 (1997), 1–26; 'Early Attitudes and Responses to HIV/AIDS in South Africa as Reflected in Newspapers, 1983–1988', *Journal for Contemporary History*, 26, 1 (June 2001), 86–103; 'Government Response to HIV/AIDS in South Africa as Reported in the Media, 1983–1994', *South African Historical Journal*, 45 (2001), 124–53; and 'Neither Health nor Education? An Historical Analysis of HIV/AIDS Education in South Africa, 1980s–1990s' (Unpublished paper, RAU Sociology seminar, 24 May 2002). For work on the USA and UK, refer to texts listed in Grundlingh's 'Government Response', 124 and P. Aggleton and H. Homan, eds, *Social Aspects of AIDS* (New York: Falmer Press, 1988); C. Chirimuuta and R. Chirimuuta, *AIDS, Africa and Racism* (London: Free Association Books, 1989); M. Cochrane, *When AIDS Began: San Francisco and the Making of an Epidemic* (New York and London: Routledge, 2004); C. Guest, 'AIDS and its Metaphors', *Social Science and Medicine*, 29, 11 (1989), 1305–6; S. Sontag, *Illness as Metaphor: AIDS and its Metaphors* (London: Penguin, 1991); E. Stillwaggon, 'Racial Metaphors: Interpreting Sex and AIDS in Africa?', *Development and Change*, 34, 5 (November 2003), 809–32; and P. Treichler, *How to have Theory in an Epidemic – Cultural Chronicles of AIDS* (Durham: Duke University Press, 1999).
5. L. Grundlingh, 'Government Response'.

This article supplements these findings by providing examples from the *SAMJ* which show the conservatism of a number of contributors to the *Journal* and, by virtue of what is allowed to be published, the *SAMJ* editorial board and by extension the Medical Association of South Africa (*MASA*).

The examples used show a range of responses that extend from outright homophobia in the worst cases, to heteronormativity in the least offensive cases, with the odd dissenting voice that attempts to reformulate the hegemonic narratives about (homo)sexuality and AIDS. Whether in the sub-text of the research articles on AIDS, or the more direct dialogue of professional correspondence, the *SAMJ* provides examples of non-scientific assumptions and associations about sexuality, particularly 'homosexuality'. These result in non-scientific creations of 'homosexuals' and 'homosexuality', constructed in contrast to subjective creations of 'heterosexuals' and 'heterosexuality'.

Not so 'Gay' in the *SAMJ* : Representations of Homosexuality

The *South African Medical Journal* / *Suid-Afrikaanse Mediese Tydskrif* is the official journal of the Medical Association of South Africa (MASA) a professional, state recognised, independent body representing a variety of medical professionals, mostly general practitioners, specialists and surgeons.[6] MASA worked with the apartheid government, representing the needs of its members on issues such as medical tariffs, medical aid schemes and laws relating to the dispensing of medicine. It provided benefits and services to its members ranging from insurance policies to the management of a benevolent fund.[7] Internationally, MASA's role and reputation in South Africa was under scrutiny and the cause of much debate, nonetheless MASA hosted the World Medical Assembly in Cape Town in 1985.[8]

In 1984, Dr G.B. Batchelor, a member of the MASA Public Relations Committee, released a statement in the *SAMJ* on 'The MASA and politics',[9] in which MASA's perception of its role and place is presented in what could best be described as 'liberal' terms. Despite the significant influence of politics and the location of the MASA in a specific political context in apartheid South Africa, Batchelor affirmed MASA's 'neutrality' and commitment to working within the existing structures. He noted that:

6. Groups affiliated to MASA range from the Academic Medical Staff Association to the Urological and Vascular Associations.
7. For detailed information on the workings of the MASA executive and smaller committees, see 'MASA Bulletin' and 'News from Congress' sections, and 'MASA Annual Reports' in the *South African Medical Journal*, specifically volumes 61–78, 1980–1990.
8. MASA resigned from the World Medical Association (WMA) in 1976 and despite formal affiliation to the British Medical Association (BMA) since 1946, MASA's request for readmission to WMA was formally opposed by the BMA. MASA was re-admitted to the WMA in 1981 despite BMA's opposition. In response to those who called for a boycott of the 1985 World Medical Assembly, MASA commented that those who called for the boycott or cancellation were merely … 'concerned that their malicious misrepresentations [of the state of health care in apartheid South Africa] will be exposed.' See MVSA/MASA Bulletin, 'Call for Ban on WMA Assembly Unjustified', *SAMJ*, 67, 6 (9 February 1985), 195.
9. G.B. Batchelor, 'The MASA and Politics', News from the Secretariat, *SAMJ*, 65, 18 (5 May 1984), 743.

> …the Medical Association of South Africa, the recognised authority representing South African doctors, has remained a non-political and autonomous body and will do everything to preserve this autonomy. Just as medicine should not be used to reject or support political ideals or policies, so politicians should not use medicine to further political ends or objectives.
>
> In a difficult sociological environment, the standard of medicine in the RSA remains high and is comparable to the standards prevailing in most western countries. In cases where government legislation may run contrary to the continuation of the best possible medical practice or health-care delivery, the MASA will invariably draw attention to this, be it via the Department of Health and Welfare, the South African Medical and Dental Council, or any other authority concerned.[10]

The *SAMJ* reflected this conservative 'liberal' stance in relation to its discussions about HIV and AIDS, although dissenting and opposing voices did find their way into the journal.

The *SAMJ* editorial that informed its readership about deaths in the US and UK specifically linked to immune deficiencies was published on 27 February 1982 and was entitled 'Immuniteitstekort en Homoseksualiteit' (Immune Deficiency and Homosexuality).[11] Despite references to heterosexuals, who had also died, the article opened with a patronising and distasteful word-play on being 'gay'. The author noted:

> The male homosexual community is often referred to as 'gay', but increasing medical evidence has brought to light that this part of the community is being exposed to dangers that can hardly be reconciled with this unlucky hallmark. In some instances it is not clear why male homosexuals are being so affected (lesbians appear not to be involved).[12]

In the article, readers were informed of 'unusual' occurrences of particularly virulent cases of Kaposi's sarcoma (KS), cases of *Pneumocystis carinii* pneumonia (PCP), and infections related to cytomegalovirus (CMV) that had proved fatal in four separate case studies in New York, Los Angeles and an undisclosed area. The summarised case studies presented to *SAMJ* readers were originally published in 1981 in leading medical journals from the UK and the US, namely the *Lancet* and the *New England Journal of Medicine*, respectively.[13]

While the majority of the fatalities reported were amongst homosexual men, heterosexual men were also dying.[14] Despite the fact that all the men were dying of illnesses that could be fatal to any member of the public, in both the case studies and in their re-telling in the *Journal,* analysis almost exclusively focused on fatalities among homosexuals.

In a discussion about KS, the author reminded *SAMJ* readers that in 'Europe and North America' KS was fairly rare, mostly harmless, and usually affected older adults. This was in

10. *Ibid*.
11. Editorial, 'Immuniteitstekort en Homoseksualiteit', 298.
12. *Ibid*. (Translated from the original Afrikaans).
13. According to the *SAMJ* article the four case studies were authored by Hymes *et al.*, Gottlieb *et al.*, Masur *et al.*, and Siegal *et al*. Hymes' case study involved eight homosexual men examined in New York. Gottlieb's study was Los Angeles based, and referred to four homosexual men. In a footnote to the Gottlieb study reference was made to six other men, four homosexual and two heterosexual. Masur's study (again in New York) referred to 11 men, six of whom were homosexual and five heterosexual. The location of Siegal's study is not specified, but was based on four homosexual men.
14. Refers to Masur's study (see previous footnote). Despite five of the 11 men being heterosexual, the six homosexual men appeared to have become the focus of the study (without any explanation).

stark contrast to the KS found in 'Black Africa' ('Swart Afrika'), particularly Uganda, which was more prevalent, occurred among younger adults, and was more lethal.[15] Later in the same edition of the *SAMJ*, an article that investigated three rare cases of KS in children referred to the high prevalence of KS among men and womyn[16] in Uganda.[17]

Rather than consider what could link fatal cases of KS in Uganda, with fatal cases of KS among people in 'Europe and North America', the *SAMJ* author focused on the sexuality of *some* of the 'European and North American' men. The article did not construct a common humanity between people who had died of KS, it drew attention to their differences. The unnecessary focus on sexuality evident in this first article about an unknown new syndrome was to be repeated in the *SAMJ* throughout the decade.

The article went on to inform readers that the USA's Center for Disease Control (CDC) was investigating 160 cases of a 'new' syndrome amongst homosexual men.[18] Despite earlier references to heterosexual deaths associated with the syndrome, the article gave no indication of how many heterosexual cases the CDC were investigating. Both the CDC and the *SAMJ* aligned the unknown, unnamed syndrome to homosexual men.

The author warned that as 'we in South Africa also have a relatively large "gay" population and a number of drug abusers[19] in our cities, it gives us more than enough reason to take the American lesson to heart and be continually on the look out for such cases'.[20] In order to identify 'such cases' the article encouraged doctors to be on the look out for any male homosexuals and/or drug users with specified symptoms, instructed doctors to undertake detailed examinations, and advised them to provide definitive treatment to prevent death.[21]

In one paragraph, the article suggested that any male homosexual was potentially infected, and twice linked the new illness to homosexuals and drug abusers. These associations overlooked the heterosexual deaths that occurred, and incorporated drug abuse and drug users into the syndrome

15. Editorial, 'Immuniteitstekort en Homoseksualiteit', 298.
16. The author asserts her preference for the spelling of 'womyn' with a 'y' as an ideological and political action marking the importance of language and feminisms in research. In this article, after engagement with the reviewer's comments, the conventional spelling of women/woman has only been used when quoting directly. The long history of attempting to categorise 'women' and construct them stereotypically as part of a subordinated 'group' (similar to some of the stereotypical constructions of 'men' discussed in this paper), makes efforts to subvert and challenge these construction important. The use of 'womyn' within this text is an effort to allude to these constructions visually and then subvert them.
17. P.J. Farrant, 'Kaposi Sarcoma in Childhood – A Report of 3 Cases', *SAMJ*, 61, 17 (24 April 1982), 636–637. The article provides information on three rare cases of KS affecting 'black' children aged under four years. It opens by noting that 'Kaposi's sarcoma is a common neoplasm in Black males south of the Sahara and is most prevalent in equatorial Africa. In Uganda it accounts for up to 9% of all malignant lesions in males and for 0.6% of those in females'.
18. For a critical account of early reporting, collating and analysis of information from cohort studies see Cochrane, *When AIDS Began*.
19. In the summaries of the case reports, drug abuse is only mentioned in Masur *et al*.'s article and relates to seven men from a group of 11. Only two of the group were both drug users and homosexual. There are no references that indicate how large these two communities (gay men and drug users) were. See Editorial, 'Immuniteitstekort en Homoseksualiteit', 298.
20. *Ibid.*
21. *Ibid*.

despite drug use only being associated with two people from one of the four studies described in the article.[22] The article concluded by expressing the hope that prophylactic measures against this 'syndrome', with its high morbidity and mortality rates, would be implemented, and issued a precautionary warning about its potential impact in South Africa.

In January 1983, the *SAMJ* lauded their capacity for fortune telling (a highly unscientific activity) by reporting on the 'first' two AIDS deaths in the country. An editorial in the *Journal* naming the newly-designated Acquired Immunodeficiency Syndrome observed, '… we prophesied that the apparently new syndrome mainly affecting male homosexuals in New York and Los Angeles … would sooner or later appear in South Africa. This prophecy has now been fulfilled'.[23] The unfortunate nomenclature of 'gay' would apparently no longer be applicable to the South African white, homosexual community either.

In describing the 'first' two people to die of AIDS in South Africa, their 'race' and biological sex were the first categories applied to them. Readers were informed: '[T]he deaths of 2 White men … apparently from AIDS, have received widespread publicity in the media and provoked a somewhat *hysterical* reaction among those sections of the community most at risk, the male homosexuals and the drug abusers'.[24]

These '2 White men' were automatically associated with homosexuals and drug abusers, although no evidence was presented to indicate that they were either. In addition, male homosexuals and drug addicts become associated with that medicalised 'feminine' trait of hysteria. No indication of what constituted a 'hysterical' reaction was provided, but the unspoken assumption is clear – heterosexual, white male, non-drug abusers would obviously not be hysterical.

The editorial goes on to explain two key points about the new syndrome: that 'AIDS is not a specific diagnosis but a convenient term for a syndrome of unknown origin manifesting itself in a variety of ways'; and that 'although the overwhelming majority of cases have been in male homosexuals a few cases have been reported in heterosexual men, women, persons of Haitian origin and haemophiliacs', and 'has been found in all race (sic) groups'.[25] In short, the illnesses associated with the syndrome appeared amongst all people, but in differing proportions. It affected people regardless of their sex, sexual orientation, or 'race' – but it was still necessary to divide and label those who were infected.[26] The patients were labelled by two (arguably) 'objective' medical or scientific markers (biological sex, and haemophilia) and three subjective

22. *Ibid*.
23. Editorial, 'Acquired Immunodeficiency Syndrome (AIDS)', *SAMJ*, 63, 4 (22 January 1983) 97–8.
24. *Ibid*. (italics mine).
25. *Ibid.*
26. The number of cases, calculations of cases, and specificity of the number of infections or deaths that need to occur for an illness to warrant classification and monitoring is a discussion that is beyond the scope of this article but does require further research. Research is also needed into the effects of variable readings of statistics and its impact on the AIDS discourse. Using the statistics above as an example, the emphasis of the discussion can be shifted. The article later mentions that 95% of all patients were males and 75% of these males were either homosexual or bisexual. Much like labels that pronounce products 95% fat-free, a shift of emphasis reveals the unspoken assumption – there is still 5% fat. In this instance, 25% of the male patients were heterosexual, 5% of the patients were female (and presumably heterosexual as they are not classified as male homosexuals or bisexuals). Therefore, 100% of the womyn infected were heterosexual, and 25% of the men infected were heterosexuals, so in total approximately 29% of the total number of patients were heterosexual.

markers – sexual orientation, one specific place of origin ('black' Haiti – not the 'white' US where most of the patients originated), and 'race'.

From the outset, a 'convenient term' for a syndrome whose 'aetiology … (was) unknown' and had 'non-specific' symptoms[27]was specifically linked to 'high-risk' groups,[28] particularly homosexuals and, 'black' people, starting with Haitians. The terminology of clearly defined 'high-risk' groups was one mirrored in government discourse about AIDS and created a measure against which 'low-risk' groups (notable by their absence) could judge themselves and their lifestyles.[29]

The editorial urged general practitioners 'to be on the alert for further cases' by searching for 'pointers' and 'clues' from a 'well-taken history'.[30] GPs were to ascertain if 'the patient belong(ed) to any of the at-risk groups?'; and if *he* fulfilled any other criteria in terms of travel to New York, San Francisco or Los Angeles; receiving blood transfusions; drug use or abuse; and 'what…*his* pattern of sexual behaviour is'.[31] While the use of a gender specific pronoun may have been unintentional, it helped to cement the association of AIDS with men.

Subsequent articles continued to reinforce the primary association of AIDS with homosexual men. The notion of high-risk groups was continually repeated in the literature about AIDS, and later HIV. From the first article in the *SAMJ*, AIDS was associated with homosexuals and drug abusers, but other high-risk groups quickly emerged, such as Haitians and haemophiliacs. Haemophiliacs were usually presented as the 'innocent victims', while the 'dangerous' trinity of 'queers', 'blacks' and 'druggies' was reinforced by repetition, and not necessarily research, in the medical literature.

The categories of sexual orientation and 'race' retained their primacy as research categories throughout the decade. In addition, homosexuality was subtly cast as 'abnormal' or 'deviant' compared to non-deviant, 'normal' heterosexuality. Thus, articles include comments such as: 'it now appears as if the AIDS agent, besides the fact that it can be transmitted through homosexual

27. Editorial, 'Acquired Immunodeficiency Syndrome', 97–8.
28. Over time the nomenclature 'high-risk groups' was replaced with the more appropriate 'high-risk behaviours'.
29. The litany of 'high risk' or 'defined' groups becomes almost obligatory in any article about AIDS. While homosexuals, Haitians, drug abusers, and haemophiliacs were the first 'groups' to be globally defined, there are some variations (See for example Editorial, 'VIGS (AIDS) – 2 Jaar Later', *SAMJ*, 64, 28 (31 December 1983), 1080, where the AIDS update refers to 'Haitians in the USA as well as in Haiti [most of them not homosexual or drug users], prisoners, infants in high-risk households, and female sexual companions of men with AIDS). In South Africa, the first cases of infection in intravenous drug users occurred relatively late (see D.S. de Miranda, R. Sher, J. Metz, D. Sifris, S.F. Lyons and B.D. Schoub, 'Lack of Evidence of HIV Infection in Drug Abusers at Present', *SAMJ*, 70, 12 (6 December 1986), 776–7; and D.J. Martin and B.D. Schoub, 'Entry of HIV-Infection into the Intravenous Drug Abusing Population', *SAMJ*, 75, 7 (1 April 1989), 349); but 'drug abusers/users' still appeared as an ongoing category. Similarly, concerns with 'Haitians' were repeated in South Africa, but also transformed into concerns about migrant labourers, the undefined 'central Africa', or more specifically people from Uganda, Zaïre, Rwanda and Burundi. When AIDS appeared in the heterosexual population in South Africa it became particularly associated with 'black' men and womyn, and increasingly 'promiscuous' womyn like prostitutes, or womyn who attended STI clinics, and then pregnant womyn. On prostitution see Editorials, 'Prostitution and AIDS', *SAMJ*, 69, 1 (4 January 1986), 5; and 'Prostitution and AIDS', *SAMJ*, 71, 5 (7 March 1987), xviii.
30. Editorial, 'Acquired Immunodeficiency Syndrome', 97–8.
31. *Ibid.* (italics mine).

contact … can also be transmitted through *normal* heterosexual intercourse'.[32] The obvious questions that arise from here are: what types of homosexual and heterosexual contact was being referred to, and why is heterosexual intercourse 'normal'?

In this understanding of sex and sexuality, 'normal' heterosexual intercourse can be read as 'penetrative' sex involving the insertion of the penis into the vagina, and 'homosexual contact' becomes shorthand for 'anal receptive' sex. Apart from the heteronormative nature of the above comment, it also reveals a series of unconscious assumptions. It presupposes that all sexual activity required some sort of penetration to constitute sex; that no heterosexuals had anal sex; and that all male homosexuals did.

In this way, representative stereotypes were applied to sexual activity that were not based on specificities, and did not allow for any individuality or complexities. The statement presumes that all (male) heterosexuals and all (male) homosexuals can be lumped together and will act in entirely predictable ways; it takes male heterosexuality as the norm against which all other sexuality is measured and it completely excludes bisexuals (in another article the term 'so-called bisexual white males'[33] is used). It also precludes sexual activity between men who may not have self-defined as homosexual or bisexual.

Other examples of the association of homosexuality with 'deviance' include references to male homosexuals as 'adults with aberrant lifestyles',[34] the aforementioned association of homosexuality with drug use,[35] and the equating of homosexuality with 'promiscuity'. Promiscuity in the *SAMJ* remains, for the most part, a particularly unclear and undefined concept considering the medium is one dedicated to the rigours and specificities of medical science.

In one article, there are multiple references to promiscuity in association with homosexuality without either a definition of promiscuity, or any acknowledgement that heterosexuals could be 'promiscuous'. The article notes: '[I]t [the unknown primary cause of AIDS] may be a novel sexually transmitted immunosuppressive agent (possibly a virus) or alternatively a promiscuity-related phenomenon due to repeated infection with sexually transmitted agents … The extent of the immunosuppression was related to the degree of promiscuity … The severity of the immunological abnormalities is related to the degree of promiscuity … Homosexual men are known to have an increased incidence of several sexually transmitted diseases. The immunosuppression observed may therefore be cumulative and promiscuity related, arising over a number of years'.[36] The unspoken assumption inherent in this association is that all homosexuals are promiscuous and that all heterosexuals are not.

In another piece, reporting on Gallo's and Barre-Sinoussi's discovery of the HTLV-III and LAV retroviruses respectively, a number of suppositions are expressed.[37] Noting that the

32. Editorial, 'Meer oor VIGS', *SAMJ*, 64, 4 (23 July 1983), 114–15 (translation and italics mine).
33. SAMJ News, 'AIDS and the RSA', *SAMJ*, 71, 12 (20 June 1987), xxi.
34. News and Comment, 'AIDS in Children', *SAMJ*, 65, 15 (14 April 1984), 587.
35. See R. Anderson, O.W. Prozesky, H.A. Eftychic, M.F. van der Merwe, C. Swanevelder and I.W. Simson, 'Immunological Abnormalities in South African Homosexual Men', *SAMJ*, 64, 4 (23 July 1983), 119–22 which includes the quote: 'It is unlikely that in this study the results were influenced by the use of "recreational" drugs, such as marijuana, cocaine, and amyl and butyl nitrite, commonly used by homosexuals', 121.
36. *Ibid*., 119–22.
37. 'Retrovirus and AIDS', *SAMJ*, 66, 2 (14 July 1984), 42. R. Gallo and F. Barre-Sinoussi both claimed to have found the causative agent of AIDS, namely a retrovirus identified as human T-cell leukamia virus-III (HTLV-III) and lymphadenopathy-associated virus (LAV). The causative agent was later named human immunodeficiency virus (HIV).

distribution of AIDS among 'homosexuals, heroin addicts, and haemophiliacs' could indicate an agent that could be transmitted by blood or intimate contact, the author concludes that the 'agent would have to be of low infectivity since the disease is still uncommon *even* in the homosexual community'.[38] Suggesting a cautious approach to the new findings, the author warns that 'the virus could be just another fellow-traveller in a population notorious for acquiring an abnormal number of viral infections'.[39] Without any credible evidence at all to support the assertions made, the author linked homosexuals to 'promiscuity' and illness in much the same way as ideas about the 'diseased native' and the 'black threat' linked black people to illness, danger and hyper-sexuality.

A letter from medical professionals in the US published in the *Journal* in 1985 reinforced the link between homosexuals and promiscuity by referring to '… recent studies in promiscuous male homosexuals with AIDS',[40] and citing an article where promiscuity featured in the title.[41] In these instances, the 'promiscuity' of one group of people in a study was applied exclusively to all other homosexuals – but not to any heterosexuals.

While the US medical professionals' contribution to the discussion in regard to single versus multi-factoral agents resulting in AIDS is important, and their conclusion refers to AIDS patients generally, the association in the article is between homosexual men, promiscuity and AIDS. They suggest '… that opportunistic infections and their sequelae, … prominent among AIDS patients, are not the principal offenders but result from a combination of 'lifestyle' hazard and immunodeficiency'.[42] The suggested 'lifestyle' hazard is not, even implicitly, linked to a 'heterosexual lifestyle'.

Even in cases where the language usage is marginally less problematic than the examples given above, the construction and use of 'the homosexual' as research category remained consistent. Ras *et al*., refer to the subjects of their articles as 'acknowledged male homosexuals' (no evidence could be found of heterosexuals having to be 'acknowledged heterosexuals') and try to use specific markers of sexual activity.[43] They relate that one patient reported an 'average of two homosexual contacts per week', while the second had 'apparently ceased all homosexual activities since they became aware that they had this syndrome'.[44] No definition is given of what 'homosexual contacts' or 'homosexual activities' are, so readers are left to make assumptions about the nature of the sexual activities of the two patients. Where this article is different, is that the authors do not refer specifically to sexual orientation in the discussion of their findings, noting that 'abnormal chemotaxis of leucocytes has not previously been described in patients with AIDS'.[45]

38. *Ibid.* (italics mine).
39. *Ibid.*
40. R.J. Ablin and M.J. Gonder, 'Immunological Abnormalities in South African Homosexuals – a Non-infectious Co-factor?', *SAMJ*, 67, 2 (12 January 1985), 40.
41. A reference given as: Purtilo, D.T. *et al.* in a publication identified only as *Fed Proc* (1984), 43, the claim is made that human T cell leukaemia virus (HTLV) is not associated with acquired immune deficiency syndrome (AIDS) or chronic lymphadenomegaly (LAD) in promiscuous male homosexuals..
42. Ablin, 'Immunological Abnormalities', 40.
43. G.J. Ras, H.A. Eftychis, R. Anderson and I. van der Walt, 'Mononuclear and Polymorphonuclear Leucocyte Dysfunction in Male Homosexuals with the Acquired Immunodeficiency Syndrome (AIDS)', *SAMJ*, 66, 21 (24 November 1984), 806–9.
44. *Ibid.*, 806.
45. *Ibid.*, 808.

A number of other articles have no qualms in linking homosexuality with promiscuity. For example, one refers to 'a homosexual of promiscuous habits',[46] while another directly links homosexual 'activity' to the 'activities' of female heterosexual prostitutes.[47] In another article, the author laments that 'we also specifically know that the virus flourishes among bisexuals and homosexuals, as well as drug addicts who inject and that very little indeed (*bitter min*) can be done to bring people in these high-risk groups to other insights'.[48] Despite not producing any evidence to support their contention, the authors of one article claimed that a drug-using homosexual 'had most probably acquired the infection through the *practice of homosexuality* and not drug abuse'.[49] In a 1987 article on gastro-enterology, value judgements were made on all 'high risk' groups when the author noted that AIDS 'is found largely in *promiscuous* male homosexuals, intravenous drug *abusers* and the *tragic* haemophiliac unwittingly given infected serum'.[50] Later in the same article the author challenges his colleagues and asserts his bias openly by stating, 'my own prejudice is that the so-called AIDS epidemic, at least in the Western world, is an epidemic of homosexual males and other high-risk groups and not of the *ordinary* person, and that the grim prediction for the year 2000 will not eventuate'.[51] Despite growing concerns about a heterosexual epidemic of AIDS by the late 1980s, which some commentators, like M. Hendricks (Department of Immunology, UOFS), framed in terms of a dire lack of morality,[52] the 'immorality' of certain (homo)sexual acts provoked a strong response.

In May 1988 the *Journal* published a letter by G.J Knobel (Department of Forensic Medicine, UCT), headed 'An Urgent Warning – Contraction of HIV Infection during Mutual Masturbation'. In the letter he recounted the case of a 38-year-old man who did not like sex with fellow homosexuals but preferred to pick up 'young heterosexual men', take them back to his home, drink alcohol, watch some 'erotic movies' and then engage in 'mutual masturbation'. The man would then use the ejaculated semen of the 'heterosexual' man on his penis as a lubricant to bring himself to orgasm. The man was HIV positive and it appeared that he had contracted the virus through this practice. Knobel called for the worldwide alteration of sex educational material on AIDS to ensure that mutual masturbation no longer be listed as safe without a warning not to use another person's semen as a lubricant.[53]

Three months later, in August 1988, a response to Knobel's letter by S.L. Sellars (Department of Otolaryngology, Groote Schuur Hospital, Cape Town) was published.[54] Sellars commented on the 'tasteful and realistic' coverage given to AIDS by Hendricks but berated the *SAMJ* for even publishing Knobel's letter. According to Sellars, the letter could not benefit the *Journal's*

46. News and Comment, 'Pitfalls in AIDS Diagnosis', *SAMJ*, 68, 5 (31 August 1985), 287.
47. Editorial, 'Prostitution and AIDS' (January 1986), 5.
48. T. Brummer, 'Die Stand van Sake met VIGS', *SAMJ*, 70, 3 (2 August 1986), 133 (translated from the original Afrikaans).
49. De Miranda, *et al*., 'Lack of Evidence', 776–7 (italics mine).
50. I.N. Marks, 'Perspectives in Gastro-Enterology', *SAMJ*, 72, 1 (4 July 1987), 8 (italics mine).
51. *Ibid.*
52. See for example M. Hendricks, 'Underestimation of AIDS – There's Nothing to be Optimistic About', *SAMJ*, 73, 10 (21 May 1988), 573–4.
53. G.J. Knobel, 'An Urgent Warning – Contraction of HIV Infection during Mutual Masturbation', *SAMJ*, 73, 10 (21 May 1988) 617.
54. L. Sellars, 'Contraction of HIV Infection during Mutual Masturbation', *SAMJ*, 74, 4 (20 August 1988), 187.

readership 'for surely the link between the dissemination of AIDS and the perverted practices of promiscuous homosexuals is common knowledge. Anyway, who is to know how this self-confessed pervert achieved his HIV infestation, and are the sordid details really relevant?'[55] In conclusion Sellars ironically accused the *SAMJ* of not exercising sufficient control over 'pseudomedical reporting' and suggested that it was not 'being used for the benefit of … subscribers … but (for) others.'[56]

In his reply to Sellars' letter, Knobel indicated that while he was aware that the topic could be regarded as offensive, his primary concern was the prevention of HIV transmission to 'any member of the public irrespective of race, creed or sexual orientation…'. As such, he had reported on the 'sordid details' because they were relevant and important in revealing the problem of 'unconditionally declaring certain practices safe'.[57] He continued:

> It was not my purpose to judge sexual acts between consenting adults in the privacy of an individual's home, or to declare people or their sexual acts 'perverts' and 'perversions'. I assumed that those who would read the letter would be concerned, educated and informed health care workers with the medical interests of all members of society at heart, including 'promiscuous homosexuals' (whether self-confessed or declared to be 'perverts' by fellow human-beings or members of the medical profession).[58]

Knobel's plea for humanism, was not however, sufficient to end the discussion. Three months later two additional responses to Knobel's letter were published, neither supported his call for a common humanity, nor upheld ideas of neutral medical professionalism. The first, by P.M Engelbrecht (Bloemfontein) replicated Sellars' congratulations to Hendricks and then turned to Knobel's letter:

> I would like to know from Professor Knobel if he referred the poor sick person (who lured 'ordinary, normal' heterosexual youths off the street, made them drunk and thereafter with the help of pornographic films sexually stimulated them so that they ejaculated and then used their semen as a lubricant to satisfy his abnormal sex desires) for psychological or even psychiatric treatment …The time has come for us 'ordinary, normal' people to start talking out against the purveyors of abnormal sex, particularly as it can be shown from this instance that it can affect anyone and presents a threat for everyone, including your and my children.[59]

The second letter from I.G. Immerman (Cape Town) agrees with Sellars and goes further, noting:

> I personally think Knobel's letter is frankly depraved and grossly disgusting and serves *no* medical purpose. It typifies and illustrates the degenerate practices that homosexuals display, and this awful segment of humanity is now trying to assert itself to become recognised as part of the normal structure of society.[60]

55. *Ibid.*
56. *Ibid.*
57. *Ibid.*, 188.
58. *Ibid.*
59. P.M Engelbrecht, 'Contraction of HIV Infection during Mutual Masturbation', *SAMJ*, 74, 9 (5 November 1988), 469–70.
60. I.G. Immerman, 'Contraction of HIV Infection during Mutual Masturbation', *SAMJ*, 74, 9 (5 November 1988), 470.

Knobel's lengthy reply easily dispatches the problematic language in Engelbrecht's letter and specifically defines an 'ordinary, normal person' as '…any informed and sexually active individual, irrespective of sex, race, creed or sexual orientation, who can consent to sexual intercourse'.[61] After listing his involvement in various AIDS and sex education projects he turns to Immerman's letter, saying 'I lack the vocabulary to express my shock and horror at the contents of the letter by Dr Immerman, who used all the judgemental superlatives of self-righteous condemnation of this 'awful segment of society'.[62] Knobel goes on to affirm his belief in the rights of teenagers, people infected with HIV, and medical students to be informed and have access to clear information about HIV transmission. He speaks of compassion towards people with AIDS and suggests that 'the strength of a culture will be measured by the level of compassion evidenced by society, health professionals and individuals'. In conclusion, he thanks the authors for 'their concerns and contributions' and goes on to wish them a 'change of heart and the fulfilment and spiritual growth which may follow on from meaningful and unconditional involvement in the global effort to fight the spread of AIDS'.[63] At the end of Knobel's response to Engelbrecht and Immerman, the editor declared the correspondence on the issue was closed. No letters of support for Knobel appeared in the *SAMJ*, either because none were submitted, or because the editor of the *Journal* had decided not to publish them.

The above letters demonstrate the extent of the prejudice against homosexuals in the medical community in 1988, and speaks to the politics of the *SAMJ* editors and editorial board. That the editors allowed such callous and outrageously homophobic letters to receive print space in a journal that supposedly committed itself to 'apolitical' and 'objective' content, demonstrates that such opinions found a sympathetic ear among those responsible for the selection of letters to be published in the *Journal*. In a contemporary context, these letters are examples of hate speech, but in the *SAMJ* (a journal representative of a wider medical community), no editorial intervention was exercised to prevent the dissemination of these views which exceeded reasonable boundaries associated with freedom of opinion and vigorous debate.

The impact of the constructed categories of 'the homosexual' in 'objective, neutral' medical research and professional correspondence, moved beyond the printed page to the personal experiences of people seeking and providing health care. This was highlighted in an *SAMJ* guest editorial in 1988, remarkable for its more sensitive engagement with the social effects of AIDS. The editorial described 'a society which frequently judges an AIDS sufferer far more harshly than sufferers from other venereal diseases and often translates this into cruel discrimination in the workplace, school and even within the family'.[64] In addition, debates about the ethical implications of health care professionals refusing to treat people with AIDS because of personal moral objections to perceived 'lifestyles' were underway.[65] (Revealingly, discussions about the ethical implications of medical professionals with AIDS treating patients are rare.)

61. *Ibid.*, 470–1.
62. *Ibid.*, 470.
63. *Ibid.*, 471.
64. B. Schoub, 'The "AIDS" Test', *SAMJ*, 74, 3 (6 August 1988), 97– 8. See also D.J. Martin, J.F.G. Tilley, A.N. Smith and B.D. Schoub, 'AIDS Clinic – a Year On', *SAMJ*, 75, 8 (15 April 1989), 381–83. (Note: the terminology of AIDS 'sufferers', as opposed to 'people living with AIDS' is said in context.)
65. See C.B. Ijsselmuiden, M.H. Steinberg, G.N. Padayachee, B.D. Schoub, S.A. Strauss, E. Buch, J.C.A. Davies, C. de Beer, J.S.S. Gear and H.S. Hurwitz, 'AIDS and South Africa – Towards a Comprehsive Strategy – Part II', *SAMJ*, 73, 8 (16 April 1988), 461–4; and G.J. Knobel, 'Medicolegal Issues in Caring for People with HIV Infection', *SAMJ*, 74, 4 (20 August 1988), 150–1.

While not all articles refer to homosexuals as 'promiscuous' or 'deviant', those that do create a short-hand or signifier that equates homosexuality with frequent, multiple partners and never with monogamous relationships. Combined with the ongoing association of homosexual men with a fatal, sexually transmitted disease, the use of an 'unscientific' marker like 'homosexuality' as an acceptable research category, and the moral overtones associated with sex generally (and homosexual sex specifically), the overall effect was to create a homogenous group of 'the gays' who behave in a particular way. In much the same way as 'the blacks' or 'the Jews' or 'the women' (sic) are historically constructed stereotypes that are used and understood in conscious and unconscious ways, so too 'the homosexual' as stereotype and research category was created.[66]

The strength of 'the homosexual' stereotype and the lack of knowledge about what, specifically, constituted homosexual experiences, had sufficient currency to result in an early attempt to try to address it. In 1985, an article written by G. Isaacs, a senior lecturer in Clinical Social Work at UCT, and D. Miller, a representative of the Gay Information Working Group, Student Health, UCT, was published which refers to 'the concerns of people affected by the current "AIDS scare"', thereby giving primacy to their humanity rather than their sexual orientation.[67] The article asserts that the 'proposed classification of homosexual men at risk of developing AIDS (that) was published in the *SAMJ*, … was not comprehensive, and (that) far more extensive guidelines for the general practitioner are needed'.[68]

With this in mind, the article proceeds to provide a 'comprehensive definition of homosexuality' that is far more nuanced, subtle and complex than 'the homosexual' and the notions of 'homosexuality' evident elsewhere in the *SAMJ*. Miller and Isaacs directly challenge the notion of 'the promiscuous homosexual' arguing that:

> In the RSA AIDS has been identified mainly in homosexual men and has been associated with the notion of promiscuity. Promiscuity, lacking as it does any useful clinical definition, has limited use in the classification of populations of individuals at risk and is misleading. Homosexuality in the Western world, and in the RSA, is not confined to the self-identified gay population. More people are at risk than has generally been recognized – not only promiscuous homosexuals are in danger.
>
> It is clearly of paramount clinical importance that the doctor takes cognisance of the fact that homosexual behaviour is not limited to an easily defined subset but is spread along the continuum of the population at large. Homosexual practice encompasses a wide spectrum of activity ranging from stable and nominally 'closed' relationships between two men … to the deliberate quest for clandestine or anonymous sexual contact by married men.
>
> …Risk evaluation cannot be carried out in terms of membership of a promiscuous population alone; it must include detailed assessment of the idiosyncrasies of the individual's sexual practice.[69]

The article goes on to provide candid information about male homosexual sexual practices (after reminding readers that 'many of the activities [are] proscribed by South African law' and

66. For further discussion on the construction of stereotypes see S.L. Gilman *Difference and Pathology: Stereotypes of Sexuality, Race and Madness* (New York: Cornell University Press, 1988).
67. G. Isaacs and D. Miller, 'AIDS – Its Implications for South African Homosexuals and the Mediating Role of the Medical Practitioner', *SAMJ*, 68, 5 (31 August 1985), 327–30.
68. *Ibid.*
69. *Ibid.*

forestalling any legal action by including the caveat: 'In listing them, attention is merely being drawn to the clinical realities; in no way is advocacy of these practices implied'[70]). It discusses the therapeutic role of the doctor, provides detailed guidelines and explanations for enquiries into psychosexual history, and provides recommendations for precautions in sexual activity.[71] In short, it provides comprehensive information that if it had been universally applied and accepted, could have altered the way in which treatment and research into AIDS was undertaken.

The article also acknowledges the person behind the 'professional doctor' and states that 'condescending behaviour and patronizing suggestions by well-meaning but uninformed doctors can be seriously offensive and deleterious to the therapeutic process'.[72] The authors of the article directly tackle homophobia and (in a rare use of non-sexist language in the *Journal*) suggest that 'if for any reason the doctor discovers revulsion, fear or intolerance on his/her behalf, then the patient should immediately be referred to another therapist'. The authors warn of 'the negative nature of social attitudes towards homosexuality',[73]and point out that:

> As yet specialised counselling services do not exist for non-homosexual AIDS victims in this country. The general problem is one of community health as with all other sexually transmitted disease epidemics … and not specifically caused by the practice of homosexuality … [and] … Since we all belong to a common society the AIDS problem should be a shared concern.[74]

While the sentiment was noble, the notion of shared 'community health' and a 'common society' was hardly applicable to apartheid South Africa. Furthermore, the 'gay societies' referred to in the article as providers of support and information for people living with AIDS, were not necessarily non-racist and non-sexist.[75] The article itself implies that all homosexuals are white and male, and unnecessarily replicates the distinction between heterosexuals and 'black' heterosexuals, indicating that the work required to bring about a 'common society' was needed in all communities.

'The Homosexual' as Research Category

M.E. West and E.A. Boonzaier, two social anthropologists from UCT, wrote an opinion piece in the *SAMJ* in 1989 entitled 'Population Groups, Politics and Medical Science'.[76] The article explores the 'far-reaching consequences' of the Population Registration Act of 1950, arguing that this legislation and the associated classification of people into deeply problematic, subjective, and undefined categories was unacceptable. The authors contend that:

70. *Ibid.*, 327.
71. R. Sher, 'Acquired Immune Deficiency Syndrome (AIDS) in the RSA', *SAMJ*, 70, 8 (11 October 1986) 23–6, presented 'promiscuity' as a measurable quantity forming part of a questionnaire aimed at establishing, amongst other things, the 'degree of promiscuity' of participants.
72. Isaacs and Miller, 'AIDS', 329.
73. *Ibid.*, 328.
74. *Ibid.*, 329.
75. The politics of gay associations involved in the early years of the AIDS epidemic will be explored in more detail in my PhD thesis on the early history of HIV and AIDS in South Africa, 1980–1995, which is currently being written.
76. M.E. West and E.A. Boonzaier, 'Population Groups, Politics and Medical Science', *SAMJ*, 76, 5 (2 September 1989), 185–6.

> in everyday interaction … it is often regarded as important to establish a person's population category, simply because it is a shorthand way of knowing about their likely social background. In scientific discussion (including medical research and publications), however, such imprecise and uncritical use of terms such as 'black', 'white' and 'coloured' is not acceptable. Their use in these contexts also raises certain fundamental political and methodological questions.

They continue:

> … given the pervasive nature of population classification, there is a great danger that these categories are unthinkingly assumed to be relevant in medical matters. We would argue, to the contrary, that their salience must be demonstrated in each case….
>
> We need to question very seriously the way in which information on population groups is collected for medical records [as] there can be no possible scientific justification for the thoughtless inclusion of questions about a person's 'race' or population category….
>
> … one needs to guard against serious methodological problems commonly associated with their use. For example, it may be possible on the basis of evidence to state that people of category A exhibit certain characteristics. But if your data are drawn solely from category A, it is not possible to say whether or not this is also characteristic of other categories. This is simply bad social science, and should equally be seen as bad medical science.
>
> …South Africa's official population categories are not based on clearly defined objective criteria. It therefore follows that these categories, in themselves, have no scientific value.[77]

West and Boonzaier's caution against the use of 'race' as a scientific research category was appropriate in a journal where racial markers were inserted to indicate when the case studies differed from the assumed norm (namely 'white' people).[78] With only minor adjustments, the same argument can be made about the use of 'sexuality' or sexual orientation as a scientific research category. The legislation against homosexuality and the stereotypes about homosexuals also allowed for a 'shorthand way' of knowing about likely sexual behaviour.

77. *Ibid.*
78. See G.H. Vos and P. Brain, 'Race and Sex Differences in Walking Under Ladders in Durban', *SAMJ*, 58, 12 (20 September 1980), 470; R. Wilkinson, 'Hepatitis B as a Sexually Transmitted Disease in a Black South African Population', *SAMJ,* 65, 24 (16 June 1984), 954–5; M.C Botha, F.A. Neethling, I. Shai, J.M. Lekabe and C.F. van der Merwe, 'Two Black South Africans with AIDS', *SAMJ*, 73, 2 (23 January 1988), 132; W.B. Becker, M.C. Botha, S. Engelbrecht and M.L.B. Becker, 'Isolation of Human T-lymphotropic Virus Type I (HTLV-I) from a Black South African with Kaposi's Sarcoma', *SAMJ*, 73, 8 (16 April 1988), 481–3; R.F. Gledhill, P.H. Dessen and P. Sneider, 'Antibody to HTLV-I in a Black South African with a Neurological Disorder Resembling Multiple Sclerosis', *SAMJ*, 75, 3 (4 February 1989), 147–8; G.N. Padayachee and R. Schall, 'Short-term Predictions of the Prevalence of Human Immunodeficiency Virus Infection among the Black Population in South Africa', *SAMJ*, 77, 7 (7 April 1990), 329–33; D.J. Pudifin, J. Duursma and C.R.B. Prior, 'The Clinical and Lymphocyte Status of HIV Antibody-positive Black Blood Donors', *SAMJ,* 77, 12 (16 June 1990), 628–9; R. Schall, 'On the Maximum Size of the AIDS Epidemic among the Heterosexual Black Population in South Africa', *SAMJ*, 78, 9 (3 November 1990), 507; C.B Ijsselmuiden, G.N. Padayachee, W. Mashaba, O. Martiny and H.P. van Staden, 'Knowledge, Beliefs and Practices among Black Goldminers Relating to the Transmission of Human Immunodeficiency Virus and Other Sexually Transmitted Diseases', *SAMJ*, 78, 9 (3 November 1990), 520; and in section Editor's Choice, 'Why do Black Runners Do so Well?', *SAMJ*, 81, 10 (16 May 1992), vii.

To paraphrase West and Boonzaier's argument: in the same way that the use of imprecise and uncritical racial signifiers is unacceptable, so too is the use of imprecise and uncritical signifiers of sexuality. Their use raises fundamental political and methodological questions about research into HIV and AIDS. In apartheid South Africa, the fervent reinforcing of heteronormativity replicated the unthinking assumption that sexual orientation was relevant in medical matters, despite there being no medical or scientific evidence produced to indicate that it was.

As with the collection of information on 'race', the collection of information on sexuality and sexual practices, when closely interrogated, often had no scientific justification and proved to be thoughtlessly included. The same methodological weaknesses identified by West and Boonzaier applies to the majority of research undertaken into AIDS because the categories of 'homosexual', 'homosexuality' and 'promiscuity' were not based on clearly defined 'objective criteria'. This translated into the uncritical use of such categories, and the 'shorthand' assumptions that were associated with them, despite their having no scientific value in themselves.

'The homosexual' and 'homosexuality' as research categories remained central to the AIDS research narrative in South Africa throughout the decade, and meant that reports on these patients became signifiers for all male homosexuals, but not all male AIDS cases. This is evident in an article entitled 'Immunological Abnormalities in South African Homosexual Men',[79] a study of 10 white homosexual men which points to the 'existence of acquired immunosuppression in *some* members of the South African homosexual community'.[80]

While readers are informed that five of the ten 'self-confessed' homosexual men were partners of a man who had died from AIDS, the sexual histories of the six 'healthy heterosexuals' used as a control group, remains hidden. Insufficient information is provided about the heterosexuals to determine if the control group was even appropriate. Why were 10 homosexuals compared to *six* heterosexuals? How comparable were the sexual activities, types of sexual contact, and number of partners of the two groups? Would these findings have been any different if, for example, the sexual contacts of a white sexually active heterosexual university student who had a history of STI's, been tested and compared to a control of 6 'healthy homosexuals'?

The authors admit that 'the significance of our findings is difficult to assess because the study group is small',[81] but this does not prevent a speculative leap in their conclusions. Moving away from the cautious stance indicated in the abstract where acquired immunosuppression existed in 'some' members of SA's homosexual community, conclusions are drawn about 'all' homosexuals in South Africa and in the US. Based on a sample of only 10 people, the authors claim that (all) homosexual men in South Africa may be similar to (all) their homosexual counterparts in the US; and that they may be partially immunosuppressed.[82]

The case report documenting the deaths of South Africans Ralph Kretzen (d. 26 August 1982) and Charles Steyn (also known as Pieter Daniël Steyn, d. 1 January 1983) is not a neutral account of their symptoms, tests and treatment. Instead, the authors of the report, Ras *et al*., directly link Kretzen and Steyn's deaths to their sexuality.[83] After confirming that AIDS occurred

79. Anderson *et al*., 'Immunological Abnormalities', 119–22.
80. *Ibid.* 119 (italics mine).
81. *Ibid.* 122.
82. *Ibid.*
83. G.J. Ras, I.W. Simson, R. Anderson, O.W. Prozesky and T. Hamersma, 'Acquired Immunodeficiency Syndrome – A Report of Two South African Cases', *SAMJ*, 64, 4 (23 July 1983), 140–2.

predominantly among the 'four well-defined groups: homosexual or bisexual males, drug addicts, Haitian immigrants to the USA and haemophiliacs', Ras *et al* also acknowledged that 'cases in females have been described and women may acquire the disease from male sexual partners'.[84] Thereafter followed the individual case reports detailing the age, sexual orientation (but not 'race' in this instance) and occupation of both patients; the symptoms they presented; the diagnosis and treatment given; and the results of tests and autopsies. Both patients had CMV infections and died of PCP – a potential outcome of AIDS completely unrelated to a person's sexuality. In the opening sentence of the discussion section of the report however, readers were informed that 'these 2 cases demonstrate the features of AIDS in male homosexuals'.[85] Kretzen and Steyn were not presented as two people in South Africa known to have died of AIDS; instead they demonstrated the effects of AIDS on gay men.

As with all research, it is understandable that medical scientists/ professionals trying to garner information on a new illness would try and gather information from 'guaranteed' sources, or use the study groups that were available to them. If as a medical scientist you focused your research on 'the homosexual community', you greatly increased your chance of finding what you were looking for. For researchers in major cities (particularly Johannesburg, Pretoria and Cape Town) there were 'ready-made' sample groups available, drawn from sites specifically set up to address AIDS amongst predominantly homosexual, white people who attended, or were referred to, the AIDS clinic at Johannesburg General Hospital or the South African Medical Research Council's AIDS Research Unit.

It is the nature of all research to review and build upon existing work in the field, and this particular work was defined by a specific sexual orientation. Why look among sexually active white, middle-class, heterosexual males when you are almost guaranteed results among white, homosexuals males? Picking the 'high risk' groups to do research means that one will more than likely have research findings, and once a set of results has been found one can mine the sources for a variety of papers, and open up new questions and areas of research based on and contained within those foundations. When the questions have been set and framed in relation to particular study groups, why would one want to consider other options?

In the South African AIDS narrative presented in the *SAMJ,* nobody was looking specifically at 'normal' 'white' heterosexuals (male or female), let alone 'indian' or coloureds; lesbians are invisible; and 'non-white' homosexual men are barely conceived of.[86] From the first reported cases, it was evident that this new syndrome was found amongst all people, but conservative morals, racism, sexism and homophobia virtually drove the research agenda, so there was no broader-based research.

This is not to argue that AIDS was experienced 'equally' by all people. Male 'white' homosexuals abroad and in South Africa were disproportionately affected by AIDS in the early years of the epidemic.[87] Nor is it claimed that this was simply because they were homosexual –

84. *Ibid.*, 140.
85. *Ibid.*, 142.
86. One article states 'Since homosexual activity is rare in Africans, the virus is probably transmitted by heterosexual contact or exposure to blood'. See News and Comment, 'Kaposi's Sarcoma in Central Africa', *SAMJ*, 68, 5 (31 August 1985), 312.
87. Similarly, the newspaper reports on AIDS among migrant workers indicate that migrant labourers were also disproportionately exposed to, and infected by, the virus at approximately the same time. See Grundlingh, 'Early Attitudes', 86–103.

vulnerability to infection, and capacity to seek and access treatment and care, are influenced by a complex interplay of class, race, age, sexual orientation and gender. The history of HIV infection rates and AIDS mortality figures clearly reveals political and social fault lines. As the AIDS epidemic took hold and began appearing in more 'groups' of people the research was forced into new directions – but these directions cannot be viewed as 'apolitical' developments unrelated to personal and public politics. An awareness of inherent biases in early research may have allowed the commonalities of those most vulnerable to infection to have been identified earlier, and altered the research, prevention, health and education strategies sooner.

Commenting on AIDS research in the US, Cochrane argues that:

> Had representations of AIDS included the more complex and multiple social, political, and economic correlates of the disease, public health interventions would have necessarily required an expansion of government services to the homeless, to substance abusers, and a program of national health care.[88]

Cochrane continues by asserting that: 'public health officials and the AIDS research establishment abrogated their responsibilities to educate the public about the social and economic risk profile of early AIDS patients'. She contends that by failing to draw attention to the 'socioeconomic status, and social marginalization' of early AIDS patients, these factors were down-played 'in increasing [an individual's] vulnerability for acquiring the disease or its progression to full-blown AIDS'.[89]

Whether in the US or in the pages of the *SAMJ* (to paraphrase Cochrane) by drawing attention towards the 'deviant', 'disposable' groups apparently responsible for spreading the deadly virus, or turning attention onto the virus or causative agent itself, those in power focused attention away from the social and political contexts of illness. In so doing, they also focused attention away from their role in maintaining an unjust distribution of power and access to healthcare. Variations of this theme are evident in the responses/ lack of responses to HIV and AIDS by both the apartheid and post-apartheid South African governments, although further research is needed in this area.

The Absent Referent

The AIDS narrative presented in South Africa makes use of assumptions, both conscious and unconscious, that construct, compare, and contrast those with AIDS against an unrealistic, constructed, uninfected 'normal' referent. The 'normal' referent was constructed using the defining terms of a stereotype of middle-class, 'white', South African morals. In this dialogue, AIDS patients, or carriers, were measured predominantly against an unrealistic 'white' heterosexual male stereotype.

This non-promiscuous 'white' male stereotype had a faceless, faithful, 'white', female partner stereotype. These two constructs inhabit a world where sex is a free choice and there is no rape and no adultery. The unspoken assumption is that sex between these two occurs within the bounds of religiously- and socially-sanctioned marriage. Sex itself involves penetrative vaginal intercourse and occurs without any 'deviances' like oral sex, mutual masturbation, or anal sex.

88. Cochrane, *When AIDS Began*, 192.
89. *Ibid.*

This couple, but particularly the 'white' heterosexual male, became the absent referent[90] against whom the actions of 'promiscuous homosexuals', drug abusers, and sexualised black men (and later black womyn prostitutes) were measured – consciously or unconsciously. The starting point from which the AIDS narrative was presented is a white, 'Western'/ 'European' South Africa inhabited by faithful, non-promiscuous middle-class heterosexual couples. The supposed 'heterosexual norm' was a stereotype of heterosexuality. This became the unspoken counterpoint against which those that did not fit 'the norm' were measured and constructed.

In this idealised South Africa populated by idealised, stereotypical, heterosexual couples there was no space for people to have complicated, nuanced identities. Group homogeneity was required. People were 'straight' or 'gay', 'white' or 'black', 'female' or 'male', 'normal' or 'abnormal', and they all behaved in ways that were predictable and predictive of the entire 'group' they were deemed to represent.

The representative stereotype of homosexual men is not scientific or medically relevant in researching AIDS; there is no biological difference between heterosexual men and homosexual men, nor is there any form of 'penetrative' sex that both are incapable of performing. The difference is not what they do, but with whom they do it. Having been defined as a 'high risk' group, homosexual men were investigated and researched because they were 'gay' – as if this was the key, defining feature of AIDS and AIDS transmission.

Conclusion

By 1990, AIDS was still an illness about which people expressed fear and ignorance, combined with intolerance and rejection of the people who were living with AIDS. It was entrenched as an illness that affected other 'race' groups, and 'promiscuous people'.[91] Knobel again wrote to the *SAMJ*, this time reminding readers of 'The Human Face of AIDS', observing that '[d]ealing with AIDS requires above all integrity and compassion', reinforcing '… the need for compassion and understanding …'.[92]

This article turns to the 'human face' of AIDS researchers and medical professionals who responded to AIDS in South Africa during this period with varying degrees of integrity and compassion. Hubbard has argued that:

> The social structure of the laboratory in which scientists work and the community of inter-personal relationships in which they live are also part of the subjective reality and context of doing science. Yet, we usually ignore them when we speak of a scientist's scientific work despite the fact that natural scientists work in highly organised social systems. Obviously, the sociology of laboratory life is structured by class, sex, and race, as is the rest of society.[93]

This article has shown that the 'sociology of laboratory life' in 1980s South Africa was also structured by ideas about sex, sexuality and sexual orientation. Researchers and doctors were

90. See C. Adams *The Sexual Politics of Meat* (New York: Continuum, 1999); and *The Pornography of Meat*(New York: Continuum, 2004) for discussions on animals and womyn as absent referents in the consumption of meat.
91. See for example C. Mathews, L. Kuhn, C.A. Metcalf, G. Joubert and N.A. Cameron, 'Knowledge, Attitudes and Beliefs about AIDS in Township School Students in Cape Town', *SAMJ*, 78, 9 (3 November 1990), 511; C.R. Evian, C.B. Ijsselmuiden, G.N. Padayachee and H.S. Hurwitz, 'Qualitative Evaluation of an AIDS Health Education Poster', *SAMJ*, 78, 9 (3 November 1990), 517; and Ijsselmuiden *et al*., 'Knowledge, Beliefs', 520.
92. G.J. Knobel, 'The Human Face of AIDS', *SAMJ*, 78, 1 (7 July 1990), 44.
93. Hubbard, 'Science, Facts and Feminism', 128.

influenced (consciously or unconsciously) by their location in a country that championed conservative morals, and enacted legislation that attempted to regulate every aspect of people's lives, from education to procreation. The insidious, stereotypical constructions of groups of people, notions of group homogeneity, and the importance of group identity and control were central to the ideological and practical implementation of the apartheid system. It was within this conservative context that AIDS emerged, a frighteningly lethal illness that was all about blood, bodily fluids, and sex.

While the construction of homosexuality prevalent in early research about AIDS and HIV was of no scientific value, it retained scientific currency among medical researchers and doctors throughout the 1980s. This reveals much about the context in which the research took place, and much about the researchers themselves.

Hubbard contends that:

> The pretense (*sic*) that science is objective, apolitical and value-neutralis profoundly political because it obscures the political role that science and technology play in underwriting the existing distribution of power in society.[94]

By showing the bias inherent in the texts of a self-styled 'apolitical' medical journal interested in the transmission of 'objective' scientific information, on behalf of an organisation (the MASA)[95] primarily interested in retaining its neutral (a) political role, this article challenges the 'pretence of objective science'. The article draws attention to the political nature of research, researchers, and the professional organisations that represent them and shows how, despite imagined neutrality, prejudice and unscientific stereotypes shaped early AIDS research.[96]

Drawing attention to the racism, homophobia, moral conservatism, and unscientific research categories evident in some early AIDS research does not equate to a wholesale rejection of the findings of medical scientists. Instead, it draws attention to how unacknowledged bias in these findings often compromised and potentially restricted the findings. In the absence of such bias, medical and political responses to AIDS may have been different, and the threat that the virus posed to *all* members of society recognised earlier. This could have resulted in a more holistic and potentially effective response to the epidemic in SouthAfrica. It is clear that analysing the historical construction of AIDS epidemiology in South Africa provides an opportunity for more nuanced and empowered understandings of contemporary epidemiological realities around AIDS. President Thabo Mbeki has cited the history of racism in bio-medical science and constructions of 'black sexuality'within the scientific discourse on AIDS as reasons for his AIDS denialism.[97]

94. Ibid., 127.
95. In 1991, as the transition to democracy began, MASA underwent a political evolution and apologised for its inaction in the case of Biko's death.
96. For discussions on the politics and power dynamics that influenced AIDS epidemiology in the US, see: G. Oppenheimer, 'Causes, Cases, and Cohorts: The Role of Epidemiology in the Historical Construction of AIDS', in E. Fee and D. Fox, eds, *AIDS The Making of a Chronic Disease* (Berkeley: University of California Press, 1992), for a discussion of the changing power dynamics between epidemiologists, virologists, and other medical specialists in relation to AIDS; see also S. Epstein, *Impure Science: AIDS, Activism, and the Politics of Knowledge* (Berkeley: University of California Press, 1996) for an examination of the 'politics of knowledge making'; and Cochrane *When AIDS Began.*
97. See M. Heywood, 'The Price of Denial (a history of political denial about the HIV epidemic)', (c.2003), available on the Treatment Action Campaign website at http://www.tac.org.za/community/debunking, accessed 26 June 2008.

This paper has shown that within the same AIDS discourse, it is possible to acknowledge similar constructions of 'white male homosexuality'. However, acknowledging such bias, does not deny the existence of HIV or the very real and varied effects of AIDS. The present South African government's failure to sufficiently address HIV and AIDS, because of claims of scientific bias, is therefore disingenuous and inappropriate.

References

Ablin, R.J., and Gonder, M.J., Correspondence, 'Immunological Abnormalities in South African Homosexuals – a Non-infectious Co-factor?', *SAMJ*, 67, 2 (12 January 1985), 40.

Adams, C., *The Pornography of Meat* (New York: Continuum, 2004).

Adams, C., *The Sexual Politics of Meat* (New York: Continuum, 1999).

Aggleton, P. and Homan, H., eds, *Social Aspects of AIDS* (New York: Falmer Press, 1988).

Anderson, R., Prozesky, O.W., Eftychic, H.A., van der Merwe, M.F., Swanevelder, C., and Simson, I.W., 'Immunological Abnormalities in South African Homosexual Men', *SAMJ*, 64, 4 (23 July 1983), 119–22.

Anonymous, 'Retrovirus and AIDS', *SAMJ*, 66, 2 (14 July 1984), 42.

Batchelor, G.B., News from the Secretariat, 'The MASA and Politics', , *SAMJ*, 65, 18 (5 May 1984), 743.

Becker, W.B., Botha, M.C., Engelbrecht, S. and Becker, M.L.B., 'Isolation of Human T-lymphotropic Virus Type I (HTLV-I) from a Black South African with Kaposi's Sarcoma', *SAMJ*, 73, 8 (16 April 1988), 481–3.

Botha, M.C., Neethling, F.A., Shai, I., Lekabe, J.M., and van der Merwe, C.F., Correspondence, 'Two Black South Africans with AIDS', *SAMJ*, 73, 2 (23 January 1988), 132.

Brummer, T., 'Die Stand van Sake met VIGS', *SAMJ*, 70, 3 (2 August 1986), 133.

Chirimuuta, C. and Chirimuuta, R., *AIDS, Africa and Racism* (London: Free Association Books, 1989).

Cochrane, M., *When AIDS Began: San Francisco and the Making of an Epidemic* (New York, and London: Routledge, 2004).

De Miranda, D.S, Sher, R., Metz, J., Sifris, D., Lyons, S.F. and Schoub, B.D., Correspondence, 'Lack of Evidence of HIV Infection in Drug Abusers at Present', *SAMJ*, 70, 12 (6 December 1986), 776–7.

Editor's Choice, 'Why Do Black Runners Do So Well?', *SAMJ*, 81, 10 (16 May 1992), vii.

Editorial, 'Acquired Immunodeficiency Syndrome (AIDS), *SAMJ*, 63, 4 (22 January 1983) 97–8.

Editorial, 'Immuniteitstekort en Homoseksualiteit', *SAMJ*, 61, 9 (27 February 1982), 298.

Editorial, 'Meer oor VIGS', *SAMJ*, 64, 4 (23 July 1983), 114–15.

Editorial, 'VIGS (AIDS) – 2 Jaar Later', *SAMJ*, 64, 28 (31 December 1983), 1080.

Engelbrecht, P.M., Correspondence, 'Contraction of HIV Infection during Mutual Masturbation', *SAMJ*, 74, 9 (5 November 1988), 469–70.

Epstein, S., *Impure Science: AIDS, Activism, and the Politics of Knowledge* (Berkeley: University of California Press, 1996).

Evian, C.R., Ijsselmuiden, C.B., Padayachee, G.N. and Hurwitz, H.S., 'Qualitative Evaluation of an AIDS Health Education Poster', *SAMJ*, 78, 9 (3 November 1990), 517.

Farrant, P.J., 'Kaposi Sarcoma in Childhood – A Report of 3 Cases', *SAMJ*, 61,17 (24 April 1982), 636–7.

Gilman, S.L., *Difference and Pathology: Stereotypes of Sexuality, Race and Madness* (New York: Cornell University Press, 1988).

Gledhill, R.F., Dessen, P.H. and Sneider, P., Correspondence, 'Antibody to HTLV-I in a Black South African with a Neurological Disorder Resembling Multiple Sclerosis', *SAMJ*, 75, 3 (4 February 1989), 147–8.

Grundlingh, L., 'Early Attitudes and Responses to HIV/AIDS in South Africa as Reflected in Newspapers, 1983–1988', *Journal for Contemporary History*, 26, 1 (June 2001), 86–103.

Grundlingh, L., 'Government Response to HIV/AIDS in South Africa as Reported in the Media, 1983–1994', *South African Historical Journal*, 45 (2001), 124–53.
Grundlingh, L., 'Neither Health nor Education? An Historical Analysis of HIV/AIDS Education in South Africa, 1980s–1990s' (Unpublished paper, RAU Sociology seminar, 24 May 2002).
Grundlingh, L., 'The Nature and Development of HIV/AIDS Historiography', *Acta Academica*, 29, 2 (1997), 1–26.
Guest, C., 'AIDS and its Metaphors', *Social Science and Medicine*, 29, 11 (1989), 1305–6.
Hendricks, M., 'Underestimation of AIDS – There's Nothing to be Optimistic About', *SAMJ*, 73, 10 (21 May 1988), 573–4.
Heywood, M., 'The Price of Denial (a History of Political Denial about the HIV Epidemic)', (c.2003), Treatment Action Campaign website http://www.tac.org.za/community/debunking, accessed 26 June 2008.
Hubbard, R., 'Science, Facts and Feminism', in N. Tuana, ed., *Feminism and Science* (Indianapolis: Indiana University Press, 1989), 119–31.
Ijsselmuiden, C.B., Padayachee, G.N., Mashaba, W., Martiny, O. and van Staden, H.P, 'Knowledge, Beliefs and Practices among Black Goldminers Relating to the Transmission of Human Immunodeficiency Virus and Other Sexually Transmitted Diseases', *SAMJ*, 78, 9 (3 November 1990), 520.
Ijsselmuiden, C.B., Steinberg, M.H., Padayachee, G.N., Schoub, B.D., Strauss, S.A., Buch, E., Davies, J.C.A., de Beer, C., Gear, J.S.S. and Hurwitz, H.S., 'AIDS and South Africa – Towards a Comprehsive Strategy – Part II', *SAMJ*, 73, 8 (16 April 1988), 461–4.
Immerman, I.G, Correspondence, 'Contraction of HIV Infection during Mutual Masturbation', *SAMJ*, 74, 9 (5 November 1988), 470.
Isaacs, G., and Miller, D., 'AIDS – its Implications for South African Homosexuals and the Mediating Role of the Medical Practitioner', *SAMJ*, 68, 5 (31 August 1985), 327–30.
Knobel, G.J., Correspondence, 'An Urgent Warning – Contraction of HIV Infection during Mutual Masturbation', *SAMJ*, 73, 10 (21 May 1988), 617.
Knobel, G.J., Letters, 'The Human Face of AIDS', *SAMJ*, 78, 1 (7 July 1990), 44.
Knobel, G.J., Opinion, 'Medicolegal Issues in Caring for People with HIV Infection', *SAMJ*, 74, 4 (20 August 1988), 150–1.
Marks, I.N., 'Perspectives in Gastro-enterology', *SAMJ*, 72, 1 (4 July 1987), 5–10.
Martin, D.J. and Schoub, B.D., Correspondence, 'Entry of HIV-Infection into the Intravenous Drug Abusing Population', *SAMJ*, 75, 7 (1 April 1989), 349.
Martin, D.J., Tilley, J.F.G., Smith, A.N. and Schoub, B.D, 'AIDS Clinic – a Year On', *SAMJ*, 75, 8 (15 April 1989), 381–3.
Mathews, C., Kuhn, L., Metcalf, C.A., Joubert, G. and Cameron, N.A, 'Knowledge, Attitudes and Beliefs about AIDS in Township School Students in Cape Town', *SAMJ*, 78, 9 (3 November 1990), 511.
MVSA/MASA Bulletin, 'Call for Ban on WMA Assembly Unjustified', *SAMJ*, 67, 6 (9 February 1985), 195.
News and Comment, 'AIDS in Children', *SAMJ*, 65, 15, (14 April 1984), 587.
News and Comment, 'Kaposi's Sarcoma in Central Africa', *SAMJ*, 68, 5 (31 August 1985), 312.
News and Comment, 'Pitfalls in AIDS Diagnosis', *SAMJ*, 68, 5 (31 August 1985), 287.
News and Comment, 'Prostitution and AIDS', *SAMJ*, 69, 1 (4 January 1986), 5.
Oppenheimer, G., 'Causes, Cases, and Cohorts: The Role of Epidemiology in the Historical Construction of AIDS', in E. Fee and D. Fox, eds, *AIDS The Making of a Chronic Disease* (Berkeley: University of California Press, 1992), 49–83.
Padayachee, G.N. and Schall, R., 'Short-term Predictions of the Prevalence of Human Immunodeficiency Virus Infection among the Black Population in South Africa', *SAMJ*, 77, 7 (7 April 1990), 329–33.

Pudifin, D.J., Duursma, J. and Prior C.R.B., 'The Clinical and Lymphocyte Status of HIV Antibody-Positive Black Blood Donors', *SAMJ,* 77, 12 (16 June 1990), 628–9.

Ras, G.J., Eftychis, H.A., Anderson, R., and van der Walt, I., 'Mononuclear and Polymorphonuclear Leucocyte Dysfunction in Male Homosexuals with the Acquired Immunodeficiency Syndrome (AIDS)', *SAMJ*, 66, 21 (24 November 1984), 806–9.

Ras, G.J., Simson, I.W., Anderson, R., Prozesky, O.W. and Hamersma, T., 'Acquired Immunodeficiency Syndrome – A Report of Two South African Cases', *SAMJ*, 64, 4 (23 July 1983), 140–2.

SAMJ News, 'AIDS and the RSA', *SAMJ*, 71, 12 (20 June 1987), xxi.

SAMJ News, 'Prostitution and AIDS', *SAMJ*, 71, 5 (7 March 1987), xviii.

Schall, R., 'On the Maximum Size of the AIDS Epidemic among the Heterosexual Black Population in South Africa', *SAMJ*, 78, 9 (3 November 1990), 507.

Schoub, B., 'The "AIDS" Test', *SAMJ*, 74, 3 (6 August 1988), 97–8.

Sellars, S.L, Correspondence, 'Contraction of HIV Infection during Mutual Masturbation', *SAMJ*, 74, 4 (20 August 1988), 187.

Sher, R., 'Acquired Immune Deficiency Syndrome (AIDS) in the RSA', *SAMJ*, 70, 8 (11 October 1986) 23–6.

Sontag, S., *Illness as Metaphor: AIDS and its Metaphors* (London: Penguin, 1991).

Stillwaggon, E., 'Racial Metaphors: Interpreting Sex and AIDS in Africa?', *Development and Change*, 34, 5 (November 2003), 809–32.

Treichler, P., *How to Have Theory in an Epidemic – Cultural Chronicles of AIDS* (Durham: Duke University Press, 1999).

Tuana, N., (ed.) *Feminism and Science* (Indianapolis: Indiana University Press, 1989).

Vos, G.H. and Brain, P., Correspondence, 'Race and Sex Differences in Walking Under Ladders in Durban', *SAMJ*, 58, 12 (20 September 1980), 470.

West, M.E., and Boonzaier, E.A., Opinion, 'Population Groups, Politics and Medical Science', *SAMJ*, 76, 5 (2 September 1989), 185–6.

Wilkinson, R., 'Hepatitis B as a Sexually Transmitted Disease in a Black South African Population', *SAMJ,* 65, 24 (16 June 1984), 954–5.