

**POLITICS, POLEMICS, AND PRACTICE:
A HISTORY OF NARRATIVES ABOUT, AND RESPONSES
TO, AIDS IN SOUTH AFRICA, 1980 – 1995**

Thesis submitted for the degree of
DOCTOR OF PHILOSOPHY IN HISTORY
of
RHODES UNIVERSITY

By

CARLA ZELDA TSAMPIRAS

September 2012

ABSTRACT

The ongoing urgency of addressing AIDS in South Africa has kept academics and activists focussed primarily on the immediate crises of AIDS 'in the present'. This thesis, covering the period 1980 – 1995, examines narratives about, and responses to, AIDS 'in the past' and explores the interplay between these narratives and elites in medical and political communities trying to address AIDS during a period of political transition.

The thesis begins by examining the hegemonic medico-scientific narratives about AIDS that featured in the *South African Medical Journal*, an important site of enquiry as AIDS was primarily conceived of as a 'medical issue'. The *SAMJ* narratives, which often relied on constructed 'AIDS avatars', framed understandings of the syndrome and influenced responses to it by medical and political communities. The first community that the thesis explores is the African National Congress (ANC) in exile, which had to address AIDS in exile communities and prepare health strategies for 'the new South Africa'. Secondly, the thesis analyses government responses to AIDS and argues that four phases of response can be identified. These phases were characterised by minimum concerns about obtaining information and providing health advice; efforts to gather infection data while exploiting political and public fear; attempts to extend health education and (belatedly) encourage broader engagement; and finally, consultative, democratic ideals. The thesis then examines the National Medical and Dental Association (NAMDA) a progressive medical organisation that worked with the ANC on influential health (and AIDS) strategies. NAMDA members 'crossed over' between various medical and political communities and both reinforced and challenged hegemonic AIDS narratives.

Finally, the thesis moves from the abstract, via the practical, to the personal and concludes with a detailed account of the experiences of two sexuality activists at the intersections of these communities and narratives. By focussing on these medical and political communities, and analysing the relationships between these communities, the existing AIDS narratives, and individuals, the thesis also reveals the constructions of morality, 'race', gender, and sexuality that infused them. In doing this it shows how polemic and politics combined to influence practical responses to, and personal experiences of, AIDS.

To Loretta Tsampiras, my mother, and Helen Tsampiras my Yia-Yia,
for love, laughter, and lessons in life.

In memory of my father, Nico Tsampiras (1939 – 1991),
I so wish you could have been here.

TABLE OF CONTENTS

ABSTRACT	i
List of Abbreviations and Acronyms	v
List of Figures and Tables	vii
Acknowledgements	viii
A Note on Language	xi
Preface: Locating the Historical ‘I’ in this Thesis	xii
INTRODUCTION	1
<i>Writing History in an Epidemic</i>	3
<i>Definitions and Directions Relating to Words and Actions</i>	8
<i>Methodologies and Archives</i>	17
<i>Apartheid, Health, and Health Care Professionals</i>	24
CHAPTER ONE: NARRATIVES OF KNOWLEDGE: SCIENCE, STEREOTYPES, AND AIDS IN THE SOUTH AFRICAN MEDICAL JOURNAL, 1980 - 1995	30
<i>The SAMJ – MASA’s Mouthpiece</i>	33
<i>Focussing on the Fatal ‘Four Hs’ - High-Risk Groups and the Hierarchy of Exposure in the SAMJ</i>	36
<i>From ‘Dark’ Country to ‘Dark’ Continent: AIDS, Race, and Science</i>	46
<i>‘Homos and Hookers’ – Sexuality and Gender in the AIDS Narrative</i>	72
<i>HAART and Human Rights – A Shift in Perspective?</i>	96
CHAPTER TWO: ‘AIDS WILL KILL YOU AS SURELY AS AN AK’: AIDS AND THE ANC IN EXILE, 1980 – 1990	102
<i>Exile and Health Care Provision</i>	105
<i>Health Care Concerns in Exile</i>	113
<i>Responses to AIDS by the ANC</i>	119
<i>Planning for the Future? The Maputo and Lusaka Meetings</i>	138
<i>Collaboration and International Assistance for ANC AIDS Programmes</i>	152
<i>People, Policy, and Politics: Comrades with AIDS and AIDS Narratives</i>	157
<i>Conclusion</i>	169

CHAPTER THREE: BETWEEN POLEMIC AND PRACTICE: GOVERNMENT RESPONSES TO AIDS FROM NP TO ANC, 1982 – 1995 174

Writing about Government Responses to AIDS in Apartheid SA 178
AIDS Narratives in Hansard, 1980 - 1995 186
Phase One: Information and Advice 192
Phase Two: Facts and Fear 208
Phase Three: Extended Engagement and Education 234
Phase Four: Democratic Ideals 271
Conclusion 279

CHAPTER FOUR: ‘CROSSOVER COMMUNITIES’ AND COUNTER NARRATIVES? NAMDA AND HEALTH ACTIVISTS RESPOND TO AIDS 284

Progressive Health Care and the Formation of NAMDA 287
The Politics of Health - NAMDA, the Government, and the ANC 296
NAMDA and AIDS 300
Conclusion 321

CHAPTER FIVE: INTRICATE RELATIONSHIPS: ILLNESS, IDEOLOGIES AND INTIMATE IDENTITIES – SEXUALITY POLITICS AND AIDS 326

Being ‘Gay’ In Apartheid SA 333
Dennis Sifris – The Physician Who Emptied the Dance Floor 335
Pierre Brouard – Counselling for Death, Counselling for Life 351
Conclusion 365

CONCLUSION: ‘THIS WHOLE WEIGHT OF MEANING’ 367

APPENDICES 376

BIBLIOGRAPHY 394

PRIMARY SOURCES 394
Archives 394
Personal Papers and Private Collections 402
Government Publications 403
Interviews and Correspondence 403
Printed Primary Sources 405
Other Primary Sources 415

SECONDARY SOURCES 420
Books 420
Journal Articles and Chapters 427
Unpublished Sources 438

LIST OF ABBREVIATIONS AND ACRONYMS

AAG	AIDS Advisory Group (also known as the Advisory Group on AIDS - AGA)
ACDP	African Christian Democratic Party
ACTUP	AIDS Coalition to Unleash Power
ADoH	ANC Department of Health
AGA	Advisory Group on AIDS (also known as the AIDS Advisory Group - AAG)
AIDS	Acquired Immunodeficiency Syndrome
ANC	African National Congress
ARV	Antiretroviral
ASET	AIDS Support and Education Trust
ATIC	AIDS Training and Information Centre (also known as ATICCs)
ATICC	AIDS Training Information and Counselling Centre (also known as ATICs)
<i>BMJ</i>	<i>British Medical Journal</i>
CDC	Centers for Disease Control and Prevention
CP	Conservative Party
DoH	Department of Health
DP	Democratic Party previously known as the PFP
DWP	Democratic Workers Party
GAB	Gay Advice Bureau
GASA	Gay Association of South Africa
GLOW	Gay and Lesbian Organisation of the Witwatersrand
GPs	General Practitioners
GRID	Gay-Related Immune Deficiency
HIV	Human Immunodeficiency Virus
LPSA	Labour Party of South Africa
MASA	Medical Association of South Africa
MRC	Medical Research Council
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
NACOSA	National AIDS Convention of South Africa
NACOSA	National AIDS (Co-ordinating) Committee of South Africa
NAMDA	National Medical and Dental Association
NAP	National AIDS Plan (also known as the National AIDS Programme)
NEHAWU	National Education, Health and Allied Workers' Union
<i>NEJM</i>	<i>New England Journal of Medicine</i>
NGO	Non-Governmental Organisation
NHUF	National Health Unity Forum
NP	National Party
NPPHCN	National Progressive Primary Health Care Network
OASSSA	Organisation for Appropriate Social Services in Southern Africa
PAC	Pan Africanist Congress
PFP	Progressive Federal Party - became the DP

PHM	Progressive health movement
PPHC	Progressive Primary Health Care
PPHCN	Progressive Primary Health Care Network
SACP	South African Communist Party
SAHSSO	South African Health & Social Services Organisation (previously NAMDA)
SAHWCO	South African Health Workers' Congress
SAIMR	South African Institute for Medical Research
SAMDC	South African Medical and Dental Council
<i>SAMJ</i>	<i>South African Medical Journal</i>
SP	Solidarity Party
STD	Sexually Transmitted Disease
STIs	Sexually Transmitted Infections
TAP	Township AIDS Project
TBVC States	Transkei, Bophuthatswana, Venda and Ciskei
TRC	Truth and Reconciliation Commission
UCT	University of Cape Town
WMA	World Medical Association

LIST OF FIGURES AND TABLES

Fig. 1.	Cartoon commenting on apartheid and health services (<i>City Press</i> , 1988).	26
Fig. 2.	Between 1980 and 1995 there were over 560 references to AIDS in the <i>SAMJ</i>	37
Fig. 3.	Detailed breakdown of formats that AIDS information appeared in within the <i>SAMJ</i> , 1980 – 1995.	38
Fig. 4.	Tables taken from article 'AIDS Clinic - A Year On', 1989.....	59
Fig. 5.	An Update on AIDS in the RSA, 1989.....	60
Fig. 6.	Table taken from 'AIDS in the RSA', 1986.....	63
Fig. 7.	Schoub <i>et al</i> 's 1988 model showing how AIDS might infect 'the heterosexual population' in SA.	66
Fig. 8.	Early AIDS awareness pamphlet issued by the ANC Department of Health, Lusaka. ...	102
Fig. 9.	Map showing the location of ANC missions, offices and settlements.	104
Fig. 10.	Structure of the ANC Department of Health with the UK RHT added.	109
Fig. 11.	Front cover of 1982 / 1983 Progress Report and extract on health care.	112
Fig. 12.	Title shot and scene from the first part of the ANC AIDS education video 'As Surely as an A.K.'	135
Fig. 13.	Comrade Luke is visited by the other characters throughout the video.	136
Fig. 14.	Scenes from the second and third parts of the video.	137
Fig. 15.	Summary of the phases of government responses to AIDS by Sadie and van Aardt, Fourie and Tsampiras.	185
Fig. 16.	Changes in the number of references to AIDS in <i>Hansard</i>	187
Fig. 17.	Breakdown of parliamentary fora in which references to AIDS were made.	187
Fig. 18.	Breakdown of how often different political parties referred to AIDS.....	189
Fig. 19.	Newspaper report about the homophobic poster telling 'moffies' not to donate.....	201
Fig. 20.	Table in <i>Epidemiological Comments</i> listing ages, length of survival, and deaths of 'AIDS cases' by 1987.....	211
Fig. 21.	Government AIDS information pamphlet from 1989.....	221
Fig. 22.	Hunt Lascaris Logo & Yellow Hand Logo.	253
Fig. 23.	Detail of AIDS Information Supplement in <i>The Sowetan</i> and <i>The Star</i> , c. 1991/2.....	253
Fig. 24.	Bright, bold figures from the YHC supplements.....	255
Fig. 25.	AIDS Information Advert, c. 1991/2.	256
Fig. 26.	Detail of AIDS Information Supplement in <i>The Star</i> , c. 1991/2.....	257
Fig. 27.	Awareness Advert/Poster aimed at Teachers and Parents, 1992.....	267
Fig. 28.	Cartoon commenting on medical organisations' responses to the murder of Biko (<i>Sowetan</i> , 1984).....	288
Fig. 29.	NAMDA Conference Proceedings 1985, 1986 & 1990.	299
Fig. 30.	Panels from the 'Keep It Hot Safe and Gay' Comic Strip.	359
Fig. 31.	Safer sex cards from the Cape Town-based organisation ASET.....	361
Fig. 32.	Safer sex postcards from the Gay Peoples' Health Forum.....	361
Fig. 33.	Cartoon by political satirist Jonathan Shapiro – Zapiro (<i>Mail & Guardian</i> , 2005).	367

ACKNOWLEDGEMENTS

Researching and writing a PhD is essentially a long, solitary process but it is one that is also dependent on a lot of communal and collegial processes. While I take full responsibility for all views, interpretations, analyses, and representations in this thesis (and any unnoticed errors), there are many people to whom I owe thanks and would like to acknowledge for making the communal, collegial processes so enjoyable.

I would like to thank Paul Maylam for his calming presence and guidance as my supervisor and for his integrity as an HOD and academic – I have learnt much from him in all these spheres. Thank you to my colleagues in the History Department at Rhodes, especially Enocent Msindo and Alan Kirkaldy for helpful advice, and special thanks to Cherry Charteris for help and support in more ways than can be counted – I would not have been able to lecture, supervise, administer courses, and write a thesis without your help.

To the committed research assistants who helped with parts of this project – Nyx Maclean and Lucie Pinson for hours of patient and thorough data capturing, Dominique Schäfer and Kylie van Zyl for help beyond the call of duty, and Anouk Verheijen, Sam Sadian, and Felicity Sibindi – thank you very much. Thanks also to the students in my Health, Dis-ease and Society course, and those who have taken my post-graduate course on AIDS and history in South Africa, for interesting questions.

As a researcher I have benefitted enormously from the advice and knowledge of numerous archivists and librarians and I would like to thank Anthony Manion from Gay and Lesbian Memory in Action for his time and help. Michele Pickover, Gabriele Mohale, and Zofia Sulej from Historical Papers at WITS, constantly reminded me of the power of archivists to be activists. The holdings and work of the South African History Archive likewise stand as testimony to the importance of archives, history and activism. Mosoabuli Maamoe at the ANC Archive at Fort Hare shared both personal and professional knowledge, as did Sandy Rowoldt-Shell and the staff of the African Studies Library at UCT. The staff at the International Institute of Social History in Amsterdam ensured I was able to return to South Africa with a copy of a video I had sought for five years. Similarly Leonard Benjamin at the

National Library of South Africa in Cape Town went out of his way to ensure I had what I needed. Thanks also to the librarian at the Medical Research Council in Cape Town for uncovering Annual Reports. Liz de Wet at the Cory Library for Historical Research, Samuel Simango from the Rhodes Law Library and numerous staff at the Rhodes Main Library and Pharmacy Library helped me locate numerous important sources.

There were also those who gave me access to their personal or organisational archives and I would like to thank Pierre Brouard, Mary Crewe, Michele Galloway, Dennis Sifris, Rina Venter and Alan Whiteside. Similarly, the following people gave generously of their time and knowledge to answer my questions and I would like to thank them for allowing me to interview them: Acalaraja (Wayne), Quarraisha Abdool Karim, Salim (Slim) Abdool Karim, Virginia Berridge, Pierre Brouard, Edwin Cameron, Dawn Cavanagh, Mary Crewe, Michele Galloway, Janet Giddy, Hoosen M. 'Jerry' Coovadia, Francie Lund, Hugh MacMillan, Shaun Mellors, Steve Reid, Helen Schneider, Rob Shell, Dennis Sifris, Vajradhara (who died in November 2011 and will be fondly remembered), Rina Venter, and Alan Whiteside.

I have intellectual debts of gratitude to the following people whose work and advice have been important in shaping my understanding of so many aspects of history and AIDS. Firstly, to Hilary Sapire whose Masters course on disease and society in Africa at Birkbeck inspired me and shaped my own teaching and research. Also to Catherine Burns, Catherine Campbell, Louis Grundlingh, Kevin Kelly, Shula Marks, and Julie Parle whose words and works continue to teach me new things. Thanks also to Rosemarie Buikema and all at the NOV (Women and Gender Studies Unit), University Utrecht for support during my time there in 2010.

I would like to acknowledge the financial assistance that I received from the Dean of Research's Office, Rhodes University, and the National Research Foundation's *Thuthuka* Programme which allowed me to undertake archival research trips and attend conferences.

To my friends who have put up with my absences while I have been writing – thank you to all of you. Special thanks to Angelo Fick, Undine Weber, and Theresa Edlmann for friendship, support, walks, conversations, coffee, vegan food, and laughter. Thanks also to my friends who have provided insights, inspirations and advice - Tracy Morrison, George Barrett-Haigh,

Anthea Lesch, Thoko Madonko, Eitan Prince and Zadie, Nomalanga Mkhize, Alex Sutherland, Nick Hamer and Jasper and Gabriel, Vashna Jarganath, Richard Pithouse and Rahul, Morgenie Pillay, Daygan Eagar, and Katherine Harrison. More special thanks to those who opened their homes and hearts to me on my research trips to Jozi, Ruth and Mark Weiner, Zara and Alon; Kurt van Staden and Rui Frizado; and Michele Ruiters who also threw in yoga!

Thanks are also due to Michelle Schloder, Bhavna Nager and Mariaan Mavro who helped me grow into myself and my being; my yoga class that made me forget the thesis and be present in the moment; the womyn who have gone before me and made it possible for me to get an education; and the people like Yolisa Ngele who are living with HIV and showing the rest of us how to get involved. I am also conscious of all those who have died from AIDS-related illnesses and left families and friends, you are remembered.

My biggest thanks goes to my family – immediate and extended – to my Mom and Dad, Yia-Yia, my sister Lee, my Nona Nicky Tsampiras, the delight that was Gerasimo Vlachoulis, my aunts, uncles, cousins (especially Sanchia, Marco, Marcessa and Gabriel), second cousins, and the rest of my family; to my extended family Roy (D2), Sue(berry), Caryll, Rafe, and Xaria Overy; and to Saskia and Nicky and the rest of the Oz family, I thank you for inspiration, nurturing, roots, history, love and for allowing me to become who I am. My most intimate thanks goes to my partner Neil Overy for discussions about aspects of the thesis, dedicated editing, and travelling the long, winding road of a complex journey - here's to the joyful anticipation of new post-thesis adventures.

A NOTE ON LANGUAGE

As a researcher I am interested in the importance of language as a means of creating, reinforcing, and changing, amongst other things, individual and collective notions of identities, meanings, and conceptual understandings. It is therefore appropriate that I explain my position on some of the language used in this thesis.

While acknowledging that 'race' is not real, the politics of constructing racial categories and the effects of this construction in terms of racism are very real. In South Africa, both during and after apartheid, racial identifiers and markers continue to be part of narratives in, and about, South Africa. As fraught, problematic, and constructed as racial markers are, they also mediated narratives about, and responses to, AIDS in South Africa and so their use is unavoidable in the thesis. When quoting from sources the racial designations of the time (as per the Population Registration Act) are used but spelled with lower-case letters to indicate their constructed nature. Some of the AIDS narratives discussed in this thesis drew from, or were premised upon, historical constructions of 'whiteness' and 'blackness' as ascribed to people considered to be phenotypically 'white' or 'black'. These terms are employed when necessary but are used with a conscious awareness of their constructed nature. I have tried to reduce the amount of 'scare quotes' used in the text for ease of reading.

As a political marker of the socially constructed binary notions of human identity, and in recognition of the feminisms that have shaped my thinking, I use the spelling 'womyn' to refer to the group of people categorised as 'female'. Conventional spellings are used when quoting from sources. While conventional spellings are used for 'man' or 'men', these terms are also understood to be constructed and increasingly contested.

Both HIV and AIDS are terms that have a political history. Similarly, the configurations in which they have appeared – HIV, AIDS; HIV/AIDS; HIV and AIDS – speak of changing global, local, personal, and collective politics around the relationships between the virus, the syndrome, and how we live, die, and interact with them. For ease of reading I use the generic term 'AIDS' in the thesis and use 'HIV' only when specifically referring to the virus.

PREFACE: LOCATING THE HISTORICAL 'I' IN THIS THESIS

Disciplinary convention in the writing of history does not necessarily welcome the 'I' into the narrative. As Paul Maylam notes there is 'a widespread tendency for historical work to be written in a style that appears to remove the author's voice from the text, creating a false impression of a seemingly neutral observer presenting authoritative accounts and explanations.'¹ While I am in many ways a product of this disciplinary convention, I also reject the notion that my voice is ever removed, even when I have chosen not to insert, or assert, the authorial 'I'. What follows is my 'outing' as a researcher that speaks of both a 'reflexivity of discomfort' and a commitment to openly declare my voice.²

Despite the importance of locating the researcher in the research work, and casting a critical and reflexive eye on the author's multiple locations (ideological, methodological, geographic and intellectual), I am not fond of inserting the personal pronoun 'I' into my academic writing. This thesis has been written and worked on part-time over six-and-a-half of the nine years I have spent as a lecturer. Throughout those nine years I have been many 'I's' and have grown, struggled and changed, because of, and throughout, the process of learning to teach, research and write. Having said this, I recognise that to be true to the ideologies that influence my research and my way of being in the world, I do need to ensure that the current 'I' writing these words is acknowledged and so this section, and a few sections in the thesis, become the exceptions to my own rule.

My work, teaching and personal/public lives have been continually moulded by feminisms, food and sexuality politics, AIDS activism, and an acute awareness of the responsibilities that the privileges of my class, 'race', age, and access to resources, have afforded me in a world that thrives on and actively promotes inequality and the perpetuation of economic, political, and resource stratification and hierarchy. As a womyn I recognise the rareness of my

¹ Maylam, P., *South Africa's Racial Past – The Historiography of Racism, Segregation and Apartheid* (Aldershot, Ashgate, 2001), p. 3.

² These terms come from work by Finlay, L., "'Outing" the Researcher: The Provenance, Process, and Practice of Reflexivity', *Qualitative Health Research*, 12, 4, April 2002; and Pillow, W.S., 'Confession, Catharsis, or Cure? Rethinking the Uses of Reflexivity as Methodological Power in Qualitative research', *Qualitative Studies in Education*, 16, 2, 2003. Thank you to Tracy Morison for the references and to George Barrett-Haig, Theresa Edlmann, Michele Ruiters, Nomalanga Mkhize, and Tracy Morison for their insightful and supportive comments.

experience – of having received an education and having done so with the support of my family. Being financially secure and employed during the process of writing are remarkable things in a world where the majority of womyn still struggle for basic survival and bodily integrity.

My teaching, my research, and this thesis are my contribution to challenging normative gender roles, highlighting the importance of language, and revealing and responding to sexism, racism, heteronormativity and homophobia. In all the fora in which I am able to, I raise awareness about these and other forms of discrimination, and about unreflective research or restrictive non-liberatory ideologies that I see and experience. I do not assume that theses change the world, but I do believe in the personal transformative power of education and in the personal as political. In recognition of the work of those who have gone before me, I write this thesis so that others may come after me and engage with the subject matter and discipline in new ways that I have not even dreamed of.

As Hans Stolten has observed, ‘the nature of history writing remains essentially selective and often ideological’ and, as I tell the students I teach, all lectures are propaganda.³ So too, I acknowledge that my work is influenced by the factors that I have disclosed, and those I am not yet conscious of, and have therefore not yet disclosed.

The other reason why I am hesitant about using ‘I’ in my research is that I do not feel that it adequately acknowledges the effect of archives, research, interviews, the writing process, and the ways ideas and thoughts develop and are influenced by the art and act of creating ‘the text’. The first and final thesis proposals submitted differ not only from each other, but also from what the thesis became. Similarly, initial planning for each chapter changed as learning occurred during the process of writing. Quotes that I read one way in my initial engagement with them were revealed in a different light when I came to read them for a second or third time, and changed again as I wrote them down and attempted to make sense of them in the context of the work. In addition, discussions with friends, colleagues and my supervisor changed the way I understood and engaged with ideas and arguments.

³ Stolten, H.E., ‘History in the New South Africa: An Introduction’ in Stolten, H.E. (ed) *History and Present Day Politics – The Meaning of Collective Memory in South Africa* (Uppsala, Nordiska Afrikainstitutet, 2007), p. 39.

For me the process of researching, writing, and learning was also somewhat organic and the people I interviewed, people who commented on my work, archivists, librarians and the holdings in the archives, as well as the process of writing the chapters, influenced me as the author and researcher as much as I influenced the texts.

In essence then, I believe that the thesis, and its component parts, should stand in and of themselves as texts derived from multiple contexts, through numerous processes, by a particular author, but also as a specific 'entity'. I am proud of what I have written, but simultaneously plagued by the vulnerability writing requires, the overly critical inner-eye and the struggle to sit 'the final exam' in my chosen profession and allow my academic voice and authority to grow always increasingly confident, but never arrogant. That said, I also hope to look back on the thesis one day and be able to see the growth, change, evolution and developments in my thinking, writing, and voice – to reflect on the thesis and the many 'I's' that wrote it initially, and compare them to the texts and 'I's' that are writing, speaking and coming into existence then.

Paul Maylam once wrote that 'what goes by the name of history amounts only to more or less imperfect, imprecise reconstructions and explanations of the past', while Stolten observed that 'history writingcan never be "free"... [but] will always be laden with meaning.'⁴ This thesis is my imperfect and imprecise reconstruction and explanation of a particular set of responses and discussions about AIDS amongst certain groups of people and amongst certain texts. I acknowledge its imperfections, without undermining its importance or contribution. I acknowledge too, that the text and author are not 'free' but always loaded with meaning and have presented, as honestly as I know how, some of the factors that have shaped those meanings so that my work and status as author are not hidden, but rather declared with integrity.

⁴ Maylam, *South Africa's Racial Past*, p. 2 and Stolten 'History in the New South Africa', p. 39.

INTRODUCTION

In July 1983 an article by five medical professionals which reported on the first officially documented cases of the recently named 'Acquired Immunodeficiency Syndrome' (AIDS) in South Africa appeared in the *South African Medical Journal (SAMJ)*.¹ While the 'two cases' were not named in the journal article, their names had already appeared in certain South African newspapers. The initial responses by the 'general public' to the first documented cases were primarily characterised by fear and stigma and reflected prejudice, homophobia and 'moral panic' that were deeply rooted in the dominant conservative morality that pervaded South Africa in the 1980s.² The men had primarily been identified as 'homosexual', 'white', flight stewards, not as two people who had died and would be mourned.³ Ralph Kretzen died on 26 August 1982 and Pieter Daniël (Charles) Steyn died on 1 January 1983, and we know very little about their personal histories.

At the start of the fourth official decade in which people live with Human Immunodeficiency Virus (HIV) and die of AIDS-related illnesses, it is often difficult to remember that health crises have histories. The ongoing urgency of addressing AIDS in South Africa, not to mention the politics of contemporary AIDS policies, have kept academics and activists focussed, for the most part, on the immediate crises of AIDS 'in the present'. Current figures affirm that millions now live with HIV in South Africa, but there are also hundreds of thousands of cases of AIDS-related deaths in South Africa many of which were, and continue to be, complicated by fear, stigma, and prejudice (Appendix A).⁴ The hundreds of thousands of 'cases' are still people, with names, who died and will be mourned, and they each have personal histories that we may never know. There are, however, histories that can be known and are visible

¹ Ras, G.J., Simson, I.W., Anderson, R., Prozesky, O.W., & Hamersma, T., 'Acquired Immunodeficiency Syndrome – A Report of Two South African Cases', *SAMJ*, 64, 4, 23 July 1983, pp. 140 – 142. With hindsight and knowledge of how the epidemic was to unfold in South Africa it is evident that people were already infected with HIV in at least the late 1970s. Nonetheless these two deaths were the ones that were officially recognised by the medical community and reported on in the South African media.

² Grundlingh, L., 'Early Attitudes and Responses to HIV/AIDS in South Africa as Reflected in Newspapers, 1983 - 1988', *Journal for Contemporary History*, June 2001, p. 87.

³ *Ibid.* p.87

⁴ According to UNAIDS, the current life expectancy in South Africa is 53 years of age, 5.6 million people are living with HIV, there are 387 000 new HIV infections every year, and 314 000 people die from AIDS-related illnesses each year. See UNAIDS, AIDSInfo Country Fact Sheet - South Africa, available from the UNAIDS website at www.unaids.org/en/dataanalysis/tools/aidsinfo/countryfactsheets (accessed July 2012).

which can help us to understand how those who died, and continue to die, were researched, framed, and interpreted within organisations, communities, and ideologies that shaped discussions about, and responses to AIDS, and contribute to our contemporary understandings of this health crisis.

Thirty years after the first officially recognised AIDS-related death in South Africa in 1982, this thesis reflects on the early years of the AIDS epidemic in South Africa starting two years prior to the officially recognised deaths (1980) up to the time immediately after political transition (1995). This thesis identifies some of the dominant narratives that influenced and framed AIDS research, examines responses to AIDS by certain communities, and shows how polemic and politics combined to influence practical responses to AIDS by elites in medico-scientific and political communities. The thesis considers AIDS 'in the past' in order to provide an historical perspective that might contribute to understandings of AIDS 'in the future'.

Allan Brandt observed that '... history holds no simple truths ... our responses to the current epidemic will be shaped by contemporary science, politics, and culture'.⁵ In light of this, the 'present' in which this thesis was written is acknowledged, as are the influences that contemporary science, politics, culture, and personal experiences have had in shaping the author's thinking and research. This thesis is a current response to the epidemic but it represents aspects of a history of AIDS in South Africa.

One of the reasons for writing this thesis was to contribute to a mandate of history identified by eminent historian Shula Marks who emphasised 'the value of historical analogy in challenging dominant preconceptions, locating contemporary reactions in context and enabling a sense of perspective'.⁶ This thesis uses historical analogy to challenge dominant preconceptions about AIDS in South Africa as an epidemic 'without a past' by revealing the changing medico-scientific narratives about AIDS, and the complex changing responses to AIDS by medico-scientific and political communities. It helps to provide historical context

⁵ Brandt, A.M., 'AIDS in Historical Perspective: Four Lessons from the History of Sexually Transmitted Diseases', *American Journal of Public Health*, 78, 4, April 1988, p. 367.

⁶ Marks, S., 'An Epidemic Waiting to Happen? The Spread of HIV/AIDS in South Africa in Social and Historical Perspective', *African Studies*, 61, 1, 2002, p. 13.

that can be used to locate contemporary reactions by examining how the African National Congress (ANC) in exile, the South African governments of the period, a progressive medical organisation, and sexuality activists responded to AIDS. The thesis contributes to the creation of historical perspectives on AIDS in South Africa and adds to the historiography of AIDS in South Africa.

Writing History in an Epidemic

By 1997 there was a sufficient body of academic work focussed on history and AIDS in the USA and the UK, that South African-based historian Louis Grundlingh was able to reflect on the 'nature and development of HIV/AIDS historiography' and identify themes in what he referred to as 'Western historiography'.⁷ Grundlingh observed that at the outset of the epidemic 'the academic world initially ignored the HIV/AIDS epidemic and its research impact on their field'.⁸ To date, AIDS research has generated a vast body of work across most disciplines covering numerous aspects of the epidemic, and there is work that addresses AIDS both on the African continent and in southern and South Africa.⁹ While

⁷ Grundlingh, L., 'The Nature and Development of HIV/AIDS Historiography', *Acta Academica*, 29, 2, August 1997.

⁸ *Ibid.*, p. 2.

⁹ For example, a search on the Rhodes University Library catalogue using the 'Primo cross search' (PCS) database and a search on the internet using Google Scholar (GS) produced the following results: for the search term 'AIDS', PCS returned 273 325 hits and GS 1 900 000; for the terms 'AIDS' and 'Africa', PCS returned 38 706 hits and GS 1 020 000; and for the search terms 'AIDS' and 'South Africa', PCS returned 26 657 hits and GS 794 000. As more concrete examples, the following works have been helpful in teaching courses on AIDS and informed my understanding of different aspects of AIDS: Barnett, T., & Whiteside, A., *AIDS in the Twenty-first Century: Disease and Globalization* (Basingstoke, Palgrave Macmillan, 2002); Campbell, C., *Letting Them Die: Why HIV Prevention Programmes Fail* (Cape Town, Double Storey, 2003); Crewe, M., *AIDS in South Africa: The Myth and the Reality* (Harmondsworth, Penguin, 1992); Cross, S., & Whiteside, A. (eds) *Facing Up to AIDS: The Socio-economic Impact in Southern Africa* (London, Macmillan, 1993); de Waal, A., *AIDS and Power: Why There is No Political Crisis - Yet* (Cape Town, David Philip, 2006); Elder, G., *Hostels, Sexuality, and the Apartheid Legacy: Malevolent Geographies* (Athens, Ohio University Press, 2003); Fassin, D., *When Bodies Remember: Experiences and Politics of AIDS in South Africa* (Berkeley, University of California Press, 2007); Heywood, M., *From Disaster to Development: HIV and AIDS in Southern Africa* (Braamfontein, INTERFUND, 2004); Marais, H., *Buckling : the impact of AIDS in South Africa 2005* (Pretoria, University of Pretoria, 2005); Mukudi Omwami, E., Commins, S., & Keller, E.J. (eds), *HIV/AIDS in Africa: Challenges & Impact* (Trenton, Africa World Press, 2008); Natrass, N., *The Moral Economy of AIDS in South Africa* (Cambridge, Cambridge University Press, 2004); Ndinga-Muvumba, A., & Pharoah, R. (eds), *HIV/AIDS and Society in South Africa* (Scottsville, University of KwaZulu-Natal Press, 2008); Poku, N., *AIDS in Africa: How the Poor are Dying* (Cambridge, Polity, 2005); Poku, N.K., & Whiteside, A. (eds), *The Political Economy of AIDS in Africa* (Aldershot, Ashgate, 2004); Susser, I., *AIDS, Sex, and Culture: Global Politics and Survival in Southern Africa* (Oxford, Wiley-Blackwell, 2009); Theodoulou, S.Z. (ed), *AIDS: The Politics and Policy of Disease* (Upper Saddle River, Prentice Hall, 1996); Whiteside, A., & Sunter, C., *AIDS: The Challenge for South Africa* (Cape Town, Human & Rousseau, 2001); and Whiteside, A., *HIV/AIDS: A Very Short Introduction* (Oxford, Oxford University Press, 2008).

historical approaches (or reflections) have featured in some of these works, full-length social histories of AIDS and historical analyses of AIDS in South Africa by historians have not appeared in great numbers.¹⁰

The most well known general history of AIDS is Mirko Grmek's work published in English in 1990, while John Iliffe wrote a history of AIDS on the African continent, published in 2006, that includes a section on southern Africa.¹¹ In the same year, Philippe Denis and Charles Becker edited a book available online in English that provided an 'historical perspective' on AIDS in sub-Saharan Africa and provided examples from South Africa.¹²

The other 'general history' of the global epidemiology of AIDS is Jonathan Engel's work and Jaap Goudsmit's has written an epidemiological history of HIV.¹³ There is also the newly published book by Daniel Halperin and Craig Timberg, a scientist and a journalist respectively, whose work follows in the mould of Randy Shilts work which was an account of the history of AIDS in the USA drawn from Shilts' personal experience and his professional experiences as a journalist.¹⁴

Some of the literature on AIDS in South Africa contains 'potted histories' of the identification and spread of AIDS in the country, or provides chronological overviews of the aspect of AIDS

¹⁰ As an example, an article by Prof. L. Kallings, a clinical microbiologist, reflected on '25 years of HIV/AIDS' which presents a chronological overview of medical responses but is not 'a history' *per se*. Kallings, L.O., 'Review Article: The First Postmodern Pandemic: 25 Years of HIV/AIDS', *Journal of Internal Medicine*, 263, 3, March 2008 (accessed using Academic Search Premier).

¹¹ Grmek, M. D., *History of AIDS: Emergence and Origin of a Modern Pandemic* (Princeton, Princeton University Press, 1990); and Iliffe, J., *The African AIDS Epidemic: A History* (Oxford, James Currey, 2006) see particularly chapter 5 'The Conquest of the South'. For a review of Iliffe's work see Marks, S., 'Review: Science, Social Science and Pseudo-Science in the HIV/AIDS Debate in Southern Africa', *Journal of Southern African Studies*, 33, 4, December 2007..

¹² Denis, P., & Becker, C. (eds) *The HIV/AIDS Epidemic in Sub-Saharan Africa in a Historical Perspective*, English addition published online by the Senegalese Network "Law, Ethics, Health", October 2006 available on the website of the *Agence Universitaire de la Francophonie* at <http://rds.refer.sn/IMG/pdf/AIDSHISTORYALL.pdf> (accessed July 2009). See part three on 'HIV/AIDS in the History of Epidemics' particularly Echenberg, M., 'Historical Perspectives on HIV/AIDS: Lessons from South Africa and Senegal' and Carton, B., 'Historicising the Unspeakable. Legacies of Bad Death and Dangerous Sexuality in South Africa'.

¹³ Engel, J., *The Epidemic: A Global History of AIDS* (New York, Collins, 2006) and Goudsmit, J., *Viral Sex: The Nature of AIDS* (Oxford, Oxford University Press, 1998).

¹⁴ Halperin, D., & Timberg, C., *Tinderbox: How the West Sparked the AIDS Epidemic and How the World Can Finally Overcome It* (New York, Penguin Press, 2012) [softback available in February 2013]. Shilts, R., *And the Band Played On: Politics, People and the AIDS Epidemic* (New York, Penguin, 1987).

under discussion in the work (for example AIDS policy).¹⁵ There are also journalistic and personal histories (autobiographical and other) of AIDS in South Africa, such as those by Lesley Lawson and Edwin Cameron.¹⁶ In addition there are works from other disciplines that are particularly sensitive to historical context and perspectives, such as Mark Hunter's work, and edited collections that include the work of historians.¹⁷ So when did historians of, and in, South Africa start writing about AIDS?

While academic texts discussing AIDS, history, historiography, the role of historians, and specific histories of, for example AIDS policy, were appearing in the USA and UK between 1988 and 1996, there were no comparable works on, or in, South Africa (aside from Grundlingh's review).¹⁸ For example, the discussions raised by Elizabeth Fee and Daniel Fox about AIDS and history, the explanations of epidemics provided by Charles Rosenberg, and

¹⁵ See for example, Abdool Karim, Q., & S. S. (eds) *HIV/AIDS in South Africa* (Cape Town, Cambridge University Press, 2008) particularly the introduction (the book was originally published in 2005); Fourie, P., *The Political Management of HIV and AIDS in South Africa: One Burden Too Many?* (Basingstoke, Palgrave Macmillan, 2006) and Natrass, N., *Mortal Combat: AIDS Denialism and the Struggle for Antiretrovirals in South Africa* (Scottsville, University of KwaZulu-Natal Press, 2007). See also Corinne Squire's work *HIV in South Africa: Talking About the Big Thing* (Abingdon, Routledge, 2007). Squire lectures in psychosocial studies and narrative research as part of the School of Law and Social Sciences and is co-director of the Centre for Narrative Studies at the University of East London, UK.

¹⁶ Lawson, L., *Side Effects* (Cape Town, Double Storey, 2008); Cameron, E., *Witness to AIDS* (Cape Town, Tafelberg, 2005); and Steinberg, J., *Three-letter Plague: A Young Man's Journey Through a Great Epidemic* (Johannesburg, Jonathan Ball Publishers, 2008). There is also the collection of work covering aspects of Mbeki-era denialism edited by journalists Kerry Cullinan & Anso Thom of Health-e News Service (see the Health-e News website at www.health-e.org.za, accessed December 2012) for more on this non-profit news agency and see Cullinan, K. & Thom, A. (eds) *The Virus, Vitamins and Vegetables: the South African HIV/AIDS Mystery* (Auckland Park, Jacana, 2009).

¹⁷ Hunter, M., *Love in the Time of AIDS: Inequality, Gender, and Rights in South Africa* (Scottsville, University of KwaZulu-Natal Press, 2010) – Hunter is a social scientist who works in both a geography department and in a school of development studies. See for example Phillips, H., 'HIV/AIDS in the Context of South Africa's Epidemic History' in Kauffman, K.D., & Lindauer, D.L. (eds) *AIDS and South Africa: The Social Expression of a Pandemic* (New York, Palgrave Macmillan, 2004); and Marks, S., 'The Burdens of the Past' in Ndinga-Muvumba, A., & Pharoah, R. (eds), *HIV/AIDS and Society in South Africa*.

¹⁸ This is not to suggest that historians of South Africa or social historians interested in health and the history of medicine in Africa, southern Africa, or South Africa were not aware of AIDS. There were numerous articles between 1989 and 2000 that considered AIDS in relation to these specific historical disciplines. See for example, Prins, G., 'But what Was the Disease? The Present State of Health and Healing in African Studies', *Past and Present*, 124, August 1989; Packard, R., & Epstein, P., 'Epidemiologists, Social Scientists and the Structure of Medical Research on AIDS in Africa', *Social Science and Medicine*, 33, 7, 1991; Marks, S., 'What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health?', *Social History of Medicine*, 10, 2, 1997; Malowany, M., 'Unfinished Agendas: Writing the History of Medicine of Sub-Saharan Africa', *African Affairs*, 99, 2000; and Van Heyningen, E., 'Review: Recent Research on the Social History of Medicine in Africa', *South African Historical Journal*, 45, 1, November 2001. More recently there was also Denis, P., 'Towards a Social History of HIV/AIDS in Sub-Saharan Africa' in Denis, P., & Becker, C. (eds) *The HIV/AIDS Epidemic in Sub-Saharan Africa*.

the explorations into AIDS and contemporary history by Virginia Berridge and Philip Strong were not taking place amongst many historians of South Africa at the time.¹⁹

In 2001 Peter Delius and Liz Walker (described by historian Catherine Burns as an historian and a historical sociologist, respectively) organised an inter-disciplinary conference at Wits University called 'AIDS in Context'.²⁰ Historian Shula Marks gave the plenary address which was published a year later as 'An Epidemic Waiting to Happen', along with an introduction by Delius and Walker.²¹ Delius and Walker noted in this introduction that in South Africa 'the [AIDS] epidemic [had] not, however, enjoyed equal prominence in social scientific research' and that 'much work remains to be done on the specific interaction of the historical, social, political and cultural factors that have shaped the epidemic'.²² Also in 2001, the *South African Historical Journal* featured an edition which published several important articles about AIDS and history. In this edition Grundlingh published his pioneering articles examining responses to AIDS as represented in the media; Simone Horwitz provided an historical perspective on AIDS and migrancy; and Howard Phillips contextualised AIDS in relation to South Africa's epidemic history.²³

It was thus only at the start of the new millennium that historians of South Africa began writing histories of AIDS in South Africa and locating AIDS in the history of health in South

¹⁹In chronological order see: Fee, E., & Fox, D.M. (eds), *AIDS: The Burdens of History* (Berkeley, University of California Press, 1988); Fee, E., & Fox, D.M., 'The Contemporary Historiography of AIDS', *Journal of Social History*, 23, 2, Winter, 1989; Rosenberg, C.E., 'What Is an Epidemic? AIDS in Historical Perspective', *Daedalus*, 118, 2, Living with AIDS, Spring, 1989, [this also appeared in Rosenberg, C. E., *Explaining Epidemics and Other Studies in the History of Medicine* (Cambridge, Cambridge University Press, 1992)]; Berridge, V., & Strong, P., 'Review Article: AIDS and the Relevance of History', *Social History of Medicine*, 4, 1, 1991; Fee, E., & Fox, D.M. (eds) *AIDS: The Making of a Chronic Disease* (Berkeley, University of California Press, 1992); Berridge, V., & Strong, P. (eds) *AIDS and Contemporary History* (Cambridge, Cambridge University Press, 2002 - first published 1993); and Berridge, V., *AIDS in the UK: The Making of a Policy, 1981-1994* (New York, Oxford University Press, 1996). These texts have however, remained invaluable to historians working on AIDS in South Africa.

²⁰ Burns, C., 'A Useable Past: The Search for "History in Chords"' in Stolten, H.E. (ed) *History and Present Day Politics – The Meaning of Collective Memory in South Africa* (Uppsala, Nordiska Afrikainstitutet, 2007), p. 356.

²¹ Marks, S., 'An Epidemic Waiting to Happen? And 'Delius, P., & Walker, L., 'AIDS in Context', *African Studies*, 61, 1, 2002.

²² Delius & Walker, 'AIDS in Context', p. 5 (also quoted by Burns).

²³ Grundlingh, 'Early Attitudes and Responses to HIV/AIDS in South Africa'; and 'Government Response to HIV/AIDS in South Africa as Reported in the Media, 1983-1994', *South African Historical Journal*, 45, 1, November, 2001; Horwitz, S., 'Migrancy and HIV/AIDS: A Historical Perspective', *South African Historical Journal*, 45, 1, November 2001; and Phillips, H., 'AIDS in the Context of South Africa's Epidemic History: Preliminary Historical Thoughts', *South African Historical Journal*, 45, 1, November 2001 (see also Phillips, H., 'AIDS in South Africa: An Historical Perspective', *Society*, 40, 4, May/June 2003).

Africa. Burns observes that Walker and Delius had noted this delay but not fully addressed the reasons for it aside from indicating that after 1994 there was an 'emergency-style focus on rapidly executed projects set up with the promise or hope of immediate and maximum clinical and behavioural benefits'.²⁴ Burns suggests that these responses effectively sidelined 'responses from researchers of language and literature, music and cultural life, deep political and sociological analyses, and responses from within the ranks of historical researchers'.²⁵

Regardless of the reason for the slow start, Burns points to the new opportunities for the 'research, writing and teaching' of history offered by 'the expansion of medical and health history' or what she refers to as 'the study of "desire, disease, delight and death"'.²⁶ Similarly, Christopher Saunders included the social history of medicine as one of the areas of South African history in which new questions were being asked, and certainly the growing body of work on AIDS by historians support both Burns' and Saunders' contentions.²⁷

In the decade since the 'AIDS in Context' conference this body of work has included articles and theses on AIDS and poverty, sexuality, film, and activism by a new generation of historians like Rebecca Hodes, Mandisa Mbali and others.²⁸ Other topics have included AIDS education campaigns, and AIDS and the ANC in exile.²⁹ In addition, Walker *et al* published an accessible public history of AIDS, while Gerald Oppenheimer and Ronald Bayer compiled an

²⁴ Burns, 'A Useable Past', pp. 356 - 357.

²⁵ *Ibid.*, p. 357.

²⁶ *Ibid.*, p. 361. See also Stearns, P., 'The Forgotten Compass of Death: Apocalypse Then and Now in the Social History of South Africa', *Journal of Social History*, 37, 1, Autumn, 2003, in which Stearns argues that social histories need to study death/mortality.

²⁷ Saunders, C., 'Four Decades of South African Academic Historical Writing: A Personal Perspective' in Stolten, *History and Present Day Politics*, p. 288.

²⁸ Hodes, R., 'HIV/AIDS in South African Documentary Film, c. 1990 - 2000', *Journal of Southern African Studies*, 33, 1, March 2007; and Hodes, R., 'Siyayinqoba/Beat It!: HIV/AIDS on South African Television c.1999-2006', PhD thesis, University of Oxford, 2009; Mbali, M., 'The New Struggle': A History of AIDS Activism in South Africa, 1982 - 2003', PhD thesis, University of Oxford, 2009; and Mbali, M., 'Gay AIDS Activism in South Africa Prior to 1994', in Reddy, V., Sandfort, T., and Rispel, L. (eds) *From Social Silence to Social Science - Same-Sex Sexuality, HIV & AIDS and Gender in South Africa* (Cape Town, HSRC Press, 2009); Phatlane, S., 'Poverty and HIV/AIDS in Apartheid South Africa', *Social Identities*, 9, 1, March 2003; Tsampiras, C., 'Not So "Gay" After All: Constructing (Homo)sexuality in AIDS Research in the *South African Medical Journal*, 1980 - 1990', *South African Historical Journal*, 60, 3, September 2008.

²⁹ Grundlingh, L., 'Challenges and Obstacles in Early HIV and AIDS Education in South Africa, 1989-1994', *Historia*, 54, 1, May, 2009; and Tsampiras, C., 'Sex in a Time of Exile: An Examination of Sexual Health, AIDS, Gender and the ANC, 1980 - 1990', *South African Historical Journal*, 64, 3, 2012 (currently available online).

oral history of AIDS in South Africa.³⁰ It is to this burgeoning body of work on different aspects of the history of AIDS in South Africa that this thesis contributes by examining how narratives and politics intertwined to influence practical responses to AIDS by elites in medico-scientific and political communities.

Definitions and Directions Relating to Words and Actions

The following section provides definitions of key terms used in the thesis, after which an overview of each chapter is provided. The terms 'discourse' and 'narrative/s' are used to refer to common social meanings, symbols, metaphors, descriptors and 'stories' that are created and understood in a number of media and fora (for example in a medical journal, in debates in parliament, in written records of organisations, and in oral testimonies) by individuals in communities, or by communities themselves. These narratives underpin and create understandings of entities, concepts, ideologies, people or (ill)health such as 'AIDS', 'high-risk-groups', racism, sexism, heteronormativity, 'the general population' and health care. The creation and role of narratives and discourses are discussed in more detail in the first chapter, as are the changes, variations and challenges to them. Having acknowledged that narratives and discourses are neither static nor unalterable, the thesis still concurs with Pieter Fourie's contention that there was a 'normative discourse' that influenced responses to AIDS and the first chapter presents the author's reading of what the 'normative' or hegemonic narratives were.³¹

The fora in which these hegemonic narratives are examined in this thesis, and most of the sources used for this research, are derived from 'elite' sources, communities, and individuals. In this context the definition of 'elites' is based on work by Michele Ruiters who defines elites as 'formal or informal leaders within a community, regardless of their class status, who, for various reasons, have access to public fora in which they publicize their

³⁰ Walker, L., Reid, G., & Cornell, M., *Waiting to Happen: HIV/AIDS in South Africa - The Bigger Picture* (Cape Town, Double Storey, 2004); and Oppenheimer, G. M., & Bayer, R., *Shattered Dreams? An Oral History of the South African AIDS Epidemic* (Oxford, Oxford University Press, 2007).

³¹ Fourie, *The Political Management of HIV and AIDS*, pp. 57 - 64. Fourie's work, as discussed later in the thesis, is focussed on AIDS policy in South Africa but the arguments apply equally well to other responses.

political visions'.³² The elites who feature most prominently in this thesis are those who formed medico-scientific communities and/or political communities (defined below). While some of the political communities examined in the thesis (like the ANC) may have considered themselves part of more democratic structures working towards egalitarian ideals, the writing of records, the articulating of ideas and opinions, and the responsibility for implementing practical responses were, for the most part, the tasks of elites within organisations and communities.³³

The medical and scientific communities investigated in this thesis are those comprising formally educated, elite, professionals involved in aspects of medical or scientific research, practice, publication, or provision related to health care. This definition recognises that medicine is a branch of science and some branches of science are related to medicine but not necessarily pursued with the same purposes (developing drugs like Viagra, for example, is from studying the HI virus). What links the disparate disciplines and people is a particular disciplinary grounding and understanding rooted in the practices and epistemologies of the 'hard sciences'. The areas of expertise and specialisation in these communities ranged from general and specialised medicine, to epidemiology, virology, haematology and so forth, but all were linked by an interest in AIDS or HIV.

These communities of medical elites thus comprised medical practitioners, scientists and researchers who had access to professional, public and political fora, which they used to promote their particular views on AIDS and health care provision. These medical elites had sufficient social capital to interact easily with governments, academic institutions, media, political parties, colleagues, and professional gatherings at local, national, and international levels.

³² Ruiters, M., 'Elite (Re-) Constructions of Coloured Identities in a Post-Apartheid South Africa: Assimilations and Bounded Transgressions', PhD thesis, Rutgers University, 2006, p. 59.

³³ Referring to intellectual history, Saul Dubow noted that it 'is not by its nature democratic or popular, since it tends to focus on the thoughts and concerns of well-educated, articulate [people]' see Dubow, S., *A Commonwealth of Knowledge: Science, Sensibility and White South Africa, 1820 - 2000* (Cape Town, Double Storey Book, 2006) p. vii. While this thesis is not an intellectual history of ideas, it is concerned with the ideas and ideologies that were transmitted in AIDS narratives and shaped responses to AIDS. These ideas and ideologies were mostly written, transmitted and implemented by well-educated, literate people such as doctors. The thesis is thus not a social history 'from below', but one mostly involving elites who would shape how 'society' (or communities) would experience and understand AIDS.

The decision to focus on medical elites and medical communities was informed by the research, and by a recognition of the importance of Grundlingh's statement that understandings of AIDS were primarily constructed through two processes, namely stigmatization and medicalization, with the latter aspect '[relying] upon the pervasive ideology of the medical model as a way of understanding health and illness'.³⁴ A striking example of the pervasiveness of this medical model and its influence on how understandings of, and responses to AIDS were shaped by it, was provided by Alan Whiteside. Whiteside recalled how he 'boldly trod into the field of HIV and AIDS' by attending one of the first conferences on the global impact of AIDS held at the Barbican Centre in London, where he was scheduled to present a paper on AIDS.³⁵ While the conference audience was a mixture of medical scientists and social scientists, Whiteside remembered that 'every time the social science people talked the medics, to a man [sic], opened their newspapers'.³⁶

While one group of medical scientists attending a conference obviously do not represent all medical professionals, Whiteside's experience, combined with Grundlingh's analysis, highlighted the importance of examining medical scientists in a history of AIDS. Medical communities and their members not only framed the narrative about AIDS, but also influenced how it was addressed by political communities, either through how their narratives were employed by those in political power, or through their membership of, and involvement in, medico-scientific or political communities.

The political communities referred to in this thesis are those comprising educated elites involved in formal government politics (for example as members of parliament, government ministers, or civil servants); elites involved in political organisations (such as the ANC or affiliated bodies); and elite political activists involved in sexuality politics or progressive health movements or organisations (such as the National Medical and Dental Association – NAMDA). Members of political communities often moved through and between these communities and the medical and scientific communities, and these points of intersection are also discussed. These communities of political elites had access to public and political

³⁴ Grundlingh, L., 'The Nature and Development of HIV/AIDS Historiography', *Acta Academica*, 29, 2, August 1997, p. 14.

³⁵ Interview with Alan Whiteside, HEARD Office, UKZN, Westville, South Africa, 20 November 2007.

³⁶ *Ibid.*

fora and had sufficient social capital to promote their particular views on politics, AIDS, and responses to AIDS at local, national, regional and international levels.³⁷

This thesis is essentially about words and actions and their relationship to a health crisis named AIDS. It analyses a variety of sources and traces the shifting narratives that were used to define and understand AIDS in certain fora such as medical journals, organisational archives, and people's memories. It also examines how certain medico-scientific and political communities, and individuals within them, addressed AIDS and how those responses changed over time. The thesis reveals the complex relationships between hegemonic AIDS narratives and these communities and their members.

Narratives, of course, are not only made and re-made by people, organisations and communities, but also reflect the social mores, ideologies, beliefs and subjectivities of the people, organisations, and communities that create, challenge, and change them. Similarly, practical responses are dependent on the vision, commitment, planning skills, and political will of those tasked with implementing them. Responses too, can reflect the social mores, ideologies, beliefs and subjectivities of people, organisations, governments and communities and these social mores influence how responses are prioritised or (not) implemented. This thesis shows how hegemonic social mores were produced, reproduced, or challenged in the words and actions of the communities under examination. It does this by highlighting the constructions of sexuality, gender, and 'race' (which were often also linked to morality) that intersected to shape the politics, polemic, and praxis associated with AIDS.

³⁷ In both the medico-scientific and political contexts the use of the word 'communities' is deliberate and denotes an understanding of multiple, often complex and contested groupings of people linked by professional or other interests related to health, science, medicine, AIDS, politics, or activism. The author's thinking around this was influenced by work on epistemic communities in the field of International Relations (IR) and feminist theory. In IR the notion of epistemic communities or counter-epistemic communities are often discussed in terms of policy analyses and development, in this context they are applicable beyond policy related matters and could be applicable to discourse and narrative analysis and non-policy responses to AIDS. Epistemic communities are communities bound by a shared belief about a subject or understanding of the world, but not necessarily by a shared, uncontested point of view about the subject or understanding. For example doctors may hold different political views or views about health care provision but still share a common belief in a biomedical model of health. For an IR perspective see Haas, P.M., 'Introduction: Epistemic Communities and International Policy Coordination', *International Organization*, 46, 1, Winter 1992; Youde, J.R., *AIDS, South Africa, and the Politics of Knowledge* (Aldershot, Ashgate, 2007), and Youde, J.R., 'The Development of a Counter-Epistemic Community: AIDS, South Africa, and International Regimes', *International Relations*, 19, 4, 2005. For a feminist perspective that interrogates the relationships between individual agency and community agency see Grasswick, H.E. 'Individuals-in-Communities: The Search for a Feminist Model of Epistemic Subjects', *Hypatia*, 19, 3, Summer 2004.

In this thesis the notion of sexuality primarily refers to the World Health Organisation's definition of sexuality as:

... a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviour, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.³⁸

Recognition is also given however, to Peter Aggleton's observations about the 'ambiguity and situatedness of sexuality'. He notes that 'sexuality is intrinsically linked to physical acts, yet it is simultaneously conceived in discourse – in words and language' and 'rather than being a fixed entity, is perhaps best conceived of as something that is constructed both by individuals and by society more generally...'.³⁹ The thesis shows how medico-scientific and political communities and individuals constructed what constituted 'normal' sexuality, or judged the 'right' and 'wrong' types of sexuality and sexual practices. What is also evident in the thesis is the lack of an analysis or awareness of sexuality by these communities that seriously engaged with gender or gender roles.

While recognising the constructed nature of gender, this thesis uses the term, as per Sue Morgan's definition, as 'an analytical category that locates [the category man and womyn] within a broader framework of their social, cultural and political relationships'.⁴⁰ Much of the analysis in this thesis is a gendered analysis in that it uses gender, in the words of Elizabeth Fox-Genovese, 'as a primary category of historical analysis' and recognises that it is 'as deeply ingrained in social and economic formations and the political institutions to which they give rise as class relations'.⁴¹ While recognising the contested and structured nature of

³⁸ World Health Organisation, *Progress in Reproductive Health*, 67, 2004, p. 3 available on the WHO website at www.who.int/hrp/publications/progress67.pdf (accessed July 2012). This definition is also quoted in Aggleton, P., 'Researching Same-sex Sexuality and HIV Prevention' in Reddy, V., Sandfort, T., and Rispel, L. (eds) *From Social Silence to Social Science – Same-Sex Sexuality, HIV & AIDS and Gender in South Africa* (Cape Town, HSRC Press, 2009), p.3.

³⁹ Aggleton, 'Researching Same-sex Sexuality', pp. 3 & 4.

⁴⁰ Morgan, S. (ed), *The Feminist History Reader* (Abingdon, Routledge, 2006) p. 9.

⁴¹ Fox-Genovese, E., 'Placing Women's History in History', *New Left Review*, 1/133, May-June 1982, pp. 15 - 16.

gender, the definition employed here also acknowledges that these relational engagements are mediated by inherent power-dynamics and other constructed identifiers of difference, such as 'race' and sexuality.⁴² As Aggleton observes 'gender and sexuality systems intersect and interact ... the one cannot be understood without reference to the other' and the thesis seeks to highlight the intersections between systems and constructions of sexuality, gender and 'race'.⁴³

The socially constructed, artificially created, mutable term 'race' is used in this thesis because of the centrality of racial categories in the socio-political and economic organisation of South Africa during the period discussed. It is also used because, despite the socially constructed nature of racial categories, the realities of racism cannot be ignored. As Paul Maylam notes 'in the past two hundred years or so the concept of race has come to rest on a variety of defining characteristics, including physical type, skin colour, genes, historical origin, language and culture'.⁴⁴ In South Africa, by the period under discussion, a combination of these elements and other even less tangible attributes, had resulted in all people in South Africa being categorised under the Population Registration Act of 1950, and both this, and the inherent racism present in many of the structures and communities being discussed, means that terms like 'race' and identifiers of phenotype like 'black' or 'white' have had to be used.⁴⁵ The thesis shows how experiences of race and racism influenced the individuals and communities discussed. It shows how racial categories were unquestioningly

⁴² Challenges to the binary notions of sex and the associated binary notions of 'gender' are offered, for example, by Judith Butler and the use of the term 'womyn' in this thesis allows these complexities of identity performativities to be recognised while also dealing with the practicalities of writing about sources that often reflect a way of ordering the world that includes ideas, actions, relations and structures that primarily divide people into 'women' and 'men'. These ideas, actions, relations and structures also proscribe and prescribe particular, though not static, (gender) roles to these categories of people. The use of 'womyn' within this text is an effort to allude to these constructions visually and subvert them in the printed text. See Butler, J., *Bodies that Matter: On the Discursive Limits of "Sex"* (London, Routledge, 1993) and Butler, J., *Gender Trouble: Feminism and the Subversion of Identity* (New York, Routledge, 2006).

⁴³ Aggleton, 'Researching Same-sex Sexuality', p. 5.

⁴⁴ Maylam, P., *South Africa's Racial Past – The Historiography of Racism, Segregation and Apartheid* (Aldershot, Ashgate, 2001), p. 7.

⁴⁵ For more on the absurdity of the Act, the trauma that it caused, and the evolution of racial categories and ideologies see Maylam, *South African's Racial Past*.

used in medico-scientific discourses and how assumptions of normative 'whiteness' featured in AIDS narratives.⁴⁶ From these definitions we now turn to an overview of the thesis.

The first chapter traces the evolving hegemonic AIDS narratives found in the *SAMJ* from their reproduction of 'high-risk group' narratives that mirrored those created in the USA and UK, to narratives that started acknowledging human-rights discourses. The *SAMJ* narratives created and relied on 'AIDS avatars' such as 'the homosexual', 'the prostitute', and numerous variations of 'the black body', which allowed for the creation of a hierarchy of exposure and reinforced divisions between 'the normal (safe) majority' and people with HIV or people dying of AIDS. The AIDS avatars employed and reinforced existing stereotypes (both international and local) and reflected existing prejudices or social attitudes linked to constructions of sexuality, 'race' and gender. The narratives act as a reminder of the subjectivities of science and scientists, and the need for self-awareness amongst researchers in all disciplines.

Although there were examples of counter-narratives in the *SAMJ*, more conservative narratives dominated and framed understandings of the syndrome while influencing responses to it by medical and political communities. The hegemonic narratives in the *SAMJ* were mirrored in non-medical, non-scientific narratives and were either directly or indirectly evoked to justify, excuse, or explain the types of practical responses to AIDS.

The second chapter explores responses to AIDS by the ANC in exile. The chapter tracks the growing awareness of AIDS amongst health care workers and shows how responses to AIDS varied between geographic regions and between different levels within the ANC hierarchy. The chapter highlights the close association between the ANC and progressive health care professionals and organisations (both regional and international) and explains how these relationships helped shape the structures, plans and strategies for addressing AIDS in post-1994 South Africa. The chapter explores how AIDS was discussed and constructed within the organisation and provides examples of how comrades with AIDS were viewed and treated.

⁴⁶ The works of Dyer and Banton have also influenced these understandings of racial theories. See Banton, M., *Racial Theories* (Cambridge, Cambridge University Press, 1998) and Dyer, R., *White* (New York, Routledge, 1997).

The chapter concludes by considering how the changing political landscape in South Africa in the early 1990s, particularly the pressure of the political negotiations that were to take place, influenced how the ANC prioritised and addressed AIDS.

In the third chapter the thesis continues to examine political communities, but in this instance it is government responses to AIDS that are interrogated. This chapter builds on the work of Fourie but extends the notion of ‘government responses’ to include not only policy, but also information programmes and other initiatives.⁴⁷ The chapter argues that government responses to AIDS can be divided into four phases beginning with the ‘information and advice phase’, 1982 – 1986, which was characterised by the government seeking advice from medical experts, requesting that epidemiological data from volunteers was collected, and ensuring that the blood supply was screened.

The second or ‘facts and fears phase’, 1987 – 1989, saw the launch of public information campaigns aimed at adults supplying facts about AIDS. It was also during this phase that narratives about ‘infected outsiders’ and fears about AIDS were used to facilitate the use of legislation to repatriate people with AIDS, particularly migrant mine workers. The third phase, 1990 – 1993, was one of ‘extended education and engagement’. This phase saw attempts at expanded public health education programmes aimed at adolescents; the structuring and restructuring of government AIDS groups; and attempts to encourage numerous sectors, communities and groups to address AIDS. Finally, 1994 marks the beginning of the fourth phase characterised by ‘democratic ideals’ and representative decision-making processes, but an inability to successfully implement AIDS programmes. The chapter also examines discussions about AIDS recorded in *Hansard* which reveal the polemics of parliamentary narratives about AIDS.

As a counterpoint to the conservative politics that influenced and shaped health care provision during apartheid (see discussion below) and informed the hegemonic AIDS narrative in the *SAMJ*, the fourth chapter examines narratives about and responses to AIDS by NAMDA, a progressive medical organisation. Formed by politicised doctors with an open

⁴⁷ Fourie, *The Political Management of HIV and AIDS*.

anti-apartheid agenda and close ties to the ANC and other anti-apartheid organisations, NAMDA was an organisation of elite medical professionals influenced by ideas of progressive primary health care. NAMDA was involved in addressing some of the immediate medical crises caused by apartheid, but was also interested in formulating health policies and plans for a post-apartheid health care system. In forming NAMDA, its members and supporters not only created new communities, but often crossed over between medico-scientific and political communities and went from working against the (apartheid) government to working with the ANC-led government.

The progressive health care networks that NAMDA was part of laid the foundations for more collaborative and consultative engagements about health care that would influence future AIDS fora. The chapter examines how NAMDA as an organisation responded to AIDS and reveals that, despite its progressive politics, the hegemonic AIDS narrative initially influenced NAMDA's response to AIDS because it framed AIDS as something that was not of immediate concern to the communities NAMDA interacted with.

Having discussed hegemonic AIDS narratives and examined when and how different political and medico-scientific communities responded to AIDS, the fifth chapter in the thesis moves from the abstract and practical, to the personal by providing a detailed account of the experiences of two people at the intersections of these communities and narratives. For Dennis Sifris and Pierre Brouard, the realities of an AIDS narrative initially 'written on', and about, gay men's bodies, directly affected their professional and political capacity to respond to AIDS. Sifris is a medical doctor who helped establish the first HIV and AIDS clinic at the Johannesburg General Hospital and Pierre Brouard provided psychological support at various public health facilities to people trying to come to terms with dying from AIDS-related illnesses or being HIV positive.

The chapter provides an overview of sexuality politics in South Africa and then presents and analyses Sifris' and Brouard's oral testimonies about their changing involvement in sexuality and AIDS activism. In doing this it exposes the intricate relationships between illness, ideologies, and intimate aspects of personal identity. It also reveals how hegemonic AIDS

narratives constructed in printed and spoken words, created social mores that affected individuals, despite the changing nature of those narratives over time. The chapter illustrates how abstractions like homophobic or heteronormative beliefs, or unquestioned conservative ideologies, had tangible repercussions for people.

Methodologies and Archives

The arguments presented in this thesis are derived from a critical reading of a variety of archives and sources; the incorporation of secondary sources; and the use of oral interviews. As indicated above, this critical reading was shaped by a concern with the interplay between words and ideologies that reinforce 'normative' social structures and hierarchies predicated on constructions of gender, 'race', and sexuality. In addition to highlighting when, where and how these social structures were created, employed, or challenged, the thesis records a history of the formation of certain organisations and tracks the changing responses to AIDS by the selected communities and individuals.

Many of the experiences of writing contemporary AIDS history described by Virginia Berridge in 1994 were mirrored in the research process for this thesis.⁴⁸ Berridge noted that while AIDS had resulted in 'a vast outpouring of publication, all of it potential grist to the contemporary historians' mill', this did not imply easy access to material, especially official committee and government documents.⁴⁹ The vast amount of information and the lack of access to documentation in official archives (discussed below) are not, however, the only similarities. The other phenomenon described by Berridge that resonated with how sources were procured for this thesis was that of "'archives on the run" or "ad hoc archives" [where] archives are picked up, sometimes literally, where they present themselves'.⁵⁰

Several of the people I interviewed not only gave of their time, but either informed me of the location of material that might be useful, gave me extra copies of documents from their personal papers, or shared presentations they had given. Mary Crewe of the Centre for the

⁴⁸ Berridge, V., 'Researching Contemporary History: AIDS', *History Workshop*, 38, 1994.

⁴⁹ *Ibid.*, p. 228.

⁵⁰ *Ibid.*

Study of AIDS (CSA) gave me unrestricted access to her filing cabinets which contained a wealth of significant documents.⁵¹ Pierre Brouard of the CSA also shared examples of early AIDS information literature designed by and for gay men that were part of his personal papers. Similarly, Alan Whiteside of the Health Economics and HIV/AIDS Research Division (HEARD) allowed me access to the HEARD library which houses both the organisation's publication archive and extensive collections of work relating to the socio-political and economic effects of AIDS on South Africa.⁵² Without these *ad hoc* archives writing sections of this thesis would have been almost impossible.

Regardless of their origins, the thesis relies predominantly on written sources and makes use of conventional sources such as correspondence and minutes as 'primary sources'. For the first chapter however, a peer-reviewed, published journal, the *SAMJ*, becomes the primary source for analysis. One of the intriguing aspects about writing a history of an epidemic that has been primarily located as 'an epidemic of the present' is that, in the absence of historical reflections on the epidemic concerned, secondary sources written at a particular time and place turn into historical sources. A belatedly discovered treasure that historians of AIDS may find useful is a number of bibliographic volumes compiled by J.H Bowen.⁵³ The five volumes list articles about HIV and AIDS in South African journals and, when used in conjunction with Faldie Esau's bibliography, are helpful in identifying research trends and creating a picture of when, where and in what media, AIDS was being discussed and written about in South Africa.⁵⁴

⁵¹ For more on the Centre for the Study of AIDS see their website at www.csa.za.org (accessed July 2012).

⁵² For more on the Health Economics and HIV/AIDS Research Division see their website at www.heard.org.za (accessed July 2012).

⁵³ Bowen was from the (then named) Natal Society Library in Pietermaritzburg. The volumes, which cover the period 1988 – 1994, began life after Bowen was 'asked to assist the Pietermaritzburg AIDS Action Committee in creating an information file of journal articles on AIDS'. African Studies Library, University of Cape Town (hereafter ASL – UCT), BRB 616.079 BOWE, Bowen, J.H., 'AIDS/HIV Infection: a select bibliography of articles in South African journals, 1988 – 1990', c. 1991; 'AIDS/HIV Infection, volume 2, 1990 – 1991', 1992; 'AIDS/HIV Infection, volume 3, 1991 – 1992', 1993; 'AIDS/HIV Infection, volume 4, 1992 – 1993', 1994; 'AIDS/HIV Infection, volume 5, 1993 – 1994', 1995.

⁵⁴ Esau's bibliography was compiled for the Southern Africa Labour & Development Research Unit and covers the period 1980 – 1992. ASL-UCT, BRB 616.079 ESAU, Esau, F., 'AIDS: Literature Review 1980-1992', Cape Town, Southern Africa Labour & Development Research Unit, 1993. See also ASL-UCT, BRB 309.16805 SOU, Andor, L.E., 'AIDS in Southern Africa' in *Southern African Update - A Bibliographic Survey*, 5, 2, October 1990.

For the first chapter of the thesis each edition of the *SAMJ* from 1980 – 1995 was manually searched for articles, correspondence, news, and information related to AIDS. Research assistants helped to compile a database that listed each of these articles and this database provided the data for the identification of trends and for the graphs and charts in the chapter. The articles themselves were read and grouped according to recurring subjects or themes, and an analysis of the themes and examples of the text of the articles are used in the chapter.

The material for the second chapter on the ANC in exile was obtained from a visit to the University of Fort Hare library in which the ANC archives are held. The size of the ANC archive and the ongoing process of updating handlists meant that the assistance and guidance of the archivist was vital in determining where to look.⁵⁵ Handlists were searched for references to AIDS and the archives relating to the ANC Department of Health were prioritised. Most of the sources were drawn from the ANC Lusaka Mission and most time was spent working on these boxes. Selected boxes from the Solomon Mahlangu Freedom College, Director's Office & Health Department Records; the London Mission records; and the Luthuli House Records were checked but these proved less fruitful. The sources that were used for this chapter include correspondence, memos and minutes of the ANC regional health teams, the ANC health secretariat (or health department) and the National Executive Committee; and conference and seminar reports and papers. Other sources, including an ANC AIDS information video, were tracked down in the International Institute of Social History in Amsterdam.

The chapter draws primarily on written and visual texts and acknowledges that oral sources could form the basis of future complementary research. Making contact or securing interviews with key ANC department of health members proved unsuccessful despite repeated attempts via email and telephone. There is thus significant scope for researchers with better contacts, networks, or access, to undertake oral interviews in the future and add to this history of the ANC's responses to AIDS.

⁵⁵ For a slightly outdated but still useful insight into the archive see Stapleton, T.J., & Maamoe, M., 'An Overview of the African National Congress Archives at the University of Fort Hare', *History in Africa*, 25, 1998. Since this article was written there have been substantial additions to the archive, and handlists and inventories have been updated.

Finding conventional sources for writing a chapter on government responses to AIDS was even more complicated than usual. In addition to the time restrictions applicable to official sources, and the purging of documents that has taken place by numerous South African governments, there is a substantial backlog in the cataloguing of available government documents due to a lack of resources, staff, and space. There are hundreds of metres of uncatalogued government records from the 1980s and 1990s. Although staff offered to bring up random samples of these unsorted documents, this haphazard process was deemed unsuitable.⁵⁶ The state of the national archives, and what appears to be a failure to deposit current official documents, is going to have serious repercussions for historians.⁵⁷

Information on government responses was pieced together from sources including correspondence from other organisations, people's private papers, and from *Hansard*, which is still available in libraries.⁵⁸ Relevant sources were photocopied and all entries relating to AIDS in *Hansard* were photocopied and a database of these compiled by a research assistant. This database was used to compile the graphs in the chapter. In addition, the Annual Reports of the Department of Health were found in the National Library of South Africa in Cape Town, which also has copies of some early AIDS information publications. The necessary government legislation was found in the Cory Library and Law Library at Rhodes, while the library at the University of Kwa-Zulu Natal (UKZN) – Durban campus, has one of the

⁵⁶ An archivist at the National Archive in Pretoria informed me 'off-the-record' that the crisis of underfunding and lack of staff that had commenced in the mid-1980s was ongoing and had resulted in severe constraints in the archive. This assessment of the state of the archive was corroborated in several other informal conversations with professional archivists with insider knowledge. It has also been discussed in Harris, V., *Archives and Justice – A South African Perspective* (Chicago, Society of American Archivists, 2007) especially chapter 18 "'They should have destroyed more": The Destruction of Public Records by the South African State in the Final Years of Apartheid, 1990 – 1994' which traces the history of document destruction from the 1960s onwards.

⁵⁷ Similarly the 'post-1994' record management systems and record management managers do not appear to have prioritised archiving and filing so that to obtain access to, or even knowledge regarding the location of documentation from the Department of Health since 1995, has proved difficult. Emails to at least two staff in each of the (new) provincial archives enquiring about the location and types of records available resulted in only two replies, one from a small archive in the Eastern Cape and one from an archivist in the Western Cape. In addition to how this will affect the capacity of historians to write histories of the last thirty years that require access to official government documentation, there is a problem, by extension, for transparency and access to information for researchers and members of the public.

⁵⁸ As per the definition provided on the South African Parliament website: '*Hansard* is a substantially verbatim report - with repetitions and redundancies omitted and obvious mistakes corrected - of parliamentary proceedings. It is named after an English printer, L *Hansard* (1752 - 1828) and his descendants, who compiled the reports until 1889.' See Parliament of the Republic of South Africa website at: www.parliament.gov.za/live/content.php?Category_ID=119 (accessed 3 January 2010).

only complete collections of *Epidemiological Comments*, a government publication that reported on notifiable diseases and on certain health issues. An extended interview with Dr Rina Venter, ex-Minister of Health, provided insights into the inner workings of government for some of the period under discussion.

Various archives at the University of the Witwatersrand (Wits) provided the majority of the documents for the remaining chapters. The Killie Campbell Library at UKZN provided initial material on NAMDA and pointed to the substantial holdings related to NAMDA held by the South African History Archive (SAHA) at Wits. SAHA's holdings for NAMDA (and other organisations that formed part of the progressive primary health care movement) are extensive and yielded substantial amounts of information. The NAMDA chapter is based on an analysis of these sources (supplemented by findings in the African Studies Library at the University of Cape Town) and on a series of oral interviews with NAMDA members and supporters.

Also at Wits, the Gay and Lesbian Archive (GALA) - now referred to as Gay and Lesbian Memory in Action - holds collections relating to the personal lives or work of activists involved in anti-apartheid politics, sexuality politics, and AIDS activism.⁵⁹ These personal archives as well as the archives of a number of sexuality organisations like the Gay Association of South Africa (GASA) and more overtly political groups like the Gay and Lesbian Organisation of the Witwatersrand (GLOW) and the Organisation of Lesbian and Gay Activists (OLGA), were consulted.

Searching through the archives of sexuality organisations revealed the diversity and complexity of sexuality politics in South Africa and provided insights into some of the early responses to AIDS by sexuality organisations, from providing counselling, support and care, to organising lectures and distributing AIDS education information. Comprehensive histories of how various sexuality organisations responded to AIDS in South Africa still need to be written, and while the responses of individuals and organisations to AIDS in the early days of

⁵⁹ For example GALA has collections for activists and organisers including Margaret Auerbach, Edwin Cameron, Mark Gevisser, Sheila Lapinsky, Alfred Machela, Barry McGeary, Julia Nicol, Simon Tseko Nkoli, Ann Smith and Ivan Toms.

the epidemic are an important aspect of the history of AIDS in South Africa, focussing on sexuality organisations or the individuals mentioned did not sit comfortably as part of this thesis. With the responses of medical elites and medico-political narratives about AIDS central to the thesis, it was necessary to ensure that a chapter that dealt with sexuality politics also connected to the other communities and narratives under discussion and revealed aspects of the experiences of elite medical professionals who were also involved in sexuality activism.

To achieve this the decision was made to focus in-depth on the oral testimony of two people who could comment on, or were part of, these aspects and communities, in addition to being sexuality activists. The final chapter in the thesis thus draws on the primary sources of sexuality activists and organisations, and on secondary analysis of sexuality politics in South Africa, to provide context for the two primary stories that feature in the chapter.

Eighteen other face-to-face interviews were carried out. All were recorded using a digital voice recorder and verbal permission was sought and obtained from interviewees to record the interviews. While specific questions relevant to the professional experiences of each interviewee were devised, all interviews were predominantly open-ended and unstructured, aside from one common question asked to each interviewee about their first memories of AIDS and how they became involved in AIDS research or activism. During the interview notes were taken by the author, and the interviews were later transcribed. The purpose of the interviews and the nature of the research were also explained to each interviewee and those who asked to be allowed to read chapters in which they were quoted have been sent copies of the relevant chapters to verify the accuracy of their statements.

As with any historical writing, the content of this thesis is shaped by the politics of archives and of people. The nature of archives are such that what is included in them, what is omitted, and what is made available to researchers are influenced by the politics of record keeping and historians have to work within that reality.⁶⁰ Similarly, the people interviewed, and their associated narratives, are located in the personal and professional politics of being

⁶⁰ For more on this see Harris, *Archives and Justice* especially chapter 14, 'The Archive is Politics'.

human. Neither the personal locations, agendas, reflexivity, politics, and self-awareness of the people interviewed, nor their untold stories, can be fully evaluated by the interviewer, and that too is a reality within which historians have to work. As Berridge observed about oral interviews, 'in an area which is still politically sensitive, there will always be attempts to rewrite history' and 'the fact that people are still alive to be interviewed (but not all...) is both an opportunity and a problem. The political and ideological battles over the interpretation of the present are intense'.⁶¹ These realities of using oral interviews are acknowledged as one of the complexities of writing contemporary history.

Informants to be interviewed were selected on the basis of availability and involvement in political or medico-scientific elite communities. Interviews often led to informants suggesting additional informants to be contacted and where possible this was undertaken. As oral testimony was one of numerous sources and the thesis is not an oral history of AIDS narratives or responses, specific and deliberate sampling targets for who should be interviewed were not set. As such, there is no even division in informants in terms of gender identity, sexual orientation, class, level of education, drug-use, or 'race'. The interviews reflect socio-political dynamics of both the period under discussion and the current political situation in terms of which people had the socio-political and economic means to become 'elites', and which people feel able to speak about the past in the present. Thus, for example, no senior members of the ANC Health Department approached for an interview replied to either direct correspondence or attempts to contact them via third-parties, instead, the written documentation that they produced and that were available in the archive, had to be used. Whether this occurred because of the informants' personal choice, because of failed communications, or any other combination of factors is unknowable. Future researchers will hopefully be able to remedy this situation.

Owing to the scope of the thesis it has been necessary to adjust the convention of providing a single literature review at the beginning of the thesis, and so smaller literature reviews on certain subjects are provided in individual chapters as necessary. Examining aspects of exile for example, or locating a history of AIDS and sexuality in a broader literature on sexuality,

⁶¹ Berridge, 'Researching Contemporary History', p. 230.

would not make sense in this introduction but are important in establishing context in individual chapters. As the medico-scientific and political communities and elites who responded to AIDS and helped create the AIDS narratives were all positioned in relation to apartheid ideologies and structures - and all were affected and influenced by them - it is also necessary to contextualise and explore the relationship between apartheid, health and health care professionals.

Apartheid, Health, and Health Care Professionals

Apartheid had an impact on the physical, mental, and emotional health of those who experienced it, and throughout the 1980s academics from a variety of disciplines published research exposing the link between apartheid ideologies, their implementation, and the (ill) health of people. People who lived and worked in South Africa had their experiences of, and access to, health services and care, health education opportunities, and health care professionals, mediated by the racial basis of apartheid health policy, in addition to the usual determinants of health access like class, gender, and mobility.

In the early 1980s renowned community and public health proponents like Mervyn Susser and Violet Padayachi Cherry were highlighting discrepancies in health care in South Africa in international journals.⁶² In 1983 Shula Marks and innovative community health researcher Neil Andersson wrote a report for the World Health Organisation (WHO) on apartheid and health that revealed the connections between health, economics and politics and their effects on peoples' lives and deaths.⁶³ Throughout the 1980s these two scholars published work on various aspects of apartheid and health, including women and health; the political economy of health; the link between the state, class structures and the allocation of health resources; and the impact of apartheid on health in 'frontline states' (written with community medicine advocate Anthony Zwi).⁶⁴

⁶² Susser, M., & Cherry, V.P., 'Health and Health Care Under Apartheid', *Journal of Public Health Policy*, 3, 4, December 1982, p. 455. See also Susser, M., 'Apartheid and the Causes of Death: Disentangling Ideology and Laws from Class and Race', *American Journal of Public Health*, 73, 5, May 1983 (accessed using JSTOR).

⁶³ Marks, S., & Andersson, N., *Apartheid and Health: Report to the World Health Organisation* (Geneva, WHO Publications, 1983).

⁶⁴ See Marks, S., & Andersson, N., 'Women and Health in South Africa', *Canadian Women Studies*, 7, 1, 1986; Marks, S. & Andersson, N., 'Issues in the Political Economy of Health in Southern Africa', *Journal of Southern*

Others like Cedric de Beer and Aziza Seedat published full-length studies on the multiple effects of apartheid on health, while academics with interests in health policy, like Max Price, reflected on 'health care as an instrument of apartheid policy'.⁶⁵ These works linked government health care policies to broader economic, political, and social factors within South Africa and beyond (figure 1).⁶⁶ Work by Nonceba Lubanga and Marks examined health care professionals and their representative bodies in relation to apartheid health care.⁶⁷

African Studies, 13, 2, 1987; Marks, S., 'Women's Health in South Africa' in Wright, M., Stein, Z., & Scandlyn, J. (eds) *Women's Health and Apartheid: The Health of Women and Children and the Future of Progressive Primary Health Care in Southern Africa: Proceedings of the Third Workshop of the Project on Poverty, Health, and the State in Southern Africa* (New York, Columbia University, 1988); Andersson, N., & Marks, S., 'Apartheid and Health in the 1980s', *Social Science and Medicine*, 27, 7, 1988; Marks, S. & Andersson, N., 'Diseases of Apartheid' in Lonsdale, J., (ed), *South Africa in Question* (Cambridge, Cambridge University Press, 1988); Zwi, A., Marks, S., & Andersson, N., 'Health, Apartheid and the Frontline States', *Social Science and Medicine*, 27, 7, 1988; and Marks, S., & Andersson, N., 'The State, Class, and the Allocation of Health Resources in Southern Africa', *Social Science and Medicine*, 28, 5, 1989.

⁶⁵See De Beer, C., *The South African Disease: Apartheid Health and Health Services* (Johannesburg, Southern African Research Service, 1984); Seedat, A., *Crippling a Nation: Health in Apartheid South Africa* (London, International Defence and Aid Fund for Southern Africa, 1984); and Price, M., 'Health Care as an Instrument of Apartheid Policy in South Africa', *Health Policy and Planning*, 1, 2, 1986.

⁶⁶ There is also a substantial body of work on the ongoing association between the state and industry, and the resultant 'industrial illnesses' that have affected migrant labourers and the working classes in South Africa since the discovery of minerals, through the apartheid era, and into the 21st century. See for instance Burke, G., & Richardson, P., 'The Profits of Death: A Comparative Study of Miners' Phthisis in Cornwall and the Transvaal, 1876-1918', *Journal of Southern African Studies*, 4, 2, April 1978; Elder, G., *Hostels, Sexuality, and the Apartheid Legacy: Malevolent Geographies* (Ohio, Ohio University Press, 2003); Jochelson, K., *The Colour of Disease: Syphilis and Racism in South Africa, 1880-1950* (Basingstoke, Palgrave, 2001); Katz, E., *White Death: Silicosis on the Witwatersrand Gold Mines, 1886-1910* (Johannesburg, Wits University Press, 1994); McCulloch, J., *Asbestos Blues: Labour, Capital, Physicians and the State in South Africa* (Indiana, Indiana University Press, 2002); McCulloch, J., 'Counting the Cost: Gold Mining and Occupational Disease in Contemporary South Africa', *African Affairs*, 108, 431, April 2009; McCulloch, J., 'Asbestos, Lies and the State: Occupational Disease and South African Science', *African Studies*, 64, 2, 2005; Packard, R., *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Pietermaritzburg, University of Natal Press, 1990); and Packard, R., 'Tuberculosis and the Development of Industrial Health Policy on the Witwatersrand, 1902-1932', *Journal of Southern African Studies*, 13, 2, 1987.

⁶⁷ See Lubanga, N., 'Are the South African Nursing Organisations Silent Partners of Apartheid?' in Wright M., Stein, Z., & Scandlyn, J. (eds) *Women's Health and Apartheid: The Health of Women and Children and the Future of Progressive Primary Health Care in Southern Africa : Proceedings of the Third Workshop of the Project on Poverty, Health, and the State in Southern Africa* (New York, Columbia University, 1988); Marks, S., *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession* (Johannesburg, Witwatersrand University Press, 1994).



Fig. 1. Cartoon commenting on apartheid and health services (City Press, 1988).

These works highlight the disparities in (ill) health and mortality and morbidity rates amongst different groups of people in South Africa (and the ‘homelands’) caused and perpetuated by apartheid policies which resulted in the dramatic distortion of health provision in South Africa and the ‘homelands’.⁶⁸ For example, government spending on the health care of people defined as ‘white’ was significantly more than for any other ‘race group’. In 1987, for every R1 spent on ‘white’ people, 60c was spent on ‘asian’ people, 57c on ‘coloured’ people and 23c on ‘black’ people.⁶⁹ Disparities were also evident in the spending on health in the ‘homelands’. For example, in ‘1982 the entire health budget for

⁶⁸ The apartheid government declared various sectors of South Africa ‘homelands’ in which black South Africans of different ‘ethnic identities’ were meant to live and ‘develop’ separately from ‘white’ South Africans. Some of these homelands, namely the TBVC states (Transkei, Bophuthatswana, Venda and Ciskei) were recognised as ‘independent states’ by the South African government but not by any other countries or international fora. There were also non-independent homelands like Gazankulu, kaNgwane (Kangwane), KwaNdebele, KwaZulu, Lebowa and Qwaqwa. See Beinart, W., *Twentieth Century South Africa* (Oxford, Oxford University Press, 2001), pp. 162 - 164, 212 – 227.

⁶⁹ Section 27, *A Background to Health Law and Human Rights in South Africa*, 2010 available on the Section 27 website at www.section27.org.za/wp-content/uploads/2010/04/Chapter1.pdf (accessed July 2012), p. 13.

KwaZulu ... [then a 'homeland' of] more than 5 million people ... was equivalent to the entire budget for [the 'whites only'] Johannesburg General Hospital'.⁷⁰

Similarly, there were disparities in the availability of health care professionals. For example 'in 1987, the number of white dentists for each person in the white population was 1: 2 000, while for black people, it was 1: 2 000 000', and 'in 1990, the number of doctors to patients in urban areas was 1: 900, while in rural areas it was 1: 4 100'.⁷¹ Unsurprisingly these disparities, combined with the effects of the migrant labour system, forced removals, and violence, meant that disease patterns and life expectancy were also mediated by 'race'. In 1990 the life expectancy for 'white' people was 73 years, for 'asian' people it was 68 years, for 'coloured' people it was 62 years, and for 'black' people, 61 years.⁷²

A comparable situation was evident in maternal and infant mortality rates within South Africa.⁷³ In 1990, for every 1 000 live births, 53 'black' babies died, 39 'coloured' babies died, 11 'asian' babies died, and nine 'white' babies died. And while three out of every 100 000 'white' womyn died in child-birth, 15 'asian', 23 'black' and 30 'coloured' womyn died.⁷⁴

During the political transition in the 1990s, academics like H.C.J van Rensburg and Solomon Benatar considered the legacy of apartheid on the health care system envisioned for the post-1994 era.⁷⁵ While work by Mary Rayner and Laurel Baldwin-Ragaven, Jeanelle de Gruchy and Leslie London, reflected on the roles and responsibilities of health care professionals as individuals and grappled with the complexities of accountability and medical ethics.⁷⁶

⁷⁰ Section 27, *A Background to Health*, p. 13.

⁷¹ *Ibid.*, pp. 11 - 12.

⁷² Department of National Health and Population Development, *Health Trends in South Africa, 1992*, available from the Pdraig O'Malley digital archive on the Nelson Mandela Organisation website at www.nelsonmandela.org/omalley/index.php/site/q/03lv02167/04lv02218/05lv02244/06lv02254.htm (accessed July 2012). Life expectancy by sex (O+ denoting female and O-> denoting male) as follows: 'whites' 76.5 O+, 69.4 O->; 'asian' 71.2 O+, 64.5 O->; 'coloured' 65.7 O+, 57.6 O->; and 'black' 64.8 O+, 57.8 O->.

⁷³ The health information from the 'homelands' were not included in these statistics.

⁷⁴ *Ibid.* For additional overviews see also Omond, R., *The Apartheid Handbook: A Guide to South Africa's Everyday Racial Policies* (London, Penguin, 1985) pp. 71 – 76.

⁷⁵ Van Rensburg, H.C.J, & Benatar, S.R., 'The Legacy of Apartheid Health and Health Care', *South African Journal of Sociology*, 24, 4, 1993.

⁷⁶ Rayner, M., 'From Biko to Wendy Orr: The Problem of Medical Accountability in Contexts of Political Violence and Torture', in Manganyi, N.C., & du Toit, A. (eds), *Political Violence and the Struggle in South Africa* (London,

The work by Baldwin-Ragaven *et al* was an extension of work undertaken for the South African Truth and Reconciliation Commission's (TRC) special and institutional hearings, which included a health sector hearing. The TRC hearing revealed the centrality and importance of apartheid ideology to health and health care provision. It showed the complex relationship between those providing health care (or seeking it) and the ideologies and practices of a society brutalised by apartheid laws.⁷⁷

The health sector hearing sought to understand how particular institutions or sectors may have facilitated the implementation and maintenance of apartheid, and to determine if certain sectors were complicit in perpetuating abuses. It revealed the complexities of peoples' experiences and sought to understand what had motivated people to behave the way they had, and consider both those who perpetrated, and those who resisted, health sector-related human rights abuses. The hearing echoed what academics and activists had been writing about in the 1980s and presented a picture of a deeply divided, unequal, and fragmented health care sector, fragmented health services, and serious ethical breaches in providing health care, equally, to all.⁷⁸

Any evaluation of responses to AIDS by medico-scientific or political communities during apartheid must take into account the extraordinary fragmentation of health services that characterised this period. Throughout the 1980s and into the early 1990s there were numerous statutory bodies responsible for health services in South Africa, in the

Macmillan, 1990); and Baldwin-Ragaven, L., de Gruchy, J., & London, L., *An Ambulance of the Wrong Colour: Health Professionals, Human Rights and Ethics in South Africa* (Cape Town, University of Cape Town Press, 1999). Into the 2000s, questions about the history of health in South Africa, contemporary contexts and medical ethics are still of interest to established and emerging academics – see for example Braude, H.D., 'Colonialism, Biko and AIDS: Reflections on the Principle of Beneficence in South African Medical Ethics', *Social Science and Medicine*, 68, 11, 2009; and Bell, S., 'The Politician, the Economist, and the Medical Professional: The Unholy Trinity of Apartheid in South Africa', *Undercurrent*, 3, 1, 2006. (*Undercurrent* is an online journal where Canadian undergraduates can 'publish' articles).

⁷⁷ Truth and Reconciliation Commission, *Human Rights Violations – Health Sector Hearings*, Cape Town, 17 - 18 June 1997, transcripts of the hearing available on the Department of Justice's website at www.justice.gov.za/trc/special/index.htm#hsh (accessed April 2011). For the relevant section in the final TRC report see *The Truth and Reconciliation Commission of South Africa Report*, 'Institutional Hearing: The Health Sector', vol. 4, ch. 5, 1998, pp. 109 - 164 available on the Department of Justice website at www.justice.gov.za/trc/report (accessed April 2011).

⁷⁸ This is not to suggest that health care is accessed or provided equitably in post-apartheid South Africa for it is not. As with global trends in health care, the notion of public health care- appropriately funded and providing for all people- struggles for survival and is under ongoing attack from those with an interest in privatised health care and governments with the lack of political will or desire to implement social health schemes effectively.

'homelands' and the TBVC 'states'. These authorities were organised along racial lines and were subject to gross disparities in funding. By 1991 there were 14 different departments of health in existence: one national department of health (the DoH); three 'own affairs' departments; six in the 'homelands', and four in the TBVC 'states'. In addition to this, there were four provincial health administrations and 780 local authorities, all of which were obligated to deliver health services with differing levels of responsibility.⁷⁹

Health issues that affected more than one 'racial group' were considered 'general affairs', and policy direction and funding to address such issues came from the national DoH.⁸⁰ The ability of the DoH to implement its policies effectively among so many different departments was limited by a number of factors. Health departments in the 'homelands' and TBVC 'states' were understaffed, poorly managed and chronically under-resourced compared to those within South Africa.⁸¹ The DoH's ability to implement policy was also complicated by the levels of autonomy that other health departments, particularly provincial health authorities, experienced. For example, provincial authorities had the right to divert all funds they received for health programmes from central government for any other purposes.⁸² In addition, the DoH lacked the legal ability to compel health authorities or other departments to implement nationally devised strategies.⁸³

This, in the words of Andersson and Marks, 'bewildering and wasteful array of health departments' was the mechanism through which a disease which desperately required a coherent and coordinated response was to be addressed.⁸⁴ It was in this fragmented and racially segregated medical and political milieu which prevailed throughout the 1980s and into the early 1990s that AIDS would be identified in South Africa, written about, and responded to.

⁷⁹ Taitz, J. L., 'The Right to Health: Medical Treatment and Medical Law in South Africa', *South African Human Rights Yearbook*, 2, 1992, p. 168 (accessed using HeinOnline).

⁸⁰ Omond, *The Apartheid Handbook*, pp. 37 – 38.

⁸¹ Andersson & Marks, 'Apartheid and Health in the 1980s', pp. 677 – 678 and Van Niekerk, R., 'The Evolution of Health and Welfare Policies in South Africa: Inherited Institutions, Fiscal Restraint, and the Deracialization of Social Policy in the Post-Apartheid Era', *Journal of African American History*, 88, 4, Autumn, 2003, p. 366.

⁸² *Ibid.*, p. 369.

⁸³ Interview with Rina Venter, Venter's residence, Pretoria, South Africa, 21 October 2011. The exception to this was in the case of national health emergencies such as outbreaks of highly contagious diseases.

⁸⁴ Andersson & Marks, 'Apartheid and Health in the 1980s', p. 677.

CHAPTER ONE:

NARRATIVES OF KNOWLEDGE: SCIENCE, STEREOTYPES, AND AIDS IN THE *SOUTH AFRICAN MEDICAL JOURNAL*, 1980 - 1995

... relations of power are produced and reproduced from every point, including through institutions of various kinds, through public discourses and through our bodies ...¹

The Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) have become such a part of life and death in South Africa that it is difficult to remember a time before them. It is difficult remembering a time before they existed, were identified and defined, received names, and had diagnoses attached to them – a world when being ‘positive’ or ‘negative’ had connotations that did not relate to HIV status. As people spoke about, wrote about and researched AIDS, and later HIV, they provided a language that constructed a history, a ‘creation story’ for AIDS and HIV. The language was so profound, and the realities of AIDS so consistent, that people and the communities they inhabited have clear memories of when they first heard about AIDS or HIV. People recall the mythologies – personal and communal – that framed their engagements with, and understandings of, AIDS and HIV. As with any narrative, the socio-political and historical contexts of the time mediated and framed discussions about AIDS and HIV during the first fifteen years of the epidemic.

While people and communities experienced AIDS differently, there were certain narratives – those commonly told, oft repeated, internalised, embellished, and built upon - that gained status as hegemonic narratives. The hegemonic narrative of AIDS in South Africa was formulated as follows: initially AIDS was found amongst white, gay men who had contact with other white gay men from the UK or the USA, and spread AIDS through homosexual sex. Then infected migrant labourers, returning exiles, and prostitutes, brought AIDS over the border or, in the case of prostitutes, acted as an infected core that threatened non-infected people and spread AIDS through heterosexual sex. Finally, pregnant black womyn

¹ Sacks, V., ‘Women and AIDS: An Analysis of Media Misrepresentations’, *Social Science and Medicine*, 42, 1, 1996, p. 60.

were infected and gave birth to infected babies, thus spreading AIDS amongst the mostly poor, black heterosexual population.²

These narratives appeared in the media, featured in parliamentary debates, occurred in academic articles, and were recalled in interviews undertaken for this thesis. As AIDS was first framed and feared as a health crisis, the narratives produced in some medical and scientific communities, and transmitted to the public through the media, were vital in shaping the characteristics of the hegemonic narratives.³ The narratives in medical and scientific communities also influenced official government responses and (in)actions. That these narratives were challenged and changed speaks to how hegemonic structures can be constantly contested, but does not deny their existence.

What then are the creation stories of medico-scientific narratives? Can we detect particular ideological or historical influences on their content? Can we scrutinise the content for what was said, or left unsaid, about both people with AIDS, and people researching AIDS? How did the narratives change over time, and what do they reveal about the subjectivities of science?

This chapter addresses these questions by analysing AIDS-related content in the *South African Medical Journal (SAMJ)* from 1980 – 1995. In the pages of the *SAMJ* the voices of members of medical and scientific communities, in various roles, are evident. Commentaries and contributions to the *SAMJ* reflect medical professionals in their roles as medical practitioners or health care workers, researchers, specialists, commentators, activists, interested and disinterested parties, and, as people influenced by ideologies and politics. In the research, the correspondence, and the articles that provided summaries of developments, hypotheses, theories, responses and new discoveries about AIDS and HIV, nationally, regionally and internationally, particular narratives about AIDS were forged and re-forged. Examining these narratives facilitates an understanding of what Sontag refers to

² Some of these understandings still resonate today and during the course of this thesis I have had people ask me why it is that only 'blacks' get AIDS but 'whites and others' do not? Conversely, many people through their activism within their communities have worked hard to break down and challenge preconceptions about people living with HIV and AIDS.

³ For definitions of 'medical and scientific communities', 'elites', 'discourse' and 'narrative(s)' please refer to the Introduction of this thesis.

as ‘... rhetorical ownership of the illness: how it is possessed, assimilated in argument and in cliché’.⁴

This chapter argues that the relationship between medical professionals and medical knowledge in South Africa, and medical professionals and medical knowledge in the UK and the USA, influenced the scope and content of AIDS narratives in the *SAMJ* and inscribed a particular rhetorical ownership of the illness amongst medical professionals.⁵ In the course of claiming rhetorical ownership of AIDS, most medical professionals relied on a discourse about ‘high-risk groups’ – replete with stereotypes and constructions of groups of people - to formulate this rhetoric. This rhetoric from medical sources would, in turn, be assimilated and reproduced in argument and cliché in other public and professional fora, and replicate the stereotypes and constructions. By highlighting these stereotypes, this chapter reveals that certain AIDS narratives were problematic, unscientific, or exclusionary, and often reproduced existing prejudices or reflected conservative social attitudes. Examining these narratives provides insights into what Hubbard refers to as ‘the subjective reality and context of doing science’.⁶

The trajectory and development of medico-scientific research into AIDS in the *SAMJ* is one that initially followed a well-known ‘script’ written predominantly by English-speaking researchers and scientists in the USA and the UK. This ‘hegemonic’ narrative originally constructed and identified particular ‘high-risk groups’, and set an agenda for research that was paralleled in South Africa. In the international narrative ‘high-risk groups’ initially comprised homosexuals, Haitians, haemophiliacs, injecting drug-users, and later sex-workers. Research into AIDS in South Africa reproduced these constructions of ‘high-risk groups’ and used them as a template for analysing and researching the epidemic.

The construction of ‘high-risk’ groups shows how social structures and ideologies, including heteronormativity, race, class, and gender reveal themselves in the scientific narratives

⁴ Sontag, S., *Illness as Metaphor and AIDS and Its Metaphors* (London, Penguin, 2002) p. 179.

⁵ Medical professionals in this context include laboratory-based scientists undertaking medical research or research related to medicine or health care.

⁶ Hubbard, R., ‘Science, Facts and Feminism’ in Tuana, N. (ed), *Feminism & Science* (Bloomington, Indiana University Press, 1989), p. 128.

created about AIDS. The ‘high-risk groups’ acted as focus areas for scientific research, and as constructed markers that reflected a number of non-scientific concerns about morality, ‘deviance’, sexuality, blame and innocence, alienation and belonging. The ‘high-risk’ groups became embodiments of other socio-political concerns and acted as AIDS avatars.

The SAMJ – MASA’s Mouthpiece

The *SAMJ*, first published in 1884, has consistently reflected the aspirations and interests of elite medical professionals in South Africa, and therefore provides unique access to the medical narratives created by, for, and about, this particular group of people.⁷ Unlike specialist medical journals aimed at particular sectors of medical science (virology, gynaecology, and so forth), the readership of the *SAMJ* was drawn from a variety of medical practitioners and scientists – from general practitioners (GPs) to epidemiologists. The *SAMJ*, a peer-reviewed journal, was the official mouthpiece of the Medical Association of South Africa (MASA), one of the two key professional bodies – the other being the South African Medical and Dental Council (SAMDC) - representing mostly white medical professionals in South Africa during this period. Similarly, the *British Medical Journal* is the official journal of the British Medical Association while the *Journal of the American Medical Association* is the US equivalent.

The report of the Truth and Reconciliation Commission’s (TRC) health sector hearing was unequivocal about the organisations, declaring that ‘history has shown that the two most powerful bodies with which doctors were associated - the SAMDC and the MASA - failed to speak out or take a stand for most of the period under review [1960 – 1994]’.⁸

⁷ Gilder, S., ‘A century of the Journal’, *SAMJ*, 66, 7, 18 August 1984, p. 241. Gilder quotes the founding editor of the *SAMJ*, Dr W. Darley-Hartley as being determined ‘... fearlessly to guide, direct and defend the common interests of the profession and the ethical proprieties of its individual members’. The contributors, contents and photos in the journal are worth additional research as the journal reflects the wider socio-political shifts occurring in South Africa. There are, for example, few women or medical professionals who are not white featured for most of the 1980s. From the 1990s however, there is a shift towards including more women as well as black, Indian and coloured doctors.

⁸ *The Truth and Reconciliation Commission of South Africa Report*, ‘Institutional Hearing: The Health Sector’, vol. 4, ch. 5, p. 144, para. 99, available on the Department of Justice website at www.justice.gov.za/trc/report (accessed April 2011).

The South African Medical and Dental Council (SAMDC) was ‘a statutory body ... responsible for the registration, education, maintenance, and monitoring of professional standards of conduct as well as for disciplinary enquiries into allegations of misconduct of all health professionals except nurses and pharmacists’.⁹ The TRC report indicated that although the SAMDC regarded itself as an independent body and received most of its funding from health care professionals, its close association with the government meant that it was ‘... viewed widely as an almost parastatal organisation, lacking in independence’.¹⁰

The SAMDC’s view of itself as independent and ‘apolitical’ mirrored the views held by MASA and reproduced in the *SAMJ*.¹¹ According to evidence presented to the TRC, MASA was ‘a voluntary, independent, professional association for medical doctors’, and ‘... was historically ... the largest professional medical organisation in South Africa, with a membership of about 14 000’.¹² In its submission to the TRC health sector hearing the organisation admitted that:

The Association in general was quite comfortable with the status quo, and its public reaction to any criticism of the inequity and the iniquities in society, particularly the inequities in health care delivery, was to dismiss that criticism as the work of enemies of the state and it defined all sorts of means to defend itself and the system.

MASA was always, without doubt, a part of the white establishment ... and for the most part and in most contexts, shared the worldview and political beliefs of that establishment. Inescapably, it also shared the misdeeds and the sins for which the white establishment was responsible.¹³

While MASA admitted its complicity in perpetuating apartheid health inequities and ideologies to the TRC, some individual members were involved in anti-apartheid activities

⁹ *TRC Report*, 4, 5, p. 144, para. 100. Note: SAMDC did not produce a journal or publication that would provide the same insights into AIDS narratives as the *SAMJ*.

¹⁰ *Ibid.*, p. 144, para. 102.

¹¹ For more on this see Tsampiras, C., ‘Not So “Gay” After All: Constructing (Homo)sexuality in AIDS Research in the *South African Medical Journal*, 1980 - 1990’, *South African Historical Journal*, 60, 3, September 2008, pp. 479 - 480.

¹² *TRC Report*, 4, 5, p. 145, para. 108.

¹³ *Ibid.*, pp. 145 – 146, para. 109 – 111.

and in openly challenging hegemonic narratives about apartheid and health (and, as will be shown, about AIDS).

Between 1980 and 1995, the *SAMJ* featured 24 articles, editorials or correspondence relating to medical ethics, and over 400 covering subjects related to politics and health (or at least the politics of health).¹⁴ Topics addressed included: the state of medical care in South Africa; the role of MASA; the treatment of prisoners and medical care of detainees and hunger strikers; children in detention; political violence and health care; the Steve Biko case; the Wendy Orr case; discussions around a national health service for South Africa; conditions at Baragwanath hospital; academic boycotts; academic hospitals; apartheid and health care; the need for a unitary health service; and, in the 1990s, discussions about new national health policies.

Although some of these articles were critical of health care in South Africa and the circumstances that created them (particularly articles from 1990 onwards), for the most part the tone of the articles ranged from 'conservative' to 'liberal' rather than progressive. Although the *SAMJ* (and by extension MASA) should be given credit for allowing some critical voices to feature in the journal, for the most part these critical voices were not supported by either the organisation or the journal. The views that were most prominent in the journal were those of conservative members whose voices far outweighed those voices that were raising concerns about health care and the ethics of health care in South Africa.

The TRC Report confirmed the conservative nature of MASA, and, while acknowledging the actions of individual members, determined that 'both the SAMDC and the MASA gave little support to those who upheld human rights, thus discouraging health professionals from challenging the system'.¹⁵ Shula Marks succinctly summed up the situation by noting that 'in

¹⁴ Based on author's analysis of her own database of *SAMJ* articles from *SAMJ*, 57, 1, 5 January 1980 to *SAMJ*, 85, 12 December 1995. drawn from *South African Medical Journal*, 57, 1, 5 January 1980 to *SAMJ*, 85, 12, December 1995. Articles, correspondence, information and news about AIDS numbered just over 560 entries.

¹⁵ *TRC Report*, 4, 5, p. 115, para. 19.

the apartheid era, the Medical Association of South Africa had a particularly pusillanimous human rights record'.¹⁶

In terms of the influence of the *SAMJ*, figures from 1982 to 1995 indicate that a total of 205 501 copies of the journal were in circulation, meaning that on average almost 15 000 copies were in circulation per annum. The *SAMJ* was available to MASA members as individual subscribers, but the vast majority of *SAMJ* subscriptions were sent to 'societies or associations' which included universities and medical schools, suggesting that readership exceeded the circulation figures.¹⁷ The *SAMJ* primarily reflected and influenced the voice of qualified medical professionals, but would also have influenced students and members of societies and associations. The *SAMJ* therefore potentially influenced hegemonic narratives in multiple fora that extended beyond the communities of medical professionals who belonged to MASA. This affirms the journal's importance as a unique 'primary' source from which to (re)construct narratives about health generally and narratives about AIDS and HIV specifically.

Focussing on the Fatal 'Four Hs' - High-Risk Groups and the Hierarchy of Exposure in the SAMJ

Once the Centers for Disease Control and Prevention (CDC) in the USA named AIDS, scientists globally began addressing basic questions about the new syndrome: What caused it? How was it transmitted? How could it be diagnosed, and how could you test for it? The journal provided information on both international and local reactions, responses, and developments in researching and addressing AIDS and, in so doing, created an AIDS narrative within its pages.¹⁸

¹⁶ Marks, S., 'South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics', *American Journal of Public Health*, 87, 3, March 1997, p. 453.

¹⁷ Information for the *SAMJ* was only available from 1982 and was kindly supplied by Charles Beiles of the Audit Bureau of Circulations of South Africa (ABC). For more information see the ABC website at www.abc.org.za (accessed November 2009). The lowest circulation figures were for 1982 (11 400) and the highest for 1992 (Jan – Jun: 12 557, Jul – Dec: 19 327) and 1993 (19 075).

¹⁸ See 'Dutch AIDS recommendations', *SAMJ*, 71, 9, 2 May 1987, p. x; 'AIDS in NZ', *SAMJ*, 72, 6, 19 September 1987, p. xiii; 'The Indian government has decided to deport...', *SAMJ*, 71, 7, 4 April 1987, p. xx; 'Global impact of AIDS', *SAMJ*, 71, 9, 2 May 1987, p. xix; 'Characteristically Iceland has developed...', *SAMJ*, 71, 10, 16 May 1987, p. xxii. For more on the parastatal Centres for Disease Control and Prevention (established in 1946) see their website at www.cdc.gov.

The first article referencing immune deficiency related fatalities (eventually a syndrome termed 'AIDS') appeared in 1982. Between 1982 and 1995, there were over 560 references to AIDS in the *SAMJ*. Between 1982 and 1984 there were on average six references per annum, between 1985 and 1995 this increased to 55, with the number of references peaking at 81 in 1992 (figure 2). This shows an increasing interest in AIDS reflecting the steady growth and apparent permanence of the epidemic from the late 1980s.

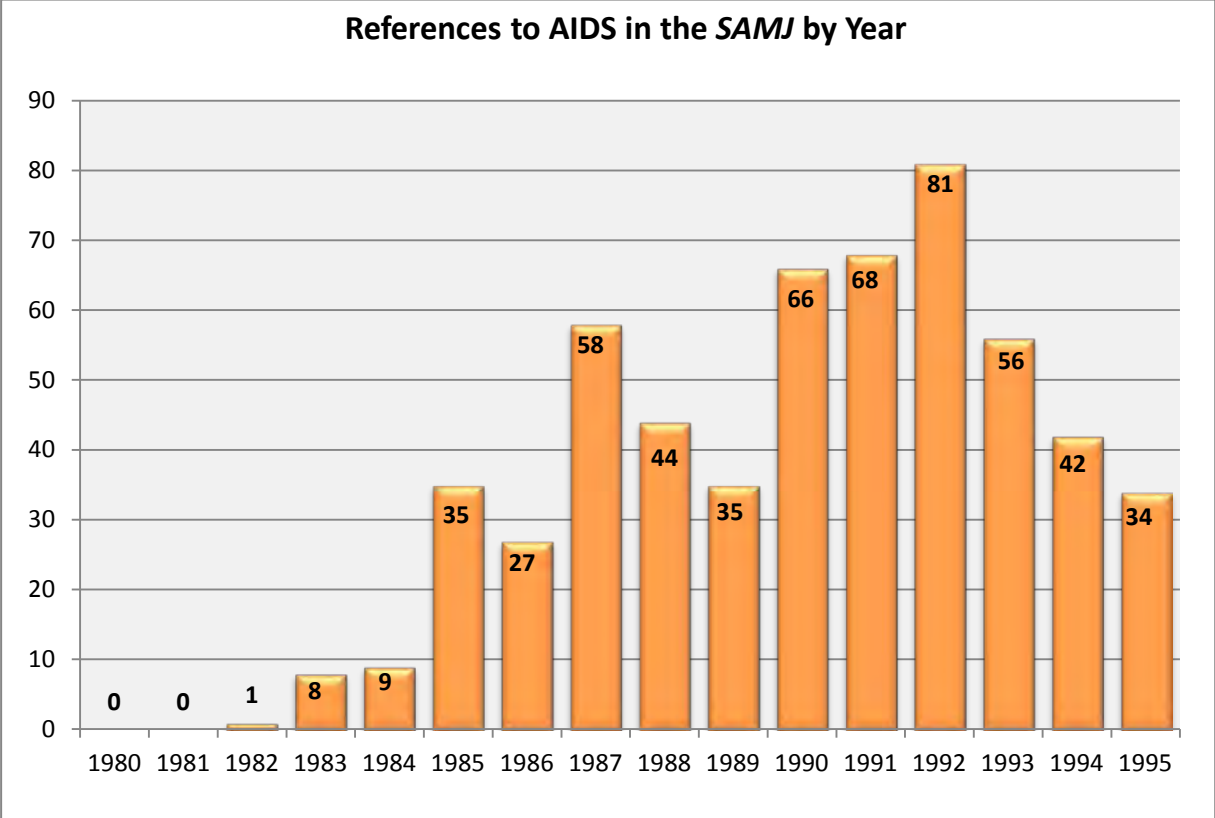


Fig. 2. Between 1980 and 1995 there were over 560 references to AIDS in the *SAMJ*.

Information about AIDS appeared in the *SAMJ* in various formats. These ranged from peripheral pieces of information and adverts, to the latest scientific discoveries, case reports, and 'socio-political' articles (figure 3).

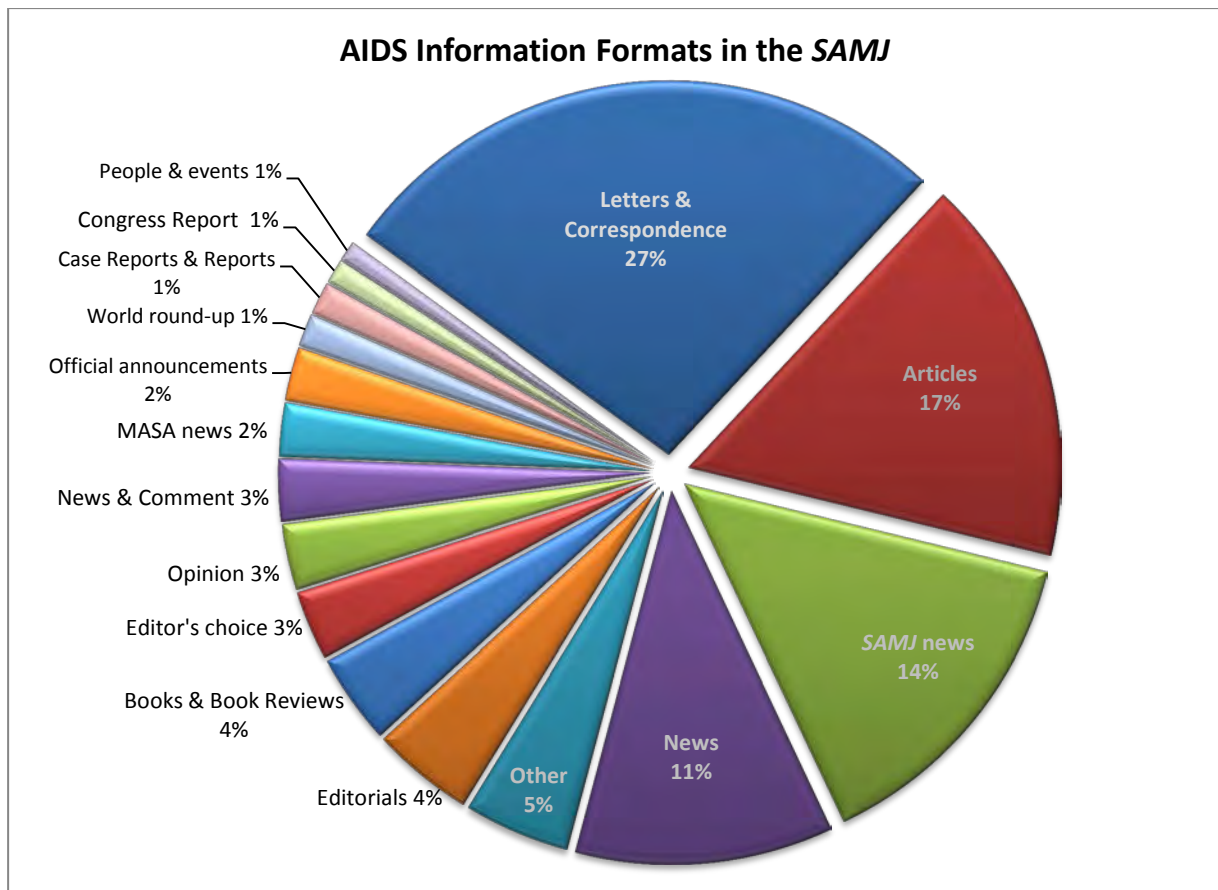


Fig. 3. Detailed breakdown of formats that AIDS information appeared in within the SAMJ, 1980 – 1995.

An analysis of these formats reveals that the information was essentially divided into five spheres of interest. Firstly, there was information of academic or research interest - including book reviews (local and international), subject-specific articles, and case reports (mostly from South Africa but occasionally from southern Africa). Secondly, the journal contained information garnered from external sources and of a more 'newsy', commercial, or 'social' nature. This information included adverts, information on products, including new drugs, and, in the 'people and events' sections, photographs and short paragraphs about leading researchers attending conferences or giving lectures locally, nationally and internationally.¹⁹ Short pieces of 'newsy' information appeared in the 'world round-up' and 'news and comment' sections, which gave examples of responses to HIV and AIDS around the world.

¹⁹ 'AIDS insurance for medical professionals', *SAMJ*, 77, 7, 7 April 1990, p. xvii.

Thirdly, AIDS information specific to the journal or related directly to MASA's engagement with AIDS was printed. This included discussions or talks about AIDS within the formal structures of the organisation and featured in sections of the journal that reported on MASA and incorporated 'MASA news', reports on MASA meetings, and 'news from the secretariat'. Information on AIDS featured predominantly in the shorter 'SAMJ news' sections of the journal, but there were also 25 editorial commentaries and 16 opinion pieces that focussed on AIDS. Fourthly, the bulk of the information on AIDS came from MASA members or SAMJ readers in the form of 95 articles and 152 contributions to the 'correspondence' and 'letters' section. The personal viewpoints of individual members often found expression in these pages.

Finally, from 1986 to 1995, the journal published thirteen official announcements and notifications about AIDS. Mostly these were 'Updates on AIDS' provided by the AIDS Advisory Group (AAG). The government established the AAG to provide expert advice on how to respond to AIDS and it included numerous MASA members.²⁰ The updates included, amongst other issues, 'vital information for practitioners', information on AIDS in RSA, 'the current situation of AIDS in the RSA', and a notice from the department of health (hereafter DoH) about HIV antibody testing. These sections reveal what information about AIDS the journal's editors found interesting enough to publish, and disclose certain formal responses to AIDS by some organisations or sectors. They also, however, serve as a reminder that narratives about the AIDS epidemic were shaped by the selection and omission of content made by the editors.

Aside from reporting on international findings (predominantly from the UK and USA), the SAMJ frequently drew on the premier English-language medical journals for references, citations and examples. New scientific findings and research that appeared in *The Lancet*, the *New England Journal of Medicine (NEJM)*, the *British Medical Journal (BMJ)* and the *Journal of the American Medical Association (JAMA)*, were not only reported on in the SAMJ, but often formed the foundation of research work in South Africa. On one level, this makes sense in terms of language accessibility and the status of these journals as key medical

²⁰ For more on the composition and function of the AIDS Advisory Group see the chapter in this thesis on government responses to AIDS.

journals in the English-speaking world. On another level though, the uncritical use of these journals also had to do with the 'idea' or perception of medicine in South Africa by certain medical professionals. MASA and contributors to the *SAMJ* overwhelmingly compared health care provision in South Africa to health care provision in minority world countries such as the USA or the UK.²¹ This construction of health care in South Africa was not based on the realities of medical provision (or lack thereof) in a majority world country where, aside from a small wealthy elite, health care provision was chronically lacking.²²

The historic association of South Africa with the UK possibly explains this gazing towards the 'metropole' by some medical professionals. Alternatively, the ambitions of some South African medical intellectuals to be identified as equal professional peers with the medical intellectual elites of the USA and the UK might also account for this relationship. On a personal level, many health care professionals and AIDS researchers studied in the UK or the USA and thus had personal or professional connections with medical professionals or medical institutions in these countries. Regardless of the reasons, the UK and USA provided intellectual 'centres' whose medical capacities, research, and approaches to health care, were used by some members of the medical fraternity as a benchmark for medicine in South Africa. Medical researchers often read and built on AIDS research coming predominantly from the USA and UK and, for the most part, initially constructed AIDS narratives modelled on that knowledge.²³

The progressive medical group, the National Medical and Dental Association (NAMDA), summarised the situation as follows:

²¹ The term 'minority world' refers to countries such as the USA, UK, Germany, France, Japan and Australia that, although politically or economically powerful or privileged, do not reflect the socio-economic or political realities experienced by the majority of the world's inhabitants and are therefore part of the minority world. The terms 'minority' and 'majority' world are used to highlight the problem with previous definitions of regions of the world that have favoured the centrality and importance of minority world countries or only focussed on economic dominance. These terms include constructions of First, Second and Third Worlds, and 'developed' versus 'less developed', 'underdeveloped' or 'developing' world.

²² There are exceptions to this understanding and, as discussed elsewhere, there were voices that challenged these understandings of health care provision more generally. See the chapter on progressive primary health care and progressive health care movements for more information.

²³ This is not to imply that this is exclusively a situation that applies to scientific or medical research. Ngugi wa Thiong'o's *Moving the Centre: The Struggle for Cultural Freedoms* (London, James Currey, 1993) for example, examined 'Eurocentrism' in literature and intellectual pursuits.

The South African medical/health system, like other aspects of South African life, most notably the economy, is integrated with and greatly influenced by Western trends and developments.²⁴

As the following sections will show, the thinking and research of many medical professionals working on AIDS was integrated with and influenced by 'Western trends and developments'. There were also, however, trends, developments and opinions influenced by the effects of apartheid ideology and the changing socio-political contexts in South Africa.

As early as 1982 medical researchers in the USA, particularly members of the CDC, identified categories of people who were apparently at increased risk of having AIDS, and placed them in a group colloquially referred to, as Mirko Grmek notes 'in an exquisite twist of black humour', as the 'Four-H Club'.²⁵ The group members were homosexuals, heroin addicts, Haitians and haemophiliacs. The first three were constructed as affiliates who had gained membership through their status as 'sexual deviants', 'outcasts', and 'foreigners', while the fourth were 'unfortunate victims'.²⁶ By the beginning of 1983, as Michelle Cochrane shows, additions to the official list of affected people had expanded to include female 'heterosexual partners' of injecting drug users and bisexual men.²⁷ Despite this, the notion of 'risk-groups' primarily populated by the original four members (with a few amendments such as the inclusion of female sex workers), and what the members of the 'high-risk groups' subconsciously represented, remained evident in both public and professional discussions about AIDS well into the early 1990s.²⁸

²⁴ South African History Archive (SAHA), NAMDA Collection, AL3182, A1.4, 'Why NAMDA?' c. 1988/89, p. 9. The quote went on to note 'The local medical establishment tends to be sensitive to censure by progressive forces abroad and derives enormous moral support from actions of apologists of apartheid drawn from conservative ranks in the U.S, U.K. and Europe generally'. For more on NAMDA see the chapter on NAMDA and health activists' responses to AIDS.

²⁵ Grmek, M. D., *History of AIDS: Emergence and Origin of a Modern Pandemic* (Princeton, Princeton University Press, 1990), p. 30. See the whole of chapter 4 'AIDS/SIDA: The "Four-H" Disease' for a detailed account of the development, construction and usage of the '4Hs'.

²⁶ Cochrane, M., *When AIDS Began – San Francisco and the Making of an Epidemic*, (New York, Routledge, 2004) p. 29.

²⁷ *Ibid.*

²⁸ For a comprehensive account of how the CDC specified and created 'high-risk groups' see Glick Schillers, N., Crystal, S., and Lewellen, D., 'Risky Business: The Cultural Construction of AIDS Risk Groups', *Social Science and Medicine*, 38, 10, 1994. For examples of articles from the late 1980s that discussed female sex workers and AIDS see Padian, N.S., 'Editorial review: Prostitute Women and AIDS: Epidemiology', *AIDS*, 2, 6, December 1988 (abstract only accessed via RU Library link) and Rosenberg, M.J., & Weiner, J.M., 'Prostitutes and AIDS: A Health Department Priority?', *American Journal of Public Health*, 78, 4, April 1988 (accessed using EBSCOhost).

Over the 15-year period under discussion, the AIDS narrative in the USA (and with some variation in the UK) can be seen to flow from one 'H' group to another – from high-risk groups, homosexuals, Haitians, haemophiliacs, heroin users, and hookers, to HAART and a human rights discourse.²⁹ The South African AIDS narrative echoed this international narrative, and this chapter will focus specifically on narratives about 'Haitians', 'homosexuals', and 'hookers' to examine what they reveal about notions of race, sexuality, and gender in both the international and local AIDS narratives. These three avatars are chosen as they appear most frequently in the hegemonic AIDS narrative and because of what they reveal about attitudes to AIDS within the medical and scientific communities during the final years of apartheid.³⁰

The notion of the '4H Club', and 'high-risk groups', became the foci of early AIDS researchers because it fulfilled two functions – on a practical level it provided guaranteed research findings and, on a sub-conscious level, it helped keep the danger of the new epidemic at bay. Essentially AIDS avatars facilitated the denial of AIDS as something that could be blamed on or would affect (kill), the 'normal majority'. The 'normal majority' was a stereotype constructed as heterosexual, not-promiscuous, moral, monogamous, married, predominantly white, predominantly male (with supporting female companions), and therefore, predominantly 'safe'.³¹ In 1994 anthropologists Nina Glick Schillers, Stephen Crystal and Denver Lewellen, reflected on the effects of the CDC's creation of 'high-risk groups' and suggested that it created a 'hierarchy of exposure' that distracted attention

²⁹ An additional two Hs that could be added are 'hostesses' in reference to panicked responses by airline passengers to flying in aeroplanes that had gay cabin attendants as crew (then called 'air hostesses') as gay air stewards were amongst the first to die from AIDS – this however is more directly linked to fears about homosexuality. The other H is for 'half-pints' - a colloquial term for children – in reference to specialized research that developed around paediatric AIDS particularly once mother-to-child transmission had been identified. HAART refers to 'highly active antiretroviral therapy' the combination of antiretroviral drugs that inhibit HIV replication in the human body.

³⁰ Haemophiliacs were cast as innocent victims in the South African narrative and although drug users were named as a high-risk group, there were few actual cases involving intravenous drug users officially documented.

³¹ For more on this see Glick Schillers, *et al*, 'Risky Business', p. 1344. In their examples, particularly in relation to using ethnographies and static ideas of 'culture', Glick Schillers, *et al*, noted that 'Racial stereotyping accompanied the allocation of segments of the population into risk groups. Because most ethnographies of HIV infected intravenous drug users have been conducted in inner city neighbourhoods and most surveys of homosexual men have been done in the gay communities of major cities, the literature on HIV infected intravenous drug users tended to be of 'minorities,' or 'blacks and Hispanics,' while homosexuals were seen as white and middle-class' (p. 1340). The article later presents research done by Glick Schillers *et al*, which provide more nuanced results.

from 'the exchange of semen and blood that transmits the virus'. Instead, the focus on sexual orientation, national identity, and drug use divided people into those 'at risk' and those 'not at risk' and failed to reinforce the obvious point that HIV could be transmitted between any people engaged in certain behaviours if one person was infected and no precautions were taken.³² This 'othering' and artificial creation of a 'safe' group of people was reproduced in South African AIDS narratives, with the safe group being defined as white, heterosexual, and male (with accompanying, peripheral, safe, white heterosexual females).

Historically, medical science has constructed (sometimes consciously and sometimes unconsciously) the 'white, male body' as the norm against which ill health or deviance is compared.³³ This stereotypical body has also been imbued with the normative logic, morality, emotions, and behaviour of 'mankind' and has stood as the marker for the top end of a hierarchy into which other bodies have been slotted – often thanks to 'proof' provided by 'objective science'. Medical science has been employed to rationalise and justify not only this hierarchy, but also the actions, politics and practices of those privileged by their location in this hierarchy.

This 'normal body' was also cast absolutely in a binary world of only two biological sexes - female and male, a construction that has remained largely unchallenged to this day.³⁴ Even when the 'normal male body' is not the centre of investigation, it exists as 'the absent referent' against which other bodies are measured. In relation to sexual activity and sexuality, what bodies are used for, and how they are used, has also been subject to scientific investigation, which has resulted in gendered, raced, and classed readings of 'the abnormal body' compared to 'the normal body'. There is, as a result, a history of sexuality ascribed to, and associated with, pathologised bodies that were then further divided by class

³² Glick Schillers, *et al*, 'Risky Business', p. 1338.

³³ For an erudite summary of the construction of 'the phantom male' body / comparison group in medicine, see Inhorn, M.C., & Whittle, K.L., 'Feminism Meets the "New" Epidemiologies: Toward an Appraisal of Antifeminist Biases in Epidemiological Research on Women's Health', *Social Science & Medicine*, 53, 2001.

³⁴ For more on this see Butler, J., *Bodies that Matter: On the Discursive Limits of 'Sex'* (London, Routledge, 1993); Delphy, C. 'Rethinking sex and gender', *Women's Studies International Forum*, 16, 1, January – February 1993; Fausto-Sterling, A., *Myths of Gender: Biological Theories about Women and Men* (New York, Basic Books, 1992); Fausto-Sterling, A., *Sexing the Body: Gender Politics and the Construction of Sexuality* (New York, Basic Books, 2000); Fausto-Sterling, A., 'The Five Sexes: Why Male and Female are Not Enough', *The Sciences*, 33, 2, March/April 1993; Fausto-Sterling, A., 'The Five Sexes, Revisited', *The Sciences*, 40, 4, July/August 2000 (and the disastrous media coverage of the Caster Semenya debacle).

and 'race' – these bodies included 'black bodies', 'womyn's bodies', 'homosexual bodies' and 'black womyn's bodies'. These pathologised bodies were frequently ascribed labels, such as 'prostitutes', 'lesbians', 'hysterical womyn', 'black womyn', 'black men', and 'homosexual men', that acted as a shorthand way of stereotypically knowing, judging, and defining these groups.³⁵

This use of labels and the continued focus on pathologised bodies prevented 'the normal body' from being subjected to the same level of interrogation and enquiry, and reinforced difference and division rather than understandings of a shared humanity. The 'high-risk groups' created in the AIDS narrative both reflected and added to the histories of pathologised and 'normal' bodies, and scientifically reinforced differences. As a result, both pathologised and 'normal' bodies have suffered.

In the USA and the UK, the media reinforced and repeated the notion of 'high-risk' groups, causing academic activist Simon Watney to remind readers, in 1987, of the existing 'cultural agenda surrounding AIDS' that 'presented the syndrome as if it were an intrinsic property of particular social groups'.³⁶ Watney argued that the association of AIDS 'with some supposed "essence" of those social groups in which it first appeared' automatically suggested that

³⁵ See for example Abrahams, Y, 'Images of Sara Baartman – Sexuality, Race and Gender in Early Nineteenth-Century Britain' in Pierson, R., & Chaudhuri, N. (eds) *Nation, Empire, Colony: Historicizing Gender and Race* (Bloomington, Indiana University Press, 1998); Ahlberg, B.M., 'Is There a Distinct African Sexuality? A Critical Response to Caldwell', *Africa*, 64, 2, 1994; Caldwell, J. & P. et al, 'The Cultural Context of High Fertility in Sub-Saharan Africa', *Population and Development Review*, 13, 3, 1987; Callaway, H. 'Purity and Exotica in Legitimizing the Empire. Cultural Constructions of Gender, Sexuality and Race', in Ranger, T. & Vaughan, O. (eds) *Legitimacy and the State in Twentieth-Century Africa* (Basingstoke, Macmillan, 1993); Callaway, H., *Gender, Culture and Empire: European Women in Colonial Nigeria* (Basingstoke, Macmillan, 1987); Fausto-Sterling, A., 'Gender, Race and Nation: The Comparative Anatomy of 'Hottentot' Women in Europe, 1815-1817', in Schiebinger, L (ed) *Feminism and the Body* (Oxford, Oxford University Press, 2000); Gilman, S.L., *Difference and Pathology: Stereotypes of Sexuality, Race and Madness* (Ithaca, Cornell University Press, 1985); Heald, S. 'The Power of Sex: Some Reflections on the Caldwell's 'African Sexuality' Thesis', *Africa*, 65, 4, 1995; Hyam, R. *Empire and Sexuality: The British Experience* (Manchester, Manchester University Press, 1990); Klausen, S., 'For the Sake of Race: Eugenic Discourse of Feeblemindedness and Motherhood in the South African Medical Record 1903 – 1926', *Journal of Southern African Studies*, 19, 3, 1993; Klausen, S., *Race, Maternity and the Politics of Birth Control in South Africa, 1910-39* (Basingstoke, Macmillan, 2004); Marks, S. *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession* (Johannesburg, Witwatersrand University Press, 1994); Stoler, A., 'Making Empire Respectable: The Politics of Race and Sexual Morality in 20th Century Colonial Cultures', *American Ethnologist*, 16, 4, 1989.

³⁶ Watney, S., *Practices of Freedom – Selected Writings on HIV/AIDS* (Durham, Duke University Press, 1994) p. 25.

those social groups presented a threat to other social groups by virtue of who they were.³⁷ This shifted responsibility for the epidemic to the people who were already ill and framed questions and understandings of the epidemic in relation to groups and not actions or contexts that were universal and applicable to all.

Watney called for an inversion of this view of the epidemic arguing that neither 'high-risk groups' nor 'high-risk behaviours' were appropriate terminologies if the cultural agenda was to be challenged, suggesting that the terms 'vulnerability' and 'highly vulnerable groups' were more appropriate.³⁸ This terminology certainly asks different questions as it is premised on contextualising people who are ill within a broader socio-political and economic context and requires an analysis of which people are, and which are not, vulnerable, and why?

Examining medical narratives about AIDS in San Francisco, Cochrane shows how particular characteristics of people with AIDS were highlighted, and others totally ignored, resulting in singular characteristics taking on disproportionate significance in medical narratives. Cochrane contends that 'between 1980 and 1985, the mode of transmission for an AIDS patient who was both a homosexual male and an intravenous drug user was attributed exclusively to his (homo)sexual orientation'.³⁹ This practice not only reduced people to one-dimensional representations of one aspect of their lives (sexual practice) but also, consciously or subconsciously, linked 'sinful' behaviours to danger using a sliding scale that judged homosexuality worse than drug dependency.⁴⁰

It is clear that the analysis offered by Schillers *et al*, Watney and Cochrane are equally valid for the narratives that emerged in the *SAMJ* and in South Africa. Schillers *et al*'s notion of hierarchies of exposure and the creation of 'safe' versus 'risk' groups that distract from broader interrogations of sexuality are evident. Similarly, as per Watney and Cochrane's observations, the complexities of human beings are often stripped down to a particular

³⁷ Watney, *Practices of Freedom*, p. 25.

³⁸ *Ibid.* While Watney's construction of vulnerability requires further elaboration to more clearly differentiate it from victimhood, it is a concept worth engaging with in terms of social inequalities and health.

³⁹ Cochrane, *When AIDS Began*, p. 14.

⁴⁰ *Ibid.* Cochrane acknowledges and draws on work done by Murray and Payne in this conclusion.

characteristic or 'essence' that becomes representative of the groups under discussion, rather than of the complexities of peoples' lives.

Examining the caricatures to which groups of people were reduced provides insights into the concerns, ideologies, moralities, reflexivity, and fascinations, not of the groups mentioned, but rather of the creators of the groups. The positioning of the researchers, and 'the moral majority' to whom many researchers aligned themselves, are thus made visible. The use of AIDS avatars also allowed for the creation of ideas of a hierarchy of infection, with the immoral or different 'other' at the bottom and the uninfected 'moral majority' at the top.

Medical research and discussions about AIDS in the *SAMJ* drew on the international 4H discourse and reproduced it or modified it to a South African context. Both the narratives in the *SAMJ* and the international narratives however, drew on older established imagery, conservative morality, and conscious or subconscious ideologies, to employ or construct stereotypes and (un)scientific categories of people when creating knowledge about AIDS. Particular understandings of race, gender, sexual orientation, sexuality, and national identity and security, fed into the creation of AIDS avatars such as 'the homosexual', 'the infected foreigner', 'the prostitute', 'the infected womb', and 'black heterosexuals'.⁴¹

From 'Dark' Country to 'Dark' Continent: AIDS, Race, and Science

The inclusion of Haitians in the initial list of high-risk groups issued by the CDC underscored both conscious and unconscious racism amongst researchers in the USA as the close analyses of early medical and scientific writings by Rosalind and Richard Chirimuuta reveal.⁴² Paul Farmer has discussed the legacy of that inclusion on Haitian communities both in the USA and in Haiti, and the responses to 'North American racism' by Haitian communities.⁴³ Cochrane, Glick Shillers *et al*, and others have also addressed the inherent, or implicit, racism in the inclusion of Haitians as a 'high-risk group'.

⁴¹ The idea of an AIDS avatar comes from a line in Watney's work that 'the notion of "high-risk groups" ... functions as an avatar for 'the AIDS carrier...'. See Watney, *Practices of Freedom*, p. 25.

⁴² See Chirimuuta, R., C., & Chirimuuta, R.J., *AIDS, Africa and Racism* (London, Free Association Books, 1989).

⁴³ Farmer, P., *AIDS & Accusation: Haiti and the Geography of Blame* (Berkeley, University of California Press, 2006).

Glick Schillers *et al* observed that 'The Haitian population was treated ... with an early assumption that high prevalence of HIV infection was a product of something culturally or biologically Haitian rather than evidence that anyone could transmit the virus through heterosexual contact'.⁴⁴ In short, Haitians were included simply because they were 'Haitians', and existing racial assumptions were sufficiently embedded amongst CDC researchers that the only members of the 4H club to be identified by a geographic marker were those read as phenotypically black and therefore 'diseased'. Political pressure and challenges to this perception within both medical science and the mainstream media, eventually resulted in Haitians being removed from the CDC's high-risk groups in 1985.⁴⁵

Racist theories have been neither the preserve of one era, nor of one community of people, and they have certainly crossed academic disciplines. In research examining the relations between medicine, science, and racism much has been written about the constructions of Africa as a 'sick continent' and of black bodies as 'diseased' and 'hypersexual'. Historians, medical historians and medical anthropologists, amongst others, have produced scholarship analysing the images of a 'sick', 'dark' continent, and the realities of tropical health concerns on various colonial enterprises. The use of concerns about health to further political agendas or reproduce ideologies of superiority thus has a long history.⁴⁶ It is therefore unsurprising that a new illness would draw on old images, even subconsciously, to find explanations and

⁴⁴ Glick Schillers, 'Risky Business', p. 1339.

⁴⁵ Chirimuutas, *AIDS, Africa and Racism*, pp. 20 - 21; & Cochrane, *When AIDS Began*, p. 14.

⁴⁶ See for example: Butchart, A., *The Anatomy of Power: European Constructions of the African Body* (London, Zed Books, 1998); Comaroff, J., 'The Diseased Heart of Africa: Medicine, Colonialism, and the Black Body' in Lindenbaum, G., & Lock, M. (eds) *Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life* (Berkeley, University of California Press, 1993); Comaroff, J., 'Medicine, Colonialism and the Black Body' in Comaroff, J. (ed), *Ethnography and the Historical Imagination* (Boulder, Westview Press, 1992); Curtin, P.D., 'The White Man's Grave: Image and Reality, 1780-1850', *The Journal of British Studies*, 1, 1, November, 1961; Fanon, F., 'Medicine and Colonialism' in Fanon, F., *A Dying Colonialism* (New York, Grove Press, 1967); Kuntz, D., & Bachrach, S. (eds) *Deadly Medicine: Creating the Master Race*, (Washington, University of North Carolina Press, 2004); Lorimer, D., 'Nature, Racism and Late Victorian Science', *Canadian Journal of History*, 25, 3, 1990; McCulloch, J., *Colonial Psychiatry and 'the African Mind'* (Cambridge, Cambridge University Press, 1995); Ranger, T., & Slack, P. (eds), *Epidemics and Ideas: Essays on the Historical Perception of Pestilence* (Cambridge, Cambridge University Press, 1992); Vaughan, M., *Curing their Ills: Colonial Power and African Illness* (Cambridge, Polity Press, 1991); Vaughan, M., 'Health and Hegemony: Representations of Disease and the Creation of the Colonial Subject in Nyasaland' in Marks, S., & Engels, D. (eds), *Contesting Colonial: State and Society in Africa and India* (London, British Academic Press, 1993).

apportion blame, and that AIDS research should reflect ideas of 'race' (or perhaps more specifically racism).⁴⁷

As Glick Schillers *et al* note: 'Since the first cases of AIDS were diagnosed in the early 1980s, authorities, researchers, and writers often reported the disease as originating from outside, wherever that was, and brought by that which was alien'.⁴⁸ In the USA, 'that which was alien' moved from being 'homosexual' 'white' men, via 'heterosexual' 'black' Haitians, to 'heterosexual' 'black' 'Africans'.⁴⁹ Beyond the USA, other countries adopted the CDC's 'high-risk' categories and prior to the removal of Haitians from the list France, Canada and South Africa also managed to find at least one Haitian case each.⁵⁰ Once Haitians were removed from the high-risk group, attention focused on 'the African connection', and 'that which was alien' was now linked to Africa in prominent medical publications from both the UK and the USA, and was subsequently incorporated into the South African AIDS narrative. The idea of the 'infected, black, foreign body' had such currency that it easily transcended the geographic and nationalist boundaries of Haiti/Haitians, and the USA/'Americans', and moved from being applied to one country, to being applied to a whole continent.

⁴⁷ For readings addressing 'race' and AIDS see for example: Bibeau, G., & Pedersen, D., 'A return to scientific racism in medical social sciences: the case of sexuality and the AIDS epidemic in Africa' in Nichter, M., & Lock, M., (eds), *New Horizons in Medical Anthropology: Essays in Honor of Charles Leslie* (London, Routledge, 2002); Cameron, E., *Witness to AIDS* (Cape Town, Tafelberg, 2005) in particular chapter 3 'Race, sex and death in Africa'; Fee, E., & Krieger, N., 'Understanding AIDS: historical interpretation and the limits of biomedical individualism', *American Journal of Public Health*, 83, 10, 1993; Larson, A., 'The Social Epidemiology of Africa's AIDS Epidemic', *African Affairs*, 89, 354, 1990; Marshall, W.E., 'AIDS, Race and the Limits of Science', *Social Science & Medicine*, 60, 11, June 2005; Ona Pela, A., & Platt, J.J., 'AIDS in Africa: Emerging Trends', *Social Science and Medicine*, 28, 1, 1989; Packard, R.M., & Epstein, P., 'Epidemiologists, Social Scientists, and the Structure of Medical Research on AIDS in Africa', *Social Science and Medicine*, 33, 7, 1991; Packard, R.M., & Epstein, P., 'Medical Research on AIDS in Africa: A Historical Perspective' in Fee, E., & Fox, D.M. (eds), *AIDS: The Making of a Chronic Disease* (Berkeley, University of California Press, 1992); Sabatier, R., Aina, T., Ardila, P., *et al*, *Blaming Others: Prejudice, Race and Worldwide AIDS*, (Washington, Panos, 1988); Stevenson, Jr., H.C., 'The Psychology of Sexual Racism and AIDS: An Ongoing Saga of Distrust and the "Sexual Other"', *Journal of Black Studies*, 25, 1, September, 1994; and Treichler, P.A., 'AIDS and HIV Infection in the Third World: A First World Chronicle', in Fee & Fox *AIDS: The Making of a Chronic Disease*.

⁴⁸ Glick Schillers, Crystal, and Lewellen, 'Risky Business' p. 1339.

⁴⁹ This is not to imply that in most countries AIDS was not blamed on 'the Other'. As Phillips and Crewe have shown AIDS (like many diseases before and since AIDS), was, for example, blamed on 'Afrikaners', 'Americans', 'communists', 'blacks' and 'whites' by various people in South Africa. The phenomenon of blaming other 'nationalities' has been reported in accounts of AIDS from many countries, see Crewe, M., *AIDS in South Africa – The Myth and the Reality* (London, Penguin, 1992) and Phillips, H., 'AIDS in the Context of South Africa's Epidemic History: Preliminary Historical Thoughts', *South African Historical Journal*, 45, November 2001.

⁵⁰ Chirumuuta, & Chirumuuta, *AIDS, Africa and Racism*, p. 19. There is no evidence of a 'Haitian case' in the UK.

Referring to articles from English-language media in the UK and the USA in 1989, Watney discusses the construction of 'African AIDS', as opposed to 'AIDS in Africa', and provides evidence of the longevity of 'heart of darkness' metaphors and imagery and the association of an entire continent with 'primitiveness' and sickness.⁵¹ Echoing his earlier work, Watney comments that 'It is as if HIV were a disease of "Africaness", the viral embodiment of a long legacy of colonial imagery which naturalises the devastating economic and social effects of colonialism in the likeness of starvation-bodies'.⁵²

Analysing the 'cultural and psychic construction' of 'African AIDS' further, Watney identified five consistent aspects of the construction in the media:

First, it speaks of a peculiar and special affinity between a virus and a continent. Second, it reads the modes of transmission of HIV as signs of a generalised and homogenous African 'primitiveness', whether sexual or medical. Third, it singles out the alleged 'mis-reporting' of African HIV and AIDS statistics as further evidence of 'backwardness' and 'unreliability'. Fourth, it equates black Africans and western gay men as wilful 'perverts' who are equally threatening to 'family values'. Fifth, it regards 'Africa' as the source of HIV infection in the sense of origin and of cause. Whilst none of these aspects are individually specific to the issue of AIDS, their collective configuration is ... unprecedented. The construction of 'African AIDS' tells us much about the west, and its major strategies of self-knowledge, rooted in systems of difference and otherness.⁵³

So what relevance did 'high-risk groups', images of a sick continent, and notions of the 'alien other' have to doctors and medical professionals located at the southern tip of 'the dark continent'? Did these doctors see themselves as part of the 'scientific West' and therefore not primitive, backward and unreliable, in other words 'not African'? What can the constructions of South African AIDS narratives tell us about 'major strategies of self-knowledge' in a country deeply 'rooted in systems of difference and otherness' socially, politically and ideologically?

⁵¹ Watney, *Practices of Freedom*, p. 106.

⁵² *Ibid.*

⁵³ *Ibid.*, p. 111.

Making '... Haitians fit in' in the *SAMJ*

As previously mentioned, the first account in the *SAMJ* of what would eventually be named AIDS appeared in February 1982 and reported on case studies in the USA initially published in the *Lancet* and the *NEJM*. The report linked the 'new danger' with 'homosexuality'; referred to Kaposi Sarcoma as it existed in 'Black Africa'; and reported on how the CDC was addressing the problem.⁵⁴ In this first report there are indications of how the AIDS narrative in South Africa would refer to findings from key medical journals and organisations in the USA and UK, would align itself with conservative heteronormativity, would identify South Africa as being apart from the rest of Africa, and would reproduce markers of 'race'.

In January 1983, the CDC's 'risk-groups' were listed in the *SAMJ* and readers were informed that the CDC had named 'the apparently new syndrome ... the acquired immunodeficiency syndrome (AIDS)'.⁵⁵ The editorial noted 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'.⁵⁶ In keeping with a discourse that differentiated between 'the general majority' and 'others', it concluded that: 'In the light of the limited and highly specific groups at risk, the most important task of general practitioners is to allay the fears of *the general public* by appropriate health education'.⁵⁷ Male homosexuals, and the 'few' heterosexual men, women, persons of Haitian origin and haemophiliacs that were listed were not considered, it would appear, members of the 'general public'.

The editorial also referred to the deaths in South Africa of '2 White men ... apparently from AIDS, [which had] ... received widespread publicity in the media and provoked a somewhat hysterical reaction among those sections of the community most at risk, the male

⁵⁴'Immunitetstekort en Homoseksualiteit', *SAMJ*, 61, 9, 27 February 1982, p. 298. As per the UK National Health Service (NHS) website 'Kaposi's sarcoma is a rare type of cancer that can affect both the skin and internal organs'. Initial symptoms include red or purple discolouration on the skin which then form nodules. For more on Kaposi's sarcoma see the NHS website at www.nhs.uk/conditions/kaposis-sarcoma/Pages/Introduction.aspx (accessed May 2012).

⁵⁵'Acquired immunodeficiency syndrome (AIDS)', *SAMJ*, 63, 4, 22 January 1983, p. 98.

⁵⁶ *Ibid.*

⁵⁷ *Ibid.*, [emphasis added].

homosexual and the drug abuser'.⁵⁸ In the editorial the deceased men were specifically identified by 'race', sexual orientation, 'deviant behaviour', and connection to outside vectors of infection by the revelation that 'In the 2 South African cases, there was a history of contact with persons in New York', and that the South African cases shared clinical features that had 'been recorded in the USA'.⁵⁹ Updating readers more generally the author noted that 'the disease had been found in all race groups' in the USA and that 'about 60 cases' had been found in Western Europe.⁶⁰

'Homosexuals' and drug-users had already headlined the 1982 article about AIDS, and in February 1983 another two 'high-risk' groups made headlines in an editorial entitled 'AIDS, Haemophiliacs and Haitians'.⁶¹ The editorial referred to 'an even more baffling finding...that AIDS is more prevalent in Haitians in the USA; the most recent report gives details of 10 heterosexual male Haitians suffering from the syndrome ...'.⁶²

Despite highlighting this 'baffling finding' and later asking '... but how do the Haitians fit in?', the author failed to provide even speculative answers to the question, and instead repeated findings from the *NEJM* and noted that 'AIDS has appeared in Haitians from widely separated areas of the USA and there is some unpublished evidence that it also occurs in Haiti. Unfortunately our knowledge of opportunistic infections in Haiti is scanty'.⁶³ 'The Haitians' were bound by a nebulous geographic marker – there is no indication if these cases referred to naturalised citizens of the USA of Haitian descent, people born in the USA of Haitian descent, or Haitian citizens who were resident in the USA. Neither is there any indication of how long the ten 'heterosexual Haitian males'⁶⁴ had been in the USA. What is highlighted is membership of an external geographic space, without the relevance or appropriateness of this being seriously interrogated.

⁵⁸ 'Acquired immunodeficiency syndrome', p. 98. There was no indication of drug users having died of AIDS.

⁵⁹ *Ibid.*

⁶⁰ *Ibid.* According to the editorial (although no reference is supplied) in the USA 'more than 750 cases (had) been reported in the period June 1981 – November 1982'.

⁶¹ 'AIDS, Haemophiliacs and Haitians', p. 257.

⁶² *Ibid.*

⁶³ *Ibid.* The refrain about 'scanty knowledge' about AIDS from 'less developed' countries (like Haiti) and /or continents (like Africa) is an oft-repeated one. As Treichler and others have shown however, the changing definition of AIDS, narrow focus on 'high-risk groups' and nature of collecting epidemiological data made most knowledge about AIDS 'scanty'.

⁶⁴ *Ibid.*

In the *SAMJ* 'Haitians' went from headlining editorials in 1983 to being repeatedly listed as 'members of four well-defined groups' amongst whom AIDS was occurring, to being dropped, without comment, by 1986 - following closely on the CDC's decision to remove Haitians from the 'high-risk group' category in 1985. During this period there were occasional transitions in terminology from 'Haitians' to '... Haitian immigrants to the USA', and 'Haitians in the USA as well as in Haiti'.⁶⁵ In a 1984 article Haitians were not listed with homosexuals, heroin addicts, or haemophiliacs, but were listed with people from whom the LAV retrovirus had been isolated 'including a homosexual man, a Haitian man and a woman from Zaire'.⁶⁶

As international attention turned to AIDS in 'central Africa', as part of a quest to find the 'African origin' of AIDS, Haitians began to fade from the 'high-risk groups' category.⁶⁷ In an article reporting on two confirmed cases of AIDS in Cape Town, Spracklen *et al* referred to 'so-called high-risk groups' and noted contestation around the inclusion of 'Haitians' by commenting that: 'Persons from Haiti and Zaire appear to have a higher risk of acquiring AIDS, although this has been disputed with regard to Haitians'.⁶⁸ One of the final references

⁶⁵See 'Meer Oor VIGS' (More About AIDS), *SAMJ*, 64, 23 July 1983, p. 114; 'AIDS in children', *SAMJ*, 65, 14 April 1984, p. 587; 'AIDS and Blood Transfusion', *SAMJ*, 65, 23 June 1984, p. 1000; Anderson, R., Prozesky, O.W., Eftychis, H.A., *et al*, 'Immunological Abnormalities in South African Homosexual Men', *SAMJ*, 64, 23 July 1983, p. 119; and Ras, G.J., Simson, I.W., Anderson, R., *et al*, 'Acquired Immunodeficiency Syndrome - A Report of 2 South African Cases', *SAMJ*, 64, 23 July 1983, p. 140; 'VIGS (AIDS) - 2 Jaar Later', *SAMJ*, 64, 31 December 1983, p. 1080.

⁶⁶ Retrovirus and AIDS, *SAMJ*, 66, 14 July 1984 p. 42. Lymphadenopathy-associated virus (LAV) was one of the names for the causative agent of AIDS. As the CDC noted in a *Morbidity and Mortality Weekly Report (MMWR)* in November 1986 'The AIDS virus has been variously termed human T-lymphotropic virus type III (HTLV-III/LAV), lymphadenopathy-associated virus (LAV), AIDS-associated retrovirus (ARV), or human immunodeficiency virus (HIV). The designation "human immunodeficiency virus" (HIV) has been accepted by a subcommittee of the International Committee for the Taxonomy of Viruses as the appropriate name for the retrovirus that has been implicated as the causative agent of AIDS (Science 1986; 232:697)'. See 'Epidemiologic Notes and Reports Positive HTLV-III/LAV Antibody Results for Sexually Active Female Members of Social/Sexual Clubs - Minnesota', *Morbidity and Mortality Weekly Report (MMWR)*, 35, 45, 14 November 1986 accessed via the CDC website at www.cdc.gov/mmwr/preview/mmwrhtml/00000819.htm (accessed May 2012). The naming of HIV was part of a larger debate about who had discovered the retrovirus between scientist Luc Montagnier (from France) and Robert Gallo (from the USA). For more on this see Epstein, S., *Impure Science - AIDS, Activism, and the Politics of Knowledge* (Berkeley, University of California Press, 1996), pp. 66 - 78.

⁶⁷ See for example Lyons, S.F., Schoub, B.D., McGillivray, G.M., & Sher, R., 'Sero-epidemiology of HTLV-III Antibody in Southern Africa', *SAMJ*, 67, 15 June 1985, p. 961 and 'AIDS in the USA and the RSA - an update', *SAMJ*, 70, 19 July 1986, p. 119. For a detailed account of the progression of scientific questioning in the African origin of AIDS see Chirumuuta & Chirumuuta, *AIDS, Africa and Racism*, particularly ch. 3 'Early African Cases'.

⁶⁸ Spracklen, F.H.N., Whittaker, R.G., Becker, W.B., *et al*, 'The Acquired Immune Deficiency Syndrome and Related Complex - A Report of 2 Confirmed Cases in Cape Town with Comments on Human T-cell Lymphotropic Virus Type III Infections', *SAMJ*, 68, 3 August 1985, pp. 139 - 143.

to Haitians occurs in November 1986 when an update of the 41 cases of AIDS diagnosed in South Africa at that point refers to one person who was diagnosed in South Africa and returned to Mozambique, but was 'initially from Haiti'.⁶⁹ The power of speculative conclusions based on stereotypes and lacking empirical proof remained however, as is evident in the World Round-up section of the *SAMJ* in August 1987 where all manner of exotic imagery and otherness was resurrected to help explain the 'baffling finding... of AIDS amongst Haitians'.⁷⁰ The paragraph reads:

It has always been a puzzle why AIDS became so common in Haiti since homosexuality did not seem especially rife in that society. It has now been suggested that voodoo is possibly the linking factor. Many Haitians are voodoo devotees and belong to secret societies such as Bizango or Cabrit Thomago which use human blood, and voodooists can be infected by swallowing, inhaling or touching ritual substances. Some voodoo practices also include making potions from infected corpses.⁷¹

Farmer has shown how such suggestions were not only unreasonable and built on an American folk model of Haitians, but also represent 'a *systematic misreading* of existing epidemiological and ethnographic data'.⁷² The appearance of the above paragraph in the *SAMJ* suggests a tacit agreement with the typecasting of black people. Such constructions of 'dark bodies' associated with 'dark magic' and other exotic, mysterious, superstitions were deemed sufficiently credible to be published in the journal.

'Race' as a Research Category in the *SAMJ*

While the construction of Haitian people was predicated on racial, and racist, suppositions drawn from the USA, South Africa of course, had its own long history of racial construction and discrimination. Paul Maylam has noted that 'racism' (and 'race') as evident in South African history and historiography, 'cannot be understood properly if treated as a monolithic

⁶⁹ 'Update on AIDS: Vital Need for Information from Private Practitioners', *SAMJ*, 70, 8 November 1986, p. 639.

⁷⁰ 'Always been a puzzle why AIDS became so common', *SAMJ*, 72, 3, 1 August 1987, p. xxv.

⁷¹ 'Always been a puzzle ...', The paragraph was printed as quoted above with '*Pharma Information*, March 1987' in brackets at the end of the paragraph indicating that it was reproduced from that source.

⁷² Farmer, P., *AIDS & Accusation*, p. 2. In addition, Farmer's work engages with the ideas (and the effects of these ideas) about 'voodoo', AIDS and Haiti in other portions of the book.

phenomenon'.⁷³ Certainly in the period under discussion racial ideology and racial doctrine as official discourse in South Africa were to undergo a dramatic transition in the public and political spheres. At the beginning of the AIDS epidemic though, the four elements Maylam suggests comprise racism were all present, albeit in varying degrees, namely: racial consciousness, racial theory or scientific racism, informal racial practice and formalised racial policy.⁷⁴ This located South African researchers as individuals living within a society predominantly defined by race and replete with ready stereotypes or constructions of 'racialised bodies'.⁷⁵

While the centrality and importance of scientific racism has ebbed and flowed in South Africa's history, the work of Saul Dubow and others has demonstrated the existence of a long and complex relationship between science, medicine (and other disciplines), and constructions of 'race', power, ideas, ideologies and politics in South Africa.⁷⁶ The following observation by Dubow about Afrikaner nationalism can be extended to refer to the influence

⁷³ Maylam, *South Africa's Racial*, p. 7.

⁷⁴ *Ibid.*, pp. 7 – 8. See also p. 203 for examples of how social apartheid was being challenged and altered; and for an overview of the changing character of the racial order.

⁷⁵ Throughout this thesis, 'race' is understood to mean the artificially constructed division of people into specific 'groups' based on subjective criteria as arbitrary as phenotype. The rejection of 'race' as a real category does not deny the lived reality of existing in a world that uses these markers. Experiences of racism, and the experiences associated with inhabiting a racialised world are therefore not dismissed in this understanding.

⁷⁶ See for example Bank, A., 'Of "Native Skulls" and Noble Caucasians: Phrenology in Colonial South Africa', *Journal of Southern African Studies*, 22, 3, 1996; Brown, B., 'Facing the Black Peril: The Politics of Population Control in South Africa', *Journal of Southern African Studies*, 13, 2, January 1987; Deacon, H., 'Racial Segregation and Medical Discourse in Nineteenth Century Cape Town', *Journal of Southern African Studies*, 22, 2, 1996; Dubow, S., *Scientific Racism in Modern South Africa* (Cambridge, Cambridge University Press, 1995); Dubow, S. (ed) *Science and Society in Southern Africa* (Manchester, Manchester University Press, 2000); Dubow, S., *A Commonwealth of Knowledge: Science, Sensibility and White South Africa 1820 – 2000* (Cape Town, Double Storey, 2006); Jochelson, K., *The Colour of Disease: Syphilis and Racism in South Africa, 1880 – 1950* (Hampshire, Palgrave, 2001); Klausen, S., *Race, maternity and the politics of birth control in South Africa, 1910-39* (Basingstoke, Macmillan, 2004); Marks, S., & Andersson, N., 'Typhus and Social Control in South Africa, 1917-1950' in MacLeod, R., & Lewis, M. (eds), *Disease, Medicine and Empire: Perspectives on Western Medicine and the Experience of European Expansion* (London, Routledge, 1988); Marks, S., *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession* (Johannesburg, Witwatersrand University Press, 1994); Packard, R., *White Plague Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Pietermaritzburg, University of Natal Press, 1990); Packard, R., 'The Healthy Reserve and the "Dressed Native": Discourses on Black Health and the Language of Legitimation in South Africa', *American Ethnologist*, 16, 1989; Packard, R., 'The Invention of the Tropical Worker: Medicine Research and the Quest for Central African Labour on the South African Gold Mines, 1903-36', *Journal of African History*, 34, 1993; Parnell, S., 'Creating Racial Privilege: The Origins of South African Public Health and Town Planning Legislation', *Journal of Southern African Studies*, 19, 3, 1993; Swanson, M., 'The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1909', *Journal of African History*, 18, 3, 1977; and Van Heyningen, E., 'Agents of Empire: The Medical Profession in the Cape Colony, 1880-1910', *Medical History*, 33, 1989.

of 'race' in medico-scientific writing in the *SAMJ* for a large part of the 1980s and the early 1990s. Dubow notes:

It is virtually a truism that racism has been, and remains, an inseparable part of the structure of South African society. ... Notions of superiority, exclusivity and hierarchy have long existed as more or less conscious 'habits of mind'. Together they comprise a folkloric amalgam of popular beliefs and traditions in which the idea of human difference appears as part of the natural order of things.⁷⁷

In the *SAMJ* this is most notable in the continuous use of race as a marker in articles.⁷⁸ These 'habits of mind' also became habits of writing and were commented upon by Bourne, and by Boonzaier and West, in opinion pieces published in 1989. Bourne's piece, titled 'Nomenclature in a Pigmentocracy – a Scientist's Dilemma', revealed what an inseparable part race was of science and medico-scientific writing:

I have in the past been criticised by colleagues for using the terms white, coloured and black in articles dealing with aspects of health in South Africa. In

⁷⁷ Dubow, S., 'Afrikaner Nationalism, Apartheid and the Conceptualization of "Race"', *Journal of African History*, 33, 2, 1992, p. 210.

⁷⁸ The following list provides specific examples of racial categories forming part of the title of the article, but it is standard practice in the majority of articles in the Journal to see racial or ethnic classifications as descriptors. See Vos, G.H. and Brain, P., 'Race and Sex Differences in Walking Under Ladders in Durban', *SAMJ*, 58, 12, 20 September 1980, p. 470; Wilkinson, R., 'Hepatitis B as a Sexually Transmitted Disease in a Black South African Population', *SAMJ*, 65, 24, 16 June 1984, pp. 954 – 955; Botha, M.C., Neethling, F.A., Shai, I., Lekabe, J.M., and van der Merwe, C.F., 'Two Black South Africans with AIDS', *SAMJ*, 73, 2, 23 January 1988, p. 132; 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, pp. 481 – 483; Gledhill, R.F., Dessen, P.H., and Sneider, P., 'Antibody to HTLV-I in a Black South African with a Neurological Disorder Resembling Multiple Sclerosis', *SAMJ*, 75, 3, 4 February 1989, pp. 147 – 148; 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, pp. 329 – 333; 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, pp. 628–9; Schall, R., 'On the Maximum Size of the AIDS Epidemic among the Heterosexual Black Population in South Africa', *SAMJ*, 78, 9, 3 November 1990, p. 507; 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, p. 520; Spargo, C., Chricton, B., de Souza, M., Phoshoko, V., and Dansey, R.D., 'Awareness of AIDS Among Black Mineworkers', *SAMJ*, 80, 3, 3 August 1991, p. 160; Klugman, K.P., Patel, J., Sischy, A., and McIntyre, J.A., 'Serological Markers of Sexually Transmitted Diseases Associated with HIV-1 Infection in Pregnant Black Women', *SAMJ*, 80, 5, 7 September 1991, p. 243; Abdool Karim, Q., Abdool Karim, S.S., and Nkomokazi, J., 'Sexual Behaviour and Knowledge of AIDS Among Urban Black Mothers', *SAMJ*, 80, 7, 5 October 1991, p. 340; included in a section called 'Editor's Choice', 'Why do Black Runners Do so Well?', *SAMJ*, 81, 10, 16 May 1992, p. vii; Cowie, R.L., 'Health Risks Among White South African Goldminers', *SAMJ*, 82, 4, 1 October 1992, p. 281; and Abdool Karim, S.S., and Abdool Karim, Q., 'Changes in HIV Seroprevalence in a Rural Black Community in Kwazulu', *SAMJ*, 82, 6, 1 December 1992, p. 484.

the pigmentocracy in which we live such terminology has become all pervasive; indeed it is a fundamental tenet of the country's constitution. Perhaps we have become guilty in applying it uncritically over the years.

For those of us who use official data in our work these colour categories are invariably the only strata into which the population is divided. Over the years the labels have changed: Native, Bantu, Plural, African, Black; European, White; Cape Coloured, Coloured; Indian, Asian, Asiatic. The description of the strata too has changed: race, ethnicity, population group. Nomenclature used in the *SAMJ* tends to follow what is popularly used in the country. Indeed terminology often changes within an article to avoid repetition and attempt to improve grammatical style. Is this scientific?

... The dilemma for the scientist is whether to use the terms white, coloured, Asian and black or not. The divisions in South African society, after many decades of legislated segregation, are real. As the World Health Organisation has indicated: "In South Africa, social, economic and political institutions are so structured by an all-pervasive racist ideology and practice that they have material effects on the incidence of disease and the provision of health care." It is therefore impossible to describe the daily reality for millions of South Africans in any other way and such terms as 'racial stratification', 'racial differences', 'black', 'white' and 'coloured' cannot be avoided ... Their use, however, does not imply the legitimacy of racist terminology.

If one were to use numerical or statistical data in a scientific paper in an anecdotal or popular way, it would be summarily rejected by a competent referee. If articles categorising the population are to maintain a scientific credibility then the strict and critical definition of these terms, and as critical a refereeing, is a *sine qua non*. None the less the choice of the most appropriate stratification and its nomenclature remains a dilemma for the scientist.⁷⁹

Anyone writing about South African history would sympathise with the almost impossible task of referring to apartheid-era South Africa without recalling the artificial categories of 'race' into which people were placed. However, that is a fundamentally different proposition from assuming that the racialised ordering (categorising) of society was in any way scientific or that there were, in any real sense, 'strict and critical definitions' of these terms. Bourne's engagement with the problem of racial markers in the *SAMJ* is noteworthy because of its

⁷⁹ Bourne, D.E., 'Nomenclature in a Pigmentocracy – A Scientist's Dilemma', *SAMJ*, 76, 2 September 1989, p. 185. Bourne was from the Department of Community Health, UCT Medical School.

self-reflective nature, and for what it reveals about the frustration in science when categories are not neat and tidy.

The piece by Boonzaier and West pertains to the orthodoxy of race as a scientific marker or category but is also applicable to the construction and use of other markers in the South African AIDS narrative. They challenged the subjective, problematic, and unscientific use of race as a descriptor and standard category in medical science.⁸⁰ Using the Population Registration Act of 1950 as the starting point, they reminded readers that the 'population groups' were in no way natural, but rather unnatural groupings defined by legislation and social practice. Furthermore, they challenged readers to consider that although racial classification influenced every aspect of peoples' lives and had become 'a shorthand way of knowing [peoples'] likely social background' they did not belong in science. They also critiqued medical methodologies that were not self-reflexive and argued that

In scientific discussion (including medical research and publications) ... 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.

... 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 ... 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. In the light of the above discussion there can be no possible scientific justification for the thoughtless inclusion of questions about a person's 'race' or population category. 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.⁸¹

Despite these critiques, race appeared as a marker in the AIDS narrative in the *SAMJ* from the outset as the figures below indicate (figures 4 & 5). Race was not, however, the only inappropriate and unscientific marker to appear in this narrative.. With minor adjustments,

⁸⁰West, M.E., & Boonzaier, E.A., 'Population Groups, Politics and Medical Science', *SAMJ*, 76, 2 September 1989, pp. 185 - 186.

⁸¹ West & Boonzaier, 'Population Groups', pp. 185-186.

West and Boonzaier's arguments can be applied to all the AIDS avatars featured as 'high-risk groups' in the *SAMJ*'s AIDS narrative.⁸² Like race, 'high-risk groups' became a 'shorthand way of knowing' people and making assumptions about their lives and behaviours. The groups used by researchers were not 'natural bounded groupings' but were rather defined as such by medical science in a way that was not methodologically or scientifically rigorous. The salience of the categories of 'high-risk groups' were not clearly demonstrated, and the way in which information and knowledge about the groups was collected continue to require interrogation. Many of the 'high-risk groups' were not based on clearly defined objective criteria, and in many instances this did mean that they lacked 'scientific' value, but, as the next section will show, they had considerable political 'value'.

⁸² Note: This idea, and use of quotes from Boonzaier & West's article are also discussed in Tsampiras, C., 'Not So "Gay" After All: Constructing (Homo)sexuality in AIDS Research in the *South African Medical Journal*, 1980 - 1990', *South African Historical Journal*, 60, 3, September 2008.

TABLE I. CATEGORY OF HIV TRANSMISSION

Type	No. of patients	Sero-positive
Homosexual	28	20
Heterosexual	10	4
Bisexual	4	1
Haemophiliac	7	7
Intravenous drug abuser	0	0
Total	49	32

TABLE II. CLINICAL STATUS OF HIV-POSITIVE PATIENTS

Status	No. of patients
Asymptomatic	13
PGL/ARC	7
Confirmed AIDS*	12
Total	32

*Defined by criteria of the US Centers for Disease Control, Atlanta, Georgia.¹¹

PGL = persistent generalised lymphadenopathy; ARC = AIDS-related complex.

TABLE III. ETHNIC GROUP

Race	No. of patients
White	47
Black	1
Asian	1
Total	49

Fig. 4. Tables taken from article 'AIDS Clinic - A Year On', 1989.⁸³

⁸³ Martin, D.J., Tilley, J.F.G. *et al* 'AIDS Clinic - A Year On', *SAMJ*, 75, 15 April 1989 p. 381.

Amptelike Aankondigings/Official Announcements

Update: AIDS in the RSA (November 1988)

TOTAL OF ALL CASES SEEN IN THE RSA			
Year	Cases	Deaths	Cumulative total
1982	3	3	3
1983	4	1	7
1984	8	3	15
1985	9	10	24
1986	33	17	57
1987	47	35	104
1988	71	37	175
	<u>175</u>	<u>106</u>	
Mortality: 60,9%			

BREAKDOWN BY COUNTRY OF ORIGIN					
Year	SA CASES		NON- SA CASES		Deaths
	Cases	Deaths	Cases	Deaths	
1982	2	2	1	1	
1983	4	1	—	—	
1984	8	3	—	—	
1985	8	10	1	—	
1986	23	14	10	3	
1987	38	26	9	9	
1988	68	34	3	3	
	<u>151</u>	<u>90</u>	<u>24</u>	<u>16</u>	
Mortality: 60,0%					

SA CASES			NON- SA CASES		
Origin	Total	Surviving	Origin	Total	Surviving
Tvl	92	41	Malawi	10	5
Cape	29	8	Zambia	8	3
Natal	28	12	Zaire	1	—
OFS	2	0	Haiti	1	—
	<u>151</u>	<u>61</u>	Canada	1	—
Johannesburg	83	40	Brazil	1	—
Cape Town	28	8	Holland	1	—
East London	1	0	Kenya	1	—
Pretoria	6	0		<u>24</u>	<u>8</u>
Durban	23	9			
Pietermaritzburg	4	3			
Ladysmith (N)	1	0			
Bloemfontein	1	0			
Welkom	1	0			
Krugerdsorp	1	0			
Middelburg	1	0			
Pietersburg	1	1			
	<u>151</u>	<u>61</u>			

BREAKDOWN BY TRANSMISSION CATEGORY			
Homosexual/bisexual	116	Homosexual/bisexual	2
Heterosexual	19	Heterosexual	21
Transfusion	5	Transfusion	0
Haemophilic	8	Haemophilic	0
IVDU	0	IVDU	1
Paediatric	3	Paediatric	0
	<u>151</u>		<u>24</u>

BREAKDOWN BY ETHNIC GROUP			
White	125	White	6
Black	21	Black	17
Asian	1	Asian	1
Coloured	4	Coloured	0
	<u>151</u>		<u>24</u>

BREAKDOWN BY SEX			
Male	140	Male	19
Female	11	Female	5
	<u>151</u>		<u>24</u>

The Advisory Group on AIDS

Fig. 5. An Update on AIDS in the RSA, 1989.⁸⁴

⁸⁴ 'Update: AIDS in the RSA (November 1988)', SAMJ, 75, 21 January 1989, p. 95.

The 'Outside Vector' and Threats from 'Across the Border'

If Haitians had been the 'black other' to 'gay white men' in the USA, in South Africa the other to 'gay white men' was 'the black heterosexual', primarily those coming from beyond the borders of the Limpopo and Orange Rivers. Between 1982 and 1994, 'that which was alien' in South Africa went from 'white homosexual men', to 'foreign blacks', to 'black heterosexuals'. Writing in 1992, Mary Crewe suggested that

In South Africa, apartheid established and legislated 'the black' as both 'other' and inferior. The distinction was readily available to be aligned with accounts of the source of AIDS. Black South Africans are regarded as closer to people from Central Africa – both because of their origins and their blackness – than they are to fellow white South Africans whose roots, however distant, lie in Europe.⁸⁵

In the early years of writing about AIDS research, the *SAMJ* drew on ideas of 'Africa as the sick continent', and entertained discussions around 'African AIDS' versus 'Western AIDS' not as markers of real scientific categories, but rather as markers of identity, class, and the constructions of race and geographic differentiation.⁸⁶ These markers focused attention on 'the outside vector' and not on the inter-relatedness, or shared responsibility, of belonging to a common species facing a new epidemic.

As the international AIDS narrative shifted its focus to 'Africa', so the *SAMJ*'s narrative followed suit. As previously mentioned, the *SAMJ* had observed in 1982 that the first two officially declared AIDS-related deaths in South Africa were the result of infection acquired in the USA. Despite this declaration of origin, AIDS was to have a second 'Great Trek' from 'central' Africa, over the border and into South Africa in line with international narratives.

Six months after the first official AIDS-related deaths in South Africa were announced and linked to the USA, the *SAMJ* reported on theories of origin centred on Zaire, and suggested

⁸⁵Crewe, *AIDS in South Africa*, p. 45.

⁸⁶The differences between 'African' and 'Western' AIDS were reinforced long before science had developed sufficiently to differentiate between HIV clades and speculate as to their geographic origin.

knowingly 'Perhaps this is once again something new out of Africa!'.⁸⁷ Within this new narrative, 'Central Africa', or just 'Africa', became akin in the South African AIDS narrative to 'Haiti' in the United States' narrative. As in the 'Haitian' narrative, the 'Central African' narrative combined markers of 'race' and geography to signify 'risk', such as when readers were warned that

People at risk include the heterosexual partners of some homosexual men, blood transfusion recipients, intravenous drug abusers, *black* men and women in contact with carriers *from Central Africa*, and the children of women who have had sexual contact with possibly homosexual carriers.⁸⁸

Countries of origin regularly featured in updates about people with AIDS, but these updates never included information that would allow the relevance of this data to be determined, such as how long a person had lived in a place. Race and country of origin became standard markers in a number of articles from the mid to late-1980s (figures 5 & 6).⁸⁹

While the *SAMJ* did report on infection rates, activities and responses to AIDS in other African countries, there are few comments about the unequal relations of power between South Africa and other countries in the region; no references to political tensions between South Africa and its neighbouring states; nor suggestions of collaborative interventions or knowledge sharing.⁹⁰ Only in an article written by two psychologists based at the University

⁸⁷ 'Meer Oor VIGS', *SAMJ*, 64, 23 July 1983, p. 115. Zaire is now the Democratic Republic of Congo or DRC. 'West Africa' also appears in the AIDS narrative, but mostly in relation to the discovery/origin of HIV or usually, HIV-2 and with curious referencing to its colonial past. See for example 'VIGS-virus sedert 1966 in Afrika' (AIDS virus in Africa since 1966), *SAMJ*, 76, 16 December 1989, p. xvi; HIV-2 at Ga-Rankuwa Hospital', *SAMJ*, 83, July 1993, p. 530; 'West African AIDS virus – HIV 2', *SAMJ*, 84, 8 August 1994, p. 9; and Rolfe, M. 'HIV-2 and its Neurological Manifestations', *SAMJ*, 84, 8 August 1994, p. 503 which includes the comment that: 'HIV-2 is endemic in West Africa, especially in the former Portuguese and French colonies'.

⁸⁸ Regarding 'Central Africa' and 'Africa' see for example 'Kaposi's Sarcoma in Central Africa', *SAMJ*, 68, 31 August 1985, p. 312; 'AIDS Advisory Group's first year', *SAMJ*, 69, 7 June 1986, p. 775. Quote from Isaacs, G., & Miller, D., 'AIDS – Its Implications for South African Homosexuals and the Mediating Role of the Medical Practitioner', *SAMJ*, 68, 31 August 1985, p. 329 [emphasis added].

⁸⁹ See for example Sher, R., 'AIDS in Johannesburg', *SAMJ*, 68, 3, August 1985, pp. 137 - 138; Spracklen, *et al*, 'The Acquired Immune Deficiency Syndrome and Related Complex', 3 August 1985, pp. 139 – 143; 'Update on AIDS: HIV Antibody Testing', *SAMJ*, 70, 13 September 1986, p. 378; Zieffer, A., & Abramowitz, J.A., 'Pneumocystis carinii pneumonia in HIV-Positive and HIV-Negative Patients', *SAMJ*, 76, 7 October 1989; Sher, R., 'HIV Infection in South Africa, 1982 – 1988 – A Review', *SAMJ*, 76, 7 October 1989; O'Farrell, N., & Windsor, I., 'Prevalence of HIV Antibody in Recurrent Attenders at a Sexually Transmitted Disease Clinic', *SAMJ*, 74, 6 August 1988, p. 104;

⁹⁰ Many reports about other countries are presented in the correspondence pages of the Journal or the 'news' section so they would not have been peer-reviewed. 'Slim Disease', *SAMJ*, 69, 26 April 1986, p. 534; 'Update on

of Zimbabwe, and published in 1993, was there a direct reference to South Africa's status in the region. Reflecting on AIDS prevention in South Africa the authors noted that 'South Africa has the advantage of facing AIDS later than east and central Africa and the disadvantage of being isolated, albeit diminishingly so, from the information and experiences of other African countries'.⁹¹ While hardly a critique of South Africa's role in the region, the article did at least refer to its isolation.

TABLE II. AIDS IN THE RSA

Patient No.	Sexual preference	Geography	Opportunistic disease	HTLV-III/LAV antibodies	Current status
1	Heterosexual	Zambian white	CMV infection of bowel	Not done	Dead
2	Homosexual	Pretoria	Pneumocystis	Not done	Dead
3	Homosexual	Pretoria	Pneumocystis	Not done	Dead
4	Homosexual	Johannesburg	Cerebral toxoplasmosis	Positive	Dead
5	Homosexual	Johannesburg	Pneumocystis	Positive	Dead
6	Homosexual	Johannesburg	Generalized histoplasmosis	Positive	Dead
7	Homosexual	Pretoria	Candidiasis, generalized herpes, CMV	Positive	Dead
8	Heterosexual	Zairean black	Pneumocystis	Positive	Zaire
9	Heterosexual	SA white	Cryptococcal meningitis	Positive	Dead
10	Homosexual	Johannesburg	Kaposi's sarcoma, candidiasis, primary lymphoma of CNS, herpes zoster	Positive	Dead
11	Homosexual	Johannesburg	Pneumocystis, Kaposi's sarcoma	Positive	Dead
12	Homosexual	Johannesburg	Kaposi's sarcoma	Positive	Alive
13	Homosexual	Johannesburg	Pneumocystis, cryptosporidiosis	Positive	Alive
14	Homosexual	Johannesburg	Pneumocystis	Positive	Alive
15	Homosexual	Johannesburg	Pneumocystis	Positive	Alive
16	Homosexual	Johannesburg	Pneumocystis, rectal abscess, neoplasia of spinal cord	Positive	Dead
17	Homosexual	Cape Town	Pneumocystis	Positive	Dead
18	Homosexual	Johannesburg	Candidiasis, intractable diarrhoea	Positive	Dead
19	Bisexual	Johannesburg	Cryptosporidiosis	Positive	Alive
20	Homosexual	Cape Town	Avian-intracellulare	Positive	Alive
21	Heterosexual	Pretoria (transfusion AIDS)	Pulmonary and hepatic aspergillosis, septicaemia	Positive	Dead

24 BYLAE TOT SAMT 11 OKTOBER 1986

Fig. 6. Table taken from 'AIDS in the RSA', 1986.⁹²

AIDS: Numbers of Cases in the RSA and Abroad', *SAMJ*, 74, 4 July 1987, p. 92; Lecatsas, G., *et al* 'HIV Seropositivity in east Caprivi, SWA/Namibia', *SAMJ*, 74, 3 December 1988, p. 590; Taylor, M.B., *et al* 'HIV Survey in Venda', *SAMJ*, 75, 1 April 1989, p. 348; Matondo, P., 'Perspectives on AIDS Control in Zambia', *SAMJ*, 83, September 1993, pp. 633 - 634; and in a dying reference to the apparently 'independent homelands' - Tshibangu, N., 'HIV Infection in Bophuthatswana: Epidemiological Surveillance 1987-1989', *SAMJ*, 83, January 1993, pp. 36 - 39. The exception regarding collaborative engagements was a reference by Sher (then Head of the SAIMR's AIDS Centre in Johannesburg) who, referring to AIDS education programmes, noted '(w)e also travel to neighbouring states to counsel and educate on AIDS' - whether these were the TBVC 'states' or other countries is unclear. See 'German Pharmaceutical Companies Donate R17 000 to AIDS Education', *SAMJ*, 77, 3 Feb 1990, p. vii.

⁹¹ Wilson, D., & Lavelle, S., 'AIDS Prevention in South Africa: A Perspective from other African Countries', *SAMJ*, 83, September 1993, pp. 668 - 674.

⁹² Sher, R., 'Acquired Immune Deficiency Syndrome (AIDS) in the RSA', *SAMJ*, Supplement, 11 October 1986, p. 24.

Prior to a general comment from the *SAMJ* editor in 1994 declaring an eagerness to interact with other parts of the continent, the overarching AIDS narrative in the *SAMJ* shows a more defensive engagement with the spaces beyond South Africa's perceived *cordon sanitaire* at its borders.⁹³ Despite the fact that two people had died of AIDS in South Africa by early 1983 and that cases of AIDS were being recorded amongst South Africans, indicating that AIDS was in the country, the notion of infection entering South Africa from beyond the borders of the country, beyond the *cordon sanitaire*, was the one most recounted in the journal. Maylam notes that:

as South Africa became an increasingly embattled, besieged pariah state during the 1970s and 1980s, trying to withstand international pressure and internal resistance, the ideology of race largely disappeared from official propaganda, giving way to the idea of the 'total onslaught' – the concerted, communist-inspired, international assault on South Africa's political and economic order.⁹⁴

Perhaps sub-conscious incorporations of the idea of external threats and 'total onslaught' go some way in explaining why AIDS was predominantly constructed in the *SAMJ* as an ever-encroaching external menace. While this hypothesis requires more research, the idea of AIDS as something 'from outside' was propounded in several articles that mentioned the country's geographic borders and the movement of certain people across them. Taken individually these articles could simply reflect genuine epidemiological interest in viral transmission routes, but seen collectively in the broader AIDS and apartheid contexts, they create a different picture.

In 1987 the government drew on the long established notion of the 'diseased native' and passed legislation to deport HIV positive mineworkers.⁹⁵ While this action did not draw much comment in the pages of the *SAMJ*, the journal published material that reinforced the

⁹³ The editor noted that the journal was '(e)ager to publish quality contributions from other parts of this continent' and 'was pleased to receive... [the]... paper by Rolfe ... of the Royal Victoria Hospital in Banjul, The Gambia'. See West African AIDS virus – HIV 2', *SAMJ*, 84, 8, August 1994, p. 9.

⁹⁴ Maylam, *South Africa's Racial Past*, p. 204.

⁹⁵ For more on this see Grundlingh, L., 'Government Response to HIV/AIDS in South Africa as Reported in the Media, 1983-1994', *South African Historical Journal*, 45, November 2001, and Horwitz, S., 'Migrancy and HIV/AIDS: An Historical Perspective', *South African Historical Journal*, 45, November 2001.

association of migrant labourers with infection.⁹⁶ One article speculated that although there was a lack of evidence for the heterosexual spread of AIDS in South Africa at that time (1986) this would soon change as ‘... some of the several hundred thousand migrant workers in the RSA may bring infection from neighbouring countries where heterosexual spread is already established’.⁹⁷ In a similar vein, another article warned:

Even more menacing is the spectre of AIDS in *our black population* ... To date various serological studies have consistently failed to reveal evidence of significant infection in South African black populations. Perhaps this is the result of the relatively restricted movement of populations and limited contact with citizens of countries to the north; alternatively, it may be the epidemiological consequence of the slow nature of the virus. In either case, it is inevitable that the African epidemic will move down and establish itself in South Africa.⁹⁸

Comparable views were expressed in articles written in the 1990s which dealt with topics as diverse as paediatric AIDS to developing micro-simulation models to estimate HIV infection in the ‘South African heterosexual population’.⁹⁹ A decade after the first identified AIDS-deaths in South Africa, narratives of ‘African AIDS spread by black heterosexuals’ moving towards or breaching South Africa’s borders, were firmly entrenched and reinforced as part of the hegemonic AIDS narrative. In an article from 1993 which suggested that ‘traditional healers’ could play a role in AIDS prevention, the author recounted a discussion with an *isangoma* regarding the cause of AIDS in South Africa. He reported that the *isangoma* ‘expounded her theory that soldiers were the main conduit for the spread of AIDS ... She said that AIDS had become a serious problem in South Africa because soldiers from neighbouring countries have been coming here’.¹⁰⁰

⁹⁶ For example, in the ‘news’ section in 1990, the writer referred to a copy of a case report from Proceedings of the Mine Medical Officers’ Association from April 1960 and pondered if showed the first AIDS case in South Africa. See ‘First AIDS Case in SA?’, *SAMJ*, 78, 18 August 1990, p. ix.

⁹⁷ Becker, W.B., ‘HTLV-III Infection in the RSA’, Supplement, *SAMJ*, 11 October 1986, p. 27.

⁹⁸ Schoub, B.D., ‘AIDS in South Africa – A Time for Action’, *SAMJ*, 71, 6 June 1987, p. 677 [emphasis added].

⁹⁹ See Friedman, S.Y., & Robertson, B.A., ‘Human Immunodeficiency Virus Infection in Children – Prevalence and Psychosocial Impact’, *SAMJ*, 78, 3 November 1990, p. 530; and Groeneveld, H., & Padayachee, N., ‘A Stochastic Model for Medium-Term Estimation of the Prevalence of HIV Infection in a South African Heterosexual Population’, *SAMJ*, 81, 18 January 1992, pp. 67 – 70. Note: in another article on children and HIV the authors comment that ‘at least one of the parents of 5 children originate from beyond South Africa (viz. Zimbabwe, Malawi and Mozambique)’, see Friedland, I., & Snipelisky, M., ‘Vertically Transmitted HIV-1 Infection in Children – A Report of 23 Cases’, *SAMJ*, 79, 2 February 1991, p. 158.

¹⁰⁰ Abdool Karim, S.S., ‘Traditional Healers and AIDS Prevention’, *SAMJ*, 83, June 1993, p. 423.

The idea of the ever-encroaching external threat of AIDS is perhaps best represented by a 1988 model depicting how 'heterosexual HIV infection' might spread AIDS into South Africa (figure 7).

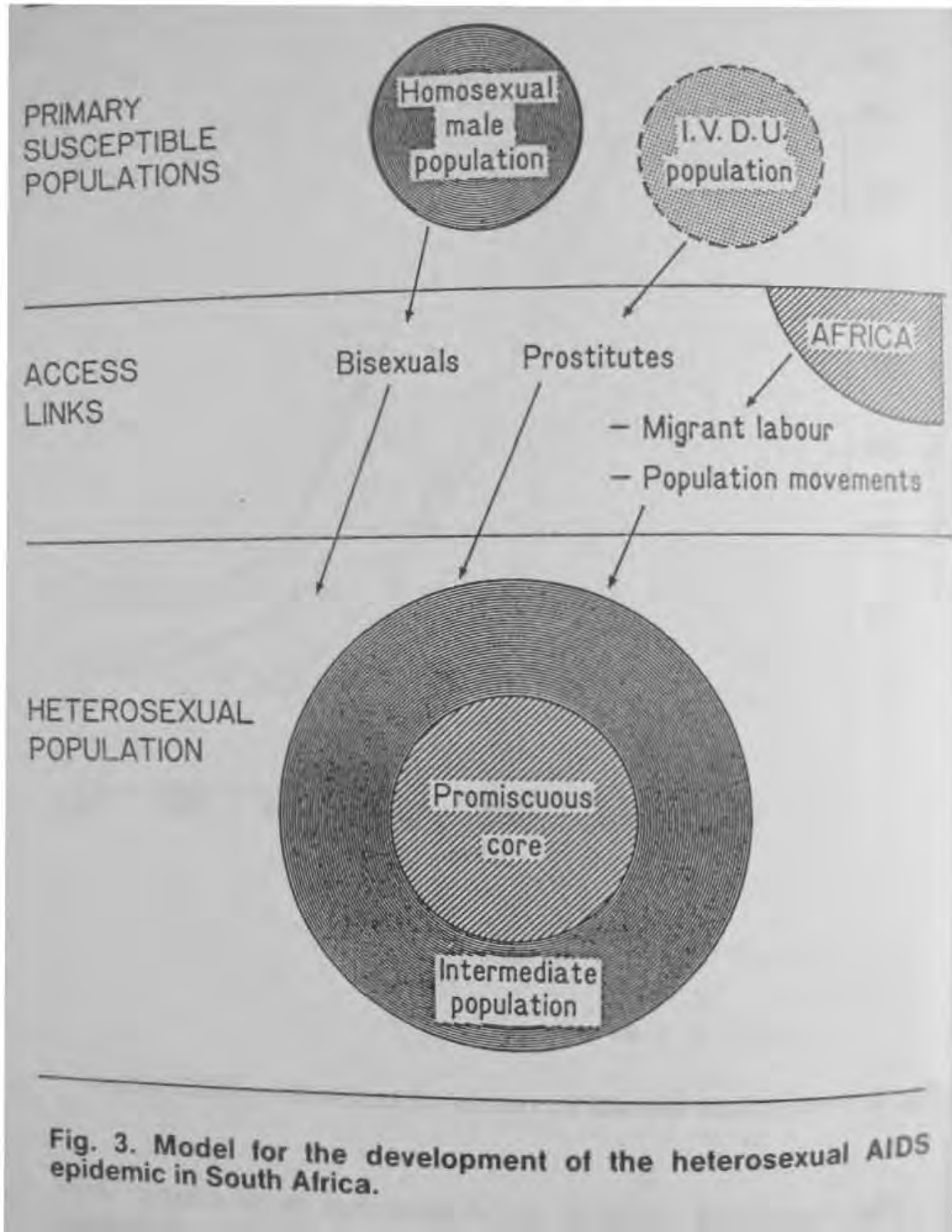


Fig. 7. Schoub *et al*'s 1988 model showing how AIDS might infect 'the heterosexual population' in SA.

Schoub *et al* suggested that the AIDS epidemic in South Africa comprised four separate epidemics: the male homosexual epidemic; the haemophilia/blood transfusion epidemic; the intravenous drug abuser epidemic; and the heterosexual epidemic.¹⁰¹ The notion of a 'promiscuous core' is examined more fully below, but the model directly invokes 'high-risk groups' in order to construct 'primary susceptible populations' and 'access links'. Noticeable in the model is the peripheral location of the rest of 'Africa' from the 'heterosexual population' of South Africa. The diagram visually represents the crossing of borders by bisexuals, prostitutes, and migrant labourers, with each group representing a threat to the heterosexual population in South Africa.

The authors explain that the model shows how '...the incursion into the heterosexual population occurs via three major links: (i) via bisexuals..., (ii) via female intravenous drug-abusing prostitutes..., and (iii) by *downward migration* of the heterosexual epidemic from Central Africa, which is clearly the major route into the South African heterosexual population.'¹⁰² The use of a word like 'incursion' adds to a sense of threat from attack; and the use of groups in which AIDS had not yet been found in South Africa (intravenous drug users) is revealing. The article took infection patterns from the UK and the USA and plotted them on a graph with 'RSA (whites)', thereby transferring an external AIDS narrative into a South African context and, in so doing, delineated AIDS based on race.

The movement of people has often played a role in the transmission of illnesses, and HIV transmission rates seem to be no different. To examine the movements of populations is therefore a standard epidemiological practice, as is trying to make sense of infection routes to determine areas of intervention. Standard epidemiological practices however, reflect, consciously or subconsciously, the socio-political realities and concerns of the researchers engaged in the practices. Thus the historical context of a country's epidemic history, the patterns of apportioning blame for infection on outsiders, and the contemporary milieu of a country, need to be acknowledged as having a sustained influence on such accepted 'standard practices'.

¹⁰¹Schoub, B.D., Smith, A.N., Lyons, S.F., Johnson, S., *et al*, 'Epidemiological Considerations of the Present Status and Future growth of the Acquired Immunodeficiency Syndrome Epidemic in South Africa', *SAMJ*, 74, 20 August 1988, p. 156.

¹⁰² *Ibid.* (emphasis in the original).

Throughout South Africa's epidemic history, the blame for various illnesses has consistently and deliberately been apportioned to various 'outsiders'.¹⁰³ This historical context, combined with the heightened fear of invasion evident in South Africa during the 1980s and 1990s, goes some way towards explaining how the handy construction of 'the outside vector' in the international AIDS narrative could easily be adapted for the South African context. It also suggests that the narrative of the 'southward migration' of AIDS may have been more than mere epidemiological modelling and acted too as a signifier of the particular socio-political and historical context of the time.¹⁰⁴

Even when AIDS was definitely present in South Africa, the use of unnecessary markers (racial and geographic), and the creation of arbitrary and imagined *cordon sanitaires* allowed 'the general (non-gay, white) population' to feel safe from infection. Similarly, the confirmation of AIDS amongst 'heterosexuals' was specifically confined to '*black* heterosexuals' not 'the general population' of 'heterosexuals', again reinforcing a sense of safety for heterosexuals who were not black. While the science of the disease did not depend on skin colour, the politics of the disease certainly did.

'African AIDS' and 'Western AIDS'

Race and geographical constructs were also linked in the use of the terms 'Western AIDS' and 'African AIDS' to describe patterns of infection and transmission - more neutrally

¹⁰³ For more on this see Phillips, 'AIDS in the Context of South Africa's Epidemic History'.

¹⁰⁴ In the South African AIDS narrative the gaze across the border could also be seen to draw attention away from key problems within South Africa's borders. AIDS was present in South Africa in the early 1980s, and early case studies made it clear that people of all 'sexual orientations' were susceptible. However a focus on 'high-risk groups' and people from beyond the country's borders meant that comprehensive strategies that recognised the potential for spread into 'the general population' need not be conceived. In addition, despite the information on infection rates from 'Africa' being scanty, within the country itself figures relating to black populations, health care and mortality were notoriously bad (see for example Bradshaw, E., & Harington, J.S., 'The Changing Pattern of Cancer Mortality in South Africa, 1949 - 1979', *SAMJ*, 68, 28 September 1985, p. 455 in which the authors comment 'In South Africa as elsewhere it should be recognized that death certification is inevitably of irregular quality and often unreliable, and that data for blacks must necessarily be regarded as underestimates' and Bradshaw, D., Dorrington, R.E. & Sitas, F., 'The Level of Mortality in South Africa in 1985 - What Does It Tell Us About Health?', *SAMJ*, 82, October 1992, pp. 237 - 240, in which the authors note: 'The poor quality of routinely collected vital statistics in South Africa has made it impossible to analyse adequately the health needs of the population or to utilise mortality data for health planning. Mortality data have been shown to be deficient in terms of under-reporting of deaths as well as misclassification of causes'). Therefore, even if infection rates had been rising there is no reason to suggest they would have been noticed, or counted because the notion of who 'our black population' was, and whether or not their health was important, was not clearly defined.

(although arguably just as inappropriately) referred to as 'Pattern I' and 'Pattern II' HIV infection.¹⁰⁵ Pattern I was held to be mainly found in 'the West', primarily amongst homosexual and bisexual men and intravenous drug users; it showed a male to female infection ratio of 10:1, and rarely involved paediatric cases. By contrast, Pattern II occurred in 'Africa', was primarily found amongst heterosexual men and women, with an infection ratio of 1:1, and was associated with national prevalence rates exceeding 1%.¹⁰⁶

These names became signifiers and markers for the understanding and construction of AIDS narratives. Their reproduction in the *SAMJ* on one level merely reproduced this signification, but on another, it could also help reinforce the subconscious heteronormative and racial distinctions that were applied to people with AIDS in South Africa. Articles in the *SAMJ* either directly made mention of 'Western' and 'African' AIDS, or referred to differences between 'the West' and Africa by referring, for example, to 'the USA and Europe' in contrast to 'central Africa'.¹⁰⁷ In the Official Announcements section of the *SAMJ* in 1987 an 'Update on AIDS: Heterosexual Spread in AIDS' informed readers that:

There is reason to believe that the incidence of AIDS among white South Africans will follow the pattern of the Western world, except that fewer cases will occur from intravenous drug abuse. However, if the pattern among black South Africans follows that of central Africa, it can be expected that most cases will spread heterosexually.¹⁰⁸

Obviously it is not 'race' *per se*, that determines how an infection will spread, neither is it appropriate to homogenise people by a racial marker (although in this example the apartheid racial categorisations, have been reduced to 'white' and 'black', excluding other 'race groups' completely). In this example, whiteness is associated with diseased

¹⁰⁵ There was also 'Pattern III' infection, which was a combination of Pattern I and II and was linked with 'Asia' and 'Latin America'.

¹⁰⁶ See Crewe, *AIDS in South Africa*, p. 21.

¹⁰⁷ See for example Lyons, S.F., *et al* 'Sero-epidemiology of HTLV-III; Sher, R., 'AIDS and Related Conditions – Infection Control', *SAMJ*, 68, 7 December 1985; 'African AIDS: A Bibliography', *SAMJ*, 69, 18 January 1986, p. 149 which refers obliquely to 'the African type of AIDS'; 'Conference on epidemiology in southern Africa', *SAMJ*, 72, 15 August 1987, p. 300 – particularly the section under 'Infectious diseases'; 'Third International AIDS Conference', and *SAMJ*, 72, 19 September 1987.

¹⁰⁸ 'Update on AIDS: Heterosexual Spread of AIDS', *SAMJ*, 72, 5 September 1987, p. 366.

homosexuality in 'the Western world' and blackness is associated with diseased heterosexuality in 'Africa'.

The application of the notion of 'Western AIDS' to the South African context is best revealed in a critical response by N. O'Farrell to a report published by the DoH in 1987. O'Farrell declared that the report required comment because its epidemiological conclusions and predictions assumed that AIDS in South Africa would be 'treated on a par with Western AIDS'; that 'the virus [had] predominantly affected members of the white homosexual community'; and that the countries whose infection patterns were most likely to resemble South Africa's were Israel and Norway.¹⁰⁹ These assumptions, O'Farrell argued, were fundamentally flawed, not only because they 'disregarded the black population', but also because they provided a skewed perspective from which to begin planning. He noted that

Allocators of health care resources are therefore likely to conclude that AIDS is not a widespread problem. A recent report by 'War on Want' does not agree with this picture and the situation in countries in close proximity to South Africa provides further evidence.

... The document concludes that the white homosexual-bisexual male holds the key. I must disagree. AIDS is no respecter of sexual proclivity and in parallel with the large number of infected prostitutes in other parts of Africa, with concomitant spread to the heterosexual community, reports of prostitutes in this country with positive tests are occurring and are bound to increase.¹¹⁰

Most of the 'homosexual men' referred to in the *SAMJ* were white homosexuals, who, although acting as a counterpoint to a constructed 'white heterosexual norm', were still identified as being associated with 'the West'. The 'heterosexual' person from Africa who had AIDS was 'black and poor' and was constructed outside of a middle class, white heterosexual norm. In either pattern, people who were not 'black' or 'gay' were always defined as being safer and less at risk of infection. The perpetual grading and categorizing of people with AIDS ensured the reinforcement of hierarchies of safety, race, class, sexuality, and gender.

¹⁰⁹ O'Farrell, N., 'South African AIDS' *SAMJ*, 72, 19 September 1987, p. 436.

¹¹⁰ *Ibid.*

Even in an article from 1990 that was cautious about using terms like ‘Western’ and ‘African’ patterns, there was still a reliance on racial classifications and a subsequent lack of clarity about who constituted ‘the general population’. The authors noted:

... there is now growing evidence that the HIV virus [sic] is spreading rapidly through *the black* and possibly *the coloured* population in South Africa through heterosexual transmission. The ‘African’ epidemic in South Africa may spread much faster than the epidemic in Western countries, and containment in high-risk groups may not be possible. In fact, with heterosexual transmission, a large part of *the general population* may be at high risk.¹¹¹

While race remained a fixed category in much medical research throughout the period, there were challenges or conscious engagements with the problems of using racial markers. In 1988 Professor Knobel from the Department of Forensic Medicine, at the University of Cape Town, noted that ‘The prevention of HIV transmission to any member of the public, irrespective of race, creed or sexual orientation, remains a priority in the global effort to contain the spread of AIDS’.¹¹² A report on World AIDS Day in 1991 referred to one of the World Health Organisation’s (WHO) ten points for contemplation: ‘AIDS threatens us all. AIDS recognises no boundaries of race, sex, class or age. No one is immune. No one will remain untouched by the disease’.¹¹³

In 1992, Govender *et al*’s article did not mention race at all, referring instead to ‘... a random sample of 50 women attending a family planning clinic in Johannesburg ...’, as well as to ‘respondents’, and ‘individuals’.¹¹⁴ Professor Sher, despite having used racial markers in his own work, affirmed that ‘AIDS does not belong to any population group. It is a disease that anyone can pick up. It is not who you are, but what you do that is relevant with regards to AIDS’.¹¹⁵ Finally, providing perhaps an example of the effects of multi-disciplinary, multi-

¹¹¹ Schall, R., Padayachee, G.N., & Yach, D., ‘The Case for HIV Surveillance in South Africa’, *SAMJ*, 77, 7 April 1990, p. 324 [emphasis added].

¹¹² ‘Contraction of HIV Infection During Mutual Masturbation’, *SAMJ*, 74, 20 August 1988, p. 188.

¹¹³ ‘World AIDS Day 1991 – Sharing the Challenge’, *SAMJ*, 80, 16 November 1991, p. xxviii.

¹¹⁴ Govender, V., Bhana, R., Pillay, R., *et al*, ‘Perceptions and Knowledge About AIDS among Family Planning Clinic Attenders in Johannesburg’, *SAMJ*, 81, 18 January 1992, p. 71.

¹¹⁵ ‘Wellcome Seminar – AIDS in Perspective’, *SAMJ*, 82, September 1992, p. xii.

sectoral research and a more 'progressive politics' in post-1994 South Africa, Blecher *et al* noted in a footnote that

At the time this study was conducted (1989) South Africans had been rigidly divided by racist legislation for many decades, making it sometimes difficult to describe our health experience without using such terms. Their use should not be interpreted as support for apartheid practice, and differences demonstrated between the area strata should be interpreted with caution.¹¹⁶

The *SAMJ* articles about AIDS published throughout the 1980s, and into the early 1990s, confirmed and reinforced existing racial ideologies and consciousness. 'Race' was already a frequently used 'scientific' marker in the South African medical narrative and was uncritically used and applied to AIDS narratives. Unscientific markers like 'race', however, were not the only ones to feature in the *SAMJ*'s AIDS narratives.

'Homos and Hookers' – Sexuality and Gender in the AIDS Narrative

Sexually transmitted infections (STIs) have always held a particularly interesting space in history. Responses to them have generated and driven public health campaigns, influenced legislation, and opened (or closed) discussions about morals and morality. Responses to STIs have been used to justify or facilitate the maintenance of power structures and the movement of people, and have depended on the creation of a 'sexual other'. In addition, STIs have been the primary focus for public discussions about sex (or ideas of sexual practice) in which sex and sexuality have been cast in the negative light of health crises.¹¹⁷ When sex was confirmed as one of the primary means of transmitting AIDS, a long history of problematic understandings and constructions of sex, sexuality, sexual orientation and gender were drawn on and incorporated into 'the AIDS narrative'. AIDS, as one doctor

¹¹⁶ Blecher, M.S., Steinberg, M., Pick, W., Hennink, M., and Durcan, N., 'AIDS – Knowledge, Attitudes and Practices among STD Clinic Attenders in the Cape Peninsula', *SAMJ*, 85, 12, December 1995, p. 1281. The authors were drawn from the Department of Community Health, UCT; the National AIDS Research Programme, MRC; Department of Community Health, WITS; Western Cape Regional Services Council; and the Cape Town City Council.

¹¹⁷ See for example Brandt, A.M., *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880* (New York, Oxford University Press, 1987); Jochelson, *The Colour of Disease*; Mohamed, J. 'Epidemics and Public Health in Early Colonial Somaliland', *Social Science & Medicine*, 48, February 1999; Quetel, C., *History of Syphilis* (Baltimore, Johns Hopkins University Press, 1990); Vaughan, *Curing Their Ills*.

noted, 'juxtapos[ed] ... one of life's greatest pleasures, sex, with man's [sic] greatest fear, death'.¹¹⁸

Valerie Sacks commented that

AIDS discourses, because they are ostensibly about disease, but equally about sexuality and power, reflect this diffusion of power relations in their reproduction of already existing mechanisms and patterns of social control. Surely all these discourses on AIDS can be seen in this light: so prolific, so fixated on 'perversions' and irregularities in sexual behavior, and so repetitive in their depictions of the practitioners of these allegedly divergent forms of sexuality as members of groups clearly distinct from the 'general population', worthy of stigma, and needing to be reached, controlled and subdued through the tentacles of discourses and institutions. Discourses help these behavioral norms to become internalized, and in so doing to reinforce existing social, political and economic hierarchies. They are patterned in systematic ways, ways which perpetuate perceptions of certain 'kinds' of behavior, and ... certain kinds of people as deviant, less valuable, more prone to and deserving of disease, and inexplicably intriguing in their apparent perversity.¹¹⁹

Narratives about AIDS, sex, and sexualities can be read as reflecting political and social power relations in South Africa, and reveal concerns about what were perceived as potential threats to the 'the general population'. Despite sex and sexuality being central to many of the scientific categories used in the 'high-risk' narrative, little attention was paid to providing a working definition of what constituted sex or even how sexuality was being understood and applied in the *SAMJ*. While some sexualities, like homosexuality, were highlighted along with some sexual practices (prostitution and promiscuity), the sexual practices of 'the general public' remained discreetly hidden. References to male homosexual sex, or heterosexual prostitution, did not show any reflexive engagement with, or interrogation of, male sexuality and male biology to determine if common modes of transmission were evident. Instead, unscientific descriptors, or imagined sex practices, fed into and informed research and data interpretation. This resulted in the use and creation of categories of

¹¹⁸ Schoub, 'AIDS in South Africa...', p. 678.

¹¹⁹ Sacks, 'Women and AIDS', p. 60.

diseased subjects such as ‘the black heterosexual’, ‘the infected foreigner’, ‘the homosexual’, ‘the prostitute’, and ‘the mother with the infected womb’.

As has been discussed, the medical narrative of AIDS in South Africa, as in the US and UK, was linked to sexuality – specifically homosexuality.¹²⁰ Despite the fact that heterosexual men and womyn were also amongst the first people to have AIDS, it was male homosexuality, rather than potential commonalities in modes of sexual transmission, that was associated with AIDS. In the first decade of the disease, the process of unscientifically equating AIDS with male homosexuality was often repeated, but the disease was also associated with other pathologised sexualities. At the beginning of the epidemic, it was not male sexual activity that was investigated to determine the relationship between men, sex, and AIDS, it was ‘homosexuality’ and so-called homosexual activities. The sexuality represented in the ‘objective’ scientific/medical journal that the *SAMJ* claimed to be, referred particularly to a constructed white, male homosexuality that was continually contrasted to a constructed white, male heterosexuality (the absent referent) imbued and influenced by the conservative racial, moral, and gendered discourses of apartheid South Africa.

SAMJ articles show a range of responses to ‘homosexuality’ that extend from outright homophobia to heteronormativity, with the odd dissenting voice attempting to reformulate the hegemonic narratives about (homo)sexuality and, by extension, AIDS. Both in the sub-text of the research articles about AIDS, and the direct dialogue of professional correspondence, the *SAMJ* provides examples of non-scientific assumptions and associations about sexuality.

SAMJ articles suggested that *any* male homosexual was potentially infected, and frequently linked homosexuals to other ‘abnormal’ people such as drug abusers and sex workers. Thus articles contain comments such as ‘it now appears as if the AIDS agent, besides the fact that it can be transmitted through homosexual contact ... can also be transmitted through *normal*

¹²⁰ The construction of ‘the homosexual’ as a ‘scientific’ research category in the *SAMJ* during the first decade of the AIDS epidemic has been detailed in Tsampiras, ‘Not So “Gay” After All’. The key findings from that article are reproduced in this section of the chapter.

heterosexual intercourse'.¹²¹ Homosexuality was also linked to 'deviance' in other ways, with references to male homosexuals as 'adults with aberrant lifestyles', and the association of homosexuality with drug use.¹²² The obvious questions that arise from these sorts of comments are: what types of homosexual and heterosexual contact were 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.¹²³ Apart from the heteronormative nature of the comment about '*normal* heterosexual intercourse' in the article above, 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.¹²⁴ In this way, representative stereotypes were applied to sexual activity that were not based on specificities, and did not allow for complexity. The statement presumes that all (male) heterosexuals and all (male) homosexuals will act in entirely predictable ways; it takes male heterosexuality as the norm against which all other sexuality is measured; and it excludes bisexuals (in another article the term 'so-called bisexual white males' is used).¹²⁵ It also precludes sexual activity between men who may not have self-defined as homosexual or bisexual.

In the *SAMJ*, homosexuality was also equated with 'promiscuity', although what constituted promiscuity remained unclear. In one article there are multiple references linking promiscuity to homosexuality without either a definition of promiscuity, or any acknowledgement that heterosexuals could be promiscuous. It notes that the unknown primary cause of AIDS 'may be a novel sexually transmitted immunosuppressive agent

¹²¹ 'Meer Oor VIGS', *SAMJ*, 64, 4, 23 July 1983, pp. 114 - 115 [my translation and emphasis].

¹²² See 'AIDS in Children', *SAMJ*, 65, 15, 14 April 1984; & Anderson, R., 'Immunological abnormalities', pp. 119 - 122 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'.

¹²³ The choice of terminology relating to penetration and insertion, rather than encapsulation and inclusion, is deliberate as it more accurately reflects the language and sub-texts present in the journal.

¹²⁴ This notion is reinforced in 'Acquired immunodeficiency syndrome', p. 98 where the author refers to hypotheses about the aetiology of the disease including that it could be 'a factor found in semen which suppresses cell-mediated immunity and which is absorbed *per rectum* but not *per vaginam*'.

¹²⁵ 'AIDS and the RSA', *SAMJ*, 71, 12, 20 June 1987, p. xxi.

(possibly a virus) or alternatively a promiscuity-related phenomenon due to repeat infection with sexually transmitted agents'. It speculated that 'the extent of the immunosuppression was related to the degree of promiscuity' as was 'the severity of the immunological abnormalities'.¹²⁶ The article concluded by declaring that '[h]omosexual 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'.¹²⁷ The unspoken assumption inherent in these associations is that homosexual men are promiscuous, while heterosexual men are not.

A letter from medical professionals based in the USA published in the journal in 1985 reinforced the link between homosexuals and promiscuity. The letter referred to '... recent studies in promiscuous male homosexuals with AIDS', and referenced an article where promiscuity features in the title.¹²⁸ 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.¹²⁹

While some articles do not refer to homosexuals as 'promiscuous', those that do create a shorthand or signifier that equates homosexuality with frequent, multiple partners and never with monogamous relationships. The ongoing association of homosexual men with a fatal, sexually transmitted disease, combined with the use of an 'unscientific' marker like 'homosexuality' as an acceptable research category, had the effect of creating an homogenous group, 'the gays', who behaved in a particular way. In much the same way as

¹²⁶ 'AIDS and the RSA', p. xxi.

¹²⁷ *Ibid.*

¹²⁸ Ablin, R.J., & Gonder, M.J., 'Immunological abnormalities in South African homosexuals - a non-infectious co-factor?', *SAMJ*, 67, 2, 12 January 1985, p. 40. Reference in article given as Purtilo DT, *et al* Human T cell leukaemia virus (HTLV) is not associated with acquired immune deficiency syndrome (AIDS) or chronic lymphadenomegaly (LAD) in promiscuous male homosexuals (Abstract). *Fed Proc* 1984; 43: 1975.

¹²⁹ A number of other articles uncritically link homosexuality with promiscuity. For example, one refers to 'a homosexual of promiscuous habits', while another directly links homosexual 'activity' to the 'activities' of female heterosexual prostitutes (see 'Pitfalls in AIDS diagnosis', *SAMJ*, 68, 5, 31 August 1985, p. 287; and 'Prostitution and AIDS', *SAMJ*, 69, 1, 04 January 1986, p. 5). 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' (see Marks, I.N., 'Perspectives in gastro-enterology', *SAMJ*, 72, 1, 4 July 1987, p. 8 [emphasis added]). Marks later challenged his colleagues and asserted his bias openly: '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'.

'the blacks' or 'the Jews' or 'the women' are historically constructed stereotypes that are used and understood in conscious and unconscious ways, so too 'the homosexual' as stereotype became a research category.¹³⁰

This is not to say that there were not isolated challenges to the stereotype and research category. In 1985 G. Isaacs, a lecturer in Clinical Social Work at the University of Cape Town (UCT), and D. Miller, a representative of the Gay Information Working Group at UCT, published an article in the *SAMJ* that asserted that the classifications of homosexual men published for GPs in the *SAMJ* were not comprehensive enough.¹³¹ They attempted to remedy this situation by providing more nuanced descriptions. Miller and Isaacs directly challenged the notion of 'the promiscuous homosexual', arguing that promiscuity lacked 'any useful clinical definition', had 'limited use in the classification of populations of individuals at risk', and was 'misleading'.¹³² They warned against attempts to define homosexual behaviour noting that it encompassed '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'.¹³³ The article also provided candid information that, if it had been universally applied could have altered the way in which treatment and research into AIDS was undertaken.

In the AIDS narrative presented in the *SAMJ*, nobody looked specifically at 'normal' white heterosexuals (male or female), let alone indians or coloureds, or black homosexual men, who were barely considered.¹³⁴ From the first reported cases, it was evident that the new syndrome was found amongst all people, but conservative morals, homophobia, racism, and sexism did much to shape the research agenda.

¹³⁰ For further discussion on the constructions of stereotypes see Gilman, *Difference and Pathology*.

¹³¹ Isaacs, G., & Miller, D., 'AIDS - Its Implications for South African Homosexuals and the Mediating Role of the Medical Practitioner', *SAMJ*, 68, 5, 31 August 1985, pp. 327-330.

¹³² *Ibid.*

¹³³ *Ibid.*

¹³⁴ One article states 'Since homosexual activity is rare in Africans, the virus is probably transmitted by heterosexual contact or exposure to blood' – see 'Kaposi's sarcoma in Central Africa', p. 312. See the chapter on sexuality activists for more information on homosexuality in South Africa.

Between 1991 and 1995 the centrality of 'gay men' in the AIDS narrative shifted, both locally and internationally, as a result of political pressure by sexuality activists in the UK and the USA, and because it had become evident that AIDS was occurring among 'the general population' of heterosexuals and their children. In South Africa interest in 'white, male homosexuals' shifted to 'black heterosexuals' as the 'imminent threat' of the 'heterosexual epidemic' became a reality. Epidemiologists, social scientists and medical scientists began turning their attention to what it that might mean for 'the new South Africa' that was on the horizon.

Reflecting the social changes occurring in South Africa in 1992 the *SAMJ* carried a book review of Gordon Isaacs' and Brian McKendrick's *Male Homosexuality in South Africa*. The reviewer stated that one in ten men was homosexual, declared South Africa a homophobic society, and noted that homophobia and racial divisions in South Africa had prevented the formation of a unified gay liberation movement. The reviewer recommended that interested members of 'the helping profession' read the book.¹³⁵

In late 1994 Pierre Brouard used a more comprehensive book review of Susan Kippax *et al's*, *Sustaining Safe Sex*, to comment on the burgeoning literature on 'social aspects of AIDS', and drew on Kippax's findings to suggest how research should be formulated in South Africa:

... health behaviour and sexuality are socially constructed and AIDS research should examine collective, social strategies of change.

... More research must establish the dynamics of the sexual lives of South African gay men, especially black gay men, and whether there are common understandings of what it means to be gay in the contexts of their interpersonal and social relationships. But we must also use social construction theories to examine the sexual lives of the heterosexual community and the implications of any findings for education and prevention strategies.¹³⁶

¹³⁵ De V. Van Niekerk, J.P., 'Male Homosexuality' *SAMJ*, 82, November 1992, p. 380.

¹³⁶ Brouard, P., 'Sustaining Safe Sex', *SAMJ*, 84, 8, August 1994, p. 518.

Brouard highlights the lack of research into sexuality and sexual practices, the absence of any common understanding about sexual orientation and sexuality, and the lack of willingness to engage with the complexities of sexuality that are evident in AIDS narratives.

While homosexual men received a significant amount of attention in the *SAMJ*, lesbians barely featured at all, and 'homosexuality' and 'bisexuality' were linked exclusively to men. Only a few direct references to lesbians appeared in the journal, one in 1982 and two in 1987. Two of the references merely noted that lesbians 'did not appear to be affected by AIDS', while another noted that those who were 'at next-to-no risk of contracting AIDS include all sexually non-active persons, all monogamous heterosexual persons and homosexual females'.¹³⁷

In 1992 Vicci Tallis explored the 'invisibility' of lesbians in South Africa and noted that literature about AIDS aimed at lesbians was rare, and even when it did exist, was incongruous and unclear and failed to address basic issues around transmission and safer sex practices. Tallis noted that while certain countries, like the USA, were 'beginning to take the issue of lesbians and AIDS more seriously, in South Africa the problem of lesbians and AIDS is completely ignored by AIDS workers in all fields, be it the government's response or that of non-governmental organisations (NGOs)'.¹³⁸ She concluded that this 'invisibility of lesbians' and 'the belief that "lesbians do not exist in our community" need[ed] to be challenged, and the issues facing lesbians regardless of race and class need to be addressed'.¹³⁹

The invisibility of lesbians and lack of research into how AIDS might affect them was not unique to the *SAMJ*, or to South Africa, and can be explained in a number of ways.¹⁴⁰ Firstly, more importance was placed on male sexuality than female sexuality, especially when that sexuality ostensibly excluded men. Secondly, 'lesbian sex' was possibly not regarded as 'real sex' and therefore did not feature as a serious subject for study. Thirdly, lesbian sexuality

¹³⁷ See 'Immunitetstekort en Homoseksualiteit' ... p. 298; & 'AIDS in the RSA', *SAMJ*, 71, 20 June 1987, p. xxi.

¹³⁸ Tallis, V., 'Lesbians and AIDS', *Agenda*, Women and Health, 15, 1992, pp. 69 - 72.

¹³⁹ *Ibid.*

¹⁴⁰ For more on lesbians and AIDS see: Dolan, K.A. & Davis, P.W., 'Nuances and Shifts in Lesbian Women's Constructions of STI and HIV Vulnerability', *Social Science & Medicine*, 57, 2003; Treichler, P.A., *How to Have Theory in an Epidemic: Cultural Chronicles of AIDS* (Durham, Duke University Press, 1999); and Wilton, T., *EnGendering AIDS: Deconstructing Sex, Text and Epidemic* (London, Sage, 1997).

was constructed as a form of female sexuality unrelated to any concerns about reproduction, and therefore not significant enough to study. Fourthly, lesbians were regarded as so peripheral to the 'general public' that they did not warrant attention, or, lastly, there was a genuine belief that transmission of HIV was impossible among lesbians and therefore there would be no point in studying them.

'The Prostitute'

Whether in academic disciplines or socio-political contexts, there has been a long held fascination with 'the prostitute', particularly the female prostitute, and her contribution to the spread of disease. This fascination has not been as marked in relation to studying the clients of 'the prostitute'. There is now a substantial body of work covering the history, politics and legislation relating to sex workers and sex work. There are also ongoing efforts to examine contemporary sex work, listen to the voices of sex workers, and understand and challenge the socio-political and economic inequalities that shape a person's engagement in sex work.¹⁴¹

While prostitutes featured as members of the 'high-risk groups' in international AIDS narratives, their position in that narrative shifted in minority world countries as the AIDS epidemic waned.¹⁴² In the South African context, they remained central to the AIDS narrative as the epidemic established itself as a 'heterosexual epidemic'. In both narratives 'the prostitute' was linked to promiscuity and AIDS in much the same way as 'the

¹⁴¹ See for example: Campbell, C., 'Selling Sex in the Time of AIDS: The Psycho-social Context of Condom Use by Sex Workers on a Southern African Mine', *Social Science & Medicine*, 50, 4, February 2000; Gilman, S.L., 'Black Bodies, White Bodies: Towards an Iconography of Female Sexuality in Late Nineteenth-Century Art, Medicine, and Literature', *Critical Inquiry*, 12, 1985; O'Neill, M., *Prostitution and Feminism: Towards a Politics of Feeling*, (Cambridge, Polity, 2001); Outshoorn, J. (ed), *The Politics of Prostitution: Women's Movements, Democratic States, and the Globalisation of Sex Commerce* (Cambridge, Cambridge University Press, 2004); Pheterson, G., 'The Category "Prostitute" in Scientific Inquiry', *The Journal of Sex Research*, 27, 3, August 1990; Pisani, E., *The Wisdom of Whores: Bureaucrats, Brothels and the Business of AIDS* (London, Granta, 2008); Scarpa, S., *Trafficking in Human Beings: Modern Slavery* (Oxford, Oxford University Press, 2008); Symanski, R., *The Immoral Landscape: Female Prostitution In Western Societies* (Toronto, Butterworths, c.1981); Thorbek, S., & Pattanaik, B. (eds), *Transnational Prostitution: Changing Patterns in a Global Context* (London, Zed Books, 2002); Van Heyningen, E., 'The Social Evil in the Cape Colony 1868-1902', *Journal of Southern African Studies*, 10, 2, 1984; Walkowitz, J.R., *Prostitution and Victorian Society: Women, Class, and the State* (Cambridge, Cambridge University Press, 1980); and West, D.J., *Male Prostitution* (New York, Haworth Press, 1993).

¹⁴² See Treichler, *How to Have Theory in an Epidemic*, chapters 2 and 8.

homosexual' had been, and the effects of the association between 'womyn sex-workers' and 'womyn who had AIDS' was to be long-lasting.¹⁴³

Sex workers were first linked to AIDS in the *SAMJ* in 1986 when a report entitled 'Prostitution and AIDS' revealed that data had shown that 'both heterosexual and homosexual activity [could] be involved in transmission'.¹⁴⁴ The article referred to a study among prostitutes and their clients in central Africa and indicated that HTLV-III infection was present amongst both sex workers and clients. The article concluded that to control infection among heterosexual populations '...prostitutes and *probably* their male customers should be regarded as high-risk groups'.¹⁴⁵ From the first report on prostitutes and AIDS it is clear that prostitutes were considered responsible for infecting their clients, rather than possibly being infected *by* their clients.

Sacks analysed 'misrepresentations' of womyn with AIDS in the media in the USA, and challenged the orthodoxy of studies that claimed significantly higher HIV infection rates in prostitutes. Sacks identified a number of themes in the representations of sex workers that resonate with the medical narrative in South Africa, most notably 'prostitute as polluter', 'client as victim', and 'prostitute as essence'.¹⁴⁶ She argued that the stereotypes of 'prostitution as a dangerous form of female pollution, and prostitutes as a category of persons especially likely to be diseased and contagious' were flawed. Instead she showed that assumptions 'that prostitutes are infecting the "general population"' were not necessarily true and that the 'evidence supporting this contention [was] quite mixed'.¹⁴⁷

Sacks noted that the 'client as victim' theme kept the focus 'overwhelmingly upon the prostitutes as the infectors, rather than as the infected', and fundamentally reversed the power relations between sex worker and client while perpetuating notions of dangerous and

¹⁴³ For an interesting account of the effects of discursive constructions of AIDS, associated external stigmas, and internalised stigmatisation among a group of womyn living with AIDS, see: Lawless, S., Kippax, S., & Crawford, J., 'Dirty, Diseased and Undeserving: The Positioning of HIV Positive Women', *Social Science & Medicine*, 43, 9, 1996, p. 1371-1377. For an interesting exploration of stigma in South Africa see Deacon, H., *et al*, *Understanding HIV/AIDS Stigma - A Theoretical and Methodological Analysis* (Cape Town, HSRC Press, 2005).

¹⁴⁴ 'Prostitution and AIDS', p. 5.

¹⁴⁵ *Ibid.* [emphasis added].

¹⁴⁶ See Sacks, 'Women and AIDS'.

¹⁴⁷ *Ibid.*, p. 61.

unclean female sexuality. Sacks argued that this representation positioned men as being 'in danger of being polluted by women' but not of 'women being polluted by men'. She observed that 'there [was] a conspicuous lack of attention to men's roles, particularly as clients' in HIV transmission.¹⁴⁸

As with the other AIDS avatars, Sacks argued that female sex workers were stereotyped, homogenised and essentialised and the creation of the category of 'prostitute' distracted not only from the diversity of experiences amongst different types of sex workers, but also from 'structural inequalities along gender, race and class lines' that influenced womyn's life choices.¹⁴⁹ The category thus also served to

direct attention away from the fuzzy boundary between 'normal' women and prostitutes, away from the context of poverty and disempowerment underlying many women's decision to engage in sex work, and away from the variation within the field of prostitution in terms of working conditions and risk for transmission of HIV.¹⁵⁰

While references to prostitutes in the *SAMJ* predominantly follow the 'high-risk discourse', there were occasions when tensions about the actual infection rates amongst sex workers were revealed. In 1987 the *SAMJ* referred to a South African government publication that contained updated information on AIDS that stated that 'other well-known high-risk groups are as yet uninfected: drug abusers, haemophiliacs, blood recipients and prostitutes'.¹⁵¹ In a response to this statement, O'Farrell asserted that, 'reports of prostitutes in this country with positive tests are occurring and are bound to increase'.¹⁵² This disagreement may indicate discrepancies in how the infection was being experienced and monitored by those compiling data (in this case the department of health) and those working 'at the coal face' as it were (O'Farrell was from Ngwelezana Hospital in Empangeni, in what was then Natal). It may also reveal the government's failure, or unwillingness, to keep accurate figures, or

¹⁴⁸ Sacks, 'Women and AIDS', p. 63.

¹⁴⁹ *Ibid.*, p. 65.

¹⁵⁰ *Ibid.*

¹⁵¹ 'AIDS in the RSA', *SAMJ*, 71, 20 June 1987, p. xxi.

¹⁵² O'Farrell, 'South African AIDS', p. 436.

indicate that there was not enough information available to comment on 'prostitution', 'prostitutes' and AIDS.

Reporting on findings presented at the 1987 International AIDS Conference, Sher and Metz observed that infection rates among prostitutes were 'increasing rapidly, both in Africa and in the West', but that 'in the latter, IV drug abuse or bisexual male partners present a greater risk for prostitutes than the number of male sexual partners'.¹⁵³ Actual figures or references to studies showing that prostitutes were 'high-risk' remained scarce, but 'the prostitute' remained a key figure in the AIDS narrative. A report from the AAG noted that 'Studies in prostitutes have indicated that the carrier incidence may be extremely low at present, but since this group may become an important future source of infection, arrangements are being made to keep this group under continuous surveillance'.¹⁵⁴ What was not revealed was how prostitutes had been defined or found; which particular studies were being referred to; and whether the arrangements for continuous surveillance were successful.

In a 1988 article discussing a 'Strategic Plan for the Containment of AIDS in South Africa', prepared for the DoH by the AAG, a distinction was drawn between 'high-risk groups' and 'potential high-risk groups', with prostitutes assigned to the latter.¹⁵⁵ The article distinguished between 'high-risk' groups that had already been identified, namely homosexuals and bisexual men, haemophiliacs, and intravenous drug 'abusers', and those who were high-risk but had not been identified. It called for 'continuous surveillance of potential high-risk groups, such as visitors to and from central Africa who may be exposed to AIDS through sexual contact, female prostitutes who *may become a serious source of infection to males*, and the infants of infected females'.¹⁵⁶

In addition to reinforcing many of the AIDS avatars, the statement reveals the centrality of concerns about 'clients as victims'. In the recommendation section of the article, relating to 'male and female heterosexuals', prostitution was highlighted but no mention was made of any interventions to address men's sexual practices. Instead, without any supporting

¹⁵³ Sher, 'Third International AIDS Conference', p. 444.

¹⁵⁴ 'Advisory Group on AIDS: Activities During 1987', *SAMJ*, 73, 5 March 1988, p. 319.

¹⁵⁵ 'Strategic Plan for the Containment of AIDS in South Africa', *SAMJ*, 73, 16 April 1988, pp. 495 - 497.

¹⁵⁶ *Ibid.*, p. 496 [emphasis added].

evidence, the article stated that 'Transmission through prostitution is a major area where intervention is needed'.¹⁵⁷

Despite there being little information on infection via, or among, prostitutes, they were identified as the main drivers of the epidemic in Schoub's epidemiological model for the development of the heterosexual AIDS epidemic in South Africa.¹⁵⁸ Schoub *et al* instantly conflated STI infection with promiscuity by referring to '...studies carried out on two cohorts of promiscuous black women – a prostitute cohort and a cohort of Johannesburg STD [sexually transmitted disease] clinic attenders', despite the fact that they did not define 'promiscuity' nor explain how 'prostitutes' and 'non-prostitutes' were identified in either cohort. The article went on to explain that although only one seropositive person was found in this study, another study indicated that 6 (or 2.1%) of 285 black female STD clinic attendees were seropositive.¹⁵⁹

Despite drawing on relatively few case studies, the article speculated on projected AIDS growth rates and, in reference to the model of infection (figure 7), declared that in relation to 'the heterosexual epidemic' one of the main 'incursions into the heterosexual population' would be 'via female intravenous drug-abusing prostitutes'. This prediction was made by extrapolating 'from the intravenous drug abuser epidemic which is a major route in certain parts of the USA and in parts of Europe'.¹⁶⁰ Despite the prominence given to womyn prostitutes with drug-dependency in this statement, and reference to the 'facts' of transmission in 'the West', no references to studies verifying this transmission route were given.

This section of the article concluded that once established in the heterosexual population the AIDS epidemic 'will be sustained, as in other parts of Africa and indeed as with all epidemics of STDs, by a promiscuous core consisting largely of female prostitutes'.¹⁶¹ Again there were no references to show how this conclusion had been reached, and no awareness

¹⁵⁷ 'Strategic Plan for the Containment of AIDS', p. 497.

¹⁵⁸ Schoub *et al*, 'Epidemiological Considerations', p. 156.

¹⁵⁹ *Ibid.*

¹⁶⁰ *Ibid.*

¹⁶¹ *Ibid.*

of the fraught history and politics of previous STI epidemics. There were, however, clear assumptions about the infected and infectious female prostitute.

Both the article, and the proposed model of infection, reflect Sacks' understanding of the essentialised prostitute as 'polluter' of the (absent) client. In this model, prostitutes are featured both at the 'core' of the epidemic, and as an external, invading vector specifically identified as 'access links' of infection. In the article 'Prostitution' received its own heading in the section on 'intervention strategies', which warned that

serious consideration will have to be given to efforts to shrink the promiscuous core of prostitution, irrespective of the guise under which it is practised. The role of legislated control of prostitution needs to be investigated but what is more important is the addressing of social and societal conditions which lead to prostitution.¹⁶²

The suggestion to address such conditions was a good one, but to be effective serious consideration would also have needed to be given to prevalent gender dynamics and the role of 'the client', and the article made no reference to either of these social concerns. Another article that referenced Schoub *et al* but was written two years later, still centred on the 'prostitute' in its analysis, but did acknowledge the role of male sexuality. It noted that 'just as female prostitutes represent a reservoir for spread of HIV into the male community, so may promiscuous HIV-positive men represent a key group for spread into the female population...'.¹⁶³ While the article may have indicated a shift in thinking among medical professionals, it was the only example found that addressed male sexuality.

In January 1988 a letter signed by five members of the Departments of Haematology and Cellular Immunology and Internal Medicine at the Medical University of Southern Africa and Ga-Rankuwa Hospital appeared in the *SAMJ*. It was written in response to an update on AIDS in southern Africa that declared that AIDS had not been detected to date in any black South

¹⁶² Schoub *et al*, 'Epidemiological Considerations', p. 156.

¹⁶³ Prior, C.R.B., & Buckle, G.C., 'Blood Donors with Antibody to the Human Immunodeficiency Virus – the Natal Experience', *SAMJ*, 77, 16 June 1990, p. 625.

Africans, but had only been seen in 'non-South Africans'.¹⁶⁴ The letter disputed the assertion that no black South African had been identified as having AIDS and reported on 'fully developed clinical AIDS with typical African [sic] presentation in 2 adult black women who have never been outside the northern Transvaal'.¹⁶⁵

What is interesting about the letter, aside from the inclusion of the African AIDS trope, is what it inadvertently reveals about the decisions that womyn have to make about sex and survival. The authors reported that 'Patient 1' (described as 'a Tswana woman, aged 33 years') had been married and had three children before her husband died. She then lived with a common-law partner, with whom she had two more children, until he deserted her six years prior to her seeking medical assistance. The patient revealed to the hospital staff that after her common-law partner had left she had turned to prostitution. The five children were seronegative, leading the authors to conclude that '... the prostitution, which commenced after the birth of her youngest child, was the epidemiological risk factor in this case'.¹⁶⁶ Rather than consider that there may have been socio-political or economic reasons that forced the womyn to turn to prostitution as a means of survival, the authors instead saw the case as '...a reminder of the importance of heterosexual promiscuity in the devastating spread of HIV-1 infection on this continent'.¹⁶⁷

From 1992 there are examples of a different understanding of sex workers and the socio-economic contexts of sex work evident in the journal. An editorial by Schoub in January 1992 does not mention a promiscuous core and instead suggests that education about AIDS alone was an insufficient response to the epidemic:

Without the resources and opportunities to implement requisite changes, knowledge and awareness are ineffective in engineering behavioural changes. Empowerment is the second goal that needs to be achieved to effect control. This involves the addressing of issues such as poverty and overcrowding and the

¹⁶⁴ Botha, M.C., *et al*, 'Two Black South Africans with AIDS', *SAMJ*, 73, 23 January 1988, pp. 132 – 134. The correspondence suggests that the *Update* was one featured in the *SAMJ* on 25 November 1987, but this update could not be found indicating either an error in the *SAMJ* or that the *Update* was from another source.

¹⁶⁵ Botha, 'Two Black South Africans with AIDS', pp. 132 – 134.

¹⁶⁶ *Ibid.*, p. 133.

¹⁶⁷ *Ibid.*

economic dependency of women, which promotes prostitution with non-negotiable sexual subservience to clients ...¹⁶⁸

That this shift was perhaps begrudgingly accepted, if not necessarily wholeheartedly supported, is illustrated by the comments of the *SAMJ* editor when referring to a paper on STDs from January 1993. The editor notes that the author of the paper

makes the important point that prostitutes, which he terms sex-workers in line with the current fashion for euphemisms, are probably a major source of infection with STDs. However, rather than cracking down on them, which has historically never been successful, it makes sense to enlist their support in trying to reduce the incidences of STDs by organising regular health checks, and to educate them about the risks they are running.¹⁶⁹

An opinion piece by Clive Evian, published later in 1993, focused on 'the socio-economic determinants of the AIDS epidemic in South Africa', and showed how poverty influenced sexual activity and HIV infection, and how AIDS contributed to poverty.¹⁷⁰ While poverty and 'the poor' are sometimes essentialised in this account, the piece made reference to human emotions, feelings of social isolation and displacement, and declared that 'sex is a basic human need, providing satisfaction, pleasure, intimacy and even security'. It highlighted economic realities that could result in womyn having to sell sex, and stressed the significance of gender inequalities.¹⁷¹ The piece also astutely observed that the 'present levels of urban violence, crime, unrest and uncertainty in South Africa promote a fatalism and despondency which are extremely detrimental to any AIDS prevention efforts'.¹⁷²

An article by Wilson and Lavelle expanded on some of the themes raised by Evian, and drew on examples from other African countries as 'germane to South Africa'.¹⁷³ It presented a

¹⁶⁸ Schoub, B.D., 'AIDS in South Africa – into the Second Decade', *SAMJ*, 81, 18 January 1992, p. 55.

¹⁶⁹ 'Where have all the venereologists gone?' *SAMJ*, 83, January 1993, p. xi.

¹⁷⁰ Evian, C., 'The Socio-economic Determinants of the AIDS Epidemic in South Africa – a Cycle of Poverty', *SAMJ*, 83, September 1993, pp. 635 - 636.

¹⁷¹ *Ibid.*, p. 635. While the cycles of poverty and AIDS were primarily explained in terms of the impact of exploitative and migrant labour systems and urbanisation on black populations and the 'legacy of apartheid and its devastating impact on the normal cultural, traditional and family life of black South Africans', this was in keeping with analyses of the time and is an area still requiring more detailed research.

¹⁷² *Ibid.*

¹⁷³ Wilson & Lavelle, 'AIDS Prevention in South Africa, pp. 668 – 674.

holistic engagement with socio-political and economic factors that impact on AIDS and contextualised sexual activity and gender relations in light of these, while also noting that sex workers were organising politically.¹⁷⁴

In these articles there was at least some recognition of the contexts in which sex work, sexual activity, and HIV infection took place. Although neither article recognised the role of rape and sexual violence in driving HIV infection among womyn, they offered a more nuanced understanding of sex work.

Womyn as Partners, Womyn with 'Infected Wombs', Womyn with Voices

Although AIDS had been found in womyn from the earliest reported cases, in the AIDS narratives 'womyn with AIDS' did not exist as a category. When they were not invisible lesbians or 'promiscuous prostitutes', womyn with AIDS were constructed in terms of their relationships to others. Initially they were linked to their sexual partners, and later almost exclusively to their foetuses or babies.

The link to infected men was based on the initial assumption that men could infect womyn and not vice versa.¹⁷⁵ Thus womyn were simply labelled as the 'sexual partners' of infected men as if no other transmission possibilities applied to them. In the *SAMJ* this is evident in statements like: 'Cases in females have been described and women may acquire the disease from male sexual partners'; and '... of 7 male heterosexual drug users that caught AIDS, it was shown that only one out of their 7 consorts was immunologically normal, one women had the full AIDS syndrome and another apparently had the pre-AIDS syndrome'.¹⁷⁶

¹⁷⁴ Wilson & Lavelle, 'AIDS Prevention in South Africa', p. 669. The article noted that a COSATU AIDS meeting 'dismissed a suggestion to incorporate prostitutes in the union movement without serious debate'. This indicates that sex workers had organised sufficiently to put the question on the COSATU agenda.

¹⁷⁵ It was only in an 'Official Announcement' by the Advisory Group on AIDS in September 1987 that readers were notified that 'Heterosexual spread of the virus may not take place as readily as homosexual transmission, but it can certainly pass from men to women and from women to men during vaginal intercourse' see *SAMJ*, 72, 5 September 1987, p. 366. Clearly, women and men were assumed to be curtailing their sexual activities to vaginal intercourse only.

¹⁷⁶ Ras, 'Acquired Immunodeficiency Syndrome', p. 140; 'Meer Oor VIGS', p. 114 (the original Afrikaans word used is 'metgeselle' which the author has translated as 'consort'). Further examples include: 'Other cases have been reported in ... female sexual consorts of men with AIDS' (see 'VIGS (AIDS) – 2 Jaar Later', p. 1080); 'AIDS in the consorts of men infected with HTLV-III and the children of such consorts (wives and girl-friends) is

Little effort was made to determine what sort of ‘partners’ womyn were in either these intimate relationships, or in their relationship to society more generally. There is no indication of the types of lives these womyn or their partners experienced – were they subject to acts of sexual and/or domestic violence? What were the employment and education levels of the people under investigation? What were their economic circumstances, and what about their mental health or their dis/abilities? Were these people who felt marginalised from society, or people who were central figures in their communities? What was common to their experiences and what uncommon? Were these merely people who had sexual contact occasionally, or did at least one ‘partner’ believe that they were in a long-term relationship? Were the relationships negotiated as sexually open? What types of sexual practices, if any, did they engage in?

After being little more than the ‘sexual partners of men with AIDS’, womyn’s bodies – or at least their fertile wombs – would play a significant role in the AIDS narrative as the site from which information was collected to determine the extent of heterosexual HIV infection rates. In the 1990s pregnant womyn attending public antenatal clinics increasingly became the sample group for HIV surveys.¹⁷⁷ As the need for information competed with heated and necessary debates about informed consent and patients’ rights, routine blood samples taken from womyn were anonymously pooled and tested for HIV.¹⁷⁸

In 1991 *SAMJ* readers were informed that the results of the first national HIV survey undertaken by the DoH had been published:

beginning to be described more frequently’ (see Klopper, J.M.L., ‘AIDS – Report of an Epidemiological Seminar’, *SAMJ*, 68, 12 October 1985, p. 618); and ‘Other groups predisposed to the development of the syndrome are intravenous drug abusers, haemophiliacs ... and the children and spouses of AIDS patients’ (see Sher, R., ‘AIDS and Related Conditions...’, p. 843).

¹⁷⁷ A pilot study of the ‘prevalence of HIV antibodies in antenatal clinic attenders in Ciskei’ featured in the correspondence section of the *SAMJ* in 1991. H. Stevens and G. Boon from the Serology Laboratory and Department of Paediatrics, Cecilia Makiwane Hospital, Mdantsane, Ciskei, reported that ‘To assess the prevalence of HIV in the adult population of Ciskei, permission was obtained to carry out a pilot survey of HIV antibodies on anonymous antenatal patients from Mdantsane and environs’ see Stevens, H & Boon, G. ‘Prevalence of HIV Antibodies in Antenatal Clinic Attenders in Ciskei’, *SAMJ*, 79, 2 March 1991, p. 282.

¹⁷⁸ See for example Friedland, I.R., & Karstaedt, A.S., ‘HIV-Related Ethics – Who Should Decide?’, *SAMJ*, 79, 4 May 1991, p. 527.

This survey was undertaken in October- November 1990 ... It was decided to focus on women attending antenatal clinics because of the logistical problems that would be encountered if the general population was included.

The advantages of using this group for the survey were that these women are sexually active, blood samples are taken from them routinely for Rh and ABO testing, and a wide geographical coverage could be achieved. By repeating the survey regularly, it will be possible to monitor the spread of the HIV/AIDS epidemic in South Africa.¹⁷⁹

In this account of the survey, pregnant womyn were both singled out from 'the general population' and made to stand in for it. Making use of an accessible sample group to determine a percentage rate for HIV infection for that particular group is a practical approach to take. However, in this instance, while pregnant womyn were visible in this sampling technique, a substantial number of people were invisible, including pregnant womyn who could afford private health care; fertile womyn who were not pregnant; infertile womyn; post-menopausal womyn; and, of course, men and children.

From 1990 to 1995 there were attempts to conduct surveys using multiple sample groups, and to develop population-based prevalence and socio-behavioural surveys, but national surveys continued to be based on antenatal groups. In one latter type of survey, Klugman *et al* noted that 'the spread of HIV infection in pregnant black women is not homogenous, but reflects increased risk in certain suburbs, and in women at risk of STDs', acknowledging that multiple factors could influence HIV infection.¹⁸⁰

¹⁷⁹ 'First National HIV Survey Published', *SAMJ*, 79, 4 May 1991, p. xvi.

¹⁸⁰ Klugman, 'Serological Markers', p. 244. The experiences of health care professionals involved in antenatal health care and the differences between dealing daily with actual (sometimes totally asymptomatic) pregnant womyn and not just anonymous blood samples, also weighed into the discussions about antenatal surveys and HIV infection in pregnancy. Friedland and McIntyre, reported on their experiences in Baragwanath Hospital: 'The problems faced by the obstetrics department have been different from those in other departments, since the vast majority of infected pregnant women were identified during seroprevalence surveys and not because of clinical suspicion'. They highlighted some particularly complex aspects of being pregnant and HIV positive:

Despite counselling advising against further pregnancies, 5 women have returned with subsequent pregnancies. One of these women requested termination of pregnancy. The other 4 had planned their pregnancies after considerations of the risks involved and did not wish to terminate them ... It is the policy of the maternity unit that when the diagnosis of HIV is made in the first trimester, termination of pregnancy is offered after counselling. However, the majority of women only attend the antenatal clinic for the first time after 24 weeks' gestation and the option of termination is not available to them. Only 2 terminations were performed for HIV-positive patients from 1988 to 1990, both patients having been diagnosed before they became pregnant.

In April 1994, in the same month that South Africa's first democratic elections were held, the findings of three annual antenatal surveys (1990, 1991 and 1992) were reported in the *SAMJ*.¹⁸¹ Aside from noting the consistent increase in HIV infection rates, the article attempted to collate information from surveys from all four provinces and all 'population groups', but excluded significant specimens from the 'homelands'.¹⁸² The article indicated that infection prevalence amongst 'population groups' varied significantly, but all had increased. What distinguished this article from previous surveys was the recognition that there were problems with sample collection and data analysis, and the inclusion of a candid reflection on the chosen sample group:

Anonymous testing in low prevalence areas requires large numbers of individuals from whom blood samples are taken for another reason for which informed consent must be given. There are few sources on such a scale which are readily accessible. Pregnant women attending antenatal clinics provide such a source. Some bias may be introduced by the inclusion only of antenatal clinic attenders and therefore the exclusion of many women of childbearing age. The group should however mirror the trend of the HIV epidemic in the heterosexually active population.¹⁸³

In the same issue, the editor raised similar concerns about the surveys:

...the appropriateness of equating the prevalence rate among ANC (antenatal clinic) attenders with the national rate is open to question. Firstly, this approach

For both the health care workers and the pregnant womyn, reaching or dealing with decisions of such magnitude must have taken an emotional toll. The decisions of pregnant womyn about whether or not to deliver their babies or terminate their pregnancies hint possibly at a faith in life or a cure for AIDS, or to a decision based on the status of fertility and producing children, or to fear or a moral objection to terminations of pregnancy. While the reasons for the decisions may never be known, the references to them show the human dynamics behind the epidemic. Friedland, I.R., & McIntyre, J.A., 'AIDS – the Baragwanath Experience: Part II, HIV Infection in Pregnancy and Childhood', *SAMJ*, 82, August 1992, p. 90.

¹⁸¹ Küstner, H.G.V., Swanevelde, J.P., & Van Middelkoop, A., 'National HIV Surveillance – South Africa, 1990 – 1992', *SAMJ*, 84, April 1994, pp. 195 – 200.

¹⁸² The apartheid government declared various sectors of South Africa 'homelands' or 'Bantustans' in which black South Africans of different 'ethnic identities' were meant to live and 'develop' separately from 'white' South Africans. Some of these homelands, namely the TBVC states (Transkei, Bophuthatswana, Venda and Ciskei) were recognised as 'independent states' by the South African government but not by any other countries or international fora. There were also non-independent homelands like Gazankulu, kaNgwane (Kangwane), KwaNdebele, KwaZulu, Lebowa and Qwaqwa. See Beinart, W., *Twentieth Century South Africa* (Oxford, Oxford University Press, 2001), pp. 162 -164, 212 – 227. Despite being markers for 'the general population' it seems some pregnant womyn had been excluded because of artificially created geographic boundaries.

¹⁸³ Küstner *et al.*, 'National HIV Surveillance – South Africa, 1990 – 1992', pp. 195 & 199.

excludes men altogether. Secondly, pregnant women may not be the most vulnerable. Moreover, women who attend ANC are self-selected, and it is not clear whether the incidence among non-ANC attenders might not affect the overall outcome, if it were known.

Nevertheless, it seems reasonable to assume that the trend among ANC attenders reflects the trend in the community at large.¹⁸⁴

The reason pregnant womyn should mirror infection rates in the heterosexually active population was not clear; and the editor only mentions the exclusion of men, and not children, and non-heterosexuals who are not pregnant. However, the recognition of the weakness of the surveys demonstrates a more reflective analysis. This was reiterated in the acknowledgement by the authors that 'complementary sentinel surveillance programmes to monitor problem areas at local level' were necessary.¹⁸⁵

From 1990 there were shifts in the AIDS narratives as they related to womyn, suggesting the influence, to varying degrees, of rights-based discourses and feminisms. Sher *et al* reported on the Fifth International AIDS Conference held in Montreal in June 1989:

The rights of women came under the spotlight. Male power and sexism leave women and their babies particularly vulnerable. Women are admonished to take control, avoid unprotected vaginal and anal intercourse and to insist that sexual activity be conditional on condom use, but the vast majority of women do not have the power within sexual relationships to negotiate a change in the rules. Until women are equal partners, sexually and economically, they will not be able to protect themselves from risk.¹⁸⁶

¹⁸⁴ 'The "Epidemic Snowball" of HIV Infection', *SAMJ*, 84, April 1994, p. ix.

¹⁸⁵ *Ibid.*, p. 199. In 1995 the figures from the Fifth National HIV survey of womyn attending public health service antenatal clinics were published and revealed that 'the epidemic is progressing rapidly throughout the country, with the main mode of transmission being heterosexual transmission, and the rate of new infection ... estimated to be doubling every 15,4 months. The national level of infection [had] increased from 4,25% in 1993 to 7,57% in 1994 ... and infection had increased in all age groups' (see 'Latest Figures on HIV Pregnancies', *SAMJ*, 85, 7, July 1995, p. 611). During the transition into the new democracy there would be an ever-growing number of citizens who were HIV positive. The struggle of pregnant womyn to access drugs that would significantly reduce the chance of mother-to-child-transmission would become a central battle in the quest for treatment access and delivery.

¹⁸⁶ Sher, R', Christie, G., & Zazayokwe, M., 'Fifth International AIDS Conference', *SAMJ*, 77, 3 February 1990, pp. 169 – 170.

In 1990 an AIDS conference, hosted by the AIDS Education Unit of the Planned Parenthood Association, was held in Cape Town. It focused on 'women's issues in the AIDS era', and included guest speakers from Zimbabwe and Namibia who 'highlighted the educational efforts currently being undertaken by women's organisations in these regions'. Topics 'included women's role and risk regarding AIDS, women in the workplace, women's attitudes to contraception and condom use, AIDS-positive women and pregnancy, and community education programmes'.¹⁸⁷

Another conference organised by the Planned Parenthood Association on womyn and AIDS was held at the University of Cape Town to coincide with World AIDS Day in 1991. This conference brought together a diverse range of womyn, and was opened by the editor of *Cosmopolitan*, Jane Raphaely, who used what was termed the 'hand-grenade in a fishpond approach' to highlight the unequal relationships between men and womyn. While some of her reported statements essentialised womyn and men, her critiques of power relations, and her observation that men were in a (stronger) position to control AIDS remains relevant. The variety of papers and concerns raised in the conference showed an attempt at expanding dialogue and discussion around AIDS.¹⁸⁸ These conferences showed that discussions about AIDS as a complex health issue for womyn were taking place in certain spaces. It is harder to establish what influence, if any, these discussions had on the medico-scientific research agenda.

Some of the complexities and subtleties of womyn's lives, and how they shaped the implementation of AIDS education campaigns, were revealed in a comment about a paper that examined womyns' knowledge of AIDS. The *SAMJ* editor noted that, '... although AIDS

¹⁸⁷ 'AIDS Conference Focuses on Women', *SAMJ*, 78, 1 December 1990, p. xv. A listing for the Planned Parenthood Association of South Africa (PPASA) notes: Since our establishment in 1932, the PPASA, has evolved each decade in response to the need of our clients. In 1995 we were influential in the liberalization of abortion laws. At the moment, PPASA works in 9 provinces providing comprehensive sexual and reproductive health services to our target groups of: 'men in shebeens', (local and home based beer halls) and football stadiums; schoolteachers; refugees; internally displaced persons; sex workers; former prisoners; counselling newly married couples. Services provided to these critical groups comprise: family planning; diagnosis and treatment of sexually transmitted infections; provision of emergency contraception; pregnancy testing; voluntary counselling and testing (VCT); and community based care. We also undertake social mobilization and peer education through Department of Health clinics as part of our outreach programmes. See the International Planned Parenthood Federation website at www.ippf.org/en/Where/za.htm (accessed May 2012).

¹⁸⁸ 'Women and AIDS', *SAMJ*, 79, 19 January 1991, p. 112.

knowledge among black women is adequate, they are still at high risk of contracting AIDS because condoms are not used. The authors suggest that black women also be instructed in communication skills so as to get the message about the dangers of AIDS across to their teenage children'.¹⁸⁹ While the use of a racial marker and the assumption that womyn should be responsible for the sexual health and education of their teenage children are problematic, the comment shows that the particular womyn featured in the research paper had acquired knowledge about AIDS, despite the paucity of accessible material at the time. Despite addressing concerns about communication skills, the article failed to consider that one of the reasons condom use may have been difficult to negotiate was that sexual partners needed to be taught communication skills to discuss the gendered nature of sexual practices and sex acts.

The necessity of undertaking research in a variety of contexts to prevent erroneous conclusions being drawn, and to obtain nuanced results that revealed information about specific, clearly defined informants, is shown in an article by Govender *et al* published in 1992. This article reported on the results of a random sample of 50 women attending a family planning clinic in Johannesburg and was careful to note the educational, generational, employment and relational characteristics of the participants. The womyn were surveyed in an attempt to 'determine the knowledge, attitudes and practices of these sexually active women' and revealed a significant difference in levels of knowledge about AIDS, provided an insight into what these womyn felt about condoms (and indirectly sex and sexuality), and how they considered AIDS patients.¹⁹⁰

¹⁸⁹ 'On the Buses', *SAMJ*, 80, 5 October 1991, p. vii.

¹⁹⁰ Govender *et al*, 'Perceptions and Knowledge, pp. 71 - 74. The results of another survey undertaken by Blecher *et al* in 1995 amongst an equal number of male and female informants also yielded more nuanced results about individual beliefs and knowledge (see Blecher *et al*, 'AIDS - Knowledge, Attitudes and Practices', pp. 1281 - 1286). In an article that discussed the counselling of HIV-positive patients at Baragwanath Hospital, there is a rare glimpse of the emotional cost of AIDS and a shared sense of vulnerability amongst womyn 'The counsellors were all senior members of the nursing staff and very busy. The counselling of HIV-positive patients was an extra duty. The counsellors expressed guilt feelings at having to limit patient contact times through work pressure. Many saw patients in off-duty time. As women exposed to the same factors in society that had caused patients to become infected, the counsellors expressed anxiety and anger when they realised their own vulnerability' (see Allwood, C.W., Friedland, I.R., *et al* 'AIDS - the Baragwanath Experience: Part IV, Counselling and Ethical Issues', *SAMJ*, 82, August 1992, p. 100).

Highlighting the necessity for diagnosis outside of the concepts of 'risk groups' was a letter from Van Wyk from Hottentots [sic] Holland Hospital which appeared in the *SAMJ* in 1993. Van Wyk referred to a case of AIDS that had almost not been diagnosed in a '72-year-old coloured woman'. This woman had initially presented at the hospital with numerous symptoms including weight loss and was later admitted with bronchopneumonia and emaciation. Two weeks after being admitted she became demented and had an atypical convulsion. Van Wyk noted:

Quite a few of our AIDS patients have presented with bizarre neurological symptoms, and at last the penny dropped and she was diagnosed as having cerebral AIDS. She died 2 days later. Another coloured women aged 65 years was diagnosed the following week. Our medical colleagues must bear in mind that the aged are not immune, as they may well still be sexually active!¹⁹¹

Apart from the tone of the letter, the points made by Van Wyk were certainly valid in an AIDS narrative that largely ignored post-menopausal or non-pregnant womyn. What was to develop into a serious health crisis for womyn in South Africa was noticed belatedly because of the fracturing or invisibility of womyn's bodies and womyn's personhood. As Mbali has shown, for the most part 'Women's HIV risk [was] buried in androgynous categories' and 'listed explicitly only in relation to 'Mother-to-child' transmission, perpetuating the notion that where HIV presented a threat for women it was principally insofar as their children would become infected'.¹⁹² Mbali shows how this delayed womyn's involvement in AIDS-related epidemiology and collaborative activism around AIDS, and notes that 'Unsurprisingly, given the focus on prostitutes in early AIDS epidemiology relating to women, most women's organisations which, in general, represented "normal" women did not take up the issue of AIDS'.¹⁹³

¹⁹¹ Van Wyk, C., 'Follow-up on AIDS at Hottentots Holland Hospital', *SAMJ*, 83, February 1993, p. 135.

¹⁹² Mbali, M., "'The New Struggle': A History of AIDS Activism in South Africa, 1982 – 2003", PhD thesis, University of Oxford, 2009, p. 194.

¹⁹³ *Ibid.*

HAART and Human Rights – A Shift in Perspective?

The discovery, successful trials, licensing and final approval of the first antiretroviral (ARV) - Azido-Thymidine (AZT) also known as Zidovudine - in the USA in 1986 changed the scientific and political landscape of AIDS because there was now hope that something could be done about AIDS.¹⁹⁴ In minority world countries this would result in AIDS becoming akin to a manageable chronic illness. In majority world countries the costs of ARVs, along with other problems, have not yet resulted in this transition and AIDS remains a fatal condition for many. The prohibitive cost of drugs was to give rise to mass global social justice campaigns – and in South Africa resulted in AIDS activists both suing and supporting the South African government in the quest for cheaper treatment and effective provision.¹⁹⁵

As Mbali and others have shown, AIDS activism in South Africa developed from the earliest days of the epidemic and often drew on knowledge and networks from anti-apartheid struggles to mobilise and campaign around the issue.¹⁹⁶ In the build-up to 1994, and consistently thereafter, discussions about public health care provision more broadly, and AIDS specifically, started to reflect the notions, laws and language of ‘human rights’.¹⁹⁷

This multi-disciplinary, multi-sectoral, politicised engagement around AIDS, as it related to broader discussions about human rights more generally, would change the narrative of the epidemic internationally and within South Africa. Locally there were hints of this in the *SAMJ*, reflecting the complexities and competing perspectives between science, politics and people. In a report back from the 1989 International AIDS Conference, Sher *et al* noted that

¹⁹⁴ Oppenheimer, G., & Bayer, R., *Shattered Dreams? : An Oral History of the South African AIDS Epidemic* (New York, Oxford University Press, 2007), p. 40.

¹⁹⁵ HAART refers to ‘Highly Active Antiretroviral Therapy’, a treatment programme combining ARVs that effectively prolongs the survival of people with HIV and AIDS and has been sporadically provided to HIV positive people in South Africa. For more on this see Cameron, E., *Witness to AIDS* (Cape Town, Tafelberg, 2005) especially ch. 6 “We are not the Red Cross” – Patents, profits and death from AIDS’ written with Nathan Geffen.

¹⁹⁶ See for example Mbali, *The New Struggle*; and Ballard, R., Valodia, I., and Habib, A. (eds.), *Voices of Protest: Social Movements in Post-apartheid South Africa* (Durban, UKZN Press, 2006) generally, and the chapter by Friedman, S., & Mottiar, S., ‘Seeking the High Ground: The Treatment Action Campaign and the Politics of Morality’, specifically.

¹⁹⁷ See chapters on government responses to AIDS, and the chapter on NAMDA and progressive health organisations.

The theme of the conference was 'The scientific and social challenge posed by the AIDS pandemic'. As such, it was the first integrated conference on AIDS in an attempt to widen perspectives on the disease. The scientific aspect of HIV infection was, however, eclipsed by the non-scientific (social and political), which led to much discontent among scientific participants who demanded a return of science to future congresses, posing a major dilemma for the organisers of future meetings.

A large number of the 11 000 strong contingent included activist groups, mostly 'People with AIDS', homosexuals and prostitutes, who turned the meeting into a socio-political event, with proceedings being marred by protest marches, demonstrations and heckling.

... The conference provided a huge leap in knowledge and understanding of AIDS from a social point of view, but from a biomedical point of view progress is incremental ... Conference participation was broader and more extensive than in previous conferences, especially as regards, cultural, social, emotional and political aspects. The way forward is towards the collaboration and solidarity of science and public health.¹⁹⁸

Between 1980 and 1995 the hegemonic AIDS narratives shifted and many of the AIDS avatars turned into AIDS activists who were able to construct and define themselves rather than exist as the stereotyped categories of researchers. The initial AIDS narratives in the *SAMJ* drew on international narratives and reproduced many of the inherent flaws in them. The AIDS narrative in South Africa was however, also influenced and shaped by the socio-political context of the country during the time. The tense political situation during the period that led to the end of formal apartheid, and the fears, concerns and hopes of medical professionals negotiating this time of transition, also shaped the AIDS narrative.

The narratives produced in the *SAMJ* were not confined to the pages of the journal, as they both influenced, and were influenced by, narratives produced in other fora and by the individuals that made up the networks of human connections that medical professionals were part of. While many communities took Sontag's 'rhetorical ownership of AIDS', much of the rhetoric reflected or reproduced key elements of the hegemonic AIDS narratives even after they had changed. Thus, even when ARVs became available and democracy arrived in

¹⁹⁸ Sher, *et al* 'Fifth International AIDS Conference', pp. 169 – 170.

South Africa, old ways of thinking, of being, and of conducting research that had been forged in the racialised, gendered, classist and heteronormative milieu of the epidemic's advent, persisted. In December 1995, for example, an article in the *SAMJ*, investigating 'AIDS - knowledge, attitudes and practices among STD clinic attenders', referred to people attending STI clinics as being 'more likely to have high sex-partner change rates and to practice other risky behaviours'.¹⁹⁹

The 'high-risk group' of the early AIDS narrative was replaced by the notion of 'risky behaviours' but these were no more clearly defined or reflected upon.²⁰⁰ While the 'high-risk groups' had for the most part disappeared, AIDS narratives and understandings still failed to acknowledge the universality and commonality of AIDS as a public health crisis, or recognise the multitude of factors that led to people who were closest to social and political fault-lines being affected differently.

The legacy of categories created by AIDS narratives and intertwined with apartheid-influenced ways of understanding and being in the world, remained prevalent well into the 1990s. Commenting on the AIDS education initiatives by the South African Institute of Medical Research, Sher noted that 'AIDS was seen by many black people as a white man's disease', and 'black people were more concerned about the political situation than their health'.²⁰¹ Another article noted that students in a township 'did not acknowledge that AIDS could affect them directly, and attributed the problem to prostitutes and "promiscuous" people ... and to "white" people ...'²⁰²

A report on the first meeting of the HIV Clinical Guideline Working Group that met in September 1994 also reflected the legacy of a raced, classed, gendered, sexuality-defined AIDS narrative that excluded or omitted people and drew on existing group generalisations:

¹⁹⁹ Blecher, M.S., Steinberg, M., Pick, W., Hennink, M., and Durcan, N., 'AIDS - Knowledge, Attitudes and Practices among STD Clinic Attenders in the Cape Peninsula', *SAMJ*, 85, 12, 1 December 1995, p. 1282.

²⁰⁰ Sexual violence and rape against womyn, for example, is a common violent crime and although a key driver of HIV infection is hardly a 'risky behaviour' that rape survivors have any control over. Similarly, partners who have remained faithful and monogamous are not knowingly engaging in 'risky behaviour' even if their partners are.

²⁰¹ 'German Pharmaceutical Companies Donate R17 000 to AIDS Education', *SAMJ*, 77, 3 Feb 1990, p. vii.

²⁰² Mathews, C., Kuhn, L., *et al* 'Knowledge, Attitudes and Beliefs about AIDS in Township School Students in Cape Town', *SAMJ*, 78, 3 November 1990, p. 511.

It was the first time since the outbreak of the epidemic in South Africa ... that a representative clinical group has sat down and talked. An encouraging sign, according to various participants at the meeting, that the great divide between HIV/AIDS treaters [sic] of mainly white gay men ('the elite' as they were called) and heterosexual black people ('the rest') is narrowing.²⁰³

In a country built on perpetually reinforced differences and deliberately fractured relationships, the bringing together of people to talk about AIDS in 1994 was significant enough for the *SAMJ* to comment on it. Whether the divisions between 'treaters' of AIDS and those who constituted 'the elite', and 'the rest' of the population have truly narrowed in the years since 1994, is still open to debate.

In recounting the creation stories of AIDS avatars and broader AIDS narratives in South Africa, this chapter has revealed the 'unscientific' subjective nature of science. On one level, this is a useful exercise in chronicling and naming bias in a space that claimed 'objective neutrality' so that future researchers can build on this work. Identifying and acknowledging the hegemonic AIDS narratives and AIDS avatars is also important because it demonstrates how stereotypes and constructed identities have been used in South Africa to marginalise and separate people.

But merely naming the narratives and avatars as 'racist', 'sexist' or 'homophobic' does not convey the complexities of people and politics revealed in the subtexts of the discourse, and it is an exercise too easily undertaken with the benefit of hindsight. Treichler has observed that

It is not simply that medicine and public health have sometimes been "sexist" [or racist, or homophobic, or classist], an accusation that in the end tells us little. The best research ... aims to illuminate the social context in which specific representations are produced, disseminated, understood and put to use.²⁰⁴

This chapter has also examined the contexts, ideologies, and historical influences that allowed the creation of 'risk-groups' in the AIDS narrative in South Africa, and has shown how they were produced, understood and disseminated in a particular media outlet (a

²⁰³ 'Clinical guidelines for HIV/AIDS sufferers', *SAMJ*, 84, 10, 1 Oct 1994, p. 16.

²⁰⁴ Treichler, *How to have Theory in an Epidemic*, p. 43.

medical journal) by a sector of society (elite medical professionals). It is not surprising that the AIDS narrative in South Africa would reproduce markers of race, gender, sexual orientation, sexuality, and external threat as

Researchers and doctors were 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.²⁰⁵

What was lacking in the construction of AIDS avatars was a real engagement with the complexity of what it means to be human. A more critical engagement with the complexities of human experience and existence (including the effects of race, age, class, geographic location, access to education, food, and economic and personal security issues) would undoubtedly have resulted in a more inclusive AIDS narrative. There can be little doubt that if people's (dis)abilities, mental and emotional health needs, levels of empowerment, exposure to violence, personalities, cosmologies, and a host of other factors that combine to influence how people exist in the world had been considered more meaningfully more appropriate research findings would have been produced. This lesson remains a salutary one to all researchers, across all disciplines, across all times. Learning the lesson however, also raises further questions that historians and other researchers will need to address about the human cost of AIDS avatars. If holistic, multidisciplinary, and transdisciplinary responses, such as those discussed by Kippax, had been put in place, would the lives lost to AIDS have been fewer?²⁰⁶

²⁰⁵ Tsampiras, 'Not So "Gay"', pp. 495 - 496.

²⁰⁶ In the case of responses to AIDS Kippax has shown how the lack of integrated responses to AIDS from the beginning, i.e. responses that combined medical and social understandings and analysis of AIDS, has hampered prevention strategies. The usefulness and effectiveness of holistic approaches drawing on multidisciplinary teams is well reviewed by Kippax. See Kippax, S., 'Understanding and integrating the structural and biomedical determinants of HIV infection: a way forward for prevention', *Current Opinion in HIV and AIDS*, 3, 4, July 2008, pp. 489 - 494.

This chapter has also shown how a lack of self-awareness amongst the majority of medical scientists led to the reinforcing of social and political divisions, and prejudices, which, in turn, resulted in the uncritical homogenisation of groups. The unacknowledged subjectivity of research and researchers enabled the formation of hegemonic AIDS narratives and avatars that ensured that people were packaged into neat categories, which circumvented the need to ask uncomfortable or difficult questions. Despite the fact that the syndrome had exposed the failings and shortfalls in medical science, these hegemonic narratives and avatars acted to reassure a fearful public that AIDS was a problem limited to those on the margins of society. The following chapters of this thesis explore the ways in which these hegemonic narratives were interpreted and added to, employed, and challenged, in other fora. They also explore how these narratives and avatars influenced responses to AIDS, and shaped peoples' experiences.

CHAPTER TWO: 'AIDS WILL KILL YOU AS SURELY AS AN AK': AIDS AND THE ANC IN EXILE, 1980 – 1990

AIDS – being a threat to mankind [sic] as a whole, the incidence of the disease is being viewed with grave concern by our department.

ANC Department of Health Annual Report for 1987.¹

As a vanguard of the South African Liberation Movement the ANC and its members have the added responsibility of handling this issue with the urgency and sensitivity it deserves.

Chris Hani, Speech given to the Lusaka AIDS Workshop, 1990.²

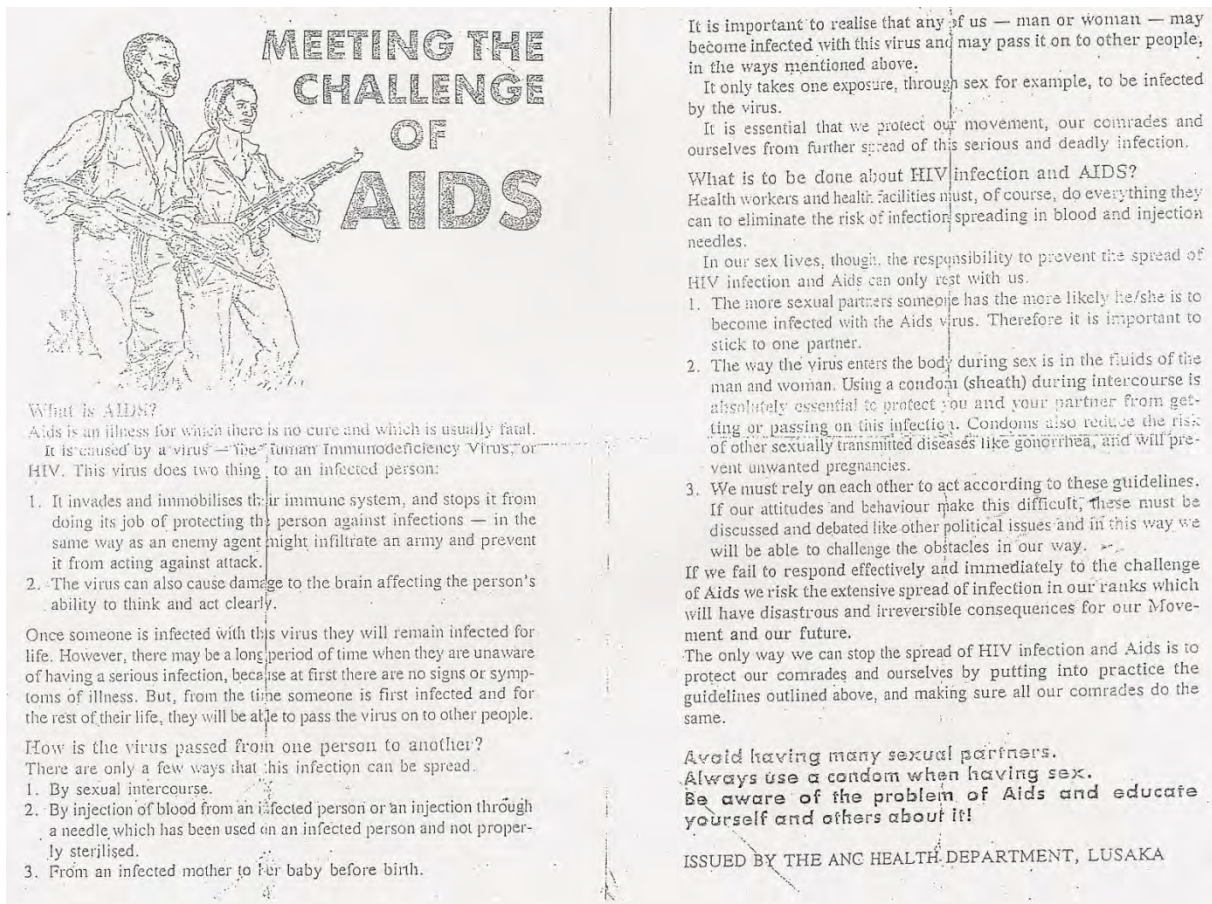


Fig. 8. Early AIDS awareness pamphlet issued by the ANC Department of Health, Lusaka.³

¹University of Fort Hare, ANC Archive (hereafter UFH-AA), ANC Lusaka Mission Papers (hereafter ALM), p2a, 41, 65, ANC Department of Health Annual Report to the ECC for the Year 1987, p. 2.

²UFH-AA, ALM, pt 2, 64, c3, Paper by Chris Hani to the AIDS Workshop, p. 3.

³The South African History Archive (hereafter SAHA), NAMDA Collection, AL3182, F1.8, Meeting the Challenge of AIDS pamphlet, ANC Health Department, Lusaka, n. d.

By the time the Acquired Immunodeficiency Syndrome (AIDS) was officially recognised in South Africa in 1982 the African National Congress (ANC) had been banned for 22 years.⁴ While some ANC members still worked underground within South Africa, leaders were tasked with building the armed wing of the ANC, *Umkhonto we Sizwe* (MK), and establishing 'ANC missions' in other countries. By the 1980s, the ANC had missions and offices in over 30 countries (figure 9), MK training camps were operational, and settlements had been established.⁵ By the time of its unbanning in 1990, the ANC reported that there were 'more than 20 000 exiles' who needed to be reintegrated into South Africa.⁶

By 1990, AIDS-related deaths had occurred in ANC exile communities and AIDS was a topic of discussion throughout the organisation. As the ANC prepared to come out of exile and

⁴ The focus on the ANC in this chapter is not intended to downplay the role of other liberation movements and future research should include analyses of, for example, the PAC's response to AIDS. The ANC has been chosen as they were the organisation that led the post-1994 government and, as such, were primarily responsible for formulating and implementing post-1994 AIDS policies and responses.

⁵ The exile community's numbers had swelled after the Soweto uprising with the addition of the '1976 generation'.

⁶ According to Stapleton and Maamoe (the archivist of the ANC Archives at Fort Hare University) the ANC missions, offices and settlements were as follows: Algeria - Algiers Office; American Mission - Washington D.C. Office and New York Office; Angola -Luanda Office; Australasia and Pacific Mission - Sydney Office; Belgian Mission -Brussels Office; Botswana Mission - Gaborone Office; Canada Mission; Cuba Mission; Egypt - Cairo Office; French Mission - Paris Office; Ghana - Accra Office; India Mission - New Delhi Office; Italian Mission - Rome Office; Japan mission -Tokyo Office; Kenya Mission; Madagascar Mission; Mozambique Mission - Maputo Office; Namibia Mission - Windhoek Office; Netherlands Mission; Nigeria Mission; Norway Mission - Oslo Office; Russia Mission; Senegal Mission - Dakar Office; Sweden Mission; Tanzania - Morogoro, Mazimbu Settlement, Dakawa Settlement SOMAFCO (Solomon Mahlangu Freedom College), and Dar-es-Salaam Office; Uganda Mission; United Kingdom Mission - London Office; United Nations Observer Mission; Zambia Mission - Lusaka Office and Zimbabwe Mission - Harare Office. See Stapleton, T.J., & Maamoe, M., 'An Overview of the African National Congress Archives at the University of Fort Hare', *History in Africa*, 25, 1998, pp. 413-422. In the 'Declaration on Health and Welfare in Southern Africa' issued at the Maputo Health Conference on 15 April 1990 there is a section dealing specifically with returning exiles that reads: 'To address the urgent problem of the return to South Africa of more than 20 000 exiles, the conference endorses the formation of a National Reception Committee, through which the ANC together with other progressive mass-based organisations, can work out concrete measures for the rapid and effective integration of returnees into South African social, political and economic life.' The declaration was printed in *Critical Health*, no. 31/32, August 1990, p. 5. There has been debate about the numbers of exiles and MK members that have been complicated by the organisation's lack of comprehensive records for all sectors - secrecy sometimes being a necessity for, particularly, the armed wing of a liberation movement - see Barrell, H., "Conscripts to their Age: African National Congress Operational Strategy, 1976-1986", unpublished D.Phil thesis, St Antony's College, University of Oxford, 1993, available from SA History Online at: www.sahistory.org.za/pages/library-resources/thesis/barrel_thesis/index.htm (accessed May 2010), Morrow, S., 'Dakawa Development Centre: An African National Congress Settlement in Tanzania, 1982-1992', *African Affairs*, 97, 389, October 1998, and Lodge, T., 'State of Exile: The African National Congress of South Africa, 1976-86', *Third World Quarterly*, 9, 1, January 1987.

negotiate the political transition, the question of how to respond to AIDS, both within the movement and as a health issue more widely, was discussed but not always prioritised.



Fig. 9. Map showing the location of ANC missions, offices and settlements.⁷

AIDS was one health concern amongst many that the ANC had to address in exile communities, and it was one amongst many they had to address in South Africa after the 1994 election. Many of the principles relating to health care provision that were discussed in exile would guide health care policy in post-1994 South Africa. Similarly, health care professionals and progressive health care organisations with whom the ANC forged relationships while in exile would be important participants in devising and implementing the post-1994 national AIDS plan. Key members of the ANC's department of health (hereafter ADoH) would go on to hold senior positions in the health department of the ANC-led government. Examining how the ANC addressed AIDS in exile provides significant insights into the 'formative years' of the ANC's engagement with AIDS.

⁷ Made using Google maps.

The chapter highlights the main health care concerns identified by the ADoH and regional health teams and focuses on the organisation's responses to AIDS from 1980 until the ANC was unbanned in 1990. While there is, understandably, little information on AIDS and the ANC prior to the mid-1980s, the chapter draws on ANC archives to provide the source material for a reading of the responses to AIDS from the mid-1980s.

Exile and Health Care Provision

Raymond Suttner has shown that 'exile was a vast and complex phenomenon extending over three decades and embracing a variety of experiences' that shaped both individuals within the ANC, the development of the organisation, and its 'character' as a ruling party post-1994.⁸ Tom Lodge argues that the ANC as a political movement was 'strengthened by the experience' of exile,⁹ while Stephen Ellis' work critically examines the ANC's ideological and organisational development and its relationship with the South African Communist Party (SACP), and reveals the darker side of ANC abuses and torture in ANC camps.¹⁰ Providing insights that examine macro and micro levels of experience, Howard Barrell's thesis provides a review of the changing operational strategies of the ANC, while Seán Morrow documents life in Dakawa and associated settlements in Tanzania.¹¹ There is also a growing body of work that has begun to examine the gendered nature of exile and 'underground' experiences, revealing the contested engagements with notions of gender that occurred in the organisation. These discussions are the result of work by, amongst others, Jacklyn Cock, Natasha Erlank, Shireen Hassim, Sheila Meintjes, Suttner, Elaine Unterhalter, and Cheryl Walker.¹²

⁸ Suttner, R., 'Culture(s) of the African National Congress of South Africa: Imprint of Exile Experiences', *Journal of Contemporary African Studies*, 21, 2, May 2003, p. 307. For more on the evolution / metamorphosis of the ANC see Jordan, P., 'The African National Congress: From Illegality to the Corridors of Power', *Review of African Political Economy*, 31, 100, special edition 'Two Cheers? South African Democracy's First Decade', June 2004, pp. 203 - 212.

⁹ Lodge, 'State of Exile', p. 2.

¹⁰ See Ellis, S., 'The ANC in Exile', *African Affairs*, 90, 360, July 1991, and 'Mbokodo: Security in ANC Camps, 1961-1990', *African Affairs*, 93, 371, April 1994. ANC incidences of human rights abuse were also examined by South Africa's Truth and Reconciliation Commission (submissions to the TRC and the Commission's final report can be found on the Department of Justice website at www.justice.gov.za/trc (accessed September 2010).

¹¹ Barrell, 'Conscripts to their Age' and Morrow, 'Dakawa Development Centre'.

¹² See Cock, J., *Colonels & Cadres: War and Gender in South Africa* (Cape Town, Oxford University Press, 1991); Erlank, N., 'Gender and Masculinity in South African Nationalist Discourse, 1912-1950', *Feminist Studies*, 29, 3, 2003; Ginwala, F., 'Women and the African National Congress 1912-1943', *Agenda*, 8, 1990; Hassim, S.,

The experience of exile was mediated by place, time, generation, gender, role within the organisation, and location. Not only did comrades perform different functions, or experience changes in function, such as from being a student to undergoing training for MK missions and becoming a soldier, but different sites performed different primary functions. The head office of the organisation in exile was in Lusaka, while smaller offices and missions were in a host of countries from the UK to Japan. The majority of MK camps were in Angola, while the primary settlements were in Tanzania, where the Solomon Mahlangu Freedom College (SOMAFCO) provided primary and secondary education to students.¹³ Selected ANC comrades were sent to study at universities around the world (for example, in the UK, Cuba, Russia, Germany and the USA). The exile experiences of these comrades would have been very different from those who only stayed in settlements. In all these contexts there were physical, mental and emotional health needs that had to be addressed.¹⁴

Suttner observed that

While not formally constituted as a government, the ANC in exile exercised many of the functions of a state in relation to its members. In many ways, the relationship between the national executive committee and membership had characteristics of dependency rather than active membership. To carry out

'Nationalism, Feminism and Autonomy: The ANC in Exile and the Question of Women', *Journal of Southern African Studies*, 30, 3, September 2004; Lyons, T., & Israel, M., 'Women, Resistance and the Armed Struggle in Southern Africa', *African Studies Association of Australasia and the Pacific: Review and Newsletter*, 21, 1999; Meintjies, S., 'The Women's Struggle for Equality During South Africa's Transition to Democracy', *Transformation*, 30, 1996; Sitas, A., 'The Making of the "Comrades" Movement in Natal, 1985-1991', *Journal of Southern African Studies*, 18, 3, September, 1992; Suttner, R., 'Women in the ANC-led Underground' in Gasa, N. (ed), *Women in South African History* (Cape Town, HSRC Press, 2007); Suttner, R., 'Masculinities in the African National Congress-led Liberation movement', *Kleio*, 37, 1, 2005; Unterhalter, E., 'The Work of the Nation: Heroic Masculinity in South African Autobiographical Writing of the Anti-Apartheid Struggle', *The European Journal of Development Research*, 12, 2, 2000; Walker, C., *Women and Resistance in South Africa* (Cape Town, David Philip, 1991); and Wells, J., *We Have Done with Pleading: The Women's 1913 Anti-Pass Campaign* (Johannesburg, Ravan Press, 1991).

¹³ Morrow recounts the growth of SOMAFCO on the site of an abandoned sisal estate given to the ANC by the Tanzanian government: 'Beginning with this collection of tumbledown estate houses and overgrown land the ANC, with the help of foreign donors and the support of the government, created a large educational institution named after one of the martyrs of the freedom struggle, as well as institutions such as a large farm, a hospital, primary and nursery schools, cultural and sports facilities, a furniture factory and extensive housing. The complex ultimately had a population of around 3,500 South Africans, as well as employing many Tanzanians from neighbouring communities'. Morrow, 'Dakawa Development Centre', p. 499.

¹⁴ Morrow refers to problems with malaria, crime, alcohol and drug abuse, and violence (Morrow, 'Dakawa Development Centre', pp. 500 & 509) and Ellis refers to MK soldiers being 'bottled up' in Angolan camps and affected by the insufficient food supplies, boredom, frustration and brutality of the camp regime (Ellis, 'The ANC in Exile', p. 445).

extensive welfare, military, educational, political and other tasks, an extensive bureaucracy was developed.¹⁵

One of its state-like functions was the provision of health care. After initially making use of local health care facilities, the ADoH was established in 1977 and formed part of the 'extensive bureaucracy' of the ANC.¹⁶ The ideologies that guided the provision of health care were influenced both by the organisation's founding principles, as declared in the Freedom Charter, and by the ANC's involvement in, and relationships with, international health care networks that were increasingly prioritising primary health care.¹⁷

The progressive public health care narratives evident in ADoH documents, such as the 1986 Basic Health Policy Guidelines (see Appendix B), reveal the ideological foundations of the organisation's ideas about health care.¹⁸ These are also revealed in articles that pondered what could be learnt from health care provision in Russia, and documents that discussed health care provision in apartheid South Africa and presented plans for what an ideal post-apartheid health care system would look like.¹⁹ In addition, the ADoH developed important relationships with progressive, democratic health organisations and progressive health care professionals in South Africa (see Appendix C).²⁰

¹⁵ Suttner, 'Culture(s) of the African National Congress', p. 313.

¹⁶ Note that the ADoH was also referred to as the Health Department or Health Secretariat. Prior to the establishment of the Health Department 'health care was delivered on an ad-hoc basis, utilising the local health facilities and also the health personnel, mainly medical auxiliaries, who had been trained since 1960' – see 'Interview: ANC Health Department', *Critical Health*, 31/32, August 1990, p. 55.

¹⁷ The Freedom Charter declaring the hopes and ambitions for a democratic, socially just South Africa was accepted by the Congress of the People at Kliptown on 26 June 1955. Under the declaration that 'There Shall be Houses, Security and Comfort!' the Charter noted the following in relation to health care:

A preventive health scheme shall be run by the state;

Free medical care and hospitalisation shall be provided for all, with special care for mothers and young children;

The aged, the orphans, the disabled and the sick shall be cared for by the state.

The text of the full charter is available on the African National Congress Website at www.anc.org.za/show.php?id=72 (accessed January 2012).

¹⁸ UFH-AA, ALM, pt.2, 20, 2, African National Congress Basic Health Policy Guidelines, 18 August 1986, pp. 1 - 3.

¹⁹ See for example, Mayekiso, B., 'The Revolutionary Road to Health - Some Lessons from the Soviet Union', *The African Communist - Journal of the South African Communist Party*, 116, First Quarter, 1989, available on Digital Innovation South Africa (DISA) website at www.disa.ukzn.ac.za:8080/index.php?option=com_displaydc&recordID=Acn11689 (accessed February 2012); and the papers presented at the Maputo Conference in 1990 – see *Critical Health*, 31/32, August 1990 for papers on numerous aspects of a national health system.

²⁰ In 1990 Ralph Mjijima acknowledged the role of medical professionals in preparing for a post-apartheid South Africa, noting: 'In the health sector at home, health workers are now affirmative in their demands for better health care; they are debating the type of health care system needed for a democratic SA; they are

These ideological foundations and relationships resulted in a focus on primary health care, and a national health service that would provide equal access to health care to all. Approaches to public health care, particularly ideas about primary health care, that would form the foundation of the ANC government's health policy post-1994, can be seen evolving during the ANC's exile, both in broader discussions about public health care provision and with specific reference to AIDS. International collaboration, and co-operation with progressive health care organisations in South Africa, influenced the types of AIDS programmes implemented in exile and drew on the knowledge and expertise of a range of 'front-line' AIDS researchers and activists. Leading AIDS health care professionals who worked closely with the ANC in exile, such as Quarraisha and Salim Abdool Karim, Mary Crewe, and Hoosen Jerry Coovadia, were central in discussing and drawing up South Africa's first AIDS policy post-1994. Key figures in the ADoH, particularly Manto Tshabalala-Msimang, would become powerful figures in the Department of Health post-1994 – often with disastrous implications for AIDS programmes.

The following section provides an overview of the structure and functions of the ADoH and highlights some of the problems that beset it. The ADoH identified its key functions as providing basic curative services, dental services, mental health services, preventative and health education services, and maternal and child health services, which were further divided into antenatal, deliveries, under-five clinic, family planning and immunization. In addition, the ADoH referred patients to hospitals if further treatment was required.²¹ Summarising its activities to funders, the ADoH stated that it was 'involved in the ongoing endeavour to render health services to all South Africans in exile as well as the neighbouring communities where they are settled in the frontline states'.²² In 1990 the ADoH identified that its objectives had been to

looking into problems facing health workers themselves; and they are developing social programmes for the unemployed.' UFH-AA, ALM, p2a, 33, 2, Minutes: Health Secretariat Meeting with the NPA, Lusaka, 14 March, 1990, p. 1.

²¹ UFH-AA, ALM, p2a, 41, 63, ANC Department of Health Project Proposal, c. 1987, pp. 1 - 2. Note that sections of this chapter have been published as part of an article. See Tsampiras, C., 'Sex in a Time of Exile: An Examination of Sexual Health, AIDS, Gender, and the ANC, 1980 – 1990', *South African Historical Journal*, 64, 3, 2012 (currently only available online).

²² UFH-AA, ALM, p2a, 41, 63, ANC Department of Health Project Proposal, p. 3 (emphasis in the original).

deliver care to our communities; disseminate information on the effects of apartheid on health and in so doing, further isolate South Africa; mobilise material and moral aid for the ANC; train health personnel for the ANC; arrange for training opportunities for ANC cadres; and engage in an analysis of the political economy of health, looking at broader issues, including the determinants of health.²³

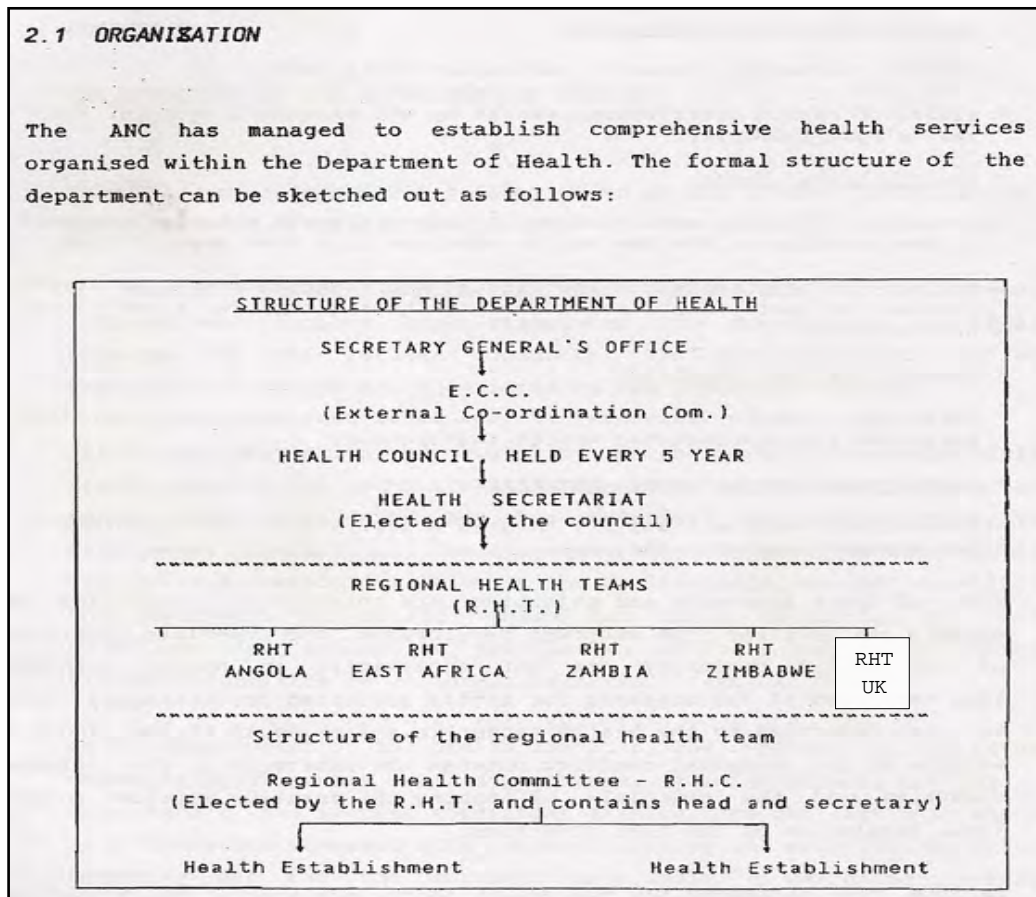


Fig. 10. Structure of the ANC Department of Health with the UK RHT added by author.²⁴

A Health Secretariat reported to the National Executive Committee (NEC) of the ANC and communicated regularly with the Secretary General of the ANC, Alfred Nzo, but had no representation on the NEC. The Secretariat was responsible for the work of the ADoH overall, and for monitoring and directing the work of five Regional Health Teams (RHTs), namely Angola, East Africa, the UK, Zambia, and Zimbabwe (figure 10). The Secretariat had to deal with the particular concerns of each clinic or health care centre in each region, and

²³ 'Interview: ANC', p. 55.

²⁴ Hippe, J.M., & Pedersen, A.W., *Health Care in an Exile Community – Report on health planning in the ANC*, The Norwegian Trade Union Research Centre, 1987.

with the complexities of planning, financing and implementing appropriate health provision for the exile community.

The archives reveal an often strained relationship between the ADoH and the RHTs, and internal conflicts between members of the Secretariat. One of the key areas of contention was the lack of communication between the ADoH and the RHTs.²⁵ In 1982 and again in 1987 the situation within the ADoH had generated sufficient concern for there to be a special meeting with the NEC to 'address the current problems and tensions in the department'.²⁶ Among the problems was the controversy around the behaviour of a key figure in the ADoH, Dr Manto Tshabalala who, among other things, alienated the vast majority of Secretariat members and allegedly failed to account for a significant sum of money intended to secure medical treatment for an ill comrade.²⁷

²⁵ UFH-AA, ALM, p2a, 42, 89, 'Reorganising for a Healthier Revolutionary Movement', Report of ANC Health Department Seminar, 1987, p. 3.

²⁶ See for example UFH-AA, ALM, p2a, 42, 89 Report of Regional Health Team UK, October 1987, p. 3.

²⁷ Tshabalala (later Tshabalala-Msimang) would go on to become the South African Minister of Health from 1999 to 2008 during Thabo Mbeki's presidency, and continued to cause controversy because of her denialist stance on AIDS. A selection of documents dating from March 1982 to September 1989 are concerned with allegations against Tshabalala-Msimang and investigations into alleged misconduct. The documents include correspondence relating to requests to Tshabalala-Msimang to account for an amount of 10 000 Tanzanian Shillings (see UFH-AA, ALM, 160, 1, correspondence from Doodles Gaboo, Regional Treasurer, to M. Tshabalala, Secretary for Health, 26 March 1982; UFH-AA, ALM, 160, 1, correspondence from Manto Tshabalala to Doodles, 23 March 1983; and UFH-AA, ALM, 160, 1, correspondence from Connie to the Treasury Department, 20 March 1982) and additional correspondence relating to the allegation in which a team member asserted that the only thing Tshabalala had 'contributed to the struggle is confusion, nothing more but confusion right through' (UFH-AA, ALM, 160,1, correspondence from Sipho Mthembu to ANC Secretary General and others, 31 May 1982). There also appears to have been significant disagreements between Tshabalala and Regina Nzo, the Regional Health Team chair person, which affected the functioning of the RHTs (UFH-AA, ALM, 160, 1, correspondence from R.V. Nzo to M. Tshabalala, 6 September 1982). In 1983 there was a 'National Commission of Enquiry into East African Health Team' established to investigate the situation in the East Africa RHT and the claims made against Tshabalala. Correspondence indicates that she failed to respond to formal requests to appear before the commission (UFH-AA, ALM, 160, 1, correspondence from Rica Hodgson to Alfred Nzo, 14 March 1983). After Regina Nzo resigned from the health department there was a commission of enquiry into her resignation that included claims relating to Tshabalala (UFH-AA, ALM, 105, 45, Joint Commission of Enquiry – Chief Representative's Office and the SOMAFSCO Directorate East Africa – on the Resignation of Comrade Regina Nzo from the Health Team of the African National Congress, 4 December 1983). The document from the commission indicates that Tshabalala was accused of not co-operating, not working to a time-table, flouting decisions made by the RHT, circumventing procedures, failing to report back to the team, not informing the RHT of courses and projects that she initiated, failing to consult with the RHT, failing to complete 'anything', not brooking any criticism, and being 'a liar – she says different thing to different people'. The situation between Nzo and Tshabalala was said to be causing 'splits' in the RHT which hampered its work. Tshabalala was also accused of removing drugs from the drug store without permission and only being interested in a few patients that she knew and not in the overall health of all the patients in the region. In April 1984, doctors stationed in Lusaka wrote to the Secretary General of the ANC expressing a lack of confidence in Tshabalala. The letter claimed that she was 'working at variance with the rest of the team', had not established a viable department, left no records or administrative files and did not communicate nor consult with other doctors

The highest decision-making body in the ADoH was the Health Council which met approximately every five years and elected the Health Secretariat.²⁸ Its meetings provided opportunities to reflect on the functioning of the ADoH and were the fora in which plans and health care priorities for the next five years were discussed.

At the Third ANC Health Council held in July 1986 the Health Secretariat reported on the successes and failures of the ADoH over the preceding five years. There were also a number of commissions on specific topics relevant to health care provision and the structure of the ADoH. The topics ranged from the structure and job descriptions of the Health Secretariat, to drafting an integrated ANC health policy and mobilising around health care. There were also a number of 'scientific papers' on the main health concerns facing the organisation.²⁹ The opening address at this Health Council was given by a member of the ANC NEC, indicating high-level ANC support for the Council, while the final report on the meeting indicates consensual decision-making processes and active participation from delegates.. The reports from the RHTs given at the Council revealed the differences in health care provision and health care responsibilities across the regions.

The largest ANC settlements were in Tanzania, and the East Africa RHT was responsible for the running and management of the hospital and health centres that served the exile communities, particularly those at the Mazimbu and Dakawa settlements with the associated SOMAFCO and Dakawa Development Centre, respectively (see figure 11). The Angolan RHT's remit included providing the health needs of the various *Umkhonto we Sizwe* (MK) training camps in Angola, while the Zambian RHT was responsible, among other things,

(UFH-AA, ALM, 105, 45, correspondence Lusaka Doctors to the Secretary General, 2 April 1984). In 1987 Tshabalala was suspended from the Health Secretariat and the ADOH as a whole (UFH-AA, ALM, p2a, 6, 8a, correspondence from Zakes Mokoena, Deputy Secretary for Health to All Departments, 20 September 1987 and UFH-AA, ALM, p2a, 33, 1 correspondence from Zakes Mokoena to James Stuart, Secretary ECC, 20 September 1987). The reasons for her suspension were listed in a two-and-a-half page document - that she repeatedly flouted collective decision making, displayed a serious lack of accountability, flouted working practices, failed to carry out assigned tasks, failed to attend meetings and was so disruptive to the ADoH that 'all members of the Secretariat based in Lusaka, [had] at one time or another threatened to resign because of cde Manto's conduct' (correspondence to Stuart, p. 2). Tshabalala's suspension was declared null and void by the NEC of the ANC in August 1989 (UFH-AA, ALM, p2a, 9, 30, correspondence Ralph Mgijima, Secretary for Health, to Heads of all RHT, 31 August 1989) despite opposition from various ADoH members (UFH-AA, ALM, p2a, 9, 30, correspondence Naicker, Nkobi and Mokoena to ANC HQ, 8 September 1989).

²⁸ All health care workers were eligible to participate in the Health Council.

²⁹ UFH-AA, ALM, 127, 236, Draft Health Secretariat Report to the 3rd Health Council Meeting, 29 July 1986 and reports from the commissions.

for a clinic and what were referred to as ‘three outlying health posts’.³⁰ The role of the Zimbabwe RHT appears to have been fairly minimal and predominantly concerned with facilitating patient transfers from other areas to Zimbabwe health centres.³¹ The UK RHT based in London did not provide health care directly, but, as will be shown below, played a unique role centred on its capacity to access health information and expertise, and to facilitate meetings and discussions with a variety of important health care professionals.

The experiences and responsibilities of, and resources available to, each of the RHTs varied considerably; this affected their capacity and ability to provide basic health care, and had an impact on the provision of AIDS education, and the provision of medical and social support to Human Immunodeficiency Virus (HIV) positive comrades or comrades in advanced stages of AIDS. The regional complexities were exacerbated because the health needs of the entire organisation were met by only ‘50 health personnel on a free and voluntary basis’.³²



Fig. 11. Front cover of 1982 / 1983 Progress Report and extract on health care.³³

³⁰ ANC Department of Health Project Proposal, c. 1987, p. 3.

³¹ UFH-AA, ALM, p2a, 42, 89, ‘Reorganising for a Healthier Revolutionary Movement’, p. 5.

³² UFH-AA, ALM, p2a, 41, 63, ANC ... Health Project Proposal, p. 3.

³³ International Institute of Social History (hereafter IISH), the Netherlands, BRO 833/10 Fol, Solomon Mahlangu Freedom College, Mazimbu & ANC Development Centre, Dakawa – ANC Progress Report 1982/1983.

Health Care Concerns in Exile

RHTs were perpetually understaffed and under-resourced, and those directly providing health care frequently complained about a lack of training for staff, an inadequate and irregular supply of medication, and insufficient basic and specialised medical equipment, including hypodermics and sterilizing equipment.³⁴

Jon Hippe and Axel Pedersen of the Norwegian Trade Union Research Centre wrote a report on health planning practices in the ANC in 1987 which notes the effect of 'poor working conditions' on the ADoH's ability to perform its functions and successfully monitor the regions.³⁵ The conditions under which the Secretariat had to operate were typical. Its six members had to share two small offices and one old typewriter and lacked basic office equipment like telephones, photocopy machines or filing cabinets. There was insufficient space to hold meetings, and ongoing transport problems made it difficult for ADoH members and patients to move between regions or even within regions. Health care workers were under additional strain due to other informal duties they were expected to perform.³⁶ These personnel and infrastructural limitations meant that there was no formal accounting system and little forward planning which often resulted in irregular drug supply and a shortage of health professionals.³⁷

Health care workers had to adapt to their regional contexts and provide medical care for a variety of health concerns.³⁸ These ranged from illnesses such as malaria, TB, and hypertension, to concerns such as child malnutrition, unwanted pregnancies and sexually transmitted infections (STIs). Drug and alcohol addiction also featured, as did other mental

³⁴ See Hippe & Pedersen, *Health Care in an Exile Community*, p. 33. The lack of hypodermic syringes, or the inability to sterilize needles before reusing them, could also have had implications for the spread of infections, including HIV.

³⁵ *Ibid.*, p. 10.

³⁶ *Ibid.*

³⁷ *Ibid.*, pp. 11 - 15.

³⁸ Hippe & Pedersen noted: 'In the development of health services, the interests of the refugee community is of course a primary concern. It is important, however, to understand the special conditions arising from the fact that the ANC is a liberation movement with responsibilities not only for the refugee community but for the movement as a whole ...'. They went on to observe that the ANC had 'to take into consideration a wide range of objectives and interests towards ... the refugee community ..., South Africa ..., host countries ..., and the international community,' pp. 6 - 7.

health issues resulting from the trauma caused by the violence, torture, and warfare that characterised the struggle against apartheid. The discussions about STIs and unwanted pregnancies are particularly relevant because they provide insight into the existing understandings and management of sexual health and other STIs prior to AIDS.

The report from the Health Secretariat, delivered to the Third ANC Health Council in July 1986, provided an overview of concerns identified by the ADoH between 1983 and 1986.³⁹ A section in the report identified malaria as the number one disease concern. There were ‘unquantifiable reports on the increase of Pulmonary Tuberculosis’, and high incidences of ‘bronchitis, asthma, ear, nose and throat infections, skin diseases, dental caries [sic] and eye-sight problems.’⁴⁰ The report contained one of the earliest references to AIDS: ‘sexually transmitted diseases, others complicating [sic] in pelvic infections and infertility continue to pose a big problem also. Lately there have been reported cases of AIDS’.⁴¹ AIDS and other STIs also featured in scientific papers presented to the Health Council.⁴²

AIDS and other STIs were, however, not the only health concerns directly related to sex that featured at the Health Council; nor were health concerns related to sex only discussed in the fora of Health Councils. Pregnancies, contraception, and STIs (with a growing focus on AIDS) regularly featured in reports, correspondence, minutes and other documents generated at all levels of the organisation from health care workers staffing clinics, to RHT members, to members of the Health Secretariat and the ANC’s NEC.⁴³

³⁹ UFH-AA, ALM, 127, 236, Draft Health Secretariat Report to the 3rd Health Council Meeting, 29 July 1986, p. 4. The report on the work done by the Health Secretariat was presented to the meeting by Peter Mfelang, then Secretary for Health of the ANC.

⁴⁰ *Ibid.*, p. 4.

⁴¹ *Ibid.*

⁴² One session of the Third Health Council was dedicated to ‘Scientific Papers’ covering the topics of AIDS, malaria, diarrhoea, and ‘The Spread of Communicable Diseases – Especially TB and STDs’. See UFH-AA, ALM, 127, 236, List of Documents, p. 1. The actual scientific paper on AIDS was not present in this file.

⁴³ For more on this see Tsampiras, ‘Sex in a Time of Exile’. Examining how pregnancies, contraceptives and STIs were discussed throughout the organisation allows for the exploration of aspects of the complexities of sex in exile and the associated links to AIDS and sexual practices. The article reveals the gendered and generational nature of the sexual landscape in exile, and that responsibility for contraception and resultant pregnancies fell primarily on womyn comrades. It shows too that certain male sexualities and sexual practices – namely those associated with heterosexual men who did not favour the use of condoms – were acknowledged, but not seriously discussed or challenged. RHT reports also show that factors such as the geographic location of ANC members, and whether they lived in settlements or as part of local communities, influenced the choice of sexual partners and the types of relationships that were formed. All of these factors link together to provide a

One scientific paper presented at the Third Health Council in 1986 shows that there was a close association between STIs and social stigma amongst comrades. The paper by Dr Hager Macberry (the MK name of Dr Davidson Masuku) covered both STIs and TB and identified areas of concern in connection with the transmission and prevention of STIs generally. With hindsight these concerns provide insights into factors that could have facilitated the spread of HIV specifically. In the introduction the paper noted that ‘... on a global scale the most talked about STD’s are still syphilis and gonorrhoea, and now AIDS has been added to the list.’⁴⁴ Macberry observed that social stigma and shame about STIs was prevalent among comrades and prevented them from seeking treatment.⁴⁵ While observing a reported rise in STIs in some ANC ‘establishments’ and highlighting the importance of tracing sexual contacts to prevent further infections, the paper did not apportion blame or evoke avatars to be blamed for transmitting infection. Instead STIs were addressed practically and presented as a shared ‘public health concern’ for all ANC comrades.

Macberry noted that for each index case presenting for treatment there were usually two more people affected - ‘the person who infected the patient and the person who infected the contact’ - but observed that ‘it is usually more complicated than this, so that by the time the index patient has sought medical care he or she may have had intercourse with a further individual. Mark you the ratio of male to female in some of our establishments is 15:1 or even 20’.⁴⁶

The specific reference to sex ratios in settlements opens up a number of areas of speculation about sexual practices. Taken in conjunction with the statement about the more ‘complicated nature’ of infection rates it could indicate that for heterosexual intercourse womyn had a large pool of men to choose from as monogamous partners. The other alternatives it suggests are that sexually active heterosexual womyn would have been ‘in

backdrop against which to consider responses to AIDS by the ANC, and understand factors relating to HIV transmission.

⁴⁴ Macberry, H., ‘The Spread of Communicable Diseases Amongst Our Communities in Exile, in Particular TB and STDs’, UFH-AA, ALM, 127, 236, Paper to the 3rd Health Council Meeting, 29 July 1986, p. 1. Davidson Masuku was the Regional Medical Officer in Angola from 1980 - 1983 and acted as Surgeon-General in South Africa from 1997 - 2000. Note: ‘STIs’ is the preferred term used by the author, but both ‘STDs’ and ‘STIs’ are used when quoting from sources.

⁴⁵ *Ibid.*

⁴⁶ *Ibid.*

high demand', and, depending on the sexual pressures and inequalities prevalent at the time, could have chosen or been coerced into having numerous male partners. Or it may suggest that sexually active men were engaging, where possible, in sexual relationships with non-ANC womyn such as those resident in surrounding areas. Finally it could indicate that there may have been male 'homosexual' or male-to-male sexual activity.

Unlike the narratives of sexual immorality that appeared in South African government statements and certain medical circles, the paper's tone was frank but not condemnatory and reflects more honestly the complexity of sexual activity. Similarly the processes identified for case management, treatment, prevention of re-infection, and control of new infections was in line with international protocols of the time which still form the basis of more contemporary STI management.⁴⁷

The paper is also important because it identified reasons why STI management was difficult. It that, apart from the feelings of shame preventing people from coming forward for diagnosis, lack of knowledge about STIs was a problem and that 'despite sexual freedom there [was] still a great [deal] of ignorance and misunderstanding of the possible health sequelae' of STIs.⁴⁸ The paper also referred to the difficulty of ensuring patients followed lifestyle changes - such as refraining from sexual intercourse or drinking - while undergoing treatment and commented on male opposition to safer sex options.. The paper noted: 'preventive measures such as the use of condoms etc. as partial barriers to infection are advised (although we do get a bit of resistance from the male comrades – because according to them there is no proper contact) ...'⁴⁹

The paper speculated on the way forward:

In the absence of effective vaccines that could help to prevent STDs there is a need everywhere in our establishments to increase community awareness of the

⁴⁷ See for example *The Public Health Approach to STD Control*, UNAIDS Technical Update, May 1998, at http://whqlibdoc.who.int/unaid/1998/a62393_eng.pdf, and UNAIDS, *Sexually Transmitted Diseases: Policies and Principles for Prevention and Care*, UNAIDS Best Practice Collection, 1999, World Health Organisation (WHO) website at http://whqlibdoc.who.int/unaid/1997/UNAIDS_97.6.pdf (accessed 18 May 2010).

⁴⁸ Macberry, 'The Spread of Communicable Diseases', p. 1.

⁴⁹ *Ibid.*, p. 2.

problem through information and long-term health education programmes, and aiming at changing people's health and illness behaviour. Some people have recognised that there is resistance in healthy individuals to information about the risk of STDs.

In the end, successful control of this group of infectious diseases will depend as much on advances in the clinical field as on an increased sense of responsibility amongst our community ...

There is no complacency and there can be no truce with ... STDs.⁵⁰

The belief that education and knowledge would provide the foundation of transmission prevention echoes much of the early thinking about HIV programmes and, as with those early programmes, appeared to assume that agency and choice were equitably accessible to all members of a community and not influenced by gender, sexual orientation, class (or economic means) or race. Similarly, an observation about resistance from healthy individuals to STI information reflects responses in which individuals seek to separate themselves from the likelihood of infection and the 'others' who are ill, either as a form of self-protection or denial, or because of a genuine belief in their invincibility. The reference to individual responsibility has remained a consistent aspect of AIDS prevention programmes, but again assumes a particularly empowered position from which responsibility can be taken that does not always reflect the realities of how sexual relations are constituted. The role of a particular type of male sexuality, or at least the type of sex practices that certain men considered appropriate (flesh-on-flesh, unprotected, penetrative sex), in STI transmission was mentioned, but not fully explored. Finally, the military language evoking ideas of a war against STIs has been an oft-used metaphor for diseases (and particularly for AIDS) and, perhaps too, was appropriate for the meeting of a banned movement engaged in an armed struggle.⁵¹

⁵⁰ Macberry, 'The Spread of Communicable Diseases', pp. 2 - 3.

⁵¹ See for example Treichler, P., 'AIDS, Homophobia and Biomedical Discourse: An Epidemic of Signification', *October*, 43, 1987, and Connelly, M., "Rumours of War: De-constructing Media Discourses of HIV/AIDS in South Africa", Rhodes University MA Thesis, 2002.

Hippe and Pedersen's report highlighted the problem of STIs while solidarity organisations offered assistance with addressing them.⁵² Gunilla, a volunteer with the ADoH from the Africa Groups of Sweden Recruitment Organisation (ARO), was sent to facilitate the training of ANC health personnel to run STI workshops.⁵³ Gunilla's major concern was that ANC health care workers themselves needed more education before undertaking education campaigns as they lacked basic information about STIs and about how to run education programmes. It appeared that health care workers believed that their efforts did not enjoy the support of all leaders in the organisation. Mirjam Dahlgren, from the ARO, made the point:

it seems that many leaders are not aware of the serious situation with the very dangerous complications of the STDs and therefore not motivated enough to start up with information campagne [sic] about the prevention of the STDs. And if the health educators don't feel that the leaders are with them they will never have the courage to start up, and the communities will suffer too much with the complications of these diseases.⁵⁴

In a rare insight into what ANC members on the ground wanted, Dahlgren reported that Gunilla had

... received many inofficial [sic] visits from various people in Tanzania, mostly men, which asked about "when will the campagne [sic] start, we need it very much etc".... People want to know so they may protect themselves from transmission and also from no-planned and no-wanted pregnancies.⁵⁵

⁵² Hippe & Pedersen, *Health Care in an Exile Community*, p. 4.

⁵³ For a brief overview of ARO see the Michigan State University African Activist Archive listing at: <http://africanactivist.msu.edu/organization.php?name=Africa+Groups'+Recruitment+Organisation> which notes that the '*Afrikagruppernas Rekryteringsorganisation* was founded in 1978 to recruit volunteers to work as health care personnel, teachers and administrators in newly independent Angola, Cape Verde, Guinea-Bissau and Mozambique and ... to take care of the volunteer activities and aid for Southern Africa. ARO sent most volunteers to Mozambique but also to Namibia, Angola, Cape Verde, Guinea-Bissau, Zimbabwe and to the ANC's freedom college, SOMAFKO, in Tanzania, and SWAPO's refugee camp, Kwanza Sul, in Angola. Volunteers were mainly involved in health care and education. ARO was also engaged in emergency aid, mainly concerning health care in Mozambique. From 1982, ARO also dealt with support for different projects, financed mainly by the Swedish International Development Authority (SIDA), a government aid agency, and ARO's own fundraising. When apartheid ended and Namibia became independent, ARO's main task became to support the reconstruction of South Africa and Namibia. As a consequence, the activities of ARO and the Africa Groups of Sweden became similar, and the organizations merged in 1992 under the name the Africa Groups of Sweden (*Afrikagrupperna*)'. Information on its current activities can be found on the *Afrikagrupperna* website at: www.afrikagrupperna.se/english (both accessed February 2012).

⁵⁴ UFH-AA, ALM, pt. 2 ad, 6, 9, correspondence, Mirjam Dahlgren to Ralph Mjijima, 4 July 1989, p. 1.

⁵⁵ *Ibid.*

Dahlgren's and Gunilla's concerns mirror RHT concerns about staff training, and the shortcomings of the organisation's leadership in not recognising the significant health implications of STIs and not fully supporting anti-STI programmes.⁵⁶ There was seemingly a disjuncture between the concerns prioritised by comrades and those prioritised by the leadership.

Discussions about STIs, contraception and unwanted pregnancies indicate that unprotected sex was occurring amongst ANC members and was a cause of concern for various health care workers in the ANC. But what of the 'new' STI called AIDS and HIV infections? How did the ADoH, health care workers, and the organisation as a whole respond to AIDS?

Responses to AIDS by the ANC

AIDS was mentioned in the ADoH's report to the Third ANC Health Council in July 1986 and was the subject of one of the scientific papers presented to the Council. The lack of an archive copy of the AIDS paper means that it is not possible to examine the narrative of this paper closely, but the minutes of the session provide some insights into the contents of the paper which was written and delivered by Dr John Sachs, the chair of the London-based UK RHT.⁵⁷

In line with hegemonic AIDS narratives of the time the paper appears to have included the standard epidemiological narrative of the differences between AIDS in 'Europe' spread by homosexual sex, and AIDS in 'Africa' transmitted via heterosexual interactions.⁵⁸ Sachs stressed the lack of any available treatment, the importance of health education to prevent further infections, and the importance of screening blood donations.⁵⁹

⁵⁶ See for example UFH-AA, ALM, p2a, 42, 89, 'Reorganising for a Healthier Revolutionary Movement' regional reports.

⁵⁷ Dr 'Johnny' Sachs would become a leading immunologist with a life-long interest in AIDS research and was one of the prominent South African AIDS researchers excluded from President Mbeki's international AIDS panel. Sachs had been outspoken in challenging Mbeki's questioning of the link between HIV and AIDS.

⁵⁸ UFH-AA, ALM, 161, 3C, 'Plenary Session – Discussion of Scientific Papers', 29 July 1986, p. 2.

⁵⁹ As a striking reminder of how much was still to be learnt about AIDS at this time, and how little was known about infection rates in a variety of communities, the minutes report that 'In reply to a question, he [Dr Sachs] said insects were not believed to spread the disease, since children under 15 do not contract it', ALM, 161, 3C, 'Plenary Session', p. 2.

At a plenary session Dr Bob Mayekiso suggested that 'TB, STDs and malaria be added to the subject of AIDS in our first health education campaign'.⁶⁰ The scientific papers and Mayekiso's suggestion indicates that AIDS was not only discussed at the Council but also considered important enough to be the topic of an education campaign.

While the 1986 Health Council marked an official, organisation-wide acknowledgement of the growing importance of AIDS, this official acknowledgement needed to be translated into practical responses and programmes and these were subject to the multitude of pressures inherent in an exiled organisation with limited resources, and with camps, settlements and offices in different regions.

There was increased organisational activity, at a variety of levels, around AIDS during 1987: a meeting between the NEC and the ADoH that generated directives about AIDS; the production of AIDS information pamphlets; an analysis of STIs and AIDS in three regions in Hippe and Pederson's 1987 report; and the ADoH reporting back to the NEC about their progress in addressing AIDS. The information provided about AIDS and the attention it received in RHT reports varied between regions. Access to information and ADoH programmes and campaigns was not the same across all regions or levels of the organisation.

In February 1987 the ANC NEC called a meeting with the Health Secretariat to inform them of a series of decisions taken by the NEC regarding the work of the ADoH. The minutes of the meeting declared that 'the rate of incidence of affected comrades with AIDS in our communities is alarming'. The NEC tasked the ADoH with 'screening our communities in exile, carrying out a massive education campaign [and] discussing the future of identified cases'.⁶¹

The minutes of a meeting between the ADoH and clinic staff from the Zambian RHT in April 1987 reveal efforts by the ADoH to brief regional teams about the NEC directives, and

⁶⁰ ALM, 161, 3C, 'Plenary Session', p. 3.

⁶¹ UFH-AA, ALM, p2a, 41, 69, Report on the Meeting of the NEC on the State of Organisation of the Department, 19 February 1987.

subsequent decisions taken by the ADoH on how to implement them. The authority of the NEC was evoked, perhaps to add gravitas: 'The meeting noted the seriousness with which the NEC regards this illness in terms of both its medical and political implications in our struggle'.⁶² The global nature of AIDS and the lack of a cure, or likelihood of a cure, were emphasised before the meeting was informed that 'Members in our communities are known to be suffering from the disease and two have died from complications of the illness'.⁶³ It is unclear if the two deaths referred only to the Zambian region or to all ANC communities, but the known number of comrades with AIDS was certainly higher.⁶⁴

The Zambian RHT was given an overview of the 'programme of action for the prevention and control of the spread of AIDS within our communities' adopted by the ADoH.⁶⁵ The programme of action would be 'an extensive ... health education campaign to cover all our settlements, a selective screening programme of high-risk comrades, a management programme which [would] offer counselling and medical support to affected comrades' and the establishment of a regional AIDS registry.⁶⁶

The call for a registry shows that the NEC and ADoH realised the necessity of obtaining basic epidemiological data to inform the organisation's responses. In the meeting with the Zambian RHT the ADoH emphasised that for both the collection of data and the broader education campaigns to be successful, the RHTs would have a 'vital' role to play and noted that the regional teams '[formed] the link between effective and on-going dissemination of information on AIDS to the community and comradely support for the community'.⁶⁷ To achieve either of these goals two major issues were identified as being 'essential' but

⁶² UFH-AA, ALM, p2a, 33, 1, Meeting of the Health Secretariat with the Clinic Staff of the Zambia Regional Health Team, 24 April 1987, p. 3.

⁶³ *Ibid.*

⁶⁴ See UFH-AA, ALM, p2a, 33, 5, Minutes Meeting 3, Emmasdale Clinic Meetings, 11 November 1986. Another clinic report for c. 1987 lists the number of known HIV cases as '5 (1 female and 2 males [sic])' – possibly indicating an additional three new infections and two previous infections. There is also an interesting reference in the 'Special Cases' section indicating 'Other known cases of HTLV III +' and listing Grace Meehlo, a 25 year old womyn due to give birth as being HTLV III positive along with five 'other cases – all Males.' The report notes the patient's files were at University Teaching Hospital and that 'Dr. Shabalala [sic] is in contact with the specialist in-charge.' HTLV-III was one of the two disputed early names for what would be named HIV. See UFH-AA, ALM p2a, 41, 70, Clinic Report for Quarter Ending Dec. '86 for meeting held 1st – 5th April 1987.

⁶⁵ UFH-AA, ALM, p2a, 33, 1, Meeting of the Health Secretariat with the Clinic Staff, p. 3.

⁶⁶ *Ibid.*

⁶⁷ *Ibid.*

‘strongly lacking’ amongst the health teams. Firstly, patient confidentiality was not sufficiently maintained and there was little ‘sympathetic and understanding attitude towards patients’, and, secondly, health workers themselves ‘[lacked] an adequate knowledge about the disease’.⁶⁸ So the meeting elected a comrade to prepare and present a lecture on AIDS for clinic health workers that would cover the ‘signs, symptoms, prevention and control’ of AIDS, and set a date for the lecture.⁶⁹ It is not clear if the lecture took place, but this lack of knowledge about AIDS confirms the comment made by Dahlgren.

The Zambian RHT reported that by the middle of 1987, 1 274 cases had been treated at the clinic of which 76 were STIs (71 males and five females). Of the STI cases, five had been ‘referred to UTH (University Teaching Hospital) for HIV’ and ‘there had been no follow up as yet’.⁷⁰ Some Zambian RHT members were aware of HIV and presumably sent ANC members to UTH as the hospital was able to test for HIV antibodies and was better equipped to deal with infections than the clinic.

The importance of specific regional contexts in understanding health concerns is highlighted by Hippe and Pedersen’s analysis of the health care context in Zambia. Their report noted that while the ANC HQ was in Lusaka, there were no fully developed settlements in Zambia, meaning that the permanent ANC community lived in and around Lusaka, which was also a major transit area for new ANC exiles. Unlike other ANC exile communities that were relatively isolated from host communities, the situation in Zambia allowed for ‘deeper integration’ into Zambian society. This came with its own consequences:

Integration does, however, increase the risk of large scale spreading of the HIV virus [sic] to the ANC members. It is estimated that 40% of the educated elite in Zambia is infected by the HIV virus. A random test among blood donors in Lusaka showed that 30% of the males in the sexually active age group carried the virus.⁷¹

⁶⁸ UFH-AA, ALM, p2a, 33, 1, Meeting of the Health Secretariat with the Clinic Staff, p. 3.

⁶⁹ *Ibid.*

⁷⁰ UFH-AA, ALM, p2a, 42, 89, Zambia Health Report – Period July – Aug-Sep, p. 2.

⁷¹ Hippe & Pedersen, *Health Care in an Exile Community*, p. 69.

Hippe and Pedersen noted that the high rate of other STIs indicated that ‘the conditions for also spreading the HIV virus [sic] among the membership could be alarmingly favourable’.⁷² They directly linked the health of host communities with those of exile communities in Zambia:

The prevalence of the virus among the local population is so high that AIDS must be regarded a very serious threat to the ANC-community. According to members of the regional health team there have been negotiations with the local authorities to establish an AIDS screening program for the exiled community.⁷³

This analysis also spoke of the Zambian authorities’ recognition of the need for epidemiological information and formalised responses to HIV and AIDS. The exile communities ‘stepped into’ and were part of the disease and health patterns of the communities they lived in, especially in situations where integration and mobility were easier.

Hippe and Pedersen noted that in Tanzania the ANC-Holland Solidarity Hospital lacked equipment for screening blood for ‘hepatitis and, of course, AIDS’, indicating that the organisation’s ability to screen comrades for HIV antibodies in this region was dependent on external health care facilities.⁷⁴ In the Angolan region STIs were ‘alarmingly high’, and ‘the risk of spreading the HIV-virus [sic] [added] a further dimension to the need for prevention of venereal diseases’.⁷⁵ The Angolan RHT had observed that although ‘some education material on AIDS [had] been circulated in the region’ there had been ‘no systematic effort to spread information on the disease’.⁷⁶

An 1987 ADoH report referred to an effort to spread information but confirmed the Angolan RHT’s perception of a lack of systematic implementation. The ADoH had ‘prepared a

⁷² Hippe & Pedersen, *Health Care in an Exile Community*, p. 70.

⁷³ *Ibid.*

⁷⁴ *Ibid.*, p. 33.

⁷⁵ *Ibid.*, p. 52.

⁷⁶ *Ibid.*

pamphlet on AIDS ... with an aim for public campaigns in our various settlements'.⁷⁷ The account of the pamphleteering was somewhat contradictory and confusing:

Pointless just to litter the whole town with pamphlets on AIDS because the public already knows something about the disease. However, main purpose of campaign was to ensure that everybody is covered and can act as facilitators to promote discussion on the subject, allay unnecessary anxiety, reassure people and to motivate a positive and supportive attitude and behaviour to people suffering from AIDS. Printed five thousand leaflets. To try to reach a wide audience, the RPC units are used as a platform where lectures on the subject are given. Unfortunately, attendance at these meetings have been rather poor. Nevertheless, we need a determined attempt before we can decide to approach the campaign departmentally. Only 18 people covered thus far.... Recently a video on AIDS has been made available.⁷⁸

It is not clear if the 'public' were ANC comrades living in the settlement or ANC comrades and 'locals' living in particular areas. The statement about public awareness of AIDS also contradicted the regional reports requesting more information as people did not know much about AIDS. It is also unclear how effective the 5000 pamphlets would have been if they were not distributed around the town and the meeting attendance was poor – possibly only 18 people? While there was self-reflection on the part of the ADoH, there were no suggested alternative strategies to address the problems. There was recognition of the need for 'a determined attempt' before a decision could be made to 'approach the campaign departmentally'. This either indicated that the decision for the ADoH to be responsible for the campaign had not yet been made (which would contradict the requests of the NEC), or that a discussion was under way on educating specific departments within the movement and possibly making them responsible for training comrades. Either way, the report showed neither clarity of purpose nor a confident response to AIDS education in the regions.

A report from the UK RHT from October 1987 suggests that the ADoH's inability to transmit AIDS education information was not for lack of access to information. The UK RHT was particularly well placed to access AIDS education and teaching materials and literature being

⁷⁷ UFH-AA, ALM, p2a, 33, 1, ANC Department of Health Report on Publicity and Information, 2 April 1987, p. 1.

⁷⁸ *Ibid.*, pp. 1-2.

generated by concerned communities and (eventually) public health authorities in the UK.⁷⁹ Although similarly constituted to other regional health teams, there were features that made the UK RHT different from other regions.⁸⁰ Because of its location, it was able to meet with ANC comrades without unduly risking their safety. It was not responsible for providing immediate health care for comrades but rather played a supportive role. It had 'access to a wide range of information and technology which puts [them] in a good position to provide educational and propaganda material particularly of a specialist nature', including material about AIDS. The report stated that the UK RHT needed to work more closely with 'sympathetic individuals' who had health-related expertise.⁸¹ It had been supplying the secretariat with 'information pamphlets, papers of interest, journals etc' and 'the problems associated with AIDS have been uppermost'.⁸² The UK RHT recommended tailoring AIDS information for ANC exile communities, including a suggestion to produce an ANC-specific AIDS education video.

The UK RHT declared its growing concern about the ADoH (and possibly NEC's) response to AIDS: 'The committee views with alarm the apparent disinterest of the threat of AIDS to our movement. As the epidemiology of the disease becomes more clear [sic] in Africa and the rest of the world, its potential to do the work of the enemy becomes very real'.⁸³ Sachs and others in the UK RHT clearly felt that, despite the information provided at the 1986 conference, and the NEC's and ADoH's public commitment to highlight AIDS, the official responses were too slow and the seriousness of the situation not fully incorporated into ADoH and NEC thinking.

⁷⁹ The ADoH referred to the UKRHT as 'a major source of information gathering' on a variety of health issues. See UFH-AA, ALM, p2a, 33, 1, Report on Publicity and Information, p. 3.

⁸⁰ Comrades on the ground also recognised the importance of the London office as a source of information, as is evident in a letter from Freda Katz of the London Education Committee to the ANC Education Secretary in Lusaka. Katz reported that the adult education section of the SOMAFCO had requested materials on AIDS and the London Health Committee was responding to their request and trying to obtain the information (UFH-AA, ALM, p2a, 6, 8a, correspondence Katz to Education Secretary, 5 February 1987).

⁸¹ UFH-AA, ALM, p2a, 42, 89, Report....Health Team UK, p. 2. Other examples of access to specialist knowledge included the UKRHT contacting a centre in Denmark that specialized in treating victims of torture. The Danish centre provided the team with 'a mass of literature on the subject' that was then made available to other regional teams and the Secretariat. For more information on responses to AIDS in the UK see Berridge, V., *AIDS in the UK: The Making of Policy, 1981 – 1994* (Oxford, Oxford University Press, 1996) and 'The early years of AIDS in the United Kingdom 1981–6: historical perspectives' in Ranger, T. & Slack, P. (eds): *Epidemics and Ideas: Essays on the Historical Perception of Pestilence* (Cambridge, Cambridge University Press, 1992).

⁸² *Ibid.*, p. 1.

⁸³ *Ibid.*

In a separate short report on AIDS education the committee's view on 'the apparent disinterest' was repeated along with a concern about the lack of feedback to the UK RHT from the ADoH. Information on AIDS had been collected and sent to the ADoH and 'other centres', and the UK RHT had 'prepared a leaflet which we hope was simple and direct on the AIDS for distribution to comrades' but had 'not had any feedback on its efficacy'.⁸⁴

This indicates a lack of effective communication between the secretariat and regions, and shows that regions were keen to receive information on AIDS, although this may not have been equally accessible to them. The importance of the effect of AIDS on the movement was not universally shared or acknowledged, despite what had been discussed at the 1986 Health Council and the ADoH / NEC meeting in early 1987.

In a progress report dated October 1987, the ADoH referred to the meeting with the NEC in March, noting that despite submitting a report on the meeting to the upper echelons of the organisation, there had been no official response.⁸⁵ This signals either ambivalence about AIDS from higher party structures or a focus on issues perceived as more important to the movement. The ADoH's frustrations were evident in the report, in which they acknowledged that 'Although there was some progress the Health Secretariat suffered serious setbacks partly due to the poor state of organisation of the Health Secretariat itself and partly due to lack of support and guidance by higher structures'.⁸⁶

The section of this progress report dealing specifically with AIDS provided information on screening procedures and data on infection and death rates. It revealed the lack of consistent protocol in making test results known to individuals found to be HIV positive. Eighty-seven comrades had been screened for 'HIV infection (commonly known as AIDS)' since October 1986 with positive results for 28 comrades, and there was 'strong evidence' that three of the 28 had died from AIDS.⁸⁷ The notion that a person could be screened for HIV infection rather than HIV anti-bodies may just have been a common misunderstanding,

⁸⁴ UFH-AA, ALM, p2a, 42, 89, Report....Health Team UK, p. 5.

⁸⁵ UFH-AA, ALM, p2a, 41, 69, ANC Department of Health Progress Report on the Work of the Department for the NEC, October 1987, p. 1.

⁸⁶ *Ibid.*

⁸⁷ *Ibid.*

and the conflation of HIV and AIDS could have shown that the difference between HIV and AIDS was not commonly understood by comrades. Alternatively, perhaps not all members of the ADoH were familiar with basic knowledge about HIV and AIDS.

The majority of comrades tested were those leaving for 'the front' to undertake MK duties, but also included students and patients scheduled to travel 'abroad'. The test results from this fairly small cohort indicated a 32 per cent infection rate. The ADoH reported that 'condoms and information bulletins [had] been distributed to all regions' and that collaborative arrangements had been entered into with the UTH in Lusaka, and regular lectures, designed especially for underground comrades, had been held. The response to the lectures was judged to be 'very encouraging'.⁸⁸

Less encouraging was an issue raised in the section on AIDS: 'It is disturbing to note that the underground comrades who are positive have, up till now, not been told. This is the responsibility of Military Headquarters (MHQ) as per agreement'.⁸⁹ While standard epidemiological practice and the provision of emotional support for positive comrades were espoused at one level, it is clear that there was no organisation-wide agreement on informing people of their status. It is possible that MHQ thought that knowledge of HIV antibody status would have a negative effect on soldiers' morale, or thought it irrelevant in light of the life-threatening situations soldiers had to face. There might also have been political and military concerns with acknowledging or admitting that AIDS was present in the organisation as declaring that one's soldiers are ill suggests weakness and could be exploited by 'the enemy'. Being too vocal about AIDS amongst the ranks could detract from the mythology of fit, healthy, young comrades fighting tirelessly and courageously for freedom. These speculations as they relate specifically to MK soldiers in exile require more research and would need to be considered in light of notions of masculinity, military strength and strategy, and the 'image' of the movement regionally and internationally.⁹⁰ It is clear that

⁸⁸ UFH-AA, ALM, p2a, 41, 69 Progress Report on the Work of the Department for the NEC, p.1.

⁸⁹ *Ibid.*

⁹⁰ Rob Shell's work on rates of infection amongst soldiers created controversy in the late 1990s but posited that infection rates amongst soldiers were not being sufficiently addressed. See Shell, R. 'The Silent Revolution: the AIDS Pandemic and the Military in South Africa', paper presented at the Consolidating Democracy in South Africa conference, Umtata, South Africa, 18 - 20 August 1999, full copy available at the, Konrad Adenauer Stiftung website at www.kas.de/suedafrika/en/publications/5111 (accessed December 2010); and Shell,

the onus was on MHQ to pass on information to comrades, and the decision not to do so may well have had an impact on HIV infection rates among comrades and the communities they lived in.⁹¹

The progress report reflected on the state of the ADoH generally and admitted that the ADoH's failure to produce either the organisation's health journal, *Impilo*, or the final Health Council report was 'due to poor organisation of the work of the Health Secretariat'.⁹² Changes relating to personnel and internal systems that had been agreed to at the ADoH's annual meeting had not yielded 'positive results' and a member of the secretariat had been suspended.⁹³ The RHTs in Angola, East Africa, and the UK were 'improving their work', while those in Zambia and Zimbabwe needed 'greater support and guidance'.⁹⁴ The ADoH declared their hope that a forthcoming seminar entitled 'Reorganising for a Healthier Revolutionary Movement' would provide a forum to solve these problems.

The seminar took place in Lusaka from 8 – 12 October 1987 and included delegates from all five RHTs. The seminar drew on the research of Hippe and Pedersen to determine areas of discussion and showed an attempt by the ADoH to use the report for consultative, strategic planning.⁹⁵ The ADoH's report to the seminar indicated that the portfolios and responsibilities of Secretariat members had been reorganised and confirmed that Regina Nzo, in her position as the ADOH's Community Programme Officer, would be responsible for the programmes on malaria, AIDS and STIs, family planning, and mental health that had

R.C.H., 'Trojan horses: HIV/AIDS and the military in Southern Africa, an epidemiological analysis with reference to Grahamstown and Port Elizabeth in the Eastern Cape, Conference paper presented in East London, July 1999. For work addressing contemporary discussions on AIDS and the military see Rupiya, M. (ed), *The Enemy Within – Southern African Militaries' Quarter-Century Battle with HIV and AIDS* (Pretoria, Institute for Security Studies, 2006) and the report by de Waal, A., Klot, J.F., Mahajan, M., Huber, D., Frerks, G., & M'Bou, S., 'HIV/AIDS, Security and Conflict - New Realities, New Responses' AIDS, Security and Conflict Initiative (ASCI), c. 2010 available on the ASCI website at http://asci.researchhub.ssrc.org/working-papers/HIV_AIDS,%20Security%20and%20Conflict.pdf (accessed December 2012).

⁹¹ In the ADoH's Annual Report to the ECC for 1987 (see in-text) the Department acknowledges that one of the components of its internal work is around participation of health workers in MK units. According to the report the roles of these health workers '...involve the organisation and supervision of medical kits, education and counselling on AIDS and supervising discussions on basic first aid...' but '...this programme [was] not being implemented as would be desired'. See UFH-AA, ALM, p2a, 41, 65, Annual Report to the ECC for the Year 1987, pp. 3 - 4.

⁹² UFH-AA, ALM, p2a, 41, 69, Progress Report on the Work of the Department for the NEC, p. 2.

⁹³ Although she is not named, this reference appears to be to Manto Tshabalala.

⁹⁴ *Ibid.*

⁹⁵ UFH-AA, ALM, p2a, 42, 89, 'Reorganising for a Healthier Revolutionary Movement', Report, p. 1.

been identified as priorities. Part of Nzo's remit was to provide guidelines for use in the regions before the end of 1987 and to take on the responsibility for training ADoH staff.⁹⁶ The concerns and responses mentioned in this report echoed those that had featured in the meetings with the NEC, but had not been acted upon.

The RHT reports provided an overview of the differing importance attached to AIDS in the regions. The Zimbabwe and Angola reports made no mention of AIDS. Among other things, the Angola report focused on the need for improved supplies of contraceptives, highlighting the 'high number of unplanned pregnancies', and affirming that 'decisions to terminate pregnancies should be left to the women concerned'.⁹⁷ This indicated that unprotected sex, with the associated risk of HIV infection and mother-to-child transmission (MTCT), was taking place in Angola, while the references to the bodily integrity of womyn with regard to both contraception and terminations of pregnancy offer an interesting insight into gender dynamics and ideologies within the movement.⁹⁸

The East Africa RHT recorded a good supply of contraceptives, and mentioned AIDS, but still linked condoms primarily to pregnancy prevention rather than STI prevention. It suggested that 'in general all women of reproductive age should be offered contraceptive measures' and 'condoms should be generally promoted as a contraceptive measure'.⁹⁹ The identification of contraceptives as primarily important in relation to birth control rather than STI control indicates that pregnancies were viewed as a more significant health concern than STIs, perhaps because of the impact pregnancies and responsibilities for child-rearing placed

⁹⁶ UFH-AA, ALM, p2a, 42, 89, 'Reorganising for a Healthier Revolutionary Movement', p. 2.

⁹⁷ *Ibid.*, p. 5 & 9, emphasis in the original. The issue of 'social abortions' was also raised in the East Africa report which noted that Tanzanian law prohibited social abortions (p. 5).

⁹⁸ Tsampiras, 'Sex in a Time of Exile' discusses the gendered dynamics of responsibilities for contraception and pregnancies, and contributes to understanding and unravelling the complicated gendered nature of experiences in exile. There was a particularly gendered conception of responsibilities for the reproductive results of sexual activity (children), and male involvement in sexual relations did not come with the same responsibilities as it did for womyn (see for example UF-AA, ALM, p2a, 6, 9, Recommendations of the 3rd Council Meeting of the A.N.C. Department of Education and Culture on "The Crèche and Prenatal Care", 14 – 18 August 1980, pp. 1 – 3). There is little evidence to suggest that men's sexuality and sexual practices were seriously interrogated, questioned or discussed. As Suttner has acknowledged, within the context of masculine identities in the ANC, 'the content and mode of construction of ... masculinities over time needs to be unpacked' (see Suttner, R., 'Culture(s) of the African National Congress', p. 305). Similarly, the content and mode of construction of masculinities over time as they related to sexual practice, sexual health, and sexually transmitted infections like AIDS need to be unpacked further.

⁹⁹ UFH-AA, ALM, p2a, 42, 89, 'Reorganising for a Healthier Revolutionary Movement', p. 5.

on the organisation. The difference in access to contraception between regions would have hampered efforts to effectively promote condom use as a means of preventing HIV and other STIs. It is interesting, but not surprising, that in both reports the responsibility for contraception is primarily linked to womyn comrades. There is no suggestion that contraceptives and advice should be offered to 'all' men of reproductive age, only that 'condoms should be generally promoted'.

The East Africa RHT report observed that 'the Youth' were concerned that 'ANC health workers should meet the challenge posed by the struggle'.¹⁰⁰ It 'noted with concern that AIDS was not discussed at all at the NYC [National Youth Conference]' and agreed 'to use Youth structures to disseminate AIDS educational material'.¹⁰¹ These statements reveal that the concerns of the 'younger' ANC comrades represented by the Youth League were focussed primarily on meeting health demands more obviously linked to the struggle than was the case with AIDS. By contrast, the 'older' members of the RHT were concerned about the lack of attention given to AIDS by 'the Youth'. The RHT members may have been seeing the effects of AIDS first-hand or were just more aware of the potential problems posed by the pandemic, or they were particularly concerned about the sexual health of younger comrades.¹⁰²

The UK RHT commented on the importance of contraceptives, referred specifically to AIDS, and echoed the concerns raised in its October report: 'The UK RHT were alarmed by the apparent failure of the membership to take AIDS more seriously' and indicated that 'posters and other information were requested from the UK Team by the meeting'.¹⁰³ The ADoH's reporting of the UK RHT's concerns as referring to 'the membership' however, shifts the emphasis of the original report which challenged both the leadership of the ANC and 'the movement' generally to take AIDS more seriously.

¹⁰⁰ UFH-AA, ALM, p2a, 42, 89, 'Reorganising for a Healthier Revolutionary Movement', p. 5.

¹⁰¹ *Ibid.*

¹⁰² Finding sufficient personal files or medical records in the archives to be able to undertake a 'generational' analysis of illnesses or health concerns would prove difficult, but this certainly opens an interesting avenue for further research.

¹⁰³ *Ibid.*, p. 7 (original emphasis).

The Zambian RHT report echoed Hippe and Pedersen's findings about 'deeper integration' in Zambia:

To avoid the problem of pregnancies in Zambian women we need to carry out health education, provide contraceptives (including condoms) to our comrades and their Zambian partners ... AIDS, STD and contraceptive preventive functions of condoms should be emphasised in our health education programmes.¹⁰⁴

The importance of condoms for sexual health and fertility control were not properly understood in this region either. The statement specifies pregnancies amongst 'Zambian women' – not womyn MK soldiers or movement members – indicating that either there were no pregnancies amongst womyn ANC members or that these were not considered as problematic. The reference to 'our comrades and their Zambian partners' suggests that male ANC members were involved in sexual relationships with Zambian womyn, but does not provide insight into the 'nationality' of female ANC members' sexual partners. The concerns about AIDS, STIs, pregnancies and managing (sexual) relationships between ANC and 'local' community members show that the transmission of HIV across 'borders' and 'nationalities' was already a reality by 1987.

During the seminar the failure of MHQ to inform soldiers of their HIV status was again raised as a problem, and sparked a discussion about what should happen to comrades who were HIV positive. A 'majority decision' was taken that HIV positive comrades were not to be sent home.¹⁰⁵ The seminar group felt that the authority for such decisions was best placed with the ADoH, but that did not imply that the MHQ agreed or would implement the decision.¹⁰⁶

¹⁰⁴ UFH-AA, ALM, p2a, 42, 89, 'Reorganising for a Healthier Revolutionary Movement', p. 7.

¹⁰⁵ *Ibid.*, p. 8.

¹⁰⁶ One of the tensions in the ANC's organisational functioning was the need for hierarchical structures that could issue orders and co-ordinate an armed struggle on the one hand, and the political commitment to forming new, democratic structures that were consultative and inclusive on the other. The seminar decided that a policy about HIV-positive comrades needed to be informed by collective decision-making throughout the movement, revealing a commitment to consultative decision making processes rather than 'top-down' approaches: 'We agreed that the movement as a whole should participate in deciding on this issue, but the debate must be informed. As health workers we must inform the membership about the disease and its medical, social and political implications, so that an informed decision can be made. The UK RHT is to draw up a leaflet with the arguments "for and against" sending HIV +ve comrades home, for discussion by all RHT's and other movement structures'. See UFH-AA, ALM p2a, 42, 89, 'Reorganising for a Healthier Revolutionary Movement', p. 8. There is, however, a vast difference between making decisions and implementing them and there is little evidence to suggest the implementation of these decisions throughout the movement. Slightly

Regardless of what was or was not being implemented throughout the movement, the ADoH referred to AIDS education programmes in project funding proposals prepared for external organisations in 1987. A request for four-wheel drive vehicles to facilitate community health programmes in Zambia, listed 'Health Education' fourth out of the six programmes and explained that the ADoH's efforts in this regard were 'concentrated at widely disseminating information on the following important subjects – malaria, contagious diseases including TB and STDs, family planning methods and AIDS'.¹⁰⁷ In a meeting between the ADoH and the *Nederlandse Organisatie Voor Internationale Ontwikkelingssamenwerking* (NOVIB) the five main ANC health programmes were listed as 'malaria, STDs and AIDS, ... Family Planning, Mental Health and curative services'.¹⁰⁸ The minutes indicate that NOVIB made positive overtures about financing a programme on STDs and AIDS.

Another project proposal listed AIDS test-kits amongst the equipment required as they were needed 'for screening students and others before travel abroad, regular screening of expectant mothers, screening on individual requests, and screening blood donors'.¹⁰⁹ The ADoH was dealing with the practicalities of certain countries (such as Russia and China) denying entry to people who were HIV positive. The ADoH was up-to-date with knowledge about MTCT and infection via blood transfusion, and was receiving requests from comrades for HIV-antibody testing.

After the increased organisational activity around AIDS during 1987, the ADoH submitted its annual report for 1987 to the ANC's External Coordinating Committee (ECC) in February

more detailed notes on the sessions and the discussions appear in the handwritten rapporteur's notes. See UFH-AA, ALM, p2a, 42, 103, rapporteur's notes UK Regional Health Team Report and Zimbabwe Report, 10 October 1987, Tanzania and Zambia Report, 11 October 1987, and General Session, 12 October 1987.

¹⁰⁷ UFH-AA, ALM, p2, 41, 69, Project Proposal for Urgent and Additional Transport for the Health Secretariat for ANC Community Health Programmes in Zambia, 2 May 1987, p. 1.

¹⁰⁸ UFH-AA, ALM, p2a, 33, 1, Minutes of meeting between ANC Department of Health and NOVIB, 5 November 1987, p. 3. NOVIB was originally called *Nederlandse Organisatie Voor Internationale Bijstand* (Netherlands Organization for International Aid) then underwent a name change. The organisation retained NOVIB as an abbreviation but became known as the *Nederlandse Organisatie voor Internationale Ontwikkelingssamenwerking* (Netherlands Organization for International Development Cooperation). NOVIB was a secular organisation that received 60% of its funds from the Dutch Ministry of International Cooperation and financed projects in about 60 countries. In its contemporary guise it now works jointly with Oxfam and is called Oxfam NOVIB. For more on the organisation see the NOVIB website at www.oxfamnovib.nl/history.html (accessed May 2010).

¹⁰⁹ UFH-AA, ALM, p2a, 41, 63, ANC ... Health Project Proposal, p. 2. It is unclear whom the intended recipient of the proposal was meant to be.

1988.¹¹⁰ This acknowledged that the ADoH viewed AIDS 'with grave concern'.¹¹¹ It summarised AIDS awareness activities for 1987:

Information on the subject in the form of pamphlets, videos and lectures has been provided / circulated and counselling sessions have been held with a number of cdes. These measures are certainly not enough and a departmental programme on AIDS will, on its own, not give the issue the desired attention. A national programme on the subject is long overdue and is a matter to be seriously considered. Our screening programme has been severely hampered by lack of transport and poor cooperation and coordination with other departments. The ECC is urged to give this matter its urgent attention.¹¹²

The report suggests the ANC's responses to AIDS were uncoordinated. The NEC had raised concerns about AIDS at the meeting with the ADoH in 1987, had issued directives to the ADoH and tasked them with implementing and managing an AIDS programme. Yet the ADoH's report to the ECC implied that there was insufficient support within the organisation to effectively implement a coordinated response. The failure of higher levels of the organisation to commit resources and energy to better directing a comprehensive AIDS plan for the whole organisation remained an ongoing concern amongst the ADoH and members of the RHTs throughout this period. Despite these concerns, the ADoH continued to plan and implement projects focused on AIDS awareness.

A report of November 1989, entitled 'Education and Information Project on STDs/HIV/AIDS in the ANC Communities', provided updates on four components of the project: education and information support; support for educational material; cultural activities; and the strengthening of laboratory services.¹¹³ Achievements over the year were recounted.¹¹⁴

¹¹⁰ The ECC was created after a planning conference in April 1983 proposed a number of changes in the ANC's 'Senior Organs' to ensure improved coordination between military and political aspects of the struggle. The External Coordinating Committee was tasked with overseeing all external work carried on outside of South Africa. Between 1985 – 1990 the ECC was chaired by Alfred Nzo and Thabo Mbeki was one of its members. For more information on ANC structures see 'ANC Structures and Personnel, 1960 – 1994' on a cached copy of the ANC website at: www.anc.org.za/ancdocs/misc/trc2a.html (accessed August 2010).

¹¹¹ UFH-AA, ALM, p2a, 41, 65, Annual Report to the ECC for the Year 1987, p. 2.

¹¹² *Ibid.* (emphasis in the original). In this context a 'national' programme presumably meant one that was carried out throughout the organisation rather than just in one department or one region.

¹¹³ The report indicates that the plans for this project were formalized in 1988 and the component parts of the project bear a striking similarity to those discussed at the ANC 'National Health seminar', with NOVIB, and with the NPA indicating ongoing attempts to implement a specific set of goals around HIV/AIDS information and

There had been a 'national' workshop 'for formal and informal leaders because of the influence they have in the communities', and two sets of training had focussed on counselling skills for health workers and health education skills for community members. There had also been a 'workshop for cultural workers in Tanzania', with 'financial support for setting up a drama/play.'¹¹⁵ A laboratory technician from Sweden had come to assist the organisation, and laboratory equipment for 'STD and HIV analysis' had been purchased.¹¹⁶

There were ongoing anti-AIDS projects, but the lack of detailed information makes it difficult to assess the efficacy of these. There is no information available, for example, on how many people attended the workshops, how many workshops there were, or how many posters were produced. A summary of an ADoH report from c. 1989 made general statements to the effect that 'a workshop, or series of workshops, was [sic] conducted, after which the participants were returned to their regions, where they are now educating the ANC population on STD, HIV, environment [sic] health and other communicable diseases'.¹¹⁷ The records reveal an ongoing willingness to run AIDS awareness training and workshops, but do not provide examples of internal monitoring or evaluation of programmes, nor sufficient evidence to attempt a retrospective analysis of the number of ANC members and local community members reached.¹¹⁸

One ANC AIDS education project that was successfully completed was the writing, filming and distribution of a context-specific AIDS education video entitled 'As Surely as an A.K.' (figure 12).¹¹⁹ Initial discussions about a context-specific video featured in organisational correspondence from 1987 and the film was completed in 1989 by Solidarity Films.¹²⁰ It is an

education in a variety of fora. UFH-AA, ALM, p2a, 41, 69, Education and Information Project on STDs/HIV/AIDS in the ANC Communities, Lusaka, November 1989.

¹¹⁴ Insufficient supporting evidence was available to verify if all the events listed had taken place or were planned to take place.

¹¹⁵ UFH-AA, ALM, p2a, 41, 69, Education and Information Project on STD/HIV/AIDS in the ANC Communities.

¹¹⁶ *Ibid.*

¹¹⁷ UFH-AA, ALM, p2a, 41, 69, Summary of Report from the Health Secretariat, c. 1989

¹¹⁸ There is one brief evaluation document written in early 1990 and copies of three evaluation questionnaires – see UFH-AA, ALM, p2a, 9, 30, Evaluation of Education and Information Project on STD/HIV/AIDS in the ANC Communities 89/90, Lusaka, 13-19 February 1990, and UFH-AA, ALM, p2a, 42, 102, Evaluation on the STD/HIV/AIDS Project – Questionnaire [sic], not dated but c. 1989/90.

¹¹⁹ IISH, BG V8/226, *As Surely as an A.K.*, (video, Solidarity Films, c.1989); 25 minutes.

¹²⁰ See UFH-AA, ALM, ad2, 6, 9, correspondence Naicker to Sachs, 23 April 1987; and UFH-AA, ALM, p2a, 42, 89, Report....Health Team UK, p. 2. While the film itself does not contain much information in the form of end-

interesting example of AIDS education media and deserves in-depth analysis in its own right because of, for the time, its progressive approach.

The film attempted to create scenarios and experiences that were appropriate for ANC comrades living in exile. It is divided into three parts, each part ending with an on-screen instruction to stop the tape and discuss the scene, highlighting the film-maker's intention that it be used as a tool for facilitating discussion and not merely for transmitting information. The UK RHT 'hoped to have a short introduction or conclusion from Cde OR as to the seriousness of the problem'.¹²¹ No message from O.R Tambo, the President of the ANC, or any other NEC member appeared in the final version of the film.



Fig. 12. Title shot and scene from the first part of the ANC AIDS education video 'As Surely as an A.K.'.

The film opens with scenes of comrades in military fatigues undergoing training, interspersed with scenes of protest, and day-to-day activities in what are presumably exile settlements. The title of the film derives from a scene where an older womyn comrade informs a younger womyn who has just arrived, that 'AIDS will kill you as surely as an A.K.⁴⁷', and that the future of the movement depends on addressing AIDS and preventing its spread. The intention was to recreate situations that sexually active comrades could relate to in a way that was presumably not possible with AIDS videos sent over from other countries and depicting non-exile situations.

credits, it is listed in the archive holdings as being scripted by Carolyn Roth and Vic Finkelstein and originating from the 'London ANC Health Team' although the film credits the ADoH.

¹²¹ UFH-AA, ALM, p2a, 42, 89, Report ... Health Team UK, p. 5.

The three scenarios that are presented take place in ANC offices and at a kitchen table but are interspersed with 'hospital scenes' where various characters visit 'Luke' – a once healthy, brave MK soldier who now lies dying in the hospital (figures 13 & 14). Although Luke is given chances to speak and raises concerns about being stigmatised and ignored by his friends. He is clear about his impending death, declaring 'I've got AIDS man, I'm not going to get better!'



Fig. 13. Comrade Luke is visited by the other characters throughout the video.

The video includes scenes that dispel basic myths on means of HIV transmission and infection (that AIDS cannot be caught from sharing a cup for instance), and highlights the importance of each comrade taking responsibility for sexual encounters and sexual health. There are scenes that address the judgements attached to womyn carrying condoms and insisting on their use, and others involving discussions of sexual relationships, with one character being a Casanova-type figure, another challenging the Casanova character, and one character being in a long-term monogamous relationship and still insisting on condom use. There are also scenes that highlight the seriousness of AIDS and emphasise that it is no less dangerous than other more immediate struggle-related health problems, or indeed the inherent risks of being in exile or being part of the movement.

The film deals with emotional responses to AIDS and declares the inappropriateness of laying blame and seeking vengeance on those who are infected. There are arguments for greater mutual respect between men and womyn – a declaration that womyn and men need to respect each other enough to practise safer sex. The film puts forward many of the concerns raised by RHT members in other fora and provides insights into the gendered dynamics that existed in the organisation and those that were being challenged within the

movement.¹²² It is, however, difficult to gauge how much impact the film had, how successfully it was distributed amongst ANC communities, or even how many people saw it. The film was frequently mentioned during interviews for this thesis and features in Mbali's oral interviews for her thesis, indicating that the memory of the film has certainly stayed with those who saw it.¹²³



Fig. 14. Scenes from the second and third parts of the video.

The politics and practicalities of devising and implementing AIDS education programmes in an exile context during a time of transition also need to be borne in mind, as Francie Lund has observed.¹²⁴ In the late 1980s Lund was involved in a number of community-based projects and conducted research into health and welfare policy. She was known to have experience in adult education and training and was invited by the ANC to Lusaka to discuss AIDS education. She spent time with both Ralph Mngijima and Nkosazana Dlamini-Zuma and refers to the problems associated with education in exile as 'one of the most intriguing things methodologically that I've been confronted with' because of the necessary secrecy surrounding knowledge about the ANC camps.¹²⁵ Basic information about the number of people in the camps, their ages and their biological sex could not be revealed to her but she was invited to facilitate a small focus group.

¹²² See Tsampiras, 'Sex in Exile' for a more detailed gendered analysis of the film.

¹²³ Mbali, M., "The New Struggle": A History of AIDS Activism in South Africa, 1982 – 2003', PhD thesis, University of Oxford, 2009, pp. 125 - 126.

¹²⁴ Prof. Lund is a Senior Research Associate at the School of Population Studies and Development Studies at the University of KwaZulu-Natal, Durban. She specialises in social policy research in a range of areas, chaired the Lund Committee in 1995 that resulted in the introduction of the Child Support Grant in South Africa, and has published extensively. For more information see the School of Population and Development Studies website at <http://sds.ukzn.ac.za/default.php?2,4,8,4,0> (accessed February 2012).

¹²⁵ Interview with Francie Lund, School of Population Studies and Development Studies Offices, UKZN, Durban, South Africa, 30 June 2011.

Lund recalls that at the focus group Dlamini-Zuma (who would go on to be the first health minister during Mandela's presidency) spoke openly about the need to discuss sex, and made it clear that comrades could not blame taxi drivers, prostitutes or migrant labourers for AIDS. Everyone had to acknowledge their role as individuals in addressing AIDS. After the focus group Lund was tasked with drawing up a survey that the ADoH would administer in the camps. The survey was designed to try and establish 'what younger comrades felt were routes of learning or what their sources of information were'.¹²⁶ Shortly thereafter, and before the survey could be administered, the announcement of the unbanning of the ANC and other organisations diverted attention to the return home.

Planning for the Future? The Maputo and Lusaka Meetings

In the first half of 1990 the ADoH was involved in two key events that reflected local, regional, intra-organisational, and international aspects of the ANC's response to AIDS. The first was the Health and Welfare conference held in Maputo in April 1990, and the second was a workshop, entitled 'Towards a South African AIDS Policy', held in Lusaka at the end of May 1990.

The Maputo conference took place almost three months after the ANC, SACP and the Pan Africanist Congress (PAC) had been unbanned in South Africa, the State of Emergency within the country had been partially lifted, and Nelson Mandela and other political prisoners had been released. The significance of these moments of political transition are evident in the speeches delivered at the conference, and in the editorial of the double edition of the progressive health magazine, *Critical Health*, that provided a comprehensive report of the 'core messages' from the conference.¹²⁷ The Maputo and Lusaka meetings were both about addressing health in exile and preparing for a future health policy.

Central to the conference was a sense of solidarity and co-operation between the ANC and a variety of local, regional, and international organisations, individuals and state

¹²⁶ Interview with Francie Lund.

¹²⁷ *Critical Health* was a magazine / journal, published quarterly, that dealt with politics and health in South Africa.

representatives. Prior to Maputo there had been three 'International Conferences on Health and Welfare in Southern Africa' organised by the progressive, US-based anti-apartheid Committee for Health in Southern Africa (CHISA). The Maputo conference was significant not only because it was the first conference not held in North America, but, as the editorial of *Critical Health* noted, was also 'historic in that it was jointly organised by the Ministry of Health, Maputo, the African National Congress, progressive health and welfare organisations in South Africa, representatives from the Anti-Apartheid Movement in the UK, CHISA and the WHO...'.¹²⁸

The progressive South African based organisations included the National Medical and Dental Association (NAMDA), the National Education Health and Allied Workers Union (NEHAWU), the Organisation for Appropriate Social Services in South Africa (OASSSA) and the South African Health Workers Congress (SAHWCO). There were over a hundred delegates at the conference, including representatives from the Congress of South African Trade Unions (COSATU), the United Democratic Front (UDF), the South African Council of Churches (SACC), the Islamic Medical Association (IMA), the Township AIDS Project (TAP), the Primary Progressive Health Care Network (PPHCN), and a host of other health care organisations. Deans from four university medical schools were present, as were representatives from Angola, Mozambique, Namibia, Tanzania and Zambia, along with representatives from the ANC RHTs.¹²⁹ The Mozambican Health Minister opened the proceedings, while the ANC Chief Representative in Maputo, Walter Seathe, gave the keynote address and Steve Tshwete represented the ANC NEC.

The conference was intended to discuss what was needed to transform South Africa's health care system into an equitable, accessible, national service that would provide for the health care needs of all South Africans. The scope of the conference was extensive and the subjects discussed included community-based health education; experiences in the frontline states; USA, UK and European experiences in the integration of health care, human rights and social change; health services and a health charter; finance and restructuring; human resources;

¹²⁸ Editorial, *Critical Health*, p. 2.

¹²⁹ UFH-AA, ALM, Additions, 2, 7, 13, Correspondence Refiloe Serote (Township AIDS Project) to Lungile, 22 May 1990. For a list of organisations represented see *Critical Health*, p. 5.

and HIV. A series of 'Special Issues' workshops focussing on occupational health, family and children, returnees, and womyn's health were meant to take place but were cancelled due to time constraints.¹³⁰ One of the cancelled sessions was on womyn and violence. *Critical Health* noted

Women's issues are sadly low down on the political agenda of most progressive organisations, and health is no exception to this. In a conference that lasted one week, 2 hours of the last session of the last day were devoted to women's health. Even then the women's health workshop was run parallel with 3 other workshops.¹³¹

Considering the important role sexual and domestic violence has come to play in HIV transmission and the gendered nature of the AIDS epidemic, these were unfortunate omissions.

The HIV session included fifteen papers and presentations on various aspects of HIV and AIDS given by academics, health professionals, and people engaged with AIDS prevention programmes.¹³² The papers presented overviews of AIDS in southern Africa and shared the experiences of health care professionals already dealing with people in the advanced stage of the illness. There were examples of responses from frontline states, and AIDS was highlighted as an issue for unions, workers, and primary health care networks. Other papers attempted to assess which education strategies were effective in prevention programmes, provided summaries of HIV and AIDS in South Africa, and suggested what public health responses would be needed to address AIDS in South Africa.

While a full set of the papers on HIV and AIDS could not be found in the archive, there are copies of the paper written by the ADoH and a draft paper written by Elizabeth (Liz) Floyd on

¹³⁰ For a list of papers and sessions see *Critical Health*, p. 3.

¹³¹ *Critical Health*, p. 45.

¹³² For a list of the papers dealing with HIV and AIDS see *Critical Health*, p. 3. Amongst the presenters were Zena Stein who had helped organise the conference, Anthony Zwi who wrote extensively about health and apartheid, Megan Vaughan and Paul Epstein who continue to do academic work around disease and society, and Liz Floyd who was involved in government AIDS responses in Johannesburg and was an active member of NAMDA.

HIV and AIDS in South Africa.¹³³ Floyd's paper gave a brief chronology of AIDS in South Africa and addressed the question of why AIDS 'did not feel very real'. It also linked conditions under apartheid to the spread of HIV, and provided examples of responses to the epidemic by certain health sectors (the Soweto Health Services), community-based organisations and unions (specifically the National Union of Mineworkers). The paper raised questions about the ANC and AIDS:

Many organisations within South Africa have said that they would like to know what the ANC is doing about AIDS and what its public commitment on AIDS is. A variety of organisations see that the ANC has an important political role to play addressing the HIV epidemic and acknowledging an important role for work on AIDS in the progressive movement. Different organisations have very different practical understandings of what this means for the ANC. E.g. some would expect ANC leadership to make a public statement on AIDS without understanding that such a statement would need to reflect an organisational process.¹³⁴

Progressive organisations concerned about AIDS were evidently eager to listen to the ANC and assess what type of leadership it would provide in addressing it. The experience of AIDS within South Africa and the scepticism with which the apartheid government's responses had been greeted, had, reading between the lines of Floyd's paper, left organisations and their members wanting clear political leadership from the ANC as a liberation movement and the assumed government-in-waiting. Floyd and other members of the progressive health movement had already worked on AIDS-related issues with the ANC, but the need for more public declarations on how the organisation would address AIDS and clearer communication about the ANC's position were highlighted.

In the keynote speech, Seathe declared that

The ANC recognises and is deeply concerned by the threat posed by AIDS – a disease which knows no geographical boundaries, class or racial divisions. It is a potential threat to every one of us, but it is a menace which is made worse in our case by aspects of the apartheid system such as migrant labour and the

¹³³ UFH-AA, ALM, p2a, 30, 24, Floyd, E., 'Draft Paper on HIV and AIDS in South Africa Today for CHISA Conference in Maputo', April 1990.

¹³⁴ *Ibid.*, p. 14.

inadequacies of the current health care system, especially for blacks. The ANC hopes that the deliberations of this workshop will result in the drafting of a programme of action on AIDS as a contribution to a national policy on disease.¹³⁵

The importance of AIDS was therefore acknowledged early on in the conference and the language used by Seathe was inclusive. This statement did not single out or morally condemn people with AIDS but presented it as a shared health concern. This shared health concern, however, was framed specifically in terms of addressing AIDS at a national (South African) level and there was no specific mention of AIDS as an ANC matter. In the context of the changing political dynamics in South Africa it is understandable that a keynote speech should direct the conference delegates to think about programmes and policies for South Africa. The lack of any acknowledgement of AIDS within the organisation, or amongst any specific ANC exile communities, however, creates a sense of AIDS being removed from the day-to-day realities of the exile communities.

A paper prepared by the ADoH addressed strategies to prevent HIV infection and reproduced a familiar AIDS narrative, starting with the assertion that 'In Africa, this epidemic is a heterosexual epidemic'.¹³⁶ The narrative is not as judgemental as some discussed previously in this thesis, and is not limited to a biomedical engagement with the subject, indicating a more progressive outlook. There are however, still references to 'high frequency transmitters' of infection, although with an extended list of participants, including 'prostitutes, soldiers, police, truck drivers (long-distance), STD clinic patients, young people – students, bar maids, and conferees'.¹³⁷ The list excluded the clients of sex workers (unless they were assumed to be found in the other named groups), and refers very particularly to 'bar maids' without explaining why womyn working in bars were assumed to be 'high frequency transmitters' or whom they were having sex with.

The paper considered the means of transmission in Africa and highlighted MTCT. It suggested primary prevention strategies for various groups, including high frequency

¹³⁵ *Critical Health*, p. 7.

¹³⁶ UFH-AA, ALM, p2a, 30, 24, Paper for Maputo Conference – ANC Department of Health: Strategies for the control of AIDS in the African National Congress p. 1.

¹³⁷ UFH-AA, ALM, p2a, 30, 24, Strategies for the control of AIDS in the African National Congress.

transmitters or reservoirs of already infected individuals, the 'general population' and school children, and discussed appropriate programmes to reduce new infections, emphasising condom use by 'the male partner'. There was a reference to the 'reuse of inadequately sterilised needles and other equipments in medical settings and by "street doctors" or traditional healers [as being] widespread and undoubtedly contribut[ing] to the spread of HIV'.¹³⁸ For the most part the paper reproduced work done by Francis Plummer and Elizabeth Ngugi, and dealt in generalities, but the inclusion of concerns about unsterilized needles reflected issues that had been raised by RHTs, and showed that the (unnamed) authors of the paper were engaging with contemporary literature on prevention programmes.¹³⁹

The paper articulated the uniqueness of the ANC's exile experience and offered a degree of self-analysis about the organisation and its members. It is not, however, clear if this awareness was the authors' individual reflections, reflected the ADoH's assessment of the situation, incorporated the viewpoints of other ANC departments or leadership structures, or represented discussions that had taken place throughout the organisation. This section consolidated and repeated concerns raised in a variety of ANC health fora prior to the Maputo conference.

There were pleas for compassion and understanding for people who were HIV positive or living with AIDS along the lines of those made by ANC health professionals at the 1986 ANC Health Council. Because of the unique circumstances of exile 'the ANC ... [had] ... a duty to develop a strong campaign for the control of AIDS', one that would provide 'support and counselling for those who are HIV-positive or ill from AIDS without ostracising, stigmatizing, intimidating and discriminating against the victims'.¹⁴⁰

¹³⁸ UFH-AA, ALM, p2a, 30, 24, Strategies for the control of AIDS in the African National Congress, p. 8.

¹³⁹ Page 2 of the paper states that 'This paper would like to use Francis Plummer and Elizabeth Ngugi's paper in exploring strategies for the control of AIDS'. While it appears that many of Plummer and Ngugi's findings were reproduced in the ANC paper, the version of the paper in the archive did not contain full references to the Plummer & Ngugi paper, nor to the other cited sources.

¹⁴⁰ UFH-AA, ALM, p2a, 30, 24, Strategies for the control of AIDS in the African National Congress, p. 9.

An overview of the ADoH's STI prevention programme revealed that workshops, talks, videos, posters and leaflets had been used at national and regional level to spread information. This account was fairly formulaic and the plea for a co-ordinated and holistic programme that followed, although more clearly articulated than in other contexts, echoed an ongoing concern first heard amongst individual health care practitioners, then RHTs, and then the ADoH:

The AIDS campaign has to be undertaken not only by the Health Department, but by a multidisciplinary team if it is to succeed. The ANC needs to incorporate an AIDS campaign in its national mobilization programme inside and outside South Africa. As a liberation movement it has the credibility which is crucial in any intervention programme in South Africa if it is to be accepted by the people. Unfortunately, the South African regime has used AIDS for its own propaganda and people are not going to take any other campaign seriously unless the ANC is involved.¹⁴¹

Anti-AIDS campaigns started by the trade union movement within South Africa were acknowledged, but these needed expanding. Future hopes for a national health system would be undermined by a 'huge AIDS epidemic'. The call for a co-ordinated and collaborative response throughout the organisation and within South Africa, and critical commentary on the credibility of programmes run by the apartheid government, were recurring themes in the two key documents relating to HIV and AIDS drawn up at the conference.

HIV and AIDS were deemed significantly important to feature both in the Declaration on Health and Welfare in Southern Africa issued by the conference, and in a separate draft statement on HIV and AIDS in southern Africa. The Declaration on Health and Welfare in Southern Africa noted that

All those present are acutely aware that South Africa and indeed the entire Southern African region is facing a crisis over the HIV epidemic. Urgent action must be initiated immediately, as the State's programmes are fundamentally limited and seriously flawed. Community-based initiatives are known to be more

¹⁴¹ UFH-AA, ALM, p2a, 30, 24, Strategies for the control of AIDS in the African National Congress, p. 10.

effective since they pay attention to the broader psycho-social implications of the disease. An alternative progressive campaign with the support of political and other representative organisations has to be set up immediately. An AIDS Task Force with strong political leadership is proposed to take this programme forward.¹⁴²

The draft statement on HIV and AIDS in Southern Africa (see Appendix D), acknowledged that HIV and AIDS were ‘an established epidemic in South Africa and throughout Southern Africa’ that required a ‘significant intervention’, but noted that ‘the South African state response has been totally inadequate’ and confirmed that representative organisations had a crucial role to play in AIDS programmes.¹⁴³ The state ‘had not displayed any genuine commitment to dealing with the problem facing the population’, and ‘the HIV campaign had been grossly inadequate’.¹⁴⁴

The statement envisioned a new approach to HIV and AIDS that would include representative, community-based organisations and political leadership. This approach would develop campaigns that were non-stigmatising and avoided stereotyping people or particular groups of people, and would recognise and address the political and social factors that aided transmission. It was declared that ‘HIV/AIDS is a social disease and should not be approached in a narrow biomedical fashion’. The features of South African life that facilitated the spread of HIV included ‘poverty, migrant labour, population relocation, homelessness, forced removals, unemployment, lack of education and poor housing’.¹⁴⁵

The statement called for a change in personal politics and relationships, noting that ‘sexism, victim-blaming and racial stereotyping decrease our ability to deal effectively with HIV infection ...’.¹⁴⁶ It located itself in a human-rights based approach by declaring that the rights of people with ‘HIV disease’ be ‘firmly recognised’, while stating that health workers had a responsibility to care for people with HIV in ‘a caring and non-discriminatory way’. Moreover, ‘discrimination against prostitutes, members of the gay community, injecting

¹⁴² HIV and AIDS in Southern Africa – Draft Maputo Statement as printed in *Critical Health*, p. 5.

¹⁴³ *Ibid.*, pp. 50 – 51. Quotes from p. 50.

¹⁴⁴ *Ibid.*

¹⁴⁵ *Ibid.*

¹⁴⁶ *Ibid.*, p. 51.

drug users and other marginalised groups should be overcome'.¹⁴⁷ The hegemonic narrative of 'high-risk groups' had sufficiently taken hold in certain public spheres to warrant a warning against its perpetuation. Also emphasised was the importance of 'involving senior progressive political leadership', with the stress that 'the African National Congress has a major role to play'.¹⁴⁸ It was held that 'the involvement of political leaders [would] help overcome suspicion and mistrust created by the South African state'.¹⁴⁹

There were demands that would need to be met by the South African government if the new AIDS programmes were to be realised. A 'democratically constituted' AIDS Task Force should be formed to 'coordinate and promote HIV and AIDS work' and implement an urgent programme of action to refine and drive a progressive response to HIV and AIDS. Current state programmes should be evaluated and any new programmes should be 'carefully and scientifically evaluated at regular intervals and modified accordingly'.¹⁵⁰ Accountability, transparency and monitoring of programmes were earmarked as essential to any responses to AIDS.

With guidelines for new responses to AIDS outlined at the Maputo Conference, a second, smaller gathering was convened in Lusaka to discuss the way forward. The five-day workshop held from 28 May to 1 June 1990 was entitled 'Towards a South African AIDS Policy', but by the time the final report was prepared this theme had been refined and renamed: 'Towards Comprehensive Intervention Strategies for the Prevention and Control of AIDS/HIV Infection'.

The workshop was organised by the ADoH and jointly funded by the Norwegian Peoples Aid (NPA) and the Health and Refugee Trust of South Africa. The number of delegates was fewer than at the Maputo Conference, with approximately 30 participants from Angola, Mozambique, South Africa, Tanzania, Uganda, and Zimbabwe. The delegates were drawn from ANC communities in southern Africa, and included members of the NEC and representatives from 'the youth, administration, women, trade unionist, culture social

¹⁴⁷ HIV and AIDS in Southern Africa – Draft Maputo Statement as printed in *Critical Health*, p. 51.

¹⁴⁸ *Ibid.*

¹⁴⁹ *Ibid.*

¹⁵⁰ *Ibid.*

welfare and political education’ and ‘key health workers ... from South Africa’.¹⁵¹ Alfred Nzo and Chris Hani represented the ANC NEC and Ralph Mgijima the ADoH. Presentations were made by a representative from the Health Education Unit of the Zambian Ministry of Health, and the WHO representative to Zambia while the African Research and Educational Puppetry Programme’s (AREPP) performed ‘Puppets against AIDS’.¹⁵²

In the project proposal submitted to raise funds for the workshop, the ADoH commented that, ‘From the outset, the involvement of the highest decision making members of the ANC is seen as of vital importance if the political will of the individuals is to be harnessed towards changes in social behaviour’.¹⁵³ The proposal identified one goal as being ‘to sensitise the leadership and other sectors of the ANC communities to the problem of HIV infection’.¹⁵⁴ This would suggest that, despite this concern being frequently raised from the mid-1980s, by 1990 not all members of the upper echelons of the ANC leadership shared the same sense of urgency about the significance of AIDS. The final report on the workshop rephrased the goal as being ‘to sensitize all the sectors and formations of our people about the problem of AIDS/HIV infection and to formulate comprehensive strategies to meet the challenges poised [sic] by the AIDS/HIV spread’.¹⁵⁵

Alfred Nzo’s keynote speech described the spread of the HIV pandemic from central to southern Africa as ‘becoming very aggressive’, and warned that the long incubation period of HIV was ‘a deadly characteristic’ as it rendered the epidemic invisible, and without visibly sick comrades it was ‘difficult to perceive of this disease as being an urgent priority’, even as infection rates increased.¹⁵⁶ There was a need to understand AIDS as ‘a “social disease”, a public health emergency, and accordingly identify the social determination of its spread and

¹⁵¹ UFH-AA, ALM, p2a, 33, 2, Project Proposal for an HIV/AIDS Workshop for the ANC, p. 1.

¹⁵² The show was very successful and generated much discussion amongst delegates. For more on AREPP’s history and its current incarnation as AREPP – Theatre for Life see the organisation’s website at www.arepp.org.za (accessed September 2010).

¹⁵³ UFH-AA, ALM, p2a, 33, 2, Project Proposal for an HIV/AIDS Workshop, p. 1

¹⁵⁴ *Ibid.* The other listed goals and objectives were: ‘to recruit activists who will form part of the team for the campaign against the spread of HIV infections; to enlist a multi sectoral [sic] participation in the formulation of a national AIDS policy; and to pilot a democratically coordinated HIV/AIDS campaign inside South Africa.’

¹⁵⁵ UFH-AA, ALM, p2a, 42, 104, African National Congress Department of Health Seminar Report, ‘Theme: Towards Comprehensive Intervention Strategies for the Prevention and Control of AIDS/HIV Infection’, p. 1.

¹⁵⁶ UFH-AA, ALM, pt 2, 64, c3, Keynote Speech by Secretary General – ANC HIV/AIDS Workshop, pp. 1 - 2.

distribution'.¹⁵⁷ Strategies had to be located within broader socio-political struggles and to reflect the interdependent nature of countries in the region.

Nzo argued that if AIDS was a social disease, responsibility for prevention and control could not be 'the main preserve and responsibility of the individual and the medical profession', and declared that 'the African National Congress wants to place on record, that through you, it stands committed to support the programmes and strategies that will alleviate the suffering of the AIDS victims and at the same time control the transmission of HIV infection'.¹⁵⁸ This analysis did much to contextualise AIDS in a broader socio-political context, but there was no clear articulation of organisational responsibility or the role of the NEC in realising these aims. Instead, support for programmes was to rest on the individuals attending the workshop.

It is possible that this may have been a means of encouraging a consultative rather than top-down process. Considering the realities of the ANC's hierarchical organisational structure however, there is little indication in this statement of the exact role that the NEC saw itself playing, and no commitment from the NEC to implement the agreed programmes. As had happened in other fora where AIDS programmes were discussed, the NEC made verbal statements that do not appear to have been matched by practical responses.

One of the most articulate and sensitive documents dealing with AIDS and the ANC is one credited to Chris Hani. He identified the Lusaka workshop as part of an ongoing effort to formulate 'a comprehensive AIDS policy for South Africa' and suggested that the urgency of addressing AIDS had been raised at NEC level by himself and others.¹⁵⁹

It is my view that a forum of this nature is long overdue. Today's meeting categorically underlines a firm belief that many of us hold, that the prevention and control of AIDS and HIV infection should not be regarded as a holy preserve

¹⁵⁷ UFH-AA, ALM, pt 2, 64, c3, Keynote Speech by Secretary General – ANC HIV/AIDS Workshop, p. 2.

¹⁵⁸ *Ibid.*, p. 3.

¹⁵⁹ UFH-AA, ALM, pt 2, 64, c3, Paper by Chris Hani to the AIDS Workshop, p. 1.

for health professionals only. It needs active and conscious participation of all of us and our communities.¹⁶⁰

His emphasis was on the need for holistic, inclusive and comprehensive responses to AIDS and for the ANC to establish itself 'as an alternative power with the capacity to govern'.¹⁶¹ He provided a layered and nuanced understanding of the requirements for successful, inclusive responses to AIDS and, more generally, for the creation of a democratic society: '... such broad popular participation is inconceivable without strong organisation which in turn must be built on the solid foundations of a deeply embedded democratic culture'.¹⁶² The legacy was 'more sinister ... leaving behind a deeply divided society characterised by mistrust, racism and mutual suspicion'; those who were devoted to 'the attainment of the noble ideals of social justice, equality and peace [were] once more called upon to inherit this unfortunate legacy' and make 'strategic interventions' around issues that would have long term consequences, such as the AIDS epidemic.¹⁶³

Hani linked responses to AIDS with broader transformation struggles and highlighted the connection between the two, '... because some of us might regard this as a diversion from the important task of transfer of power to the people ...'.¹⁶⁴ There was a strong imperative to take the problem seriously:

We cannot afford to allow the AIDS epidemic to ruin the realisation of our dreams. Our people want a better life. They are fighting heroically to achieve this. As vanguard fighters we have a duty, in fact a moral obligation to continuously identify those factors which block the way to that future. This is also a major political task.¹⁶⁵

As a high-ranking MK soldier Hani used military language when 'strongly appealing' to health workers to 'initiate appropriate programmes that will raise awareness within our ranks' before directly addressing MK soldiers: 'I also wish to make a special appeal, on behalf of the

¹⁶⁰ UFH-AA, ALM, pt 2, 64, c3, Paper by Chris Hani to the AIDS Workshop, p. 1.

¹⁶¹ *Ibid.*

¹⁶² *Ibid.*

¹⁶³ *Ibid.*, p. 2.

¹⁶⁴ *Ibid.*

¹⁶⁵ *Ibid.*, p. 3.

Military Head Quarters for greater involvement of the cadres of Mkonto we Sizwe [sic] in such programmes'.¹⁶⁶ Soldiers were not sufficiently engaged in addressing AIDS. His final appeal was impassioned:

We, ourselves, have to reassess our attitudes and shed the baggage we might have inherited from the past. We must struggle hard to produce cadres, who by power of example, will inspire our people to even greater commitment to destroy apartheid ... and in its place build a caring, equitable non-sexist and non-racial democracy.¹⁶⁷

The final report on the workshop was more assertive in affirming the ANC's position on AIDS:

The African National Congress, true to its historical calling as leader and organiser of the people of our country, and indeed as an alternative [sic] to the apartheid regime, has taken a decision to prioritize the problem of AIDS.

... the ANC is increasingly being called upon to make strategic interventions. The African National Congress has renewed its commitment to the prevention and control of AIDS/HIV as a matter of priority.¹⁶⁸

The report acknowledged that 'in the beginning', as with all responses world-wide, the lack of clarity about AIDS within the ANC, combined with the close association of AIDS with the taboo subject of sexuality, resulted in the ADoH belatedly 'looking for responses' to it.¹⁶⁹ The ADoH only 'began to ponder upon this situation [the situation relating to AIDS]' in 1988, with the assistance of the Swedish International Development Cooperation Agency (SIDA), and this 'delayed response ... caused the movement to pay a high price'.¹⁷⁰ A formal programme had been launched in 1989, but a 'lack of facilities' hampered implementation. Despite these setbacks the ADoH had provided practical responses to AIDS and had succeeded in 'mobilising health educators, providing videos on AIDS, and holding seminars'.¹⁷¹

¹⁶⁶ UFH-AA, ALM, pt 2, 64, c3, Paper by Chris Hani to the AIDS Workshop, p.3.

¹⁶⁷ *Ibid.*

¹⁶⁸ UFH-AA, ALM, p2a, 42, 104, Department of Health Seminar Report...Control of AIDS/HIV Infection', pp. 2 - 3.

¹⁶⁹ *Ibid.*, p. 3.

¹⁷⁰ *Ibid.* For more on SIDA see the SIDA website at www.sida.se (accessed August 2010). The website defines SIDA's role as working 'according to directives of the Swedish Parliament and Government to reduce poverty in the world.'

¹⁷¹ UFH-AA, ALM, p2a, 42, 104, Department of Health Seminar Report...Control of AIDS/HIV Infection', p. 3.

The final report emphasised key themes and decisions from the workshop, especially the importance of political commitment and inclusive, community-driven responses to successfully address AIDS. Stress was placed on the need to include AIDS campaigns in overall political campaigns undertaken by the ANC and the MDM (Mass Democratic Movement), and to develop holistic responses that drew on a variety of media to get prevention and education messages across. The suggestions made in Lusaka built upon the progressive discourse evident at the Maputo conference and produced a vague blue-print for responses at organisational, regional and country level.¹⁷²

The report produced a series of recommendations for the ANC's AIDS programmes: a call to strengthen the programme desk responsible for AIDS interventions within the ADoH, and the establishment of 'Health Education Units' in areas where they did not exist. It recommended that the NEC create an ANC AIDS Task Force composed of elected full-time individuals from a number of ANC departments, including women, youth, education, health, culture, and military HQ. While the ADoH was tasked with ensuring the creation of this Task Force, no deadlines for implementation of any of the suggestions were set.¹⁷³

The lack of archival sources from mid-1990 to 1994 dealing with the implementation of any of the Lusaka recommendations relating to AIDS programmes suggests that the ANC's engagement in negotiations for political transition in South Africa took organisational priority. As the external missions and offices closed down and ANC members began returning to South Africa, files, folders and minutes also got packed up, transported, or forgotten, so there is little paper evidence of any additional AIDS campaigns or interventions aside from ANC members involved in the NACOSA conference and committee. When the ANC re-emerged as the ruling-party in 1994, its responses to AIDS were no longer focussed on the movement, but rather on the country as a whole and were guided by the National AIDS Plan.

¹⁷² UFH-AA, ALM, p2a, 42, 104, Department of Health Seminar Report...Control of AIDS/HIV Infection' pp. 4 - 7.

¹⁷³ *Ibid.*, pp. 4 - 5.

Collaboration and International Assistance for ANC AIDS Programmes

By the 1980s the ANC had established a significant number of international ties with several governments, solidarity groups, anti-apartheid organisations, aid groups and international bodies like the United Nations. These relationships extended to the ADoH which maintained ties with solidarity groups and progressive health organisations and had well-established links with the World Health Organisation (WHO). ADoH representatives were sufficiently active in the WHO Africa Regional Committee to ensure that an international conference on 'Health and Apartheid' was held in 1981.¹⁷⁴ Ongoing international collaboration and support for the ANC extended to the provision of health care, perhaps best symbolised by the ANC-Holland Solidarity Hospital opened in 1984, and to addressing AIDS amongst comrades.

The ADoH was involved in regional collaborations, running health workshops and formulating joint programmes of action on an array of health topics with organisations like the South West African People's Organisation (SWAPO).¹⁷⁵ The regional support for the ADoH was evident from the messages of support received for the Third Health Council held in 1986. Messages came from the WHO, SWAPO, SACTU, the SACP, and the ministers of health of Zambia, Angola, Zimbabwe and Tanzania.¹⁷⁶

In addition to meetings between progressive health care workers and ANC members held in South Africa, the UK RHT provided opportunities for meetings between ADoH members and members of progressive health organisations like NAMDA in the safer locale of London. The UK RHT had contact with 'a senior establishment person in the Medical Research Council (MRC) who was concerned that nothing was being done for the prevention of AIDS in the

¹⁷⁴ UFH-AA, ALM, p2a, 6, 7, Health Department Circular to ALL A.N.C. (S.A) Health Teams, 26 November, 1980. For a list of other international conferences relating to apartheid see E. S. Reddy *International Conferences, Seminars and Other Events against Apartheid, 1964-1994* on the ANC website at: www.anc.org.za/ancdocs/history/solidarity/conferences/confs.html (accessed June 2010).

¹⁷⁵ 'Interview: ANC Health Department', *Critical Health*, 31/32, August 1990, p. 55.

¹⁷⁶ WHO – the World Health Organisation, SWAPO – the South West Africa People's Organisation, SACTU-South African Congress of Trade Unions, and the SACP – South African Communist Party. There were also messages of support from within the organisation from MK, the ANC's Women's Section, and the ANC Youth League and a member of the NEC gave the opening address on behalf of the ANC. UFH-AA, ALM 127, 236, Draft Health Secretariat Report to the 3rd Health Council Meeting, 29 July 1986.

Black community in SA'.¹⁷⁷ The MRC was the key site for AIDS research in South Africa and was government-funded. So some medical professionals working within apartheid health structures were meeting with members of a banned organisation, presumably out of a sense of urgency over the apartheid government's inadequate response to AIDS in particular communities.¹⁷⁸

As early as the 1986 Health Conference, some health care professionals highlighted the importance of learning from host communities and making use of relations with local governments. Dr Bob Mayekiso suggested that the ADoH obtain 'a copy of the Zambian Conference on AIDS proceedings', while urging that 'AIDS be the topic of our first health education campaign'.¹⁷⁹

The ANC and NAMDA met in Zimbabwe in October 1989 to discuss key health concerns. NAMDA published a *Special Bulletin* on the meeting that included the report from the commission on AIDS. The *Bulletin* was circulated to NAMDA members and progressive health care workers in South Africa and provided them with insights into how AIDS was perceived and understood by the ANC. The report highlighted the fragmentation of health services, migrant labour, hostility to family planning, and inhibitions about discussing sexual practices as some of the factors that would complicate addressing AIDS in South Africa.¹⁸⁰ The report noted that 'AIDS is already a problem of massive proportions. At this stage it is not possible to defeat the HIV virus [sic], but it could be possible to contain it'.¹⁸¹ The lack of an efficient and effective response to AIDS was noted: 'The Commission felt a strong sense of urgency about this problem and great anxiety that "lip-service" only was being paid to this extremely

¹⁷⁷ UFH-AA, ALM, p2a, 42, 89, Report....Health Team UK, p. 4.

¹⁷⁸ For more on this see the chapter on NAMDA and health activists.

¹⁷⁹ UFH-AA, ALM 161, 3C, 'Plenary Session – Discussion of Scientific Papers', p. 2. Hugh Macmillan, who was close to the ANC in exile and a history lecturer at the University of Zambia from 1978 – 1995, recalls that the public declaration by Zambian President Kenneth Kaunda in January 1987 that his son Masuzyo Gwebe Kaunda (who had died on 23 December 1986) had died of AIDS was significant for the country. MacMillan recalls that although there was awareness of HIV in Zambia by 1986, 'Kaunda's announcement was the major event in raising awareness and concern' and this was discussed amongst ANC members in the country. Personal email correspondence with Hugh MacMillan, 4 February 2012.

¹⁸⁰ SAHA, NC, AL3182, A1.8.2, 'NAMDA – ANC Meeting, 21–22 October 1989', NAMDA Special Bulletin 3, February 1990, p. 19.

¹⁸¹ *Ibid.*

serious problem by the various organisations who needed to become involved in combating AIDS'.¹⁸²

Information on international assistance for ANC-led AIDS programmes is most abundant for 1989 – 1990 and reveals a variety of types of support. A letter from Rigmor Thorstensson, an immunologist based in Stockholm, to Ralph Mgiijima reveals an ongoing relationship between Thorstensson's department and ANC health sites in Lusaka and Mazimbu that included the training of lab personnel.¹⁸³ A colleague or student of Thorstensson, Lilian Walther, visited the sites in 1989 to train laboratory personnel in HIV and STI screening, but the training was hampered because the laboratory buildings in Lusaka were unfinished.

There was also a plan to conduct 'some kind of sero-survey in the ANC communities'.¹⁸⁴ The survey was to have tested anonymous samples of clinic attendees or been a targeted study incorporating informed consent and counselling. Thorstensson had made previous visits to Mazimbu and a consultative process with health care members and staff at the Holland-Solidarity Hospital had resulted in a strategy to collect anonymous samples on an ongoing basis. These samples were to be tested and analysed by Walther on her arrival and used to train ANC lab personnel. But this project was delayed and Thorstensson was awaiting more information from Mgiijima about the progress of the lab before organising follow up visits. There is no further correspondence indicating whether additional training took place or whether the sero-survey was ever carried out. The chance to fulfil one of the Health Secretariat and NEC requirements - to obtain epidemiological information on HIV infection rates amongst comrades – could have been met and could have provided useful information to facilitate responses to HIV and AIDS.

Thorstensson's collaboration with the ANC had been facilitated by the ARO. The ADoH had initially approached the ARO to administer the AIDS programme, which itself was one of three programmes funded by SIDA.¹⁸⁵ SIDA's collaboration with the ANC was divided into

¹⁸² SAHA, NC, AL3182, A1.8.2, 'NAMDA – ANC Meeting', p. 21.

¹⁸³ UFH-AA, ALM, pt.2 ad, 6, 9, correspondence Thorstensson to Mgiijima, 1 August 1989.

¹⁸⁴ *Ibid.*, p. 1.

¹⁸⁵ For more on the cooperation between the ANC and SIDA see UFH-AA, ALM, pt.2 ad, 6, 9, ANC Department of Health *ANC-SIDA Co-operation Progress Report*, 1988-1989.

three components: information provision (specifically the provision of booklets and teaching materials); the supply of laboratory equipment for HIV anti-body testing; and funding for regional AIDS education programmes, including workshops and home visits.¹⁸⁶

The flow of letters between the ARO's Mirjam Dahlgren and Mgijima reveal a comfortable and friendly correspondence on a variety of subjects, including the way in which ARO could assist with setting up labs and shipping out laboratory equipment, which HIV anti-body test kits should be purchased and who would be tested.¹⁸⁷ This correspondence eventually resulted in Thorstensson's and Walther's visits.

The ARO ordered medical literature for the ANC, and Dahlgren attended a seminar on HIV and AIDS information and counselling work that included participants from Sweden, Mozambique, Zambia, Uganda and Tanzania. She posted a book on the subject (entitled *Society and HIV/AIDS*) to Mgijima with offers to secure more copies if they were deemed useful.¹⁸⁸ In between coordinating health care professionals to work with the ANC, Dahlgren sent copies of articles and extracts from books such as Chirumuuta's *AIDS, Africa and Racism*.¹⁸⁹ The ARO paid for subscriptions to four AIDS-related journals, and for AIDS videos from the WHO, shared contact details for useful organisations and individuals, and provided funding for workshops, pamphlets, and information packages on STIs.¹⁹⁰

Dahlgren suggested an additional workshop for health educators and called for greater efforts to remove the stigma attached to discussing STIs and unplanned pregnancies.¹⁹¹

¹⁸⁶See UFH-AA, ALM, pt.2a, 33, 2, Minutes of Meeting between H.S and NPA, 4 May 1990 and UFH-AA, ALM, p2a, 9, 34, Memorandum to NPA-Oslo/Gunvor from NPA-Harare/Laila, 9 May 1990.

¹⁸⁷ UFH-AA, ALM, pt.2 ad, 6, 9, correspondence, Ralph Mgijima to Mirjam Dahlgren, 27 January 1989. In relation to types of tests and how they would be used, Mgijima notes: 'As to for the question of whether testing should be at "different levels in different places" I thought we had agreed that all ANC settlements need the ELISA test whereas one Western Blot method would be made available only in East Africa. If the question refers to the community levels the answer would be at all levels depending on the indications for the testing.'

¹⁸⁸ UFH-AA, ALM, pt.2 ad, 6, 9, correspondence, Mirjam Dahlgren to Ralph Mgijima, 21 March 1989.

¹⁸⁹ UFH-AA, ALM, pt.2 ad, 6, 9, correspondence, Mirjam Dahlgren to Ralph Mgijima, 5 April 1989.

¹⁹⁰ UFH-AA, ALM, pt.2 ad, 6, 9, correspondence between Mirjam Dahlgren and Ralph Mgijima, 29 June 1989, 30 June 1989 and 8 March 1990.

¹⁹¹ It must be noted that Dahlgren's comments were not made in a patronizing way and the letter indicates her concern about not being too 'preachy' but offering support and advice based on similar experiences in Sweden. Later correspondence indicate that times for a follow-up seminar and evaluations of ANC health professionals' experiences in counselling comrades about HIV or other STDs, were discussed. See UFH-AA, ALM, pt.2 ad, 6, 9, correspondence, Christina Larsson to Ralph Mgijima, 20 September 1989.

Additional seminars were held, although there is no clear indication of how successful these may have been. The agreement between the ARO and the ANC was extended and the project expanded from the original three regions (Tanzania, Angola and Zambia) to include Zimbabwe and Mozambique. The RHT heads for these regions were asked to discuss the issue of stigma and the need for workshops with their health teams.¹⁹² SIDA, via the ARO, agreed to fund regional seminars and workshops in 1990, but the ADoH declared the need for a national workshop on AIDS.

In May 1990 the ADoH approached Norwegian People's Aid (NPA) to fund a national workshop and discussed the matter during a meeting with the NPA Regional Director, Laila Nikolaisen.¹⁹³ At the meeting it was acknowledged that the ANC needed to look at AIDS policies in southern Africa in order to formulate a strategy, and declared that NPA needed to 'bail them out'.¹⁹⁴ It is not clear if the 'bail out' was financial in nature or referred to other types of support, but the use of such a strong term implies a crisis on some level. The minutes of the meeting noted that the ANC worked 'hand in glove' with the regional WHO representatives who were coordinating AIDS programmes in Zambia, and that the aim of the workshop was 'to commit the ANC in [sic] issuing a policy statement on AIDS'.¹⁹⁵ It is not clear how the Maputo and Lusaka meetings and the Draft Statement on AIDS related to this discussion.

The NPA assisted the ADoH in a number of ways: covering office rental, supplying textbooks, contributing to building maintenance, and providing ambulances in Angola and Uganda.¹⁹⁶ An AIDS workshop was proposed with the primary aim 'to enable the ANC to work out a ANC policy on AIDS for the whole of Southern Africa including South Africa' with the hope that by

¹⁹² UFH-AA, ALM, p2a, 9, 30 correspondence, Lungile Makhanda to Comrade Alice, Head RHT, Harare, 9 March 1990.

¹⁹³ For more on Norwegian People's Aid (NPA) see the NPA website at www.npaid.org (accessed August 2010). A brief overview of NPA's specific involvement in South Africa is available on the website under the 'Where we work' page. More generally, the NPA describes itself as '...a humanitarian organization rooted in the Norwegian Labour Movement' that 'supports people in their struggle for more power and influence over their own lives and in the development of their societies.'

¹⁹⁴ UFH-AA, ALM, p2a, 33, 2, Minutes of Meeting between H.S and NPA, 4 May 1990, p. 3.

¹⁹⁵ *Ibid.*, p. 4.

¹⁹⁶ UFH-AA, ALM, p2a, 9, 34, Memorandum to NPA-Oslo/Gunvor from NPA-Harare/Laila, 9 May 1990.

the end of the workshop an 'ANC policy on AIDS is worked out.'¹⁹⁷ A positive response to the workshop funding request was likely based on preliminary discussions within the NPA.

The information sent by ARO, combined with internal organisational reports and presentations at seminars, and additional literature and information provided by the RHT UK, suggests an ongoing flow of information to the ADoH about AIDS. In addition to 'training information' and global medical updates, members of the ADoH would also have had formal and informal reports of the experiences of health care providers at the clinics and hospitals. Health care providers not only had first-hand experience of providing care and support for comrades with AIDS, but also communicated with doctors and other health personnel in situations where comrades were referred to university or local hospitals for treatment. Despite these information flows it is evident that information was not spread equally across the organisation, or amongst all levels of leadership.

People, Policy, and Politics: Comrades with AIDS and AIDS Narratives

The written archive primarily provides information on ADoH and RHT plans and programmes relating to AIDS and offers insights into the agendas, discussions, meetings, seminars, conferences and workshops that took place. The archive offers glimpses into the types of educative media produced and the struggles involved in implementing programmes and campaigns. Less easy to see are the people behind the programmes, the comrades and health care workers who were facing the realities of living and dying with AIDS and related complexes. The experiences of comrades with AIDS were complicated by the fears, stigmas and myths surrounding AIDS, and people with AIDS, and by the lack of effective policy and programme implementation by the ADoH, MHQ, and RHTs. Their experiences were also complicated by the overarching politics inherent in a liberation movement.

While reports and minutes necessarily presented infection figures in a less personal way, there are reminders in the archives of the individuals behind the figures and of the complex personal relationships between health care workers and comrades with AIDS. In a letter of

¹⁹⁷ UFH-AA, ALM, p2a, 9, 34, Memorandum to NPA-Oslo/Gunvor from NPA-Harare/Laila, 9 May 1990, p. 2.

1987, for example, Dr Haggard of the RHT in Luanda wrote to the ADoH in Lusaka: 'Dear Comrades, This is to inform you that comrade Dorah's diagnosis has been confirmed by the authorities from our region. And that she has AIDS'.¹⁹⁸ Another letter from Ralph Mgijima to the Secretary General in Lusaka in 1988 relates to HIV-positive comrade, Mercy Singh,¹⁹⁹ and considers which country would be the best one for Singh to reside in. Singh's father was a citizen of the German Democratic Republic (GDR) and Mgijima recommended that the GDR embassy be approached 'frankly' to see if she would be allowed to stay in the GDR.²⁰⁰ Alternatively, Mgijima suggested that a scholarship could be found to allow her 'to continue her studies in Harare or U.K. where she would be residing at student's quarters' and presumably have better access to care.²⁰¹ No further correspondence relating to Singh was found, so where she ended up and what happened to her is unknown.

At the 1986 Health Council a response to a paper on AIDS from Comrade Doreen is minuted: 'Cde Doreen pleaded that, where comrades fall victim to AIDS, we do not abandon them, but give them the support they desperately need'.²⁰² Doreen's plea was a compassionate call for support rather than stigmatisation. In light of other comments made at the Health Council and elsewhere about stigma associated with STIs generally, and a specific lack of information about AIDS amongst health care workers and comrades resulting in an unsympathetic attitude, this was not surprising.²⁰³

Some health care workers were proactive in raising concerns about stigma, as the minutes of a meeting of the Emmasdale Clinic staff in Zambia held in November 1986 reveal:

Third patient diagnosed [with] AIDS, arrived from the Soviet Union. His medical report will follow. There are now 6 patients in all with the same diagnosis. Dr

¹⁹⁸ UFH-AA, ALM, p2 ad, 6, 6, correspondence Haggard to Health Secretariat, 24 August 1987.

¹⁹⁹ UFH-AA, ALM, p2 ad, 6, 9, correspondence Mgijima to ANC Secretary General, Lusaka, 21 July 1988.

²⁰⁰ The German Democratic Republic or *Deutsche Demokratische Republik* comprised the socialist state established in 1949 in the Soviet zone of occupied Germany (including East Berlin) and was sometimes referred to as 'East Germany'. In 1990, Germany was reunified and the GDR and the Federal Republic of Germany now make up the new FRG or *Bundesrepublik Deutschland*.

²⁰¹ UFH-AA, ALM, pt2ad, 6, 9, correspondence Mgijima to ANC Secretary General, Lusaka, 21 July 1988.

²⁰² UFH-AA, ALM, 161, 3C, 'Plenary Session – Discussion of Scientific papers', p. 2.

²⁰³ See comment earlier in text regarding the 'lack of a sympathetic and understanding attitude towards patients' and health care workers 'lacking adequate knowledge about the disease', UFH-AA, ALM, p2a, 33, 1, Meeting of the Health Secretariat with the Clinic Staff, p. 3.

Chabalala [sic] suggested that we arrange some educative programmes on AIDS and other STDs for the comrades so that they should not shun the patients but stay with them as comrades. The comrades next door are already complaining of the presence of this other patient from the Soviet Union.²⁰⁴

Not only are the concerns of health care staff about how to address AIDS evident, but the minutes also provide insight into the early experiences of ANC comrades with AIDS who faced disapproval, lack of support and social isolation. Conversely, the health report from Zambia for July to September 1987 contained information on the case of a comrade, Joe Ethwell, who appears to have received support and sympathy from health care workers.²⁰⁵

The notes on Ethwell's case provide one of the most detailed accounts of the experience of a comrade with AIDS

Joe Ethwell: Died at the UTH on the 5th October 1987. Cde Joe was 23 yrs old and he first attended our clinic on 2/6/87, and diagnosis was STD. According to his case notes he stated that he had the same problem in 1985. Anti-biotics were administered and condoms were given. The patient never reported back for review.

He then reappeared on 28/7/87 with multiple body abscesses – for which he was treated with Ampiciliin caps. Again he didn't come for review. The patient reappeared on the 11/8/87, c/o chest pain on breathing, rashes all over the body – with a temperature of 37.3 degrees ... we reached a diagnosis of 1. Flu; 2. Fungal infection. He was treated and appeared to be responding to treatment.

²⁰⁴ UFH-AA, ALM, p2a, 33, 5, Minutes Meeting 3, Emmasdale Clinic Meetings, 11 November 1986, p. 1. The urban-based Emmasdale Clinic in Lusaka, Zambia, was built by the ANC to provide primary health care to ANC members in the region. The minutes note particular concerns about comrades not being willing to help medical staff with the cleaning, shifting, or moving of corpses, but then clamouring to go to funerals as an 'outing'. This suggests a burden of care placed on health care workers despite the assumption that comrades using the facilities would provide help where possible. On another note, considering the narrative of 'the infected vector' from 'beyond the border' that occupied much of the early medico-political AIDS narrative, it would be interesting to establish if the patient 'from the Soviet Union' had contracted HIV while in the Soviet Union or had already been infected when he left. According to AVERT the first official AIDS cases in Russia were recorded in 1987 and were followed by massive testing drives and 'fear-driven' campaigns (see the AVERT website, History of AIDS section at www.avert.org/aids-history87-92.htm, accessed May 2010), so preliminary infections would have occurred in the early 1980s. The ANC had a relationship with the Soviet Union that included sending students to study in Soviet universities, and sending patients requiring specialist medical attention to the Soviet Union for treatment.

²⁰⁵ UFH-AA, ALM, p2a, 42, 89, Zambia Health Report – Period July – Aug-Sep, p. 2.

On the 14/9/87, the patient reported again with a severe headache – occipital and very anaemic symptomatic treatment was given. On the 22/9/87, the patient reported back with the same occipital headache and a backache – his condition had deteriorated. He was referred to the UTH for admission.

At the UTH the patients' condition was deteriorating very fast, he was unable to feed himself or sit up in bed. We were feeding him each time we took food to the hospital.

He passed away in the early hours at 00h01 on Monday 5/10/87. The doctors suspected AIDS? [sic] (HIV).²⁰⁶

The support of health care workers is evident in this account, and the case notes detailed the AIDS-related illnesses that were already part of the global litany of opportunistic infections. The emotional anguish of Ethwell as he became weaker and eventually died - away from his home and family - can only be guessed at, and perhaps differed from the experiences of others who died in exile in that he may not have been aware of what it was that he was dying from.

At the seminar in Lusaka in October 1987, the rapporteur's notes indicate that there was 'a moment of silence observed for a deceased comrade, Joe Ethwell'.²⁰⁷ The rapporteur's notes go on to reveal that 'Cde N..., the M.O [medical officer], gave a brief medical history of the deceased. The matter is still being looked into'.²⁰⁸ It is unclear if it was standard practice for all deaths to be investigated or if Ethwell's death was significant because it was suspected that he died from AIDS-related illnesses. Later in the proceedings a question was raised whether 'in the event of comrades dying of AIDS ... the MOs [should] confirm that the comrades did die of AIDS'?²⁰⁹ While no answer is recorded, the fact that the question was asked indicates a specific concern about AIDS as a cause of death, although the reason for the concern is unknown. It is possible that there were concerns about the memory of the deceased being tarnished, or it is possible that people wanted AIDS deaths to be publically acknowledged to highlight the seriousness of the syndrome. A third possibility is that there

²⁰⁶ UFH-AA, ALM, p2a, 42, 89, Zambia Health Report – Period July – Aug-Sep, pp. 3 - 4.

²⁰⁷ See UFH-AA, ALM, p2a, 42, 103, rapporteur's notes on the Adoption of Agenda, Programme of Work, 10 October 1987, and General Session, 12 October 1987.

²⁰⁸ *Ibid.*

²⁰⁹ See UFH-AA, ALM, p2a, 42, 103, rapporteur's notes on the Report of the East Africa RHT, 11 October 1987.

was a concern about the political implications of HIV transmission and AIDS-related deaths becoming known to the apartheid government and being used as propaganda against the movement.

During the Lusaka seminar there were several discussions which highlight the complex interplay between the health needs of members of the movement, including those living with AIDS, the need to allay fears amongst comrades, and the broader political agenda of the organisation. The topics ranged from where comrades who were HIV positive should be allowed to go to what they should be allowed to do, and included questions about personal responsibilities for safe sexual practices, and organisation-wide decisions and directives.

The seminar attendees took a decision that 'people with HIV positive [sic] and AIDS must forthwith not be sent inside the country [South Africa]'.²¹⁰ It was revealed that all comrades who were homeward bound were already being screened for AIDS and other diseases, and that AIDS campaigns specifically designed for comrades in transit back to South Africa had been initiated.²¹¹ Notes from another discussion listed three political implications associated with sending HIV positive comrades into South Africa namely 'that it would do enormous harm to us should the enemy find it out, the danger to our people, the morality of the issue'.²¹²

Despite the support and legitimacy that the ANC and other liberation movements had amongst the majority of South Africans, and the fact that AIDS was already a reality in South Africa by 1987, the ANC clearly felt that knowledge that comrades had HIV would be so politically sensitive to cause 'enormous harm' to the organisation, presumably both within South Africa and internationally. It is possible that the organisation was concerned that the AIDS stigma within South Africa was so great that knowledge of ANC comrades having AIDS would result in a loss of support for the organisation, tarnish its image as a liberation

²¹⁰ See UFH-AA, ALM, p2a, 42, 103, rapporteur's notes headed 'General', 12 October 1987.

²¹¹ See UFH-AA, ALM, p2a, 42, 103, rapporteur's notes on Report to the NEC from the Health Secretariat, 10 October 1987.

²¹² See UFH-AA, ALM, p2a, 42, 103, rapporteur's notes from plenary session – treatment abroad, 11 October 1987.

movement, and provide its political rivals with damaging information that could be exploited.²¹³

Another possibility is that some ANC members had unresolved issues related to stigma and shame about comrades having AIDS. The reference to the 'morality' of the issue would suggest either that there was a perception of the organisation as having a particular moral or ethical personality that would be called into question by a public acknowledgement of sexually transmitted infection amongst members, or it could speak to a broader ideological engagement with, and concern about, the racist stereotyping of 'rampant black African sexuality' associated with the hegemonic AIDS narrative. This speculative analysis requires additional research, and would be interesting to pursue in light of Mbeki's evocation of scientific racism in AIDS research during his presidency. The concern about 'the danger to our people' is one that highlights the complexities of sexual landscapes and the features that form and shape them. It also highlights the tensions between the political objectives of a liberation organisation and the personal decisions made by its members.

According to Lund by the late 1980s there were 'concerns about the rate of AIDS in the camps', which took on added significance when the ANC was preparing to come back to South Africa, as the ANC 'would just get hammered for bringing AIDS into the country'.²¹⁴ She observed that the years 1989 – 1990, 'the time of change ... was an extremely historical moment for AIDS because suddenly the attention was on much, much bigger ... national priorities ...'.²¹⁵ This shift in focus resulted in 'one of those extraordinary historical ironies' as other priorities occupied the ANC, both during and after transition. The significance of AIDS was relegated at a time when infection rates increased.²¹⁶

²¹³ The reference to 'enormous harm' if the enemy found out may indicate that the ANC was aware of the threat of the 'infected terrorist from across the border' being invoked by certain political parties within South Africa to engender fear amongst sectors of the South African population. See chapter on government responses to AIDS.

²¹⁴ Interview with Francie Lund.

²¹⁵ *Ibid.*

²¹⁶ Additional research on how extensive stigma was or how it affected comrades individually or as part of communities is needed.

The notes from the seminar refer to the ADoH testing home-bound comrades for HIV antibodies and sending the results to MHQ, who then failed to inform people of the results. This echoes a similar complaint made by the ADoH to the NEC, and demonstrates a lack of concern about the anxiety that those awaiting the results may have felt.²¹⁷ There were discussions about ‘the feasibility of such a person [an HIV positive person] being able to carry out a mission in the first place’, and ‘The general feeling of cdes in the army is that they [HIV positive people] should be given suicide missions’.²¹⁸ It is difficult to assess how widespread or strongly held such feelings were, or whether they merely speak to the harsh realities of a liberation war in which some soldiers may have felt that if people were going to die anyway, they might as well die for the cause.

At the seminar it was stated that there was ‘an urgent need for a serious meeting with the MHQ because we are sitting on a time bomb and they must be made aware of this’.²¹⁹ The time bomb related to the behaviour of individuals (in this instance presumably MK soldiers) and reference was made to the case of an HIV positive person who had been stationed in Angola when his status was confirmed. The person apparently indicated that he understood the implications of having multiple sexual partners and indicated that he would no longer ‘sleep around’ but was known to be ‘sleeping around’ in Zambia.²²⁰ People at the meeting were particularly concerned about the implications of ‘such a person’ going home. This served as a reminder that decisions about sexual practice are complex and not easily altered by merely telling people to change their behaviour.²²¹

A progress report on AIDS projects in the Angola region for late 1989 reveals that some of the ideas raised in the 1987 seminar were still prevalent and shows that knowledge about AIDS amongst comrades had not necessarily improved. The report noted that ‘the [AIDS] project and some other things were suspended due to the process of withdrawal’, but, despite the unsettled nature of the region there had been talks, discussions and video screenings that ‘had an impact especially regarding knowledge about transmission of the

²¹⁷ See UFH-AA, ALM, p2a, 42, 103, rapporteur’s notes from plenary session.

²¹⁸ *Ibid.*

²¹⁹ *Ibid.*

²²⁰ *Ibid.*

²²¹ *Ibid.*

disease and attitudes towards AIDS patients'.²²² The programme had been initiated on the assumption that 'people's knowledge was minimal and confused', but there was an 'intense wish to learn about the subject'.²²³

The report goes on to list five key questions needing further discussion. The first related to the origin of AIDS: 'cde's are more interested in it than any other thing' and had not been satisfied with the information that had been provided. There were two questions relating to HIV antibody testing, one proposing that partners should be tested before marriage, and a second suggesting that all ANC comrades should be tested. Members of the RHT tried to explain that there was no need for this but that some comrades were 'still pushing it'.²²⁴

The remaining two questions provide evidence of the stigma and fear amongst comrades referred to in other fora and documents. Some comrades 'feel that those cde's who are H.I.V. positive must be isolated from the community' and that 'M.K must give suicide missions to those who are H.I.V. positive'.²²⁵ It would appear that attempts to disseminate information about AIDS and encourage comrades to support rather than abandon people with HIV had not been particularly effective.

As late as June 1990 there is evidence that the discussions around, and decisions on, an organisational response to HIV-positive comrades had not met with much success. A letter from the regional secretary, Thami Magigwane, to the ADoH in Lusaka stated:

As common knowledge we have a steadily increasing number of patients suffering from H.I.V disease [sic]. This obviously affects our medico-political set up. Recently we have had to transfer one patient in the afore-mentioned category.

... we plead with the health secretariat to give us a clear-cut policy on the transfer of H.I.V patients for terminal care in Zimbabwe. We do not want at the

²²² UFH-AA, ALM, p2a, 42, 102, Angolan Region: Progress Report on "AIDS Project", compiled by Marks Seatlholo, November 1989, p. 1.

²²³ *Ibid.*

²²⁴ *Ibid.*, p. 2.

²²⁵ *Ibid.*, p. 1.

end to be accused unfairly when H.I.V patient will demand the same consideration.²²⁶

The East Africa RHT was frustrated at the lack of a clear policy, as the number of HIV-positive comrades in the region had increased. HIV-positive comrades were considered to be terminally ill patients who needed palliative care. Considering the lack of access to antiretrovirals (ARVs) in 1990, this is not a surprising finding, but it does point to the emotional challenges faced by HIV-positive comrades and health care staff, and the logistical implications of moving people across borders to access palliative care.

Although archival material relating exclusively to AIDS for 1990 – 1994 is lacking, it is clear that there were comrades with HIV during this period. HIV positive comrades would still have needed assistance, and those with AIDS-related illnesses would still have needed medical or palliative care, so there must have been ongoing practical support of some type during this period of transition. Future research on how AIDS was addressed during this time will have to rely on private collections or oral interviews to shed light on the realities of addressing AIDS in a community about to come out of exile.²²⁷

The archive reveals differences to the hegemonic narratives found in the USA, the UK, and within South Africa, but also exposes some echoes of those narratives. The most evident difference in the ANC AIDS narratives is that the conservative, moralistic, and condemnatory tone evident in the hegemonic South African narrative is not as evident in official ANC correspondence. AIDS is also predominantly referred to as a shared health concern and not one assigned to an obvious external 'other' or AIDS avatar. There is, however, evidence of the repetition of the 'Western' and 'African' AIDS narrative, and some reference to high-risk groups.

²²⁶ UFH-AA, ALM, p2a, 9, 30, correspondence Thami Magigwane to Health Secretariat, Lusaka, 4 June 1990.

²²⁷ The reasons for a lack of information at this time could include the fact that ANC missions were preparing to return to South Africa and not all materials were retained or taken to South Africa; there may still be material in the ANC headquarters that has not yet been given to the archives; complete inventories of deposited materials may not be available; information that was deemed 'harmful' to the organisation may have been destroyed; or material may have simply been misplaced.

The minutes of an ADoH meeting with clinic staff of the Zambian RHT in April 1987 referred to ‘a selective screening programme of high-risk comrades’.²²⁸ This reference mirrors the idea of high-risk groups discussed elsewhere in the thesis, but there is no indication of how ‘high-risk comrades’ were defined or would be identified. If the conventional AIDS high-risk narrative was the basis for this statement then it would seemingly refer to homosexuals, drug users, haemophiliacs or sex workers (presumably Haitians were already excluded). Haemophiliacs would presumably have been few in number within the organisation given the limited health care available. Openly gay comrades may have fallen into the category but it is unclear how many comrades were openly LGBTI, or what the frequency of male-to-male sex was. It is also unlikely that intravenous-drug use would have been allowed, but that does not mean that IV drug use was not occurring. While it is unlikely that prostitution would have been formally condoned in the communities, it is possible that there was knowledge of comrades having sex with sex workers and therefore being considered high-risk.

The ‘high-risk’ categories could have been derived from concerns about the increasing incidence of STIs, and therefore referred specifically, for example, to comrades who had received treatment for STIs or sought advice on unplanned pregnancies or contraception. It is possible that sexually active comrades (of a particular age) were considered ‘high-risk’, but this definition was also mediated by the physical geography of exile, as a NAMDA Special Bulletin reveals.

The Bulletin reported on a meeting between the ANC and NAMDA in October 1989. Referring specifically to exile communities in southern Africa it noted that ‘their risk [was] increased’ by three factors namely: ‘a high incidence in the local population, e.g. Zambia, Tanzania, Uganda; there are many young people involved on the move resulting in many “one-night stands”; HIV is seen as less important than the political struggle’.²²⁹ The

²²⁸ UFH-AA, ALM, p2a, 33, 1, Meeting of the Health Secretariat with the Clinic Staff, p. 3.

²²⁹ SAHA, NC, AL3182, A1.8.2, ‘NAMDA – ANC Meeting, p. 19. A similar statement appeared in an ADoH paper prepared for the Maputo conference in 1990. The report noted that ANC communities were ‘unique in a number of ways’, one of which was the high level of mobility of ANC members, which meant that ‘...even most families are unable to live together... [and] ...this then poses a problem about the one partner strategy’. Reflecting on the realities of sexual activity in exile communities the paper further noted that ‘the communities are also very close-knit and there is a great deal of mixing in terms of relationships which create a potential for high rates of transmission even though the reservoir may be small’. See UFH-AA, ALM, p2a, 30, 24, Strategies

reference to ‘young people on the move’ engaging in ‘one-night stands’ suggests that it was ‘younger’ sexually active comrades who were seen as being more at risk. The reference to high incidences of AIDS in host populations relates risk to geographical boundaries and nationality in a manner that is reminiscent of hegemonic AIDS narratives, and of similar statements made by the East Africa RHT in a Health Report from 1987.²³⁰

The report intimated that the increased demand for condoms by comrades was being influenced by a growing concern or awareness about AIDS, but noted that STIs were rare among ‘the South African community’, and by implication, more common among the local (Tanzanian) community.²³¹ The use of the term ‘South African community’ suggests differences in sexual health between ‘South Africans’ and ‘non-South Africans’ and removes any distinctions relating to length of time in the region, length of time to get to the region, and original places of origin within South Africa, which may have influenced the health status of ANC members. The term was clearly meant as a short-hand way of identifying people which, although not used to vilify an ‘infected other’, does suggest a threat to an apparently uninfected ‘South African community’ by a ‘non-South African’ group.

Geography and nationality were also evoked in a paper given by the ADoH at the Maputo conference in 1990:

The African National Congress cannot escape the epidemic since its exile communities are in the countries [sic] with established epidemics ... South Africa is just at the start of the epidemic so it is critical and urgent that a national campaign should take root now if we are to avoid a catastrophic epidemic that other African countries are experiencing and whose magnitude is only beginning to be understood.²³²

This suggests a recognition of the AIDS epidemic beyond the borders of South Africa, but little engagement with what was known (or being speculated upon) about the epidemic in

for the control of AIDS in the African National Congress, p. 9. Ironically, of course, the realities of high levels of mobility were not unique to ANC members nor was the separation of families.

²³⁰ UFH-AA, ALM, p2a, 41, 64, Annual Regional Health Report East Africa from 1 January 1986 to 27 March 1987, p2a.

²³¹ *Ibid.*

²³² UFH-AA, ALM, p2a, 30, 24, Strategies for the control of AIDS in the African National Congress, p. 9.

South Africa, which was already eight years old by 1990. It also creates the impression of non-infected exile communities arriving in 'infected' host countries, without acknowledging the possibility of ANC exiles themselves being HIV-positive on arrival.

The concerns about the political significance of HIV positive ANC comrades returning home after having lived in 'high-risk' countries raised in the Lusaka seminar in 1987, featured again in the Maputo conference in 1990. By 1990 the HIV status of ANC comrades in exile communities featured in discussions in Parliament in South Africa, and also featured in discussions amongst organisations represented at the conference.²³³ A report on the special session on returnees noted that 'ANC cadres were only tested for HIV when entering countries that required this. However, the issue of AIDS in relation to returnees needs to be highlighted in order to dispel the myths that have been established around this issue'.²³⁴

What these myths were and where they were established is not elaborated on in the *Critical Health* report on the Maputo conference, but they were significant enough to have warranted a special mention in the publication. In an internal ANC report on the conference one of the 'important points' from the HIV commission states that 'all progressive health workers must pre-empt the regime's campaign that exiles will bring the AIDS virus into SA...'.²³⁵ This statement is problematic. AIDS was already in South Africa by 1990 – and, although primarily constructed as a 'gay white' disease, - the 'heterosexual transmission' of the HI virus amongst all 'population groups' was a reality so there should not have been any particular concern with dispelling myths relating to returnees with HIV.

Faced with the political myths and realities around HIV and AIDS at the time of transition, the ANC responded in contradictory ways. In some fora the ANC declared the need for AIDS education programmes in the organisation that would challenge the stigmatisation of people with AIDS. However, the ANC inadvertently stigmatised returnees with HIV by not fully

²³³ For more on concerns about the threat of infection from returnees see the chapter on government responses to AIDS.

²³⁴ *Critical Health*, p. 46.

²³⁵ UFH-AA, ALM, p2a, 30, 24, Mayford, Mkhulu and Mike, 'Report of Maputo Health and Welfare Conference (Apr 9-16 '90)', Harare, 3 May 1990, p. 2. The other 'important points' from the commission were listed as: 'formation of an AIDS task force in SA; AIDS to be put on the political agenda; the NEC of the ANC to make a statement on AIDS; and the State's resources must be used in the campaign'.

acknowledging their existence in other fora. The ANC did not have a clear idea of how many of the returnees were HIV-positive but had acknowledged that AIDS-related deaths were occurring, while highlighting the importance of addressing AIDS within the organisation and amongst the broader anti-apartheid movement. In light of this the ANC could not insist that returning exiles were HIV-negative or that AIDS was not already a reality in the movement.²³⁶

Conclusion

It is evident that the way in which AIDS was discussed, addressed, and responded to by ANC members and the ANC as an organisation, was context-specific, often contested, and influenced by the complexities of life in exile. The experiences of those providing health care to comrades with AIDS were mediated by a different engagement with AIDS to those of ANC members who were concerned with AIDS as only one aspect of health care. Similarly these engagements were different from those of members higher up in the organisation for whom health formed only one part of a much larger series of organisational concerns for a liberation movement engaged in an armed struggle and dependent on the support of sympathetic governments and anti-apartheid organisations for its survival.

The ANC NEC and the ADoH were initially unaware of, or not concerned with, AIDS during the early years of the epidemic in southern Africa. By 1986 AIDS was being discussed in Health Councils, and from 1987 AIDS appeared as more of an issue for the movement, featuring as a topic for discussion at meetings.

While the official structures may have been slower at recognising the importance of AIDS, RHTs and individuals with professional and / or personal experiences of AIDS were active in raising their concerns about AIDS with the ADoH and suggesting appropriate responses.

²³⁶ The experiences of doctors like Clarence Mini who worked in a hospital in Harare, Zimbabwe which treated soldiers from MK from the mid-1980s to the early 1990s, confirms that HIV infection and AIDS related opportunistic infections were prevalent amongst MK soldiers. He recalled 'We were saying to ourselves, now these guys are in transit, these guys are going home, and at some stage, if they are going to meet up with girls, the virus is going to spread. When we get home ... we just have to immerse ourselves in this and not have it devastating our country like Zimbabwe'. From Oppenheimer, G., & Bayer, R., *Shattered Dreams? : An Oral History of the South African AIDS Epidemic* (New York, Oxford University Press, 2007), p. 47.

Attempts at running AIDS education programmes, providing testing and counselling, or implementing responses, were hampered by various factors. These included the geographic spread of the organisation, material scarcity, and competing demands for limited resources across the organisation. Personal dynamics and personnel issues between members of the ADoH and RHTs, and communication problems between different sections of the ADoH and across various departments in the organisation hampered policy and protocol formulation and the implementation of practical responses.

The organisation also lacked the capacity or resources to address a new, unknown illness that was fatal and primarily transmitted via sexual intercourse. The ADoH had already highlighted unplanned pregnancies and STIs as organisation-wide problems, and then HIV complicated the sexual landscape further. While the physical end results of sexual activity were being highlighted as problematic, there was little engagement with the socio-political and personal ideologies that influenced sexual behaviour and, as a result, insufficient engagement with masculinities and gender dynamics within the movement that might have helped to address HIV transmission.

At a departmental level, the ADoH was dealing with a lack of basic equipment and had insufficient staff to provide basic health support to comrades. There were also 'bigger' health concerns like TB, malaria, and the mental health needs of comrades, which overshadowed the importance of AIDS until it was prioritised in 1990. The unbanning of the ANC in 1990 heralded a time of political change and the organisation began to prepare itself for a new role in negotiating the transition in South Africa. At the same time, growing concerns about AIDS within the ANC and amongst progressive organisations aligned with it were prioritised at the Maputo conference and the Lusaka workshop. The Maputo conference reframed HIV and AIDS in a human rights based narrative that began to challenge biomedically dominated understandings of AIDS. These relationships and ideologies would lay the foundation for the establishment of NACOSA (the National AIDS Committee of South Africa) in South Africa in 1992. People drawn from these networks would also be central in devising South Africa's post-1994 AIDS programme in line with these ideas.

While the Lusaka workshop reinforced the ideals of collaborative and inclusive responses to AIDS, it also revealed that the urgency of addressing AIDS, and knowledge about basic aspects of transmission and prevention, were not uniformly shared or understood amongst all levels of the organisation despite the fact that both the NEC and the ADoH had access to information about HIV and AIDS from multiple sources. The speeches by Nzo and Hani suggest that amongst NEC members the recognition of the importance and impact of AIDS on the ANC had not been equally shared and had been contested.

Although the ADoH was short of certain material resources, it was not short of knowledge and updates about the AIDS situation – locally, regionally and globally – and received information from a variety of sources. RHT members, especially those who referred comrades to local hospitals for more extensive treatment, had contact with local doctors and at least one university medical hospital, and reported back to the ADoH about AIDS cases (as is evident in Joe Ethwell’s case). ANC members were sent on AIDS training courses offered by hospitals, and the UK RHT provided information to the ADoH and produced material specifically designed for ANC AIDS education purposes.²³⁷

The flow of knowledge and information about AIDS from a variety of sources to the ADoH is evident and there was certainly sufficient information for the department to make informed decisions about the seriousness of the epidemic.²³⁸ How, or if, that information was circulated to other departments and leadership structures is less apparent and may account for the uneven attention given to AIDS within the organisation.

The narratives about AIDS present in official ANC documents were, on the whole, less moralistic and judgemental than some of those found amongst political parties in South

²³⁷ The Network of AIDS Researchers of Eastern and Southern Africa (NARESA) for example, invited an ANC member to attend a workshop on ‘The Use of Microcomputers in AIDS Research’ in Zimbabwe in 1990 (see UFH-AA, ALM, ad 2, 7, 13, correspondence Latif to Mkgangisa, 14 March 1990). ADoH members also approached organisations for assistance such as when Lungile Makhanda contacted Professor Harwarth of Chainama Hills Hospital about the inclusion of ANC members in the hospital’s AIDS counsellors training course (see UFH-AA, ALM, as 2, 7, 13, correspondence Lungile Makhanda to Prof. Harwarth, 17 July 1990).

²³⁸ In one folder entitled ‘letters and AIDS Action’ (UFH-AA, ALM pt 2, 64, 25) for example, there are copies of *AIDS Action* the international AIDS newsletter, from December 1990, undated photocopies on a series of advice column questions and answers about AIDS from an unnamed English-language newspapers (possibly from Uganda), and a copy of another international AIDS publication, *World AIDS* from January 1991.

Africa. This is unsurprising considering that struggle narratives were embedded in rights-based discourses and the ADoH worked closely with progressive health care workers and organisations both regionally and internationally. However, the archival evidence also acts as a reminder that official narratives, while they may maintain some hegemony, are also not necessarily reflective of all viewpoints. The myths and stigma associated with STIs and AIDS are present in the archival evidence and media like the AIDS education video that sought to actively address and challenge them.

Considering the significance of unplanned pregnancies, STIs and contraceptives in ADoH and RHT documents, there was little serious engagement with sexual practices or sexuality. While the hegemonic AIDS narrative present in South African and elsewhere focussed initially on homosexuals and homosexuality, this did not occur in ANC narratives in exile. There were openly gay comrades in the movement, such as Simon Nkoli who would become a prominent AIDS and sexuality activist in the 1990s, but there is no archival evidence of how homosexuality was constructed or understood in terms of AIDS narratives. This is perhaps because of homophobia or because homosexuality was primarily associated with white men, or merely because heteronormative viewpoints were dominant and sexual practices were primarily discussed in terms of practical medical interventions to prevent pregnancies and STIs. It is also possible that by the time AIDS narratives featured in fora like the Health Council, the hegemonic international narrative of 'homosexual Western AIDS' and 'heterosexual African AIDS' had been accepted as accurate and most closely resembled the experiences of certain exile communities living in countries with established AIDS epidemics.

There were still hints of 'African sexuality' narratives, linked not to 'race' as in the hegemonic narratives emanating from the UK and the USA, but rather linked to nationality or belonging to the movement. Thus, in certain countries, the sexual health of 'local' non-ANC partners of ANC members was viewed differently to the sexual health of ANC members from South Africa, and geographic identity was evoked to demarcate risk of infection.

Boundaries and borders featured in the hegemonic narrative in South Africa which evoked the threat of infected exiles from across the border returning to the country and bringing infection with them. Possibly concerned about the implication of being seen as bringing both

liberation and new infections into the country simultaneously, members of the ANC leadership were sufficiently concerned about this perception to want to address it. In doing so, however, they made use of constructed boundaries and borders and occasionally suggested that the exile community was 'healthier' than the host communities.

It is evident from the archive that knowledge about a topic does not readily or easily translate into action, especially in an organisation with many competing political demands. The flow of knowledge between the ANC leadership structures, the key players in the ADoH, international organisations, and leading progressive AIDS researchers and health care providers, would be reflected in who was selected to direct the process of writing up an AIDS plan for South Africa, and the contents of the first AIDS plan drawn up for the 'new' South Africa. Key members of the ADoH in exile would become important figures in the Department of Health in South Africa, tasked with implementing the plan. Networks and relationships established while the organisation was in exile remained or were re-forged when the organisation returned to South Africa.

At the meeting between NAMDA and the ANC in October 1989, on the eve of the period of transition that would see the ANC move out of exile and into political power, both challenges and hopes relating to AIDS were raised. The report from the Commission on AIDS at that meeting included a quote from a paper delivered by Stan Houston urging action and expressing fears that were, with hindsight, prophetic:

In South Africa it is self evident that the government is completely lacking in the credibility necessary to influence sexual behaviour in the black community. The only political organisations which have that credibility among the majority of South African people are the liberation movements, internal and external. It is my greatest fear and recurring nightmare, that I will go to South Africa after Independence and find the wards of the hospitals full of AIDS patients, the new country burdened with the morbidity, mortality and expense of an AIDS epidemic indefinitely. In one sense you are uniquely fortunate in knowing enough, early enough, to prevent this. But the time to act is now. And you are the people who must act.²³⁹

²³⁹ SAHA, NC, AL3182, A1.8.2, NAMDA – ANC Meeting, p. 21.

CHAPTER THREE: BETWEEN POLEMIC AND PRACTICE: GOVERNMENT RESPONSES TO AIDS FROM NP TO ANC, 1982 – 1995



*IN HUMBLE SUBMISSION to Almighty God,
WE DECLARE that we
ARE CONSCIOUS of our responsibility towards
God and man;
ARE CONVINCED of the necessity of standing
united and of pursuing the following national
goals:
To uphold Christian values and civilized norms,
with recognition and protection of freedom of
faith and worship...*

Republic of South Africa Constitution Act 110 of 1983¹

We, the people of South Africa,
Recognise the injustices of our past;
Honour those who suffered for justice and
freedom in our land;
Respect those who have worked to build and
develop our country; and
Believe that South Africa belongs to all who
live in it, united in our diversity.

We therefore... adopt this Constitution as
the supreme law of the Republic so as to:
Heal the divisions of the past and establish a
society based on democratic values, social
justice and fundamental human rights;

Improve the quality of life of all citizens and
free the potential of each person; and
May God protect our people.

Constitution of the Republic of South Africa, 1996



¹For an electronic version of the 1983 Constitution see the South African government website at: www.info.gov.za/documents/constitution/83cons.htm (accessed January 2011).

Responses to diseases and the allocation and provision of health care resources are shaped by political ideologies, checked by political and economic realities, and influenced by social reactions, but ultimately they are discussed and decided upon by political elites in government buildings and official papers that act as symbolic and legislative markers of a country's political practice. Health – or ill-health – often provides the clearest example of 'the personal as political', but also of the political as immensely personal. The politics of health and the dis-ease created by the collision of ideologies, social constructs, and economics are evident in the histories of any number of health issues from terminations of pregnancies to government responses to Acquired Immunodeficiency Syndrome (AIDS).

In South Africa from the mid- to late-1980s the government of P.W Botha largely ignored AIDS, beyond trying to allay panic among 'the general public', ensuring the safety of blood supplies, and gathering a small group of medical and scientific experts and charging them with gathering information from 'high-risk groups'. These responses were primarily aimed at obtaining data that would reassure (heterosexual) voters that they were 'safe' from the new disease. There was little, if any, focus on supporting people infected with Human Immunodeficiency Virus (HIV) or dying of AIDS.² As the political landscape shifted in the early 1990s under F.W de Klerk, responses to AIDS changed only marginally, largely because the imminent political transition dominated the political landscape. During this time space for civil society engagement opened up, or was forced open by unions, activists, legal professionals, sexuality activists, NGOs and others working with and on behalf of people with HIV and AIDS. Despite this responses remained inadequate to stop the growing epidemic. The National Party (NP)-led government lacked the political will, and the courage and conviction, to realign its AIDS prevention strategies to take into account the realities of most peoples' lived experiences of sex, sexuality and AIDS in South Africa.

After 1994 Nelson Mandela's administration identified AIDS as a 'Presidential Lead Project' but failed to deliver the comprehensive but ambitious National AIDS Plan (NAP) because of capacity constraints and the overwhelming task of trying to transform the public service.

² This is not to imply that those who worked with or for government-funded initiatives did not try to meet the mental, emotional and physical health care needs of people with HIV or AIDS, just that this was not a priority for government decision makers.

Thabo Mbeki's turbulent administrations from 1999 - 2008 were characterised by dissident viewpoints, and the concomitant failure to distribute antiretrovirals (ARVs) in the face of sustained protests from increasingly organised, politicised and vocal HIV and AIDS activists.³ Since the start of his presidency in 2009 Jacob Zuma has evolved from the man who spoke about showering to prevent AIDS during his trial for an (alleged) rape, to the president who challenged citizens to get tested and publicly took an HIV antibody test, to the president whose government now implements (fitfully at times) the largest ARV treatment programme in the world.⁴ Regardless of who has been president, the politics of AIDS in South Africa has been fraught and complicated and has resulted in many avoidable deaths largely because of a consistent disjuncture between the polemics associated with AIDS and practical responses to it.

This chapter provides an overview of official national government responses to AIDS from 1982 to 1995 and tracks the changing plans, programmes, policies or initiatives implemented by the various ministers of health.⁵ In the absence of official archives, the chapter draws on annual reports from the health department, *Hansard*, and government publications like *Epidemiological Comments*, to show that official government responses to AIDS were sporadic, often delayed, and, for the most part, not driven by any formal policy or sense of urgency.⁶ Government responses can be divided into four phases, and were influenced and

³ Kgalema Motlanthe acted as president after Thabo Mbeki's resignation and served in the position from September 2008 to May 2009. He functioned primarily as a caretaker president and did not engage significantly with AIDS policy.

⁴ The government is responsible for policy and programme implementation and oversight, while major donors have contributed significant resources. For example the United States Embassy posted a statement on their website in 2010 that noted: 'Through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the US has made the largest commitment in history by a single nation to combat a disease, providing more than \$25 billion (R188 billion) to the fight against global AIDS. In South Africa, PEPFAR support from 2004-2009 has totaled over \$2 billion (R15 billion), representing the largest contribution from PEPFAR to any country. In 2010, PEPFAR will add \$559 million (R4.2 billion) to the cause in South Africa'. See 'Statement on PEPFAR Funding to Fight HIV and AIDS in South Africa', 28 January 2010 available at the United States Diplomatic Mission to South Africa website available at <http://southafrica.usembassy.gov/press100128.html> (accessed December 2012).

⁵ Responses to AIDS at national, provincial, and local level would have differed between provinces and areas and research into how different areas responded would make a valuable contribution to understanding AIDS in South Africa.

⁶ *Epidemiological Comments* was an official government publication issued monthly and distributed to health care professionals. It carried features on specific diseases and epidemics (such as measles, TB, AIDS and malaria), provided official statistics and tallies for notifiable diseases, gave regular reports on the growing discipline of epidemiology in South Africa, and gave updates on health campaigns in South Africa. It was first published in 1973, and by 1989 was distributed to 1 350 subscribers (including medical training institutions such as the School of Nursing at UKZN). Of the subscribers, '99 ... [were] resident in Africa outside the borders

informed by the opinions and research of government-funded medical bodies and expert medical professionals, many of whom were responsible for creating the hegemonic medico-scientific AIDS narrative discussed earlier.

National government responses to AIDS were, and continue to be, shaped and influenced by socio-political and economic contexts. The 1980s was a period of mounting turmoil in South Africa, characterised by escalating internal unrest, violence and state repression, growing international sanctions, ongoing states of emergency and associated militarisation, economic recession, and contested constitutional 'reforms'. In the early 1980s the official governing structures of the country, including the constitution, were altered, as parliament was reconstituted. The first change occurred after a 'whites only' referendum in 1983 indicated support for reform which resulted in the creation of a tricameral parliament in 1984. This tricameral model saw the addition of two extra parliamentary chambers which operated alongside the 'white' House of Assembly: the House of Representatives to which 'coloured' people could elect 'coloured' representatives, and the House of Delegates to which 'asian/indian' people could elect 'asian/indian' representatives.⁷

Ongoing shifts in the political landscape, resulting from local, regional and international opposition to apartheid eventually resulted in the total restructuring of parliament into a single National Assembly in 1994.⁸ The early 1990s saw the unbanning of the African National Congress (ANC), South African Communist Party (SACP), Pan Africanist Congress (PAC) and other anti-apartheid organisations and witnessed the release of political prisoners, focussing national and international attention on an imminent political transition. During this time there was sustained violence and socio-political tension as the transition to democracy was contested.⁹ The sustained violence and other socio-political contexts, along with existing

of the RSA and 33 overseas'. See National Library of South Africa (hereafter NLSA), Cape Town General Collection (CTGC), SA Reports (sometimes SA Rpts), Department of National Health and Population Development (hereafter DNHPD) Annual Report, 1989, p. 19.

⁷ Note that the terms for people designated under the Population Registration Act often changed numerous times and during this period people designated as 'asian' were also sometimes designated as 'indian'.

⁸ For more on the tricameral parliament, including resistance to its formation, how it functioned, and how shallow a reform it was, see Beinart, W., *Twentieth Century South Africa* (Oxford, Oxford University Press, 2001).

⁹ See Manganyi, N.C., & du Toit, A. (eds), *Political Violence and the Struggle in South Africa* (London, Macmillan, 1990).

socio-economic disparities, created ideal circumstances for HIV transmission, just as attention was diverted away from AIDS in favour of political issues deemed more pressing.¹⁰

Writing about Government Responses to AIDS in Apartheid SA

Work on apartheid and AIDS, or work focussing on pre-1994 government responses to AIDS, is scarcer than work addressing government policies, programmes and responses post-1994. What is available includes academic texts, research papers produced by members of non-governmental organisations (NGOs) or civil society organisations (CSOs) active 'at the coal face' of the epidemic, or articles written by commentators reflecting on the situation at the point of the 1994 transition. One of the earliest publications providing information on the socio-economic effects of AIDS on the country and the continent was the newsletter *AIDS Analysis Africa*, founded by health economist Alan Whiteside in 1990.¹¹

One of the earliest academic articles to attempt to summarise the epidemiology of AIDS in South Africa, providing an overview of responses to AIDS by a variety of sectors (including government) and making suggestions about a way forward towards a public health response to AIDS, was by Anthony Zwi and Deborah Bachmayer in 1990.¹² In 1992, Edwin Cameron and Edward Swanson considered questions around public health, AIDS, and coercive legal measures; while Virginia van der Vliet's 1992 work provided a synopsis of state responses.¹³ Neil McKerrow examined the South African response to the epidemic during apartheid in an input paper for a 1997 report on poverty elimination.¹⁴ McKerrow critiqued the apartheid government's reactions to AIDS:

¹⁰ See Marks, S., 'An Epidemic Waiting to Happen? The Spread of HIV/AIDS in South Africa in Social and Historical Perspective', *African Studies*, 61, 1, 2002.

¹¹ Health Economics & HIV/AIDS Research Division (HEARD) Library (hereafter HL), UKZN Westville, South Africa, *AIDS Analysis Africa*, 1990 – 1995.

¹² Zwi, A., & Bachmayer, D., 'HIV and AIDS in South Africa: What is an Appropriate Public Health Response?', *Health Policy and Planning*, 5, 4, 1990.

¹³ Cameron, E., & Swanson, E., 'Public Health and Human Rights – The AIDS Crisis in South Africa', *South African Journal on Human Rights*, 8, 2, 1992; and Van der Vliet, V., 'Apartheid and the Politics of AIDS' in Feldman, D.A. (ed), *Global AIDS Policy* (London, 1994).

¹⁴ HL, ID: 1891, McKerrow, N., 'The South African Response to the HIV/AIDS Epidemic', Input report prepared for the Poverty and Inequality report, Greys Hospital, Pietermaritzburg, 1997. For full report see *Poverty and Inequality in South Africa: Final Report*, 13 May 1998, available at South African Government Information website at www.info.gov.za/view/DownloadFileAction?id=70499 (accessed February 2011).

This response has been characterised by poor co-ordination, limited inter-sectoral collaboration and variable commitment from role players. At the outset HIV/AIDS was seen, in South Africa, as a gay, type-1 epidemic confined to select high-risk sub-groups within the larger urban centres of the country. As a result it evoked minimal response from the formal state structures. This contrasted with the various initiatives from the non-governmental sector which responded by initiating localised preventative, care and support programmes for identified high-risk groups.¹⁵

McKerrow's observations summarise the prevailing perception of pre-1994 government responses. Much of the secondary literature on government responses to AIDS during apartheid has pointed to its failure to respond to the epidemic and has drawn attention to the lack of legitimacy with which government-sponsored programmes were met. The detail and chronology of government campaigns has not received much attention, and while many academics have provided brief histories of government responses, few historians have written on the subject, although Louis Grundlingh's work has begun to address this shortfall.¹⁶

Among political scientists, Yolanda Sadie and Maxi van Aardt's article, published in 1992, was one of the earliest to address the government's AIDS policy between 1987 and 1992 and highlighted criticisms levelled at the policy from a variety of sectors.¹⁷ They suggested that three phases could be identified in the government's handling of AIDS. The first, covering roughly 1987 to November 1991, was characterised by a mass information strategy geared towards the 'general public'; the second, from December 1991 to July 1992, saw a shift in emphasis towards encouraging behavioural changes; and a third, launched in August 1992, built on the first two phases but added aspects of 'care and support'. The article also

¹⁵ McKerrow, 'The South African Response', p. 1.

¹⁶ Grundlingh, L., 'Early Attitudes and Responses to HIV/AIDS in South Africa as Reflected in Newspapers, 1983 – 1988', *Journal for Contemporary History*, June 2001; 'Government Response to HIV/AIDS in South Africa as Reported in the Media, 1983-1994', *South African Historical Journal*, 45, 2001; 'Challenges and Obstacles in Early HIV and AIDS Education in South Africa, 1989-1994', *Historia*, 54, 1, May 2009; and 'Neither Health Nor Education? An Historical Analysis of HIV/AIDS Education in South Africa, 1980s - 1990s', unpublished paper presented to RAU (now UJ) Sociology Seminar, 24 May 2002.

¹⁷ Sadie, Y., & Van Aardt, M., 'VIGS-Politiek in Suid-Afrika: 1987 – 1992', *Politikon*, 19, 3, December 1992.

highlights the political nature of AIDS and its politicisation by racist, right-wing parties, as well as by more progressive left-wing parties and organisations alike.¹⁸

Pieter Fourie, another political scientist, has written the most comprehensive work on public policy-making and responses to AIDS by South African governments between 1982 and 2004.¹⁹ He argues that the National Party (NP) government's AIDS policy-making can be placed into three 'loosely defined phases'. Drawing on Van der Vliet's terminology he refers to the first phase, from 1982 – 1988, as the 'silent phase', which was an 'era ... notable for government inaction on AIDS'.²⁰ During this period AIDS failed to make it onto the public policy agenda and 'no comprehensive AIDS strategies or public policies were drafted', primarily because the groups most affected were constructed as being on 'the isolated fringes of South African society'.²¹ Rather than plan a public health response for something that could affect everyone, 'a few pieces of legislation were drafted to restrict the behaviour of those individuals who were deemed to threaten the rest of society', namely foreign mineworkers, immigrants, male homosexuals, and later, returning ANC exiles.²²

The second phase in Fourie's analysis is that of 'flux and re-conceptualisation' between 1989 and 1992 when 'it became clear to the government that its "no explicit AIDS policy" was no longer tenable', and the government had to address increasing pressure from a variety of sectors - including activists, civil society, the private sector, and sections within government - to take action.²³ These demands, along with the political shifts that were occurring in the country, the legal system's increasing recognition of the rights of people with HIV, and the growing human-rights based discourse that featured as part of the political negotiations, meant that the government had to reassess its response. Fourie indicates that this phase put 'an end to reactive, inappropriate, *ad hoc* and ill-conceived strategies that aimed at apportioning blame, or at a biomedical "solution" to the problems of AIDS' and saw the NP

¹⁸ Sadie & Van Aardt, 'VIGS-Politiek', p. 85 (author's translation of original).

¹⁹ Fourie, P., *The Political Management of HIV and AIDS in South Africa: One Burden Too Many?* (Basingstoke, Palgrave Macmillan, 2006). See page 8 for Fourie's definition of 'policy' as defined by Anderson.

²⁰ Fourie, *Political Management*, p. 97.

²¹ *Ibid.*

²² *Ibid.* Also see chapter on political narratives that tracks the evolution of this discussion.

²³ *Ibid.*, p. 99.

government begin drafting 'more appropriate policy'.²⁴ This process saw the 'AIDS policy problem' being redefined in a way that would have favourable long-term repercussions for policy drafting, but

the fact that the government maintained its exclusion of the broader political players, civil society and AIDS activists; that nothing could change the fact that it was an illegitimate government; as well as that it was focussing primarily on constitutional negotiations ... meant that the AIDS public policy environment remained difficult to navigate, with no comprehensive, inclusive and successful public policy emerging.²⁵

The third phase was the 'democratisation of AIDS policy-making' from 1992 to 1994, characterised by events such as the 1992 'South Africa United Against AIDS' conference at which representatives from a broad spectrum of sectors were present, including 'members of the ruling NP government, key ANC officials, trade unionists, AIDS activists as well as members of the medical community'.²⁶ The conference resulted in the formation of the National AIDS Co-ordinating Committee of South Africa (NACOSA), which, Fourie explains, functioned as 'an "AIDS caucus" where influential and powerful AIDS stakeholders could meet and develop a truly democratic public response to the epidemic'.²⁷

The changing political and social environment, along with the establishment of NACOSA, led to the drafting of the NAP - 'South Africa's first comprehensive public document on HIV and AIDS' which was adopted by the ANC cabinet shortly after the 1994 elections. While the drafting and acceptance of the NAP represented a significant shift in thinking about AIDS, driven as it was by the idealism and human rights discourses of the time, there was a significant disjuncture between the promise of the plan and the practice of delivering it. The NAP turned out to be an overly ambitious project that did not take the realities and practicalities of government structures, and governing, into account.²⁸ Fourie identifies the NAP as part of the first phase of policy-making under the Mandela administration, lasting from 1994 – 1996. This was characterised by the failure of the NAP, and a shift 'from a pro-

²⁴ Fourie, *Political Management* p. 99.

²⁵ *Ibid.*, pp. 99 – 100.

²⁶ *Ibid.*, p. 100.

²⁷ *Ibid.*

²⁸ *Ibid.*, pp. 107 – 122.

poor policy-making stance to a pro-growth macroeconomic policy stance’, and ‘the emergence of an AIDS policy environment defined by public scandal’.²⁹

This chapter builds on the work of Fourie and Sadie and Van Aardt, and provides additional detail and nuance to what is already known about early national government responses. It suggests an alternative periodization of government reactions that incorporate and complement the policy phases suggested by Fourie, and by Sadie and van Aardt (figure 15). It extends the notion of ‘government responses’ to include policies, programmes and initiatives.³⁰ This chapter contends that national government responses to AIDS between 1982 and 1995 can be divided into four phases. The first phase, from 1982 – 1986 was characterised by epidemiological data gathering, advice-giving by medical experts and medical responses (such as securing the blood supply) and can be considered the ‘information and advice phase’.

The second, ‘the facts and fear phase’ (1987 – 1989), was overseen by Minister of Health, Dr Willie van Niekerk, and was marked by two key transitions. The first was from information-gathering to information-distribution – with an emphasis on public education aimed at adults. The second saw narratives about the threat of AIDS and the infected outsider move from being a political device to justify inaction, to being employed to justify practical, legislative responses, particularly in relation to migrant mine workers.

The appointment of Dr Rina Venter (NP) as Minister of Health in September 1989 marked the start of the third phase, the ‘extended engagement and education’ phase. The focus of

²⁹ Fourie, *Political Management*, pp. 121 & 122.

³⁰ It is problematic to conceive of ‘the government’ as a monolithic entity without recognising that government functions at different levels of state including international, intra-national, national, provincial, regional, municipal and local level (and there is scope for a substantial amount of research in all of these areas). For the purposes of this thesis, the responses, and discussions around responses, that occurred at a national level will be the primary focus of the chapter. Policy was meant to be designed and driven by national levels of government and then implemented, as appropriate, by lower levels of government, therefore it is important to examine responses driven by the national department. Research into responses at various levels of government would make an interesting addition to existing literature. It is also problematic to imagine ‘the government’, or government-funded or controlled spaces, as being uncontested terrains. The members of a ruling party will present a party line that will be opposed by other parties (and other party lines) in a parliamentary forum, for example, but the political parties themselves will be filled with the intrigues and complications of members with differing viewpoints and different ambitions. Similarly, within government structures individuals may use existing spaces to reinforce or subvert political agendas, and there is scope too for further research into these complicated areas.

public information campaigns shifted to educating adolescents and younger students through school programmes, while government structures responsible for addressing AIDS were reshaped. The period was marked by a growing discourse on the importance of community engagement, and a shift towards decentralised approaches to determining AIDS strategies. Despite these shifts, the official decision-making processes were neither fully representative nor inclusive of all organisations, sectors and communities involved in AIDS work.

From 1990 to 1993 changes were occurring within official government structures, but there were also parallel processes going on in 'unofficial' and non-governmental contexts that laid the foundation for what Fourie refers to as the democratisation of AIDS policy-making. While acknowledging the importance of the unofficial democratic processes taking place at the time, this chapter suggests that 1994 marks the beginning of a fourth phase in official government responses, namely the 'democratic ideals' phase that lasted until 1996.

In line with the overall timeframe of this thesis only the first two years of this fourth phase will be examined, namely 1994 – 1995. This phase was characterised by profound idealism and faith in the democratic transition which, it was hoped, would witness a reinvention of health care provision based on a universal human rights discourse. Part of this new discourse was a determination to ensure that decision-making processes and structures were consultative, representative and inclusive, including structures established to address AIDS and implement the NAP.

During the first two years of this phase, 1994 and 1995, narratives about AIDS were more complex and inclusive, and were framed in more progressive language as were the guidelines and strategies contained in the NAP. Despite the idealism of this period, government capacity constraints and questionable governmental commitment to the plan meant that the objectives of the NAP remained largely unfulfilled.

One of the realities that influenced, and continues to influence, any form of government intervention in public health is party politics and the associated short-term tenure of those

tasked with drawing up national health strategies.³¹ Throughout the 13-year period under discussion the leadership of both the government and the Department of Health (DoH) changed, as did the remit and responsibilities of the department itself. The ministers of health and the designation of the department also changed six times between 1982 and 1995.³² This must have negatively influenced the realisation of policy objectives.

Before exploring the four phases in greater detail, this chapter turns to the pages of *Hansard* to examine how narratives about AIDS were presented in a political sphere. Analysing *Hansard* reveals how AIDS was perceived, discussed, and narrated by political elites in parliament. The discussions in *Hansard* reveal the personal and party political ideologies and beliefs that influenced and motivated those in parliament and, by extension, the citizens who were eligible to vote for them. The elected political elites influenced the formulation of public health programmes around AIDS, and helped shape responses and understandings of AIDS. Their discussions help expose the relationship between polemic and practice in relation to AIDS.

³¹ Arguably, it is implementation, rather than the creation, of strategies that is more problematic in terms of people's lived experiences and the statement is not made to suggest, for example, that benevolent dictatorships provide better public services. The point is rather to raise the issue and note that the entire approach towards meeting social justice needs and ensuring equity of access and provision is part of a much wider discussion that is outside the realm of this thesis but is acknowledged by the author.

³² Rather than referring to the changing names for the department for ease of reading the term Department of Health (DoH) will be used throughout this chapter. From 1982 until 1983 Dr L.A.P.A. Munnik (NP) was the Minister of Health, Welfare and Pensions. In 1983 he was replaced by Dr C.V. van der Merwe (NP) who was now designated the Minister of Health and Welfare. On Van der Merwe's death in 1985, Munnik stepped in as acting Minister of Health and Welfare until the appointment of Dr W.A. van Niekerk (NP) in 1986, who became the minister in the Department of National Health and Population Development (DNHPD). Van Niekerk was replaced by Dr E.H. Venter in late 1989 and the department and minister both received new titles as the Department and Minister of National Health and then, briefly, National Health and Welfare. Finally in 1994, Dr N.C. Dlamini-Zuma (ANC) became the Minister for Health.

	Sadie & Van Aardt (1992)	Fourie (2006)	Tsampiras (2012)
1st Phase	First Phase	Silent Phase	Information & Advice
Time period	<i>1987 – Nov 1991</i>	<i>1982 – 1988</i>	<i>1982 – 1986</i>
Characteristics	<ul style="list-style-type: none"> • Mass information strategy aimed at ‘general public’ 	<ul style="list-style-type: none"> • No public policy or strategy drafted • Government inaction • Legislation to restrict behaviour 	<ul style="list-style-type: none"> • Epidemiological data collected • Expert medical advice group established • Blood supply screened
2nd Phase	Second Phase	Flux & Reconceptualisation	Facts & Fear Phase
Time period	<i>Dec 1991 – Jul 1992</i>	<i>1989 - 1992</i>	<i>1987 - 1989</i>
Characteristics	<ul style="list-style-type: none"> • Emphasis on behaviour change 	<ul style="list-style-type: none"> • Not just bio-medical solution • Attempts to draft policy 	<ul style="list-style-type: none"> • Public information and education programmes aimed at adults • Evocation of fear of the ‘infected outsider’ to facilitate AIDS legislation
3rd Phase	Third Phase	Democratisation of AIDS Policy Making	Extended Engagement & Education
Time period	<i>Aug 1992</i>	<i>1992 - 1994</i>	<i>1990 - 1993</i>
Characteristics	<ul style="list-style-type: none"> • Phase 1 + Phase 2 + • Care and support 	<ul style="list-style-type: none"> • Conferences with multiple representatives from a variety of sectors • NACOSA conference ↓ • National AIDS Co-ordinating Committee of South Africa ↓ • National AIDS Plan 	<ul style="list-style-type: none"> • Public information and education programmes aimed at adolescents • Restructuring of AIDS group • Attempts at increased engagement with multiple sectors
4th Phase	---	1st Phase of Mandela Administration	Democratic Ideals
Time period	---	<i>1994 – 1996</i>	<i>Begins 1994</i>
Characteristics	---	<ul style="list-style-type: none"> • The failure of NAP • Move from pro-poor to financially conservative policies. • AIDS policy defined by public scandal 	<ul style="list-style-type: none"> • Democratic ideals and representative decision making processes • Dubious delivery or implementation

Fig. 15. Summary of the phases of government responses to AIDS by Sadie and van Aardt, Fourie and Tsampiras.

AIDS Narratives in *Hansard*, 1980 - 1995

An analysis of *Hansard* reveals that AIDS did not feature as a significant topic in parliamentary debates, or within parliamentary committee meetings. Between 1980 and 1995, 119 references to AIDS were found in *Hansard*: questions asked by members of parliament (MPs) during sessions; comments or statements about AIDS made by MPs; and written questions about AIDS and the replies given to them (listed in *Hansard* as 'Interpellations, Questions and Replies or IQRs').³³ Fifty-two per cent of the references to AIDS were made during debates, the remainder were IQRs.

No significant 'AIDS debates' occurred, nor were there any scheduled debates specifically about AIDS. Comments about AIDS were primarily made in response to other statements, listed alongside other health concerns, or evoked to make a point. AIDS featured most frequently as a discrete subject in the IQRs, or occasionally formed the subject of a specific question made during a debate about health. Despite being an infrequent topic of discussion, the number of references to AIDS did change over time. After the first mention in 1983, there were no significant references until 1987, and it was not until 1990 that references to AIDS accelerated, with 70 per cent made between 1990 and 1993 (figure 16).

Fifty-four per cent of all references to AIDS were made in the House of Assembly, fourteen per cent in the House of Representatives, and seven per cent in the House of Delegates. Thirteen per cent of comments were made in committee meetings, and seven per cent in joint meetings that included representatives from all the houses. From its inception in 1994 until the end of 1995, six per cent of references to AIDS were made in the National Assembly (figure 17).

³³ The volumes of *Hansard* were manually searched for references to AIDS, all Appropriation Bills relating to the department of Health were read, and the indexes for the volumes were also checked. Where discussions in parliament took place over two or more days, and references to AIDS occurred on more than one day, the incidences/references were counted as a single reference because they formed part of one debate. AIDS was mentioned during discussions around National Appropriation Bills (NABs), particularly as they related to the DoH at national and provincial levels and in different houses. AIDS was also mentioned in discussions around NABs for Correctional Services, Trade & Industry, Manpower, Transport Services, and Education and Culture.

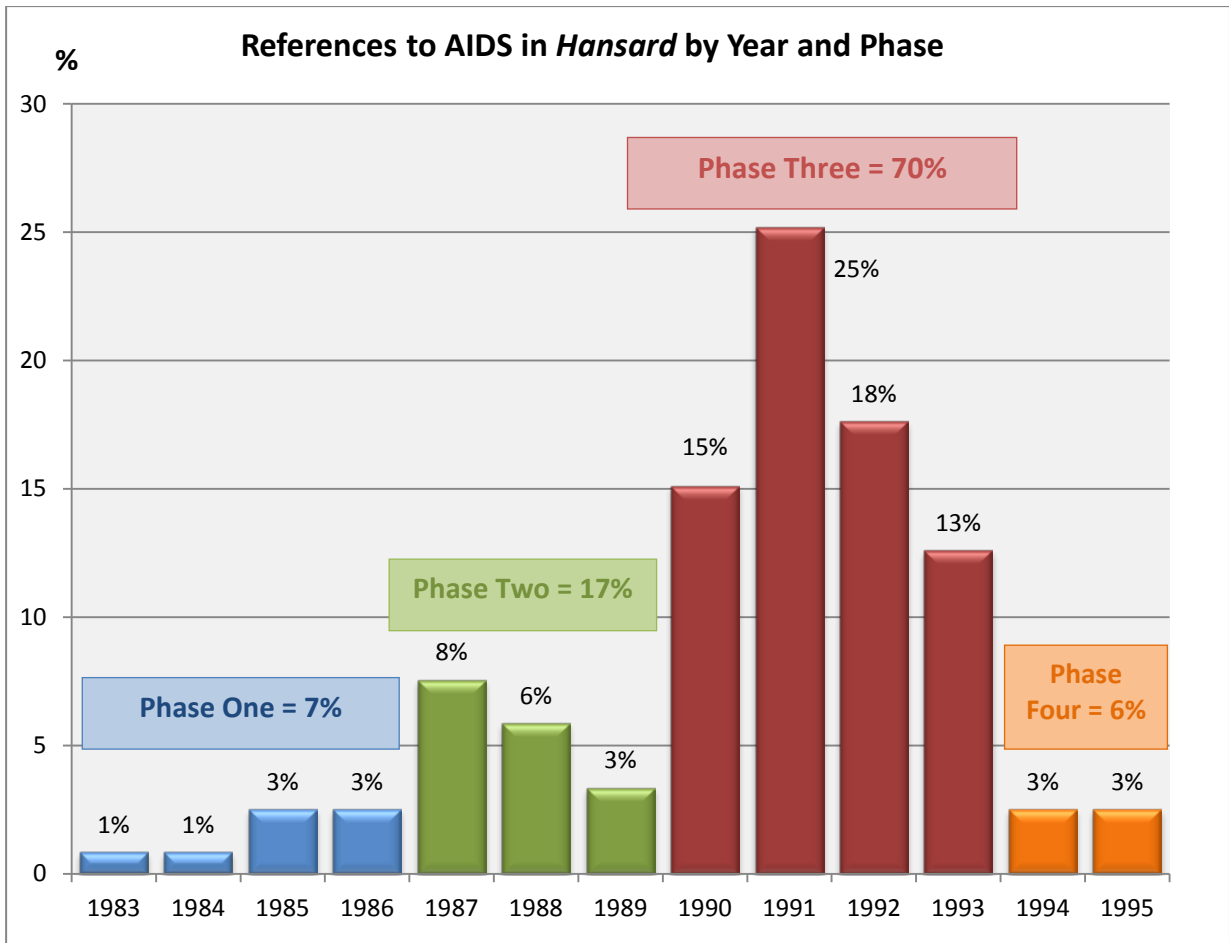


Fig. 16. Changes in the number of references to AIDS in *Hansard*.

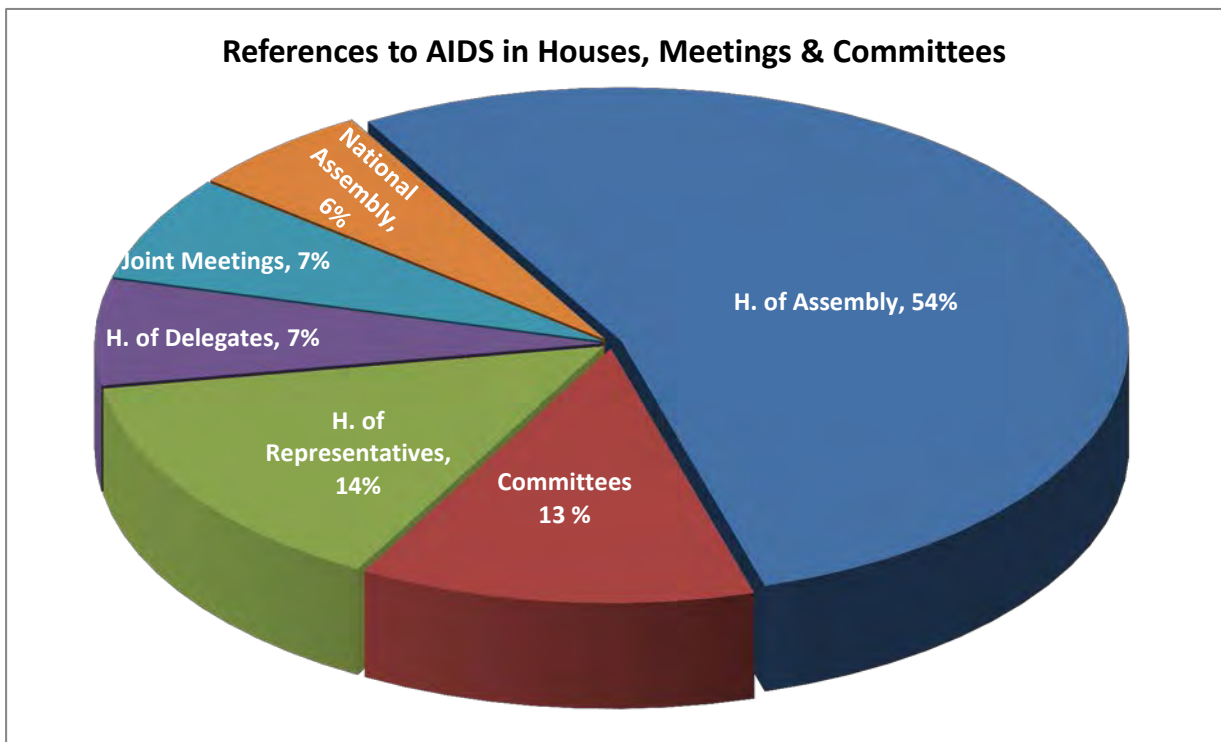


Fig. 17. Breakdown of parliamentary fora in which references to AIDS were made.

The political parties whose members made the most references to AIDS were the NP and the Democratic Party (DP) which was initially called the Progressive Federal Party (PFP), followed by the Conservative Party (CP), the Labour Party of South Africa (LPSA), and the Solidarity Party (SP) (figure 18).³⁴ There is, unsurprisingly, a direct correlation between the size of a party, their role in their respective chambers, and how much their voices were 'heard'.³⁵ The NP, for example, held 72 per cent of the seats in the House of Assembly during 1988 and 1989, and made 41% of the references to AIDS.³⁶ For the same time period the DP held eleven per cent of the seats and made 24 per cent of the comments, and the CP held 13 per cent of the seats and made eight per cent of the comments.³⁷

³⁴ The parties represented in parliament were as follows: ACDP (African Christian Democratic Party), ANC (African National Congress), AVU (Afrikaner Volksunie), CP (Conservative Party), DP (Democratic Party previously known as the PFP), DRP (Democratic Reform Party), DWP (Democratic Workers Party), FF (Freedom Front), FP (Freedom Party of South Africa), HNP (Herstigte Nasionale Party), I (Independent Members), IE (Indirectly Elected Members), IFP (Inkatha Freedom Party), LPSA (Labour Party of South Africa), MPP (Merit Peoples Party), NDM (National Democratic Movement), NP (National Party), NPP (National People's Party), NRP (New Republic Party), PAC (Pan Africanist Congress of Azania), PFP (Progressive Federal Party - became the DP), PIP (Progressive Independent Party), PPSA (Peoples Party of South Africa), PRP (Progressive Reform Party), SP (Solidarity Party), and the UDP (United Democratic Party). 'Unknown' refers to members whose party affiliations could not be conclusively identified.

³⁵ The NP, CP and DP were represented in parliament throughout the period under discussion, while the LPSA and SP were represented throughout the period of the tricameral parliament. During the period under discussion other parties were disbanded, or renamed, or only joined parliament after the 1994 elections. In addition to being in parliament throughout the period under discussion, the NP and the DP would both have representatives in all three houses by 1993 and continue to have a presence in the National Assembly. The CP only had representatives in the House of Assembly and the National Assembly. The LPSA only functioned during the tricameral parliament and only had members in the House of Representatives. Note that while the graph provides an impression of which parties were involved and which were not, additional research is needed in this area before substantive conclusions can be drawn.

³⁶ This is not to suggest that party size was the only determining factor. Legal requirements and personal or political interests would also have been influential as would the personalities of members, and their skill at engaging other members of the parliament.

³⁷ Similarly, in the House of Representatives the LPSA held 85 per cent of the seats during 1988 and 1989, and in the House of Delegates the SP held 36 per cent of the seats, making them the largest parties in those houses. Mr M.J. Ellis (DP) engaged the departments of health more times over AIDS than any other MP in any of the chambers. Ellis, mostly making use of written questions to the ministers of health, asked 39 questions about AIDS between March 1989 and June 1993. These questions included requests for AIDS statistics ('by race'), questions about AIDS orphans, and questions relating to the AIDS programme budget and the AIDS education programme in schools. Ellis continued to serve in parliament post-1994 and was the spokesperson for health and the Chief Whip of the Democratic Alliance (DA) as the DP became known.

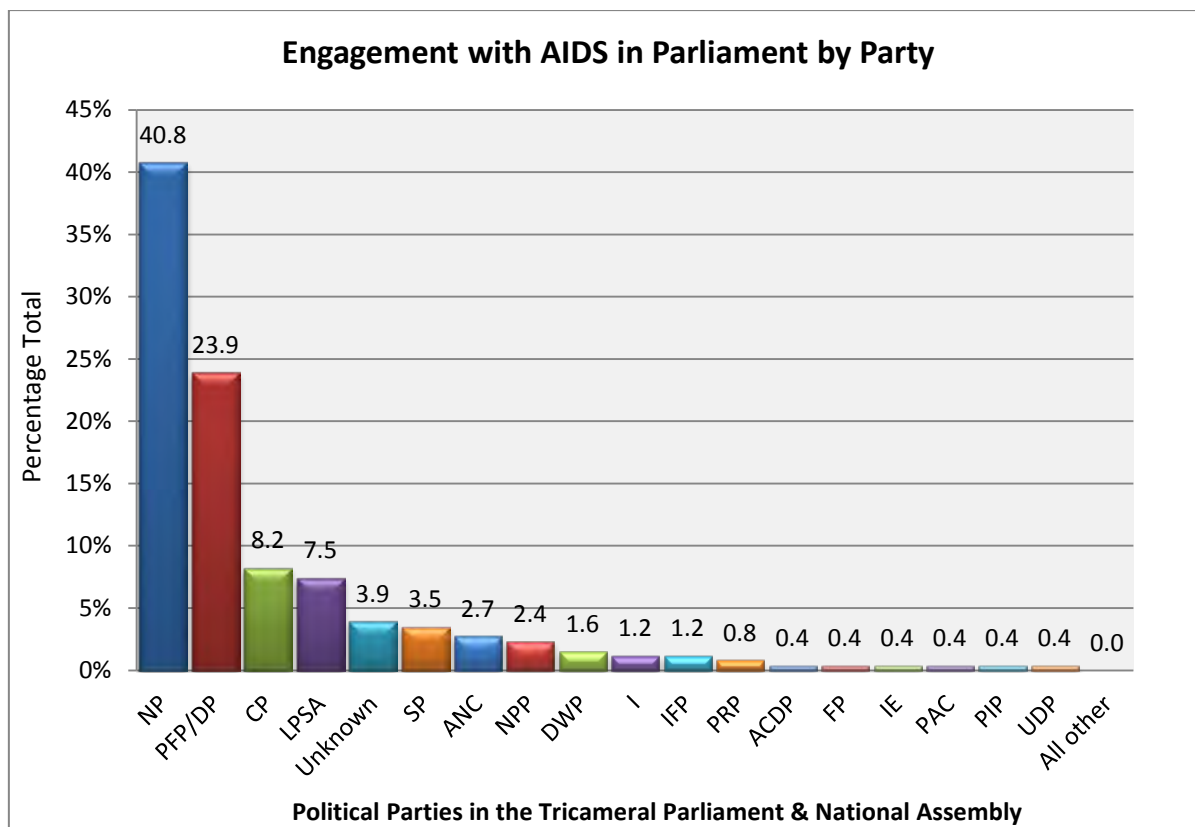


Fig. 18. Breakdown of how often different political parties referred to AIDS.

In common with early hegemonic narratives about AIDS as a health concern of the ‘othered minority’ rather than the ‘normal majority’, early comments about AIDS in parliament by NP MPs insisted that AIDS was ‘a special problem’ and was not a public or national health threat as it mainly affected homosexual men.³⁸ *Hansard* reveals that members’ statements about AIDS were often openly informed by ideas of morality and religious doctrine. Similarly, feelings about those who were designated AIDS avatars (homosexuals and prostitutes for example) and concerns with immorality, moral degeneracy and promiscuity were often freely expressed throughout the period and in all houses.³⁹

³⁸ See *Hansard* House of Assembly (hereafter HA), vol. 105, Wednesday, 9 March 1983, col. 2741; *Hansard* HA, vol. 105, Thursday, 10 March 1983, col. 2756; *Hansard* HA vol. 117, Wednesday, 6 June 1984, col. 1479; and *Hansard* HA vol. 117, Tuesday, 12 March 1985, col. 508.

³⁹ Concerns with morality, promiscuity, prostitutes and prostitution, and homosexuals and homosexuality featured in almost a third of the references to AIDS made during debates. The tone and content of these references include, for example the observation by Mrs E. J. Chait (NP) that ‘While the church teaches morality, we on the other hand are bombarded in the popular media daily, in magazines as well as in the electronic media, with images and perceptions glorifying a promiscuous lifestyle’, *Hansard* Public Committee on Health and Population Development, vol. 11, Tuesday, 18 April 1989, col. 5663; and Dr W.J. Snyman (CP), referred to. ‘... the decadent literature, films and theatre productions and [television] programmes ... to which a blind eye is being turned’, *Hansard* Proceedings of Extended Public Committee, vol. 19, Wednesday, 16 May 1990, col.

In 1987 Y.I. Seedat (National People's Party) from the House of Delegates blamed the spread of AIDS on a lack of religious morality: 'Unfortunately, humanity has not respected the Word of God. If religious practices had been taught, Aids [sic] could never have spread'.⁴⁰ Later that year in the House of Assembly, J.J. Vilonel (NP) affirmed that 'We learnt the solution to the Aids problem at our mother's knee and in the Bible. That is a clean moral and ethical life. That is all.'⁴¹ In 1989 J.H. Cunningham (Freedom Party) noted in the House of Representatives that 'People must be told clearly and distinctly that a licentious life can mean the death sentence'.⁴²

In one of her first debates as health minister in 1990, Rina Venter's choice of language revealed much about the moral viewpoints that influenced the NP's thinking on AIDS: 'Aids [sic] is everyone's problem, and not only that of those who are guilty of living promiscuously.' She later commented, 'People do not like hearing this, but we shall have to convey the message to everyone that all forms of promiscuity will have to disappear if we want to stop the spread of this disease'.⁴³ Despite the more inclusive notion of AIDS as 'everyone's' problem, Venter's remarks clearly divided 'everyone' into those who were 'guilty of living promiscuously' and those who were not, and by implication those who deserved to get AIDS and those who did not. W.J. Snyman (CP) also raised the notion of deserving and undeserving AIDS 'victims' in 1992, when he noted that haemophiliacs who had been infected were '... unsuspecting, unfortunate victims'.⁴⁴

9402. For other comments see also *Hansard* House of Representatives (hereafter HR), vol. 14, Wednesday, 5 August 1987, col. 1877; *Hansard* HR, vol. 3, Monday, 25 April 1988, col. 7296; *Hansard* HA, vol. 3, Monday, 18 April 1988, col. 6152; *Hansard* HR, vol. 3, Monday, 25 April 1988, col. 7333; *Hansard* HR, vol. 3, Monday, 25 April 1988, col. 7336; *Hansard* House of Delegates (hereafter HD), vol.3, Tuesday, 26 April 1988, col. 7520; *Hansard* HD, vol. 3, Tuesday, 26 April 1988, col. 7526; *Hansard* HR, vol. 4, Tuesday, 10 May 1988, col. 9509; *Hansard* Debates of Parliament: Public Committee on Health and Population Development, vol.11, Tuesday, 18 April 1989, col. 5650-5651; *Hansard* HR, vol.26, Monday, 13 May 1991, col. 8447; *Hansard* HA, vol. 33, Monday, 11 May 1992, col. 7165 – 7166; *Hansard* HA, vol. 33, Monday, 11 May 1992, col. 7168; and *Hansard*, National Assembly (hereafter NA), vol. 2, Thursday, 20 October 1994, col. 3471.

⁴⁰ *Hansard* HD, vol. 13, Monday, 15 June 1987, col. 850. Note that in *Hansard*, AIDS is spelled 'Aids' hence the insertion of [sic] at this first quote. For ease of reading the insertion will not be included in future quotes and spelling in the original source will be used in all subsequent quotes.

⁴¹ *Hansard* HA, vol. 19, Thursday, 3 September 1987, col. 5159.

⁴² *Hansard* Public Committee on Health and Population Development, vol. 11, Tuesday, 18 April 1989, col. 5652.

⁴³ *Hansard* HR, vol. 19, Thursday, 17 May 1990, col. 9620 & 9622.

⁴⁴ *Hansard* HA, vol. 33, Monday, 27 April 1992, col. 5387. The issue of notifiability, and the moral and ethical problems around whether health care workers had a right to refuse to treat people who had AIDS, or had a right to be informed if a patient had AIDS, was a topic of discussion in particular because of the Barry McGeary

In 1991 fellow CP MP F. H. Pauw argued that prescriptions relating to lepers in the Old Testament (Leviticus 13) should be applied to 'unclean' people with AIDS who should 'be obliged to inform nursing staff and doctors of their contagiousness.'⁴⁵ The responses to his statement are recorded in *Hansard* as 'interjections', with sufficient laughter to prompt Pauw to comment, 'We might find this amusing, but it is no joke'.⁴⁶ To their credit, other members of parliament dismissed both this suggestion and another by Pauw that people with HIV or AIDS have 'a distinctive tattoo ... placed on the inside of the right upper arm ... so that the handler of the patient can see what he [sic] is dealing with at first contact'.⁴⁷ Pauw's tattoo suggestion caused uproar within the House, with members being recorded as stating that he was 'talking tripe'.⁴⁸

In 1994 K.R. Meshoe, leader of the African Christian Democratic Party (ACDP), echoed this religious conservatism, arguing that 'health information centres must let people know that Aids [sic] is a death sentence for which there is no appeal, and that promiscuity is what spreads this dreadful disease more than anything else. They must be told the truth'.⁴⁹ The way to stop the spread of AIDS was to prevent educational establishments from 'presenting homosexuality as a normal alternative lifestyle, because it is a sin', and to ensure that the DoH did not distribute free condoms in public schools 'as this would make our children even more promiscuous'. As an alternative, bibles should be freely distributed to schools to 'teach [children] that true love waits, and that premarital sex is sin'.⁵⁰ Like Snyman three years

case. McGeary's doctor had disclosed McGeary's status to other medical professionals over a game of golf and McGeary undertook a landmark case against his doctor because of a breach of confidentiality.

⁴⁵ *Hansard* Public Committee on Provincial Affairs: OFS, vol. 24, Wednesday, 27 March 1991, col. 4879 - 4880. Snyman declared openly that his party's engagement with AIDS would be framed and directed by conservative Christian theology based on ideas of a vengeful god raining punishment down on sinners in the form of AIDS see *Hansard* Proceedings of Extended Public Committee, vol. 19, Wednesday, 16 May 1990, col. 9402. In that same meeting he also affirmed that, 'promiscuity and sexual immorality [were] ... the most important causes of infection'.

⁴⁶ *Hansard* HR, vol. 26, Monday, 13 May 1991, col. 8447.

⁴⁷ *Ibid.*, col. 8447 - 8448.

⁴⁸ In a continuation of the debate on Tuesday, 14 May 1991 an NP MP referred to this suggestion as 'a ridiculous idea' and suggested that Pauw should rather walk 'about in the passages with this kind of proposal shouting : Stupid! Stupid!'. The brouhaha which followed his comments indicates that there was, at least from some quarters, opposition to his suggestions.

⁴⁹ *Hansard* NA, vol. 2, Thursday, 20 October 1994, col. 3444.

⁵⁰ *Ibid.*

before, he also suggested that 'Aids carriers' be required to register with hospitals or clinics and provide a list of their sexual contacts.⁵¹

While not every political party expressed such moral conservatism, moral and religious stances have been a consistent feature in the AIDS narratives in parliament, and among those charged with discussing, shaping and approving government responses to AIDS. The views expressed in parliament, to greater or lesser degrees, represented the voices of those who had elected them.

The MPs who made these statements moved between the spheres of politics and other professions that shaped discourses around AIDS, including medical and religious spheres. These MPs and the personal beliefs and political ideologies they subscribed to, or represented, helped shape the form and content of polemic about AIDS, but also of practical government responses (or lack thereof) to AIDS.

Phase One: Information and Advice

During the first phase, between 1982 and 1986, medical experts gathered information about AIDS, such as epidemiological data, and used it to advise government officials. Some of the medical experts were themselves government officials, while others worked in government-funded research units or in academic hospitals. In addition, there were medical experts who represented the interests of the military and the mining industry.

Throughout this phase there was a constant flow of information between government officials and medical experts on a variety of topics related to AIDS, from infection and death rates, to determining responsibility for covering the costs of HIV antibody tests. The government also distributed some AIDS education materials and ensured, when it became possible, that blood supplies were screened for HIV-antibodies.

⁵¹ *Hansard NA*, vol. 2, Thursday, 20 October 1994, col. 3444 - 3445.

Medical Expertise – The AIDS Advisory Group

On 22 January 1983 the *South African Medical Journal (SAMJ)* reported that the DoH had ‘called a meeting [on 7 January 1983] of representative specialists to formulate a surveillance and containment strategy’ around AIDS.⁵² This meeting was called following the deaths of Ralph Kretzen (who had died on 26 August 1982) and Pieter Daniël (Charles) Steyn who had died on 1 January 1983, both from AIDS-related complications. No information was given as to who was invited to the meeting, who they represented, or what their specialities were. Those at the meeting decided to trace all the contacts of the deceased patients; use blood count and skin tests to screen ‘a group considered to be at particularly high risk’; and ‘make contact with a larger group also regarded as at risk’.⁵³ Discussions were held as to whether or not AIDS should be made a notifiable illness, but apparently no decision was reached. A central processing unit was set up, and ‘records of suspects and cases’ would, and could, be voluntarily forwarded to this unit.⁵⁴

Why the DoH had called the meeting so quickly after Kretzen and Steyn’s deaths is a matter of conjecture. It is possible that the DoH had decided to assess the importance and potential public health threat that AIDS represented, which would explain the collection of basic epidemiological data. However, given the government’s apparent lack of interest in AIDS at this time this seems unlikely. Far more likely, especially considering the public’s reaction to news about AIDS and AIDS-related deaths, the DoH may have wanted to quell panic amongst sectors of the population.⁵⁵ Most of the January 1983 edition of *Epidemiological Comments* was dedicated to explaining what was known about AIDS and the immune response, including details of the medical conditions of the two men who had died. Dr H. Küstner, the Director of Epidemiology in the DoH and editor of *Epidemiological Comments*, observed that

⁵² ‘Acquired immunodeficiency syndrome (AIDS)’, *SAMJ*, 63, 4, 22 January 1983, p. 98.

⁵³ *Ibid.*

⁵⁴ *Ibid.*

⁵⁵ 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; and ‘Government Response to HIV/AIDS in South Africa as Reported in the Media, 1983-1994’, *South African Historical Journal*, 45, 1, November 2001.

the two deaths had 'triggered off a spate of articles in all sectors of the public news media, varying from the sauciest to the serene'.⁵⁶

Although the first meeting of experts took place early in 1983, it was only in 1985 that the AIDS Advisory Group (hereafter AAG) – also known as the Advisory Group on AIDS – was officially formed.⁵⁷ The reason for the delay is unclear and there may have been an informal arrangement in place in the intervening period. The delay does, however, suggest that AIDS was not initially considered sufficiently important to warrant any formal association between medical experts and government officials. The *SAMJ* suggested that the formation of the AAG in 1985 occurred 'in the light of the escalating incidence of the disease overseas, and in anticipation of the same pattern occurring in South Africa'.⁵⁸

The DoH described the AAG as consisting of 'experts in the field of AIDS', having 'a representative geographic distribution', who were mandated to perform three primary tasks: to advise the government on interventions to restrict HIV transmission; to assist in the collection, collation and analysis of epidemiological data relating to AIDS throughout the country; and lastly, to provide 'advice on possible actions' that could be taken to address AIDS.⁵⁹

Another DoH AIDS fact sheet outlined the relationship between the AAG and the DoH, and identified their respective responsibilities. The AAG had to:

- advise the Department on steps to counter AIDS.
- support the Department with the collection of data on AIDS.
- regularly analyse and disseminate data on AIDS countrywide.

⁵⁶ Küstner, H. *et al*, *Epidemiological Comments*, 10, 1, January 1983, pp. 1 – 12. AIDS did not feature again in the bulletin during this phase.

⁵⁷ The group appeared to have been called different things at different times, by the end of 1985 it was being referred to in official government correspondence and reports in the *SAMJ* as both 'the Advisory Group on AIDS', and the 'AIDS Advisory Group'. The lack of catalogued archives for the Department of Health covering this time means that the relationship between the advisory group and government officials has to be primarily reconstructed from sources such as *Hansard* and the *SAMJ*, and from information held by other organisations. Minutes or official correspondence for the meetings and group could not be located.

⁵⁸ 'AIDS Advisory Group's first year', *SAMJ*, 69, 12, 7 June 1986, p. 775.

⁵⁹ Gay and Lesbian Archive (GALA) [now referred to as Gay and Lesbian Memory in Action], Triangle Project (AM 2974), HIV and AIDS Information and Publications, AIDS Fact Sheet 13 'The AIDS Advisory Group?', c.1988, p. 1.

determine the extent of AIDS in countries with which South Africa has contact.
keep national records on HIV infections of all types in South Africa.
monitor already identified high risk groups and new ways in which AIDS spreads.
provide relevant information to the Department and media.⁶⁰

While the DoH:

is responsible for controlling the spread of AIDS.
must consider the implementation of recommendations made by the Advisory Group.
must provide the Advisory Group with information on the occurrence of epidemiological trends of AIDS.
is responsible for health education and the provision of information to the public through the production, printing and distribution of educational material.
must, in co-operation with a committee of people able to communicate effectively with the Black population, formulate a strategy to educate target groups within these communities.⁶¹

The medical expertise of the group was lauded revealing the reliance on medico-scientific knowledge in the shaping of official responses to AIDS.⁶² One NP MP declared that the DoH's AIDS prevention strategy had been to bring together 'all the experts' with the AAG representing 'all organisations involved in the combating of AIDS'.⁶³

Despite this claim, the AAG contained no representatives from sexuality-based organisations who were providing counselling and support services to people with AIDS, nor did it have any members openly living with AIDS, nor any representatives from faith-based organisations providing palliative care. There was no representation from 'high-risk groups', even if they were, like Dennis Sifris (whose experiences are recounted later in the thesis) medical professionals involved in AIDS work, indicating that only certain medical

⁶⁰ GALA, Triangle Project (AM 2974), HIV and AIDS Information and Publications, AIDS Fact Sheet 12 'Who Does What, and What Steps Have Been Taken in SA?', c.1988, p. 1.

⁶¹ *Ibid.*

⁶² Van Niekerk commented that the register of people with AIDS was being kept 'under the supervision of experts', see *Hansard HA*, vol. 5, Tuesday, 12 March 1985, col. 508-509. The use of expertise as a qualifier when referring to the group appears frequently in government statements or media.

⁶³ *Hansard HA*, vol. 19, Thursday, 3 September 1987, col. 5194.

professionals and medico-scientific organisations were regarded as having the necessary expertise, and that only medico-scientific interventions were regarded as important.⁶⁴

The AAG initially comprised six doctors and six professors, all of whom were, unsurprisingly, 'white' and 'male'.⁶⁵ It was chaired by Professor Jack Metz of the South African Institute for Medical Research (SAIMR), which was maintaining a central register of AIDS cases and records.⁶⁶ The work of the doctors, virologists and epidemiologists who made up the AAG featured prominently in both the *SAMJ* and *Epidemiological Comments* and contributed to the creation of the hegemonic medico-scientific AIDS narrative. Between them, the members of the group authored or co-authored 12% (68 papers) of the total number of *SAMJ* articles dealing with AIDS between 1980 and 1995. One of the members was Küstner, who edited *Epidemiological Comments*.⁶⁷ The AAG not only provided advice, but also 'created knowledge' about the epidemic.

By the end of 1986 the AAG had 15 members drawn from a number of medical disciplines and organisations. The SAIMR was represented by Metz, who remained the chair, and by Dr Ruben Sher, who helped set up the AIDS clinic at Johannesburg General Hospital and

⁶⁴ See the chapter on sexuality and AIDS for more on the experiences of Dennis Sifris, a white, male, gay doctor who tried to join the group.

⁶⁵ 'AIDS Advisory Group's first year', *SAMJ*, 69, 12, 7 June 1986, p. 775. The members were listed in the *SAMJ* as 'Professors J. Metz (Chair), W. Becker, T.H. Bothwell, P. Brain and A. Du P. Heyns, Drs H. Küstner, J.H. Lombard and G. Ras, Professor B. Schoub and Drs R. Sher, F. Spracklen and G. Watermeyer.

⁶⁶ The government was also providing financial support to the SAIMR, the National Institute of Virology (NIV), and various medical faculties for 'research on viruses which thus includes work on AIDS' (*Hansard HA*, vol.5, Tuesday, 12 March 1985, col. 508-509). The distribution of funding for 'viruses' generally, rather than research into viruses directly linked to AIDS, suggests only a partial financial commitment by the government to research in the field. The SAIMR and the NIV were both government-funded, and staff from both these institutions were members of the AAG.

The SAIMR is now the National Health Laboratory Service (NHLS). According to their website 'the National Health Laboratory Service (NHLS) was established in 2001 by an Act of Parliament, amalgamating the former South African Institute for Medical Research (SAIMR), National Institute for Virology (NIV) and National Centre for Occupational Health as well as university and provincial pathology laboratories'. See NHLS website at www.nhls.ac.za (accessed December 2011). The SAIMR was originally established to assist the gold-mining industry with health concerns related to miners and was a collaboration between the government (who donated the land); the Chamber of Mines; and mine recruitment agencies who all contributed annual grants to fund the institute. The institute undertook both research and screening and diagnostic work and developed serum such as antivenom and vaccines. For more information see Murray, J.F., 'History of the South African Institute for Medical Research', *SAMJ*, 37, 20 April 1963; and Johnson-Barker, B., 'Thirty Years of the MRC - A short general history of the South African Medical Research Council' available on the Medical Research Council website at www.mrc.ac.za/history/history.pdf (accessed July 2012).

⁶⁷ Amongst the most published were Schoub, who was listed as author or co-author of 25 articles; Sher with 14 articles; and Spracklen with nine articles.

became the Head of the SAIMR AIDS Programme. Professor B. Schoub represented the National Institute for Virology (NIV), and Professor P. Brain, the National Blood Fractionation Centre. There were also six members were from university medical schools, medical departments, and hospitals. However, while a variety of scientific medical disciplines were represented, there was no representation by professionals drawn from the humanities or social sciences who could have considered the epidemic more holistically.⁶⁸

The DoH was represented by Drs H. Küstner, J.H. Lombard, and G. Watermeyer, the Deputy Director-General of Health. The presence of government officials presumably ensured that information and knowledge about AIDS was available to government. Information collected by the AAG was used by Küstner in a number of key articles in *Epidemiological Comments*, which provided overviews and updates on AIDS in South Africa, tracked changing AIDS definitions, and provided summaries of scientific developments relating to the management, testing, identification and characteristics of HIV and AIDS.

At the end of 1986 two new members representing the mining and military sectors, joined the AAG - Dr J. Laing from Anglo American Corporation Health Services, and Dr W. Sieling from One Military Hospital. The close link between government and the mining industry has long been a feature of South African history and the increasing furore over mineworkers with HIV may account for Laing's membership. Given the political power of the mining sector it is possible that the sector insisted on representation in the AAG as concerns over labour losses grew.⁶⁹ Sieling's presence on the AAG may have indicated concerns about AIDS among South African soldiers, or about AIDS as a security issue more generally, or as a security issue linked directly to the concerns about 'infected terrorists'. State sanctioned homophobia was such that doctors were allowed to experiment on homosexual conscripts at One Military

⁶⁸ The six members were Professor W. Becker from the Department of Medical Virology, University of Stellenbosch and Tygerberg Hospital; Professor T.H. Bothwell from the Department of Medicine, University of the Witwatersrand; Professor J.W. Moodie from the University of Cape Town's Department of Medical Microbiology; Professor D.J. Pudifin from the University of Natal's Department of Medicine; Professor A. Du Plessis Heyns from the Department of Haematology at the University of the Orange Free State; and Dr F. Spracklen from the Department of Medicine at Somerset Hospital.

⁶⁹ For more on Anglo American see the website as www.angloamerican.co.za and with particular reference to their corporate response to AIDS see the press release 'Anglo American continues its global leadership in the fight against HIV/AIDS', 2 December 2009 at www.angloamerican.co.za/en/media/press-releases/2009/02-12-09.aspx. Note that Anglo American indicates that it started giving out ARVs to employees in 2002 despite having knowledge about the likely spread of the epidemic, through the AGA, since 1986.

Hospital.⁷⁰ With homosexual men considered a 'high-risk' group, Sieling's presence was possibly a natural extension of this concern.

As Gould and Folb have shown, scientists were co-opted into the chemical and biological warfare programme, so it is possible that there may have been interest in AIDS as a potential 'weapon'.⁷¹ In statements submitted to the Truth and Reconciliation Commission two security officers referred to HIV-positive *askaris* being instructed to have sex with sex workers in Hillbrow in 1988 to deliberately spread HIV.⁷²

Aside from direct contact with the DoH, the AAG imparted information, findings and updates about AIDS to other medical professionals, the public, and the private sector in the form of

⁷⁰ Van Zyl, M., de Gruchy, J., Lapinsky, S., Lewin, S., and Reid, G., 'The Aversion Project - Human Rights Abuses of Gays and Lesbians in the South African Defence Force by Health Workers during the Apartheid Era', report compiled on behalf of the Gay and Lesbian Archives (GALA), Health and Human Rights Project, Medical Research Council (MRC) and the National Coalition for Gay and Lesbian Equality, Cape Town, October 1999. Available electronically at the South African Medical Research Council website at www.mrc.ac.za/healthsystems/aversion.pdf (accessed December 2010). See also Kaplan, R., 'The Aversion Project - Psychiatric Abuses in the South African Defence Force During the Apartheid Era', *SAMJ*, 91, 3, March 2001, p. 216-217 and Kaplan, R. M., 'Treatment of Homosexuality during Apartheid - More investigation is needed into the shameful way homosexuality was treated', *British Medical Journal*, 329, 18-25 December 2004, pp. 1415 – 1416.

⁷¹ Gould, C., & Folb, P., 'The Role of Professionals in the South African Chemical and Biological Warfare Programme', *Minerva*, 40, 1, 2002, pp. 77 – 91.

⁷² The term *askaris* referred to members of liberation organisations who were captured by South African military or security forces and 'turned' into spies for the apartheid regime. For more on the case see the following TRC related documents available on the Department of Justice's website: South African Press Association (SAPA), 'De Kock Amnesty hearings Scheduled for Next Week', Pretoria, 11 November 1990 at www.justice.gov.za/trc/media/1999/9911/p991111a.htm; Statement by the Truth and Reconciliation Commission - Media Release, 10 November 1999 at www.justice.gov.za/trc//media/pr/1999/p991110.htm; TRC Amnesty Hearing Transcript, Eugene Alexander de Kock, application number AM0066/96, 6 September 1999 at www.justice.gov.za/trc/amntrans/1999/99090616_pre_990906pt.htm and TRC Amnesty Hearing Transcript, Andries van Heerden, application number AM3764/96, 23 October 2000 at www.justice.gov.za/trc/amntrans/2000/201023jb.htm (all websites accessed December 2010). Note that Van Heerden originally included the spreading of AIDS as one of things for which he was applying for amnesty, but when questioned further the following exchange took place: 'Mr Richard: And you similarly believed it was correct to go and spread AIDS amongst innocent people in Hillbrow?' 'Mr Van Heerden: Chairperson, I did not spread AIDS. I withdrew that application of AIDS, because it was an incorrect interpretation of what happened there. I did not assist in the spreading of any AIDS.' For more on the impact of beliefs (and myths) about deliberate infections on State run anti-AIDS programmes, and other aspects of understanding AIDS in South Africa, see Shell, R. 'The Silent Revolution: the AIDS Pandemic and the Military in South Africa', paper presented at the Consolidating Democracy in South Africa conference, Umtata, South Africa, 18 - 20 August 1999, full copy available at the, Konrad Adenauer Stiftung website at www.kas.de/suedafrika/en/publications/5111 (accessed December 2010); van der Vliet, V., 'AIDS: Losing "The New Struggle"?', *Daedalus*, 130, 1, Why South Africa Matters, Winter, 2001 (accessed using JSTOR); and Youde, J., 'The Development of a Counter-Epistemic Community: AIDS, South Africa, and International Regimes', *International Relations*, 19, 4, December 2005 (accessed using JSTOR).

articles in the *SAMJ*, pamphlets, commentary in the media, and through lectures.⁷³ The 'voices' of the AAG and its individual members, combined with the various government department 'voices', helped to create, and reinforce, the hegemonic AIDS narrative in South Africa at the start of the epidemic.⁷⁴

Safe Blood

One AAG member observed that

The establishment of the Advisory Group on AIDS by the Department of National Health and Population Development is an important step in co-ordinating the planning and implementation of effective control measures. These will include the availability of diagnostic and counselling services; ensuring that donated blood and its products are safe, as well as donated tissue and semen; and the prospective follow up of contacts, including neonates and children at risk.⁷⁵

Public concern about the safety of general blood supplies in South Africa and specific blood products used for treating haemophilia was such that as early as February 1983, J. Gilliland, the Deputy Director-General of the DoH, wrote a letter to the *SAMJ* urging doctors to allay fears among haemophiliacs about the safety of blood products used in replacement therapies.⁷⁶ Gilliland's letter noted that publicity around AIDS and blood products had resulted in certain patients not reporting for treatment. He encouraged doctors to reassure patients about the precautions being taken to ensure the safety of blood products.⁷⁷

⁷³ See for example the AAG updates in the *SAMJ* such as 'AIDS in the USA and the RSA – an Update', *SAMJ*, 70, 19 July 1986 p. 119 and subsequent annual updates.

⁷⁴ See the first chapter on hegemonic narratives in the *SAMJ*.

⁷⁵ W.B. Becker 'HTLV-III Infection in the RSA', *SAMJ* Supplement, 70, 8, 11 October 1986, p. 27.

⁷⁶ People with haemophilia have a genetic condition that negatively affects the body's ability to clot blood. The condition is fairly rare and occurs in men (according to the NHS around 1: 5000 'males' are born with Haemophilia A and 1:30 000 'males' with Haemophilia B). Treatment includes transfusing blood products into the individual to assist the body with clotting. For more information see the South African Haemophilia Foundation / Suid-Afrikaanse Hemofilie-Stigting at www.haemophilia.org.za/Hem2.htm or the National Health Service (UK) information on haemophilia at its website at www.nhs.uk/conditions/haemophilia/Pages/Introduction.aspx (accessed October 2010).

⁷⁷ 'The acquired immunodeficiency syndrome (AIDS) and blood products in haemophilia', *SAMJ*, 63, 8, 19 February 1983, p. 260.

The AAG had advised the DoH not to make AIDS a notifiable condition for fear of driving those with the syndrome underground. Although the debate about notifiability raged (and continues to rage) in both medical and political spheres, the DoH appeared to take this advice on board. Despite this, legislation passed in 1983 effectively targeted and stigmatized gay men. The government enacted the Human Tissue Act (65 of 1983) which prevented certain groups of people from donating blood, including homosexual men.⁷⁸ Fourie concludes that ‘the aim of the legislation was to draw attention to those individuals who were thought to be risky donors, and by implication to protect the rest of the population against their unsafe blood’.⁷⁹ The passing of the legislation against the AAG’s advice indicates that despite the primacy given to medical expertise and advice, it was not always followed by government.

Once the NIV announced in 1985 that immunofluorescence tests were available to check for HIV-antibodies, it became standard practice for provincial blood services to screen all donations. The blood services reproduced the hegemonic AIDS narrative by discouraging homosexuals, as members of the ‘high-risk groups’, from giving blood. A homophobic poster displayed by the blood service in Natal (now KwaZulu Natal) declared ‘if you are “gay” or a “moffie” or have had sex with a “gay” or “moffie” DO NOT GIVE BLOOD’ (figure 19).⁸⁰ The effects of this poster are still evident in the current national blood transfusion questionnaires which still frame a particular question in a sexist and homophobic way by asking donors if they are ‘a man who has had anal sex with another man’. Homophobia and the association of gay men with the disease carried such stigma that some haemophiliacs did not want to attend the same AIDS clinic as gay people at the Johannesburg General Hospital.⁸¹ The DoH, in its annual report for 1986, reproduced the hegemonic AIDS narrative

⁷⁸ Fourie, *Political Management*, p. 88. The actual Act itself did not specifically mention homosexual men although it did give the Minister the capacity to ‘make regulation regarding the conditions for the removal or withdrawal of tissue, blood and gametes from the bodies of living persons...’ (37. 1.b). Fourie and others have quoted this Act but it is possible that references specifically to homosexual men were made in subsequent regulations but have credited to the Act itself. See Human Tissue Act no. 65, 1983 (assented to 20 May 1983), *Government Gazette*, vol. 216, no. 8734, notice no. 1162, Cape Town, 1 June 1983, pp. 1 – 34.

⁷⁹ Fourie, *Political Management*, p. 88.

⁸⁰ “Moffie” is a derogatory term for male homosexuals used in South Africa. GALA, GASA Collection (AM 2975), Media Scrap Books, ‘Scrap Book Kept by Leon Eksteen’, Leon Eksteen. Newspaper article Harris, S., ‘Row brews over “moffie” posters’, unknown newspaper, c. 1986. See also GALA, GASA (AM 2975), Media Scrap Books, 8, Author unknown, ‘Gays angry over blood transfusion poster’, *The Citizen*, 29 January 1986, p. 15.

⁸¹ See chapter on ‘Intricate relationships’ for Dr Dennis Sifris’ account of this.

when it observed that 'persons belonging to known high-risk groups are discouraged from donating blood'.⁸²



Fig. 19. Newspaper report about the homophobic poster telling 'moffies' not to donate.

By August 1986 blood and blood products were being routinely screened in South Africa, on the recommendation of the AAG. The various blood transfusion services in the country were also in contact with the AAG regarding epidemiological information and the monitoring of positive testing rates among donors.⁸³ The symbolic and physical centrality of blood (and other bodily fluids) to the South African AIDS narrative requires additional research.

Testing and Other Epidemiological Data

In order for the AAG to fulfil its mandate to maintain a central record of AIDS cases, and to collect, analyse and disseminate data on AIDS, it needed ways to create, accumulate, and collate information. The availability of serological tests that could detect HIV antibodies provided an obvious way to start gathering information, but some doctors raised questions

⁸² NLSA, CTGC, SA Reports, National Department of Health and Population Development (hereafter NDHPD) Annual Report, 1986, p. 10.

⁸³ In August 1986, three of the 31 reported cases of 'AIDS' were linked to blood related infections. An update in the *SAMJ* indicated that one haemophiliac had received infected blood from the USA, and two other people - a 'heterosexual man' and a two-year old child - had been infected via blood transfusions. See 'Update on AIDS from the Advisory Group on AIDS – Blood and blood products', *SAMJ*, 70, 2 August 1986, p. 187.

about who would be responsible for paying for these tests. After a period of negotiation between the AAG and the government, the DoH agreed to pay for the tests. The Director-General of the DoH, C.M. Cameron addressed the issue in a letter to the *SAMJ* noting that although existing legislation declared the DoH responsible for the cost of tests essential in confirming the diagnoses of sexually transmitted infections in patients where there was 'sound *clinical* evidence' of the likely diagnosis, the letter of the law would be re-interpreted for HIV-antibody testing.⁸⁴ He noted the importance of diagnosing AIDS 'in the preclinical phase':

... this Department will, as recommended by the Advisory group on AIDS, also accept responsibility for the costs of diagnostic serological tests for patients who, on the grounds of sound *circumstantial* evidence, may have contracted the disease or who on epidemiological grounds belong to a high-risk group.⁸⁵

Only two types of tests would be covered under this concession and doctors were 'requested to exercise restraint when requesting the ... tests'.⁸⁶ Although the letter reproduced narratives around 'high-risk groups', the special dispensation that Cameron highlighted by allowing tests on the basis of 'circumstantial' versus 'clinical' evidence was directly linked to advice from the AAG.⁸⁷

The NIV's AIDS research laboratory played an important role in the testing process. By the end of 1986 the NIV was able to undertake tests for the purposes of routine screening for HIV-antibodies, diagnosing HIV status, and confirming tests results from other laboratories. The NIV was also involved in carrying out 'a number of surveillance projects of high-risk

⁸⁴ Cameron, C.M., 'Serological tests for AIDS', *SAMJ*, 68, 13, 21 December 1985, p. 914. [Emphasis added].

⁸⁵ *Ibid.*

⁸⁶ Testing would be limited to ELISA (enzyme-linked immunosorbent assay) and IFA (indirect fluorescent antibody) tests and would not include the Western Blot test. ELISA tests are initially used to determine if a person has anti-bodies to HIV. If the ELISA test is positive, a second test is done to confirm the positive result. IFA and Western Blot tests are usually used to confirm ELISA results. Cameron, 'Serological tests...', p. 914.

⁸⁷ The *SAMJ* carried a series of articles and correspondence about tests, the costs of tests, and the accuracy of different test kits. In a direct response to Cameron's letter, Dr Denise Sifris commended the Department's decision to make the tests free but pointed out that the letter wrongly suggested that testing for HIV (then called HTLV-III/LAV) allowed for a diagnosis of AIDS when AIDS was actually the final stage of the clinical spectrum of being HIV positive. The letter went on to note that this was significant because of the major psychological implications of being told that one had AIDS that had resulted in people with positive results attempting suicides. See D. Sifris, 'Serological test for AIDS', *SAMJ*, 69, 9, 26 April 1986, pp. 539 - 540.

groups' to determine 'antibody prevalence in these populations'.⁸⁸ The DoH noted that the laboratory had 'been established in order to develop the virological expertise to address this extremely important public health problem in South Africa'.⁸⁹ After highlighting AIDS as a health threat, the DoH then drew on the hegemonic AIDS narrative to allay fears:

Thus far, no evidence of endemic African AIDS [in] South Africa has been demonstrated and to date the AIDS picture is predominantly that of Western AIDS occurring exclusively in high-risk groups. Continual monitoring for the appearance of African AIDS is a major public health priority.⁹⁰

The DoH had been in contact with the Centers for Disease Control and Prevention (CDC) in the USA since 1981, and staff members, such as Dr Watermeyer, had been trained there in the combating of AIDS.⁹¹ Despite this, Küstner noted in 1983 that epidemiology as a discipline was 'still very much in its infancy' in South Africa.⁹²

What types of data formed the basis of the information collected by the AAG and informed the research undertaken by AAG members? From the outset the reporting and monitoring of HIV infections and AIDS-related deaths was not carried out equally by all sectors of the medico-scientific community or amongst all sections of the population. An AAG update in the *SAMJ* in November 1986 affirmed the AAG's belief that it received accurate information on AIDS patients when they were treated in public hospitals, but cautioned that it was vitally important for surveillance and response purposes to move beyond merely recording cases of 'full-blown [sic] AIDS'.⁹³ The article noted that 'meaningful surveillance [was] impossible without the availability of data on seropositivity to the human immunodeficiency virus (HIV)', and that without 'adequate surveillance' health authorities would not be able to forecast epidemic trends and plan appropriate responses.⁹⁴ This indicates that as early as

⁸⁸ NLSA, CTGC, SA Reports, NDHPD Annual Report, 1986, p. 39. The surveillance projects were not listed individually so it is not possible to verify exactly which 'high-risk' groups were under surveillance. Oral interviews however indicate that samples from gay men were actively sought.

⁸⁹ *Ibid.*

⁹⁰ *Ibid.*

⁹¹ *Hansard HA*, vol. 19, Thursday, 3 September 1987, col. 5193.

⁹² Küstner, H., *Epidemiological Comments*, 10, 9, September 1983, p. 2. The *Epidemiological Comments* also carried reports on the annual Epidemiological Conferences which started in 1982.

⁹³ 'Update on AIDS: Vital Need for Information from Private Practitioners', *SAMJ*, 70, 8 November 1986, p. 639.

⁹⁴ *Ibid.*

1986 the very group mandated to collect and collate information was not confident that accurate information was available.

This is not to say that the AAG did not receive any information on seropositivity because such information was forthcoming, from the blood transfusion services and from 'individual studies conducted among homosexuals, drug addicts and mineworkers'. AAG members reported 'a reluctance on the part of private medical practitioners to divulge information on [HIV positive] patients'.⁹⁵ This reveals that groups regarded as 'high-risk' were subject to investigation, as were labourers central to the country's economy (see below for more on mineworkers), and those who used public health facilities. Those who used private practitioners were not 'studied' in the same way and so did not form, or inform, the hegemonic South African AIDS narrative or official responses as pre-identified 'risk-groups' did.⁹⁶

As the submission of information about HIV status or AIDS diagnosis was voluntary, it is difficult to determine how many cases among 'non-high-risk groups' were not reported. Information on the status of people from the 'independent' TBVC states and homelands was almost non-existent. The information that shaped research foci, and was available to the DoH for planning purposes, was thus based on a relatively small proportion of the population, primarily those identified as forming some of the 'risk-groups' identified in the hegemonic AIDS narrative.⁹⁷

The *SAMJ* article noted that the attitude of medical practitioners was understandable, as 'basic principles of medical ethics [were] involved'. Nonetheless it appealed to private practitioners to provide details such as 'age, race, sex, sexual preference, possible source of infection ... and ... history of opportunistic infections' to the AAG.⁹⁸ The ethical issues concerning 'high-risk' or other groups accessing public health were not discussed, nor were

⁹⁵ 'Update on AIDS: Vital Need for Information', p. 639.

⁹⁶ This also raises the question of whether political imperatives/ideologies drove research, or whether research was selectively used to justify political/ideological imperatives?

⁹⁷ TBVC stand for the Transkei, Bophuthatswana, Venda and the Ciskei – the so-called 'independent states' created during apartheid.

⁹⁸ 'Update on AIDS: Vital Need for Information', p. 639.

the use of categories like 'race' or definitions of 'sexual preference,' or non-binary notions of 'sex'.

As infection rates increased the AAG appealed to readers to report HIV-positive results and AIDS diagnoses to AAG members in Johannesburg, Pretoria, Cape Town, Durban and Bloemfontein.⁹⁹ It is not clear how health care practitioners in under-resourced rural areas were meant to report their results. While the DoH may have identified the gathering of information about AIDS as important, as with other health data in South Africa at the time, the information available was limited and incomplete.

Communication and Public Health Information

Outside the AAG, some AAG members, such as Ruben Sher, were actively involved in AIDS research, and in raising awareness about AIDS through public lectures and training. The AAG liaised with the Gay Association of South Africa (GASA) suggesting that information about responses to AIDS by certain sectors of the gay community (and associated concerns about AIDS as a health problem) were being fed back to government officials within the AAG.¹⁰⁰

The AAG compiled a booklet entitled 'What you should know about AIDS', which was published by the DoH in October 1986.¹⁰¹ It was available in English and Afrikaans only, was free, and could be obtained by contacting the Director-General of the DoH. It addressed four questions – 'What is AIDS? How is AIDS transmitted? What are the symptoms of ARC and AIDS?' 'What is being done about AIDS?' It included sections on laboratory testing and 'people at high risk', the latter reinforcing the hegemonic AIDS narrative, using the well-known AIDS avatars of homosexual and bisexual men, intravenous drug users (IVDUs), and haemophiliacs.

⁹⁹ 'Update on AIDS: Vital Need for Information', p. 639.

¹⁰⁰ 'AIDS Advisory Group's first year', p. 775. See also the chapter on sexuality and AIDS. Sher and other AAG members also worked with gay medical professionals like Dennis Sifris and Steve Miller (see sexuality and AIDS chapter).

¹⁰¹ NLSA, CTGC, AP. 1988-593, Department of National Health and Population Development and the Advisory Group on AIDS, 'What you should know about AIDS', October 1986. See also 'AIDS Pamphlet', *SAMJ*, 71, 21 February 1987, p. xviii.

While haemophiliacs were described as having been infected through blood products, IVDUs were described as 'drug abusers'. Homosexual and bisexual men were identified as being particularly high-risk groups, 'partly because of the sexual practices they indulge in' [and] 'partly because of promiscuity which increases the likelihood of their having sex with a carrier of the AIDS virus'.¹⁰² As with the hegemonic narrative in the *SAMJ*, undefined dangerous 'sexual practices' and 'promiscuity' were linked to certain sexual orientations.

The booklet ended with a section printed in bold red lettering, and headed 'To remember', presenting a somewhat contradictory picture of people with AIDS to that conjured up by the high-risk avatars:

Victims of AIDS face an enormous emotional and social crisis. Unnecessary fear and prejudice on the part of their friends, families and colleagues tend to isolate them even more from the human warmth and support that such seriously ill people need. By showing compassion to AIDS patients, should you come into contact with them, you will be doing a great deal towards alleviating a lot of suffering. You will not get AIDS by being kind to its victims.¹⁰³

Information on the number of booklets published and distributed is unavailable so it is difficult to determine what impact the booklet had or which sectors of the public or medical profession read it.

Annual Reports

Focussing on responses to AIDS does not contextualise them in relation to other health concerns which occupied the DoH. By looking at the DoH's annual reports insight can be gained into the relative priority given to HIV and AIDS. Annual reports do not provide detailed information about departmental campaigns or activities but rather summarise the particular health priorities in each given year.¹⁰⁴

¹⁰² NLSA, CTGC, AP. 1988-593, Department of National Health and Population Development and the Advisory Group on AIDS, 'What you should know about AIDS', October 1986, p. 2.

¹⁰³ *Ibid.*, p. 4.

¹⁰⁴ The contents of the annual reports from 1980 – 1987 were organised under the following headings, with minor variations to account for changing departmental nomenclature: Matters of Prominence; Legislation; Administration; Infectious, Communicable and Preventable Diseases; Mental Health; Medical Care; Health

AIDS was not mentioned in DoH annual reports between 1981 and 1984. The 'matters of prominence' identified over this period included the changes in responsibilities for health care provision under the constitutional amendment that created the tricameral parliament and made health matters an 'own affairs' issue; and a commission of enquiry into the health services that was underway by 1984.¹⁰⁵ Featured diseases included 'Congo'-haemorrhagic fever, tuberculosis (TB), and malaria.¹⁰⁶

In the 1985 report, AIDS was listed as one of the 'matters of prominence'. The report noted that a 'major diagnostic advance' had been made in 1985 with the development of a test for 'HTLV-III/LAV virus infection'. Under the 'Communicable Diseases' section, the confirmation of cases of 'Crimean Congo' haemorrhagic fever and Rift Valley fever were of primary concern, as there was no mention of AIDS.¹⁰⁷ The 'matters of prominence' in the 1986 report included, inter alia, information on the commission of inquiry into health services. It noted that the commission had issued its final report and had 'concluded that it will be impossible to establish an efficient and cost-effective health care system unless adequate, accurate and

Protection; Associated and Support Services; Professional Welfare Services; Social Auxiliary Services; Civil Pensions and Fund-raising (or Civil and Military Pensions); Research and Publications; and Visits and Congresses. From 1988 – 1995 there were more variations in the headings and from 1989 there were headings for Personal Primary Health Care; Environmental Health Control; Forensic and Research Services; Population Development; and by 1992, 'Medical Schemes Administration. In 1994 'Nutritional Programmes' were included while the 1995 report was unlike any previous reports and its contents focussed on transformation, and new plans and priorities for the department. The 1996 report returned to the more conventional contents.

¹⁰⁵ Under the tricameral system, a bloated bureaucratic structure saw service provision being negotiated between a national department, provincial departments, and parallel departments in the Houses of Representatives and Delegates. While referring to education, Bunting's explanation is equally applicable to health: 'A key element in the creation of the three separate parliamentary houses in the RSA in 1984 was a distinction drawn between 'own affairs' and 'general affairs'. What were described as 'own affairs' were matters specific to the 'cultural and value frameworks' of the coloured or Indian or white communities. 'General affairs' were those which had an impact across all racial communities. Education was considered by the 1984 constitution to be an 'own affair' as far as whites, coloureds and Indians were concerned. This implied that all education for whites (primary, secondary and higher) was the responsibility of the House of Assembly, for coloureds that of the House of Representatives, and for Indians that of the House of Delegates. This constitution considered education for Africans in the RSA to be a 'general affair'. See Bunting, I., 'The Higher Education Landscape Under Apartheid' in Cloete, N., Maassen, P., Fehnel, R. *et al* (eds), *Transformation in Higher Education - Global Pressures and Local Realities*, Centre for Higher Education Transformation (CHET) available on the CHET website at http://chet.org.za/webfm_send/64 (accessed January 2012), p. 36. Regardless of the service, the two houses were subordinate to the House of Assembly and could make very few decisions. In the case of the health bureaucracy there was the Department of National Health and Population Development (which underwent frequent name changes), the Natal, Transvaal, Orange Free State, and Cape Provincial Health Departments, and the Departments of Health Services and Welfare in both the House of Delegates and the House of Representatives.

¹⁰⁶ NLSA, CTGC, SA Rpts, Department of Health, Welfare and Pensions, Annual Reports 1982, 1983; Department of Health and Welfare Annual Report 1984.

¹⁰⁷ NLSA, CTGC, SA Reports, NDHPD Annual Report, 1985, p. 1 & p. 47.

comparable statistical information is available on all branches of the health services'.¹⁰⁸ The conclusion of the commission's report suggests that central record-keeping and information-gathering across the branches of the health services were lacking. If the DoH was unable to organise its own internal information-gathering and collation it seems unlikely that it would be able to effectively and efficiently oversee broader national information-gathering exercises relating to health concerns such as AIDS. This perhaps accounts for why the responsibility for central record-keeping and information gathering about AIDS was given to the AAG.

The 1986 report indicated that almost fifty cases of AIDS had been identified amongst an 'overwhelming majority' of homosexual men but that there had been no new blood transfusion cases.¹⁰⁹ Readers of the report were assured of a safe blood supply and informed that 'the Advisory Group on AIDS is still functioning well'.¹¹⁰ Furthermore, the dissemination of information on AIDS 'to interested groups as well as the lay public is receiving high priority. A number of articles have been published, interviews were given and lectures presented in this regard; a brochure is available'.¹¹¹ The testing of high-risk groups was occurring and 'surveillance studies are being done at various clinics for sexually transmitted diseases to monitor the magnitude and spread of this disease, especially amongst the high-risk groups'.¹¹²

Phase Two: Facts and Fear

In 1987 MPs in all three houses of the tricameral parliament challenged the government to respond more decisively to AIDS, to formulate a comprehensive AIDS strategy, and to 'provide a clear lead to the people'. MPs asked the government to ensure that information about AIDS was made publically available, and to concentrate on AIDS training and education, indicating a disjuncture between what the DoH claimed it was doing in its annual

¹⁰⁸ NLSA, CTGC, SA Reports, NDHPD Annual Report, 1986, p. 1.

¹⁰⁹ *Ibid.*, p. 10.

¹¹⁰ *Ibid.*

¹¹¹ *Ibid.*

¹¹² *Ibid.*

reports and the perceptions of MPs and members of the public.¹¹³ These requests suggest either a shift in public concern about people with AIDS, or, more likely, that AIDS, and fears about AIDS, were featuring more prominently in the minds and imaginations of the public.

The DoH assured that AIDS was considered a serious health concern, drawing attention to the dissemination of information to the public, the opening of AIDS health centres, and the significant medical expertise that was involved in addressing it.¹¹⁴ Between 1987 and 1989, the DoH's annual reports and *Epidemiological Comments* continued to report on a number of communicable diseases, but AIDS began to feature more in both government publications and legislation. The second phase of the government's response to AIDS was characterised by an increase in the accumulation and dissemination of 'facts' about AIDS, and by the framing of AIDS narratives and policies with due cognisance to the fear of AIDS and the fear of 'infected outsiders' among the public and political elites.

By 1987 information about the development of the global AIDS epidemic was being compiled and distributed to governments by the World Health Organisation (WHO), while information on AIDS in South Africa continued to be collected and analysed by the AAG. The AAG continued to provide updates, via the *SAMJ*, government AIDS brochures, and media releases, on its work, identifying the number of AIDS cases in South Africa, and confirming the spread of AIDS in the heterosexual population.¹¹⁵ The AAG's information fed into updates on AIDS, and analyses of the expected epidemiology of AIDS in the country, that

¹¹³ See *Hansard* HA, vol. 14, Friday, 20 February 1987, col. 1185 statement by G.B.D McIntosh (PFP); *Hansard* HD, vol. 13, Wednesday, 17 June 1987, col. 996 – 997 comment by Mr F.M. Khan (NPP); and *Hansard* HR, vol. 14, Tuesday, 1 September 1987, col. 2710- 2711, declaration by Mr L.J. Hollander (LP).

¹¹⁴ These interventions, which all had good publicity value, occurred while the government simultaneously used concerns about AIDS to pass legislation to prevent migrant workers from entering the country – a response which had more to do with economics than health care.

¹¹⁵ See Advisory Group on AIDS, 'Update on AIDS: Number of Cases in the RSA and Abroad', *SAMJ*, 72, 1, 4 July 1987, p. 92; Advisory Group on AIDS, 'Update on AIDS: Heterosexual Spread of AIDS', *SAMJ*, 72, 5, 5 September 1987, p. 366; Advisory Group on AIDS, 'Advisory Group on AIDS: Activities During 1987', *SAMJ*, 73, 5, 5 March 1988, p. 319; Advisory Group on AIDS, 'Strategic Plan for the Containment of AIDS in South Africa', *SAMJ*, 73, 8, 16 April 1988, pp. 495 - 497; Advisory Group on AIDS, 'AIDS - The Current Situation in the RSA', *SAMJ*, 74, 6, 17 September 1988, p. 317; Spracklen, F.H.N., 'AIDS: Prevention and Control', *SAMJ*, 74, 6, 17 September 1988, p. 317; Advisory Group on AIDS, 'Update: AIDS in RSA', *SAMJ*, 74, 11, 3 December 1988, p. 600; Advisory Group on AIDS, 'AIDS in the RSA', *SAMJ*, 75, 2, 21 January 1989, p. 95 and Gay and Lesbian Archive (GALA), Gay Association of South Africa (GASA) Collection (AM 2974) News Release from Advisory Group on AIDS, 2 November 1987. Information from the AAG continued to be distributed in the *SAMJ*, in government AIDS brochures, and in media releases.

featured in *Epidemiological Comments* (figure 20). In April 1987 Küstner collated available international and local AIDS information and dedicated 62 pages of the publication to an overview of AIDS epidemiology.¹¹⁶ He provided a sense of how AIDS featured in the public imagination by speculating on why ‘AIDS holds the hearts and minds of all mankind [sic] in terror’, and reflected on the difficulty of conducting ‘sensible and practical health education ... in a quiet and rational way’ when sensational AIDS stories continually appeared in the media.¹¹⁷ He saw himself as providing sound information that would ‘pave the way for [the] only current intervention strategy, namely HEALTH EDUCATION’.¹¹⁸

The article summarised reports, graphs and maps showing infection rates and the geographic distribution of infections based on WHO AIDS surveillance as at March 1987. It illustrated ‘the cases of AIDS seen by people defined as “local” or “foreign”, described the outcome for each case, and classifies cases by population group, sex and probable risk factor’.¹¹⁹ It referred to ‘Western AIDS’ and ‘African AIDS’ and used information from Norway, Israel and Denmark, which were considered to have ‘similar populations-at-risk’, to draw comparisons with infection rates in South Africa.¹²⁰ The narrative mirrored the hegemonic AIDS narrative in the *SAMJ*, the same ‘scientific’ categories and findings were uncritically reproduced.¹²¹

While using the ‘high-risk’ group narrative, the article indicated that a group of sex workers in Johannesburg had all tested negative; that no ‘drug abusers’ in South Africa were known to be infected; and that a survey of mine workers revealed that ‘HIV-positivity rate in Black [sic] males is low’.¹²² These findings highlighted the tensions between macro hegemonic narratives built on assumptions, and the realities of specific research findings at a micro level.

¹¹⁶ Küstner, H. G. V, ‘AIDS: The 1979-Pandemic, with Special Reference to South Africa, *Epidemiological Comments*, 14, 4, April 1987.

¹¹⁷ *Ibid.*, pp. 2 - 3.

¹¹⁸ *Ibid.*, p. 4.

¹¹⁹ *Ibid.*, p. 17.

¹²⁰ *Ibid.*

¹²¹ Küstner did note that ‘not all white homosexual males carry the same risk of infection since the added feature of PROMISCUITY greatly adds to their risk. Clearly not all who fall within this high-risk group are promiscuous’ (*Ibid.*, p. 48). He did not however define promiscuity and associated it solely with female sex workers with no mention of their clients.

¹²² Küstner, ‘AIDS: The 1979-Pandemic’, p. 56.

Table 6.

THE 1979-AIDS PANDEMIC : SOUTH AFRICAN AIDS SURVEILLANCE.

PROVEN AIDS CASES: Survival of Status on : 20 MAR 1987
South African cases.

<u>Serial Number</u>	<u>Date of Diagnosis</u>	<u>Age at Diagnosis</u>	<u>Date of Death</u>		<u>Survival in months</u>
1	Dec 1982	42 yrs.	Dec 1982		less than 1
2	Dec 1982	40	Dec 1982		less than 1
3	May 1983	41		Alive	46 mo.
4	1983	-	1983		-
5	Aug 1983	41	Sep 1983		1
6	Dec 1983	34	Dec 1984		12
7	Jan 1984	37	-		-
8	Jan 1984	43		Alive	38
9	1984	36	1985		-
10	1984	24	1985		-
11	Mar 1984	42	1985		-
12	Jul 1984	37	1984		-
13	Nov 1984	-	1985		-
14	Dec 1984	34	Dec 1985		12
15	Jan 1985	38	1986		-
16	Feb 1985	21	1986		-
17	Jun 1985	26	1986		-
18	Jun 1985	38	Aug 1986		14
19	1985	-	1985		-
20	Oct 1985	13	Oct 1985		less than 1
21	1985	33	Dec 1985		-
22	Dec 1985	30	Dec 1985		less than 1
23	Jan 1986	29	Jun 1986		5
24	Apr 1986	-		Alive	11
25	Jun 1986	52	Nov 1986		5
26	Jun 1986	37	Jun 1986		less than 1
27	Jun 1986	37	Jun 1986		less than 1
28	Jun 1986	37		Alive	9
29	Jun 1986	45	Sep 1986	SUICIDE	-
30	Jun 1986	41		Alive	9
31	Jul 1986	22		Alive	8
32	Jul 1986	35		Alive	8
33	Aug 1986	39		Alive	8
34	Aug 1986	68	Aug 1986		less than 1
35	Aug 1986	-	Oct 1986		2
36	Sep 1986	52		Alive	6
37	Nov 1986	34		Alive	4
38	1986	34	Nov 1986		-
39	Dec 1986	37		Alive	3
40	Dec 1986	36	Dec 1986		less than 1
41	Dec 1986	26		Alive	3
42	Dec 1986	42	Feb 1987		2
43	Dec 1986	34		Alive	3
44	Jan 1987	-		Alive	2
45	Feb 1987	-		Alive	1
46	Feb 1987	38	Feb 1987		less than 1
47	Feb 1987	47	Mar 1987		1
48	Feb 1987	28	Feb 1987		less than 1
49	Mar 1987	33	Mar 1987		less than 1
50					

Source : SA Advisory Group on AIDS. "-" means no information.

Fig. 20. Table in *Epidemiological Comments* listing ages, length of survival, and deaths of 'AIDS cases' by 1987.

There was insufficient data at this time to accurately deny or support hegemonic narratives, yet these narratives were constantly reproduced. Küstner concluded with ‘some broad generalisations [that bore] repeating’ by noting that ‘the entire monogamous heterosexual population is at present next to no risk’ (along with female homosexuals) and that AIDS had ‘become the most persuasive argument in favour of monogamous sexual relationships’.¹²³

During 1989 *Epidemiological Comments* featured a three-part AIDS update containing revised global AIDS information from the WHO, and a synopsis of AIDS in South Africa with information collated by the AAG from the SAIMR and NIV.¹²⁴ Küstner noted that ‘notions of “high-risk groups” [had] been replaced by “high-risk behaviour”’, that sex and health education programmes needed to be culturally sensitive, and that changing sexual practices were the only way to address AIDS. He then drew on embedded stereotypes of race and sexuality, observing that sexual practices ‘... led to the social and demographic devastation reported from many parts of sub-Saharan Africa. Poverty, prostitution and promiscuity invariably feature prominently in such accounts’.¹²⁵

The continued importance attached to the opinions of medical experts, particularly within the AAG, was reinforced in parliament by Van Niekerk who, in 1987, paid ‘tribute to the way they [the AAG] have continuously given excellent service and advice to the government’ – perhaps in an attempt to instil public and political trust in the NP’s handling of the disease.¹²⁶ It is unclear how seriously the DoH took the AAG’s advice, but it is possible that the DoH was content to let the AAG gather information and make suggestions – some of

¹²³ Küstner, ‘AIDS: The 1979-Pandemic’, pp. 58 – 60.

¹²⁴ Küstner, H. G. V, ‘AIDS-Update, Part 1’, *Epidemiological Comments*, 15, 8, August 1988; Küstner, H. G. V, ‘AIDS-Update, Part 2’, *Epidemiological Comments*, 15, 9, September 1988; Küstner, H. G. V, ‘AIDS-Update, Part 3’, *Epidemiological Comments*, 15, 12, December 1988. Tables and statistics on AIDS were also published throughout 1989, see *Epidemiological Comments*, 16, 3, March 1989; *Epidemiological Comments*, 16, 4, April 1989; *Epidemiological Comments*, 16, 7, July 1989; *Epidemiological Comments*, 16, 8, August 1989; *Epidemiological Comments*, 16, 10, October 1989; *Epidemiological Comments*, 16, 11, November 1989; and *Epidemiological Comments*, 16, 12, December 1989. Tables of identified AIDS cases were also reproduced in the *SAMJ*.

¹²⁵ Küstner, ‘AIDS-Update, Part 3’, p. 25. While epidemiology as a discipline was still developing in South Africa during this period, there was a steady flow of information between medical experts, ministers and departments of health. The available information and how it was reported on, reproduced, and analysed in these contexts perpetuated the hegemonic AIDS narratives, and ruling political ideologies. For more see Küstner, H. G. V, ‘The Practice of Epidemiology’, *Epidemiological Comments*, 15, 7, July 1988.

¹²⁶ *Hansard*, HA, vol. 19, Thursday, 3 September 1987, col. 5148. See also *Hansard* HA, vol. 20, Tuesday, 28 July 1987, col. 417-418.

which the DoH would follow - in lieu of the DoH actually developing a pro-active, comprehensive response to AIDS itself.

By early 1987 the DoH claimed that there was a pro-active response underway. In February the *SAMJ* indicated that the DoH had 'adopted a detailed strategic plan for combating AIDS', centred on 'health education and the dissemination of information on AIDS to the public and health professionals', together with the surveillance of new and current infections.¹²⁷ Moreover, 'the Department [was] concerned with the provision of health services and counselling to patients infected with the virus', and was establishing an executive body charged with implementing the 'government's strategic plan for control of the disease', a body separate from the AAG which would continue to advise the government.¹²⁸ These plans were motivated by recommendations made to the government by the AAG early in 1987 when the AAG proposed the creation of a 'departmental AIDS Action Group' and the launch of a public education campaign.¹²⁹ By June 1987 a new body had been created - referred to as the 'National Executive' - but what this executive did and what the 'detailed strategic plan' actually comprised is unknown because records of the 'National Executive' and the strategic plan appear not to have survived.¹³⁰

In keeping with the biomedical engagement with AIDS and the emphasis on medical expertise, the government did, through its funding of the parastatal Medical Research Council (MRC), assist in the establishment of an AIDS Virus Research Unit (AVRU) at the NIV in 1987.¹³¹ By the end of 1987 the AVRU was lauded in parliament for its 'sophisticated

¹²⁷ 'Action Against AIDS', *SAMJ*, 71, 21 February 1987, p. xii. Information was also sent to MPs, see Historical Papers, WITS University, Peter Soal Collection (A2683), Health File - Correspondence from W A Van Niekerk to P. G. Soal, Memorandum Regarding AIDS, c. 1988.

¹²⁸ 'Action Against AIDS', *SAMJ*, 71, 21 February 1987, p. xii.

¹²⁹ 'Advisory Group on AIDS: Activities During 1987', *SAMJ*, 73, 5 March 1988, p. 319. These plans could be the same ones that were published in three parts the following year in the *SAMJ*, see Ijsselmuiden, C.B., Steinberg, M.H., Padayachee, G.N, Schoub, B.D., *et al*, 'AIDS and South Africa - Towards a Comprehensive Strategy', parts 1, 2 & 3, *SAMJ*, 73, 16 April 1988, pp. 455 - 465, and AGA, 'Strategic Plan for the Containment of AIDS in South Africa', p. 495.

¹³⁰ Schoub, B.D., 'AIDS in South Africa - a time for action', *SAMJ*, 71, 11, 6 June 1987, p. 678. Despite a concerted effort to find these records they could not be located in any major holdings in South Africa.

¹³¹ The MRC was established by an Act of Parliament in 1969 which tasked it to, as Johnson-Barker notes "'promote the improvement of the health and the quality of life of the population of the Republic and to perform other such functions as may be assigned to the MRC ... through research, development and technology transfer".' For an overview of the MRC's history see 'Johnson-Barker, B., 'Thirty Years of the MRC - A short general history of the South African Medical Research Council' on the South African Medical Research

technology for AIDS research' and for the 'international contributions' it was apparently making to AIDS research.¹³² The AVRU was mandated to do research 'into the virology, epidemiology, pathogenesis, molecular biology and therapeutic aspects of AIDS and HIV infection' and to perform routine and confirmatory HIV antibody tests.¹³³

According to the DoH, the AVRU evaluated new diagnostic kits and undertook antibody surveillance programmes on 'a number of high-risk groups for example STD [sexually transmitted disease] clinic attendees, prisoners, prostitute populations, etc'.¹³⁴ The AVRU established an AIDS clinic at Rietfontien Hospital (where samples were collected from people who attended and where clinical examinations and counselling were provided) and consulted at the AIDS clinic established by Sher and Dr Dennis Sifris at the Johannesburg General Hospital.¹³⁵ The DoH noted that aside from the work being done in the country the AVRU had an 'international reputation' and enjoyed 'close working relationships with various prestigious international scientific organisations e.g. the CDC, WHO in Geneva and its laboratories in London'.¹³⁶

By the end of 1989 the AVRU noted that, based on an analysis of cases reported to the AAG, there was 'a disquieting increase [of AIDS] among heterosexuals ... predominantly in the Black community'.¹³⁷ Studies of men attending sexually transmitted infection (STI) clinics,

Council website at www.mrc.ac.za/history/general.htm (accessed March 2012). The MRC still receives government money and is responsible for co-ordinating medical research throughout the country. It distributes funds to researchers and undertakes medical research in line with the country's health priorities. Current health priorities include: HIV and AIDS, tuberculosis, malaria, cancer, African Traditional Medicine and Drug Discovery; genomics, proteomics and computational biology; nutrition; Crime, violence and injury; women, maternal and child health; cardiovascular and metabolic diseases; mental health and functional disorders; and health and research policy and implementation. The MRC defines its current vision as 'Building a healthy nation through research' and its mission 'to improve the nation's health and quality of life through promoting and conducting relevant and responsive health research' - see the Medical Research Council website at www.mrc.ac.za (accessed March 2012).

¹³² *Hansard* HA, vol. 19, Thursday, 3 September 1987, col. 5193.

¹³³ NLSA, CTGC, SA Reports, NDHPD Annual Report 1987, p. 33. The lab performed the full spectrum of available HIV-antibody tests namely ELISA, IF, and Western blot tests. The AAG also commissioned the AVRU to 'establish a national quality control programme for laboratory diagnosis of HIV infection'.

¹³⁴ NLSA, CTGC, SA Reports, NDHPD Annual Report 1987, p. 33.

¹³⁵ Rietfontein Hospital is now called Sizwe Tropical Disease Hospital. For an overview of the hospital's achievements see Davie, L., 'Sizwe Hospital, 109 years later', 26 November 2004, on the City of Johannesburg website at www.joburgnews.co.za/2004/nov/nov26_sizwe.stmm (accessed March 2012). For more on Sifris see the chapter on sexuality politics and AIDS.

¹³⁶ NLSA, CTGC, SA Reports, DNHPD Annual Report 1988, p. 50.

¹³⁷ NLSA, CTGC, SA Reports, DNHPD Annual Report 1989, p. 75.

black womyn attending family planning clinics, and migrant labourers, revealed an increase in the number of HIV-positive people.¹³⁸ The AVRU confirmed a second clade of HIV in ‘black subjects’ resulting in a change in routine testing to check for both clades. While the DoH acknowledged that the AVRU’s identification of a second HIV clade and the surveillance data ‘yielded useful information regarding the rapid growth of infection in the heterosexual urban Black community’, these facts did not appear to hasten the DoH’s response to AIDS.¹³⁹

An AIDS information and education centre at the SAIMR was opened in 1987.¹⁴⁰ This centre and the others that would open after it, were referred to as AIDS Training Information and Counselling Centres (ATICCs), or AIDS Training and Information Centres (ATICs), and were government funded. Their purpose was to provide ‘experts and interested groups with information as well as study methods to enable them to give proper information to smaller groups’.¹⁴¹ Individuals or members from various communities or organisations could come to the ATICCs and learn about AIDS, and about how to educate others about AIDS. Some ATICs provided support groups and counselling for people who were HIV positive or had AIDS.

By February 1989 ATICCs had been opened in Cape Town, Port Elizabeth, Bloemfontein, Durban, Pretoria and Johannesburg.¹⁴² The location of these ATICCs in major (‘white’) urban areas reveals the urban-focus of the response. Not all urban areas were equally catered for, as an MP for Kimberley noted when he questioned why an ATICC had not been established there.¹⁴³ Rural areas (and of course the ‘independent homelands’) were not catered for at all.

¹³⁸ NLSA, CTGC, SA Reports, DNHPD Annual Report 1989, p. 75.

¹³⁹ NLSA, CTGC, SA Reports, DNHPD Annual Report 1988, p. 51.

¹⁴⁰ *Hansard* HR, vol.14, Tuesday, 1 September 1987, col. 2711 – 2712.

¹⁴¹ *Hansard* HA, vol.19, Thursday, 3 September 1987, col. 5194.

¹⁴² *Hansard* (Joint Meeting), vol.9, Monday, 20 February 1989, col. 1080.

¹⁴³ *Hansard* (Public Committee Meeting), vol. 11, Tuesday, 18 April 1989, col. 5663. Venter repeated the contention that the spread of the virus was a behavioural more than a medical problem in response to a question asked in the House of Assembly in 1991, See *Hansard* HA, vol. 29, Tuesday, 26 February 1991, col. 169.

Facts to the Public

MPs were assured that information was being made available to the 'general public' and that 'all channels of the media e.g. television, radio, daily newspapers, magazines and technical journals [had] been harnessed', and doctors had been encouraged to distribute information brochures.¹⁴⁴ In September 1987, Dr P.J.C. Nel (NP) reported that the information campaign undertaken by 'the authorities and the private sector' was 'considered by [the] department to be the most important single strategy in the fight against Aids'.¹⁴⁵ The AAG noted in November 1987 that 'education of all population groups, and particularly blacks, is becoming increasingly important to prevent the spread of the virus', and 'urged the Government to expedite the extension of current programmes aimed at containing the spread of sexually transmitted diseases'.¹⁴⁶

From January to April 1988 the first 'intensive AIDS awareness campaign' was launched by the DoH. It was not conceived of as a single nation-wide campaign, but rather as a campaign with two parts, one aimed at heterosexual 'whites' and one at heterosexual 'blacks'.¹⁴⁷ The campaign was influenced by the moral ideologies of the time, as indicated in a comment from Van Niekerk:

...what is more important is that we have established the importance of a monogamous lifestyle with regard to sexuality as a requisite for those who do not want to be infected by this virus. I think we conveyed this with a reasonable measure of success, namely that when a promiscuous lifestyle is maintained, the use of condoms is essential.¹⁴⁸

Government responses to AIDS were not solely premised on evaluating a series of education options and choosing the one that would have the most practical public health benefit. From

¹⁴⁴ *Hansard* HR, vol. 14, Tuesday, 1 September 1987, col. 2711 – 2712.

¹⁴⁵ *Hansard* HA, vol. 19, Thursday, 3 September 1987, col. 5194.

¹⁴⁶ GALA, GASA Collection (AM 2974), News Release from Advisory Group on AIDS, 2 November 1987, p. 2.

¹⁴⁷ NLSA, CTGC, SA Reports, DNHPD Annual Report 1988, p. 17.

¹⁴⁸ *Hansard* HA, vol. 3, Tuesday, 19 April 1988, col. 6332.

the start the campaign was informed by concerns about both 'race' and morality and how they were supposed to be related to the spread of AIDS.¹⁴⁹

The campaign was devised by a private advertising agency (the McCann Group) and used a poster showing a coffin going into a grave for the 'black' community, while for the 'white community' reference was made, via graffiti on a wall, to the dangers of engaging in sex with multiple partners.¹⁵⁰ Hilton-Barber Hayes, a firm of public relations consultants, produced and distributed a press kit as 'part of the [DoH's] pro-active information policy of "Prevention is better than cure".¹⁵¹ This repeated the call for monogamous relationships and provided 'Fact Sheets' explaining what AIDS was and what the government was doing to prevent it..¹⁵²

For Van Niekerk the campaign 'had a great impact on the Whites, but more especially on the Black population.'¹⁵³ Television, radio and 'the Press' were used 'in both the Black and White markets, with radio as the main thrust for the Black market, while the White market employs

¹⁴⁹ Moral overtones were also evident in comments about condom distribution such as when Mr D.T. de la Cruz (DWP), leader of the official opposition in the House of Representatives, recognised condoms as 'our first line of defence' and suggested that they 'be made available cheaply to people who have to use them' but then quoted from an article by the World Federation of Doctors Who Respect Human Life: 'Could it be possible that this dangerous disinformation ... that the condom can prevent Aids ... was and still is given because most doctors under the influence of the permissive society, have lost the moral courage to tell a hedonistic world that sodomy, and other forms of extra-marital sex, is morally and medically harmful, even fatal, and that the best method of avoiding Aids and for that matter any other sexually transmitted disease is to practise virginity before marriage and to remain totally and exclusively faithful to your spouse'. *Hansard* HR, vol. 3, Monday, 25 April 1988, col. 7296. See also *Hansard* Proceedings of Extended Public Committee, vol. 19, Wednesday, 16 May 1990, col. 9402- 9403. The Federation is an international organisation still in existence that opposes abortion, euthanasia, IVF and eugenics. According to its website it is 'an affiliation of medical doctors throughout the world who support the traditional medical ethic of service to the life and health of their patients. There are members in more than 70 countries and membership numbers over 350,000 (situation 1995)'. See the Federation website at www.euthanasia.com/belgium.html. The website of the USA chapter of the organisation includes statements such as 'In these modern dilemmas, we see that nonmarital (out-of-wedlock) sexual activity is a root problem' and articles such as 'Homosexual "Marriage" a Health Risk, Doctors Warn Parliamentarians' – for more see Physicians for Life website at www.physiciansforlife.org. (Both sites accessed July 2012).

¹⁵⁰ See Sadie & Van Aardt, 'VIGS-Politiek', p. 86 – 87. If memory serves the author correctly the graffiti posters used the name Kevin and had variations of the theme 'Kevin loves Linda' with Linda's name then being crossed out and another woman's name appearing underneath it, and so forth.

¹⁵¹ GALA, GASA Collection (AM 2974), Correspondence, Hilton-Barber Hayes, 'AIDS Awareness Campaign Press Kit', January 1988, p. 1.

¹⁵² GALA, GASA Collection (AM 2974), Correspondence, Hilton-Barber Hayes, 'AIDS Awareness Campaign'. A company called 'Complete Communication Services' based in Pretoria also sent GASA a copy of 30 AIDS 'Fact Sheets' that provided information on topics including transmission, symptoms, testing, reporting, the AAG, the government's response and organisations involved in AIDS work. It is not clear if these were compiled on behalf of the government.

¹⁵³ *Hansard* HA, vol. 3, Thursday, 19 April 1988, col. 6331.

TV to reach the majority of the population.¹⁵⁴ He referred to research that 'found that for the Black man [sic] Aids is regarded as a White man's [sic] disease.'¹⁵⁵ He made no mention of how 'the white man' viewed the disease, and noted that anti-Aids messages needed to be 'handled with sensitivity and the facts presented clearly, concisely and with credibility.'¹⁵⁶ Aside from the apparent exclusion of womyn and how they might have viewed the disease, people initially highlighted as one of the key 'high-risk' groups, namely 'gay' men, were rendered invisible in the campaign. Nonetheless, the programme launch was judged successful as Van Niekerk reported that the regional offices had received more than 1000 enquiries shortly after it had started.¹⁵⁷

While the programme was influenced by ideologies of 'race' and 'high Christian and moral standards', Van Niekerk emphasised its conformity to international standards and its appropriateness for South Africa.¹⁵⁸ The mass media AIDS information campaign was 'in keeping with international trends in health care and education', and 'international campaigns and research data were evaluated in the design of [the] campaign' which was directed at 'all levels of the South African society.'¹⁵⁹ Van Niekerk's rhetoric maintained that a strategy had been developed 'to address high risk behaviour rather than high risk groups.'¹⁶⁰ He explained the objectives of the campaign:

To create an awareness of Aids, to detail its causes, and to outline the means of prevention. The message was at all times a positive one, namely that faithful, long-standing, single-partner relationships were safe. There is, therefore, only one kind of safe sex: one has to lead a monogamous sexual lifestyle. There is no

¹⁵⁴ *Hansard* HR, vol. 3, Monday, 25 April 1988, col. 7332.

¹⁵⁵ *Ibid.*, col. 7334.

¹⁵⁶ *Ibid.* The lack of credibility of the apartheid-government amongst a significant portion of the South African population has frequently been referred to by activists and academics as a key reason for early interventions making any impact on infection rates, see Sadie and Van Aardt 'VIGS-Politiek', p. 89.

¹⁵⁷ *Hansard* HR, vol. 3, Monday, 25 April 1988, col. 7332.

¹⁵⁸ *Ibid.* For more on the centrality of conservative Christianity in shaping apartheid ideology, education, policy and legislation see Marks, S., & Trapido, S. (eds) *The Politics of Race, Class & Nationalism in Twentieth Century South Africa* (London, Longman, 1987); Moodie, T. D., *The Rise of Afrikanerdom: Power, Apartheid, and the Afrikaner Civil Religion* (Berkeley, University of California Press, 1975); O' Meara, D., *Forty Lost Years - The Apartheid State and the Politics of the National Party, 1948 - 1994* (Randburg, Raven Press, 1996); and Posel, D., *The Making of Apartheid, 1948 - 1961* (Oxford, Oxford University Press, 1997).

¹⁵⁹ *Ibid.*

¹⁶⁰ *Hansard* HR, vol. 3, Monday, 25 April 1988, col. 7332.

other kind of safe sex... except no sex, but, I do not think that no sex is practical.¹⁶¹

As a next step in the campaign, Van Niekerk reported that 'benchmark research' was being undertaken to evaluate its 'communication recall'.¹⁶² Market-appropriate posters would continue to be distributed nationally; information lines would be 'manned' by trained staff; and there would be ongoing liaison with church leaders, women's groups, and cultural and labour organisations. The money spent on the information campaign, on condom distribution, and AIDS research, amounted to more than R5 million.¹⁶³ Such was the level of self-congratulation that all three houses of parliament were told of the campaign's success.¹⁶⁴

The initial education and information initiatives were largely targeted at medical professionals and adults.¹⁶⁵ It was only after an 'AIDS *Indaba*' held in November 1989, and attended by a number of education departments including the Department of National Education, the Department of Education and Training, the Department of Education and Culture (House of Assembly), the Department of Education and Training (House of Representatives), and the Department of Education and Culture (House of Delegates), that discussions around school-specific anti-AIDS programmes took place.¹⁶⁶

In late 1989 the *SAMJ* reported that two and a half million copies of a new AIDS brochure had been distributed nationally. The brochure, entitled 'The more you know, the safer you'll

¹⁶¹ *Hansard* HR, vol. 3, Monday, 25 April 1988, col. 7332.

¹⁶² *Ibid.* 'Communication recall' is a reference to determining whether or not people who have seen posters or other media can remember what they were about and what their central message was.

¹⁶³ *Ibid.*, col. 7335. The distribution of condoms, primarily through family planning clinics, was already occurring as part of the DOH's population control plans. In response to AIDS the DoH increased the numbers of condoms distributed. The politics of government funded birth control programmes meant, however, that messages about condom use were seen as efforts by the apartheid regime to control 'black' people's fertility. For more on the history of 'race' and population control see Brown, B., 'Facing the "Black Peril": The Politics of Population Control in South Africa', *Journal of Southern African Studies*, 13, 2, January 1987; and Klausen, S., *Race, Maternity and the Politics of Birth Control in South Africa, 1910-39* (Basingstoke, Macmillan, 2004).

¹⁶⁴ See *Hansard* HD, vol. 3, Tuesday, 26 April 1988, col.7582 and *Hansard* HR, vol. 3, Wednesday, 27 April 1988, col. 7679.

¹⁶⁵ Rev H.J Hendricks, Minister for Education and Culture, made passing reference to the fact that AIDS discussions took place during STI education programmes in schools. See, *Hansard* HR, vol. 3, Wednesday, 27 April 1988, col. 7678.

¹⁶⁶ *Hansard* HA, vol. 21, Thursday, 10 May 1990, col. 1265-1266.

be', was available in English, Afrikaans, isiZulu, isiXhosa, seTswana, 'North-Sotho', 'South-Sotho', Tsonga and Venda, providing appropriate information about AIDS in an easily readable style.¹⁶⁷

Another multilingual brochure (figure 21), was published simultaneously in English, Afrikaans, isiZulu, isiXhosa, seSotho and seTswana in 1989.¹⁶⁸ It defined AIDS, explained how it was and was not transmitted, and stated that 'longstanding relationships with one sexual partner (such as in an ideal marriage) are safe' and that 'multiple sexual partners (promiscuity) increase the risk of coming into contact with an infected person'.¹⁶⁹ The brochure emphasised that AIDS was 'a social behavioural problem within the community that cannot be solved by legislation, a government department or the State' but rather needed individuals to take responsibility for their actions and for sharing information about the disease with others.

The brochure revealed the potential threat and economic implications of AIDS, warning that AIDS could 'assume catastrophic proportions in our country and can claim the lives of thousands of people (innocent children too) causing serious damage to the country's economy'. The importance of the economic implications of AIDS was sufficient that a sentence about the cost of treating AIDS patients appeared in bold in the brochure indicating that as it could be 'anything from R30 000 to R60 000 ... no taxpayer should ... feel that he [sic] is not affected by this problem.'¹⁷⁰ The inclusion of this statement, in bold text, suggests that the government assumed that many people did not see AIDS as a problem that affected them.¹⁷¹

¹⁶⁷ 'Nuwe VIGS-Brosjyre', *SAMJ*, 76, 21 October 1989, p. xxi. (Author's translation of the original). It went on to indicate that 2, 5 million had already been distributed nationally and provided readers with the government address to contact to order copies of the brochure.

¹⁶⁸ NLSA, General Collection, AP 1990-229.

¹⁶⁹ *Ibid.*

¹⁷⁰ *Ibid.*

¹⁷¹ In total the DoH claimed to have distributed over three million AIDS brochures up to the end of 1989 see NLSA, CTGC, SA Reports, DNHPD Annual Report 1989.



Fig. 21. Government AIDS information pamphlet from 1989.

Selective Fears from Beyond the Border

Aside from new education training and information initiatives, and an apparent shift from ‘high-risk groups’ to ‘high-risk behaviours’, phase two witnessed a shift in the focus of government AIDS interventions towards those from beyond the country’s borders. In direct contrast to the supposed move away from notions of ‘high-risk groups’, mineworkers, particularly those from outside South Africa, were turned into a new ‘high-risk group’.

The idea of, and anxiety about, infection being associated with mineworkers and migrant labourers has long featured in South Africa’s history and was evoked during discussions about AIDS. The close association between mining corporations and successive South African governments, as well as the intimate link between living and working conditions on the mines and the (ill)health of mineworkers (migrant and others) and the friends, families and

colleagues of mineworkers, has long been researched.¹⁷² As much of the existing scholarship shows, the 'alien infected other' has provided an easy (absent) referent summoned by establishment figures to evoke fear, or further the political or economic goals of a variety of ruling elites.¹⁷³

During the first five years of the AIDS epidemic little mention was made of threats from outside South Africa, but in 1987 Mr F.M. Khan (Progressive Independent Party), after quoting figures for AIDS deaths and possible infection rates in other African countries, cautioned 'we cannot rely on the fact that we have boundaries. [AIDS] will reach South Africa; as a matter of fact it already has ... How will one stop infected people from outside our borders coming into South Africa?'¹⁷⁴

In debates in each of the houses of parliament mineworkers, and migrant labourers more generally, became a new 'high-risk' group, by virtue of their nationalities, race, and status as infected outside vectors 'carrying the disease prior to entering the country'.¹⁷⁵ The AIDS avatar of the 'infected foreigner', evident in hegemonic AIDS narratives, was replicated in numerous parliamentary discussions. The representation of AIDS as a danger from beyond South Africa's borders carried by 'infected foreigners' evoked historically familiar menacing

¹⁷² See chapter on AIDS narratives in the *SAMJ* and Burke, G., & Richardson, P., 'The Profits of Death: A Comparative Study of Miners' Phthisis in Cornwall and the Transvaal, 1876-1918', *Journal of Southern African Studies*, 4, 2, April 1978; Elder, G., *Hostels, Sexuality, and the Apartheid Legacy: Malevolent Geographies* (Ohio, Ohio University Press, 2003); Jochelson, K., *The Colour of Disease: Syphilis and Racism in South Africa, 1880-1950* (Basingstoke, Palgrave, 2001); Katz, E., *White Death: Silicosis on the Witwatersrand Gold Mines, 1886-1910* (Johannesburg, Wits University Press, 1994); McCulloch, J., *Asbestos Blues: Labour, Capital, Physicians and the State in South Africa* (Bloomington, Indiana University Press, 2002); McCulloch, J., 'Counting the Cost: Gold Mining and Occupational Disease in Contemporary South Africa', *African Affairs*, 108, 431, April 2009; McCulloch, J., 'Asbestos, Lies and the State: Occupational Disease and South African Science', *African Studies*, 64, 2, 2005; Packard, R., *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Pietermaritzburg, University of Natal Press, 1990); Packard, R., 'Tuberculosis and the Development of Industrial Health Policy on the Witwatersrand, 1902-1932', *Journal of Southern African Studies*, 13, 2, 1987. Packard, R., 'The Healthy Reserve and the "Dressed Native": Discourses on Black Health and the Language of Legitimation in South Africa', *American Ethnologist*, 16, 1989; and Packard, R., 'The Invention of the Tropical Worker: Medicine Research and the Quest for Central African Labour on the South African Gold Mines, 1903-36', *Journal of African History*, 34, 1993.

¹⁷³ For more contemporary examples that address the discrimination faced by immigrants trying to access public health see Grove, N.J., & Zwi, A.B., 'Our Health and Theirs: Forced Migration, Othering, and Public Health', *Social Science & Medicine*, 62, 2006 (accessed using Elsevier).

¹⁷⁴ *Hansard* HD, vol. 13, Wednesday, 17 June 1987, col. 997.

¹⁷⁵ See also, for example, *Hansard* HR, vol. 14, Tuesday, 1 September 1987, col. 2712 and *Hansard* HA, vol. 19, Thursday, 3 September 1987, col. 5161. Discussions about mineworkers and migrant labourers refer usually only to 'black' mineworkers and migrant labourers.

images of a sick, infected 'black Africa' threatening the health and wealth of the 'white' South African population. Lesley Lawson has drawn attention to the South African government's attempts to create a physical *cordon sanitaire* around its northern borders during this period, to prevent individuals with the disease from entering the country.¹⁷⁶ This analysis needs to be extended to include the mental and psychological *cordon sanitaire* that featured at this time in the imaginations of many 'white' South Africans who were told they were facing a 'total onslaught' from beyond the country's borders.¹⁷⁷ At a time of increased political and economic insecurity and a very real anxiety about the future of 'white' South Africa, narratives of the *cordon sanitaire* being breached could be exploited.

Merely evoking a group of people as infected is, by itself, no more than an attempt to reproduce, allay, or create a fear or threat for political or ideological purposes, and can be used as a means of deflecting attention away from a whole host of issues, such as underlying socio-economic considerations (discussed below).¹⁷⁸ In the case of AIDS and mineworkers, specifically migrant labourers from beyond South Africa's borders, the concerns identified above gave rise to very real government responses that had a negative effect on the lives of many mineworkers.

In June 1987 W.J.D. van Wyk (NP) presented a series of questions in parliament to Van Niekerk, inquiring whether workers 'from other African countries' were 'medically examined with a view to Aids', how many were seropositive, and what was being done about it?¹⁷⁹ Van Niekerk reported that seven cases of AIDS had been diagnosed, and 940 blood tests had returned positive results. He declared that South Africa's response was in line with international practice in that 'persons with positive blood tests' were hospitalised, examined

¹⁷⁶ Lawson, L., *Side Effects: The Story of Aids in South Africa* (Cape Town, Double Story, 2008) See specifically chapter 1 'From "gay plague" to "African AIDS"', pp. 32 & 35. Borders were places that young people crossed to train for the liberation struggle, or places young people were sent to defend or destabilise. As African countries 'north of the border' received independence, politicians and others also played on the fears and anxieties of minority communities or privileged elites and much of that fear was centred around the symbolic 'borders' of the country.

¹⁷⁷ See Maylam, P., *South Africa's Racial Past – The History and Historiography of Racism, Segregation and Apartheid* (Aldershot, Ashgate, 2001), and Visser, W., 'The Production of Literature on the "Red Peril" and "Total Onslaught" in Twentieth-Century South Africa', *Historia*, 49, 2, November 2004.

¹⁷⁸ For a discussion on why blame and chastisement have so commonly characterised responses to 'dreaded diseases', including AIDS, and the role that fear has played in shaping responses see Doka, K.J., *AIDS, Fear, and Society: Challenging the Dreaded Disease* (New York, Taylor and Francis, 1997).

¹⁷⁹ *Hansard*, HA, vol. 20, Tuesday, 23 June 1987, col. 265-266.

and 'rigorously counselled on an individual basis' about preventing further infection and, where possible, sexual contacts were traced. He emphasised that the same procedure was applied to 'foreign as well as South African miners' and commented that the mines had 'launched an extensive educational campaign on Aids.'¹⁸⁰ Van Niekerk's reply did not indicate the extent of the government's involvement, if any, with the mines' overall procedures or education campaign. However 'the Cabinet [had] requested the Chamber of Mines to repatriate all foreign miners with positive blood tests', and the 'responsibility for medical tests on mineworkers lies with the mines.'¹⁸¹ Despite the historically close association between the Chamber of Mines and government, the burden of responsibility for HIV positive miners was to be borne by the industry. As the year proceeded though, Van Niekerk, in consultation with other government departments, passed legislation to facilitate the removal of 'foreign' HIV positive mineworkers (see below).

In a number of instances, discussions in parliament raised concerns about AIDS and HIV infection as a pretext to consider the migrant labour system more broadly. In the House of Delegates, in 1987, A.E. Arbee (Solidarity Party) highlighted living and working conditions in the mining industry:

The hostel concept is an outdated one. If the hon. the Minister is concerned, as we all are, about the danger of Aids spreading in such conditions, I believe he has a moral obligation to allow the development of family life of miners. He should not allow the Chamber of Mines to get away with cheap working conditions by allowing people from the neighbouring states to live there and work under such conditions. We have unemployment in our own country. We should allow our own workers the opportunity to work in the mining industry and to live within the proximity of the mine in a healthy environment, otherwise this deadly disease will not only cripple the mining industry, but also pose a danger to all South Africans... [I want to ask the Minister] at least to deal with this matter very seriously, namely in getting the Chamber of Mines to encourage families to live with the people working in their mines. That is very important.¹⁸²

¹⁸⁰ *Hansard*, HA, vol. 20, Tuesday, 23 June 1987, col. 265.

¹⁸¹ *Ibid.*, col. 266.

¹⁸² *Hansard*, HD, vol. 13, Monday, 10 August 1987, col. 1767.

Arbee's comment links hostel-life to ill-health and the breakdown of families, and calls for corporate accountability.¹⁸³ It also reflects an argument that was gaining ground in South Africa - that 'local' unemployment problems should be solved rather than importing 'foreign' labour.¹⁸⁴ Arbee used apprehension about the spread of AIDS to articulate concerns about living and working conditions on the mines, and to make a moral argument about the sanctity of marriage and family. These arguments were also articulated in 'nationalistic' terms that differentiated between 'local' and 'foreign' mineworkers.¹⁸⁵ In a reply which indicated an unwillingness to address the structural problems raised by Arbee, the Minister of Economic Affairs and Technology, addressed neither AIDS nor local unemployment, instead referring to migrant workers who returned to 'their countries'.¹⁸⁶

By late 1987 debates about migrant labourers and mines, framed within discussions about AIDS, were evoking images of migrant workers as potentially 'infected foreigners'.¹⁸⁷ On 1

¹⁸³ Discussions about migrant labour and urbanisation causing 'families' or 'the family' or 'family life' to disintegrate and facilitating the spread of illnesses have long appeared in a variety of fora. It has formed a central theme in relation to the transmission of STI's and features frequently in articles about AIDS. While the migrant labour system, as part of a capitalist global order, is indeed responsible for placing a variety of strains on inter-personal relationships and individual, community and environmental health, these discussions have been hampered by the unproblematic use of the idea of 'family', 'families' and 'family life' which require further debate and definition.

¹⁸⁴ For discussions on the impact of fluctuating gold prices on the South African economy and related labour concerns see Wilson, F., 'Minerals and Migrants: How the Mining Industry Has Shaped South Africa', *Daedalus*, 130, 1, Winter, 2001 (accessed using JSTOR), pp. 113 - 115; and Natrass, N., 'The Crisis in South African Gold Mining', *World Development*, 23, 5, 1995.

¹⁸⁵ In 1989, Dr I. Essop (LPSA) explicitly linked HIV infection and migrant labour conditions noting that HIV infection in South Africa was compounded by, amongst other things, '... the migrant labour system which separates men and women from their spouses for long periods, the size of our migrant labour population, the large number of single-sex dwellings which is conducive to prostitution and promiscuity, the political tension in townships, the large number of language groups and, last but not least, the fragmentation of curative and preventive health services. All these factors impede concerted and effective action'. Essop's comments contain a moral overtone and are based on concepts of heterosexual marriage arrangements, but they do at least indicate a multi-causal understanding of (ill) health. Furthermore the statement highlights the inter-relatedness of social, political, and economic factors with an individual's wellness. See *Hansard*, Public Committee on Health and Population Development, vol. 11, Tuesday, 18 April 1989, col. 5654.

¹⁸⁶ In this instance it is not clear if 'migrant workers' referred to those from the 'independent homelands' as well as those from other countries. In some statements a distinction is drawn and 'migrant workers' are defined as excluding workers from the TBCV states. He declared instead that it would be 'impossible to house the families of migrant workers in South Africa' observing that new mine hostels built by the Chamber of Mines were 'among the finest five-star hotels ... anywhere in South Africa', see *Hansard*, HD, vol. 13, Monday, 10 August 1987, col. 1770.

¹⁸⁷ See, for example, *Hansard* HR, vol. 14, Tuesday, 1 September 1987, col. 2710 - 2713 and 2751 - 2752; *Hansard* HD, vol. 3, Tuesday, 26 April 1988, col. 7581; and *Hansard* HR, vol. 4, Tuesday, 10 May 1988, col. 9509. Other discussions, however, revealed a desire for stricter border controls for anyone trying to enter the country not just labourers. For example Mr L.J. Hollander (LP), from the House of Representatives, raised the issue of proof of 'AIDS status' as a requirement for entry into South Africa noting 'It does not help us to combat

September 1987 Van Niekerk stated ‘... we have to come up with some plan regarding the labourers, the foreign workers whose tests are positive’.¹⁸⁸ He linked HIV to broader security issues, commenting that the development of a vaccine was unlikely because the virus was ‘like a terrorist’.¹⁸⁹ Van Niekerk’s ‘plan’ was revealed in the House of Assembly on 3 September 1987. He emphasised the apparently high occurrence of HIV infection amongst ‘workers from outside the borders’ and from ‘Central Africa’, noting that entry into South Africa of ‘workers from high-risk areas... require[d] special attention’.¹⁹⁰ Discussions with ‘other departments and [affected] organisations ... including the Chamber of Mines’, had begun.¹⁹¹ And the DoH had ‘already prepared draft regulations in terms of the Health Act’ which would allow transmittable diseases including ‘AIDS or HIV contamination’ to be identified and isolated in ‘special units’ for compulsory medical treatment.¹⁹² The Department of Home Affairs had been tasked with facilitating the removal of ‘such persons’ from South Africa, using ‘aliens control legislation and regulations’.¹⁹³

While the new measures were not meant to apply to all visitors, but to all ‘labourers recruited elsewhere’, Van Niekerk specifically drew attention to migrant labourers from Malawi.¹⁹⁴ His department had ‘sent two delegations to Malawi to negotiate with Government officials there’, and they were ‘available to help them with an epidemiological study, to help them with their guidance and to help them to combat that situation in that country’.¹⁹⁵ In blood samples tested from blood transfusions, five per cent of Malawian mineworkers tested HIV positive compared to less than one per cent of workers from

the illness locally if people are still crossing our borders. Here I am referring particularly to carriers. Carriers can have the illness for years without being aware of the fact that they are Aids carriers. People who enter our country will have to prove that they are not ... we cannot try to find a cure for Aids within our country if carriers from outside are still entering our country ... This does not apply only to mineworkers. I understand that this disease is rife in some African countries. People from America – incidentally, this is where the illness had its origin – and all those entering the country by air or sea, should give proof of being free of Aids’ (*Hansard* HR, vol. 14, Tuesday, 1 September 1987, col. 2712). See also *Hansard* HD, vol. 14, Wednesday, 2 September 1987, col. 3036 – 3037.

¹⁸⁸ *Hansard* HR, vol. 14, Tuesday, 1 September 1987, col. 2752.

¹⁸⁹ *Ibid.*, col. 2712.

¹⁹⁰ *Hansard*, HA, vol. 19, Thursday, 3 September 1987, col. 5148-5149.

¹⁹¹ *Ibid.*, col. 5149.

¹⁹² *Ibid.*

¹⁹³ *Ibid.* Note that Cameron clarified that AIDS but not HIV were added to the schedule of ‘communicable diseases’ under the Health Act, see Cameron and Swanson ‘Public Health’, p. 211.

¹⁹⁴ *Ibid.*, col. 5149 – 5150.

¹⁹⁵ *Ibid.*, col. 5149.

Mozambique, Lesotho and Botswana who were, therefore, not considered a 'problem'.¹⁹⁶ As South Africa had yet to adopt any kind of comprehensive response to AIDS, it is unclear what guidance the delegation could have offered the Malawian government. It appears that the offer of help amounted to little more than monitoring and the distribution of basic public health information.

There was a lack of logic in the selective application of the legislation. If the theory was that no HIV-positive person should be allowed to work in the country for fear that they would spread HIV, then the legislation should have applied to all people working in or entering the country, and not be dependent on arbitrary percentage differences in national infection rates. Van Niekerk spoke about the plan in relation to migrant workers on mines, but not to foreign workers in other sectors. Migrant labourers from the TBVC states were also absent from any of the discussions. Despite these contradictions, Van Niekerk was confident: 'with this measure the Republic of South Africa may rest assured that we are doing everything in our power to spare South Africa from this disease, which has a 100% mortality rate'.¹⁹⁷

Responses to Van Niekerk's measures varied along party political lines. Dr W.J. Snyman (CP) appeared to have noticed the contradictions in Van Niekerk's statement and suggested that testing and deportation of HIV-positive people should be considered for 'all visitors to South Africa'.¹⁹⁸ Dr D.M.S. Barnard (PFP), supported calls for isolation and deportation, but called on the Minister and the Chamber of Mines 'to treat these unfortunate people ... as human beings':

I think it would be good for our relations with the rest of the world and for our labour relations if we could show that the mines and the South African people have compassion and will treat these unfortunate people in a way that is humane and a credit to our medical profession of South Africa.¹⁹⁹

Replying to Snyman, Van Niekerk noted that testing all visitors to South Africa had been considered, but because of the delay in the formation of antibodies, the costs involved, and

¹⁹⁶ *Hansard*, HA, vol. 19, Thursday, 3 September 1987, col. 5149 – 5150.

¹⁹⁷ *Ibid.*, col. 5150.

¹⁹⁸ *Ibid.*, col. 5151.

¹⁹⁹ *Ibid.*, col. 5161 – 5162.

the fact that tests were not '100 % accurate' it had been deemed 'impracticable to test all people entering SA'.²⁰⁰ The same issues would apply to mine-workers, but no comment was made on this, indicating perhaps that the money to test mine-workers was available and there was less concern about accuracy for migrant labourers' tests. Van Niekerk took pains to 'make it quite clear' that his suggestions in relation to isolation did not refer to 'institutionalisation in the sense of quarantine' but rather 'a place where he [sic] can be treated to eliminate the risk of infection'.²⁰¹ He reinforced this point: 'I wish to reiterate this very clearly so that the media do not think we intend placing them all in concentration camps'. These would be 'places where they will not contract other infections because they have no resistance to them and they die from other infections'.²⁰² Deportations would 'be done with great circumspection and compassion'; South Africa had already sent two delegations to Malawi and were 'going to help them with their programme in handling these cases'; this would 'of course be done with great compassion in the true tradition of medical services in South Africa'.²⁰³

Noteworthy in Van Niekerk's reply is the desire to separate NP responses to AIDS from statements made by the CP about putting people with AIDS into quarantine; the evident concern with ensuring 'accurate' media coverage of the measures; a vague explanation of what these 'places' actually would be or do; and the projection of the South African government as thoughtful and compassionate. But there was little substantive information about what the government understood by compassion, and there was no reflection on the effect these deportations would have on the livelihoods of migrant labourers.

The legislation appeared in the *Government Gazette* of 30 October 1987. An amendment to the Admission of Persons to the Republic Regulation Act, 1972, now included 'acquired immune deficiency syndrome (AIDS); and infection with human immuno deficiency [sic] virus (HIV)' to the list of diseases which would render a person 'a prohibited person' if they were

²⁰⁰ *Hansard*, HA, vol. 19, Thursday, 3 September 1987, col. 5214.

²⁰¹ *Ibid.*, col. 5217 – 5218.

²⁰² *Ibid.*, col. 5218.

²⁰³ *Ibid.*

'afflicted' with them.²⁰⁴ New regulations for the Health Act, 1977, 'relating to communicable disease and the notification of notifiable medical conditions' now included AIDS amongst a list of communicable diseases.²⁰⁵ These two pieces of legislation allowed for people who were HIV positive or had AIDS to be quarantined, denied entry into the country, or repatriated. While there is no evidence to date that people were quarantined, people were repatriated.²⁰⁶

In April 1988, during a vote on national health, Dr Snyman of the CP questioned why the DoH annual report had listed the number of AIDS cases in the country but did not mention mineworkers, 'particularly those from Malawi'.²⁰⁷ Van Niekerk dismissed the omission: members were already 'aware of the Malawian mineworkers', and 'No worker from any high risk country will be allowed into South Africa without an Aids negative certificate'. Moreover, 'hundreds – almost all – of those who were already working in South Africa, are already back in their countries of origin'.²⁰⁸ Van Niekerk appeared to suggest that Malawi was no-longer considered the only high-risk country, and proceeded to outline infection rates in Tanzania and Zaire, reiterating the danger of AIDS and linking it specifically to the threat of infected persons in exile crossing over the border into South Africa:

[AIDS] is a disease of which we must take cognisance because people who are being trained in certain areas of Africa, and who sneak across our borders, are Aids carriers. We must now take note of the possibility of positive Aids results among those people, because they are trained in camps in which, as we know,

²⁰⁴ Government Notices, Department of Home Affairs, No. R. 2439, *Government Gazette*, vol. 268, no. 11014, Pretoria, 30 October 1987, pp. 1 – 2.

²⁰⁵ Health Act, 1977, No. R. 2438, *Government Gazette*, vol. 268, no. 11014, Pretoria, 30 October 1987, pp. 68 – 80 (see particularly Annexure 1, p. 79). The regulation outlined the powers that local authorities, medical officers of health, and medical practitioners had to address communicable diseases. Medical officers of health and medical practitioners employed by the state could, 'in order to prevent the spread of a communicable disease', use their powers to obtain information from and about people; restrict peoples' movement; place people in quarantine; prevent the transport of bodies; and enforce compulsory medical examinations, hospitalisation or treatment of people with communicable diseases, see particularly pp. 71 – 78.

²⁰⁶ Cameron and Swanson's explanation and critique of the direct coercive measures incorporated in the legislation were extensive. Referring specifically to isolation and regular mandatory testing that could have been implemented using the regulation they noted that 'the proposition is untenable and the suggestion not worthy of sober consideration'. Cameron & Swanson, 'Public Health and Human Rights', p. 213.

²⁰⁷ *Hansard*, HA, vol. 3, Monday, 18 April 1988, col. 6143.

²⁰⁸ *Hansard*, HA, vol. 3, Tuesday, 19 April 1988, col. 6332.

there is a high incidence of Aids. I am mentioning these things because it is a matter we shall take further on the security level.²⁰⁹

In a single debate Van Niekerk had linked AIDS to mineworkers, other countries, and 'terrorists' but had failed to recognise or acknowledge any 'real' threat from within South Africa. 'Africa' was not only associated with infection but also with sheltering 'terrorists'. The statement is replete with menacing images of borders being breached by terrorists carrying AIDS as well as AK-47s. A week later, in a similar evocation, Van Niekerk personified AIDS and described it as 'creeping into this country'.²¹⁰

For the men who were not *Umkhonto we Sizwe* (MK) soldiers, but mineworkers from Malawi, the changing legislation directly affected their livelihoods and security, as Wiseman Chirwa's work shows.²¹¹ Chirwa observes that 'the old conceptions of "high-risk" groups and racial or ethnic differences in human susceptibility to disease ideologically influenced the decision to repatriate Malawian workers. However, the reasons were non-racial and non-ethnic'.²¹² Rather, the need to use regional labour more efficiently, the economic climate in South Africa combined with economic sanctions and disinvestment, the labour and social unrest (including strikes) in the country, rising unemployment, and internal pressure to reduce dependency on 'foreign' labour, influenced the government's decisions.²¹³ This would seem to suggest that the alleged concerns with HIV and AIDS, particularly as they

²⁰⁹ *Hansard*, HA, vol. 3, Tuesday, 19 April 1988, col. 6332.

²¹⁰ *Hansard* HD, vol. 3, Tuesday, 26 April 1988, col. 7520.

²¹¹ *Hansard*, Public Committee on Health and Population Development, vol. 11, Tuesday, 18 April 1989, col. 5664. In Chirwa, W.C., 'Aliens and AIDS in Southern Africa: The Malawi-South Africa Debate', *African Affairs*, 97, 386, 1988, the legal position is explained more fully on p. 70. In summary, a person who had AIDS or was HIV positive was regarded as a 'prohibited person' for the purposes of Admission of Persons to the Republic Regulation Act of 1972 and under section 51 anyone who knowingly helped a 'prohibited person' enter the country was guilty of an offence. Government Notice No. R.2439 of 30 October 1987, Regulation 17 declared that for the purposes of the Act, people who *inter alia* had AIDS or were HIV positive were regarded as prohibited persons.

²¹² Over a four year period (1988 – 1992), the legislation was used to repatriate approximately 13 000 Malawian mine-workers, creating tensions between the South African and Malawian governments, between the Chamber of Mines and the South African and Malawian governments and between the repatriated miners and the Malawian government. Chirwa, 'Aliens and AIDS', p. 55.

²¹³ Chirwa notes that the threat of preventing migrant labourers from gaining access to South Africa, or expelling migrant labourers of certain nationalities was used as a political tool by the South African government to argue against international sanctions, and to intimidate countries that hosted the ANC. Chirwa also argues that at the root of the repatriations were Malawi's decreasing importance as a labour source for South Africa; a time of crisis within the mining industry; and increasing attempts to stabilize labour within the country (see Chirwa, 'Aliens and AIDS', p. 56)

related to Malawian workers, were a 'smoke screen' used by the government to reduce the number of Malawians seeking work in South Africa.

Cameron and Swanson argue that 'Public fear and panic, as well as a desire on the part of the authorities to be seen to take strong and decisive action, make the temptation to resort to coercion and to invoke the law in applying it strong'.²¹⁴ The government may also have been trying to demonstrate to the electorate that it was taking decisive action against AIDS. Therefore the deportation of Malawians served both to emphasise government action and to alleviate certain economic and labour pressures, neither of which related to the alleged health crisis facing South Africa from Malawians nor offered any realistic means of addressing the alleged health crisis. Chirwa suggests that by this time researchers at the SAIMR had 'argued that AIDS was already entrenched in South Africa and the ban on the employment of foreigners with the disease would not do anything to curb its future development in the country', further undermining the government's stated reasons for deporting Malawians.²¹⁵ The pervasive fear of AIDS, together with the idea of 'high-risk groups', was used to justify the repatriation of Malawian mineworkers.²¹⁶

Chirwa notes that 'within a period of just about 24 months, the number of Malawian workers employed on the South African mines dropped from 13 090 to zero'.²¹⁷ Malawian government officials complained that the mandatory testing procedure was degrading, undertaken without consent, and contrary to international anti-discrimination policies relating to HIV status and employment. The Chamber of Mines too, was reluctant to repatriate 'less militant' migrant labourers in the face of increasing militancy amongst South African miners. Despite these concerns the testing and repatriation continued.²¹⁸

Simonne Horwitz's work has highlighted the complex association between infection rates (in her examples of TB, HIV, and AIDS) and migration, and has cautioned that nuanced

²¹⁴ Cameron & Swanson, 'Public Health and Human Rights', p. 232.

²¹⁵ *Ibid.*, p. 72.

²¹⁶ See Chirwa 'Aliens and AIDS', p. 66 for a table showing positive HIV tests results by country. The legislation does not appear to have been applied evenly across all countries but was used selectively to exclude recruitment from Malawi.

²¹⁷ Chirwa, 'Aliens and AIDS', p. 67.

²¹⁸ *Ibid.*, p. 71.

understandings are needed to account for the 'whole context of political, economic and social circumstances, not merely the migrant nexus'.²¹⁹ During the late 1980s the South African government focused on a fear of AIDS (not on other issues related to health and migrant labour) and used it to implement policies more closely linked to economic and political dynamics than health concerns.²²⁰ After repatriations had begun, Van Niekerk did not again mention infection rates in Malawi or the danger from infected foreign mineworkers in parliamentary discussions.

The inherent contradiction in introducing legislation to discriminate against those with HIV or AIDS, while simultaneously addressing 'high-risk behaviour rather than high-risk groups' in local AIDS programme could not be sustained with any credibility. At the end of 1989, when Van Niekerk was replaced by Dr Rina Venter, the DoH's stance on the legislation would change, but the issue of infection from beyond the *cordon sanitaire* would remain a feature of discussions about AIDS.

The department's 1989 annual report noted that in terms of 'combating and controlling AIDS' the key responses were preventing spread through the screening of blood products, by 'informing and motivating the public toward safer sexual practices', and issuing free condoms on request.²²¹ The report did not mention the new executive that was meant to be implementing a new strategic plan but rather referred to the AAG's plan from 1987 noting

²¹⁹ Horwitz, S., 'Migrancy and HIV/AIDS: A Historical Perspective', *South African Historical Journal*, 45, November 2001, p. 119.

²²⁰ See also Chirwa, W.C., "'No TEBA...Forget TEBA": The Plight of Malawian Ex-migrant Workers to South Africa, 1988-1994', *International Migration Review*, 31, 3, Autumn 1997 (accessed using JSTOR); and 'The Malawi Government and South African Labour Recruiters, 1974-92', *The Journal of Modern African Studies*, 34, 4, December 1996 (accessed using JSTOR). For more on a variety of aspects of migration, migrant labour, and AIDS see: Brummer, D., 'Labour Migration and HIV/AIDS in Southern Africa', IOM (International Organization for Migration) Report, 2002, available on the Southern African Regional Poverty Network (SARPN) website at www.sarpn.org/documents/d0000572/P534_Labour_Migration_HIV.pdf (accessed January 2011); Campbell, C., & Williams, B., 'Beyond the Biomedical and Behavioural: Towards an Integrated Approach to HIV Prevention in the Southern African Mining Industry', *Social Science & Medicine*, 48, 1999 (accessed using Science Direct); Crush, J., 'Fortress South Africa and the Deconstruction of Apartheid's Migration Regime', *Geoforum*, 30, 1999 (accessed using Elsevier); Crush, J., Williams, B., Gouws, E., & Lurie, M., 'Migration and HIV/AIDS in South Africa', *Development Southern Africa*, 22,3, September 2005 (accessed using Academic Search Premier); Lurie, M., 'Migration and AIDS in Southern Africa: A Review', *South African Journal of Science*, 96, June 2000 (accessed using SA ePublications); Mtika, M.M., 'Political Economy, Labor Migration, and the AIDS Epidemic in Rural Malawi', *Social Science & Medicine*, 64, 2007 (accessed using Science Direct); and Wilson, F., 'Minerals and Migrants: How the Mining Industry Has Shaped South Africa', *Daedalus*, 130, 1, Winter, 2001 (accessed using JSTOR).

²²¹ NLSA, CTGC, SA Reports, DNHPD Annual Report 1989, p. 28.

that it had been implemented by the department and 'all measures contained in that plan [were] strictly adhered to'.²²² The report was also silent on the repatriation of mineworkers.

Both nationally and internationally the government's response to AIDS was being criticised. Sexuality activists such as John Pegge, the Director of the Gay Association of South Africa in Cape Town (GASA-6010) and the AIDS Coalition to Unleash Power (ACTUP) in Cape Town, were urging increasing international pressure.²²³ In a November 1989 letter to the head of external relations of the WHO Global AIDS Programme, Pegge suggested they request a copy of the AIDS strategy for the Western Cape as there was 'increasing evidence that the South African regime under President F W De Klerk [was] sensitive to foreign pressure'.²²⁴ In a project report Pegge commented on the government's responses to AIDS, claiming that the government had failed to engage with both gay community groups and health care professionals working with gay communities, even though the government acknowledged that most AIDS cases had initially been identified among gay men:

A meaningful, relevant and significant response to AIDS by the apartheid regime is ... unlikely ... to materialise.... [It] is amongst the disenfranchised and disempowered, on account of their racial origin and sexual orientation that the highest levels of prejudice and discrimination take place. Part of this scenario is the widespread distribution of misinformation with ideological overtones. What is needed is factual information which could lead to an informed, educated understanding and compassionate response.

It would appear that only when large numbers of people living with HIV start to manifest with AIDS related conditions, that the urgency will be felt for effective health care ... AIDS is a political issue for it highlights and brings into sharp focus other discrimination and prejudice practices.²²⁵

²²² NLSA, CTGC, SA Reports, DNHPD Annual Report 1989, p. 28.

²²³ See Sadie & Van Aardt, 'VIGS-Politiek', p. 92 for an account of international condemnation of South Africa's AIDS strategy at the San Francisco AIDS Conference in 1990 at which the government's strategy was equated with strategies in Cuba, Saudi Arabia, and China.

²²⁴ GALA, GASA Collection (AM 2974), Correspondence, John Pegge to Terry Mooney, 25 November 1989.

²²⁵ GALA, GASA Collection (AM 2974), "ACT-UP" Cape Town, Project report, c. 1989.

Phase Three: Extended Engagement and Education

In December 1990 an article in *Epidemiological Comments* noted that to date 613 cases of AIDS had been identified, and 270 people had died from AIDS-related illnesses in South Africa.²²⁶ By December 1993 the number of identified AIDS cases had reached 2 697 with 711 deaths; and the results of the annual national HIV surveys of womyn attending antenatal clinics (initiated in 1990) indicated growing HIV prevalence rates in this group. Between 1990 and 1993, AIDS featured more prominently in DoH annual reports, in *Epidemiological Comments* and in parliamentary debates. This phase coincided with a shift in the health care focus of the DoH which was influenced by the changing political situation in the country which saw F.W de Klerk becoming leader of the NP and State President, the freeing of political prisoners, the unbanning of anti-apartheid organisations, and the start of negotiations that led to the 1994 elections.²²⁷

Ongoing Fears about Borders

Soon after her appointment as minister of health, Venter declared: 'Not a single community is immune to this dreaded disease. All of us in South Africa are concerned about this problem. Aids is not coming – it is here'.²²⁸ She framed AIDS not as an external threat but an internal reality, the first health minister to do so. She highlighted the limitations of legislative interventions, but seemed to absolve the government of any responsibility to address AIDS:

I would like to stress that one cannot control it [AIDS and HIV infection] by legislation or any measure that the State might take. I think it is necessary for private enterprise to have an employment policy on HIV carriers or Aids sufferers, based on realistic and sound scientific principles. It is also important that all workers should be educated on the basic aspects of HIV infection and

²²⁶ 'Update: AIDS in South Africa Since 1982 (as on 14 December 1990)', *Epidemiological Comments*, 17, 12, December 1990.

²²⁷ After a stroke in early 1989 P.W Botha resigned as leader of the NP and State President, and was replaced by F.W de Klerk who led the party through the negotiations in the 1990s. For an overview of this period see Beinart, *Twentieth Century South Africa*, especially chapter ten 'Insurrection, Fragmentation, and Negotiations, 1984 – 1994'.

²²⁸ *Hansard* HD, vol. 21, Thursday, 22 February 1990, col. 137.

how it should be prevented. Individuals could be identified for specific training at Aids training centres.²²⁹

While narratives about ‘infected outsiders’ still featured in parliamentary discussions, specific legislation intended for select groups of people with AIDS was no longer considered. Some of the legislation enacted in phase two was either revoked or, in the case of repatriation, ‘relaxed after criticisms’.²³⁰ The powers given to officials to force people to have HIV tests and the listing of HIV as a health concern that would render a person ‘prohibited’, were rescinded in the Aliens Control Act 96 of 1991. As Cameron and Swanson note ‘On 1 October 1991, the government without publicity or fanfare removed AIDS and HIV infection from the list’ and ‘the government’s own AIDS Unit discouraged reliance on legislative measures’.²³¹

While Venter did not completely abandon assumptions about external vectors of infection, she did signal a change in official government discourse around border controls: ‘Migrant workers on the mines are not the only problem – airlines and hauliers are too. There is no practical way to seal these borders’.²³² From 1991 the focus on outside vectors shifted from migrant mineworkers to returning exiles, and drew on ideas of ‘foreignness’ which were contrasted with notions of ‘belonging’ and ‘citizenship’. These assumptions were evident in discussions about a proposed amendment to the South African Citizenship Bill that would, among other things, allow exiles to return to South Africa and make access to South African citizenship easier.

In February 1991 Mr H.D.K van der Merwe (CP), voicing opposition to the amendments, warned against an uncontrolled influx of people at a time of increased public fears about personal safety. He drew attention to research that showed that both white and black South

²²⁹ *Hansard* HD, vol. 21, Thursday, 22 February 1990, col. 137.

²³⁰ Chirwa, ‘Aliens and AIDS’, p. 73. Sadie and Van Aardt, ‘VIGS-Politiek’, p. 93, note that the 1987 legislation was repealed in 1991 on the advice of the AIDS Unit.

²³¹ Cameron & Swanson, ‘Public Health and Human Rights’, pp. 221 & 217. Venter observed that some aspects of HIV transmissions such as multiple sexual partners (‘be it homosexual or heterosexual’) and intravenous drug use were ‘not medical problems but forms of social behaviour which cannot be successfully controlled by legislation but rather by education’, *Hansard* HD, vol. 21, Thursday, 22 February 1990, col. 133.

²³² *Hansard* HD, vol. 21, Thursday, 22 February 1990, col. 137.

Africans felt increasingly unsafe and insecure.²³³ He insisted that the proposed amendments were dangerous and called on the minister 'not [to] allow individuals, or a larger number of people into South Africa, who make it unsafe for everyone, whatever one's skin pigment might be'. The basis of his assertion was partly that 'a terrorist is a terrorist, whether he is against apartheid or whatever else', and because they might have AIDS: 'It is not only the insecure situation which prevails in South Africa today, but also the entire medical and health situation in South Africa which causes us great concern, and this is a result of people who have not been tested [for AIDS] coming into the country'.²³⁴ In reply, I.J. Pretorius (NP) dismissed Van der Merwe's comments: '...the hon. member is now conjuring up spectres. All he is trying to do is score a few political points', suggesting that the NP did not share the view that the nation's health system was under threat from untested people arriving in South Africa.²³⁵

The CP accused the NP of withholding information about HIV transmission and claimed that HIV was being spread in saliva, in swimming pools, and at nursery schools.²³⁶ The party's MPs tenaciously and repeatedly demanded HIV tests for immigrants, exiles and migrant labourers. Snyman made the point:

I should very much like to repeat the insistence of the CP in respect of the so-called exiles who are now going to return in their thousands from lands to the north of the Limpopo, where the incidence of Aids has already assumed epidemic proportions ...

... Why cannot it be required as a condition for the acquisition of citizenship or permanent residence that a negative blood test in respect of Aids should be produced? It is absolutely essential.²³⁷

²³³ *Hansard* Extended Public Committees – Assembly, vol. 23, Friday, 15 February 1991, col. 1135-6. Van der Merwe maintained that the research showed that a sense of insecurity or of feeling unsafe had doubled amongst 'whites' and trebled amongst 'blacks'. The research to which Van der Merwe referred could not be located so the veracity of these claims is difficult to determine.

²³⁴ *Hansard* Extended Public Committees – Assembly, vol. 23, Friday, 15 February 1991, col. 1135.

²³⁵ *Ibid.*, col. 1137.

²³⁶ See *Hansard* Extended Public Committee on Provincial Affairs: TvI, vol. 17, Tuesday, 26 March 1991.

²³⁷ *Hansard* HA, vol. 29, Tuesday, 26 February 1991, col. 174.

This statement elicited interjections in the House. Venter did not deny the link between returning exiles and AIDS but raised a legal question: 'As far as the exiles are concerned, I think it is essential for me to ask the hon. member on what grounds one can refuse persons who have been identified as citizens of this country access to South Africa because they are Aids sufferers'?²³⁸

In March 1991 Snyman, after extrapolating future AIDS figures for South Africa, argued:

Because the incidence in neighbouring countries to the north of us, for example Uganda, Zambia, Malawi and Zaire – is far higher than that in South Africa, the CP feels very strongly that exiles who left this country more than seven years ago – in other words, people who have already lost their South African citizenship in terms of the Aliens Act – should only be allowed to naturalise themselves if in addition to the normal requirements in respect of contagious diseases, for example tuberculosis, they also test negative for HIV, before they qualify to become citizens of this country.

In light of the alarming figures in countries to the north of the Republic it is of absolutely urgent importance to protect the inhabitants of this country. When the CP requested this in January of this year, only the ANC reacted by refusing. I think the time has come for the hon. the Minister to give a clear answer to our representations. We want to know what the Government is planning to do in respect of the protection of our people.²³⁹

This statement clearly uses multiple fears and threats for party-political purposes; it encodes 'white' fears about 'black' people and the changing political context in the country. It has as much to do with fears about AIDS and HIV infection as it does with challenging the policies of the NP.

By identifying those who needed to be protected as 'our people', the CP invoked a sense of 'white' nationalist identity that would not include the returning exiles. The exiles – most of

²³⁸ *Hansard* HA, vol. 29, Tuesday, 26 February 1991, col. 175. In this reply Venter also responded to a question from Dr Pauw (CP) about making AIDS a notifiable condition noting 'the hon. member Dr Pauw, who is a medical practitioner, ought to know better than to wish to suggest the matter of notifiability as one of the protective mechanisms'.

²³⁹ *Hansard* HA, vol. 24, Monday, 18 March 1991, col. 3145. Snyman continued to raise fears about 'Aids sufferers freely crossing our northern borders' until at least April 1992 see *Hansard* HA, vol. 33, Monday, 27 April 1992, col. 5388.

whom would have been 'black' people and all of whom would previously have been considered terrorists and communists by the CP, its supporters, and many other conservative South Africans – were clearly not considered to be in need of 'protection' and did not belong to 'our people'.²⁴⁰

The CP never explained how an influx of people (HIV positive or otherwise) could be a threat to security. Would the threat be in terms of bodily and physical integrity with a sub-text that evoked ideas of rape and/or 'the diseased black body'; or would it be an economic or social threat to public health resources, or community resources required to care for people with HIV? It was the undefined, nebulous nature of the threat that made it powerful enough, or at least sufficiently adaptable enough, to camouflage the actual arguments or political points being made.

In her reply Venter merely referred to her previous responses: 'I gave him the answer then that on the basis of the fact that the exiles coming back to South Africa – if they are citizens of South Africa – have right of entry, we will have to assist them with their problem'.²⁴¹ While this statement implied that 'their problems' were outside of 'our' problems, there was at least an acknowledgment that the returning exiles were not foreigners and had a right to health care on their return. The issue of providing proof of HIV status continued to feature in parliamentary discussions until early 1993.²⁴²

²⁴⁰ In the statement the CP also referred to the ANC - the party most associated with exiles, terrorism, and '*the swart gevaar*' (the black peril or danger) - as the only party that had responded to, and rejected, their request. This seemed to imply that the ANC was not concerned with 'protecting our people' but was seemingly also an attack on the NP for failing to act in the interests of 'white' South Africans. The notion of the white minority in South Africa perpetually threatened by various perils or danger (including the '*rooi gevaar*' (red peril) of communism and the '*swart gevaar*' (black peril) evocative of 'black' people swamping 'white' people who were experiencing a 'total onslaught' from these and other threats, featured prominently in the public and political imagination of sectors of the South African population. See for example: Brown, B., Facing the 'Black Peril': The Politics of Population Control in South Africa', *Journal of Southern African Studies*, 13, 2, 1987; Posel, D., 'What's in a Name? Racial Categorisations under Apartheid and their Afterlife', *Transformation*, 47, 2001; Visser, W., 'The Production of Literature on the "Red Peril" and "Total Onslaught" in Twentieth-Century South Africa', *Historia*, 49, 2, November 2004.

²⁴¹ *Hansard* HA, vol. 24, Monday, 18 March 1991, col. 3159.

²⁴² The focus of these discussions was new immigrants and migrant labourers (with Mozambicans receiving particular attention in 1992, although there were also suggestions that testing should be made mandatory for health workers in South Africa), see *Hansard* HR, vol. 26, Monday, 13 May 1991, *Hansard* HA, vol. 32, Tuesday, 24 March 1992; *Hansard* Extended Public Committee – Assembly, vol. 40, Friday, 30 April 1993; and *Hansard*, HR, vol. 41, Monday, 24 May 1993, col. 9015. The focus on Mozambicans was seemingly because of the high HIV infection rates in Natal (which borders Mozambique) and Mozambicans being viewed as the

The overtones evident in discussions about the HIV status of returning exiles cast the debate in a particularly racialised and racist light. The idea of ANC members 'bringing AIDS into South Africa' was also of concern to the ANC. In a post-1994 context the legacy of this racialised discourse was that research into the infection rates of returning MK soldiers created controversy and accusations of racism.²⁴³ The racialised discourse meant that little attention was paid to the predominantly white South African Defence Force (SADF) soldiers who had been based beyond the borders to 'protect' apartheid South Africa – despite the fact that, as Lawson points out, many of them were based in areas with high HIV-prevalence rates.²⁴⁴ Lawson suggests that 'When apartheid's illegal wars came to an end in the late 1980s, thousands of SADF soldiers came home. With them, surely came HIV'.²⁴⁵ While the politics of race and blame played out from the 1980s into the new millennium, soldiers from all sides of the struggle received few appropriately devised anti-HIV messages, endured HIV-positive status with little support or access to treatment, and died of AIDS.²⁴⁶

The language of fear, threat, and danger that permeated discussions about AIDS and HIV provides a sense of the political and social mood during this period.²⁴⁷ While the rhetoric of

vectors of infection in that area. Venter seems to bring an end to this discussion in parliament when she noted, 'One of the reasons why it is very difficult to implement such a step is due to the window period of this infection. The person could already be a carrier. One cannot identify him [sic] as a carrier by testing because he has not yet developed anti-genes. On what basis can a state issue a certificate stating that a person is really free of the virus? I believe that this is actually a political argument. I believe South Africa should base its standpoint on sound scientific proof. One really needs factual information on which to base this issue.' *Hansard* Extended Public Committee – Assembly, vol. 40, Friday, 30 April 1993, col. 6734. For more on this see Cameron & Swanson, 'Public Health and Human Rights', pp. 222 - 228. The focus of these discussions was new immigrants and migrant labourers (with Mozambicans receiving particular attention in 1992, although there were also suggestions that testing should be made mandatory for health workers in South Africa)

²⁴³ Rob Shell's work on the military and the 'Trojan Horse' theory of infection for example created much controversy. See Shell, R.C.H., 'Trojan horses: HIV/AIDS and the military in Southern Africa, an epidemiological analysis with reference to Grahamstown and Port Elizabeth in the Eastern Cape', Conference paper presented in East London, July 1999.

²⁴⁴ Lawson, *Side Effects*, pp. 45 – 47. Lawson notes that SADF soldiers were 'holed up' in northern Namibia with their army headquarters in the town of Katimo Mulilo which was considered the epicentre of the region's epidemic. Lawson describes the Caprivi Strip - which borders Angola, Botswana Namibia, Zambia and Zimbabwe – as the military frontier of the region and further discusses the movement of ANC cadres through Uganda, Tanzania and Zambia.

²⁴⁵ *Ibid.*, p. 46.

²⁴⁶ For recent developments in this regard see: Whiteside, A., De Waal, A', & Gebre-Tensae, T., 'AIDS, Security and the Military in Africa: A Sober Appraisal', *African Affairs*, vol. 105, no. 419, 2006, pp. 201 - 218 and 'South Africa: Battle won for HIV-positive soldiers' 11 November 2009 on PlusNews at <http://www.plusnews.org/Report.aspx?ReportId=86974> (accessed February 2010).

²⁴⁷ Kenneth Doka provides some insight into why blame and chastisement have so commonly characterised responses to 'dreaded diseases'. He observes that someone with a dreaded disease may be blamed for

‘infected others’ was still present, the NP employed it less in this phase than they had previously. This change in the NP’s position may have been strategic as they worked to cast themselves in a more positive light. The following section looks at government responses during this phase and who was providing the advice that was informing these responses.

A Change in Strategy and Engagement

The groups of experts charged with securing data, providing information, and implementing government responses to AIDS changed during this phase, as did the DoH’s overall health strategy, which included a new approach to AIDS. The DoH’s annual report for 1990 announced a new health plan which included ‘the prerequisites and principles for the reconstruction of health services’, and encouraged the ‘development of partnerships between the public and private sector, the various public institutions and professional councils and associations, as well as community health institutions’.²⁴⁸

Venter’s main priorities at the time were to shift the focus of health care provision towards addressing primary healthcare; to consolidate and streamline the health bureaucracy; and to remove ‘apartheid from health care’, in line with F.W. de Klerk’s reforms.²⁴⁹ The annual reports from the period echo some of these intentions, with the 1991 report referring to ‘a new health model ... introduced to rationalise and to restructure the various health services in order to eliminate duplication and overlapping’ with a new emphasis being placed on primary health care as a vehicle for bringing ‘affordable health services within the reach of everybody in the RSA’.²⁵⁰

In 1992 the DoH listed five requirements for health services in South Africa, namely that they should be ‘accessible, efficient, acceptable, affordable and equitable’. To this end, the

‘conspiring to bring others into misery’ by spreading the disease, and blamed for their own, somehow deserved, infection. If these ideas are taken as applying to the South African situation as well, they would also allow fear to be articulated and manipulated to suit political ends. See Doka, K.J, *AIDS, Fear, and Society: Challenging the Dreaded Disease*, (New York, Taylor and Francis, 1997).

²⁴⁸ NLSA, CTGC, SA Reports, DNHPD Annual Report 1990, p. 3.

²⁴⁹ Interview with Rina Venter, Venter’s Residence, Pretoria, South Africa, 21 October 2011.

²⁵⁰ NLSA, CTGC, SA Reports, DNHPD Annual Report 1991, p. i. The new health model and the envisioned restructuring are also outlined in the report, see pp. 6 – 7.

building and upgrading of clinics and crèches were highlighted as part of the drive towards primary health care provision.²⁵¹ The discourse of the DoH reports started to incorporate the language of change and inclusivity. Terms like ‘new health dispensation’ and ‘active involvement by the community’ appeared, no doubt reflecting the changing political environment in South Africa.²⁵² In the 1993 annual report the DoH announced that, in light of amendments to the constitution, health services, which had previously been delegated to different houses in parliament as an ‘own affair’ issue, had been redefined as a ‘general affair’. As a result of this, health functions would be rationalised and would now fall under national and provincial programmes.²⁵³

The 1990 report acknowledged that ‘the AIDS problem [had] gained momentum’ and ‘was more commonly found in heterosexuals of both sexes’, while the 1991 report indicated that during the year ‘the AIDS problem reached alarming proportions’, estimating that on average more than 300 people per day were being infected.²⁵⁴ By 1992 the annual report stated that daily infections had risen to between 300 and 400 people, noting that these figures were ‘conservative, as serious under-reporting still [prevailed]’.²⁵⁵ The report indicated that womyn and children were most at risk, although no explanations as to why were forthcoming.

The 1992 annual report announced an apparent change in how the DoH would be responding to AIDS. This echoed statements made by Venter in parliament in 1990 highlighting the centrality of AIDS education, emphasising the need for government departments to share responsibility for AIDS campaigns and acknowledging that community involvement in educational programmes was a prerequisite.²⁵⁶ Moreover, the ‘State...could not succeed on its own’, and responsibility for addressing AIDS rested with the public and private sectors, and with individuals who would be willing to receive training to take back to

²⁵¹ NLSA, CTGC, SA Reports, DNHPD Annual Report 1992, p. 1.

²⁵² *Ibid.*, p. 2.

²⁵³ NLSA, CTGC, SA Reports, DNHPD Annual Report 1993, p. 1.

²⁵⁴ NLSA, CTGC, SA Reports, DNHPD Annual Report 1990, p. 13; NLSA, CTGC, SA Reports, DNHPD Annual Report 1991, pp. i & 8.

²⁵⁵ NLSA, CTGC, SA Reports, DNHPD Annual Report 1992, p. 17.

²⁵⁶ *Hansard* HD, vol. 21, Thursday, 22 February 1990, col. 134. These ideas were also reiterated in an article about the DoH’s responses to AIDS published in the *SAMJ* in January 1990, see Du Toit, M., ‘Wye steun vir VIGS-veldtog’ (Wide support for AIDS campaign – author’s translation), *SAMJ*, 77, 6 January 1990, pp. x - xii.

their communities.²⁵⁷ There was 'a dire need for well-co-ordinated, active private sector participation in the Aids control programme'.²⁵⁸ These statements were made at the time that discussions around health care reform and privatised health care were occurring.²⁵⁹ In order to meet the 'dire need' and 'ensure optimum utilisation of scarce resources' a National AIDS Foundation was being established by the private sector that would function independently of the public sector.²⁶⁰

The 1992 annual report noted that the severity of the pandemic had necessitated a re-evaluation of the AIDS Programme, with a view to it being 'aligned with the primary health care model, bringing about an integrated and holistic approach to AIDS prevention'.²⁶¹ The DoH claimed that it had 'intensified its actions to combat HIV/AIDS' with an 'AIDS Control Strategy' in line with one suggested by the WHO, 'to create a network of organisations that work together in one programme'.²⁶² The DoH would ensure the creation of 'networks between organisations in the AIDS field through public appearances and person contact', and identified 'the business sector; government institutions; non-governmental organisations; religious institutions; traditional healers; health and welfare organisations; ATICs; educational institutions; women's organisations; and drama groups' as important sectors.²⁶³ This list was the most extensive in relation to AIDS strategies in any of the phases, but what exactly would be gained by working with these different sectors or how networking would translate into an effective AIDS strategy was not clear.

²⁵⁷ *Hansard*, HD, vol. 21, Thursday, 22 February 1990, col. 134 - 138.

²⁵⁸ *Ibid.*, col.138.

²⁵⁹ See for example Benatar, S.R., 'Privatisation and Medicine', *SAMJ*, 72, 10, 21 November 1987, pp. 655 - 656; Naylor, C.D., 'Privatisation of South African health services - are the underlying assumptions correct?', *SAMJ*, 72, 10, 21 November 1987, pp. 673 - 677; Klopper, J.M.L., 'Privatisation', *SAMJ*, 72, 11, 5 December 1987, pp. 734 - 735; Schulman, A., 'Privatisation and medicine', *SAMJ*, 73, 5, 5 March 1988, p. 311; Feinstein, F., 'Privatisation and medicine', *SAMJ*, 73, 5, 5 March 1988, p. 311; Roux, F.G., 'Privatisation and medicine', *SAMJ*, 73, 5, 5 March 1988, p. 312; Keen, G.A., 'Privatisation and medicine', *SAMJ*, 73, 5, 5 March 1988, p. 313; Cohen, P.L., 'Privatisation and medicine', *SAMJ*, 73, 5, 5 March 1988, pp. 311 - 312; Badenhorst, C.H., 'Privatisation and medicine', *SAMJ*, 73, 5, 5 March 1988, pp. 312 - 313; Cowan, D., 'Privatisation and medicine', *SAMJ*, 74, 1, 2 July 1988, pp. 38 - 39; College of Medicine of South Africa, 'The case for a unitary health service', *SAMJ*, 77, 5, 3 March 1990, pp. 225 - 226; de Beer, C., & Broomberg, J., 'Achieving health care for all', *SAMJ*, 78, 3, 4 August 1990, p. 119; Ezekowitz, M.D., 'South Africa revisited - lessons to be learned from mistakes in American health care policy', *SAMJ*, 80, 6, 21 September 1991, p. 262; and Editor, 'Medicine - business or profession?', *SAMJ*, 81, 4, 15 February 1992, pp. 181 - 182.

²⁶⁰ Further research into this Foundation and the ongoing relationship between state structures and the private sector around AIDS programmes needs to be undertaken.

²⁶¹ NLSA, CTGC, SA Reports, DNHPD Annual Report 1992, p. 17.

²⁶² *Ibid.*, p. 41.

²⁶³ *Ibid.*, p. 42.

The aim of the newly aligned AIDS programme was 'to control the spreading of HIV/AIDS and to decrease the socio-economic impact on the Southern African community'.²⁶⁴ The programme was to focus on 'the formulation of policy and guidelines regarding HIV/AIDS related matters at national level, in co-operation with the parties concerned'.²⁶⁵ The report later indicated that the DoH had worked with the Department of Correctional Services, the South African Police, and the SADF to 'formulate [their] own AIDS strategies ... aimed at meeting their needs'.²⁶⁶

The emphasis on shared responsibility and increased engagement between the DoH and other groups was reiterated in the report, which declared that the department's

approach to AIDS control is based on the primary health care model [which] entails decentralisation, leading to far greater participation by departmental regional offices, ATICs and other role players. The aim is to involve the entire community in actions aimed at controlling HIV/AIDS and caring for persons with HIV/AIDS.²⁶⁷

It is not evident whether these ideas were motivated by a genuine belief in primary health care and shared responsibility, influenced by concerns over the cost of caring for AIDS patients, or were part of a broader political exercise by the NP to demonstrate that it was transforming both itself and its attitude to all South Africans.²⁶⁸

The DoH concentrated on four aspects of the newly aligned AIDS programme: education and training; care and support services; research and information; and marketing.²⁶⁹ The 1992 budget indicated that NGOs involved in AIDS-related work were receiving financial support from the DoH (see below). The research aspect of the programme was different from

²⁶⁴ NLSA, CTGC, SA Reports, DNHPD Annual Report 1992, p. 41.

²⁶⁵ *Ibid.*

²⁶⁶ *Ibid.*, p. 42.

²⁶⁷ *Ibid.*, p. 43.

²⁶⁸ The report noted that the DoH had formulated 'guidelines for the home care of persons with HIV/AIDS' noting that such guidelines were 'one of the most important aspects of care services because sophisticated health care in Southern Africa will be unaffordable and inappropriate when the AIDS pandemic starts taking its toll.' NLSA, CTGC, SA Reports, DNHPD Annual Report 1992, p. 42.

²⁶⁹ *Ibid.*, p. 41.

anything seen in the previous phases. While there had been passive data collecting through the information passed to the SAIMR and some seroprevalence studies, the research component of the new programme was more active and involved universities and research organisations like the Human Sciences Research Council (HSRC).²⁷⁰ The annual report noted that ‘a comprehensive country-wide research project concerning the knowledge, attitudes, perceptions and behaviour of the population as well as certain target groups within the population’ in relation to AIDS was underway and that the University of South Africa (UNISA) had been approached to compile a national database of ‘all people and groups involved in the AIDS field’.²⁷¹

The new approach to AIDS was outlined in parliament. In 1993 Venter explained to parliament that the restructuring was ‘indicative of a shift away from a specialist unit situated at Head Office to an expansion which include[d] departmental regional offices, the ATICs [and] ... other role-players’.²⁷²

²⁷⁰ The HSRC is a statutory research organisation established by the Human Sciences Research Act 23 of 1968 (amended by the Human Sciences Research Amendment Act 99 of 1990). As per the HSRC’s website, in its current incarnation ‘The core business of the HSRC is to conduct large-scale, policy-relevant, social-scientific projects for public-sector users, non-governmental organisations and international development agencies. [Through] partnership with researchers globally, but specifically in Africa. Our commitment to cutting-edge research which supports development nationally, in the Southern African Development Community and in Africa is evident, but it is our commitment to the dissemination of that research that demonstrates the remarkable and measurable impact of our work’. See the Human Sciences Research Council (HSRC) website at www.hsrc.ac.za (accessed July 2012).

²⁷¹ NLSA, CTGC, SA Reports, DNHPD Annual Report 1992, p. 43.

²⁷² *Hansard* HA, vol. 45, Wednesday, 5 May 1993, col. 1425 - 1426. Similarly Dr I. Essop (NP) presented the restructuring of the AIDS Unit as part of a revised government strategy and renewed commitment to addressing AIDS declaring that the DoH had ‘committed itself once more to the intensification of the Aids prevention campaign’ ‘in line with’ recommendations from the WHO. As evidence of this he referred to ‘the vast amount’ of R21 million allocated to the AIDS programme for the 1993-94 financial year, despite the fact that it was exactly the same amount as had been allocated for the 1992 – 93 financial year which would thus, in real terms and taking into account inflation, have been less money. He declared that ‘to symbolise the department’s policy change it [would] henceforth talk of the Aids programme, which replace[d] previous emphasis on the Aids unit’. Essop explained that ‘on an executive level’ the head office would focus on policy formulation and guidelines ‘in collaboration with interested parties and organisations’ and that the ‘strongly centralised approach which ha[d] previously been followed [would] therefore be expanded to include all role-players at executive level’. Decentralisation of the AIDS programme would also occur at a ‘functional level’ in order to ‘fully utilise the existing health structures at grassroots level’ and to this end the regional offices and ATICs would ‘focus their attention increasingly on the specific needs of the communities in which they are involved’ and would thus be better able to concentrate on the ‘particular problems experienced by the various regions’. *Hansard* HA, Extended Public Committee Meeting, vol. 39, Friday, 30 April 1993, col. 6642 - 6644. See also *Hansard* HA, Interpellations, Questions & Replies, vol. 45, Thursday, 24 June 1993, col. 2205 – 2206.

The 1993 annual report noted that AIDS had resulted in an increase in the incidence of tuberculosis and provided a breakdown of the money spent on addressing AIDS.²⁷³ The 1993 budget for AIDS was allocated to education and information; disease observation; research; the ATICs; administration; and NGOs.²⁷⁴ The support for NGOs marks a significant shift in DoH thinking because it reflects an effort to engage with some non-biomedically orientated ways of dealing with AIDS. However, supporting NGOs engaged in providing services such as palliative care programmes (one of the features of the Churches' AIDS Programme, for example) would have reduced the government's burden. In 1986 a government report had recommended a reduction in the state's financial responsibility for welfare services, stating that 'private welfare organisations, irrespective of being for profit or not, should take responsibility for welfare services'.²⁷⁵ The motivation for the support of NGOs may thus have been more about finances than increased concern for the care of people with HIV or AIDS. The report noted that financial support was provided to, amongst others, the Churches' AIDS Programme, Lifeline, SA Red Cross, the AIDS Support and Education Trust (ASET), the National AIDS Co-ordinating Committee of SA (NACOSA) and grass roots organisations.²⁷⁶

The 1993 report indicated that national policy guidelines had been devised for HIV testing, community/home-based care, the handling of HIV infected people and people with AIDS, and HIV prevention in health care workers.²⁷⁷ Under the legal and ethical aspects of the programme it reported that 'the regulations with regard to communicable diseases and the notification of medical conditions have, as a result of various representations, been amended to exclude AIDS as a communicable disease'.²⁷⁸

Seventeen research projects relating to the 'knowledge, attitudes, perceptions, beliefs and behaviour (KAPBB)' of different groups of people with regard to AIDS had been undertaken.

²⁷³ NLSA, CTGC, SA Reports, DNHPD Annual Report 1993, pp. 15 & 24. The annual report for 1992 also carried a fairly extensive budget breakdown that included information on the money spent on the AIDS programme but did not provide as much detail as the 1993 budget.

²⁷⁴ NLSA, CTGC, SA Reports, DNHPD Annual Report 1992, p. 40.

²⁷⁵ Report on the Investigation into the Present Welfare Policy of the Republic of South Africa, 1986 quoted Van Niekerk, R., 'The Evolution of Health and Welfare Policies in South Africa: Inherited Institutions, Fiscal Restraint, and the Deracialization of Social Policy in the Post-Apartheid Era', *Journal of African American History*, 88, 4, Autumn, 2003, pp. 366 – 367.

²⁷⁶ NLSA, CTGC, SA Reports, DNHPD Annual Report 1993, p. 24.

²⁷⁷ *Ibid.*

²⁷⁸ *Ibid.*

These would be used to determine how best to influence sexual behaviour to curb the AIDS epidemic. The research projects included KAPBB studies of teachers, social workers, health care workers, long-distance truck drivers, hostel dwellers, intravenous drug users, commercial sex workers and their clients, people with STIs, people living in informal settlements, street children, tertiary students and men who have sex with men.²⁷⁹

Rather than focusing on infections amongst one group of AIDS avatars, the starting point was to pursue research into different groups of people. This would result in more nuanced findings that would assist in the development of more credible programmes to counter AIDS. Sex workers were referred to as 'sex workers' rather than prostitutes, and the project recognised the role of clients. Rather than 'promiscuous homosexuals', the phrase 'men who had sex with men' was used.²⁸⁰ These changes in nomenclature suggest a subtle change in the hegemonic AIDS narrative. Also evident from the research project is the growing representation of experts from beyond the medico-scientific community, as social scientists were tasked with undertaking research outside of laboratories.

Expertise and Information

Medico-scientific expertise still remained central to data collection and information provision, and still informed much of the government's response. One development in AIDS surveillance during this phase was the 1990 introduction of annual countrywide HIV seroprevalence surveys of pregnant womyn attending public pre-natal clinics.²⁸¹ These surveys showed rising numbers of womyn who were HIV anti-body positive, from 0.76% in 1990, to 1.49% in 1991, and to 2.69% by 1992. It was estimated that 311 452 persons were HIV positive at the time of the 1992 survey, a total which included 8 455 paediatric cases.²⁸²

²⁷⁹ NLSA, CTGC, SA Reports, DNHPD Annual Report 1993, p. 25. The research tenders had been awarded to, amongst others, the HSRC, Markinor, and the WITS University Department of Obstetrics.

²⁸⁰ NLSA, CTGC, SA Reports, DNHPD Annual Report 1993, p. 25.

²⁸¹ The analysis of samples from these surveys was undertaken by the AVRU.

²⁸² NLSA, CTGC, SA Reports, DNHPD Annual Report 1991, p. 16; NLSA, CTGC, SA Reports, DNHPD Annual Report 1993, p. 19. Venter announced that the first survey had been completed in Hansard HA, vol. 29, Tuesday, 26 February 1991, col. 170. The 1991 annual report indicated that the first national HIV survey of womyn attending antenatal clinics had occurred in October and November 1990 with HIV-positivity found to be 0,76% throughout the country with Natal having the highest infection rate (1, 61%) and the Cape Province the lowest (0, 16%). This put the estimated number of people infected with HIV by the end of 1990 at between 74 000 to

The AVRU continued to undertake diagnostic screening and surveillance programmes amongst black womyn and men attending STD clinics, and black womyn attending family planning clinics.²⁸³ The AVRU was responsible for ‘the national quality assurance programme for HIV testing for virology and blood transfusion laboratories’. It reported that it had ‘fared well in international quality control programmes’, including those run in the USA and the UK.²⁸⁴ The AVRU continued to diagnose an increasing number of specimens in 1992; surveys showed ‘an alarming rise in HIV seropositivity rates and the expansion of HIV infection into rural areas of South Africa’.²⁸⁵

Throughout this phase *Epidemiological Comments* continued to provide regular updates on reported AIDS cases in South Africa, and featured far more articles about AIDS than previously.²⁸⁶ The articles outlined government responses, discussed the pros and cons of various strategies, and analysed the annual national HIV surveys.²⁸⁷ The updates in *Epidemiological Comments* were the same ones that featured in the *SAMJ* so the research

102 000 people. See NLSA, CTGC, SA Reports, DNHPD Annual Report 1991, p. 16 and Author Unknown, ‘First national HIV survey published’, *SAMJ*, 79, 4 May 1991, p. xvi. The debates about the use of womyn’s bodies as sites of medical investigation without informed consent, and with the associated symbolic burden placed on womyn’s bodies as sites of infection, are hereby acknowledged. So too are the debates about HIV testing of pregnant womyn and the broader debate over reproductive rights. For a basic overview of some of the arguments see ‘HIV Testing in Pregnancy’ on the AVERT website at: www.avert.org/hiv-testing-pregnancy.htm (accessed February 2011).

²⁸³ NLSA, CTGC, SA Reports, DNHPD Annual Report 1990, p. 37.

²⁸⁴ NLSA, CTGC, SA Reports, DNHPD Annual Report 1991, p. 53.

²⁸⁵ NLSA, CTGC, SA Reports, DNHPD Annual Report 1992, p. 66. See also NLSA, CTGC, SA Reports, DNHPD Annual Report 1993, p. 42 for information on the number of specimens investigated by the AVRU in 1992.

²⁸⁶ By April 1991, 2 233 copies of the publication were being sent to 1 861 addresses including health services, other state departments, academic institutions, private companies and the press. Most of the copies of the publication were distributed in South Africa (1 651) with the remaining copies sent to other countries in Africa, Europe, Asia, Australia and to the USA. *Epidemiological Comments*, 18, 4, April 1991, p. 90.

²⁸⁷ See for example Küstner, H., ‘AIDS in South Africa’, *Epidemiological Comments*, 17, 2, February 1990, pp. 4 - 11; Küstner, H., ‘The Truth About AIDS’, *Epidemiological Comments*, 17, 3, March 1990, pp. 3 -14; Küstner, H., ‘First National HIV Survey of Women Attending Antenatal Clinics, South Africa, October/November 1990’, *Epidemiological Comments*, 18, 2, February 1991, pp. 35 – 50; Küstner, H., ‘HIV Screening Results of Blood transfusion Services’, *Epidemiological Comments*, 18, 4, April 1991, pp. 84- 85; Küstner, H., ‘AIDS: The Threat to Children’, *Epidemiological Comments*, 18, 5, May 1991, p. 111; *Epidemiological Comments*, 18, 11, November 1991; Küstner, H., ‘Second National Survey of Women Attending Antenatal Clinics, South Africa, October/November 1991’, *Epidemiological Comments*, 19, 5, May 1992, pp. 80 – 95; Küstner, H., ‘Third National HIV Survey of Women Attending Antenatal Clinics, South Africa, October/November 1992’, *Epidemiological Comments*, 20, 3, March 1993, pp. 35 – 48; Küstner, H., ‘Summary of AIDS Patients Reported to the Department of National Health and Population Development during the period April to September 1993’, *Epidemiological Comments*, 20, 10, October 1993, p. 179; and *Epidemiological Comments*, 20, 11, November 1993.

categories (homo/bisexual, heterosexual), markers of race ('asian, black, coloured, white'), modes of transmission (homo/bisexual, IV drug abuse, heterosexual, haemophiliac, paediatric), and national identity (South African and non-South African) were reproduced.²⁸⁸

One of the most significant changes during this phase was the revised role of the AAG. While individual AAG members continued to be involved in AIDS programmes, the opinions and expertise of the AAG did not feature as prominently in parliament or in DoH statements. It remained active and continued to advise government but its role seems to have diminished, probably because of the establishment of the AIDS Unit (see below).²⁸⁹

Throughout this phase there was an increase in the number of ATICs being funded by the DoH, as seven more opened in urban areas bringing the total number to 17.²⁹⁰ This expansion coincided with changes relating to who was responsible for supporting the ATICs. In 1990 the DoH created a sub-directorate based in Pretoria, known as the AIDS Unit, tasked with facilitating the implementation of anti-AIDS programmes and 'the combating of Aids'. The Unit's functions included 'setting up and supporting ATICs ... updating the National AIDS

²⁸⁸ See *Epidemiological Comments*, 17, 1, January 1990, p. 24; *Epidemiological Comments*, 17, 4, April 1990, p. 20; *Epidemiological Comments*, 17, 5, May 1990, p. 24; *Epidemiological Comments*, 17, 6, June 1990, p. 24; *Epidemiological Comments*, 17, 7, July 1990, p. 20; *Epidemiological Comments*, 17, 8, August 1990, p. 13; *Epidemiological Comments*, 17, 9, September 1990, p. 17; *Epidemiological Comments*, 17, 11, November 1990, p. 29; *Epidemiological Comments*, 17, 12, December 1990, p. 17; *Epidemiological Comments*, 18, 2, February 1991, p. 60; *Epidemiological Comments*, 18, 4, April 1991, p. 97; *Epidemiological Comments*, 18, 5, May 1991, p. 125; *Epidemiological Comments*, 18, 6, June 1991, p. 153; *Epidemiological Comments*, 18, 8, August 1991, p. 191; *Epidemiological Comments*, 18, 9, September 1991, p. 210; *Epidemiological Comments*, 19, 7, July 1992, p. 130; *Epidemiological Comments*, 19, 8, August 1992, p. 145; *Epidemiological Comments*, 19, 9, September 1992, p. 162; *Epidemiological Comments*, 19, 10, October 1992, p. 181; *Epidemiological Comments*, 19, 11, November 1992, p. 201; *Epidemiological Comments*, 19, 12, December 1992, p. 234; *Epidemiological Comments*, 20, 1, January 1993, p. 17; *Epidemiological Comments*, 20, 2, February 1993, p. 33; *Epidemiological Comments*, 20, 3, March 1993, p. 50; *Epidemiological Comments*, 20, 5, May 1993, p. 88; *Epidemiological Comments*, 20, 6, June 1993, p. 104; *Epidemiological Comments*, 20, 7, July 1993, p. 121; *Epidemiological Comments*, 20, 8, August 1993, p. 138; and *Epidemiological Comments*, 20, 12, December 1993, p. 225.

²⁸⁹ Evidence of the AAG's ongoing activities included a statement in the SAMJ in 1992 written by the AAG explaining to readers that the group had decided 'to recommend that AIDS and HIV infection in South Africa not be made notifiable' see AIDS Advisory Group, *SAMJ*, 81, 1 February 1992, p. xxi. Note that the statement was dated October 1991. The DoH followed this suggestion indicating ongoing collaboration between the group and the DoH on certain issues. Similarly, a national strategy on HIV antibody testing published in the *SAMJ* in September 1993 listed the authors as being part of a subcommittee of the AAG while the DOH annual report for 1993 referred to the creation of a national HIV testing strategy. See Fleming, A.F., & Martin, D.J., 'National strategy for serological diagnosis of HIV infection', *SAMJ*, 83, September 1993.

²⁹⁰ NLSA, CTGC, SA Reports, DNHPD Annual Report 1990, p. 13 and NLSA, CTGC, SA Reports, DNHPD Annual Report 1993, p. 26. New ATICs were opened in Pietersburg, Pretoria and East London in 1990 and in Brakpan, Klerksdorp, Queenstown and Vanderbijlpark in 1993.

strategy and ... promoting and developing educational interventions for young persons'.²⁹¹ Breaking from the strictly medico-scientific membership of the AAG, the Unit consisted of 'a multidisciplinary team including a surgeon, an Aids specialist, a clinical psychologist, a social worker, a teacher, a liaison officer and a nurse'. It was initially headed by Dr Manda Holmshaw, a clinical psychologist, and then by Natalie Stockton from June 1992.²⁹² Dr Wilson Carswell was appointed as medical advisor to the unit in December 1990 - described in the *SAMJ* as an 'international AIDS expert with extensive experience, particularly in Africa ... gained in both the government and private health care sectors'.²⁹³

One of the first tasks of the AIDS Unit was to revise the existing AIDS strategy and in 1991 a national AIDS strategy and a communication strategy covering a 30-year period were devised and 'sent to interested parties for their comments' before being accepted by the DoH.²⁹⁴ It is unclear who these interested parties were, how their interest had been identified, or what impact, if any, they had on the strategy. While a copy of the new strategy could not be found, a reference in Cameron and Swanson suggests that the AIDS Unit did distribute a document in 1991 entitled 'Background and Strategy for AIDS Prevention'.²⁹⁵ It is assumed that this strategy may have influenced the changing response to AIDS within the DoH.

During this phase the AIDS Unit was responsible for launching new AIDS campaigns and programmes but problems within the unit hampered their implementation and led to the demise of the Unit at the end of 1992 after, amongst other things, alleged financial irregularities.²⁹⁶ Whatever the internal reasons for the AIDS Unit being restructured, the

²⁹¹ *Hansard* HA, vol. 29, Tuesday, 26 February 1991, col. 198. The function of the unit was also explained in the Annual Report for 1991 and readers were informed that the unit grew in size from two to 18 staff members, see NLSA, CTGC, SA Reports, DNHPD Annual Report 1991, pp. 8 – 9.

²⁹² *Hansard* HA, Extended Public Committee Meeting, vol. 26, Monday, 13 May 1991, col. 8492.

²⁹³ Author Unknown, 'Government Strategies in the fight against AIDS', *SAMJ*, 79, 20 April 1991, p. xiv.

²⁹⁴ NLSA, CTGC, SA Reports, DNHPD Annual Report 1991, pp. i & 9; and *Hansard* HA, vol. 29, Tuesday, 26 February 1991, col. 169.

²⁹⁵ Cameron & Swanson, 'Public Health and Human Rights', p. 203. Footnote 17 references 'Department of National Health and Population development AIDS Unit *Background and Strategy for AIDS Prevention (1991)*'.

²⁹⁶ In early 1993 M.J. Ellis (DP), referred to 'the serious problems' experienced in 1992 which had 'paralysed the Aids unit for some months, with, no doubt, serious consequences in terms of the spread of Aids in the country' (*Hansard*, Extended Public Committee Meeting, vol. 39, Wednesday, 7 April 1993, col. 5000). Ellis repeatedly requested information on the AIDS Unit. In May 1993 Venter explained that the unit had been restructured to bring it into line 'with principles suggested by the WHO ... that a network of organisations be established to

DoH's official line was that a new approach to addressing AIDS and a new strategy had informed it.²⁹⁷

Another new structure, the Interdepartmental Committee on AIDS (ICA), which represented sixteen government departments, provincial administrations and three 'own affairs' administrations, was to meet biannually to 'co-ordinate the actions of the public sector'.²⁹⁸ It had four main functions:

to identify areas in which various departments can play a role in the fight against Aids, both internally and interdepartmentally; secondly to create an Aids combating programme in as well as outside the department; thirdly to co-ordinate and evaluate projects and to report to the hon. the Minister, and fourthly ... to ensure that the full potential of the State's capacity is utilised effectively for this matter.²⁹⁹

function together as one comprehensive Aids prevention programme' (*Hansard HA*, vol. 45, Wednesday, 5 May 1993, col. 1425 – 1426). Sadie and Van Aardt suggest that the AIDS Unit was dissolved 'after an investigation into alleged mismanagement' (Sadie & Van Aardt, 'VIGS-Politiek', p. 97, author's translation). This assessment is borne out by media releases from the DoH at the time, while Venter has since confirmed that an investigation into financial irregularities had resulted in a number of dismissals and the restructuring of the unit. Interview with Rina Venter. See also South African Press Association (SAPA), 'AIDS-Lead-Funds'(OA633), Johannesburg, 7 June 1992; and SAPA, 'AIDS-Funds' (OB656), Johannesburg, 7 June 1992 available online at 'e-tools' a portal for SAPA media releases at www.e-tools.co.za/newsbrief/1992/news9206.08 (accessed August 2012). The media releases note that the DoH had 'ordered a complete investigation by a chief magistrate into management aspects of its Aids unit following the recent discovery of irregularities' but 'adamantly denied the reported diversion of funds set aside for Aids control for any other purpose'. The release went on to say that staff members had lodged a complaint against Holmshaw and she in turn, along with Carswell, had laid a formal complaint against Dr Hans Steyn, the Deputy Director-General of the DoH and their supervisor for a dereliction of duty in the management of the AIDS Unit. Another media release noted that the Director General of the DoH Dr C. F. Slabbert 'denied weekend press reports that funds intended to be used in AIDS education had been diverted into other projects [after]weekend press reports alleged that R4,5 million earmarked for AIDS prevention in last year's budget was redirected to other uses. And when personnel in charge of the project complained, they were demoted. Dr Slabbert refuted the allegations saying the head of the AIDS unit, Dr Manda Holmshaw, was appointed as a senior psychologist in the Department of Health and still occupies the same position with the same salary. He said deputy head of the unit Dr Wilson Carswell was appointed as medical adviser was still working in that capacity and earning the same salary'. Natalie Stockton was then appointed to manage the unit on a full-time basis.

²⁹⁷ NLSA, CTGC, SA Reports, DNHPD Annual Report 1992, p. 17.

²⁹⁸ *Hansard HA*, vol. 29, Tuesday, 26 February 1991, col. 169. The only ICA minutes that could be located were those for the first meeting that were included in a memo from the Director of Planning Services to the Director of Administration. The minutes list the name and designation of all 37 people who attended the first meeting, summarise what was discussed, and acknowledge the lack of representation on the Committee by delegates from the TBVC states. It is likely that a full set of minutes is waiting to be uncovered and catalogued. See National Archive, BAO DJ6/3/3/475, vol. 18/178, memo from Director of Planning Services (Beplanningsdienste) to Director of Administration (Administrasie), Interdepartementele Komitee: VIGS-Bekamping, & March 1991.

²⁹⁹ *Hansard HA*, vol. 29, Monday, 18 March 1991, col. 3131-3132.

The ICA was created to educate state officials about AIDS because knowledge of the disease was uneven among departments. It is not clear if knowledge amongst departments was seen as important generally to prevent AIDS or if there were concerns about the potential impact of AIDS on civil servants. The ICA would provide a space for discussion of AIDS programmes being devised by the DoH, enabling representatives from other departments to contribute to the formulation and implementation of policies.³⁰⁰ The ICA met for the first time in January 1991 and decided to arrange a workshop that would, in recognition of 1991 being the year of youth and AIDS, focus on devising a schools educational programme.³⁰¹

The 1991 annual report noted that both bi-lateral and multi-lateral meetings about AIDS were taking place 'on a continuous basis' with 'neighbouring countries and states'.³⁰² These meetings provided an opportunity for the exchange of information, strategies, and policies.³⁰³ Which 'neighbouring countries and states' the report was referring to is unclear, but it seems likely that this comment was made in reference to so-called TBVC states and self-governing territories rather than independent African states to the north. The report announced that an 'AIDS strategy for Southern Africa [would] also be developed in collaboration with the TBVC States and the Self-governing Territories', seemingly indicating that South Africa was not yet discussing AIDS with independent African states.³⁰⁴

The establishment of the AIDS Unit and the ICA, and the regular meetings with 'neighbouring countries and states', indicate the start of a shift in thinking about AIDS. No longer was the DoH trying to tackle the disease in purely medico-scientific ways, but was reaching out to multiple sectors which had different ways of understanding and confronting the disease. While this shift was limited in scope at this stage, and the groups involved may have lacked credibility in the eyes of many anti-apartheid activists and liberation movements, it indicates a different approach that was not evident in previous phases.

³⁰⁰ Interview with Rina Venter.

³⁰¹ *Hansard* HA, vol. 29, Tuesday, 26 February 1991, col. 169. The composition and first meeting of the ICA was commented on in a paragraph in the *SAMJ* news section see Author Unknown, 'SAMJ News Note', *SAMJ*, 79, 16 February 1991, p. xii.

³⁰² NLSA, CTGC, SA Reports, DNHPD Annual Report 1991, p. 9.

³⁰³ *Ibid.*

³⁰⁴ *Ibid.*

Information to the Public and Education Campaigns Aimed at Adolescents

During this phase the DoH continued to distribute AIDS information to the public. A new brochure was distributed on World AIDS Day in 1990, a colour booklet entitled 'Women and AIDS' circulated via a 'women's magazine' and two films aimed at adolescents were produced.³⁰⁵ By 1993 'experimental AIDS training packages' that aimed to equip 'all nursing personnel with knowledge and skills to cope with every aspect of HIV/AIDS' were also being distributed.³⁰⁶ Between 1990 and 1992 the AIDS Unit was involved in the creation and implementation of AIDS information campaigns, which included a new public campaign directed at adolescents and adults.

Holmshaw (the head of the AIDS Unit) informed regional ATICs that a mass communication campaign would be launched on International AIDS Day, 1 December 1991.³⁰⁷ The Sandton-based advertising agency Hunt, Lascaris TBWA won the tender to design and implement this campaign, launching the Yellow Hand Campaign (YHC) (figure 22).³⁰⁸

The YHC programme was rolled out in stages, starting with the credo ('AIDS. Don't let it happen') and the symbol (an open yellow hand) being launched in the print media on 1 December 1991, accompanied by full-page adverts and double-page colour supplements and inserts that appeared in national newspapers (figure 23, see also appendices E – G for legible enlargements).³⁰⁹

³⁰⁵ NLSA, CTGC, SA Reports, DNHPD Annual Report 1990, p. 13.

³⁰⁶ NLSA, CTGC, SA Reports, DNHPD Annual Report 1993, p. 15.

³⁰⁷ Mary Crewe, Private Papers (hereafter MC-PP), Correspondence (fax), M. Holmshaw to All Regional ATICs, 'Communication Campaign', 28 November 1991, p. 2.

³⁰⁸ For Hunt Lascaris TBWA's current incarnation see their website at TBWA South Africa at www.tbwa.co.za (accessed February 2011). According to the website, Hunt Lascaris decided in 1987 to partner 'with a like-minded global network TBWA. This allowed us to play more on the world stage.' A search did not reveal any reference to their work on the AIDS campaign.

³⁰⁹ The newspapers included those in the Argus group, and the *Sunday Times*, *The Star* and *The Sowetan*.

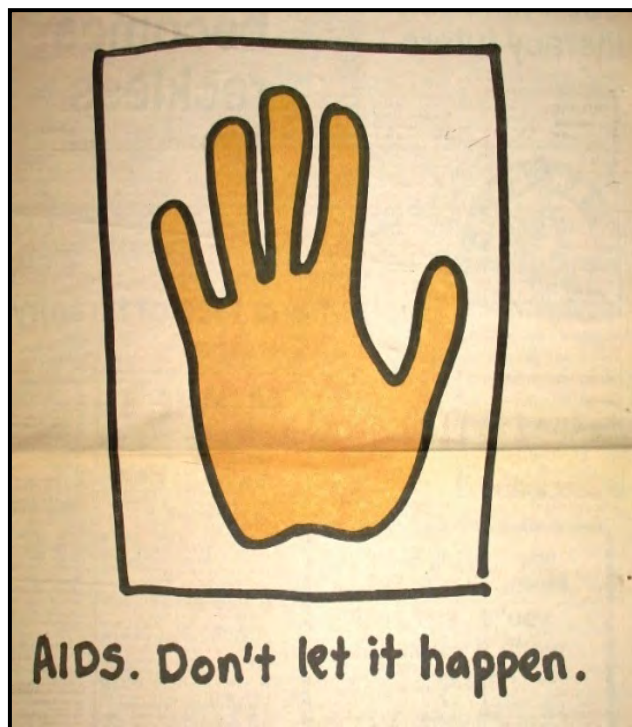


Fig. 22. Hunt Lascaris Logo & Yellow Hand Logo.

SOWETAN 
Building the Nation

Parents, children and
AIDS

WHAT IS AIDS

AIDS is a condition in which our immune system, the system in our bodies that protects us from disease, breaks down. This means that eventually our bodies can no longer fight off illnesses they used to deal with easily, and after quite a long time, usually eight to 15 years, we die.

Aids stands for Acquired Immune Deficiency Syndrome. Acquired means it is something you get, rather than something you were born with. Immune means you can't get it. Deficiency means lack of being immune. And syndrome means a group of symptoms forming an illness.

Aids is caused by a tiny germ, a virus known as the Human Immunodeficiency Virus, or HIV. There is no medicine, vaccine or antibiotic that can remove the virus once it is in our bodies, or protect our bodies from it. The virus seriously destroys the body's ability to protect itself, so that it becomes a bit like a soccer team without a goalie — there is nothing there to protect the goal, and the team is easily beaten.

The virus is contained in blood and in sexual fluids such as semen or vaginal fluids, so that the main way it is passed on is when people have sex. Sex with no protection, such as a condom, can allow the virus to pass into the partner's body. The virus can also be passed on by a pregnant mother to her baby, and when this happens the baby usually dies before it is two years old.

If we allow blood from an infected person to enter our bodies we will probably become infected with the virus too, so it is very important that doctors and dentists use clean, sterilized injection needles on every patient. Drug addicts who share needles and syringes are putting themselves at great risk.

It used to be possible to get Aids through blood transfusions, but since 1985 all donated blood is tested for the virus. It is very unlikely now for the virus to be passed on this way. You cannot get Aids from donating blood either.

Once someone is infected it usually takes about three months before there are any signs of the infection in that person's blood. During this time and for several years to come, an infected person is likely to be perfectly healthy. But at the same time they are capable of infecting other people.


You can't tell if someone is infected. Because of this, it is wise always to take precautions against the virus. The best way to avoid the virus is to avoid having sex until you are married, and after that to remain faithful to your partner. If you do have sex, use a condom, because condoms reduce the risk for both partners.

If you avoid unsafe sex and injecting yourself with drugs it is impossible to get Aids. You cannot get it from ordinary everyday contact at school, from touching, from kissing (not even French kissing), from swimming in the same pool as an infected person, from lavatories, from sharing cups or glasses or a straw, or from having a bite of someone else's sandwich. You can't get it from donating blood.

People between the ages of two and 12 are almost never infected by the Aids virus, because they have not had sex. But they need, by the time they become teenagers, to know about the disease, and how to avoid it. Forewarned is forearmed.



HIV is a very fierce germ that attacks the white blood cells themselves

The Star 

Meeting the challenge of
AIDS

THE LANGUAGE OF AIDS

AIDS is a pandemic (world-wide epidemic) which is going to affect everyone directly or indirectly. There is still no vaccine and no cure, so prevention is the only way to deal with it.

In South Africa 300 people a day are becoming infected, most of them heterosexual adults, many of them with children to support.

Aids stands for Acquired Immuno-Deficiency Syndrome, and is caused by a virus known as the Human Immunodeficiency Virus or HIV.

The disease was first diagnosed in America in the early 1980s, and the first two South African patients, both white homosexuals, were diagnosed in 1982.

At first most of the patients were homosexuals, but now the main way the virus is spreading is by heterosexual sex, that is, sex between men and women. It can also be spread from mothers to their unborn or newly born babies.

The virus enters the bloodstream and attacks the body's immune system — the system which protects the body against infections — and gradually destroys it. Once the immune system is destroyed, you have no protection against a series of opportunistic infections which healthy people easily fight off.

When you are first infected with the HIV virus you look and feel well, and usually do not know the virus is in your body. But you are infectious and you can pass the virus on.

It usually takes about three months for antibodies to the virus to show up in your blood, and this period — when you are infectious but there are no signs of the virus in your blood — is known as the window period.

After about five to 10 years, when the body has little natural immunity left, you feel tired and get sick often, with illnesses such as thrush in the mouth, shingles, pneumonia, a rare skin cancer, or TB.

There is a drug called AZT which can delay the onset of symptoms and allow people to live full, active lives for longer. But its effect is temporary. It is also very expensive, costing more than R1 000 a month.

You are safe from Aids if you are involved in a long-term, faithful relationship with someone, or if you don't have sex, or if you masturbate.

Sex with an infected person allows infected semen, vaginal fluids or blood, including menstrual blood, to enter the body.

Condoms act as a barrier and prevent the exchange of fluids. They are made of fine latex rubber and are very sensitive. It is safe and responsible to use condoms every time you have sex outside a long-term, faithful relationship.




Fig. 23. Detail of AIDS Information Supplement in *The Sowetan* and *The Star*, c. 1991/2.

The supplements provided basic information about AIDS, women and AIDS, AIDS and the economy, AIDS and TB, negotiating safer sex, telling a partner about your HIV status, mother-to-child transmission (MTCT), and teenagers and AIDS. They stressed the importance of communicating across generations, with supplements that included letters exchanged between parents and their children about AIDS and sex. The campaign provided contact details for toll-free AIDS information telephone help-lines set up by the DoH. The helpline had pre-recorded messages providing general information about AIDS available in eight languages, and callers were given the number of the Lifeline counselling service staffed by trained counsellors.³¹⁰

A week later the YHC's 'personal testimonial campaign' appeared in print and electronic media, showing well-known South Africans and 'experts' delivering AIDS awareness messages.³¹¹ Pamphlets on AIDS and teenagers, AIDS and womyn, and pregnancy and AIDS were translated and distributed in isiZulu, isiXhosa and Afrikaans. The campaign shifted focus at the end of January 1992, promoting educational packages for secondary schools that would be introduced in March as part of the AIDS Lifestyle Education Programme (discussed below).³¹²

The YHC differed from previous AIDS education campaigns with its focus on both adolescents and adults, and in its presentation. The bright and bold colourful human characters were reminiscent of the popular artwork created by Keith Haring and used in anti-AIDS campaigns internationally in the mid-1980s, although in this instance presented only heteronormative images (figure 24).³¹³ The campaign encouraged discussion between parents and children about AIDS, condom use, sexual health and sexuality and provided information on where external support could be sought.

³¹⁰ Author Unknown, 'Toll-free AIDS helpline in eight SA languages', *SAMJ*, 81, 4 January 1992, p. xiv.

³¹¹ MC-PP, Correspondence, Holmshaw to Regional ATICS, 'Communication Campaign', p. 2. See also MC-PP Jeanne Bestbier on behalf of the AIDS Unit, 'AIDS Unit Message on Schools Package Goes Out to Parents, Teachers and Teenagers', for first use 12.00 noon, 30 March 1992, p. 3. 'Role models' who had already appeared on TV included sports personalities, beauty queens, actors, DJs, and musicians such as Brian Mitchell, Anneline Kriel, Treasure Tshabalala, Shadow Twala and Siphso 'Hotstixs' Mabuse. The theme of the TV campaign was called 'Experts Explain'.

³¹² Holmshaw indicated in her correspondence that 'workshops would be held with teachers in all the provinces to train them in the use of the package' but it is not clear if these workshops ever took place.

³¹³ Haring died of AIDS related complications in February 1990. For more on Haring and his work see the Keith Haring Foundation website at www.haring.com (accessed July 2012).



Fig. 24. Bright, bold figures from the YHC supplements.

The campaign acknowledged that parents might find it difficult to talk to their children about sex but advised that 'children who have been taught about the relationships context of sex, and have had their questions answered honestly, are less likely to experiment', and 'talking to children about sex warmly and lovingly will help a child to associate sex with warmth and love'. The supplements provided guidelines and scenarios for couples to talk to each other about AIDS: 'with the arrival of the AIDS virus it is more important than ever that partners discuss sex openly with each other. The legacy of the Victorian era, when sex was practised but not talked about, has to change'. Considering the conservative nature of much of South African society these were forthright suggestions (figure 25).

Indlela ekugulisa ngayo I-AIDS.

Lingisa wakho ukuba khona imikhumbulo emacella agazi amkhulu. Lama-cells amkhulu akulula amagqwane nembewu yokuba - virus, ezile ukuthi ngafe. Ngakho naba ka, ama-cells amkhulu agazi akulula ekugqeni umzimba wakho uphila. Imbewu yikuba ye-AIDS, noma i-HIV, iyile ngazo



iyinto okuyiphela kabi, yinjenge ocansini nabantu abaningi, ukuya ocansini "ongagqokekanga ngazi" - ungayifakanga i-condom phela, uma lona unaye ngaphambili naye, kanti ukuzalishaniswa kuzakwela nezidakamizwa dedango.

Izindlela ongeke uyithole ngazo I-AIDS.

Kubaluleke ukwazi ukuthi ngoko uyithole i-AIDS ngokuphelele, ukufaka

Izimpawu nezi-komba zokuqala.

Igqwane le HIV ligqale ngezindaba eziningi. Ungaphathwa ngomkhathiso ongapheli izindaba, ikakhulu kabi kwi-emo ngapheli, amakhophu nasemabaphu zizala zivukela. Uphuhliso somawu se-igqwane ngaphambili kuzakwela,



Iqiniso elimsulwa nge AIDS.

nakokunye okukufakazi lomzimba thasela ibulale ama-cells agazi amkhulu, loyo umzimba ungakwazi ukuzivela emagqwani nasemabaphu yokuba. Ungaba ne-AIDS ukhathi eside ngaphambi kokuthi kugulise. Kayelaphi i-AIDS, le virus ibhubhisa ukuthi lokuyikala umzimba okuyiphela ngokuthi loyo one-AIDS abulawa yizifo ezinengeniso sofoke - isishiso samaphaphu, kanye nezinye izifo ezingo phangamathaba.



izindaba ezikhawule ngenge izifo ezinye, ucingo, ezindle zangasese, imiyane, ukufakwa okungqokekanga ngumutho one-AIDS, nasemabaphu yonhondoloko.

Izindlela zokuvimbela I-AIDS.

Siyazi sonke ukuthi indlela enesiqiniseko sokuvimbela i-AIDS ukungayi ocansini nhlaba. Kodwa lokhu akuzeki ngezo sonke isikhathi; nansi imibono embalwa: Ngaphambi kokuthi uye ocansini, cabangisise kahle ngazi ongasazi faka kuyo. Khawule ukuya ocansini nanoma ngubani - ukuya ocansini dedango, noma ubudletwano besikhathana ngaphandle kokusebenzisa "ijazi lomnumzana" - i-condom.



konke lokhu yizinkomba zeqinane le-HIV. Ezinye izimpawu zibulalabulaka kwesilo okungapheli, ukulafakazi yezimbo zomzimba nezilo ufoke.

Khumbula ukuthi lezizinkomba aziphathi abantu abane-HIV kuphela. Zingadlwa nangezinye izifo. Uma uvucela lezizimpawu, gquthuma ku-docokela wakho noma e-clinic.

Indlela ongayithola ngayo I-AIDS.

Lingiswani le-AIDS landa ngezindaba ezintathu ezinqoka. Ungayithola ngokuya ocansini okungavikelekile nokwizalane noma ovesulise unyayo. Unina wengane onateligqwane angathela ingane yakhe ezilwe noma emgqazaleni. Nangokukolekana ngezindaba zomjovo uma kufakwa izidakamizwa amithanjani. Ukulafakelwa



Okwemukelekayo wukuba yizithandani ezethambekile zungenayo i-AIDS. Uma ungumsebenzisi wezidakamizwa musa ikubekisana ngenaliti yomjovo.



Ufuna ulwazi olwedulele?

Uma ufuna ulwazi oluthaxaxa thandana nekhawule lesoqo lomnyengo weMpilo yelizwe nokuThuthukiswa kwaBantu aba Khulayo - Regional Office of the Department of National Health and Population Development, i-AIDS Training and Information Centre (ATIC) noma usheyele ucingo kwa-Lifeline AIDS Line, Toll-Free kwa 0800 012 322.

KONKE OKUYOKHAWA KUYOBAYIMPHILO.



I-AIDS. Ungayiniki ithuba.

Department of National Health and Population Development

PLAF 1402/1987/1988/1989/1990/1991/1992

Fig. 25. AIDS Information Advert, c. 1991/2.

Despite this openness the messages discouraged pre-marital sex and reinforced the idea that marriage was the best defence against the disease: 'the best way to avoid the virus is to avoid having sex until you are married, and after that to remain faithful to your partner'. The messages only discussed heterosexual relationships, although a helpline number for GASA was provided in some adverts. Those aimed at adolescents were all framed as lifestyle messages which encouraged confidence and empowerment and stressed that responsibility was part of becoming an adult. They failed however, to account for how prescribed gender roles and issues such as sexual violence mediated adolescents' experiences. More positively the messages did deal with stigma noting that 'by being non-judgemental, caring and supportive, you can help a person with AIDS not only to come to terms with the diagnosis, but also to live with it' (figure 26).



Fig. 26. Detail of AIDS Information Supplement in *The Star*, c. 1991/2.

The client service director of Hunt Lascaris, Reihner Behrens, described the campaign as 'a sincere, heartfelt communication rather than advertising', which was why participants were being given 'as much freedom of expression as possible'. Hunt Lascaris would 'be monitoring

the campaign closely' and could 'refine and reinforce it where necessary'.³¹⁴ There is no indication as to whether independent evaluations occurred, and it is thus difficult to speculate on the effectiveness of the campaign.

Eighteen months into the YHC, Hunt Lascaris prepared a presentation as a 'stock-taking' review of the campaign's achievements and lessons. The presentation formed part of a motivation for Hunt Lascaris to be reappointed as the agency commissioned to handle the 'AIDS awareness account' for the DoH. Hunt Lascaris declared that they had 'totally re-assessed' their initial strategy but, unsurprisingly, 'reached the conclusion that it is fundamentally correct and on-track'.³¹⁵

The presentation included information drawn from 'research' – primarily interviews – undertaken among influential AIDS activists and researchers from a wide spectrum of organisations. This revealed that 'there had been criticism as well as praise for what has been done,' conceding that the campaign could be strengthened by increasing the involvement of 'grass roots', community and progressive organisations.³¹⁶ Many of Hunt Lascaris' insights and suggestions regarding AIDS education campaigns showed an accurate reading of the political and social context at the time. For all the positive aspects of the campaign, the DoH and the government lacked credibility amongst most South Africans, meaning that no matter how well packaged anti-AIDS messages were their legitimacy would be suspect.

Throughout this phase the DoH tried to promote STI and AIDS literacy among school pupils and their parents. The DoH's AIDS marketing section, the ICA and the AIDS Unit were all involved in trying to implement programmes in collaboration with education authorities, but

³¹⁴ MC-PP, Bestbier, 'AIDS Unit Message on Schools Package...', p. 4.

³¹⁵ MC-PP, Hunt Lascaris TBWA, AIDS Presentation, 21 April 1993, p. 1.1.

³¹⁶ *Ibid.*, pp. 1.3, 1.6 – 1.7. See also MC-PP, Hunt Lascaris TBWA, AIDS Strategy 1993/94 - part of the Presentation, 21 April 1993. The Appendices to the presentation included responses to a questionnaire that HLT had used during their research. Respondents included members of gay and community organizations involved in AIDS support (Shane Petzer from the AIDS Support and Education Trust – ASET and Resiloe Serote of the Township AIDS Project), medical researchers (Dr Reuben Sher), senior members of the ANC Health Department (Dr Ralph Mgiijima), and members of health networks both governmental and non-governmental (Shan Ramburuth of Primary Prevention Health Care, and Dr Clive Evian of the Hillbrow AIDS Clinic, and ATIC managers).

with little apparent success. When asked in parliament in 1990 about government initiatives to implement AIDS information programmes in schools Venter could give no concrete information on when, how, or in which schools such programmes would be introduced.³¹⁷

The education system in South Africa at the time, much like the health system, was fragmented, subject to provincial authority, racially organised, and inequitably funded, making the acceptance and execution of a national schools programme a fraught process. In 1985 there were no less than 18 different departments of education and 15 ministers of education. In 1989 more than four times as much was spent on the education of each 'white' child than was spent on each 'black' child.³¹⁸ Regardless of how proactively (or not) school-specific programmes were being devised in or between departments, there was a disjuncture between any AIDS education strategy the DoH may have wanted to implement and what was actually taking place within schools through their respective 'own affairs' or provincial education departments.

During 1990 and 1991 DP MPs Ellis and M. Rajab, took up the issue of AIDS education in schools with ministers of education in both the House of Assembly and the House of Delegates, in an attempt to determine if such programmes would be made compulsory. Ellis asked the Minister of Education and Culture, Mr P.J. Clase (NP), what his attitude towards a school anti-AIDS programme was and whether he would allow these programmes into the ('white') schools under his control: 'Aids knows no colour bar ... and needs to be combated in all classrooms'.³¹⁹ Clase sidestepped the question and reported on a 'Care for our Youth' campaign which had been launched by his department to 'determine the causes rather than treating the symptoms' of AIDS among youth.³²⁰ What was meant by 'determine the causes of AIDS' is unclear and was not elaborated on – presumably the department knew how AIDS was transmitted so this may have been an indirect comment on the morality (or immorality) amongst 'youth'.

³¹⁷ *Hansard* HA, vol. 21, Wednesday, 21 March 1990, col. 619.

³¹⁸ Omond, R., *The Apartheid Handbook: A Guide to South Africa's Everyday Racial Policies* (London, Penguin, 1985) p. 77; and Davenport, T., *South Africa: A Modern History* (Basingstoke, Macmillan, 1991) p. 354.

³¹⁹ *Hansard* HA, vol. 17, Thursday, 22 March 1990, col. 4209 – 4210.

³²⁰ *Hansard* HA, vol. 17, Friday, 23 March 1990, col. 4484.

Rajab submitted a similar question to K. Rajoo (SP), the Minister of Education and Culture in the House of Delegates. Rajoo reported that while the education authorities under his control were not involved in devising programmes, five teachers' centres were 'disseminating titles of video tapes and pertinent literature to all Indian [sic] schools.' While his department co-operated with the national committees tasked with designing awareness and preventative programmes, the ICA was responsible for co-ordinating the process. No recommendations were made to education authorities, but the education department was 'giving attention to the revision of its Health Education syllabuses to make provision for the teaching of topics which deal not only with present day health issues but also the inculcation of values and attitudes which hold good for all time'.³²¹

Rajab and Ellis repeated the question at different times to Venter, Clase, L. Pienaar (NP), the Minister of National Education, and C.J van der Merwe (NP) the Minister of the Department of Education and Training (DET). Each time they asked whether the department concerned was devising AIDS information programmes for use in schools, which educational authorities were involved in the programme, whether advice was sought from other individuals or organisations in devising the programme, and whether any instructions or recommendations were conveyed to the various education authorities regarding the introduction of the programmes at school level.

Venter pointed to the AIDS *Indaba* held at the end of 1989, which demonstrated a willingness to seek external advice from experts, and stressed the important contribution that educational institutions could make by providing 'factual information' that would prepare 'the youth' to make 'informed and responsible decisions'. She acknowledged that the DoH could 'at most supply medical advice' but '[could not] be prescriptive towards other departments'.³²²

Clase reported that his department was involved in establishing an AIDS education programme for junior and secondary phases in 'white' schools in close collaboration with 'several experts', and was working with the DoH on an anti-AIDS video. The anti-AIDS

³²¹ *Hansard* HD, vol.21, Friday, 18 May 1990, col. 1401 – 1402.

³²² *Hansard* HA, vol.21, Thursday, 10 May 1990, col. 1266 - 1267.

programme would be presented to pupils either by existing staff members responsible for 'family education programmes, or as arranged by each provincial education department [or] by local communities'.³²³ The programme would be compulsory in all secondary schools, but 'the right of parents to withdraw their children from these types of programmes [would] be acknowledged'.³²⁴

Van der Merwe indicated that the DET, responsible for 'black' education, was involved in establishing programmes targeting 'the teenage school population' which would be presented by 'deputy chief education specialists ... school Guidance teachers and officials of the Provincial Administrations' and had been compiled by DoH officials and DET experts. A 'sexual guidance programme' would be presented to teenagers 'after school hours and on a voluntary basis' but 'parents had to give permission for their children to attend'.³²⁵ The DET was involved in a number of anti-AIDS initiatives, among them the dissemination of an animated video and training module on AIDS 'in all the African languages' which was being 'made available to teaching staff throughout the country'. Assistance was being offered to the Rural Foundation to distribute AIDS information in rural areas.³²⁶

In March 1991 the ICA held a workshop for educational authorities to discuss the contents of a school AIDS programme. Venter recounted that 'all education authorities were represented, as well as some of the self-governing education departments and the ATICs'. After 'theoretical presentations', working groups were established to address specific problems with programme implementation. The most important resolution coming out of the meeting was that 'all school going children should be Aids-literate by Std. 5', and that the DoH was going to provide instruction in primary schools.³²⁷

³²³ *Hansard* HA, vol. 29, Tuesday, 19 March 1991, col. 610 – 611.

³²⁴ *Ibid.*, col. 611.

³²⁵ *Hansard* HA, vol. 29, Friday, 12 April 1991, col. 1007 – 1008.

³²⁶ *Ibid.*, col. 1008. The Rural Foundation was established in 1982 to promote the development of farm workers skills and improve their quality of life. It was not an NGO as it was mostly government funded. Doreen Atkinson has noted that people are divided about its efficacy as, although there were some successes its close association with the government damaged its credibility and some of the innovations were considered to be paternalistic. It was terminated in 1994. See Atkinson, D., *Going for Broke: the Fate of Farm Workers in Arid South Africa* (Cape Town, HSRC Press, 2007) available online from HSRC Press at www.hsrcpress.ac.za (accessed August 2012). For information on the Rural Foundation see the chapter 'Civil Society and Farm Life'.

³²⁷ *Hansard* HR, vol. 26, Monday, 13 May 1991, col. 8492 – 8493. Standard 5 was the last year of primary schooling so school pupils were usually 11 turning 12, or 12 turning 13 years old in this standard.

If Venter had hoped for co-operation and support from the national minister of education it was not forthcoming. Pienaar explained that the existing national policy on syllabuses, examinations and certification for junior and secondary schools was being revised, but he doubted that this revision would include 'specific guidance programmes' about AIDS. While the department would recommend guidance, 'the development of specific programmes [would] be in the hands of the various ministers of departments of State [sic] responsible for education and the Department of National Education [would] not be involved'.³²⁸ The department responsible for national education appeared unwilling to take direct responsibility for implementing AIDS awareness programmes in schools, possibly because it saw this as the responsibility of the DoH.

Despite Pienaar's apparent disinterest the workshop appeared to mark a change of attitude on the part of education authorities who seemed to have started to take AIDS education more seriously.³²⁹ In May 1991 Venter announced that the DoH and the departments of education would work 'in close partnership' to ensure that teachers received 'special training to give Aids education to children.' This would be in the form of 'a lifestyle programme ... which [would] provide for the needs and values of different communities to select educational models that [were] most appropriate for their needs'.³³⁰ From May 1991 until the launch of a the new school-based lifestyle programme in March 1992, statements were made in both the House of Representatives and the House of Delegates calling for greater co-operation between departments and the national implementation of the programme.³³¹ Mr B. Dookie, the Minister of Health Services and Welfare in the House of Delegates noted that 'greater emphasis [needed] to be placed on sex education in schools' and that 'religious and cultural barriers will have to be overcome'.³³²

In March 1992 Venter announced that the new 'Aids and Lifestyle Education Programme for Teenagers' would initially be aimed at secondary school pupils, but would be extended to

³²⁸ *Hansard* HA, vol. 29, Wednesday, 10 April 1991, col. 955.

³²⁹ Pienaar would also be replaced as Education Minister in August 1991.

³³⁰ *Hansard* HR, vol. 26, Monday, 13 May 1991, col. 8493.

³³¹ See *Hansard* HR, vol. 26, Monday, 20 May 1991, col. 9177 – 9178 and *Hansard* HD, vol. 26, Monday, 20 May 1991, col. 9241 and 9296.

³³² *Ibid.*, col. 9241.

primary and pre-school children. It was to be made available to all education departments including those of the TBVC 'states' and the 'self-governing territories'.³³³ A circular informed readers that the programme had been designed to meet the needs of teenagers, their parents and teachers, but was flexible enough to be adapted to suit specific school communities.³³⁴ Unlike programmes in other countries (including Malawi and Zambia), which had failed because they had focussed primarily on information transmission about AIDS and not taken into account the contexts and relationships in which sexual activity took place, this one was different.³³⁵

The new programme took this into account and adopted a different approach aimed at addressing 'lifestyle issues' more broadly, attempting to empower teenagers to resist peer pressure and overcome their insecurities and need for acceptance. It recognised that 'to tell teenagers not to have sexual relations before marriage [would] only bear fruit if they were also equipped with the skills to resist the pressure from the opposite sex to give in to demands for sex'.³³⁶ A specific Christian morality and the primacy of the 'no sex before marriage' rule was still the dominant guiding principle for the programme. In line with this overarching morality, all teenagers were assumed to be heterosexual. The comment about 'pressure from the opposite sex' indicated an apparent belief that 'female' and 'male' teenagers negotiated sex as equals.

The circular emphasised that in 1991 research had been undertaken with education authorities, parent committees and adolescents, the results of which had informed the foundation of the lifestyle programme. The circular did not indicate which education authorities, parents or adolescents had been involved nor how representative the groups were.³³⁷ The circular noted that primary schoolchildren were targeted as they were 'uninfected ... mainly because they were not yet sexually active'.³³⁸

³³³ *Hansard* HA, vol. 36, Wednesday, 18 March 1992, col. 427. Venter noted that the DoH intended to develop the programme for pre-school children.

³³⁴ MC-PP, Author unknown, 'The Importance of Implementing an AIDS Programme in Primary Schools', 1992, p. 1 (author's translation of the original).

³³⁵ *Ibid.*

³³⁶ *Ibid.*, p. 2. (Author's translation of all quotes).

³³⁷ *Ibid.*, p. 3.

³³⁸ *Ibid.*, p. i.

The document does not reveal if knowledge about MTCT featured in the formulation of the programme. The epidemic was already ten years old and initial infections would have occurred in the late 1970s, so the likelihood of HIV-positive mothers giving birth to HIV-positive children was a reality. The first national antenatal survey had already indicated HIV infection amongst pregnant womyn attending public clinics, meaning that a percentage of primary schoolchildren – or future primary schoolchildren – were likely to be infected. It appears that the programme did not consider incidents of sexual violence and rape as possible routes of infection in children. On one level, the premise for the programme makes logical sense in that infection rates should be significantly less amongst primary school children, but it also shows a lack of engagement with the multiple realities faced by children in South Africa.

The programme had a number of stated aims: providing factual information about AIDS and other STIs, including information on transmission and prevention; teaching effective communication, responsible decision-making, assertive behaviour and appropriate relationship skills; reducing fears about accidental infection; and promoting non-blaming and positive attitudes towards people with AIDS. To this end, the programme contained modules addressing adolescence as a time of change, AIDS and STIs, relationships, life-skills, sexual abstinence, and practical ideas.³³⁹

Perhaps in an attempt to address an expected backlash from more conservative education authorities, or from parents and teachers, the document noted that ‘different school communities would follow different approaches to the subject and the format of the programme [made] it possible to choose what modules and/or lessons to use. Content viewed as inappropriate [could] be excluded with ease’.³⁴⁰ The document stressed the need to inform adolescents about sex and STIs in order to prevent infections and subsequent deaths, and assured teachers and parents that information about sexuality and sexual activity did not encourage promiscuity, but rather curtailed it.³⁴¹ The programme would only be successful if teachers, parents, community leaders, religious leaders (‘church leaders’)

³³⁹ MC-PP, Author unknown, ‘The Importance of Implementing an AIDS Programme in Primary Schools’, 1992, pp. 3 - 5 (author’s translation of quotes).

³⁴⁰ *Ibid.*, p. 5.

³⁴¹ *Ibid.*, p. 6

and other prominent people in communities were willing to get involved - a further example of the DoH's attempt to seek greater community engagement in the programme.

The programme was launched on 30 March 1992 in Cape Town, with a government media release heralding the programme as bringing 'good news on AIDS' and providing 'hope' that children could be kept AIDS-free. The media release reiterated the ICA decision that all children should be AIDS-literate by Standard 5 and noted that 'preventive education programmes [would] be made available to children in pre-primary, primary and secondary schools', while assuring adults that 'educational communities [could] choose all or only those [modules] they consider[ed] relevant to their specific needs'.³⁴² The flexibility to allow conservative communities to not fully engage with the 'messy' bodily realities of sexual activity, was repeated in another media release.³⁴³ It was however, not the challenge of adolescence that needed to be addressed, but rather the challenge of adults who did not want to make sexuality issues matters for discussion and scrutiny within schools and elsewhere.

The second media release explained that the idea of the modules was to 'increase a teenager's sense of control' so that they could 'cease to be a passive agent and ... take an active role in shaping both the adolescent years and the future'.³⁴⁴ The notion of imparting skills to increase a sense of control and agency are certainly laudable, but immediately negated by the fact that teenagers would have little to no say in whether, or how, the programme would be taught in their schools. Moreover, many children in South Africa were already actively involved in anti-apartheid struggles and were dealing with the realities of ongoing violence and unrest, so the notion of passivity was perhaps misguided. The media releases and programmes evoked, and relied upon, an idealised notion of 'the adolescent' (a very particular type of 'middle-class', heterosexual, and non-politicised adolescent).

³⁴² MC-PP, Press Release by Dr E H Venter MP, Minister of National Health and of Health Services and Welfare, 'Now There's Hope We Can Keep Our children AIDS-Free As They Move to Adulthood', 30 March 1992, pp. 1 – 3.

³⁴³ MC-PP Author Unknown, press release 'AIDS Education Programme Begins with Challenge of Adolescence', 30 March 1992.

³⁴⁴ *Ibid.*, p. 1.

A third media release, issued on behalf of the AIDS Unit, addressed generational concerns and the discomfort felt by certain adults when discussing sex. It included a quote from Holmshaw that acknowledged that 'talking about lifestyle matters to the younger generation can be difficult and distressing. Some may not always feel comfortable in these circumstances. However, the need is so vital, the stakes so huge, that we feel most schools will welcome the opportunity to make a contribution'.³⁴⁵

This particular media release recognised that the problem in South Africa was very much part of a wider African AIDS problem. Holmshaw was again quoted:

It is an African programme, shaped by African needs and conditions. We face an African AIDS pandemic, not Western AIDS. In Africa, heterosexual intercourse is the main method of transmission – which means the general population is at risk. The danger cannot be restricted to easily identifiable groups.³⁴⁶

While still employing the problematic distinction between 'Western' and 'African' AIDS, this was a noticeable shift from the narrative of 'infected others' sneaking across the border and mirrors the changing narrative in parliament. Holmshaw claimed that South Africa was doing pioneering work with the lifestyle and education campaign, and would 'share results and experience with our neighbours in Africa' as 'we are all Africans, and all engaged in the fight against African AIDS'.³⁴⁷

The lifestyle and education campaign was promoted in national Sunday newspapers on 3 April 1992, in 'metropolitan daily and weekend papers, in both English and Afrikaans', and was 'aimed primarily at parents'.³⁴⁸ Basic guidelines were scripted for DJs to allow them to 'deliver the message in their own style' on 'radio beamed at teenagers, but the majority of DJs selected were those who presented English-language radio programmes'.³⁴⁹ This seems

³⁴⁵ MC-PP, (issued by) Jeanne Bestbier, 'AIDS Unit Combats AIDS Ignorance with Education Programme for Teenagers', embargoed first use 30 March 1992, ref. number 13524/92/eb, p. 2.

³⁴⁶ *Ibid.*, p. 1. In another press release a Hunt Lascaris employee made similar comments noting 'This campaign may well serve as a model for other African countries. We all face the same challenge from the African AIDS pandemic. Hopefully, we can all start fighting back together.' See MC-PP, Bestbier, 'AIDS Unit Message on Schools Package...', p. 4.

³⁴⁷ *Ibid.*, p. 2.

³⁴⁸ MC-PP, Bestbier, 'AIDS Unit Message on Schools Package...', pp. 1 – 2.

³⁴⁹ *Ibid.*, p. 1.

to support the contention that the adolescents being targeted were from English-speaking communities and had access to their own radios. The programme was not properly targeted at 'black' or non-English speaking communities who primarily relied on the radio for their news and information.

Furthermore 'specialist journals targeted at the teaching community' were to carry adverts about the campaign.³⁵⁰ The AIDS Unit planned to send letters to school principals announcing the programme and describing the 'content and ethos' of specially prepared 'packs' that each school was to receive (figure 27).³⁵¹ The 'AIDS and Lifestyle Education Programme pack' contained 25 full-colour posters, quiz cards, a booklet, a video, and a manual as well as a standard letter to teachers and parents.³⁵²

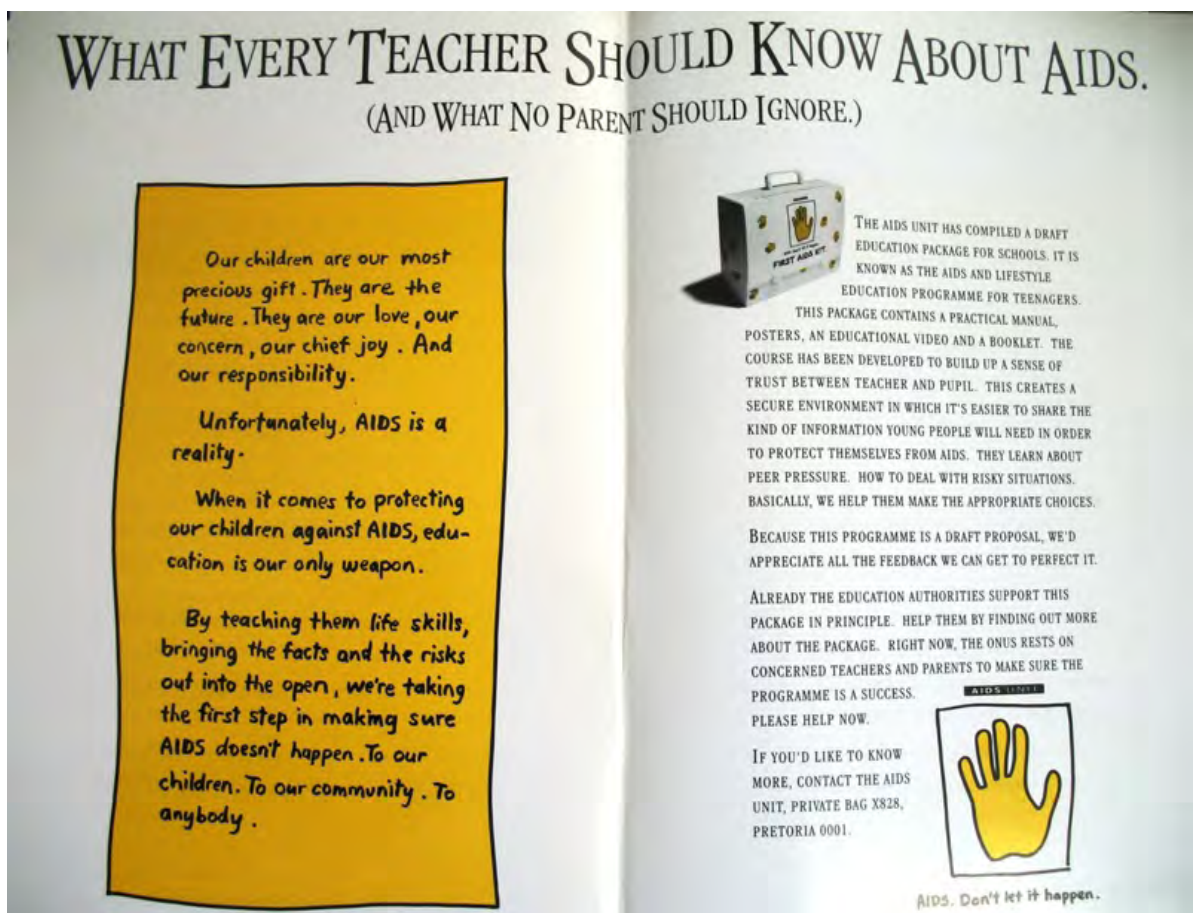


Fig. 27. Awareness Advert/Poster aimed at Teachers and Parents, 1992.

³⁵⁰ MC-PP, Bestbier, 'AIDS Unit Message on Schools Package...', p. 1.

³⁵¹ *Ibid.*, p. 2.

³⁵² An additional AIDS information package called the First AIDS Kit which contained information pamphlets and a video. Marais also noted that t-shirts and stickers were distributed as part of the campaign. *Hansard HA*, vol. 33, Tuesday, 28 April 1992, col. 5562 - 5565.

Supporting the campaign in parliament, J.A. Marais (NP) drew on an idealised notion of parental duty to protect children against the dangers of AIDS: 'We are very glad about our valuable treasures, namely our children, whom we want to look after ... When it comes to the protection of our children against Aids, education is our best weapon'.³⁵³ The notion of vulnerable children and a societal desire to protect children may have held (and still holds) as a shared myth, but then, as now, it reflects a vast difference between this ideal and the realities for the majority of children growing up in the world. There is a particular irony in this comment coming at a time when adolescents and youth were not treated as equal 'treasures' but rather ascribed varying 'value' determined by their 'race', class, language, gender, and political involvement. Ellis remarked that the programme would 'undoubtedly prove to be extremely important in combating Aids in this country'.³⁵⁴

The AIDS and Lifestyle Education Programme was not accepted uncritically by everyone in parliament. Snyman for example, dismissed not only the Lifestyle and Education Programme but the entire YHC.³⁵⁵ In the House of Representatives, R.T. Rhoda (NP) criticised the programme arguing that 'strategies to address the management of this unique disease are still evolving and many issues – political, legal, ethical, educational etc – remain controversial and unresolved'.³⁵⁶ Despite these criticisms, within three months of its launch, thirteen departments of education had requested the pack and 2 000 packs had been distributed to schools and received 'positively'.³⁵⁷

Reflecting on her time in office, Venter noted that while she was 'the *de facto* national minister of health', she was not 'the *de jure* national minister' because she was subject to the cooperation (or otherwise) of provincial authorities.³⁵⁸ The DoH was unable to compel other government departments at national, provincial and local level, including those mandated to provide health services, to implement health strategies.³⁵⁹ This lack of

³⁵³ *Hansard* HA, vol. 33, Tuesday, 28 April 1992, col. 5665.

³⁵⁴ *Ibid.*, col. 5503.

³⁵⁵ *Hansard* HA, vol. 33, Monday, 27 April 1992, col. 5385.

³⁵⁶ *Ibid.*, col. 7360.

³⁵⁷ *Hansard* HA, vol. 36, Tuesday, 16 June 1992, col. 1358 – 1359.

³⁵⁸ Interview with Rina Venter.

³⁵⁹ While there are no substantive archives for the ICA, it cannot have fulfilled its mandate given the lack of evidence of a cohesive inter-departmental response to AIDS.

intergovernmental cooperation undermined the implementation of any comprehensive health campaigns.³⁶⁰ The fragmented health system did, however, allow state-funded health authorities to implement innovative and more progressive responses to AIDS such as those developed at the Esselen Street public clinic in Hillbrow.³⁶¹

While Venter highlighted the distribution of pamphlets and the dissemination of ‘knowledge’ as key responses to AIDS by the DoH, there is a significant difference between providing information and ensuring that information is understood, interpreted, internalised, and engaged with sufficiently to become individual, public, or community ‘knowledge’. Providing information does not necessarily constitute ‘education’, but in many of the government responses there is an emphasis on ‘education’ as the crux of anti-AIDS programmes without much reflection on the way that ‘education’ and ‘information’ were conflated. For information to become internalised knowledge the means by which it is distributed, and the way in which the message is framed, must be relevant to the personal lived experiences of the recipients. Rhoda critiqued the DoH’s reliance on education policies centred on the message of prevention:

Education on its own ... is insufficient to effect sustained behavioural changes in the population, and the well-worn aphorism, “education is the only vaccine”, is simplistic and naïve. Without resources and opportunities to implement the required changes, knowledge and awareness are ineffective in engineering behavioural changes.³⁶²

Rhoda stressed the need to address poverty, over-crowding, migrant labour, womyn’s economic dependency, and other social and economic conditions. He referred to successful education campaigns in the USA that had resulted in behaviour modification, but they had been within ‘well-motivated and empowered populations’, presumably in contrast to much

³⁶⁰ This is not to imply that there was a comprehensive AIDS strategy, rather that, even if such a policy had existed its implementation would have been compromised.

³⁶¹ The Esselen Street clinic was funded by the City of Johannesburg health authority demonstrating the level of autonomy present in the system. For more on this see the chapters on NAMDA and on sexuality activists that refer to the Esselen Street clinic and the interesting AIDS-related work undertaken there.

³⁶² *Hansards* (HR), vol. 33, Tuesday, 12 May 1992, col. 7360.

of the South African population which had been living under segregation and apartheid for generations.³⁶³

For all the intimations about holistic responses to AIDS that had featured in DoH statements and publications, Rhoda's insightful comments reveal the inadequacy of a campaign that made no attempt to even acknowledge, let alone address, the structural issues in South African society that contributed to the spread of AIDS. The campaign failed to recognise that some schools were being burnt down or boycotted in political protests.³⁶⁴ Many others were severely under-resourced and would not have had electricity, let alone video machines to show AIDS education films. Schools were not necessarily safe places for pupils who faced the risk of sexual violence and rape from peers and teachers – contexts in which skills in negotiating condom use would have been useless.³⁶⁵ The constructs of 'the family' and familial relations in the campaign were idealised and assumed that parents and children lived together, and that parents were at home talking to their children and not away working. It assumed familial structures free of domestic or sexual violence.³⁶⁶ It was not a campaign that took into account the realities of South Africa in the early 1990s as Dr Ralph Mgiijima, the head of the ANC department of health, observed in 1992 'What does someone from the white suburbs of Pretoria know about the problems in Soweto?'³⁶⁷

As the following section demonstrates, it was these very same realities which confronted the first post-apartheid government in 1994 as it formulated policies to address AIDS in a democratic South Africa.

³⁶³ *Hansards* (HR), vol. 33, Tuesday, 12 May 1992, col. 7360 – 7362.

³⁶⁴ Beinart, *Twentieth Century South Africa*, p. 273.

³⁶⁵ See Jewkes, R., & Abrahams, N., 'The Epidemiology of Rape and Sexual Coercion in South Africa: An Overview', *Social Science & Medicine*, 55, 7, 2002 for an overview on rape in South Africa. Their findings in 1999 indicated that 'One third of rapes were perpetrated by school teachers and 21% by relatives', p. 1237. There is nothing to suggest that the situation was not comparable throughout the 1990s.

³⁶⁶ Human Rights Watch, *Report: South Africa - The State Response to Domestic Violence and Rape*, November 1995 available on the Human Rights Watch website at www.hrw.org/legacy/reports/1995/Safrica-wm-02.htm (accessed August 2012). The report noted that Rape Crisis in Cape Town stated that 'most of the women Rape Crisis sees are adolescents'.

³⁶⁷ Quoted in Sadie & Van Aardt, 'VIGS-Politiek', p. 95.

Phase Four: Democratic Ideals

While the DoH was busy restructuring the AIDS Unit and redefining the AIDS programme in 1992, a progressive, inclusive consultative process was already underway outside the corridors of government in the form of the 'National AIDS Convention of South Africa' and the resulting 'National AIDS Co-ordinating Committee of South Africa' (both referred to as NACOSA).³⁶⁸ This structure was more representative and incorporated the NGOs that had been at the forefront in responding to AIDS during the 1990s. McKerrow notes:

... the major contribution to the South African response to the epidemic during the early 1990s occurred in the non-governmental sector. Foremost amongst the various organisations which became increasingly active were the National AIDS Co-ordinating Committee of South Africa (NACOSA), the National Association of People with HIV and AIDS (NAPWA), Lawyers for Human Rights (LHR) and the AIDS Legal Network (ALN). NAPWA, LHR and ALN all played a crucial advocacy role with respect to both law reform and human rights. NACOSA not only created a networking forum, but more importantly pursued strategy development and implementation plans.

Equally important was the role of numerous organisations working with affected individuals and communities in prevention (PPHC National AIDS Programme), care and support.

The initial strengths of most of these programmes lay in the commitment of their staff, their grassroots contacts, their perceived legitimacy and credibility in comparison with state associated structures and their access to international support and funding.³⁶⁹

The ANC-led 'Government of National Unity' came to power in 1994, twelve years after the first official cases of AIDS in South Africa had been identified. Preparation for the political transition in 1994 saw the ANC move from addressing AIDS amongst ANC members, soldiers,

³⁶⁸ Note that depending on context and time NACOSA refers to both the 'National AIDS Convention of South Africa' and the 'National AIDS Committee of South Africa' which is also sometimes referred to as the 'National AIDS Co-ordinating Committee of South Africa'. The convention was held in 1992 to discuss how to address AIDS and brought together representatives from government, the progressive health movement, community organisations, other civil society organisations, and liberation organisations. The committee was formed at the convention to guide further discussions and plans to address AIDS nationally.

³⁶⁹ McKerrow, 'The South African Response', pp. 2 - 3.

and supporters living outside of South Africa, to addressing AIDS as a public health concern in 'the new South Africa'. Events like the Maputo Conference held in 1990 provided the groundwork and seemed to herald a new era of co-operation between political elites, the people they represented, medical professionals, NGOs, and other community-based organisations, generating optimism about how AIDS would be addressed in post-apartheid South Africa.³⁷⁰ Many of those who had been involved in the Maputo and Lusaka conferences and had supported the ANC and progressive health care movements in South Africa took an active part in the NACOSA process.³⁷¹

The National AIDS Plan (NAP) devised by NACOSA in 1994 formed the basis of the AIDS and STD plan adopted by the DoH in 1995, and was formally adopted as the country's National AIDS Plan in 1996.³⁷² The NAP retained a focus on education, stressing the need to instil an 'increase in general awareness of HIV and AIDS transmission throughout the South African population' through the development and implementation of 'comprehensive sexuality and sex education programmes for all'.³⁷³ The NAP acknowledged the continuing need to 'address fears and misconceptions about HIV transmission and its consequences', and noted that its education programme should incorporate 'an understanding of transmission'. This programme should be cognisant of the 'knowledge, attitudes, beliefs and practices relating to HIV/AIDS amongst the general public and specific target audiences'; consider the communication channels available for use by different target audiences; and assess the health and social support services available'.³⁷⁴

Rather than the 'high-risk group' narratives which blamed people for contracting and spreading AIDS due to something apparently 'innate' about their being from a particular geographic region, having a particular sexual orientation, or being a particular 'race', what is noticeable in the plan is the acknowledgement that diverse groups of people required specific HIV and AIDS education tailored to their particular needs and realities. To this end, the plan named seven 'main target groups' for HIV education: people most vulnerable to

³⁷⁰ For a fuller exploration of the ANC's response to AIDS see the relevant chapter in this thesis.

³⁷¹ For more on this see the chapters on the ANC in exile and on NAMDA.

³⁷² McKerrow, 'The South African Response', p. 4.

³⁷³ NACOSA, *A National AIDS Plan for South Africa, 1994 – 1995*, July 1994, p. 17.

³⁷⁴ *Ibid.*, p. 19

infection (listed as youth, women, long distance truck drivers, migrant and domestic workers, and illiterate persons); people marginalised in society (commercial sex workers, street children, gay and lesbian people, injecting drug users, people in informal settlements); people already in health care settings; people in education and training institutions; people in state/private institutions (including defence personnel, prisoners and civil servants); people in formal employment; and people who were influential.³⁷⁵ Helen Schneider observed that the importance of the NAP lay in ‘the participatory manner in which it was developed’ which involved ‘large numbers of people’.³⁷⁶ Clearly the broadening of participatory inputs from a diverse group of people explains the NAP’s recognition that a number of different education strategies were needed to maximise the reach of campaigns.

During 1994 the new health minister, N.C. Dlamini-Zuma (ANC) declared the DoH’s support for the NAP and the associated ‘National AIDS Strategy’ compiled by NACOSA. She affirmed boldly in parliament that the department ‘will implement it’, later repeating comments made by three previous health ministers when she asserted that the DoH understood that AIDS was a matter that ‘needed to be taken very seriously’.³⁷⁷

She later indicated that budgets to address HIV and AIDS would be increased and would include European Union funding. Money would be allocated to various projects: a national HIV and AIDS awareness campaign; the publication of AIDS information materials; the development of educational packages; a Red Ribbon campaign; supporting NGOs and ATICs to continue their work; HIV testing; and purchasing condoms.³⁷⁸ A year later she indicated that a school-based life skills programme was one of the DoH’s key strategies for 1995 – 1996, and that there had already been ‘successful negotiations with the Department of Education to introduce this into normal curricula’.³⁷⁹ Another strategy would be to call on

³⁷⁵ NACOSA, *A National AIDS Plan for South Africa*, p. 20.

³⁷⁶ Schneider, H., ‘On the Fault-line: The Politics of AIDS Policy in Contemporary South Africa’, *African Studies*, 61, 1, 2002, p. 146.

³⁷⁷ See *Hansard NA*, Interpellations, Questions & Replies, vol. 3, Tuesday, 2 August 1994, col. 37 -39; and *Hansard NA* vol. 2, Thursday, 20 October 1994, col. 3470-3471.

³⁷⁸ *Ibid.* The complete health budget can be found in more detail in NLSA, CTGC, SA Reports, Department of Health (hereafter DoH) Annual Report 1994, pp. 3 – 10.

³⁷⁹ *Hansard NA*, vol. 6, Monday, 19 June 1995, col. 2853. An earlier reference to school education and information programmes was made by B.M. Nzimande (ANC) noted in 1994 that ‘the Department of Health had

'the media to popularise key prevention concepts', consisting 'of messages such as the right to say no to sex, the right to say yes for one partner, non-discrimination against people with HIV virus [sic] and, of course ... the importance of condoms'.³⁸⁰ Many of the projects were, in essence, similar to projects that had been started in the 1990s, but would now be conceived, and shaped by post-1994 notions of consultation and collaboration, and would supposedly be forged in new democratic spaces.

In 1994 the DoH was restructured after a 'consultative, participatory and transparent process'. The aim of the department was

to promote the health of all South Africans and to create and support a caring, efficient, comprehensive national health system that involves and serves all individuals and communities in an equitable manner through a primary health care approach using professional and scientific means.³⁸¹

Addressing AIDS 'was identified as one of the 22 Presidential Projects'.³⁸² The fourth annual HIV survey among womyn attending ante-natal clinics had shown an increase in infection rates from the previous year.³⁸³ Discussions were underway with the department of education to include HIV and AIDS as aspects of the lifestyle education curricula.³⁸⁴ Education packages designed for AIDS trainers were launched and 'several training sessions' were held with 'professional (social workers, nurses) and other groups of people (truck drivers)', while the DoH also distributed 60 million condoms.³⁸⁵ There was now 'a NACOSA implementation working group' within the DoH's AIDS programme which was responsible for ensuring the implementation of the NAP.³⁸⁶

to join forces with the Department of Education to ensure that sex education is included as part of the school curriculum as soon as and as early as possible!' *Hansard NA*, vol. 2, Thursday, 20 October 1994, col. 3460.

³⁸⁰ *Hansard NA*, vol. 6, Monday, 19 June 1995, col. 2853

³⁸¹ NLSA, CTGC, SA Reports, DoH Annual Report 1994, p. 1.

³⁸² *Ibid.*, p. 11. The 'Presidential Projects' were key projects that were identified as requiring attention if the aims of the Reconstruction and Development Programme (RDP) were to be met. The RDP was the socio-economic policy framework that was meant to guide government programmes and ensure redress after apartheid.

³⁸³ *Ibid.*, p. 14, the percentage of womyn found to be HIV positive (with incomplete data sets) was 4,25% compared to 2,42% in the previous survey.

³⁸⁴ *Ibid.*, p. 19. The lifestyle education curricula was the forerunner of what is now referred to as 'life orientation skills' that teach pupils about manners, nutrition, basic health, road safety, managing finances etc.

³⁸⁵ *Ibid.*, p. 20.

³⁸⁶ *Ibid.*

The DoH annual report for 1995 was primarily concerned with explaining how the health sector was being restructured 'into a single national health system'.³⁸⁷ The report identified the leading causes of morbidity as 'tuberculosis, measles, malaria, parasitic and worm infestations and sexually transmitted diseases (including HIV/AIDS)', noting that 'the incidence of AIDS [had] shown a tenfold increase over the past five years' with 'approximately two million people infected'.³⁸⁸

AIDS was also reported on in an update on the presidential lead projects. The DoH had identified five key intervention strategies: 'life skills education targeted at youth in and out of school; mass communication strategies; increasing access to barrier methods; STD control and management; and the provision of appropriate levels of care and support for those infected or affected by HIV'.³⁸⁹ The report reviewed the status of each strategy: mass communication had been developed to the extent that billboards, posters, stickers and other media had been produced, and radio and television spots featuring people with AIDS (PWAs) and celebrities would be broadcast in December 1995.³⁹⁰ It also referred to the 'AIDS-related theatre production "Sarafina 2"', which had premiered in December and was scheduled to go on a twelve-month tour.³⁹¹ Allegations of secrecy and financial irregularities in the commissioning of 'Sarafina 2' would end up being the first AIDS-related scandal to hit the new government.³⁹²

During the first two years of the fourth phase, *Epidemiological Comments* continued to provide information and updates about AIDS and listed the number of AIDS cases by region, mode of transmission, sex and 'race'.³⁹³ It continued to carry information on international

³⁸⁷ NLSA, CTGC, SA Reports, DoH Annual Report 1995, p. i.

³⁸⁸ *Ibid.*, pp. 24 - 25. Infection rates were given as 770 daily.

³⁸⁹ *Ibid.*, p. 47.

³⁹⁰ *Ibid.*

³⁹¹ *Ibid.*

³⁹² For more on this see Johnson, K., 'The Politics of AIDS Policy Development and Implementation in Postapartheid South Africa', *Africa Today*, 51, 2, Winter, 2004, pp. 121 - 122 (accessed using JSTOR).

³⁹³ See *Epidemiological Comments*, 21, 1, January 1994, pp. 9 - 13, & 19; *Epidemiological Comments*, 21, 2, February 1994, pp. 40 - 41; *Epidemiological Comments*, 21, 3, March 1994, pp. 65 - 66; *Epidemiological Comments*, 21, 4, April 1994, pp. 90 - 91; *Epidemiological Comments*, 21, 5, May 1994, p. 108; *Epidemiological Comments*, 21, 6, June 1994, pp. 128 - 129; *Epidemiological Comments*, 21, 7, July 1994, pp. 153 - 154; *Epidemiological Comments*, 21, 8, August 1994, pp. 171 - 172; *Epidemiological Comments*, 21, 9, September 1994, pp. 200 - 201; *Epidemiological Comments*, 21, 10, October 1994, pp. 221 - 222; *Epidemiological Comments*, 21, 11, November 1994, pp. 246 - 247; *Epidemiological Comments*, 21, 12, December 1994, pp. 286

AIDS trends and conferences, and featured analyses of the results of HIV-serosurveys among womyn attending antenatal clinics. The 1994 survey worried Küstner: 'it is troublesome in the extreme to witness the continued exponential rise in HIV-infections which suggests that whatever training and education has been offered has not led to the absolutely essential behaviour changes among those who are at risk'.³⁹⁴

The entire November 1994 edition of *Epidemiological Comments* was dedicated to AIDS, and featured articles on World AIDS day; the global HIV and AIDS situation; national surveys in South Africa (including surveillance by blood transfusion services); and AIDS reporting in South Africa.³⁹⁵ It noted that the total number of AIDS cases for 1994 stood at 5480.³⁹⁶ Küstner's editorial, while concluding with the hope that the NAP would provide new impetus and new priorities, made a number of observations that remain germane to understanding AIDS in South Africa:

The evidence ... points incontrovertibly to its [AIDS] uncontrolled expansion worldwide and in South Africa. In response, the optimistic positivists pursue their activism, hoping against hope that education, information, conscientisation, empowerment, involvement, community participation, TV-programmes, radio-spots, comic strips, puppet shows, condoms, condoms, condoms [sic], and all the many other initiatives aimed at stemming the tide, will save the day. The pessimists withdraw in sullen silence, while the reflective transcendentalists keep on probing the basic dilemma [of whether HIV/AIDS is] a medical, social, anthropological, or other problem?³⁹⁷

- 287; *Epidemiological Comments*, 22, 1, January 1995, p. 20; *Epidemiological Comments*, 22, 2, February 1995, p. 45; *Epidemiological Comments*, 22, 3, March 1995, p.66; *Epidemiological Comments*, 22, 4, April 1995, p. 87; *Epidemiological Comments*, 22, 5, May 1995, p. 108; *Epidemiological Comments*, 22, 6, June 1995, p. 141; *Epidemiological Comments*, 22, 8, August 1995, p. 182; *Epidemiological Comments*, 22, 9, September 1995, p. 217; *Epidemiological Comments*, 22, 10, October 1995, p. 234; *Epidemiological Comments*, 22, 11, November 1995, p. 201; and *Epidemiological Comments*, 22, 12, December 1995, p. 234.

³⁹⁴ Küstner, H., 'Editorial', *Epidemiological Comments*, 21, 4, April 1994, p. 67 and 'Fourth national HIV survey of women attending antenatal clinics, South Africa, October/November 1993', *Epidemiological Comments*, 21, 4, April 1994, pp. 68 - 78. See also Küstner, H., 'Fifth national HIV survey in women attending antenatal clinics of the public health services in South Africa, October/November 1994', *Epidemiological Comments*, 22, 4, April 1995, pp. 90 - 100.

³⁹⁵ See *Epidemiological Comments*, 21, 11, November 1994.

³⁹⁶ *Ibid.*, p. 247.

³⁹⁷ *Ibid.*, p. 223.

Later Küstner drew attention to the results of the fifth national antenatal survey which showed a 3.2% increase in seropositivity between 1993 and 1994 and noted that 'HIV infection undoubtedly is increasing exponentially'.³⁹⁸ By October 1995 *Epidemiological Comments* listed the total number of AIDS cases in South Africa as 8 784.³⁹⁹

Some of the discussions about AIDS and AIDS programmes that occurred in parliament in 1994 and 1995 were continuations of discussions started in the mid-1980s. They included questions about notifiability; obtaining accurate information on infection rates and AIDS related deaths; the lack of a comprehensive disease-surveillance programme; the national antenatal surveys; the morality of condom distribution; expenditure on AIDS; and AIDS in prisons. From 1994 a narrative about health care provision grounded in a human rights discourse and focussed on primary health care became more prevalent in parliament. There was more recognition of the role played by NGOs in providing support to people with HIV and AIDS, and a concern about the future of those NGOs as new funding regimes came into play.

Discussions in parliament between 1990 and 1995 shifted from a focus on 'AIDS-infected migrant labourers' to a broader consideration of migrant labour and the conditions experienced by migrant labourers. The notion of 'the infected other' was never totally banished, even in a post-apartheid parliament: in 1994 Nzimande declared 'As we are talking now, our country is being inundated with refugees and illegal immigrants – several million from high-risk Aids areas'.⁴⁰⁰ During the same debate, Dlamini-Zuma referred to 'illegal aliens' and noted that 'there may be problems in that area ... and ... our health services may be inundated, but that is not within my jurisdiction. It is within the jurisdiction of the Minister of Home Affairs'.⁴⁰¹ For all the human rights discourses that began to feature in the new parliament from 1994, and despite the fact that the ANC had been exiled in other African countries, refugees and illegal aliens from 'high-risk Aids areas' were apparently already 'inundating' the health service.

³⁹⁸ Küstner, *Epidemiological Comments*, 22, 5, May 1995, p. 89.

³⁹⁹ *Epidemiological Comments*, 22, 10, October 1995, p. 234.

⁴⁰⁰ *Hansard* NA, vol. 2, Thursday, 20 October 1994, col. 3459.

⁴⁰¹ *Ibid.*

For all the democratic-decision making that had featured in the NACOSA process, the narratives of health care grounded in realising human rights, and the extensive detail of the NAP, the Mandela administration failed to prioritise AIDS, could not effectively implement the NAP, and did not significantly slow down new HIV infections or reduce the number of deaths from AIDS. Schneider notes that the 'AIDS Plan was a detailed, lengthy document, subsequently viewed as vastly overestimating the implementation capacity of the new government', and 'the implementation of the AIDS Plan rapidly became subsumed by the enormous tasks of government restructuring in the early post-1994 period'.⁴⁰²

Fourie summarised Marais' review of the Mandela administration's handling of the AIDS epidemic:

... although legitimacy became less of a problem for HIV and AIDS policy formulation, structural impediments within state structures, dissonance and a clear lack of capacity between different spheres of government (notably national and provincial government levels) led to the failure of the government to implement its policies effectively. The irony, according to [Mary] Crewe, is that although the new government did have a good inclusive and multifaceted AIDS strategy at its disposal in 1994, the structural impediments, together with the fact that South African society was in the midst of a fundamental social constitutional change, distracted policy implementers from adequately addressing this issue.

These problems were compounded by a government which became increasingly belligerent and defensive in the face of criticism.⁴⁰³

The participatory engagement between government and other sectors that had been a feature of the development of the NAP was not maintained. Schneider observes, 'in contrast to the period leading up to the change of government, there was little discussion or contact with the range of non-governmental AIDS actors regarding the implementation of an AIDS policy once the new government was in place'.⁴⁰⁴ Krista Johnson later reviewed post-apartheid policy:

⁴⁰² Schneider, 'On the Fault-line', p. 147.

⁴⁰³ Fourie, *Political Management*, p. 4.

⁴⁰⁴ Schneider, 'On the Fault-line', p. 147.

A long-term, effective response to AIDS in South Africa has been hampered by institutional constraints as a result of the legacies of apartheid, democratic restructuring, inappropriate and authoritarian patterns of political leadership, and the dominance of neoliberalism, domestically and internationally.⁴⁰⁵

Conclusion

Hayley Fletcher has argued that 'governmental responses to the AIDS epidemic have been inundated with contradiction, conflict and contestation'.⁴⁰⁶ This conclusion applies equally to government responses to AIDS during the last years of formal apartheid and the transition to democracy.

The contradictions are evident in the chasm between the rhetoric of successive ministers of health who identified AIDS as a serious problem, and the responses which they implemented, or tried to implement to address it. The responses of the apartheid era reveal an inability, or perhaps an unwillingness, to conceptualise programmes that would address AIDS as a national crisis, potentially affecting all South Africans regardless of their 'race', gender or sexual orientation. At the start of the post-apartheid era the AIDS plan did acknowledge AIDS as a national crisis affecting everyone, but the programmes could not be implemented.

⁴⁰⁵ Johnson, 'The Politics of AIDS Policy Development', p. 107. The author's understanding of the meaning of neoliberalism inferred by Johnson is that it correlates to the definition by Robbie van Niekerk of 'economic strategies and political objectives that privilege the market over the state, and call for (1) the diminishing of the economic influence of the state through privatization of state assets, (2) the state becoming a non-intervening regulator of economic relations between capital and labour, (3) the reduction in social support for the poor and unemployed received through social security and other non-market mechanisms in favour of labour market based strategies such as public works programs, and (4) the erosion of the concept of "public good" through an increased emphasis in social and economic policy on "individual responsibility" for social goods, such as health and education', see Van Niekerk, 'The Evolution of Health and Welfare Policies in South Africa', p. 361. For other work that includes commentary on AIDS policy during the Mandela administration see: Butler, A., 'South Africa's HIV/AIDS Policy, 1994-2004: How Can It Be Explained', *African Affairs*, 104, 417, October 2005; Fletcher, H., 'Conflict, Contradiction and Crisis: An Analysis of the Politics of AIDS Policy in Post-Apartheid South Africa', MA Thesis, Rhodes University, 2008; Marais, H., *Buckling: The impact of AIDS in South Africa 2005* (Pretoria, University of Pretoria, 2005); Mbali, M., 'HIV/AIDS Policy-making in Post-apartheid South Africa' in Daniel, J., Habib, A., & Southall, R. (eds), *The State of the Nation: South Africa 2003 – 2004* (Cape Town, HSRC Press, 2003); Schneider, 'On the Fault-line'; Schneider, H., & Stein, J., 'Implementing AIDS Policy in Post-apartheid South Africa', *Social Science & Medicine*, 52, 5, March 2001; Shisana, O., & Zungu-Dirwayo, N., 'Government's Changing Response to HIV/AIDS' in Everatt, D., & Maphai, V. (eds), *The Real State of the Nation: South Africa after 1990* (Interfund, *Development Update*, 4, 3, November 2003); and Van der Vliet, V., 'AIDS: Losing "The New Struggle"?' , *Daedalus*, 130, 1, Winter, 2001 (accessed using JSTOR).

⁴⁰⁶ Fletcher, H., 'Conflict, Contradiction and Crisis', p. i.

In phase one the apartheid government looked to do little more than allay 'white' fears by ensuring the safety of blood supplies and distributing basic public health information. While the AAG, with its exclusive membership of medical experts, was established in this phase its brief was essentially to observe a disease that seemed to offer little or no threat to 'ordinary' South Africans, restricted as it was believed to certain 'high-risk' groups on the fringes of society.

In phase two Van Niekerk reinforced the importance of biomedical expertise in addressing AIDS, but also opened ATICs and implemented a wider information and education campaign aimed at adults. However, during this phase the government's primary response to AIDS was focussed on using legislation based on fears about 'infected outsiders', to repatriate mineworkers in the face of labour protests during a period of economic uncertainty.

The first two phases were marked more by a series of reactions rather than the development and implementation of comprehensive policies or strategies. Both phases were characterised by moral conservatism which prevented open discussions about sex and sexuality. During phase three noticeable differences in the government's response emerged. A more comprehensive approach was developed, with, for example, the 1991 'Background and Strategy for AIDS Prevention' document and the Yellow Hand Campaign. And money was invested in AIDS research that was not exclusively laboratory-based. A new language emerged which for the first time talked about involving NGOs and communities and recognised the vital role of non-biomedical approaches. There was now, too, an apparent willingness to engage in conversations with children and parents about sex and AIDS.

Despite these achievements, the fragmented nature of apartheid bureaucracy and inadequate inter-departmental cooperation hampered the implementation of programmes. The priorities of the DoH, to the detriment of AIDS initiatives, were on the reform and restructuring of the health departments to align them with the new primary health care focus. Nevertheless, the changes during this phase may speak, in part, to Venter's personal beliefs and ideals, but they certainly do speak to the changing political landscape that made

it important for the NP to be seen to be adopting a reformist agenda no matter how politically expedient this may have been in reality.⁴⁰⁷

Venter maintains that the new AIDS strategy and structures, such as the ATICs, which could have been useful in a post-1994 context, were totally ignored after the political transition because they were associated with the NP and apartheid.⁴⁰⁸ She decided not to publicly involve herself with NACOSA out of a concern that her participation would be viewed as a political stunt, despite the fact that NACOSA was being funded by the DoH and department officials were actively involved in NAP discussions. She claimed that high-level officials from her department held talks about AIDS strategies with key ANC health leaders. In her assessment this involvement in addressing AIDS has been ignored by subsequent governments: in the sphere of 'health our important achievements and what we had changed were crossed out as if they didn't exist'.⁴⁰⁹

Sadie and Van Aardt, reflecting on government responses to AIDS from 1987 to 1992, claim that the ANC criticised the NP's AIDS information and education campaigns because they were designed by people who were 'not in touch' with the realities of life for the majority of South Africans and did not, therefore, transmit the right messages (see Phase Three above).⁴¹⁰ What Venter does not seem to have fully comprehended is that any programme or strategy originating from the NP, regardless of its merits or otherwise, would inevitably be viewed with suspicion and mistrust.⁴¹¹

The ANC refused to have any formal involvement with DoH AIDS advisory bodies or DoH-organised AIDS conferences, and was openly critical of the government's handling of AIDS.

⁴⁰⁷ Andersson and Marks noted in 1986 that an emerging international discourse on primary and community health care had been adopted by the DoH but that no real attempt had been made to actually give effect to this discourse. They noted at the time, 'There can be few countries where the rhetorical and ideological role of health care is so blatant.' See Andersson, N., & Marks, S., 'Apartheid and Health in the 1980s', *Social Science and Medicine*, 27, 7, 1988, p. 678.

⁴⁰⁸ Interview with Rina Venter.

⁴⁰⁹ Interview with Rina Venter. Venter is reported to have made similar claims in a news article from 2004, see Meyer, J., 'The Aids Plan that Never Saw the Light of Day', IOL News website, 10 October 2004, available on the IOL website at www.iol.co.za/news/south-africa/the-aids-plan-that-never-saw-light-of-day-1.223704#.UBIzOaDhqSp (accessed April 2011).

⁴¹⁰ Sadie & Van Aardt, 'VIGS-Politiek', pp. 94 – 96 (author's translation of original).

⁴¹¹ *Ibid.*

According to Sadie and Van Aardt, the ANC's main criticisms were that the government determined the agenda rather than discussing it, and invited the ANC to attend meetings but not to participate in policy formulation. The ANC was frustrated at the lack of community participation in the process and the composition of the AIDS Unit which was not deemed representative.⁴¹²

By the time Dlamini-Zuma became health minister during phase four, there were consultative, democratic processes in place that did result in a comprehensive and more holistic AIDS plan, and a clearly outlined strategy for its implementation, in the form of the NAP. However the plan was never effectively implemented because of capacity constraints and a national focus on reorganising the public service, including the various departments of health tasked with implementing the NAP.

A shared characteristic of all the phases was the importance accorded to medical experts, and the centrality of biomedical understandings in shaping government responses. In the first two phases the government almost exclusively made use of medical expertise via the AAG. In phase three there was a growing recognition of the importance of opinion from outside the purely medical and scientific communities. While the advice from experts from the humanities and social sciences arguably increased toward the end of phase three and into phase four, the ANC-led government drew on its existing relationships with progressive medical communities and health networks to shape its responses to AIDS.⁴¹³

The inter-party and inter-departmental disagreements and variances around responses to AIDS provide examples of contestations linked to government reactions to AIDS. Contestation was also evident in numerous sectors outside of formal governmental structures. As the chapter on the ANC in exile and the next chapter on progressive health movements show, there were alternative fora in which responses to AIDS were discussed. Throughout the phases but particularly during the NACOSA process, the discussions held in and amongst these and other sectors helped shape the NAP. In the post-apartheid context,

⁴¹² Sadie & Van Aardt, 'VIGS-Politiek', p. 96 (author's translation of original).

⁴¹³ See the chapter on NAMDA and the progressive health care movement.

non-governmental and civil society sectors, activists and citizens have continued to contest government responses to AIDS.

What was also similar across all the phases was that all the ministers of health drew on international standards and precedents in addressing AIDS. Regardless of whether or not the responses did meet international precedents, the ways in which responses, particularly those involving the distribution of condoms and sex education, were discussed in parliament were also similar throughout this period. The discussions almost always included debates about morality that were at odds with aspects of the various responses.

During all the phases much emphasis was placed on delivering information and educating the public, but the information provided and the content of the educational material was mediated by the social mores of the time. Both the discussions about the responses and the content of the information and education campaigns reflect varying degrees of sexism, racism, homophobia (or at least heteronormativity) and conservative morality.

For all the changes in public health education campaigns and government responses that took place they all essentially followed a similar behavioural approach seemingly inspired by the ABC (Abstain, Be faithful, Condomise [sic]) strategy. As Shari Dworkin and Anke Ehrhardt have suggested, it is perhaps because government responses to AIDS (both then and now) have not seriously interrogated or challenged gender roles and power-dynamics, critically considered the economic contexts in which people live, or proactively addressed the effects of population movement and migration, that they have had such little success in addressing AIDS.⁴¹⁴ As Mgijima noted when critiquing the apartheid government's AIDS programme in 1992 'What use is it to tell a person who does not have money for food or clothes to use a condom?'⁴¹⁵

⁴¹⁴ Dworkin, S. L., & Ehrhardt, A., 'Going Beyond "ABC" to Include "GEM": Critical Reflections on Progress in the HIV/AIDS Epidemic', *American Journal of Public Health*, 97, 1, January 2007. For other work that examines aspects of ABC campaigns see Heald, S., 'It's Never as Easy as ABC: Understandings of AIDS in Botswana', *African Journal of AIDS Research*, 1, 1, 2002; Deacon, H., Stephney, I., & Prosalendis, S., *Understanding HIV/AIDS Stigma - A Theoretical and Methodological Analysis* (Cape Town, HSRC Press, 2005); Hunter, M., *Love in the Time of AIDS: Inequality, Gender, and Rights in South Africa* (Scottsville, University of KwaZulu-Natal Press, 2010); and Robins, S., 'Sexual Politics and the Zuma Rape Trial', *Journal of Southern African Studies*, 34, 2, June 2008; Stein, J., 'HIV/AIDS Stigma: The Latest Dirty Secret', *African Journal of AIDS Research*, 2, 2, 2003.

⁴¹⁵ Quoted in Sadie & Van Aardt, 'VIGS-Politiek', p. 95.

CHAPTER FOUR: 'CROSSOVER COMMUNITIES' AND COUNTER NARRATIVES? NAMDA AND HEALTH ACTIVISTS RESPOND TO AIDS

... new forms of intervention and care in the health system were being developed in that era. There was a whole community of people who started looking at STIs as well and [they had] links to ... NAMDA-types of people - so there were these kinds of crossover communities.

Helen Schneider, 2008.¹

In South Africa government responses to Acquired Immunodeficiency Syndrome (AIDS) (particularly post-1994) have galvanised and mobilised people, organisations, and academics in waves of activism that have become the subject of academic study.² These waves of activism, with AIDS at their epicentre, were part of longer, older struggles around access to health care in South Africa. By the late 1980s and early 1990s, reactions to the 'illness' that was apartheid and struggles for more equitable and just health care had brought together from different professions and communities people who collaborated in challenging existing health structures or began preparing and planning for new ones. These collaborations also occurred around specific health concerns including, as Schneider notes, sexually transmitted infections (STIs).

Whether planning for health care systems for a post-apartheid context, or addressing STIs as a specific issue, the period was characterised by 'crossover communities' of people who moved between organisations and groups in their personal, professional, and political capacities. The networks and relationships built during this time, as well as the variety of methods employed in their struggles, and the principles that guided how they functioned and collaborated extended beyond the immediacy of the anti-apartheid struggle. In the spheres of sexuality politics and AIDS activism many of the mechanisms for engaging with

¹ Interview with Helen Schneider, WITS School of Public Medicine, Johannesburg, South Africa, 12 February 2008. Schneider is a medical doctor and an academic with specialist training in community health. At the time of the interview she was the Director of the WITS Centre for Health Policy, WITS University. She was appointed as a Professor to the School of Public Health, University of the Western Cape, in 2011.

² See for example Friedman, S., & Mottiar, S., 'Seeking the High Ground: The Treatment Action Campaign and the Politics of Morality' in Ballard, R., Habib, A., & Valodia, I., *Voices of Protest - Social Movements in Post-Apartheid South Africa* (Durban, UKZN Press, 2006).

the state around sexual orientation and AIDS, evolved from strategies employed by progressive organisations during apartheid.³ Relationships and networks forged during apartheid, continued to link activists, individuals and communities in the post-apartheid context, and were called upon, revived, or re-forged when organising around AIDS-related concerns.

Health care during the 1980s was not only fragmented and intimately bound to apartheid ideologies, but the two most influential medical organisations, the South African Medical and Dental Council (SAMDC) and the Medical Association of South Africa (MASA) were politically conservative.⁴ In this context, progressive health care professionals had to create communities in which to organise, challenge apartheid ideologies and structures, and address AIDS. From 1982, progressive, politicised medical professionals could join the National Medical and Dental Association (NAMDA), an organisation that formed part of a broader progressive health movement united by its opposition to apartheid.⁵

Drawing on the NAMDA archive and interviews with NAMDA members and supporters, this chapter discusses the formation of NAMDA and provides an overview of the association and its health priorities. The chapter examines when and how NAMDA started responding to AIDS, and what it provided in terms of 'counter-narratives' or alternative responses to AIDS. The chapter shows how members of NAMDA crossed over between numerous medical and political communities, tracing the contributions and legacies of individual NAMDA members to post-1994 AIDS research and government plans to address AIDS.

³ Mandisa Mbali clearly outlines this connection in relation to AIDS activism in her thesis, see Mbali, M., "The New Struggle": A History of AIDS Activism in South Africa, 1982 – 2003', PhD thesis, University of Oxford, 2009; while Edwin Cameron and Mark Gevisser note the historical importance of resistance in shaping sexuality politics and organisations in South Africa, see Gevisser, M., & Cameron, E. (eds) *Defiant Desire: Gay and Lesbian Lives in South Africa* (New York and London, Routledge, 1995), particularly the Introduction.

⁴ Writing in 1992, Taitz referred to the SAMDC as the 'all powerful' statutory controlling body of the dental and medical professions, and noted that 'MASA became associated with what were considered government views in a number of matters which had strong political overtones', Taitz, J. L., 'The Right to Health: Medical Treatment and Medical Law in South Africa', *South African Human Rights Yearbook*, 2, 1992, p. 170 and p. 172 (accessed using HeinOnline).

⁵ The use of the word 'progressive' in this thesis denotes the self-identified descriptor used by individuals and organisations that opposed apartheid and held a set of ideological beliefs that were grounded in notions of human rights, democracy, equality, and equitable wealth distribution. Progressive organisations and individuals often disassociated themselves from 'liberals' and ideological notions of liberalism.

Like MASA, NAMDA represented the interests of elite medical professionals, and both organisations were influential in South African and international medical fora. The two organisations, however, had little in common politically. From its inception, NAMDA openly declared its anti-apartheid stance. Through its publications and its relationship with anti-apartheid organisations and the African National Congress (ANC), it both influenced discussions about how health care systems would need to transform in a post-apartheid context, and created and shaped AIDS narratives. In contrast, MASA declared itself apolitical, did not align with anti-apartheid organisations and accepted the legitimacy of the apartheid government. MASA, through its publication the *South African Medical Journal (SAMJ)*, and its relationship with the government, cautiously raised discussions about possible changes in health care provision and helped create and shape hegemonic AIDS narratives in apartheid South Africa.⁶

While there is no equivalent NAMDA publication to MASA's *SAMJ*, there are NAMDA documents that show medico-scientific AIDS narratives existing parallel to the hegemonic narratives. The hegemonic AIDS narratives informed, and sometimes framed or overlapped with, the AIDS narratives evident in NAMDA publications. However, the NAMDA AIDS narratives differed in that they considered possibilities outside existing hegemonic understandings.

Key MASA and NAMDA members played roles in determining and influencing government AIDS policy both during and after apartheid. Members of the AIDS Advisory Group (AAG) belonged to MASA which advised the government on responses to AIDS, and contributed to the hegemonic AIDS narrative. Similarly, key NAMDA members were involved in working with the ANC Department of Health in exile, contributed to a more progressive AIDS narrative in published fora and at key events like the Maputo and Lusaka conferences, and played important roles in creating and implementing the first post-apartheid AIDS plan. Some NAMDA members were members of MASA, and held positions in government-funded research institutes or public health sectors, meaning that there were also crossovers

⁶ See chapter on AIDS narratives in the *SAMJ*.

between 'conflicting' communities in which people tried to use their positions to challenge or change existing spaces.

Progressive Health Care and the Formation of NAMDA

In its submission to the Truth and Reconciliation Commission (TRC) health sector hearing MASA admitted that it

... was so wrapped up in its white, male, elitist, educated, professional world as individuals and as a collective organisation and as part of a broader society from which doctors were drawn, that it failed to see the need to treat all people as equal human beings ... MASA allowed black and white people to be treated differently, and this is the form of human rights violations for which it stands disgraced.⁷

One of the most notorious cases of the complicity of professional medical organisations' with the apartheid regime relates to the death of Black Consciousness leader Steven Bantu Biko while in police custody in September 1977. Despite being examined by at least two district surgeons, Biko died of injuries sustained during days of police 'interrogation'. Initially neither the SAMDC nor MASA censured the surgeons concerned or held them in any way accountable for their actions.⁸ Biko's death, and the failure of the two most important professional health bodies to act deepened a growing political schism between the two organisations and politically conscientised, progressive, health care professionals.

From the late 1970s there emerged a new generation of medical students, health care professionals, doctors and scientists who, as Gerald Oppenheimer and Ronald Bayer note, 'saw themselves as a part of the broader struggle for liberation [and] began to confront the embedded racial biases of the medical care system'.⁹ Influenced by ideals of progressive health care provision and human rights, angered by the medical establishment's response to

⁷ *The Truth and Reconciliation Commission of South Africa Report*, 'Institutional Hearing: The Health Sector', vol. 4, ch. 5, 1998, pp. 145 - 146 available on the Department of Justice website at www.justice.gov.za/trc/report (accessed April 2011).

⁸ For a comprehensive summary of the role of SAMDC and MASA in the Biko case see *TRC Report*, 4, 5, pp. 112 - 113, & pp. 147 - 155.

⁹ Oppenheimer, G., & Bayer, R., *Shattered Dreams? An Oral History of the South African AIDS Epidemic* (Oxford, Oxford University Press, 2007), p. 17.

Biko's murder, and bearing witness to state repression and racism, a group of health care professionals formed NAMDA in Durban on 5 December 1982. The majority of NAMDA members were doctors and other health professionals who experienced both the fragmented and racialised public health system, and the consequences of anti-apartheid activities.¹⁰

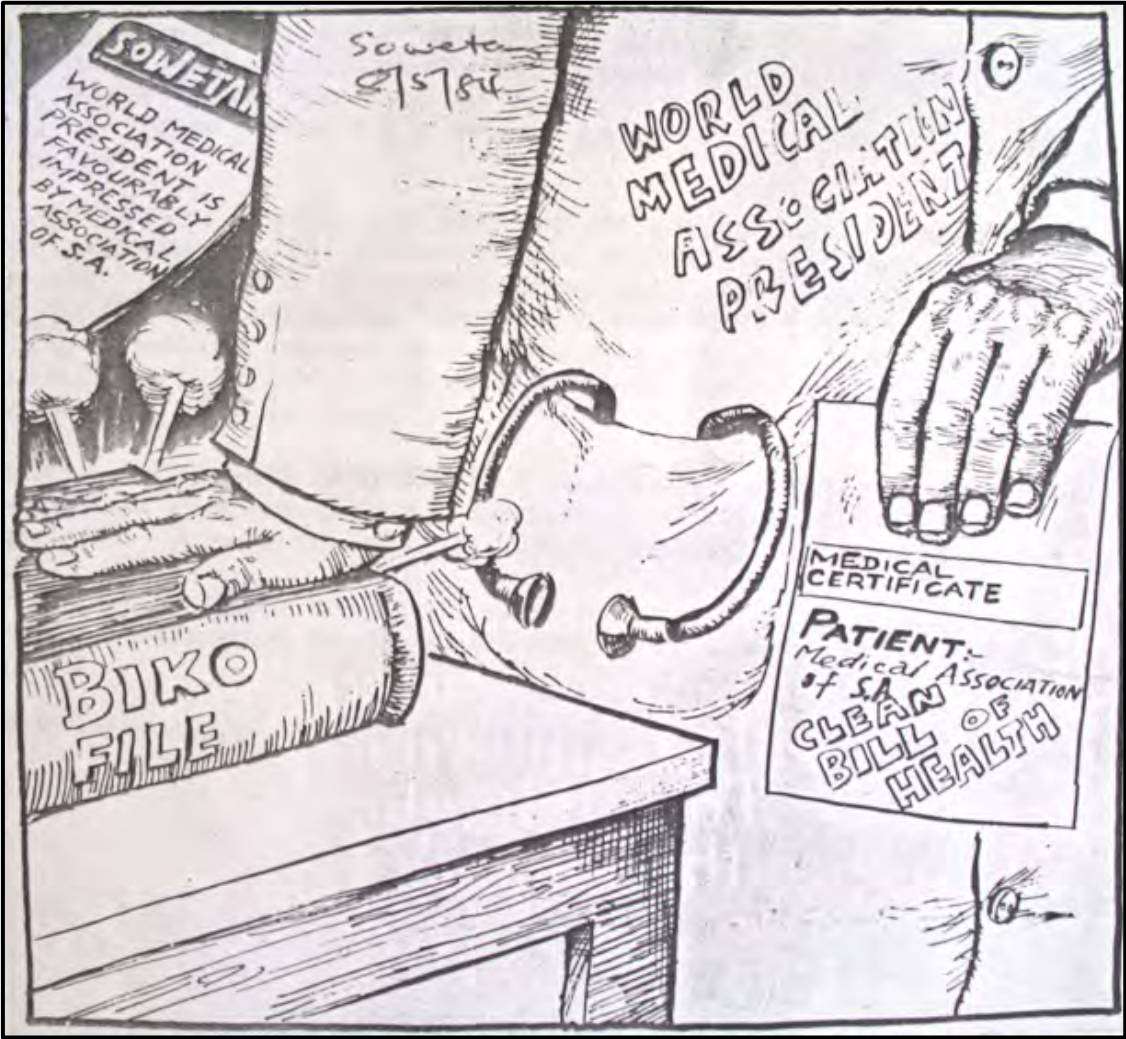


Fig. 28. Cartoon commenting on medical organisations' responses to the murder of Biko (Sowetan, 1984).

NAMDA was one of a number of progressive health organisations that worked together to form a loosely defined progressive health movement (PHM). The PHM included not just a

¹⁰ NAMDA members ranged from medical professionals who held positions in academic faculties or research centres, to students at medical schools. Such members influenced, and were influenced by, the socio-political and intellectual milieu of universities and teaching hospitals – particularly in relation to segregationist practices and the unethical engagement with health care within the health education system.

broad spectrum of health care professional (such as doctors, scientists and nurses), but also trade unions and labour organisations, academics, and community-based organisations.¹¹

Many of the health care professionals who joined these organisations were politically active, and were opposed to apartheid and its health care system. Narratives of freedom, equality and human rights influenced both the members and the organisations, and resulted in individual and organisational collaborations that constituted 'progressive health movements', and 'progressive health care workers'. Members and supporters of this movement came from a variety of backgrounds and professions and often contributed their expertise in an appropriate field. In some cases therefore, members crossed over from their usual 'community' and contributed to others. Some academics, in addition to publishing academic articles about health and apartheid, wrote papers that contributed towards understandings of progressive health care.¹²

As Shula Marks has shown, notions of, and experiments in, community-based primary health care in South Africa date back to the 1930s and were pioneered by people like Emily and Sidney Kark.¹³ The Karks, and the work they had done in Pholela, inspired new generations

¹¹ Other organisations and networks that comprised the PHM included: the Health Workers' Association (HWA), the National Emergency Services Group (NESG), the National Progressive Primary Health Care Network (NPPHCN), the National Health and Unity Forum (NHUF), the National Education, Health and Allied Workers' Union (NEHAWU), the Organisation for Appropriate Social Services in Southern Africa (OASSSA), the South African Health Workers' Congress (SAHWCO), and the South African Health and Social Services Organisation (SAHSSO). Some holdings for these organisations can be found in the South African History Archive (hereafter SAHA), NAMDA Collection (hereafter NC), AL3182. Comparative research into the types of responses to AIDS amongst, and within, these organisations is still needed.

¹² The NAMDA archival collection contains numerous papers on health care and apartheid drawn from a number of organisations. See, for example, SAHA, NC, AL3182, particularly A2.11, the Papers for the Centre for the Study of Health policy, WITS: Abdullah, F., 'The Demand for a National health Service', 1987; Buch, E., 'Health Services in the South African Homelands', c.1987; Coovadia, H., and Marks, S., various National Health Service papers from NAMDA Annual Meeting 1987; de Beer, C., 'The Health Sector - Definition, Description and Major Policy Debates', rough draft of discussion paper for joint ANC/COSATU Development Research Group (DRG) meeting, 4- 5 September c.1992; de Beer, C., 'The Role of the Health Worker in South African Society', undated; Dommissie, J., 'A Future Glimpse Towards Health and Health-Care in Post-Apartheid South Africa', University of Pittsburgh Seminar, 1986; Louw, G.M., 'Epidemiological Transition in the RSA - Implications for Primary Health Care', 1991; Mji, D., 'The Struggle for Health: The Struggle for Democracy', Institute for Social Studies Amsterdam, December 1986; Price, M., Steinberg, M., & de Beer, C., 'The New Constitution and Health', NAMDA Constitution Group, c.1983; Author Unknown, 'The Health Sector: Policy Positions and Organisational Developments', Paper for DRG meeting 3 - 4 December, date unknown; Variava, Y., 'A Perspective on Health Care in South Africa', date unknown; and Zwi, A., 'Piecing Together Health in the Homelands', Carnegie Conference Paper no. 187, UCT, (c.1983).

¹³ Marks, S., 'South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics', *American Journal of Public Health*, 87, 3, March 1997.

of students, like Mervyn Susser and Zena Stein who would become pioneers in epidemiology and public health and, in turn, as Mbali has shown, teach students who would play prominent roles in the post-apartheid health sector.¹⁴ These students included NAMDA members and supporters who drew on discussions about community-driven PHC, their personal and professional experiences, and liberation politics to shape NAMDA.

NAMDA defined itself as

an Association of Doctors, Dentists, Paramedicals and Students who share a common belief in:

A non-racial democratic South Africa.

Unitary non-racial health services and education.

The importance of the social causes of ill-health.

Health services and practice appropriate to the needs of all South Africans.

The value of collective action in pursuit of these deeds and goals.¹⁵

¹⁴ See Kark, S., *Promoting Community Health: from Pholela to Jerusalem* (Johannesburg, Witwatersrand University Press, 1999). Mbali, 'The New Struggle' especially chapter 2 on 'Progressive Healthworker AIDS Activism, 1982 – 1994' and p. 98. Zena Stein and Mervyn Susser are internationally renowned epidemiologists who were born in South Africa and then lived in the UK and the USA where they shaped the course of disciplines like epidemiology and public health, and engaged in extensive medical research. Both trained initially as medical doctors and then moved into epidemiology, driven by ideas of PHC and social justice. They maintained ties with progressive health organisations and professionals in South Africa throughout apartheid and continued to be involved in health in South Africa post-1994. Both have published extensively and received numerous international awards. Amongst her achievements, Zena Stein has held positions as the Director of the Epidemiology Research Unit in the New York State Psychiatric Institute; and been a professor of epidemiology at Columbia University's School of Public Health and Gertrude Sergievsky Center. She is also a Co-Director Emerita at the HIV Center for Clinical and Behavioral Studies at the New York State Psychiatric Institute and Columbia University. She is credited as being the founder of the field of reproductive epidemiology and published groundbreaking research on women and HIV. For more on Stein see the HIV Center for Clinical and Behavioral Studies at the New York State Psychiatric Institute and Columbia University website at www.hivcenternyc.org/people/zenastein-pb.html (accessed May 2012); the Columbia University Center for Bioethics website at www.cumc.columbia.edu/dept/bec/staff/stein.html (accessed May 2012); and Wilcox, A.J., & Stein, Z., 'A Conversation with Zena Stein', *Epidemiology*, 14, 4, July 2003 (accessed using JSTOR). Mervyn Susser has held positions at the University of Manchester and was the Chair of the Division of Epidemiology at Columbia University and the founding director of the Gertrude H. Sergievsky Center at Columbia that focuses on psychiatric, developmental and neurological epidemiology. For more on Susser see the Gertrude H. Sergievsky Center website at www.cumc.columbia.edu/dept/sergievsky/fs/susser.html (accessed May 2012); and Paneth, N., & Susser, M., 'A Conversation with Mervyn Susser', *Epidemiology*, 14, 6, November 2003.

¹⁵ SAHA, NC, AL3182, A1.4, 'A Guide to the National Medical and Dental Association (NAMDA) and an Invitation to Join', 1986, p. 1.

Membership of the organisation was open to medical professionals and students as part of a strategy that relied on 'organising along occupational lines', but encouraged collaboration with 'other organisations fighting for a more just society'.¹⁶ Members were permitted to belong to other professional medical organisations, like MASA, but could not hold office in those organisations. Executive members of NAMDA included Dr Diliza Mji (who was president of NAMDA), Dr Barry Kistnasamy (who held executive positions and later represented NAMDA at the TRC special sector hearings), Dr Salim (Slim) Abdool Karim (who was assistant general secretary of NAMDA), Prof. Hoosen (Jerry) Coovadia, and Dr Mvuyo Tom (chairperson of the active Southern Transvaal regional branch and then NAMDA vice-president).¹⁷

NAMDA had small local committees or branches within different regions, and a national executive committee (NEC).¹⁸ By 1988 ten local branches or regions addressed both local and national health issues. National concerns and policy positions were determined at annual general meetings (AGMs), while the NEC managed affairs between AGMs. During the 1980s key areas of concern at both national and regional level included 'the [state of] emergency, the medical needs of detainees and unrest victims, and apartheid in the health services'.¹⁹

To address these concerns, NAMDA set up 'Emergency Services Groups' that trained volunteers from 'communities affected by violence' in first aid; established medical panels where NAMDA members provided medical services to released detainees; drew up guidelines for ethical behaviour for health professionals dealing with victims of political unrest; opposed existing apartheid health structures; and discussed alternative national health structures.²⁰ NAMDA declared its primary aim to be 'promot[ing] the attainment of

¹⁶ 'A Guide to ... NAMDA', p. 1.

¹⁷ Dr Mvuyo Tom is currently the Vice Chancellor of Fort Hare University in the Eastern Cape and a member of Higher Education South Africa (HESA). He also served as Director General of the Provincial Government of the Eastern Cape. Attempts to secure a personal, e-mail, or telephonic interview with Dr Tom were unsuccessful.

¹⁸ NAMDA regions included the Durban, Southern Transvaal, and Eastern Cape regions. Local branches included the Border, Durban Dental, Durban Medical, Midlands, North Eastern Transvaal, Port Shepstone, Qwa Qwa, Western Cape Dental and Western Cape Medical branches. For details on branch and regional activities see SAHA, NC, AL3182, A1.3.16, 'NAMDA Annual Reports' particularly for 1987/88, 1988/89, and 1989/90.

¹⁹ 'A Guide to ... NAMDA', pp. 1 - 2.

²⁰ *Ibid.*, pp. 2 - 3.

HEALTH-FOR-ALL within a unitary democratic South African state', acknowledging that it sought 'to develop a broad perspective on medicine and society in the specific conditions prevailing in southern Africa' that included 'changes in the social perspective of health and disease in Southern Africa'.²¹

NAMDA attempted to meet its goals not only through practical responses such as workshops, but also 'through research into and exposure of the health consequences of the political and economic system in South Africa'.²² The NAMDA archives show that its members constantly reflected on the organisation's composition and role in South Africa as the political landscape changed. Particular areas of concern were the elite nature of its membership, and how the organisation could best serve and mobilise that membership, while also contributing towards developing a less elitist, more democratic, health care sector.

NAMDA organised a meeting in April 1987 that was open to all health care workers who rejected apartheid and shared a desire to establish democratic primary health care services in South Africa. This meeting resulted in the formation of the the National Progressive Primary Health Care Network (NPPHCN) in September 1987.²³ While NAMDA was one of the organisations in the network and its members could be elected onto NPPHCN committees, the NPPHCN had its own national and regional structures and pursued its own agenda. This allowed both NPPHCN and NAMDA members to be involved in a broader structure that formed part of the progressive health movement.²⁴

The NPPHCN 'emphasised community accountability, comprehensive health care and ensure[d] that health workers use[d] their knowledge and skills to service the needs of the disadvantaged'.²⁵ Quarraisha Abdool Karim, noted that organisations like NAMDA and the

²¹ SAHA, NC, AL3182, A1.4, NAMDA Policy Statement pamphlet, n.d.

²² SAHA, NC, AL3182, A1.4, NAMDA document, 'Why NAMDA Was Started', n.d., p. 1.

²³ Note that the NPPHCN is also referred to as the Progressive Primary Health Care Network (PPHCN).

²⁴ Author Unknown, 'A Brief History of the National Medical and Dental Association (NAMDA)', *Critical Health*, 25, December 1988, p. 64.

²⁵ Truth and Reconciliation Commission, *Human Rights Violations – Health Sector Hearings*, Cape Town, 17 - 18 June 1997, Day 2, NAMDA Submission, transcripts of the hearing available on the Department of Justice's website at www.justice.gov.za/trc/special/index.htm#hsh (accessed April 2011).

NPPHCN allowed doctors and scientists to get involved with multiple communities (professional, activist, grassroots) directly, but achieved this in different ways. She preferred working with the NPPHCN 'because it was all encompassing across different health sectors', while 'NAMDA was seen as elitist in only including dentists and clinicians ... I wasn't either category, but as a molecular biologist I found a more appropriate home in the NPPHCN which cut across health sectors and wasn't a professional organisation but was really about delivery and a better understanding of health care'.²⁶ For her however, this difference did not result in a polarised relationship or a dichotomy between the NPPHCN and NAMDA, but rather in members wearing 'many different hats' within the movement.²⁷ The relationship was not confrontational, but rather one where different communities provided different things while working towards a common goal:

The function of NAMDA was more at a political policy level ... The NPPHCN on the other hand was more of an implementation body and ... the body that pulled many disparate bodies together. So it was the only body that brought SAHWCO [the South African Health Workers' Congress] and NAMDA together. NAMDA itself didn't 'do' – it was a thinking body not a doing body, whereas the NPPHCN ... was more about what that [policy meant] in terms of programmes and at a practical level.²⁸

Jerry Coovadia corroborated this understanding of the primary function of NAMDA: while it 'became part and parcel almost of the UDF, part and parcel of the broad liberation activities', and worked on as many fronts as possible to support the struggle, it also performed a 'thinking' function.

So it was both grassroots, participating in the political struggle, assisting in health-related issues and so on, and then, secondly, determin[ing] an ideological framework within which we could formulate our own policies and also use that as a counter-point to the deficiencies of apartheid medicine.

So we continually exposed, in a 101 ways, all the defects and all the tragedies of apartheid healthcare. And I guess ... many of us, wrote or did what we were good at, to expos[e] that. We did that and then mobilized internationally [ensuring]

²⁶ Interview with Quarraisha Abdool Karim, CAPRISA, UKZN, Durban, South Africa, 19 November 2007.

²⁷ *Ibid.*

²⁸ *Ibid.*

quite a lot of support from solidarity groups ... where the anti-apartheid movement was strong.²⁹

Salim Abdool Karim noted that although NAMDA originally started out in response to the government's 'negative approach to health care and the way it dealt with the Biko issue ... it grew rapidly beyond that'.³⁰ He considered the 'elite' nature of NAMDA to have been a good mobilising point, and one with unexpected consequences. NAMDA's

... strength was that it attracted the general practitioners (GPs) in a big way, they were a big part of the organisation. In fact, the private practitioners outnumbered the hospital doctors in the organisation for quite a while. It attracted GPs because of their disillusionment with MASA [and] MASA's failure to deal with Tucker and Lang set the foundations for us to attract them. Not that they were necessarily political, they were just so disgusted at what happened and many of them had no personal connection to Black Consciousness or to Steve or to anything, they just saw it as a violation of rights that they couldn't condone and their organisation shouldn't condone.

So I think it was quite a powerful move for us to capitalise on this and create this movement. Its ideologies were largely driven by academics and activist academics, so although the bulk of the membership were GPs the actual office bearers were ideologues and the people driving it were quite serious political heavyweights and the membership was happy to support that.³¹

These organisations and their members created a variety of interconnected communities. Individuals moved between organisations, new communities were forged, and new opportunities for mobilisation were created. With these crossovers, personal convictions and political ideologies could be altered, strengthened or articulated within a broader 'progressive' narrative.

²⁹ Interview with Hoosen M. 'Jerry' Coovadia, CAPRISA, UKZN, Durban, South Africa, 20 November 2007. The UDF (United Democratic Front) was a coalition formed in 1983 that brought together community groups from a variety of sectors (including church groups, students groups, labour groups, grass-roots organisations, and women's groups) to organise against apartheid. The UDF maintained close links to the ANC and other anti-apartheid liberation organisations. For more see Beinart, W., *Twentieth-Century South Africa* (Oxford, Oxford University Press, 2001) pp. 251 - 252.

³⁰ Interview with Salim (Slim) Abdool Karim, CAPRISA, UKZN, Durban, South Africa, 19 November 2007.

³¹ Interview with S. Abdool Karim. Tucker and Lang were the two doctors called to see Biko prior to his death.

By 1989 NAMDA's contributions to the health sector were made, according to a discussion document written by the Southern Transvaal NAMDA branch, on an intellectual, organisational, and service level.³² NAMDA sub-committees were organised around a number of issues: occupational health; the rehabilitation and health care of detainees; and the identification of health problems in rural communities and those that had experienced forced removals. There were sub-committees responsible for producing newsletters to publicise NAMDA activities, and for researching, writing about, and reassessing medical education in South Africa in light of emerging community-based ideals.³³ NAMDA had sub-committees tasked with preparing documents on health legislation before parliament and building international networks.³⁴

Compared to MASA's 14 000-strong membership, NAMDA had a relatively small membership that peaked at around 1 000, but it maintained a strong national and international presence.³⁵ NAMDA representatives participated in international conferences and raised awareness about apartheid and health in international fora and used international connections to campaign against MASA's membership of the World Medical Association (WMA).³⁶

NAMDA 'built a powerful support network at an international level' and had links with both the Committee on Health in South Africa (CHISA), headed by Mervyn Susser, and the American Association for the Advancement of Science (AAAS). NAMDA built relationships with anti-apartheid and progressive health groups in Australia, Canada, and Europe, and had

³² SAHA, NC, AL3182, A1.4, NAMDA document, STVL NAMDA Branch, 'The Role of NAMDA in the Health Sector', 29 August 1989, pp. 3 – 4.

³³ This is often referred to in the literature by the acronym CBME.

³⁴ 'Why NAMDA Was Started', pp. 1 – 2.

³⁵ 'A Brief History of ... NAMDA', p. 66.

³⁶ SAHA, NC, AL3182, A1.4, NAMDA document, 'Why NAMDA?', c.1988/89, pp. 9 – 11. Note that MASA dedicated an entire supplement in the *SAMJ* to countering statements made by NAMDA see 'Statements made in the USA by the President of the National Medical and Dental Association (NAMDA) regarding the MASA and health services and conditions in the RSA', *SAMJ*, 72, 2, 18 July 1987. There was also a flurry of correspondence in the *SAMJ* between September and November 1987 on the topic of MASA and NAMDA – see 'MASA and NAMDA', *SAMJ*, 72, 5, 5 September 1987; *SAMJ*, 72, 6, 19 September 1987; and *SAMJ*, 72, 9, 7 November 1987. By 1990, the *SAMJ* was carrying information on the NAMDA conferences, see '7th Annual National NAMDA Conference', *SAMJ*, 77, 11, 02 June 1990. See 'Why NAMDA Was Started', pp. 1 – 2.

'informal associations with UNICEF and other international agencies'.³⁷ It became internationally recognised as the legitimate voice of progressive medical professionals, resulting in it receiving funding from international aid organisations and foreign governments.³⁸

In 1989 Mencer D. Edwards, of the National Minority AIDS Council in the USA, delivered the keynote address at the NAMDA conference and spoke about responses to AIDS.³⁹ Susser and Stein, who had influenced key NAMDA members and supporters, maintained contact with anti-apartheid health workers and organisations, and highlighted the importance of AIDS to progressive health movement members.⁴⁰ Susser delivered the keynote address at the 1990 NAMDA conference in his capacity as both an academic at Columbia University and as the President of CHISA, and included a section on AIDS in his address.⁴¹ Susser's and Edwards' involvement at NAMDA conferences (discussed in detail below) reveal the extent of NAMDA's international connections, and show that knowledge about AIDS was being shared with NAMDA members by international supporters directly involved with AIDS research or education and international progressive health organisations.

The Politics of Health - NAMDA, the Government, and the ANC

NAMDA's political profile and anti-apartheid convictions were sufficient for it to be mentioned in parliament at least five times between 1987 and 1989. In 1987 J.J. Vilonel, National Party (NP) linked NAMDA to the ANC and described it as '... much more of a

³⁷ 'A Brief History of... NAMDA', p. 62. CHISA was a US-based organisation that opposed apartheid and drew its members from liberal, progressive, or left-wing health care workers in the USA and, to a lesser degree, from exiled anti-apartheid activists who were medical professionals. CHISA was one of the primary organisers and funders of the Maputo Conference.

³⁸ TRC *Health Sector Hearings*, Day 2, NAMDA Submission, evidence given by Barry Kistnasamy.

³⁹ SAHA, NC, AL3182, Keynote Address by Mencer D. Edwards, executive director, National Minority AIDS Council, Washington, DC to the 6th Annual National Conference of the National Medical and Dental Association of South Africa, delivered May 12, 1989, Johannesburg, South Africa.

⁴⁰ Mbali, 'The New Struggle' especially chapter 2 on 'Progressive Healthworker AIDS Activism, 1982 – 1994' and p. 98.

⁴¹ 'NAMDA Annual Report 1989/90', p. 20.

political organisation than a medical association'.⁴² Helen Suzman, Progressive Federal Party (PFP), however, publically defended NAMDA and challenged Vilonel:

...if it were not for Namda [sic] the disgraceful behaviour of the two doctors who failed to treat Steve Biko in a proper manner would never have been brought to light by the Medical Council itself, neither would they have been punished. It was entirely due to the efforts of Namda that this did happen, and the hon. member can label it political or whatever he likes - I call it justice, long delayed justice.⁴³

A year later W.J. Snyman, Conservative Party (CP), declared NAMDA an undesirable organisation, and condemned

the dreadful way in which health services are being abused in South Africa by subversive elements, whose objective is to overthrow the existing order. A relatively apolitical, neutral sphere of life like health services is, in my opinion, being blatantly exploited in a subtle way by revolutionary elements such as Namda [sic].⁴⁴

The NP's position on NAMDA was articulated in 1989 when Health Minister W.A van Niekerk (NP) declared that 'there is very little doubt that Namda [sic] is a front organisation of the ANC'.⁴⁵

NAMDA did have a long-standing association with the ANC and the Mass Democratic Movement (MDM) which ensured the attention of the apartheid state. NAMDA's offices in Port Elizabeth were 'burgled' in 1988; security police raided its head office in Durban in 1989; and Jerry Coovadia's house was firebombed.⁴⁶ Despite this, members did meet with various ministers of health, both officially as NAMDA representatives, and unofficially as

⁴² *Hansard* (House of Assembly, hereafter HA), vol. 18, Wednesday, 19 August 1987, Appropriation Bill, col. 4060. Vilonel also quoted from a publication from an international conference, presumably on apartheid and health, held in Amsterdam in 1986: 'The formation of Namda [sic] heralded a new era in the history of professional organisations. Unlike Masa [sic] the aims of the body were not concerned primarily with the interests of doctors but with highlighting the broader socio-political issues of health and apartheid - how apartheid breeds disease and the need to get involved in the day-to-day health struggles of the victims of apartheid which range from community issues and trade union work up to direct political activities'.

⁴³ *Hansard* HA, vol. 18, Wednesday, 19 August 1987, Appropriation Bill, col. 4084.

⁴⁴ *Hansard* HA, vol.3, Monday, 18 April 1988, col. 6141.

⁴⁵ *Hansard* Public Committee on Health and Population Development, vol. 11, Wednesday, 19 April 1989, col. 5843.

⁴⁶ For NAMDA statements on the burglary and raid see SAHA, NC, AL3182, A1.6, NAMDA Press Statements, 'Press Statement on Burglary in P.E. Offices', 13 April 1988; and 'NAMDA Press Statement', 10 May 1989.

medical professionals. In 1989 a NAMDA delegation met with Van Niekerk to discuss the health care needs of detainees, while in the early 1990s Salim Abdool Karim and Coovadia, in their capacity as employees of the Medical Research Council (MRC), met with Health Minister Rina Venter to discuss measles vaccines.⁴⁷

In October 1989 NAMDA met with the ANC in Harare. The meeting opened with an unnamed ANC representative noting that 'NAMDA had an important role to play in bringing health professionals into an alliance with the broad anti-apartheid forces', and that the 'organisation of doctors and dentists [was] crucial both for the struggle and for the post-apartheid period'.⁴⁸ Mji, in his opening address as NAMDA president, 'emphasized that unlike other delegations, NAMDA had not come merely to test the views of the ANC on the future, but to work out and consolidate common positions and perspectives on various issues'.⁴⁹

The remainder of the meeting included discussions on unity in the health sector; the ANC position on negotiations; academic and cultural boycotts; a national health service; the relationship between state and homeland medical structures and how these should be transformed; pharmaceutical and drug policy; compulsory community service for doctors; and a report back from a commission on AIDS. While the ANC supported NAMDA's elitist membership of doctors and dentists it noted that 'one of the important roles for NAMDA

⁴⁷ SAHA, NC, AL3182, A1.5.1, NAMDA News, 'Delegation Meets Minister of Health', *NAMDA News*, 3, 2, June 1989, p. 1. Salim Abdool Karim recounted how he and Jerry Coovadia, in their professional capacities while at the Medical Research Council, had written a very critical piece about Rina Venter regarding measles vaccinations. Shortly thereafter Abdool Karim and Coovadia were contacted by Venter's assistant who arranged for them to travel to Cape Town to meet with Venter. She asked Coovadia and Abdool Karim to explain their concerns more fully and suggest solutions to address the situation. They explained that a lack of fridges in clinics meant that the measles vaccines used for infant immunisation were becoming inactive and that more fridges were needed. Venter's Director General was also present at the meeting and Abdool Karim said that their concerns appeared to be taken seriously (although it is unclear if any action was taken). Abdool Karim remarked, ironically, that by the late 1990s and early 2000s the new government (under Mbeki) 'just would not have a parastatal (like the MRC) attacking the Minister' and that 'this government doesn't bear that kind of comment'. The MRC is a parastatal started in 1969 and is responsible for co-ordinating medical research in the country and undertaking research according to identified national health priorities. See the Medical Research Council website at www.mrc.ac.za (accessed March 2012).

⁴⁸ SAHA, NC, AL3182, A1.3.13, Report, NAMDA-ANC Meeting, 21 – 22 October 1989, p. 1.

⁴⁹ *Ibid.*, p. 2.

[was] to engage the Afrikaner and White [sic] sectors where most of the doctors and dentists [were] and thereby broaden its base'.⁵⁰

NAMDA's relationship with the ANC was such that the NEC of NAMDA was invited to consult with Nelson Mandela prior to his release from prison January 1990. Mji described this as recognition of NAMDA's contribution to the liberation movement and the 'cause of freedom', and as confirmation that NAMDA had 'firmly entrenched [it]self in the MDM'.⁵¹ In 1990 NAMDA worked with the ANC to organise the Maputo and Lusaka conferences. Ahmed Kathrada from the ANC's Information Division gave the keynote address at the 1990 NAMDA conference.⁵²



Fig. 29. NAMDA Conference Proceedings 1985, 1986 & 1990.⁵³

NAMDA was clear that health was neither apolitical nor neutral, and that all aspects of health in South Africa required rethinking. Its conference proceedings included papers identifying and attempting to address existing barriers to health in South Africa, commentaries on dominant health care concerns, and reflections on the current and future roles of health care professionals (figure 29). There were papers directly equating the

⁵⁰ SAHA, NC, AL3182, A1.3.13, Report, NAMDA-ANC Meeting, 21 – 22 October 1989, p. 5.

⁵¹ SAHA, NC, AL3182, A1.3.16, NAMDA Annual Report 1989/90, Presidential Address, March 1990, p. 1.

⁵² See SAHA, NC, AL3182, A1.8.1 'NAMDA Conference Proceedings', 7th National Annual Conference, 1990, pp. 3 – 8.

⁵³ SAHA, NAMDA Collection, AL3182, A1.8.1, Conference Proceedings 1985, 1985 & 1990.

struggle for health with the struggle for democracy, and others that examined the history of efforts to establish a national health service, and the relationship between health professionals and human rights.⁵⁴

NAMDA and AIDS

These topics remained the core concerns of NAMDA and other progressive health movements throughout the 1980s as the focus remained on the political issues at hand, the urgency of the struggle and the need to deal with the effects of apartheid on people's health. Discussions about these topics occurred at conferences, at AGMs, at regional and branch level, and were published in articles and research papers by members and sympathetic academics. In this context, engagement with the new syndrome known as AIDS, and later the HI virus, was not a priority for NAMDA or the PHM more generally, especially as it was primarily associated with a gay minority.

Janet Giddy and Steve Reid are two medical doctors who briefly lived in Durban in the mid-1980s before spending ten years at a rural hospital in Zululand. Both were involved in the UDF and were members of the Durban branch of NAMDA. Giddy reflected on the priorities of NAMDA during this period: 'I don't think NAMDA had any interest in AIDS whatsoever at that time. There was no mention of it in meetings – it was not on the agenda at all. None of us took it seriously - in our daily work it wasn't an issue'.⁵⁵

Reid emphasised other priorities: the 'State of Emergency and chaos in the country' resulted in ongoing violence and 'the townships [being] effectively sealed off'. Reid and Giddy recalled that the priorities for NAMDA were to provide care to those wounded in the

⁵⁴ For more detailed information see SAHA, NC, AL3182, A1.8.1 'NAMDA Conference Proceedings', 1985, 1986, 1987, 1989 & 1990. Historian Shula Marks delivered the keynote address, entitled 'The Historical Origins of National Health Services', at the 1987 NAMDA Conference. Other topics included: detention and the health needs of detainees; 'unrest' injuries such as bullet wounds, ocular injuries, maxillo-facial injuries and the effects of tear gas; violence and health care; the effects of oppression on children's well-being; mental health care; and occupational health concerns relating specifically to workers, including miners. Other papers explored health care (or the lack thereof) in the homelands; community health; fragmented health services; privatisation versus nationalisation of health care; health care expenditure; multinationals and medicine; and economic and academic sanctions.

⁵⁵ Interview with Janet Giddy & Steve Reid, Giddy & Reid's Residence, Hillcrest, South Africa, 19 November 2007.

townships, and to teach people how to treat wounds so that they would not have to risk arrest at hospitals. Reid observed, 'the mid-1980s was coloured by the political situation' and everything else, including AIDS, 'was superseded by all the violence'.⁵⁶ Giddy reiterated this point: 'NAMDA concerns were all about emergency medical treatment and care - bullet wounds, stabbed abdomens, gunshot wounds – [those were] the medical issue of concern. How do you keep people who were shot in the townships alive who can't get to hospitals? That [was] all as far as NAMDA and medical issues went'.⁵⁷

In addition to the primacy placed on more immediate health concerns, the personal awareness of AIDS (or lack thereof) among NAMDA members or supporters shaped the response of the organisation and the progressive health movement more generally. Jerry Coovadia admitted:

..when it came to AIDS, well I was the Head of Department for Paediatrics. My problems were malnutrition and TB - so I read about this and I thought, like every other denialist, ... is this a problem for me? I thought it's a white, male, American problem - I don't give a shit about what happens ... I've got enough problems, you know! And I was really wrong... by the late '80s we saw our first few children with AIDS and it wasn't difficult to recognise.⁵⁸

Quarraisha Abdool Karim worked with Ruben Sher and Steve Miller at the South African Institute for Medical Research (SAIMR) in 1982 and had first-hand experience of early specimen collection and later screening for Human Immunodeficiency Virus (HIV) antibodies.⁵⁹ While she remained interested in AIDS she moved back to Durban in 1985 to continue her haematology research as 'an activist involved in the PPHC movement'. She recollected:

⁵⁶ Interview with Giddy & Reid.

⁵⁷ *Ibid.*

⁵⁸ Interview with Coovadia. Giddy maintains that in the late 1980s medical professionals in Durban did not take AIDS as seriously as some of the medical professionals based in Johannesburg and Cape Town. Giddy, who had been working in a rural hospital from July 1986, recalled attending a medical update held at the medical school in Durban in either 1989 or 1990 and raising the issue of MTCT (mother to child transmission). She remembers Coovadia dismissing her concerns, and her impression was that the issue was not taken seriously.

⁵⁹ Interview with Q. Abdool Karim.

At that stage we [the PPHC movement] weren't particularly concerned with AIDS, we saw it as a very restricted epidemic. We were given to believe from data in the mid-1980s [that it was] largely an MSM [men who have sex with men] epidemic, and the Blood Transfusion Services had been doing extensive screening. On a personal level, having gay friends meant knowing what was going on, but largely the response [to AIDS] was driven by gay and lesbian NGOs and CBOs, particularly in Cape Town and Johannesburg where there was more openness about same sex relationships going on, but as for a government response - there wasn't much.⁶⁰

NAMDA's focus on injuries related to political violence highlights the reality of the political situation in South Africa at the time, but also shows the effect of the hegemonic AIDS narrative on NAMDA's decision-making. AIDS was not linked to the communities that NAMDA were most concerned with, namely black South Africans living in townships, people in detention, and communities who suffered from the inadequate provision of health care. AIDS was presented and understood as something that primarily affected white gay men and was therefore not a priority.

None of the communities that NAMDA primarily worked in, or identified with, resembled the communities who were associated with AIDS. Neither the identified AIDS avatars that comprised the 'high-risk groups', nor the medical conditions most associated with AIDS in the hegemonic AIDS narrative of the time, resonated with the majority of NAMDA members. NAMDA members focussed on providing health care to people experiencing political violence, so their identity as political activists rather than any other identity (such as sex-worker, homosexual, or drug-user) was primary. NAMDA members with a strongly anti-racist outlook would have regarded the association of AIDS with diseased, black African bodies with scepticism. Or NAMDA members may have assumed that AIDS was just not a significant problem amongst black communities.

Giddy recounted that in 1989 the Blood Transfusion Service came to a hospital in Zululand to screen the blood of staff who acted as an emergency blood donation panel.⁶¹ Of the 70 staff

⁶⁰ Interview with Q. Abdool Karim.

⁶¹ The supply of packed cells to the hospital was restricted to five or ten units per month and had to come from Empangeni, which was two hours away. However, the hospital frequently needed more blood for emergency

members screened, four were HIV positive. People were surprised at the results as it was assumed that AIDS was not a significant problem: 'We thought "Oh my goodness" this disease is already here'.⁶² One of the people who was positive was an elderly, energetic, 'well-rounded' woman who worked on the switchboard. This revelation imprinted on Giddy's memory the association of AIDS not with thin, dying gay men, but with 'asymptomatic carriers' discovered through blood screening.⁶³

So what, if anything, was NAMDA's specific response to AIDS in the years from its formation in 1982, until the period of transition in the early 1990s when AIDS began to feature more obviously on the NAMDA agenda? How did NAMDA contribute to responses to AIDS by the progressive health movement more generally, and what was NAMDA's legacy?

For the reasons indicated above, NAMDA was slow in recognising the importance of AIDS, and AIDS did not feature in published NAMDA conference proceedings or annual reports until 1989 when the organisation started to pay attention to the pandemic. Mencer D. Edwards, the Executive Director of the National Minority AIDS Council in Washington, gave the keynote address at the 1989 NAMDA conference. The address was entitled 'Community Development and Personal Empowerment: Lessons from the Responses of African-American People to the HIV Epidemic'.⁶⁴ Edwards evoked and invoked the spirit of Steve Biko in his gospel-style talk and reflected on his interpretation of African-American responses to AIDS in the USA, while challenging NAMDA to consider their response.⁶⁵ He highlighted the inherent heterosexism, homophobia, classism, racism, patriarchy, and religious conservatism that influenced how these responses were formulated within the African-American community.⁶⁶ Thinking in the US African-American community reflected hegemonic AIDS narratives around 'high-risk groups':

transfusions so staff members agreed to act as an emergency donation panel and provide 'fresh' blood on site as and when needed. After the screening the Blood Transfusion Service withdrew the hospital's permission to bleed staff.

⁶² Interview with Giddy.

⁶³ *Ibid.*

⁶⁴ SAHA, NC, AL3182, Keynote Address by Mencer D. Edwards, executive director, National Minority AIDS Council, Washington, DC to the 6th Annual National Conference of the National Medical and Dental Association of South Africa, delivered May 12, 1989, Johannesburg, South Africa.

⁶⁵ Edwards appears to use the term 'African-American' to denote specifically phenotypically 'black' citizens of the USA who claimed Africa as their continent of origin.

⁶⁶ Edwards, Keynote address, p. 2.

By 1983, the die had been cast, though we did not know it at the time ... No hue, no cry. After all, it wasn't about us. It was called GRID – Gay Related Immune Disease. And that certainly was not us. We were men – the descendants of empire builders, of kings, we said. Not queens, we said.

Edwards asked NAMDA members to reflect on their own 'othering' of people with AIDS and to learn from the mistakes made in the USA. He asked NAMDA members to reflect on their priorities:

Are any of you – my esteemed members of NAMDA, especially you my brothers and sisters of color, physicians in practice, guardians of your people's health, of their lives – are any of you angry? Angry about the misinformation, angry about the callousness, the inadequacy, the fraud? Are any of you excited? Do any of you recognize an opportunity to focus the spotlight on the package of race, politics, and health? Are any of you excited about the potential of this issue, locally, nationally, internationally? Do you get excited about anything anymore? Or unlike Steven Biko, is your plate too full with your private practice. Are you too legitimate to deal with a really dirty, complex, damnably problematic little pandemic?⁶⁷

Edwards drew on his personal experiences and feelings of anger, fear, and excitement, to provide a history of the responses to AIDS in the USA by African-Americans. There had been different types of engagement with AIDS in the USA, ranging from protest actions, to engagement with government offices and officials, to the establishment of local AIDS service organisations (ASOs). He offered insight into what it was possible to do about AIDS, how difficult that journey might be, and provided a template for possible responses, guidelines and potential pitfalls. NAMDA's decision to invite a keynote speaker so intimately associated with AIDS work may be indicative of a shift in perspective within the organisation about the importance of AIDS. It may also have been a means to raise awareness and change perceptions about AIDS amongst NAMDA members, or a way to allow NAMDA members to reflect on their own engagements with AIDS.

⁶⁷ Edwards, Keynote address, p. 5.

At the AGM in March 1990 executive members of NAMDA presented their annual reports, while spokespersons from regional branches reported on their activities. The annual report described what different NAMDA branches and regions were doing about AIDS. It revealed that there was a variety of responses amongst the branches, and no coherent organisational response. The Border branch, spurred by the impetus from the 1990 Maputo Conference, had established a NAMDA AIDS group that it hoped would contribute to the 'regional AIDS task group'.⁶⁸ It had also collaborated with another organisation to hold an AIDS education meeting for 'trade unions and community organisations'.⁶⁹

The Durban Dental branch held a lecture on AIDS that 'generated a lot of interest with dental nurses, hygienists and therapists'. The highlight of the Western Cape Dental branch meetings was a talk on AIDS; and members of the Eastern Cape branch participated in an AIDS workshop organised by the NPPHCN.⁷⁰ The Southern Transvaal region had a NAMDA AIDS Group, whose organising members included Liz Floyd, Malcolm Steinberg, Carel Ijsselmuiden and Helen Schneider, all of whom would go on to become actively involved in AIDS research and support structures.⁷¹ The NAMDA president's address referred to an AIDS 'special interest group' within NAMDA, while the General Secretary's report noted that 'NAMDA's role [in combating AIDS] needs to be more clearly defined'.⁷²

AIDS had featured as a topic of discussion at the October 1989 meeting between NAMDA and the ANC. NAMDA published a 'Special Bulletin' about the meeting, including the report from the commission on AIDS, the opening statement of which declared that 'AIDS is already a problem of massive proportions. At this stage it is not possible to defeat the HIV virus [sic], but it could be possible to contain it'.⁷³ It highlighted the lack of credibility of government-run interventions and the need for credible organisations and community groups to 'carry

⁶⁸ SAHA, NC, AL3182, A1.3.16 'NAMDA Annual Report 1989/90' presented at the 7th Annual General Meeting, 3 – 4 March 1990, p. 21.

⁶⁹ *Ibid.*

⁷⁰ *Ibid.*, p. 23, 37 & p. 27.

⁷¹ *Ibid.*, p. 35.

⁷² *Ibid.*, pp. 2 & 7.

⁷³ SAHA, NC, AL3182, A1.8.2, 'NAMDA – ANC Meeting, 21 – 22 October 1989', NAMDA Special Bulletin 3, February 1990, p. 19.

forward the campaign ... through their own structures'.⁷⁴ The role of progressive health organisations was mentioned:

The [N]PPHC network could play an important role in this work. Various organisations, e.g. ANC, [N]PPHC and NAMDA would all have specific roles. These would have to be interacting [sic] with the MDM.

The Commission felt a strong sense of urgency about this problem and great anxiety that "lip-service" only was being paid to this extremely serious problem by the various organisations who needed to become involved in combating AIDS.⁷⁵

The call to all concerned parties to spend less time talking and more time doing speaks perhaps to a sense of frustration from some members at the slowness of the responses from liberation and progressive health movements.

During the 1990 NAMDA AGM both local members and international guest speakers discussed AIDS. Three papers dealing with different aspects of AIDS were presented: 'Community Perspectives and Organisational Issues', the 'Epidemiology of AIDS in South Africa', and 'Popular Theatre for AIDS Education' (the latter being presented by Clive Evian). Mervyn Susser's keynote address contextualised the notion of health as a human right, discussed efforts at implementing national public health services in the UK and Cuba, and then turned to 'one more topic [that] demand[s] attention', 'a spectre haunting Africa' - the HIV epidemic.⁷⁶

Susser referred to the advanced state of the epidemic in Central and East Africa, mentioned work published by NAMDA members on infection rates in South Africa, and emphasised that, despite the seemingly low infection rates, 'the epidemic presents a national emergency and should be a national political priority'.⁷⁷ The official South African response was 'ineffectual', 'empty and vapid' and insufficiently resourced; even the significant allocation of resources was useless if people 'read all Government health messages on AIDS in the light

⁷⁴ 'NAMDA – ANC Meeting, 21 – 22 October 1989', pp. 20 – 21.

⁷⁵ 'NAMDA Annual Report 1989/90', p. 21.

⁷⁶ *Ibid.*, p. 20.

⁷⁷ *Ibid.*

of apartheid'.⁷⁸ Such was the crisis that 'nothing less than a social movement on a national scale can hope to stem the tide', and such a social movement could form the foundation of a people-driven health care service.⁷⁹ Susser's suggestions were prophetic in that health, or more particularly, access to antiretrovirals (ARVs) for HIV-positive people, did later form a rallying-point for a large social movement, the Treatment Action Campaign (TAC), and the collaborative relationships it formed with other non-governmental and civil society organisations.

Throughout 1990 AIDS featured more prominently in a variety of NAMDA fora. It is possible that the growing sense of urgency about addressing AIDS at both international and local levels may have influenced NAMDA, or that more information about HIV infection rates in South Africa became known, revealing that AIDS and HIV were not confined to a gay minority. Through its meetings with the ANC and other anti-apartheid organisations, NAMDA may also have been influenced by the fact that AIDS was present in the liberation organisations. As NAMDA took a more serious interest in AIDS, and NAMDA members became involved in AIDS research, they contributed their expertise and knowledge in different spheres. These included broader progressive health fora (like the NPPHCN), other organisations (most notably the ANC), international meetings (like the Maputo and Lusaka conferences), and meetings with international visitors such as USA Congressperson McDermott.⁸⁰ In August 1990 McDermott met with ANC representatives and members of the PHM, including NAMDA members, to discuss potential US funding for AIDS programmes. The ANC presented a number of documents about AIDS in South Africa to McDermott which summarised responses to AIDS by the apartheid government and 'alternative organisations', and suggested a way forward for AIDS planning and programmes. The documents themselves were a product of collaboration between the ANC and the NPPHCN and drew on

⁷⁸ 'NAMDA Annual Report 1989/90', p. 20.

⁷⁹ *Ibid.*, p. 21. It could be argued that Susser's words were prophetic and that the Treatment Action Campaign (TAC) and its allies ended up being the mass social movement that was mobilised to address AIDS, not against the apartheid government, but, ironically, against the ANC-led government.

⁸⁰ See chapter on the ANC's responses to AIDS and SAHA, NC, AL3182, A2.1, 'AIDS in South Africa: Experiences and Responses – A paper prepared for the ANC presentation to Congressman McDermitt [sic]', August 1990; AL3182, A1.15 & A1.16 NAMDA Correspondence.

NPPHCN briefings. They provided an insightful overview of the experiences of AIDS amongst a number of communities.⁸¹

The documents revealed the influence of the hegemonic AIDS narrative on the understandings of AIDS by members of the PHM, particularly in relation to AIDS avatars. They also indicated that NAMDA's delayed response to AIDS was a result of the political context of the time and a belief that AIDS was not relevant to the majority of those communities whom NAMDA served. A section of one document presented a summary of how progressive, anti-apartheid community and health groups had viewed AIDS. It noted that in 1987 AIDS was viewed as 'a gay disease' but by 1988 it was considered a 'black disease', although one closely linked to 'confusion' and 'denial'.⁸² There was reference to the fact that the ANC only considered AIDS 'our problem' in 1989. But there had been some achievements in 1990: the Maputo statement on HIV and AIDS; NPPHCN involvement in AIDS education; and the drafting of practical plans and policies among the ANC, churches and civic organisations and unions.⁸³ It was in many of these fora, particularly in the NPPHCN, that the role of NAMDA members in addressing AIDS was most evident.

NAMDA's primary contribution to addressing AIDS in South Africa was through its membership of the NPPHCN, and through relationships between NAMDA branches and other progressive health movements undertaking AIDS education or support programmes. A discussion document written by Liz Floyd for a national NAMDA retreat held in 1991 provides insights into how and why NAMDA became involved, both in the NPPHCN and in the struggle against AIDS.⁸⁴ NAMDA had engaged in 'activities on AIDS from 1989' but had prioritised other health concerns.⁸⁵ NAMDA had been involved in developing and supporting the NPPHCN AIDS programmes; providing AIDS education and information to NAMDA members; addressing primary care for people with AIDS; and undertaking AIDS policy work and analysis. While NAMDA drew on the knowledge of members working in the AIDS field to

⁸¹ 'AIDS in South Africa: Experiences and Responses.'

⁸² *Ibid.*, p. 1.

⁸³ *Ibid.*

⁸⁴ SAHA, NC, AL3182, A1.11, NAMDA document, Liz Floyd, 'NAMDA: Our Contribution to the Fight Against AIDS', National Retreat, June 1991.

⁸⁵ *Ibid.*

contribute to AIDS policy analysis and development amongst progressive organisations, the demands for this level of engagement were high and the resources, and time to do so, limited. For the most part NAMDA had emphasised the development of NPPHCN AIDS programmes and contributed to facilitating the development of these programmes. According to Floyd, NAMDA members were 'very active' in NPPHCN AIDS structures from the NEC through to regional committees and contributed to specific AIDS-related local activities.

The NPPHCN's broad mandate concerning AIDS was to help 'develop and sustain community education prevention programmes and activities through the training and support of community groups and individuals and the provision of available resources'.⁸⁶ It did so through ongoing education programmes that provided updates on epidemiological data and information on responses to AIDS by various sectors.⁸⁷

As part of the NPPHCN, NAMDA had to determine how best to position itself in relation to AIDS work being carried out in a variety of sectors. The 1991 discussion document posited, 'If we are committed to a united effort, why should we have our own role, identity and structures in HIV? Our particular role can strengthen the PPHC programme but could also compete with it'.⁸⁸ In light of scarce resources and the ideals of collaboration and communal engagement that characterised the progressive health movement, this was a valid consideration.

NAMDA ran AIDS-specific events, including a series of meetings in Soweto, entitled 'AIDS – Towards Comprehensive Care', which dealt with 'preventive, clinical, psychological and social issues related to AIDS'.⁸⁹ NAMDA's involvement in AIDS programmes varied significantly between regions with most activity occurring in the Southern Transvaal. This region was most influential in determining the direction of NAMDA's national AIDS

⁸⁶ Quoted in SAHA, NC, AL3182, Reports, Report for NAMDA S.Tvl Regional Meeting: NAMDA and Its Role in Combating the Spread of HIV Infection and AIDS, n.d., p. 1.

⁸⁷ *Ibid.* The education programmes incorporated information on available AIDS education resources, and discussed health education techniques.

⁸⁸ 'NAMDA: Our Contribution to the Fight', pp. 1 – 2.

⁸⁹ SAHA, NC, AL3182, A1.11, Correspondence, NAMDA AIDS Group, Johannesburg, to NAMDA members, c.1990.

response.⁹⁰ In 1991 the Southern Transvaal NAMDA AIDS group merged with the NPPHCN AIDS Working Group (AWG) in an effort to combine scarce resources, develop a single unified AIDS programme, and to garner support from AIDS-specific organisations for a united AIDS body.⁹¹

In addition to the NPPHCN AWG which co-ordinated and administered AIDS discussions and programmes, there was also an NPPHCN AIDS Forum which brought together regional NPPHCN AIDS groups and representatives from different organisations and facilitated collaborative work on mutually beneficial projects. The '2nd Community AIDS Education' symposium held at the University of the Witwatersrand in 1990 was organised by NPPHCN AIDS Forum member organisations: NAMDA, the Organisation for Appropriate Social Services in Southern Africa (OASSSA), the Township AIDS Project (TAP), The AIDS Centre (run by the South African Institute for Medical Research), the Community AIDS Information and Support Centre and the Outreach Programme (the last two were part of the Johannesburg City Health Department). Two of the primary organisers were Mary Crewe, who at the time was employed by the City Health Department, and Clive Evian in his capacity as a NAMDA member. This event gives an insight into the range of organisations and sectors represented in the NPPHCN.⁹²

The symposium had a number of interesting sessions. The first day covered 'AIDS: Basic Information, Epidemiology, Psychological, Clinical and Nursing Care'. This part of the proceedings updated the attendees about the state of AIDS in South Africa; explained the testing procedure and the importance of counselling; raised issues relating to nursing and home care needs of people with HIV. It also included a personal account from an HIV-positive person of their experience living with the disease. The second day created more space for people living with HIV to discuss their experiences and included a keynote address and drama production on women and AIDS. One session covered 'comprehensive holistic

⁹⁰ It is not clear why this region was more active in addressing AIDS other than that Johannesburg and Cape Town were the two urban areas in which most AIDS research was being undertaken and the areas in which government and non-governmental responses were most evident.

⁹¹ SAHA, NC, AL3182, A1.11, Correspondence, NAMDA S.Tvl AIDS Group to NAMDA branches, Re.: Consultation on a Regional AIDS Programme by the S.Tvl AIDS Working Group of the PPHC', 17 January 1991.

⁹² SAHA, NC, AL3182, F1.7, PPHCN, Provisional Programme, PPHCN AIDS Forum, 2nd Community AIDS Education Symposium, 29 & 30 November 1990.

approaches to people with HIV/AIDS and community initiatives', while at another the legal rights of HIV positive people in regard to employment policies were considered.⁹³

The NPPHCN AWG and AIDS Forum, with its collaborative, consultative and representative approach, echoed (or perhaps provided a template for) the ethos and structure of both the National AIDS Convention of South Africa (NACOSA) conference in 1992, and the multi-sectoral committee of the same name, the National AIDS Co-ordinating Committee of South Africa (NACOSA), that arose out of it.⁹⁴

To ensure that the views of the PHM and its partners were represented at the Convention a meeting of 'progressive health organisations involved in AIDS work' was convened in October 1992 specifically to prepare for NACOSA.⁹⁵ Twenty-three delegates who attended the meeting represented, among others, the AIDS Consortium, the NPPHCN, the South African Health and Social Services Organisation (SAHSSO), the ANC, and COSATU. The meeting was called to determine a common position around the Convention and its objectives, and represented organisations and individuals that would be central in subsequently developing and attempting to implement the national AIDS plan of 1994.

Delegates expressed concerns about a lack of consultation during the planning of the Convention, and speculated as to whether the Convention would result in a diminished role

⁹³ Provisional Programme, PPHCN AIDS Forum.

⁹⁴ NACOSA refers to both the 'National AIDS Convention of South Africa' and the 'National AIDS Co-ordinating Committee of South Africa' which is also sometimes referred to as the 'National AIDS Committee of South Africa'. The convention was held in 1992 to discuss how to address AIDS and brought together representatives from government, the PHM, community organisations, other civil society organisations, and liberation organisations. The co-ordinating committee was formed at the convention to guide further discussions and plans to address AIDS nationally. Official documents and subsequent academic texts on the convention (conference) and the committee do not differentiate between them by using two different acronyms. While this can make the process of distinguishing between the conference and committee difficult, the convention of using the same acronym for both is maintained in this thesis as this best reflects the acronyms used in archival and other sources. For more on the discussions and development of the NPPHCN's AIDS programmes and plans, see the following documents (all documents SAHA, NC, AL3182, B1.10.5, the OASSSA papers, thematic documents, 1990 - 1995): National AIDS Programme Proposed by the National Progressive Primary Health Care Network, 4 March 1991; National Strategic Planning Workshop: PPHC AIDS Programme with CBDP: February 1992; PPHC National AIDS Programme, February 1992; and The Political Agenda of AIDS: A Preliminary OASSSA Discussion Paper, undated. See also SAHA, NC, AL3182, F1.10.1, the National Progressive Primary Health Care Network (NPPHCN) Papers, thematic documents, 1990 – 1992; and Killie Campbell Library, Manuscripts, KCM 03/7/59/6 & 7, National Progressive Primary health Care Network Papers. See also chapter on government responses to AIDS in this thesis.

⁹⁵ SAHA, NC, AL3182, G1.2, SAHSSO minutes of meetings, Minutes of meeting of progressive organisations involved in AIDS work in preparation for the NACOSA conference, held on Monday, 19 October 1992.

for non-governmental organisations' (NGOs) AIDS programmes in favour of government-approved programmes. The meeting observed that the state needed to properly finance an AIDS programme, and questioned the 'feasibility of developing an isolated policy around AIDS, without addressing the broader policy and unilateral restructuring of the health sector'.⁹⁶ Group discussions considered what structures should co-ordinate a programme at national, regional and local levels, what resources were available, and how to ensure community involvement. A unanimous decision was made that progressive organisations should participate in NACOSA, and be 'visible and vocal' during the Convention. A declaration was made that progressive organisations must form part of any policy or strategy-drafting group that resulted from the Convention.⁹⁷

The progressive health movement provided a model of engagement and consultation for determining AIDS programmes, differing significantly from the hierarchical, non-consultative approach of the government health department. The significant number of organisations from a variety of sectors, representing an extensive and varied membership, ensured that the NPPHCN and the recommendations it made, enjoyed greater credibility. The structures of the NPPHCN and other progressive health organisations represented an alternative way of determining AIDS policy, and encouraged crossover between communities, reflecting the hopes and aspirations for future health policy planning and implementation.

By 1990 NAMDA was placing increased emphasis on its publications as vehicles for discussing and disseminating information about AIDS. NAMDA's publications section was responsible for collecting, editing and publishing conference proceedings, brochures, pamphlets, and newsletters. It also produced 'Special Bulletins' that focused on specific health concerns or events important to NAMDA. In May 1990 a nine-page NAMDA bulletin on 'HIV-Infection and AIDS' was published for distribution amongst NAMDA branches and affiliated groups.⁹⁸ It was heralded as 'a comprehensive set of guidelines' that would form the basis for a 'NAMDA policy on HIV infection and AIDS' and was the product of internal

⁹⁶ SAHHSO minutes of meetings, pp. 1 – 2.

⁹⁷ Minutes of meeting of progressive organisations involved in AIDS work, p. 3.

⁹⁸ SAHA, NC, AL3182, A1.8.2, 'HIV-Infection and AIDS', NAMDA Special Bulletin 4, May 1990.

discussions within NAMDA, and more extensive discussions with a number of progressive health organisations including the NPPHCN.⁹⁹

Carel Ijsselmuiden, Liz Floyd, Malcolm Steinberg, Clive Evian, Sharon Fonn and Tshepo Motsepe of the NAMDA AIDS Group in Johannesburg compiled and edited the publication. The Bulletin reflected a growing sense of urgency on the part of both NAMDA and the progressive health movement:

... NAMDA wants to continue efforts to bring this epidemic to prominence in the progressive health and political movement, because the silence with which it spreads completely belies the extremely serious consequences it will have on a post-apartheid South Africa if it remains unchecked ...

... the HIV epidemic is of such importance that it should become a high priority on the agendas of all progressive organisations.¹⁰⁰

It contained a call to the progressive health movement to unite to prevent HIV infection and to 'assist the mass democratic movement in playing its role in HIV prevention'.¹⁰¹ It concluded with a summary of the role of NAMDA in addressing AIDS:

To inform its membership on all aspects of HIV infection.

To provide medical expertise to progressive organisations, especially the National Progressive Primary Health Care Network of which NAMDA is a member.

To strive for unity of response within the progressive health sector to the HIV epidemic.

To continue to mobilise the progressive leadership in the fight against HIV infection.

To critique the government's handling of the HIV epidemic, and to provide ethical guidelines for the treatment and control of HIV infection.

To mobilise resources for the control of HIV infection in general, and to initiate the establishment of an AIDS/HIV Unit which can take on the above aims in a full-time capacity and expand them.¹⁰²

⁹⁹ 'HIV-Infection and AIDS', p. 1.

¹⁰⁰ *Ibid.*, Preface.

¹⁰¹ *Ibid.*

¹⁰² *Ibid.*, p. 8.

These priorities suggest that, aside from organisations with a specific interest in AIDS, NAMDA and other progressive organisations had not been particularly effective in ensuring AIDS education and information was reaching members, and that responses to AIDS from the progressive health sector had not been uniform or well coordinated. There is too an implication that 'progressive leadership' (which presumably included the leadership of the ANC and other anti-apartheid organisations) required ongoing mobilisation to ensure effective engagement with AIDS.

There are parallels between the 'medical expertise' offered to the apartheid government by the AAG, and the 'medical expertise' offered by NAMDA to anti-apartheid organisations, including the ANC as government-in-waiting. While the politics of these two groups of medical experts may have been at odds with each other, both expressed a singular focus on the central importance of bio-medical knowledge in responding to AIDS.

Despite these shortcomings, the Bulletin is nonetheless an interesting example of an AIDS narrative that was more rooted in notions of health as part of a human-rights ideology that was concerned with the dignity of people. In contrast to AIDS narratives that had identified (and often judged) 'risk groups' and other AIDS avatars, the preface of the Bulletin observed that since the first identified AIDS cases in 1982 the HI 'virus has spread throughout the country affecting people of both sexes, of any origin, of any sexual orientation, of any occupation, and of almost any age'.¹⁰³ Considering the recollections of some informants and the evidence that the PHM saw AIDS first as a 'gay disease' and only much later as a 'black disease', it is possible that the benefit of hindsight and the changing national and international narratives about AIDS influenced NAMDA's position.

While still focussed on health access, treatment and prevention of infection (and not for, example, confidence, empowerment, mental health, social power structures and dynamics) the narrative in the Bulletin did underscore the links between politics and health more vociferously than was the norm in the dominant AIDS narratives:

¹⁰³ 'HIV-Infection and AIDS', p. 8.

The sheer number of persons with HIV infection and of People with AIDS (PWA's) makes this epidemic a direct medical, social and political problem. Many of the basic determinants of the distribution and rapid spread of the disease, and of the quality of preventive, promotive and curative care are social and political in nature, and are a consequence of the effects of apartheid on health and health care. It follows, therefore, that addressing these determinants adequately is of major importance to the effective control of the spread of the virus, and of the humane and dignified treatment of those already infected.¹⁰⁴

In addition to the outright evocation of human dignity, the use of terms like 'persons with HIV infection' and 'People with AIDS (PWA's)' rather than 'AIDS victims' or 'people suffering with AIDS', recognises the humanity of the people dealing with the syndrome in a way that was not always evident in the hegemonic AIDS narrative. However, as previously shown in this thesis, the 1990s did mark a shift in hegemonic medical narratives (including within more conservative publications like the *SAMJ*) as they were influenced by national and international human rights based discourses.

Taken by itself, the NAMDA Bulletin could be seen as merely reflecting a broader (global and local) narrative shift, or as an isolated exception to more hegemonic AIDS narratives. Reading the Bulletin in conjunction with other documents, it seems likely that NAMDA members helped to create and further this narrative shift. When read in relation to other NAMDA documents (such as the Annual and Conference Reports and the *NAMDA News*) and other progressive health publications or documents that dealt with issues of health care generally, or AIDS specifically (such as *Critical Health* or the Maputo Statement on HIV and AIDS), the Bulletin can be seen as emblematic of a different narrative and understanding of health care and AIDS.¹⁰⁵

¹⁰⁴ 'HIV-Infection and AIDS', p. 8.

¹⁰⁵ For example, NAMDA provided information about AIDS to its members in regional and national newsletters entitled 'NAMDA News'. The information ranged from short articles or paragraphs, to dedicated articles that discussed aspects of AIDS. See for example the following published between June 1988 and June 1989: SAHA, NC, AL3182, A1.5.1, NAMDA News, 'AIDS, South Africa and NAMDA', NAMDA Southern Transvaal Newsletter, June 1988, pp. 1 - 3; SAHA, NC, AL3182, A1.5.1, NAMDA News, 'AIDS in South Africa' and 'AIDS in South Africa – Progressive Perspectives', NAMDA News, c. June 1988, pp. 2 - 3; SAHA, NC, AL3182, A1.5.1, NAMDA News, 'AIDS Series' which listed publications dealing with AIDS and epidemiology, 'the fate of HIV-positives', AIDS and health workers, AIDS and the workplace; and AIDS prevention and public policy, NAMDA Southern Transvaal Newsletter, August 1988, pp. 3 - 4; SAHA, NC, AL3182, A1.5.1, NAMDA News, 'How many people must AIDS kill before we do something about it?' NAMDA Western Cape Medical Branch Newsletter, November 1988, pp. 1 - 2; SAHA, NC, AL3182, A1.5.1, NAMDA News, Steinberg, M., 'Some Pointers to an Effective Education Strategy

NAMDA worked with other health-related organisations and anti-apartheid bodies and emphasised the relationship between socio-economic factors and ill-health. While NAMDA had consistently linked health care access and provision to politics and social conditions, it still fundamentally prioritised scientific and medical interventions to address health problems rather than locating bio-medical responses in a more 'holistic' intervention that would incorporate non-medical, social science and humanities-influenced examinations of health and well-being. Despite NAMDA supporters also working in the social sciences, humanities and civil society more broadly, there was little collaboration with appropriate non-medical professionals or organisations to address the systemic, socio-political aspects of AIDS.

Mary Crewe reflected on how the PHM and NAMDA engaged with AIDS:

... I think we have had our own problems in a way here [in South Africa] because the early gurus of the epidemic were the doctors. And on one level, correctly so, because they were the people who were picking it up, but ... we came onto the whole human rights thing too late, and I think that nobody in the early stages challenged the medics enough ... and the International AIDS conferences really reflect that. You [still] have basic science, clinic science, epidemiology, and then social science.¹⁰⁶

Crewe speculated on how a fuller engagement with, and knowledge of, social theory by medical scientists could have strengthened AIDS research and laid the foundations for more holistic responses.¹⁰⁷

The NAMDA Bulletin was an extension of the work of authors making active contributions to the reshaping of the hegemonic AIDS narrative in other fora. The nature of contributions by NAMDA members to the *SAMJ*, where they reproduced the ideologies evident in the Bulletin, would suggest that NAMDA members actively challenged the hegemonic AIDS

for the Prevention of HIV Infection', NAMDA Southern Transvaal Newsletter, January 1989, pp. 2 - 5; and SAHA, NC, AL3182, A1.5.1, NAMDA News, 'Epidemiology of AIDS', NAMDA News, 3, 2, June 1989, p. 2.

¹⁰⁶ Interview with Mary Crewe, Centre for the Study of AIDS, Pretoria, South Africa, 8 February 2008.

¹⁰⁷ *Ibid.* While acknowledging that additional research would be required to support or refute Crewe's analysis of the relationships and engagements between NAMDA members with medico-scientific backgrounds and those from other pedagogical backgrounds, her observations are worth recording as an example of a critical reflection on NAMDA's history.

narrative and contributed to the creation of a changing AIDS narrative and expanded AIDS research foci. Between 1988 and 1995 NAMDA members or supporters contributed twenty-one articles, correspondence, reviews or case studies to the *SAMJ*, which constituted about four per cent of the total number of *SAMJ* articles related to AIDS between 1980 and 1995.¹⁰⁸

NAMDA members or supporters, such as Quarraisha Abdool Karim, Salim Abdool Karim, Jerry Coovadia, Cedric de Beer, Clive Evian, Mary Crewe, Carel Ijsselmuiden, Helen Schneider and Malcolm Steinberg, all contributed to the *SAMJ*. In 1988 Ijsselmuiden, Steinberg, and De Beer were amongst the co-authors of three articles outlining a 'comprehensive strategy' for addressing AIDS in South Africa.¹⁰⁹ While the articles primarily suggested bio-medically linked responses to AIDS, they did highlight key ethical issues relating to HIV antibody testing, consent and notification.

Clive Evian's articles and letters highlighted compassionate and ethical responses to AIDS, while Quarraisha and Salim Abdool Karim presented new findings about AIDS among previously under-researched groups (like womyn) or prompted questions about collaborative engagements with non-medical healers. Schneider's work incorporated social science perspectives on topics such as spending on AIDS education, while Crewe's contribution highlighted the importance of evaluating AIDS interventions.¹¹⁰

¹⁰⁸ Author's analysis of her own database listing *SAMJ* articles (or other printed text) relating to AIDS from 1980 – 1995.

¹⁰⁹ Ijsselmuiden, C., Steinberg, M., Padayachee, G.N., Schoub, B.D., (*et al*), 'AIDS and South Africa - Towards a Comprehensive Strategy', Parts I, II & III, *SAMJ*, 73, 8, 16 April 1988, pp. 455 – 467.

¹¹⁰ The articles are, in chronological order: Padayachee, N., Ijsselmuiden, C.B., & Hurwitz, H., 'Quality of condoms', *SAMJ*, 76, 3, 5 August 1989; Evian, C.R., Ijsselmuiden, C.B., Padayachee, G.N., & Hurwitz, H.S., 'Qualitative evaluation of an AIDS health education poster', *SAMJ*, 78, 9, 3 November 1990; Ijsselmuiden, C.B., Padayachee, G.N., Mashaba, W., (*et al*) '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; Bobat, R., Coovadia, H.M., & Windsor, I.M., 'Some early observations on HIV infection in children at King Edward VIII Hospital, Durban', *SAMJ*, 78, 9, 3 November 1990; Evian, C., 'AIDS - a need for uniform terminology', *SAMJ*, 79, 4, 16 February 1991; Evian, C., de Beer, M., Crewe, M., Padayachee, G.N., & Hurwitz, H.S., 'Evaluation of an AIDS awareness campaign using city buses in Johannesburg', *SAMJ*, 80, 7, 5 October 1991; Abdool Karim, Q., Abdool Karim, S.S., & Nkomokazi, J., 'Sexual behaviour and knowledge of AIDS among urban black mothers', *SAMJ*, 80, 7, 5 October 1991; Evian, C., 'Imagine...', *SAMJ*, 81, 12, 20 June 1992; Abdool Karim, S.S., & Abdool Karim, Q., 'Changes in HIV seroprevalence in a rural black community in Kwazulu', *SAMJ*, 82, 6, 1 December 1992; Evian, C., 'Rapid 'bedside' HIV tests and testing - useful but needs to be used with caution', *SAMJ*, 8, 4, 1 April 1993; Abdool Karim, S.S., 'Traditional healers and AIDS prevention', *SAMJ*, 83, 6, 1 June 1993; Evian, C., 'The socio-economic determinants of the AIDS epidemic in South Africa - a cycle of

NAMDA members or supporters raised issues which had either not been raised in the *SAMJ* before, or, if they had been raised, wrote about them in different ways: evaluating health interventions, researching womyn in capacities other than as sex-workers, considering the beliefs and knowledge of research subjects, sensitively acknowledging the link between infection and socio-economic factors, and documenting paediatric AIDS. These interventions provided an alternative discourse and way of engaging with AIDS that contrasted with existing hegemonic AIDS narratives.

NAMDA's most notable legacy was in creating a community of health care professionals who would play a significant role in AIDS research and policy development at national and international levels. Numerous people who were aligned to NAMDA remained active in the sphere of health care. NAMDA members and supporters not only moved from their professional communities to political or activist communities, but also created new ones in both apartheid and post-apartheid South Africa. NAMDA members went from resisting the apartheid government to supporting the post-apartheid government; and from speaking out against apartheid-based government health policies and AIDS interventions to helping create health and AIDS policies, strategies and interventions post-1994.

After the 1994 elections NAMDA members occupied senior positions in health structures addressing AIDS, and many are still involved in AIDS research. NAMDA founding member, Salim Abdool Karim, has held various academic and academic management positions at the University of Kwa-Zulu Natal (UKZN), is the Director of CAPRISA (the Centre for the AIDS Programme of Research in South Africa) which is part of a UNAIDS collaborative global HIV prevention research programme. In April 2012 he was appointed President of the Medical Research Council (MRC). Both Salim and Quarraisha Abdool Karim have received

poverty', *SAMJ*, 83, 9, 1 September 1993; Evian, C., 'Consent for HIV testing', *SAMJ*, 83, 12, 1 December 1993; Evian, C., 'AIDS and your response', *SAMJ*, 84, 3, 1 March 1994; Schneider, H., & McIntyre, J., 'Is the 1993/4 AIDS programme budget adequate?', *SAMJ*, 84, 4, 1 April 1994; Lee, T., Masobe, P., & Schneider, H., 'Proposals for the feasible management of tuberculosis in HIV-seropositive South Africans', *SAMJ*, 85, 2, 1 February 1995; Bobat, R., Coutsoodis, A., Moodley, D., & Coovadia, H.M., 'Moving from AIDS to symptomatic HIV infection', *SAMJ*, 85, 6, 1 June 1995; and Blecher, M.S., Steinberg, M. (et al) 'AIDS - knowledge, attitudes and practices among STD clinic attenders in the Cape Peninsula', *SAMJ*, 85, 12, 1 December 1995.

international attention because of the latest microbicide trials.¹¹¹ Quarraisha is a leading global AIDS epidemiologist and the current Associate Scientific Director of CAPRISA. Prior to her work at CAPRISA, she was head of the MRC AIDS Research Unit in Durban in the late 1990s and early 2000s, and, the first National Director of the HIV/AIDS and sexually transmitted disease (STD) Program for the Department of Health from 1995 to 1996.¹¹²

Jerry Coovadia, who was both a NAMDA member and actively involved in the Natal Indian Congress and UDF, became a leading expert in paediatric AIDS and perinatal HIV transmission, and was the Head of the Department of Paediatrics at UKZN until 2000. He is currently the Victor Daitz Professor of HIV/AIDS Research and Associate Scientific Director at CAPRISA.¹¹³ Despite a long acquaintance with Mbeki, Coovadia consistently spoke out against Mbeki's denialism. Under the new Minister of Health, Dr. Aaron Motsoaledi, Coovadia is contributing to a new government AIDS plan.

Clive Evian worked both as a part-time clinician at the HIV Clinic at the Johannesburg General Hospital and at the Department of Community Health, University of Witwatersrand (along with Cedric de Beer and Helen Schneider) as the Director of the Health Services Development Unit. In 1989 he became Deputy Director of the Johannesburg City Health Department and 'initiated and was head of the Departments HIV programme which included the establishment of the Esselen Street Community AIDS Centre'.¹¹⁴ He also held positions in the Department of Health from 1997 to 2000. He is currently a consultant for government departments, NGOs and other sectors providing support on a number of HIV and AIDS-related issues, including AIDS care provision, implementing the ARV roll-out, and primary HIV care. He has continued to publish articles and books about AIDS.

¹¹¹ See the CAPRISA website at www.caprisa.org and AVAC (AIDS Vaccine Advocacy Coalition) website at www.avac.org/ht/d/sp/i/28226/pid/28226 for more information and trial results announced in 2010 (accessed June 2011).

¹¹² Information from interviews with S. Abdool Karim & Q. Abdool Karim and CAPRISA website at <http://www.caprisa.org> (accessed June 2011).

¹¹³ Interview with Coovadia and CAPRISA website.

¹¹⁴ Information about Clive Evian based on designations given in early journal articles and from biographies on the following websites: Awareness Publishing Group at www.awarenesspublishing.co.za/writers.htm; Right to Care at www.righttocare.org/index.php?option=com_content&view=article&id=159&Itemid=235 and Who's Who Southern Africa at www.whoswhosa.co.za/clive-evian-5181 (all accessed June 2011).

Mary Crewe worked for the Johannesburg City Health Department and was the manager of the Community AIDS Centre at the Esselen Street clinic in Hillbrow. She worked with members of the ANC Health Secretariat prior to 1994, and became a member of the National HIV/AIDS and STD directorate of the Department of Health from 1995 to 1996. She is currently the Director of the Centre for the Study of AIDS at the University of Pretoria.¹¹⁵

Malcolm Steinberg was head of the National Centre for Occupational Health's Epidemiology Unit and of the MRC's National HIV/AIDS Programme. While at the MRC, Steinberg and colleague Michele Galloway compiled and edited the *AIDS Bulletin*, which first appeared in 1992. The *AIDS Bulletin* was designed to provide comprehensive, up-to-date AIDS information for, and encourage networking between, people involved in AIDS related work, from AIDS educators to policy makers.¹¹⁶ Steinberg is currently the Clinical Assistant Professor and Program Director of Public Health Practice at Simon Fraser University in Canada.¹¹⁷

Diliza Mji went on to occupy several key ANC positions, and after 1994 became the ANC Provincial Treasurer in KZN. His interests in medicine turned towards private health care provision; and he is 'chairperson of Capensis Management, owners of Ethekewini Hospital & Heart Centre'.¹¹⁸ In addition to the significant shift in his personal politics from interests in public health care to private health care, Mji's business interests have also been linked to corruption scandals, including the arms deal.¹¹⁹

These examples indicate that some of the key people involved in the PHM and NAMDA participated in new forms of collaboration and intervention between different communities

¹¹⁵ See the Centre for the Study of AIDS website at <http://www.csa.za.org> (accessed June 2011).

¹¹⁶ *AIDS Bulletin*, 1, 1, August 1992 – personal copy provided by Michele Galloway of the MRC.

¹¹⁷ See Simon Fraser University website at www.fhs.sfu.ca/portal_memberdata/msteinberg (accessed June 2011).

¹¹⁸ Hospital Association of South Africa (HASA) website at www.hasa.co.za/about/director. For more on Ethekewini Hospital and Heart Centre see the website at www.ehnc.co.za/aboutus/index.htm (both accessed June 2011).

¹¹⁹ See Sole, S., 'Sutcliffe's Achilles Heel?' *Mail & Guardian*, 1 June 2009; Tolsi, N., 'Three horsemen visit Durban', *Mail & Guardian*, 16 October 2008; Basson, A., Sole, S., & Brümmer, S., 'Arms probe reopened', *Mail & Guardian*, 20 March 2008; author unknown, 'How arms dealer got its hooks into the ANC', *Mail & Guardian*, 19 January 2007; and Rubin, C., 'SA armour "used in Iraq"', *Mail & Guardian*, 30 June 2006. All articles accessed via Mail & Guardian Online at <http://mg.co.za> (accessed June 2011).

at a point of political transition in South Africa. After the political transition they actively assisted in researching, providing, or managing health care interventions, including those linked to HIV and AIDS.

Conclusion

While NAMDA was formed in the same year that the first official AIDS cases were announced in South Africa, the organisation did not prioritise AIDS. Its major concerns were with the broader issues of apartheid and health, and how a new health system would look in a post-apartheid world. Its political focus resulted in little initial interest in a syndrome associated in the hegemonic narrative with gay men.

NAMDA created spaces within which the progressive health movement could think about and respond to health care concerns, which were outside of the constraints of conventional medical narratives and structures. By the 1990s these health concerns had expanded to include AIDS. Within progressive primary health care structures, the influence of politics on health care and AIDS was discussed more freely. Medical professionals with a commitment to social change could work out how best to put that commitment into action. Those people with a personal or professional interest in AIDS could initiate responses to AIDS or collaborate with those already involved in addressing it.

In NAMDA and the PHM, new progressive ways of collaborating and working together - within and across organisations - were practiced. Narratives infused by liberation ideologies and human rights discourses were crafted and disseminated which countered, and contributed to prevailing hegemonic understandings of health care provision, and some aspects of AIDS narratives.

NAMDA was slow to respond to AIDS and always maintained an 'elite' membership, but when it did respond it drew on the expertise of those 'elite' members to work for a 'common good'. NAMDA worked within structures that tried to incorporate collaborative and/or 'community'-centred (or community-driven) approaches in line with broader community-focused health care ideals. NAMDA did not, however, seriously engage with responses to

AIDS that were not centred on bio-medical interventions and understandings of epidemics. There is little in NAMDA narratives that address homophobia, male sexuality, gender roles, or domestic violence.

With the unbanning of the ANC and the beginning of the negotiations that led to democratic elections in 1994, NAMDA reconsidered its role in the changing political landscape, and reflected on how it could be most effective in the new dispensation. Initially NAMDA and other progressive groups, including the Health Workers' Society (HWS), the NPPHCN, OASSSA, SAHWCO, and the Overseas Medical Graduate Association (OMEGA), merged into the National Health Unity Forum (NHUF). In 1992 the NHUF evolved into the South African Health and Social Services Organisation (SAHSSO).¹²⁰

As the press statement announcing the formation of SAHSSO declared, 'the new structure locate[d] itself as an independent organ of civil society, bringing together the widest range of progressive health and social services workers ...', and 'firmly [took] its place alongside the other independent organs of civil society, the national civic movement, and the labour movement'.¹²¹ SAHSSO members could join 'interest groups' dealing with policy and research, trauma and rehabilitation, particular fields (for example nurses, psychologists, doctors, social workers etc), and AIDS. NAMDA members who were interested in AIDS were able to continue to work in the field under the auspices of SAHSSO, and SAHSSO members were present at meetings about AIDS up to and beyond NACOSA.¹²²

A core group of NAMDA doctors went on to become members and supporters of the Progressive Doctors Group that, from 1995, was involved in negotiations to form 'a united medical association for South Africa that [would] espouse the true values of health and

¹²⁰ TRC *Health Sector Hearings*, Day 2, NAMDA Submission, evidence given by Barry Kistnasamy; Taitz, J. L., 'The Right to Health: Medical Treatment and Medical Law in South Africa', *South African Human Rights Yearbook*, 2, 1992, p. 172 (accessed using HeinOnline).

¹²¹ SAHA, NC, AL3182, G1.8, SAHSSO Press Statements, Press statement issued by SAHSSO, WITS University, Sunday, 5 July 1992.

¹²² SAHA, NC, AL3182, G1.1.2, outgoing correspondence, SAHSSO pamphlet, undated, c.1992.

human rights'.¹²³ After three years of negotiations, MASA and the Progressive Doctors Group merged in May 1998 to form the South African Medical Association (SAMA).¹²⁴

During the TRC Health Sector Hearings in June 1997, Kistnasamy observed that

health policy initiatives by NAMDA ... are now coming to bear within the Department of Health's formulation of health policy and we are glad to say that NAMDA's earliest contributions have contributed in more ways than one to a national health system for South Africa, a new system of medical education and training for the health sciences, and lastly debates on health financing. Those policy options are now firmly entrenched within the South African government's programme of action.¹²⁵

From working against the government, NAMDA members began working with it in the hope of realising the principles of progressive health care. One of the most notable examples of NAMDA members influencing policy was their involvement in NACOSA and in drawing up the first National AIDS Plan (NAP). Helen Schneider recalled the mood of the time and reflected on the plan itself:

... it was unbelievably exciting, but just not tempered by any realism of governing really. We produced this ridiculously thick document ... and it ... captured imaginations.

I think it was just incredibly optimistic and hopeful and yes, it was just part of the whole attitude to transformation generally, you know. A very naïve conception of what was possible and not I think realistic. I think it was also quite a creative time – it was the beginning of new conceptions of primary health care and new kinds of involvement, particularly by patients. There were new notions of the doctor/patient relationship and treatment activism.¹²⁶

Quarraisha Abdool Karim observed that 1992 was a 'pivotal year', and that the establishment of NACOSA mirrored 'the political process ... underway at CODESA in that it brought the private sector, it brought government and it brought the non-governmental

¹²³ SAHA, NC, AL3182, G1.1.2, outgoing correspondence, SAHSSO pamphlet.

¹²⁴ *Ibid.*

¹²⁵ TRC *Health Sector Hearings*, evidence given by Barry Kistnasamy.

¹²⁶ Interview with Schneider.

sectors together to work with one goal in mind ... what should the National AIDS Plan look like?'¹²⁷ She believed that NACOSA developed a strategic and operational plan that 'was very comprehensive', reflecting the contributions of a number of communities, but there were problems:

[there was] a disjuncture between the strategic plan and the operational plan ... and I can tell you [as someone] involved in both the process and then ... appointed to set up the National AIDS Programme in 1995, there was no way that plan could be implemented. The capacity wasn't there, the skills base, the budget had been upped several fold but the people with the skills to implement that, were completely lacking.

AIDS got lost between all the processes, between national and provincial [levels] and between the priorities of switching [from] an apartheid run government to a democratically elected government ... I think people can look back and say we should have done things like this, and we should have done them like that, but there's a lot of wisdom with hindsight.

... at that point there was a priority plan put into place and I still believe it was the right thing to do at that stage. I think what happened was a lack of appreciation of the epidemic, and the rapidity with which the virus would spread, and [a lack of] understanding of the transmission dynamics, and the conflation of multiple epidemics through that exponential phase. So by the time we were getting to grips with what to do, and how to do it, the epidemic overtook us.¹²⁸

¹²⁷ Interview with Q. Abdool Karim. CODESA was the Convention for a Democratic South Africa and was the forum in which the negotiations that would result in the first democratic election in 1994 occurred. The fraught negotiations took place between 1990 and 1993 and broke down several times. However, by April 1993, a Multiparty Negotiating Forum (MPNF) was in place that ratified the interim Constitution in November 1993, leading to the creation of the Transitional Executive Council (TEC), which functioned until the elections in April 1994. See Beinart, *Twentieth-Century South Africa*, pp. 270 – 285.

¹²⁸ Interview with Q. Abdool Karim. Abdool Karim's analysis of the situation suggests that work being done by other professionals such as R. Schall who presented a projecting of infection in the *SAMJ* in 1990 and Peter Doyle, who devised a model for the insurance industry in October 1990 that would become one of the key models, were not reaching those charged with planning and implementing responses to HIV infections and AIDS. Commenting in 1998 on the work being done by demographers, Alan Whiteside noted that demographers had 'made considerable progress in understanding the dynamics of the epidemic and being able to measure and predict the impact' but there was a problem in 'that there was a barrier between them, and policymakers and planners'. See Whiteside, A. (ed), *Implications of AIDS for Demography and Policy in Southern Africa* (Pietermaritzburg, University of Natal Press, 1998), p. ix. See also Schall, R., 'Statistical Analysis of HIV Prevalence', *SAMJ*, 77, 1, 6 January 1990, p. 52; Schall, R., 'On the Maximum Size of the AIDS Epidemic Among the Heterosexual Black Population in South Africa', *SAMJ*, 78, 9, 3 November 1990, p. 507; Doyle, P., Mühr, T., Steinberg, M., & Broomberg, J., 'Towards Optimisation of the HIV Modelling Process in South Africa' in Whiteside, A. (ed), *Implications of AIDS for Demography and Policy in Southern Africa* (Pietermaritzburg,

Coovadia commented on NAMDA's dissolution and health care provision in a post-apartheid context:

Once the ANC came into power ... everyone else, whether it was the UDF or NAMDA or the NPPHCN ... all of that just folded up. Stupidly, ... most of us thought that once you had a democratic government all people would have the right to speak up and the government would have the interests of all the people at heart, so what was the need for a professional NGO ...? It didn't make sense logically, and I guess it's been in a way ... a harbinger of what transpired so tragically in this country.

Many of us thought that about everything and we relied on and trusted the democratic process to reflect peoples' interests. The fact is, it just hasn't - it hasn't worked and AIDS is a ... particularly grotesque expression of the dissonance between the state and society. How have we become so stupid? How?¹²⁹

University of Natal Press, 1998); and Doyle, P., 'The Demographic Impact of AIDS on the South African Population', in Whiteside, A. & Cross, S. (eds.), *Facing Up to AIDS: The Socio-economic Impact of AIDS in Southern Africa* (London, Macmillan, 1993).

¹²⁹ Interview with Coovadia. During the TRC public sector hearings Kistnasamy appeared to express disappointment at the dissolution of NAMDA when he observed: 'Where is the organisation [NAMDA] today? Unfortunately the Association finally merged with other progressive organisations in 1992 to form SAHSSO'. TRC *Health Sector Hearings*, evidence given by Barry Kistnasamy.

CHAPTER FIVE: INTRICATE RELATIONSHIPS: ILLNESS, IDEOLOGIES AND INTIMATE IDENTITIES – SEXUALITY POLITICS AND AIDS

Throughout the final phase of the struggle against apartheid during the 1980s and the transition to democracy in the 1990s, organisations like the National Medical and Dental Association (NAMDA), the exiled African National Congress (ANC), and the National Party (NP) and ANC-led governments and health departments did not prioritise responses to Acquired Immunodeficiency Syndrome (AIDS). For some organisations, activists, and health care professionals, their sexual identity or personal and professional relationships with (gay) men dying of AIDS mediated the urgency of responding to AIDS. Efforts to organise 'gay communities' around AIDS forced a number of inter-related and complex identity issues to surface which influenced the reactions, discussions and responses to AIDS by individuals and organisations. As always, addressing AIDS brought to the fore the intricate relationships that existed between illnesses, ideologies, and (intimate) identities. This meant, as Edwin Cameron observed 'the unavoidable politicisation of homosexuality'.¹

It is perhaps more accurate to say the unavoidable *public* politicisation of homosexuality, as the private (personal) spheres of sexuality and sexual orientation in 1980s South Africa were already politically fraught. In addition to the usual influences of race, class, gender, morality and religion, conservative politics and laws attempting to regulate sex also shaped sexual identity. While neither laws nor religious condemnation have ever stopped people having sex, they negatively affected public expressions of sexual identity, personal experiences, and discussions about sexual practice. The panic and moral outrage stoked, and provoked, by the initial association of AIDS with white male homosexuals did not allow for reflexive discussion about sex and sexuality. Instead, discourses around AIDS positioned 'homosexuality' and 'homosexuals' negatively in broader public spheres and, in so doing, politicised homosexuality.

¹ Interview with Edwin Cameron, Origins Centre, WITS University, Johannesburg, South Africa, 7 February 2008.

Notions of sexuality, sexual practice and sexual orientation are continually evolving and constantly challenged. The positioning of 'homosexuals' and 'homosexuality' in the hegemonic AIDS narrative in South Africa was mediated by the socio-political context of the time. Authors of the hegemonic scientific narratives often used the term 'homosexuality' to refer to undefined sexual contact between white men. Lesbians, bisexuals, transgendered, intersex and queer people do not feature prominently, if at all, in this narrative, which was preoccupied with an imagined middle-class, white, male, sexuality that was the primary referent against which normative and non-normative behaviours were judged. The hegemonic narrative about homosexuality was constructed as strictly white, excluding the possibility of interracial homosexual relationships. It did not identify men who had sex with men (MSM) but did not consider themselves 'homosexual', nor did it speculate on the class or material conditions of the men involved.² The evocation of ideas of heterosexual 'African AIDS' moving southwards towards South Africa, and homosexual 'Western AIDS' brought into the country by white male homosexuals also served to bind sexualities to imaginary geographic boundaries. In this understanding, 'African' sexuality was heterosexual and dangerous, while homosexuality was not 'African', linked as it was to infected (white) men in 'Europe' and the USA.

Many of these ideas have persisted and continue to be contested in personal, organisational, and academic spaces. Work undertaken by Ruth Morgan and Saskia Wieringa, and by Oka Obono, has explored the diversity of sexualities across the African continent, while Robert Morrell, Graeme Reid and Liz Walker, have explored notions of masculinity and sexuality in southern Africa.³ Work on lesbian, gay, bisexual, transgender and intersex (LGBTI) sexuality in South Africa has captured personal histories and testimonies, and tracked struggles for

² See Aggleton, P., 'Researching Same-sex Sexuality and HIV Prevention' in Reddy, V., Sandfort, T., and Rispel, L. (eds) *From Social Silence to Social Science – Same-Sex Sexuality, HIV & AIDS and Gender in South Africa* (Cape Town, HSRC Press, 2009), for a comprehensive discussion of definitions and understandings of sexuality. For the purposes of this chapter homosexuality refers to definitions of homosexuality prevalent in South Africa at the time, namely sexual relations between people declared to be of the same 'sex', particularly men. Unless otherwise stated, 'gay' is used to define homosexual men.

³ See Morgan, R., and Wieringa, S. (eds) *Tommy Boys, Lesbian Men and Ancestral Wives: Female Same-Sex Practices in Africa* (Johannesburg, Jacana Press, 2005); Obono, O. (ed), *A Tapestry of Human Sexuality in Africa* (Johannesburg, Fanele, 2010); Morrell, R. (ed), *Changing Men in Southern Africa* (Scottsville and London, University of Natal Press and Zed books, 2001) and Reid, G., and Walker, L. (eds) *Men Behaving Differently – South African Men Since 1994* (Cape Town, Double Storey Books, 2005).

LGBTI rights.⁴ Many of these works are reflexive about the history of gender, class and race dynamics inherent in sexuality organisations and research work, and their ongoing significance in contemporary research and activism. There are, however, still obvious absences in work addressing sexuality, as research still focuses predominantly on male sexual activity, with womyn, intersex and transgendered people either less visible or invisible.⁵ In terms of work on male sexual activity, researchers like XinLing Li have begun to interrogate the multiple identities that all individuals hold. Li examines the overlap between identities of 'gayness' and 'blackness' among young black men in South Africa.⁶

There are also publications by organisations like Human Rights Watch, which reveal the extent of violence and abuse still experienced by people because of their sexual orientation and sexuality.⁷ These works remind readers that the personal, especially in terms of sexual identity, is still very political. Many works on sexuality either make reference to AIDS or address different aspects of the intersection between sexuality and AIDS.⁸ Reddy *et al's* *From Social Silence to Social Science* is exclusively focused on themes around same-sex sexuality, gender, and AIDS in South Africa.⁹ The book examines how AIDS and sexuality in South Africa has been researched, and contemplates future research and research practices.

⁴ See De Waal, S., & Manion, A. (eds) *Pride – Protest and Celebration* (Johannesburg, Fanele, 2006); Germond, P., and de Gruchy, S. (eds) *Aliens in the Household of God – Homosexuality and Christian Faith in South Africa* (Cape Town, David Philip, 1997); Gevisser, M., & Cameron, E. (eds) *Defiant Desire: Gay and Lesbian Lives in South Africa* (New York and London, Routledge, 1995); Hoad, N., Martin, K., and Reid, G. (eds) *Sex & Politics in South Africa* (Cape Town, Double Storey Books, 2005); Judge, M., Manion, A., & De Waal, S. (eds) *To Have and To Hold: The Making of Same-Sex Marriage in South Africa* (Johannesburg, Fanele, 2008); and Luirink, B., *Moffies – Homo- en Lesboleven in het Zuiden van Afrika* (Amsterdam, Jan Mets, 1998).

⁵ Over the last few decades the acronym mostly commonly associated with sexuality rights in the English-speaking world has changed from LGB, to LGBT, to LGBTI and, most recently (on internet sites) to LGBTIQQA. The letters stand for L - lesbian, G - gay, B - bisexual, T - transgendered, I - intersex, Q - Queer, Q - querying / questioning, and A – asexual.

⁶ See Li, X., 'Disjunctures within Conventional Knowledge of Black Male Homosexual Identity in Contemporary South Africa', Masters Thesis, Rhodes University, 2009.

⁷ Human Rights Watch Report, "'We'll Show You You're a Woman" - Violence and Discrimination against Black Lesbians and Transgender Men in South Africa' (Human Rights Watch, 2011) available on the Human Rights Watch website at www.hrw.org/sites/default/files/reports/southafrica1211.pdf (accessed December 2011).

⁸ See, for example, Afolabi, M.O., 'Sexual Health Needs of People Living with HIV/AIDS in Osun State, Nigeria' in Obono, *A Tapestry of Human Sexuality*; Campbell, C., 'Going Underground and Going After Women': Masculinity and HIV Transmission amongst Black Workers on the Gold Mines' in Morrell, *Changing Men in Southern Africa*; and Hunter, M., 'Cultural Politics and Masculinities: Multiple-partners in Historical Perspectives in KwaZulu-Natal' in Reid and Walker, *Men Behaving Differently*.

⁹ Reddy *et al* (eds) *From Social Silence to Social Science*. The work also raises important points about the consistent lack of information on homosexual transmission rates. It is ironic, if predictable, that considering the initial scientific research conducted using gay men's bodies and the public focus on homosexual men at the start of the known epidemic, that so little information on something as basic as current transmission and

Gevisser situates AIDS in the history of sexuality politics and sexuality organisations in South Africa, while Mbali's work locates 'gay AIDS activism' in the broader history of AIDS activism.¹⁰ Some activists have written work themselves or featured in published works. There are archival holdings donated by, or pertaining to, activists and organisers that provide insight into individual's experiences of AIDS and sexuality politics. Cameron's autobiographical *Witness to AIDS*, Pegge's chapter entitled 'Living with Loss in the Best Way We Know How', and a description of Shaun Mellor's experience in *Side Effects* all recount personal experiences of addressing AIDS.¹¹ The Gay and Lesbian Archive (GALA) - now referred to as Gay and Lesbian Memory in Action - holds collections relating to the personal lives or work of activists involved in anti-apartheid politics, sexuality politics, and AIDS activism.¹²

Many of these activists were involved in sexuality organisations. As Gevisser's overview of gay 'politics' from the 1950s to the 1990s shows, by the 1980s a number of gay and lesbian organisations existed in South Africa, mostly active in larger urban areas like Johannesburg, Soweto, and Cape Town.¹³ Hoad *et al* incorporate GALA holdings into their work and provide insights into a number of sexuality organisations in South Africa.¹⁴ The GALA holdings include collections relating to a variety of organisations, ranging from the short-lived AIDS Coalition to Unleash Power (ACTUP) Johannesburg, to the Gay Association of South Africa (GASA), and

infection rates is available. For some information in this regard see Wells, H., & Polders, L., 'HIV & Sexually Transmitted Infections (STIs) Among Gay and Lesbian people in Gauteng: Prevalence and Testing Practices', Research initiative of the Joint Working Group conducted by OUT LGBT Well-being in collaboration with the UNISA Centre for Applied Psychology, n.d. c.2004, available on the Southern Africa HIV and AIDS Information Dissemination Service (SAFAIDS) website at www.safaid.net/files/HIV_and_STD_among_Gays_and_Lesbians_research_findings.pdf (accessed December 2011); and Alan Johnson, C., 'Off the Map – How HIV/AIDS Programming is Failing Same-Sex Practicing People in Africa', International Gay and Lesbian Human Rights Commission (IGLHRC), 2007, available on the SAFAIDS website at www.safaid.net/files/Off%20the%20Map.pdf (accessed December 2011).

¹⁰ Gevisser, M., 'A Different Fight for Freedom: A History of South African Lesbian and Gay Organisations from the 1950s to 1990s' in Gevisser & Cameron, *Defiant Desire*; Mbali, M., 'The New Struggle': A History of AIDS Activism in South Africa, 1982 – 2003', PhD thesis, University of Oxford, 2009, especially Chapter 1: Gay AIDS activism prior to 1994; and Mbali 'Gay AIDS Activism in South Africa Prior to 1994', in Reddy *et al From Social Silence to Social Science*.

¹¹ See Cameron, E., *Witness to AIDS* (Cape Town, Tafelberg, 2005); Pegge, J.V., 'Living with Loss in the Best Way We Know How: AIDS and Gay Men in Cape Town' in Gevisser & Cameron, *Defiant Desire*; and Lawson, L., *Side Effects* (Cape Town, Double Storey, 2008), p. 64.

¹² For a more detailed discussion of the GALA holdings see the introduction to this thesis.

¹³ Gevisser, 'A Different Fight for Freedom'.

¹⁴ Hoad, *et al* (eds) *Sex & Politics in South Africa*. The work also contains an excellent guide to the GALA resources.

the Cape Town-based AIDS Support and Education Trust (ASET) which grew out of the 6010 organisation, became GASA-6010, then morphed into ASET, and still exists today as the Triangle Project.¹⁵ These archives provide insights into early responses to AIDS by sexuality organisations which provided counselling, support, and care, organised lectures and workshops, and distributed AIDS education information.

The thesis has primarily focussed on the creation of narratives about AIDS by elites (both medical professionals and people or organisations in positions of political power), and responses and reactions to AIDS by medical and political organisations and successive governments. The initial association and official linking of AIDS with white homosexual men shaped and influenced responses, research, and narratives about AIDS in these and other spheres. There were gay medical professionals and politicians in the organisations and structures discussed in this thesis (although some may have been closeted), but there is no 'gay equivalent' to NAMDA or the Medical Association of South Africa (MASA) or the Progressive Primary Health Care Network (PPHCN). While a small group of gay medical doctors in Johannesburg did occasionally meet up, they were an informal, social group. Neither were there equivalent interest groups within the ANC, although activists like Simon Nkoli worked hard to change conservative attitudes about homosexuality within the organisation.¹⁶ Similarly, MPs for the most part did not declare their sexuality.

The work and archives of individuals provide insights into the experiences of lawyers, progressive figures, and sexuality activists but do not reveal much about the experiences of homosexual medical practitioners. The stories of gay health care professionals living and working in a homophobic society and within a professional medical community at the start of an epidemic linked explicitly to gay men are important, but not readily available. To address this shortcoming, this chapter is going to follow the example set by Oppenheimer and Bayer in *Shattered Dreams* and use oral interviews to examine the experiences of two

¹⁵ See GALA collections: ACTUP Johannesburg (AM 2690); GASA (Gay Association of South Africa) (AM 2975); and ASET (the AIDS Support and Education Trust) (AM 2974). For information on the Triangle Project see their website at www.triangle.org.za (accessed December 2011).

¹⁶ For more on the ANC's attitude to homosexuality see the Foreword to Hoad *et al Sex & Politics* by R.S. Mompoti and the essay and archival materials on pp. 140 – 153.

gay health care professionals addressing AIDS during the early years of the epidemic.¹⁷ *Shattered Dreams* uses oral histories to chronicle the experiences of a range of health care professionals involved in AIDS research, treatment, support, and activism. The book incorporates interviews with gay doctors, including Dennis Sifris and Steve Miller, and, in recording their oral histories, begins to address how some gay health care professionals experienced the epidemic. This chapter expands on the oral testimony of Sifris that appears in *Shattered Dreams* and contributes the oral testimony of Pierre Brouard.¹⁸

Sifris is a medical doctor who worked with Ruben Sher and helped establish the AIDS Clinic at the Johannesburg General Hospital (also known as 'Joburg Gen') and has been involved in AIDS education campaigns since the early 1980s.¹⁹ Brouard is a clinical psychologist who was involved in early counselling and support initiatives for people who were Human Immunodeficiency Virus (HIV) positive at a variety of venues, including the clinic at Joburg Gen, the first AIDS Training and Information Centre (ATIC) based at the South African Institute for Medical Research (SAIMR), and the City of Johannesburg's Esselen Street sexually transmitted infection (STI) clinic in Hillbrow.²⁰ Both Sifris and Brouard moved between and through the spheres of medical science, activism and sexual identity while attempting to address AIDS. They were also involved with a number of official political

¹⁷ Oppenheimer, G.M., & Bayer, R., *Shattered Dreams? An Oral History of the South African AIDS Epidemic* (New York, Oxford University Press, 2007).

¹⁸ Both Brouard and Sifris agreed that their stories could be used in this chapter and both have seen and commented on drafts of the chapter. Reflecting on the similarities between events that are recorded in *Shattered Dreams* and which also featured as part of Sifris' interview with the author it is evident that some of the events were significantly central to Sifris' personal history that he chose to recount them in both interviews. Considering that individuals, families, and communities recount and refine the stories that are significant to us and our sense of ourselves and our identities this is worth noting. It also suggests that an interesting avenue of research would be to do detailed discourse analyses of how individuals recount their central stories in relation to their involvement in AIDS-related fields. Many of the questions asked of oral history more generally, and of the role of oral history in South African historiography specifically in relation to autobiography and anti-apartheid struggle narratives, would be interesting to re-exam in relation to narratives around the 'new struggle' against AIDS.

¹⁹ Ruben Sher was one of the first medical researchers into AIDS in South Africa. The Johannesburg General Hospital is now the Charlotte Maxeke Johannesburg Academic Hospital, see www.johannesburghospital.org.za for more information (accessed December 2011).

²⁰ The SAIMR is now the National Health Laboratory Service (NHLS). According to their website 'the National Health Laboratory Service (NHLS) was established in 2001 by an Act of Parliament, amalgamating the former South African Institute for Medical Research (SAIMR), National Institute for Virology and National Centre for Occupational Health as well as university and provincial pathology laboratories'. See NHLS website at www.nhls.ac.za (accessed December 2011).

bodies or organisations, and moved in the same professional, political or personal circles as people mentioned in previous chapters.

Sifris worked with Sher who was a member of the Advisory Group on AIDS that collated information on AIDS cases and advised the NP-led government on matters relating to AIDS policy, procedures, HIV infection rates, and testing. Sher was based at the SAIMR. Quarraisha Abdool Karim - who was part of the PPHCN, a NAMDA supporter, and would go on to become the Director of the ANC-led government's National AIDS Plan in 1995 – was one of Sher's postgraduate students. Brouard, through his work at Joburg Gen and the SAIMR ATIC, knew both Sher and Sifris, and worked with Mary Crewe, Clive Evian and Simon Nkoli at the Esselen Street clinic. Crewe and Evian were involved in progressive primary health care structures and organisations, while Evian was a member of NAMDA. While Sifris and Brouard are both professional, white, middle-class, urban, gay men, whose paths overlapped and who shared some similarities in their experiences of the early days of the AIDS epidemic, their professions, personalities, and individual contexts resulted in different experiences. But the politics of sexual identities influenced both of their engagements with the AIDS epidemic.

This chapter focuses on intimate, personal recollections to show how the words and comments written and printed in other spheres helped create social mores - like homophobia – which were experienced by thinking, feeling, individuals. Sifris' and Brouard's recollections serve to document the emotional effects of AIDS. This is an important counterpoint to the 'unemotional' writing about AIDS in the *South African Medical Journal (SAMJ)*, or the politically charged language in parliament, or the official organisational correspondence of the ANC, and serves as a reminder of the emotional and psychological realities of an epidemic that continues to take lives.

Sifris and Brouard were mostly involved in AIDS work in urban centres and their personal reflections provide *vignettes* that contribute to understanding how narratives about, and responses to AIDS (and sexual orientation) affected individuals. Their stories provide insight into personal experiences of addressing AIDS in the early years of the epidemic when researchers and decision-makers were constructing a hegemonic AIDS narrative that was

fundamentally conservative and homophobic. Their stories are micronarratives that act as a counterpoint to the metanarratives featured elsewhere in this thesis.

Being 'Gay' In Apartheid SA

Being gay in South Africa has been a process mediated by apartheid legislation and questions of morality, race, sex, gender and class. As Gevisser and Cameron note, 'there is no single, essential "gay identity" in South Africa. What has passed for "the gay experience" has often been that of white, middle-class urban men'.²¹ At the outset it was predominantly communities of urban, middle-class, white, men – with multiple gay identities - who came together to organise around AIDS and it is this 'community' that is most visible in the historical record.²²

The oppressive, conservative, moral climate of 1980s South Africa did not allow sexuality organisations or LGBTI 'communities' to flourish, especially not in a context where (male) homosexuality - or more specifically, sodomy - was illegal.²³ While gay organisations and communities in the USA and UK had fought for, and built on, social changes in the 1960s and 1970s, in South Africa apartheid's effect on sexuality politics meant that corresponding socio-political gains had not been made. Despite this, some gay activists maintained international contacts with gay organisations and AIDS education organisations in the UK and the USA, resulting in a flow of information and exchange of ideas between South Africa and countries with more established and politically active gay communities.

Gay groups were not necessarily concerned with addressing sexism, racism, homophobia, or sexuality politics. Agendas ranged from providing safe social spaces to gather and talk,

²¹ Gevisser & Cameron, *Defiant Desire*, p. 3.

²² This is not to suggest that there were no (lesbian) womyn or gay 'black' activists - *Defiant Desire* shows this is not the case – but rather that additional research is needed to reveal their involvement more fully as the archives and publications mostly record the voices of white, middle-class gay men. While recognising that there is no essential 'gay identity' this does not preclude people with differing notions of gay identity coming together around common causes and concerns and thereby forming 'communities' of people.

²³ This said, as Conway has shown, there were also complex, and sometimes surreal, moments in South Africa's 'gay history' that highlighted the multifaceted interplay between ideologies and socio-political realities in the country. See Conway, D., 'Queering Apartheid: The National Party's 1987 "Gay Rights" Election Campaign in Hillbrow', *Journal of Southern African Studies*, 35, 4, December 2009.

directing legal challenges to homophobic legislation and laws that discriminated against people because of their HIV status, to aligning the struggle for sexuality rights within broader anti-apartheid and international human rights campaigns. Gevisser and Cameron note that the two factors that exemplify 'homosexual experiences' in South Africa are 'the history of division and resistance' and 'the demographic divergence our country reflects'.²⁴ They note that 'From the "developed world", we inherit notions of sexual freedom and gay subculture; from the "developing world" we gain the imperatives of struggle, resistance, and social transformation'.²⁵

As with the change over time in the medico-scientific AIDS narratives from a focus on 'high-risk groups' to an emphasis on broader 'human rights', the narratives and course of sexuality politics also moved from 'group' to 'global' engagement. Gevisser argues that there was a 'major shift from the "apolitical" (read conservative) gay movement of the 1980s to the liberationist gay movement of the 1990s, which took as its starting-point the need to fold lesbian and gay issues into the agenda of the broader anti-apartheid movement'.²⁶

While the individual and collective aspects of sexuality politics have often existed in tandem, what is evident in sexuality politics in South Africa is a movement from efforts to support the individual needs of certain groups of people dealing with the processes of understanding their sexual identity, to broader struggles for sexuality rights as human rights. Gevisser notes that 'the failure of gay politics in the 1980s was that it was overtaken by the march of black liberation in those same years, and that it was unable – or unwilling – to align itself in any way with that march'.²⁷

While AIDS featured strongly in gay politics in the 1980s, the struggle against it was not linked by many white homosexuals to the wider struggle against apartheid. This had the effect of sowing division within gay constituencies, because of competing ideas of freedom, struggle, identity, and activism. Cameron put it this way:

²⁴ Gevisser & Cameron, *Defiant Desire*, p. 5.

²⁵ *Ibid.*

²⁶ *Ibid.*, p. 10.

²⁷ Gevisser, 'A Different Fight for Freedom', p. 48.

That whole debate in the gay and AIDS movement was quite an important debate because it's the debate about, to put it grandiosely, the ultimate politicisation of sexuality and of identity, so ... I was trying to persuade gay organisations that you couldn't take any stand removed from the freedom struggle ... you couldn't say 'well we're just a gay lobby group we are neutral on those issues' so that was the larger debate ... to what extent did they ignore the very pressing issues of national politics? And the white gay men wanted to ignore them.²⁸

The 1980s was a time of increased organisation and mobilisation around sexuality issues. In the early 1980s the apolitical GASA was established, growing into a national organisation with over a thousand members. It had its own publication (*Link/Skakel*), and established a counselling service known as the Gay Advice Bureau (GAB).²⁹ Its membership was predominantly made up of white, male, middle-class professionals and there was little space for progressive activists (whether gay or lesbian), or for black members.³⁰ The organisation 'facilitated a groundswell of gay activity that focussed the gay community and provided the basis for the more radical and politically explicit lesbian and gay activism that was to follow it'.³¹ Simon Nkoli's experience of being a black man in the predominantly white Johannesburg GASA branch led to his establishing organisations that catered for black gay men and for people with AIDS. Some of the earliest responses to AIDS came from GASA-aligned organisations, or GASA members like Dennis Sifris.

Dennis Sifris – The Physician Who Emptied the Dance Floor

Sifris and Sher first started working together in the late 1970s. Sher had heard that Sifris had 'a large gay practice' and asked Sifris if he would collect serum samples for a hepatitis B study. After the first official AIDS deaths in South Africa they met to discuss possible research collaboration. Sher was based at the SAIMR and Sifris had his practice rooms in Jeppe Street in Johannesburg's CBD. While this initial collaboration would result in a long-term professional relationship between them, Sifris' experience as a physician involved in AIDS

²⁸ Interview with Edwin Cameron.

²⁹ Gevisser, 'A Different Fight for Freedom', pp. 48 - 50.

³⁰ *Ibid.*, p. 52.

³¹ *Ibid.*

research was mediated by how colleagues and government officials responded to his sexual orientation.

While collaborating with Sher, Sifris initiated moves to address AIDS among ‘the gay community’.³² Sifris contacted other gay doctors (an anaesthetist, a psychiatrist, and a neurosurgeon) to discuss what actions could be taken. One of the first things they did was to ‘put the word out in the gay community that there was this disease which nobody really knew about’, while calling for volunteers to come forward and give blood samples to be sent to Sher at the SAIMR.³³ Sher and Sifris also compiled a questionnaire that followed research in the USA and UK and included questions about the number of sexual partners volunteers had, their medical history and current state of health, and their use, if any, of recreational drugs.

To undertake this work Sifris decided to open his practice for an additional period on Saturday mornings:

word got out and we actually got about 700 to 800 people coming to my office over a period of about four or five months and we pulled the bloods and we didn’t quite know what we were looking for. We did a full blood count, we did an STD [sexually transmitted disease] profile and we stored bloods to see if there was anything we could find³⁴

Sifris kept a list of names that linked volunteers to their blood samples, but there was little that could be done medically to assist the increasing number of people who in the mid-

³² As the quote from *Defiant Desire* included in the text above indicates, the notion and definition of ‘a gay community’ (as opposed to many different communities, or even the total lack of a community) is a complex one. In the context of this chapter it refers to notions of community identified by the informants themselves. While the definitions of ‘community’ may have varied between informants, the fact that the term was used indicates a notion of communal identity that framed the informants thinking. Sifris, for example, used the term ‘gay community’ but also noted, in reference to a request by an international speaker to speak to the gay community that ‘the gay community wasn’t really in existence at that time’(mid-1980s).

³³ Interview with Dennis Sifris, Sifris’ Practice, Johannesburg, South Africa, 26 February 2008.

³⁴ *Ibid.* In addition to encouraging people to go to Sifris’ practice, Quarraisha Abdool Karim recalls that Sher and Steven Miller (who was also based at the SAIMR) went on radio and asked concerned men to come for screening at the SAIMR. Her experience echoed Dennis Sifris’ as she recalls ‘long queues of men arriving from across South Africa [and from] Swaziland and Lesotho. We were clueless – took brief histories, took specimens, and ran every possible test.’ Interview with Quarraisha Abdool Karim, Abdool Karim’s Office, CAPRISA, UKZN, Durban, South Africa, 19 November 2007.

1980s had given samples and started to become sick and die. The lack of an effective medical response did not necessarily make the medical community in Johannesburg more interested in learning about non-medical engagements and responses, as is evident from Sifris' account of a visit to Johannesburg by Glen Margo in 1985. Margo, who was originally from South Africa, was involved in AIDS education in San Francisco. He contacted GASA as he wanted to deliver talks about AIDS to the gay community. Sifris was involved with GASA and agreed to set up lecture opportunities for Margo. Sifris also arranged for Margo to give a lecture to the Department of Medicine at Joburg Gen. At the time, the public academic hospital was segregated and primarily served the white residents of Johannesburg. Despite this, it was to play a central role in early medical responses to AIDS. The politics and social mores of the times, however, often hampered these responses, as is evident in Sifris' recollection of Margo's lecture:

There were all these cardiologists and respiratory physicians and this hippy San Francisco guy came along with handmade sandals and ringlets in his hair and told them about this funny disease that was affecting gay men that they should all be aware of ... and he was almost laughed off as a joke. It was a wee bit embarrassing but that was the context of the medical community.³⁵

It is unsurprising that medical elites in Johannesburg did not pay serious attention to a 'hippy' social worker talking about something that apparently only affected 'gays'. However, as Sifris was to discover, even being a medical doctor defined as 'non-hippy', 'white', and male, did not guarantee an attentive audience if one did not also 'pass' as heterosexual.

Sifris and Sher managed to persuade hospital authorities to allow them to establish an AIDS Clinic at Joburg Gen in 1983. By 1985 Sifris was managing the daily running of the clinic, and Sher moved between the clinic and the SAIMR. Sifris and Sher decided to bring specialists from various fields, including respiratory illnesses, dermatology and gastroenterology, into the clinic. Despite the association of AIDS with gay men, Sifris recalls that the first person they saw as an outpatient at the clinic was an HIV-positive (at that point HTLV-III positive) womyn. Sifris remembered the occasion:

³⁵ Interview with Dennis Sifris.

She came in and we sort of sat there, eight of us doctors ... you know this poor woman came in, I still remember her sitting there. She didn't even know she was married to a bisexual man – she knew nothing about it ... and I think she was intimidated by all these doctors sitting there in their white coats.³⁶

After that consultation, the group decided that it would be better to call in various specialists on a consultancy basis rather than have all specialists present. The experience of being surrounded by doctors, or nurses in biohazard suits, would be a common experience for AIDS patients for many years, as Shaun Mellors' experience confirms.³⁷

During the mid-1980s there was an increase in the number of patients attending the clinic, along with increasing admissions of people with AIDS-related complex to the hospital. Sifris noticed that among those admitted 'were some of the guys we had seen two or three years ago, who were friends of mine. A lot of them were SAA people who were now getting sick and dying with this disease, and this was the time in the hospital where they were doing barrier nursing'.³⁸ For Sifris, the epidemic had a particularly personal dimension.

In 1985 the Advisory Group on AIDS (AGA) was formally constituted with Sher as one of its members. A medical background, an interest in AIDS, and experience researching and monitoring the epidemic did not guarantee membership of the Group, as Sifris was to discover. He was told that he 'unfortunately' could not join because he belonged to a high-risk group and '... if we [the Group] have a gay man on the AIDS Advisory Group we have to

³⁶ Interview with Dennis Sifris.

³⁷ In 1986 Mellors was studying to become a teacher and worked part-time at a supermarket. After collapsing at work, Mellors was rushed to Joburg Gen where a doctor asked him if he had had swollen glands or unexpected weight loss, and if he was homosexual. Mellors confirmed that he was gay after which the doctor left the room for a few minutes. When she returned she informed him that he had AIDS, despite not having taken any blood tests, and probably had about six months to live. Mellors spent two weeks in the hospital undergoing tests without access to any counsellors: 'I remember having endless groups of students coming in to have a look at me, to prod me, to feel me, to ask me questions – but they all had the full space suit on before they would come in - and then they'd feel and prod and ask you questions, "How do you think you got this?" It was horrible and intense this two weeks of being prodded and ... eventually after they came and drew the blood and the test came back as positive they decided to discharge me. Then they referred me to Prof. Ruben Sher at the SAIMR and he was the first person that actually said to me "It's ok – it isn't a death sentence"' (Interview with Shaun Mellors, Mellors' Office, International HIV/AIDS Alliance, Brighton, UK, 8 September 2006). Mellors not only survived and is still living with HIV, but went on to become a prominent international AIDS activist

³⁸ Interview with Dennis Sifris.

have a prostitute, we have to have a Haitian, and we have to have a “black”...’.³⁹ This decision made him determined to ‘just go ahead and do my own thing’. This meant calling on other medical professionals like Steve Miller, Des Martin and Clive Evian to work with him at Joburg Gen; and, in conjunction with GASA, he established an alternative AIDS group.⁴⁰ Sifris and other ‘...concerned professionals and volunteers’ formed the AIDS Action Group in 1985, with the intention of providing ‘psychological, social and concrete support services for people with AIDS and the AIDS-related complex.’⁴¹ The group shared information about AIDS with interested parties and undertook education campaigns amongst sections of the gay community in Johannesburg.

On trips to the USA and UK, Sifris gathered literature ‘and came home with bundles of it’.⁴² The AIDS Action Group decided to distribute information leaflets and safe-sex cards in gay clubs in Johannesburg. The Group asked club owners if they could set up information desks outside their clubs and make announcements inside. The owner of one club was helpful and with his support the Group set up ‘a little [information] thing outside and people walked passed and we said, “Hey, we are giving out safe sex cards”, and everyone kept away from us’.⁴³ Sifris asked on one occasion if the music in the club could be stopped at midnight so that he could make an announcement:

...so they stopped the music and I came out onto the dance floor with a microphone and I said, “listen this is not a police raid or anything, just relax, nothing is happening here, I just want to make everybody aware that there is a problem called HTLV-III which is affecting gays in America and all over the world”

³⁹ Interview with Dennis Sifris. This story is also recounted, with variations in Oppenheimer & Bayer, *Shattered Dreams*, p. 30.

⁴⁰ As discussed in the chapter on NAMDA, at this time Steve Miller worked at the SAIMR and had ties with NAMDA while Clive Evian worked part-time as a clinician at the HIV Clinic at the Johannesburg General Hospital, worked at the Department of Community Health, University of Witwatersrand and became Deputy Director of the Johannesburg City Health Department in 1989. Desmond Martin worked at the National Institute of Virology, lectured in virology at WITS and the University of Pretoria and was a founder member and President of the HIV Clinicians Society of South Africa (1998) and launched the *Southern African Journal of HIV Medicine* in 2000. For more information on Martin see: Bekker, L, ‘Tribute - Des Martin’, *Southern African Journal of HIV Medicine*, 8, 2, 2007 (accessed on journals website at www.sajhivmed.org.za/index.php/sajhivmed/article/view/72/37, December 2011).

⁴¹ Interview with Dennis Sifris, and Sifris, D., ‘Serological test for AIDS’, *SAMJ*, 69, 9, 26 April 1986, pp. 539 - 540. The AIDS Action Group never kept any formal minutes or archives and there is scope for additional research and oral interviews.

⁴² Interview with Dennis Sifris.

⁴³ *Ibid.*

and everyone just moved away from me. I stood there in the middle of the dance floor trying to say, “Now listen people it is up to you to volunteer, to create awareness, to get the people aware, to give out pamphlets and please we have a desk in front, please come and sign.” Two people came to sign. There was no interest, just apathy – like we were ruining the party.⁴⁴

The pre-emptive declaration in Sifris’ statement that his announcement was not part of a police raid speaks to the constant stress, suspicion, and fear of arrest that was associated with being gay in South Africa.⁴⁵ The unwillingness of people to listen or respond to a potential health concern mirrors responses in most communities when faced with frightening news.⁴⁶ It is not possible to determine how effective these interventions ultimately were, nor how much impact the distributed literature may have had on awareness raising. Nonetheless, it is significant that at a time when official responses to AIDS failed to cater for a group of people identified as ‘high-risk’, alternative, non-official efforts were made to raise awareness and provide support.

The group decided to focus their energy on talks, engaging with the press and fundraising for AIDS-related work. Sifris and Sher were already doing talks in a variety of fora for audiences ranging from medical professionals to staff and students at schools, to ‘a group of Jewish single people over the age of 40’. Sifris gave talks to gay groups around the country and spoke at the official opening of Simon Nkoli’s Township AIDS Project (TAP) in Soweto in 1990.⁴⁷

Sifris spent time receiving phone calls from journalists seeking his expert medical opinion, or challenging journalists and editors about homophobic or inaccurate content in articles. He felt frustrated that many journalists were more concerned with writing sensationalist articles than with conveying educational information. These challenges extended to his

⁴⁴ Interview with Dennis Sifris . This incident is recounted in Oppenheimer & Bayer, *Shattered Dreams*, pp. 26 – 27.

⁴⁵ Fear of the police and security forces and of being arrested for being ‘black, indian, coloured’, communist, subversive, immoral or gay, was an overarching feature of 1980s South Africa. In terms of sexual practices, activities deemed subversive or illegal, included sexual activity across the ‘race’ line and male same sex intimacy.

⁴⁶ For more on this see Doka, K.J, *AIDS, Fear, and Society* (New York, Taylor and Francis, 1997).

⁴⁷ GALA - Cameron Collection (AM 2629), Correspondence and Organisational Material, GLOW Newsletter *Glowletter*, June 1990.

engagements with the editor of *Exit* the longest running gay magazine in South Africa. *Exit* was originally known as *Link/Skakel*, and started in the early 1980s as GASA's newsletter. It was renamed *Exit* in 1985 and published its 200th edition in 2006 when it cast a reflexive eye on some aspects of its reporting on AIDS. Henk Botha and David Moolman both edited the publication during the 1980s. Sifris criticised Moolman for running a sensationalist article about a person apparently getting AIDS from their dentist, rather than featuring comprehensive AIDS education information.⁴⁸ Botha reflected on the early years of *Exit*:

During the 1980s a new 'gay disease' was discovered in America and eventually found its way here. Although we started publishing safe sex guides and lists of symptoms, very little was known about this mysterious killer affecting - at that stage - mostly gay men. This is where I, to my shame, made a crucial error. I am still haunted by the front-page headline that said something to the effect "Aids [sic] Scare Overrated". How wrong could I have been?⁴⁹

Sifris' and Botha's experiences reveal the tensions in the media's role in contributing to public knowledge and providing 'bland' medical information, and the imperative to publish exciting 'newsworthy' stories.⁵⁰

An exclusive 'black-tie' event and art auction launched the AIDS Action Group's fundraising initiative. Invitations targeted wealthy, white gay men with disposable income. The event raised close to ten-thousand rand for what was referred to as the 'AIDS Action Fund'. Another 'big gala fete' called 'Shaft 8', included information and education stalls and provided an opportunity to remember those who had died. Sifris

set up a little AIDS stall ... and ... I bought those ... Jewish *yahrzeit* candles, and I laid out a table with one candle for each person who had died of AIDS. I think

⁴⁸ When GASA started experiencing internal crises in the mid-1980s it decided to stop publishing *Link/Skakel*. Moolman then invested his own money and revived the publication as *Exit* until his death in the late 1980s. Henk Botha had been the initial editor of *Link/Skakel* and had continued to work with Moolman on *Exit*. Botha took over after Moolman's death and ran the magazine until January 1990 when he sold it to Gerry Davidson. For more on *Exit*'s history see the following available on the *Exit* website: Botha, H., 'Exit: Memories of the Early Years' at www.exit.co.za/frnArticle.aspx?art=41; and Hayward, G., 'Exit @ 200: South Africa's Gay Newspaper' at www.exit.co.za/frnArticle.aspx?art=37 (both accessed December 2011).

⁴⁹ Botha, 'Exit: Memories'.

⁵⁰ Sifris and his partner James Myhre now contribute to the health section of *Exit* by addressing 'Questions to Dr D' to do with AIDS, HIV, and sexual health, so his current engagement with the (gay) press does allow for the passing on of medical information.

that was something like 32 people at the time - 32 candles burning right through the whole night. It was my way of doing something to remember them ...⁵¹

The Shaft 8 event raised a significant amount of money and brought 'all the gay communities together' - a gay Christian community, a support group called Outreach, the Gay Medical Group (Sifris was a member of this group who met to socialise and discuss work), a gay motorcycle group, and 'gay lesbians'. While AIDS may have connected these communities, it hardly united them. Sifris noted that there was 'all sorts of internal politics ... and stress' in the organisation.⁵² There was little engagement with any black gays or lesbians and often a lack of gender sensitivity or awareness of racial prejudice. AIDS may have created spaces for collaboration and cooperation, but these spaces were not necessarily all-inclusive or self-reflexive; and addressing AIDS amongst a certain group of gay men who experienced discrimination did not amount to challenging the economic, social or racial position of that group of men, nor other forms of discrimination.

In order to increase fundraising opportunities, and more effectively distribute and manage funds, the group needed an official fundraising number.⁵³ It prepared a proposal outlining its plans to print pamphlets and undertake a countrywide outreach programme, and had it endorsed by medical professionals, a professional in the finance sector, and people in the marketing and advertising sectors. The group presented the proposal to a representative from the Department of Health and asked for a grant of twenty-thousand rand. However, because the organisations associated with the project were sexuality organisations, the fundraising number and the grant request were denied.⁵⁴ The group made a presentation backing the grant request to 'Buks' Lombard, a member of the Department of Health in Pretoria. Lombard apparently listened carefully to the presentation and then said, 'You

⁵¹ Interview with Dennis Sifris. In Judaism the death of a loved one can be commemorated annually at the *yahrzeit* during which a *yahrzeit* candle, which burns for 24 hours, is lit in remembrance of the deceased person.

⁵² *Ibid.*

⁵³ Under the Fundraising Act of South Africa, 'charity' organisations that wanted to fundraise had to be registered as a charity and apply for a fundraising number. This process required government approval of the organisations. This Act was repealed and the Non-Profit Organisation Act was passed which made registration as an NPO voluntary and removed the legal requirement to have an NPO 'fundraising' number.

⁵⁴ Miller recounts a similar story in *Shattered Dreams* noting that 'the government quite openly said we do not give fundraising numbers to criminals.' To circumvent this, gay organisations would collaborate with sympathetic organisations who would allow them to use their fundraising numbers. See Oppenheimer & Bayer, *Shattered Dreams*, p. 26.

know, AIDS is not a problem in this country, TB is a problem in the country. Besides which homosexuality is illegal, and we don't have homosexuals, so we don't have AIDS'⁵⁵.

The Department's rejection of their request for funds meant that they were not able to initiate extensive AIDS education programmes based on those of the San Francisco AIDS Foundation, the Gay Men's Health Crisis, London Lighthouse, and the Terrance Higgins Trust, whose pamphlets they were using as a basis for their own small, local campaigns.⁵⁶ The content, politics, and practice of AIDS education programmes developed by, and for, male gay communities in the USA and UK, along with the alternative narratives they presented, shaped and influenced responses amongst some sectors of the male gay community in South Africa. In Sifris' case, the frustration at not being able to implement 'ready-made' education programmes that could help prevent deaths, was compounded by the denial of the very existence of homosexual men. This served as a reminder of how groups of people were rendered 'invisible' in official apartheid discourse.

Even if the grant had been successful, there is no guarantee that imported education campaigns would have been appropriate to the South African context, or that they would have been effective. In the absence of any official response or help for gay communities, they would at least have bolstered existing education efforts by gay organisations to prevent new infections.⁵⁷ Access to medical scientists and research organisations in the UK and USA shaped both Sifris' and Sher's professional engagement with AIDS, and contact with gay activists in the USA and UK deeply influenced Sifris' personal and political outlook.⁵⁸

⁵⁵ Interview with Dennis Sifris. Sifris also stated, 'I only wish I had a tape recorder, because I quote verbatim and I remember ... what he said.'

⁵⁶ *Ibid.* Sections of this story are recounted in *Shattered Dreams*, p. 31, but without reference to Lombard's comment about homosexuality being illegal.

⁵⁷ While further research is needed on the 'efficacy' of campaigns amongst gay communities in South Africa, work by Nicoll et al indicate that UK-based programmes designed and implemented by gay communities or organisations (including some of those mentioned by Sifris) did help reduce infection rates. See Angus Nicoll, A., Hughes, G., Donnelly, M., Livingstone, S., De Angelis, D., Fenton, K., Evans, B., Gill, N., & Catchpole, M., 'Assessing the Impact of National Anti-HIV Sexual Health Campaigns: Trends in the Transmission of HIV and Other Sexually Transmitted Infections in England', *Sexually Transmitted Infections*, 77, 4, August 2001 available on the *British Medical Journal* website at <http://sti.bmj.com/content/77/4/242.full> (accessed December 2011).

⁵⁸ Sher had contact with the Centre for Disease Control and other hospitals in the USA, and attended key international AIDS conferences. For more information see: Mbali, M., 'The New Struggle', Chapter 1: Gay AIDS activism prior to 1994; Sher, R., & Metz, J., 'Third International AIDS Conference', *SAMJ*, 72, 6, 19 September 1987; and Sifris, D., 'Tribute - Remembering Ruben Sher', *Southern African Journal of HIV Medicine*, 8, 3, 2007

Sifris remembered going with Sher to a research lab in Bethesda, Maryland, and being 'drag[ged] into the halls of the Walter Reed Hospital in Washington or to some top-level research conference'.⁵⁹ In 1985 Sifris went on ward rounds at the San Francisco General Hospital and at the AIDS unit in London, experiences that 'really opened [his] eyes' to the realities of the epidemic, the strategies being employed to address AIDS, and the remarkable solidarity and politicisation occurring around AIDS.⁶⁰

Sifris had his most profound experiences at the points of intersection between personal, professional, and political spheres. In the mid-1980s he attended an AIDS conference in Washington where members of the AIDS Coalition to Unleash Power (ACT-UP) protested over the lack of action in addressing AIDS. The conference changed Sifris' understanding of how to address AIDS:

... Larry Kramer was there from ACT-UP and he was wearing a concentration camp uniform. At the time, and I thought this was very strange, he would shout and scream and carry on. They had a scientific session, and they had one or two sessions of people with AIDS and it was very funny because people stood up and said, 'I am so and so, and I have got HIV' - and everybody applauded, and everybody clapped for support ... it was really something special. I remember that to this day and I really learnt a hell of a lot [particularly] that there was a lot of mobilisation.⁶¹

During trips to London, New York and San Francisco, Sifris took part in AIDS memorials that made a lasting impression on him. He remembered

available on the journal's website at www.sajhivmed.org.za/index.php/sajhivmed/issue/view/5 (accessed December 2011).

⁵⁹ Sifris, 'Tribute', p. 7.

⁶⁰ Interview with Dennis Sifris.

⁶¹ *Ibid.* Note: Sifris dates the conference to June 1985, however ACT-UP was only formed in 1987 and the International AIDS Conference of 1987 was held in Washington, D.C so it is possible that this was either another conference that Kramer participated in as a member of a pre-ACT-UP organisation (Kramer was initially a founding member of the Gay Men's Health Crisis) or that Sifris made a mistake with the dates. ACT-UP defines itself as 'a diverse, non-partisan group of individuals united in anger and committed to direct action to end the AIDS crisis' and was founded by, amongst others, playwright and outspoken activist, Larry Kramer. For more on ACT-UP (AIDS Coalition to Unleash Power) see the website at www.actupny.org and for more on the history of ACT-UP and interviews with founding members see the ACT-UP Oral History Project website at www.actuporalhistory.org. For the filmed interview and transcript of the interview with Larry Kramer made as part of the oral history project see Interview with Larry Kramer, by Sarah Schulman, Interview no. 035, 15 November 2003, available at www.actuporalhistory.org/interviews/images/kramer.pdf (all websites accessed December 2011).

... being at Rock Hudson's memorial. I was in Castro Street and they had it at Castro's station there, a candlelight memorial for Rock Hudson [it was] very moving. I remember seeing the memorial quilt in Vancouver, for the first time. They unfurled the quilt and there wasn't a dry eye in the house, everybody was crying ...⁶²

Contacts with gay organisations and (gay) doctors working in AIDS research and education in the USA and UK were important in providing models of engagement, education, commemoration, and grieving. For Sifris and others, like Miller, who participated in conferences and marches overseas, these were spaces that demonstrated the potential for public protest, and subsequently influenced education and mobilisation efforts among sectors of the gay community in South Africa.⁶³

On a trip to San Francisco a group called 'Physicians for Human Rights' invited Sifris to attend a braai. Inspired by the experience, Sifris decided to start a gay doctors group in Johannesburg. This group of clinicians, who numbered about twenty, used to meet at the HIV Clinic on a monthly basis, brought together because of an interest in HIV. The primary aim, was 'just to keep everybody up to date with HIV news', but 'eventually it just sort of fell to pieces because nobody was interested in coming anymore because there was not much more we could do'.⁶⁴ It was only in the late 1990s that Sifris, Des Martin and others decided to establish a new association, the Southern African HIV Clinicians Association. This was open to all clinicians involved in HIV work and included a number of gay doctors. Martin was appointed the first chair of the organisation, and its initial meetings were held at the National Institute of Virology. From small beginnings the organisation has continued to grow

⁶² Interview with Dennis Sifris. Sifris also wrote about the memorials and candlelight vigils when he presented the Inaugural Prof. Ruben Sher Memorial Lecture in 2008 at a meeting of the Southern African HIV Clinicians Society noting: 'I remember the candlelight vigils in San Francisco. New York and all major US cities, I remember particularly being at the poignant and moving candlelight memorial for Rock Hudson in The Castro in San Francisco' and 'This was the start of Community mobilization, the founding of the AIDS Memorial Quilt, which I remember seeing for the first time, unfurled, in huge football stadium in Montreal. A moving, unforgettable and emotional experience'. Copy of lecture given to author by Sifris.

⁶³ In the Inaugural Prof. Ruben Sher Memorial Lecture, Sifris recounted that 'There were protest marches, and I remember marching at the Sixth International conference on AIDS in 1990 with the American Association of Physicians for Human rights in Montreal. Steve Miller and I were so proud that we marched right next to June Osborn, who was the Dean of medicine at UCSF and Paul Volberding one of the first and foremost HIV specialists in San Francisco.'

⁶⁴ Interview with Dennis Sifris.

and five years ago claimed to be ‘the largest professional HIV interest group in the world, with over 12,500 members’.⁶⁵

The mid-1980s were to be a particularly turbulent time in South Africa, both for anti-apartheid activists and for sexuality activists. In 1986 GASA collapsed, but its demise, Gevisser notes, resulted in ‘two new forms of gay political activity’. One ‘found the notion of single-issue gay politics to be untenable in South Africa’ and sought to align sexuality struggles with broader human rights and anti-apartheid struggles; the second ‘insisted on fighting specifically for the reform of laws that discriminated against homosexuals’.⁶⁶ The focus on law reform came about because of a decision by President PW Botha to investigate the Immorality Act, leading to the creation of an *ad hoc* committee tasked with investigating homosexuality. This committee proposed a strengthening of legal prohibitions against homosexuals, that greater effort should be made to determine how to appropriately rehabilitate or punish homosexuals, and that a strategy should be formulated to express society’s repugnance for homosexuality.⁶⁷

The collapse of GASA and the suggested law reforms had a direct impact on the AIDS Action Group and on organisations that had come together around AIDS to raise money at events like Shaft 8. Key gay activists established a National Law Reform Fund (NLRF) to fund challenges to the proposed legislation. The organisers of Shaft 8 were asked to consider reallocating the money they had raised to support the NLRF. Numerous meetings ensued. Sifris recalls that ‘it was decided among the committee that the Law Reform Fund was now more of an emergency than AIDS, so all the money was given over to the law reform committee. We thought we could always just raise more money for AIDS’.⁶⁸ Determining which threat – AIDS or the further criminalisation of homosexuality – was the more pressing could not have been an easy task, but the historical coincidence of the two issues coming

⁶⁵For more information see the Southern African HIV Clinicians Society website at <http://sahivsoc.org/> (accessed December 2011).

⁶⁶ Gevisser, ‘A Different Fight for Freedom’, p. 60.

⁶⁷ *Ibid.*

⁶⁸ Interview with Dennis Sifris.

into the spotlight at the same time did detract from plans to address AIDS.⁶⁹ As it turned out, the investigations into homosexuality and law reform never got underway and the NLRF was transformed into a charitable trust.⁷⁰

The late 1980s were also difficult times for Sifris and others working at the HIV Clinic at Joburg Gen, primarily because of the inherent homophobia and stigma associated with AIDS. Even though Sifris and Sher had managed to convince hospital authorities to provide space for the HIV clinic it was not easily accessible or visible, and both the name of the clinic, and those who attended it, became points of contention.⁷¹ The clinic was initially called the 'Immune Disorders Clinic', but Sifris was adamant that after the identification and naming of the HI virus it was important for the clinic to be known as 'the HIV Clinic' so as to reduce the secrecy and fear associated with HIV. After several years of running the clinic on an honorary basis, Sifris was formally employed as its director in 1985.⁷² Despite vocal opposition, one of the first things Sifris did as director was to rename the clinic, 'the HIV Clinic'. It was to retain that name until Sifris' resignation in 1990, after which the clinic was again renamed 'the Immunity Clinic'.⁷³

The hegemonic AIDS narrative of the time was such that gay men with AIDS were constructed as 'guilty offenders' who got AIDS because of their sexual orientation and 'deviant lifestyles'. Conversely, haemophiliacs infected through contaminated blood products were constructed as 'innocent victims'. So strong was the stigma and homophobia that a separate clinic was established for haemophiliacs and other infected people. Sifris recalled that

⁶⁹ It is possible that this was not an historical coincidence at all but that the identification of a 'gay plague' played a part in the decision to establish the *ad hoc* committee. Further research into this connection is required.

⁷⁰ The funds accrued in the Trust's account until 1993 when they were 'transferred to the Equality Foundation for lobbying for the inclusion of "sexual orientation" in the Equality Clause in South Africa's new Constitution', Hoad *et al*, *Sex and Politics in South Africa*, p. 9.

⁷¹ The clinic was 'in a remote, even secluded, location' - Oppenheimer & Bayer, *Shattered Dreams*, p. 35.

⁷² Sifris was appointed at the level of a part-time casualty offer (one of the lowest paid skilled wage levels) and commented 'So I was the lowest of the low, in charge of one the largest HIV clinics on the continent.' Interview with Dennis Sifris.

⁷³ Oppenheimer & Bayer, *Shattered Dreams*, p. 35, and interview with Sifris. Sifris noted that the clinic did eventually return to being called 'the HIV Clinic'. The politics behind naming and renaming the clinic would be interesting to investigate for what, if anything, it revealed about changing perspectives on AIDS.

... the haemophiliacs had their own clinic because they didn't want to come to the gay clinic – they didn't want to come to the HIV clinic, so they had their own clinic ... and they were separate from the HIV clinic. We never had anything to do with them - they didn't want anything to do with us because we were gays.⁷⁴

Things came to a head for Sifris and Miller because of a devastating interplay between discrimination, drug pricing and public health care provision. In 1986 one of the first antiretroviral (ARV) drugs, Azido-Thymidine (AZT) also known as Zidovudine, came onto the market in the USA. This was a breakthrough because it was the first significant medical intervention to address AIDS, it was, however, staggeringly expensive, costing approximately ten-thousand dollars a year in the US at the time.⁷⁵ The number of South Africans who could afford it when it was first distributed to the country in 1987 was minimal. While the drug was unaffordable for most patients attending the HIV Clinic it did at least provide hope because it prolonged the life of AIDS patients. The hospital eventually purchased AZT but only wanted to prescribe it to haemophiliacs. Sifris explains, 'the hospital said we will give AZT to the haemophiliacs but we won't give it to the gay people because it is their own fault and haemophiliacs are innocent victims'.⁷⁶

Livid at this blatant discrimination, Sifris contacted the media and informed them of the hospital's policy, resulting in the story being featured in newspapers.⁷⁷ Shortly afterwards the superintendent of the hospital informed Sifris that they had been called to a meeting with the Secretary of Health in Pretoria. At this meeting Sifris was reminded that as a member of staff of a public hospital he was not allowed to make statements to the media about hospital policy, and was duly admonished by the health secretary. Sifris 'went in and said "F. You", I now resign ... I don't want anything more to do with the hospital'.⁷⁸ After

⁷⁴ Interview with Dennis Sifris. Miller is quoted as saying that 'any attempt to amalgamate services were absolutely rejected' by hospital authorities, *Shattered Dreams*, p. 35.

⁷⁵ Oppenheimer & Bayer, *Shattered Dreams*, p. 40.

⁷⁶ Interview with Dennis Sifris.

⁷⁷ It has not been possible to locate the specific articles and Sifris did not keep copies of them so it is not possible to give exact dates or comment on the content of the articles but a version of this account also appears in Oppenheimer & Bayer, *Shattered Dreams*, p. 40.

⁷⁸ Interview with Dennis Sifris.

Sifris' resignation Miller took over as head of the clinic, but after supporting a patient's legal claim against the hospital, hospital authorities told him to leave.⁷⁹

A final example of the ongoing frustrations experienced by Miller and Sifris during this time relates again to the AGA, the official body that advised the government on AIDS. Miller, like Sifris, had also been excluded from joining the group because of his sexual orientation and his designation as a member of a 'high-risk group'. Sifris however, made a second attempt to join the group when it decided to expand its membership. Frustrated that the government had 'sewed together a bunch of old fogies who didn't do anything', Sifris thought that membership of the group might afford him the chance to facilitate some change or action. In his application Sifris argued that as head of the largest HIV Clinic in the country he had considerable experience in addressing AIDS, experience that was augmented by the lectures he had given, the travelling he had done both regionally and internationally in connection with AIDS work, and the conferences he had attended. He also indicated that he would bring his 'own coffee cup in case you are worried that a gay man is going to infect you'.⁸⁰ Sifris' application was rejected, and the group appointed someone who 'had never seen an HIV patient in his life'.⁸¹

While Sifris never explicitly commented on the racial dynamics within GASA or any of the AIDS-related organisations that he was involved in, he did discuss the problems he and Sher faced at the clinic in 'getting black doctors involved'.⁸² They organised a World AIDS Day event and wanted to invite black doctors to attend but were unsuccessful: 'we searched and searched and searched and searched and couldn't find any black doctors to come out.' They approached a prominent black doctor in Soweto with known links to the ANC but were turned down. Sifris speculated that black doctors 'weren't interested because it was not a black problem, it was a gay disease. It was a gay disease and nobody worried about the

⁷⁹Oppenheimer & Bayers, *Shattered Dreams*, p. 41. Miller had a patient who was going blind because of an opportunistic infection and was denied a drug that could reverse his condition by the hospital even though the medication was being offered to cancer patients. After he supported the patients legal claim he 'became *persona non grata*' in the hospital. *Ibid.*

⁸⁰ Interview with Dennis Sifris.

⁸¹ *Ibid.*

⁸² *Ibid.*

gays'.⁸³ Because AIDS was not being identified among black patients, and places like the HIV Clinic were either not legally integrated or welcoming of black patients, it was not seen as important amongst black health care professionals. The hegemonic narrative of AIDS as a white, gay, male disease would certainly have shaped this perception. There are complex reasons why black doctors may not have wanted to participate in the events, not least of which were the other more pressing health concerns exacerbated by apartheid.

In the early days of the epidemic Sifris found it difficult coping with the deaths, government and community inaction, and general homophobia. He realised that he was displaying many of the symptoms of 'burnout'. Added to the stresses and strains of battling government and hospital officials, he experienced a personal loss that caused him to withdraw from professional and public spheres. Sifris met an HIV positive man at an AIDS conference in Stockholm and the two fell in love and lived together for five years. As his partner's health began deteriorating, the couple travelled to Sweden for treatment twice a year. After his partner suffered a mini-stroke that left him paralysed, the couple decided that he needed to return to Sweden to see his doctors and be with his family. While they were in transit at Brussels airport, Sifris' partner suffered a major stroke and a massive brain haemorrhage: '... as we were getting onto the plane he collapsed and died. So, I sort of withdraw at that time a little bit, but [since then] I've slowly gotten back'.⁸⁴

After seeing so many people die of AIDS, Sifris expressed disappointment that successive post-1994 governments have put up so many barriers to procuring and distributing life-saving drugs. Sifris continues to run his private practice, deliver lectures on AIDS to a variety of sectors, and contribute health information to *Exit*. His recollections reveal the inherent and blatant homophobia that gay men experienced, regardless of their race or class. Frustration at official inaction around AIDS and the reality of friends, colleagues and lovers dying, provided the impetus for Sifris and others to mobilise. The importance of international connections and experiences is evident in Sifris' personal politicisation around AIDS. As a doctor involved in the first HIV clinic in South Africa, his professional status and resources allowed him to travel to international conferences and connect with other doctors

⁸³ Interview with Dennis Sifris.

⁸⁴ *Ibid.*

and with gay organisations addressing AIDS, and to bring important information and ideas back to sectors of the gay community in South Africa.

Pierre Brouard – Counselling for Death, Counselling for Life

Pierre Brouard is a clinical psychologist and is the Deputy Director of the Centre for the Study of AIDS at the University of Pretoria. Brouard's recollections on the early days of the AIDS epidemic are noticeable for their reflexive and contemplative nature. His discussions about the epidemic, and his involvement in various counselling and support positions, are imbued with a critical awareness of the broader socio-political landscape of South Africa during the 1980s and early 1990s.

Brouard came out in the late 1970s and believes that coming out before AIDS 'was on the scene' gave him an interesting perspective on the fears and considerations that framed peoples' sexual lives. He believes that in the late 1970s the primary concern for most gay people was that homosexuality was illegal. While there was always the threat of being arrested, harassed, hounded, shamed or imprisoned, from a personal physical health perspective the most immediate health concerns were STIs like herpes, syphilis or gonorrhoea, all of which were treatable. In the early 1980s the 'first murmurings ... that something was amiss started to surface' with news often coming from 'middle class, white, gay men' who travelled internationally, and from people working in the airline industry.⁸⁵ The murmurings turned into reports of a 'new disease' that was framed entirely as a gay disease complete with the acronym GRID (Gay-Related Immune Deficiency).

Central to both Brouard's and Sifris' narratives, is the importance of international travel and networks for the transmission of information about AIDS. Brouard remembers that people who travelled internationally 'brought back newspapers, pamphlets and magazines – or knew or corresponded with people overseas'.⁸⁶ In the early 1980s Brouard and his partner at the time noticed that one of their friends who had moved to the UK, but regularly visited

⁸⁵ Interview with Pierre Brouard, Pierre Brouard's Office, Centre for the Study of AIDS, University of Pretoria, Gauteng, South Africa, 19 February 2008.

⁸⁶ *Ibid.*

South Africa, was getting increasingly ill. Brouard and his partner speculated as to whether their friend had AIDS, but he never told them and they never asked. The friend subsequently died. Brouard was acquainted with the reality of AIDS-related deaths from early on in the epidemic.

Brouard saw that AIDS-related illness and death mobilised people both as individuals and as members of organisations: 'Those early responses were really located in the gay community. People ... mobilised around friends, tried to get support groups going ... tried to understand the treatment options available, and set up informal networks.'⁸⁷ Important work was undertaken by individual activists like Gordon Isaacs and John Pegge, who was the Director of GASA-6010, was HIV-positive and died of AIDS-related illnesses.⁸⁸ Brouard was aware of the differences in political outlook between organisations: 'GASA was ... the main ... organisation for more middle-class, mainstream, men and women and was apolitical'.⁸⁹ Gay organisations that were more 'left-orientated' were active in Cape Town, but were not as prevalent in Johannesburg.

Regardless of geographic location however, Brouard's sense of the situation was that 'middle of the road, white, gay men were really just trying to hold it all together in the absence of really much available [sic]'.⁹⁰ Aside from the emotional impact of the deaths of friends, family members, lovers and partners, Brouard suggests that AIDS forced people to address their sexuality without internalising AIDS as something that was intrinsically related to being gay. At the same time as challenging ideas that being gay was 'wrong, evil or sick', gay men were faced with a health crisis that was focused on what was apparently 'gay sexuality'. Gay men thus had to address both internalized homophobia and societal perceptions of homosexuality being evil or sick, in the context of a new disease that directly linked death to sexuality.⁹¹ The ramifications of AIDS affected both individual and community identity formation, as Brouard recalls:

⁸⁷ Interview with Pierre Brouard.

⁸⁸ John Pegge for example was the Director of GASA-6010 but also set up a branch of ACT-UP in Cape Town. For more see GALA - GASA Collection particularly correspondence file and correspondence John Pegge to Jeff Neff (ACT-UP Los Angeles), 31 July 1991(AM 2974).

⁸⁹ Interview with Pierre Brouard.

⁹⁰ *Ibid.*

⁹¹ *Ibid.*

...just to try and retain a sense of healthy sexuality and healthy identities when AIDS spoils your identity and spoils your sexuality ... that was a real challenge of those times. I remember having feelings like 'the community is self-destructing', there's just so much stuff going on, and people just aren't caring for themselves or each other.

It was an incredibly distressing and painful time to live through and people were just getting sick and the thing about AIDS is that it struck the old and the young, and the beautiful and the ugly, the fat and the thin – it was a great equaliser My sense of the time, perhaps it was a psychological sense, was that some people who were the beautiful glittering stars of the gay firmament, were deeply shamed and humiliated and distressed about being HIV positive because it ... reduced them to their physicality and was ultimately a reminder that we are physical creatures and we get ill and we die and nobody is immune from that no matter how beautiful or glamorous you or your lifestyle are.

... it was really an incredibly fraught time to be gay and I don't know that, historically, if we look back, how that whole time affected the psyche of the gay community. To what extent it damaged it, or created a particular response or a feeling of what it means to be gay in the twentieth century.⁹²

Brouard's questions are similar to those raised by Seidman and Altman's work in relation to gay male identity and AIDS in the USA. Research into how AIDS, the illegality of homosexuality, socially sanctioned homophobia, apartheid ideologies, and race shaped gay male identity in South Africa historically is another area of research that still needs to be fully explored.⁹³ As this thesis has shown, the medico-scientific narratives created around men and AIDS suggested that it was not types of sexual practices and behaviour that needed to be examined, but rather something intrinsic to being gay that was of concern. The focus was thus not on sexual acts and practices that could be performed by sexually active men regardless of their sexual orientation, but rather on constructed 'deviant' gays, 'dirty' prostitutes, 'infected' foreigners, and then 'sexually rapacious' black people. This focus prevented the attention falling on male sexuality more broadly and assumed a normative, healthy, white male sexuality.

⁹² Interview with Pierre Brouard.

⁹³ Seidman, S., 'Transfiguring Sexual Identity: AIDS & the Contemporary Construction of Homosexuality', *Social Text*, 19/20, (Autumn), 1988; and Altman, D., 'Transfiguring Sexual Identity: AIDS & the Contemporary Construction of Homosexuality: Comment', *Social Text*, 19/20, (Autumn), 1988.

For Brouard narratives of the time ‘conflated identity with risk’ and assumed that something about “the gay condition” [or] “the gay being” presupposed vulnerability to AIDS to HIV’.⁹⁴ This ‘fitted in’ with broader public health paradigms of the time that were modelled on popular understandings of sexuality, that did not sufficiently interrogate the relationships between sexual practice, sexual identity, and basic biology. In this paradigm it was ‘not the fluid that was the problem, it was who you were that posed the risk’.⁹⁵

This understanding of sexuality and confusion over sexual practice and sexual identity resulted, in Brouard’s experience, in ‘a lot of mythologizing even in the medical sphere’.⁹⁶ He recalls a counselling session that he had with a heterosexual couple in the Esselen Street Clinic. The man was concerned that they were at risk of HIV infection because they practised anal sex. Brouard asked the couple about their HIV status and the boundaries of their relationship and they replied that they were both HIV negative and in a committed monogamous relationship. Brouard explained that, in light of this, they were not likely to be at risk of HIV as it was not the practice of anal sex per se, that was the primary risk, but rather bodily fluids containing the HI virus. These and other experiences left Brouard with a sense that for many people understandings of AIDS and HIV transmission, and sexuality more broadly, ‘were very mystifying and mystified’.⁹⁷

Brouard first started counselling people in the early to mid-1980s when he became involved with GAB a counselling service that provided support and information for gay people or people exploring their sexuality. While GAB at that time was not dealing with many people with HIV, one of the people Brouard trained with was diagnosed as having AIDS. So GAB set up an informal support system for him and his partner. After his death, GAB launched a support group for people living with HIV but it never took off.

⁹⁴ Interview with Pierre Brouard.

⁹⁵ *Ibid.*

⁹⁶ *Ibid.*

⁹⁷ *Ibid.*

While completing his masters degree in the late 1980s, Brouard volunteered at the AIDS Centre at the SAIMR, which opened to the public in January 1988.⁹⁸ The Centre offered an evening counselling and testing clinic. Brouard did pre- and post-test counselling with the clients who at the time were predominantly white, gay men. He and a friend established an HIV support group at the SAIMR, which was attended by a small number of gay men. The experience allowed Brouard and his friend 'to explore what it means to be positive, and what support one needed, and what was out there'.⁹⁹

During his internship year as a masters student in 1989, Brouard volunteered at the HIV Clinic at Joburg Gen doing informal counselling and support work, and acting as a 'resource person'. He recalls that 'people like Ruben Sher, Dennis Sifris and Steve Miller ran the clinic ... and it was a fascinating period because it was very 'other'.¹⁰⁰ While the hospital was still segregated and primarily served the needs of white patients, these doctors and patients were 'other' because of their sexual orientation or because of the demands that they made on the hospital on behalf of gay people:

... suddenly this group of gay men who were feeling more entitled in some ways, or more informed, or more empowered, were coming in and it created some envy and resentment among the medical fraternity because why was there a need for a special clinic? AIDS was still very much a disease of gay men, it was still stigmatised, and Dennis, Ruben and Steve had to really fight to get staff, to get funds. They had constant battles with hospital management.¹⁰¹

In the context of apartheid ideology that sought to categorise people in unambiguous ways and thereby create specific, often binary, identities, white gay men could be viewed as problematic. They were men and so were expected to occupy a particular place in patriarchal structures, and they were white and thereby afforded the privileges of their 'race'. They were, however, gay men and therefore their privileged status in terms of

⁹⁸ GALA - GASA Collection (AM 2974), Correspondence from Susan Hyde, AIDS Centre, SAIMR, to Diana, GASA, 1 June 1989. The Centre offered HIV-Antibody Testing, counselling, referral, information, lectures and workshops.

⁹⁹ Interview with Pierre Brouard.

¹⁰⁰ *Ibid.*

¹⁰¹ *Ibid.*

masculinities could be called into question.¹⁰² Instead of being shamed into silence by their sexual orientation, these men took advantage of the social capital they had as white elite medical professionals, and challenged the hospital authorities. It is unsurprising that they antagonised others in positions of privilege both within the health sector and in other sectors. The transformative nature of a group of informed and empowered people challenging government authority has played out repeatedly in the histories of AIDS in South Africa and can be seen in the formation of the Treatment Action Campaign (TAC), the struggle for the ARV rollout, and the ongoing empowerment of people living with HIV and AIDS.

Brouard recalled how the accessibility and availability of ARVs at Joburg Gen highlighted the class dynamics inherent in a health care system divided into public and private sectors. He felt ineffectual at the Clinic 'because it seemed to be an overwhelming problem and you just saw so much death and dying, and just sadness and grief'. Unlike Sifris and Miller who were seeing their private practice patients who could afford ARVs, there was no hope of this at the Joburg Gen. By the early 1990s both Sifris and Miller had left the Clinic and worked predominantly in their private practices. Brouard in the meantime, continued to volunteer at Joburg Gen and got a job in Hillbrow at the Esselen Street Clinic with Mary Crewe and Clive Evian, who were starting up the Johannesburg City Council AIDS programme.

¹⁰² Definitions of 'masculinities' and 'femininities', are drawn from work by Robert Morrell and work by Lindsay and Miescher. Morrell notes that 'Masculinity [and femininity are] . . . collective gender [identities] and not . . . natural attribute[s]. [They are] socially constructed and fluid. There is not one universal masculinity, but many masculinities [and similarly not one universal femininity, but many femininities]. These are 'not fixed character types but configurations of practice generated in particular situations in a changing structure of relationships' see Morrell, R., 'Of Boys and Men: Masculinity and Gender in Southern African Studies', *Journal of Southern African Studies*, 24, 4, December 1998, p. 605. Lindsay and Miescher (quoted in Suttner, R., 'Masculinities in the African National Congress-led Liberation movement', *Kleio*, 37, 1, 2005, p. 74) note that masculinities and femininities are a 'cluster of norms, values and behavioural patterns expressing explicit and implicit expectations of how men [and womyn] should act and represent themselves to others. Ideologies of masculinity like those of femininity are culturally and historically constructed, their meanings continually contested and always in the process of being renegotiated in the context of existing power relations'. In short masculinities and femininities are a collection of variable constructed behaviours associated with correctly 'performing' as 'a man' or 'a woman' in contexts which can be mediated by any number of factors including historical, temporal, cultural, political, social, economic, generational, linguistic, sexual, intellectual and physical. Hegemonic 'masculine' and 'feminine' characteristics, although also constructed and mediated, can also be ascribed to 'men' and 'women' inter-changeably as either positive or negative characteristics i.e. a sensitive man or an 'unfeminine' woman. While masculinities are not fixed and there have been debates about the notion of 'hegemonic masculinity' (see Beasley, C., 'Rethinking Hegemonic Masculinity in a Globalizing World', *Men and Masculinities*, 11, 1, October 2008), the phrase is used here to denote an idea of 'white masculinity' presented as the norm against which other masculinities were judged by ruling white elites.

Despite being government-funded, and having to negotiate the complexities of national and local budgetary funding processes, Evian, Crewe, Brouard and others managed to pioneer some innovative programmes and responses at the Esselen Street Clinic. Brouard started a closed support group run along strict psychotherapeutic lines for HIV-positive gay men which ran for three years.¹⁰³ With so little access to AZT the primary focus of the group was on how to adapt to living with HIV and preparing to die of AIDS. Several of the group members died - Brouard remembers those years as his 'most significant immersion into counselling people who were dying or confronting mortality'.¹⁰⁴

The Esselen Street clinic was not a specific AIDS or HIV clinic but rather sought to provide comprehensive sexual health services with an AIDS training and support component. The clinic had family planning services, a TB clinic, an STI clinic that incorporated HIV antibody testing, and an outreach programme that focussed on sex workers and gay men. The clinic was used extensively by all sectors of the Hillbrow community and developed a reputation for meeting the needs of all people in the community and for being 'gay friendly'. Shifts in the epidemic's dynamics were reflected in who used the clinic as the primary users went from gay men to heterosexual womyn.

Brouard knew many of the gay people who came to the clinic for help, and, despite having few resources, never turned people away. The clinic became a space where community members or groups working as part of the AIDS outreach programme could develop new intervention strategies. Drama productions, comic strips, and other innovative AIDS education materials were developed. The other strength of the clinic was that it successfully collaborated with other organisations. It ran a support group for black womyn, worked with community groups and skills development programmes like AIDS Link, got involved in running 'AIDS weeks', and piloted AIDS education adverts on public buses.¹⁰⁵ Brouard felt that they were also doing interesting training work, running innovative counselling courses, and providing non-judgemental testing services and STI treatments. The background and

¹⁰³ Interview with Pierre Brouard.

¹⁰⁴ *Ibid.*

¹⁰⁵ See also Evian, C.R., de Beer, M., Crewe, M., Padayachee, G.N., & Hurwitz, H.S., 'Evaluation of an AIDS awareness campaign using city buses in Johannesburg', *SAMJ*, 80, 7, 5 October 1991; and Editor, 'On the Buses', *SAMJ*, 80, 7, 5 October 1991.

politics of the people who worked there, and a guiding assumption that any response to STIs required a multi-disciplinary rather than a mere medico-scientific approach, influenced the integrative outlook of the Esselen Street clinic. Brouard refers to the 'interesting mix of people' and the variety of skills that came together at the clinic, with Clive Evian bringing in a community medicine perspective while Mary Crewe applied her academic knowledge to try and understand the sociological roots of AIDS, and in so doing, provide a foundation for implementing practical programmes at the clinic.

In the late 1980s and early 1990s more alliances were built, both nationally and locally. These were alliances with more progressive organisations in the gay communities such as the Gay and Lesbian Organisation of the Witwatersrand (GLOW) and the TAP; between progressive organisations involved in AIDS work, giving rise to, for example, the AIDS Consortium; and between gay organisations and activists and the clinic.¹⁰⁶ Simon Nkoli was involved in both GLOW and TAP, and together with Brouard ran HIV prevention workshops in Hillbrow for black, gay men that were based on sex positive, risk reduction approaches. In addition to providing information and distributing condoms, they also used the workshops to explore relationships, sexuality, and identities. Brouard and Nkoli criticised the 'Abstain, Be Faithful, use Condoms' ('ABC') types of programmes and messages that were most prominent at the time, concluding that gay communities would not be receptive to the moralistic, conservative message. Nkoli eventually had an office in Esselen Street and started an organisation for HIV-positive black, gay men. Brouard recalls how 'you would walk into his office and there were all these explicit posters of naked black men - so he was fantastically subversive'.¹⁰⁷

Nkoli, Brouard and Sifris, as well as organisations like the Gay Peoples' Health Forum, and GASA-6010 / ASET, were all responsible for subverting the conservative, homophobic, moralistic narratives about sex and sexuality by virtue not only of their sexual orientation and politics, but also because of the safer sex material that they distributed or produced. In

¹⁰⁶ The AIDS Consortium was 'a loosely structured affiliation of about 50 organisations active in the AIDS/HIV field' and was central in providing a platform for AIDS organisations to work together, especially in the run up to NACOSA. Clive Evian and others from the PPHCN were members. For more on the AIDS Consortium see GALA - Triangle Project Papers AM2974 particularly AIDS Consortium Minutes B9.1.

¹⁰⁷ Interview with Pierre Brouard.

stark contrast to the government's 'ABC' messages, the AIDS education material developed by gay organisations or by AIDS support groups in the mid-1980s, was radically different in both messaging and in assumptions about the intended audience. As the examples of AIDS education materials pictured below reveal, images and messages from gay organisations treated the audience as sexually active and did not assume that abstinence was a realistic solution. Instead, the images and words encouraged safer sex practices as a normalised part of enjoyable, erotic, healthy, sexual activity, and depicted sex across the colour line.

Brouard was on an editorial board that produced a comic pamphlet called 'Keep It Hot, Safe and Gay'. The pamphlet featured two characters, Hot Shot and Safe Sex, a lycra-clad super hero and a condom, who delivered unabashed information about anal sex, oral sex, mutual masturbation and thigh-sex (figure 30). The information about HIV infection and transmission was underscored by a central message that 'Playing safe with the one you love puts the fun back in and takes the danger out'.¹⁰⁸ The comic provided contact information for the Esselen Street clinic and gay organisations in Johannesburg.



Fig. 30. Panels from the 'Keep It Hot Safe and Gay' Comic Strip.¹⁰⁹

The safer sex cards distributed by ASET in Cape Town (figure 31) combined basic facts about HIV transmission with information on how to contact the organisation. The cards used frank

¹⁰⁸ Pierre Brouard – Private Collection, 'Keep It Hot, Safe and Gay' pamphlet.

¹⁰⁹ *Ibid.*

language and (for the time) explicit images, such as that of a black man and a white man kissing, to convey their message. The photo credits on the card indicate that some images were reproduced from the Terence Higgins Trust in London, while others were created for the organisation.¹¹⁰ In 1991, when ASET was still GASA-6010, John Pegge, the director of the organisation at the time, confirmed how important the exchange of information between international organisations was:

We run a large Safer Sex campaign amongst the Gay [sic] minority and for this purpose we use Safer Sex posters donated to us by Gay AIDS service organisations in other countries. We have a wide selection from Australia, New Zealand, the United Kingdom, the Netherlands, Canada and the United States of America.¹¹¹

These explicit images depicting a sexuality that was illegal flew in the face of South Africa's conservative pornography laws, but organisations and individuals managed to circumvent the law. GASA-6010 had no difficulty in receiving material, despite it 'running foul' of pornography legislation, because the state of transition in the country was such that authorities no longer appeared sure of what legislation was applicable. When apartheid laws were being more rigorously implemented, 'pornography' received by mail did not result in criminal prosecution if the person receiving the mail could prove that they did not solicit the material. Nonetheless, Pegge urged caution: 'I would suggest that you send any materials that might be deemed pornographic in a separate envelope without a covering letter.'¹¹²

¹¹⁰ GALA - ASET Collection (AM 2974). Note that some of the collections share the same call numbers.

¹¹¹ GALA - GASA Collection (AM 2974), Correspondence, John Pegge, GASA 6010, to Benjamin Hal, B M Switchboard, 16 October, 1991.

¹¹² GALA - GASA Collection (AM 2974), Correspondence, John Pegge, GASA 6010, to Bob Webster, Hamilton AIDS Network for Dialogue and Support, 15 May, 1991. Before distributing the ASET safer sex cards in 1993 Pegge did send a complete set of the cards to Edwin Cameron, who wrote a 15-page legal opinion for ASET, concluding that given censorship provisions were changing the cards would not be found 'undesirable' see GALA - Cameron Collection (AM 2629), HIV/AIDS Material, Correspondence, John Pegge, ASET, to Edwin Cameron, Centre for Applied Legal Studies, 29 October 1992; and Edwin Cameron, Legal Opinion on Imported AIDS Educational Material for Gay Clients for ASET, 6 March 1993.



Fig. 31. Safer sex cards from the Cape Town-based organisation ASET.¹¹³

Safer sex cards produced for the Johannesburg-based Gay Peoples' Health Forum, were designed as actual postcards with space for people to write on, and included the contact information of the organisation. Some of the cards showed a 'white' man and a 'black' man in intimate poses and reminded the recipient to protect their partners by using condoms, and that healthy sex was not boring (figure 32).

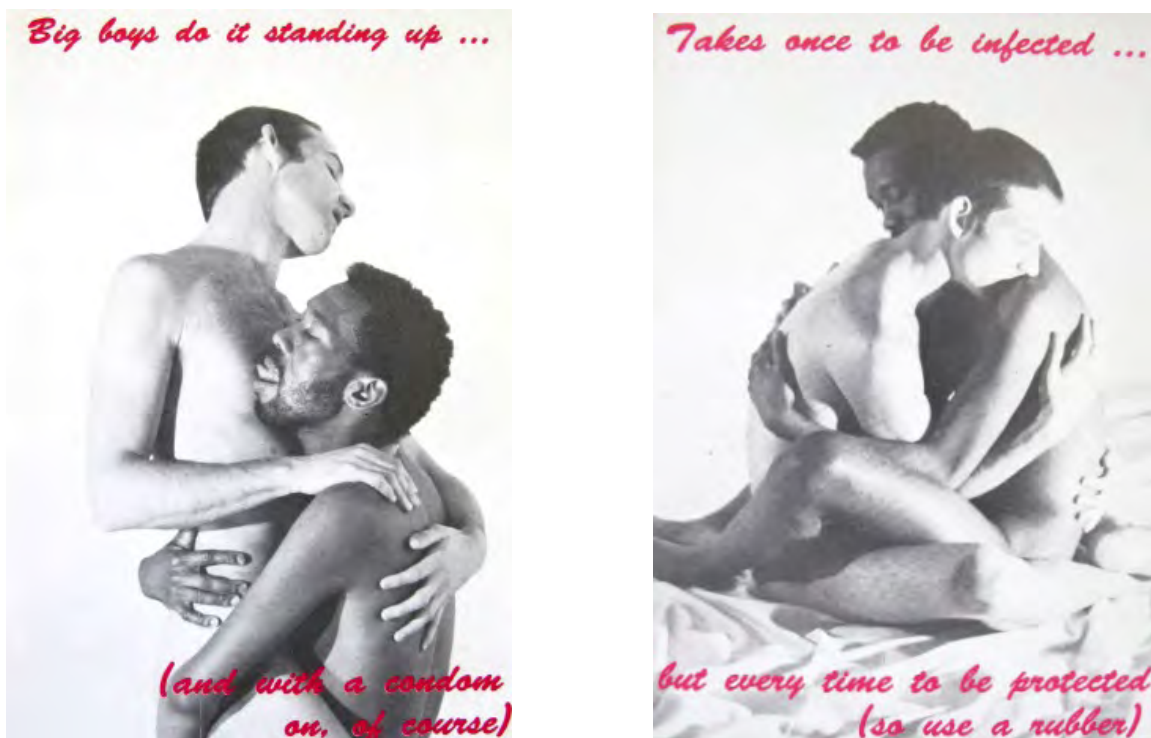


Fig. 32 . Safer sex postcards from the Gay Peoples' Health Forum.¹¹⁴

¹¹³ GALA - ASET Collection (AM 2974).

¹¹⁴ *Ibid.*

While he was working at Esselen Street, Brouard continued to volunteer at the Joburg Gen and, in the early to mid-1990s, witnessed the change in clients in Esselen Street. Rather than the predominantly white gay males that had been the initial client base, there was now a greater mix, including more heterosexuals and black South Africans. Many of the black South Africans whom Brouard counselled were returnees who had either lived in exile communities or travelled to countries outside South Africa. One of the womyn he counselled had been involved with a senior MK operative who subsequently died of AIDS. While she came frequently to counselling, the operative only came once.

The other shift during this time was a renewed sense of hope derived from the political transition underway in the country, and from developments in ARV treatments. Progressive health organisations like the PPHCN became increasingly involved in AIDS work and approached the clinic to obtain training materials and discuss the mobilisation of health workers. Brouard recalled that while

the epidemic was still 'othered' in South Africa ... it was the build up to '94 ... and the whole NACOSA [National AIDS Convention of South Africa] process had generated an incredible amount of coming together and talking and debating a first national [AIDS] plan. People were pulling together more ... so it was also a fascinating time to be living through.¹¹⁵

While in the UK and USA it was possible for sexuality organisations or gay professionals to exert some pressure on policy makers, or influence the AIDS policy-making process itself, there was less opportunity for this in South Africa.¹¹⁶ In the 1980s the criminalisation of homosexuality and the government's homophobic stance made any interactions between sexuality activists and government officials fraught and complicated. During the transition phases of the early 1990s there were more opportunities for sexuality activists to engage with decision makers. However, at that stage the focus for sexuality activists was no longer only on fighting legislation or raising awareness about AIDS amongst gay communities, but rather on securing citizenship rights and equality for people regardless of their sexual

¹¹⁵ Interview with Pierre Brouard.

¹¹⁶ See for example Berridge, V., *AIDS in the UK: The Making of Policy, 1981 – 1994* (New York, Oxford University Press, 1996); and Berridge, V., 'The Early Years of AIDS in the United Kingdom 1981–6: Historical Perspectives' in Ranger, T., & Slack, P. (eds), *Epidemics and Ideas: Essays on the Historical Perception of Pestilence* (Cambridge, Cambridge University Press, 1992).

orientation.¹¹⁷ Similarly, the shift in the narrative towards AIDS as a heterosexual problem altered perceptions of the epidemic, while mass-based AIDS activism which focussed on the human rights and the needs of people living with HIV and AIDS only emerged in the mid to late 1990s with the formation of the Treatment Action Campaign (TAC).

How much space was there for gay doctors, health care professionals or activists to bring about any change in their places of work or in other fora from the mid-1980s into the 1990s? Brouard's assessment is that the level of homophobia prevented any meaningful engagement. While gay men, like Brouard himself, were involved in the government-funded ATICS, the ATICS followed and worked within 'a conventional public health paradigm ... they did ... testing, counselling training, community prevention, [and] fairly dull ... AIDS in the workplace stuff'. Within this conventional paradigm, it would have been difficult for gay activists to bring about radical changes in AIDS education messaging or campaigns, so their influence would have been primarily at the individual level, with people they counselled, or possibly within the ATIC structures.

The levels of homophobia and the broader public health paradigms and policies that resisted integrating AIDS into the public health care system created a situation that was difficult to challenge. Brouard maintains that even people like Ruben Sher, who had the ears of the AGA, would have had limited opportunities to bring about substantive changes to national AIDS policies or programmes. With AIDS ring-fenced as something 'other' and outside of the public health care system, it was seen as a challenge to existing health care systems and structures. Brouard recalls that even at the Esselen Street clinic, which was championing a more integrated approach to sexual health, nursing staff and other staff who were less involved in AIDS work, saw 'the AIDS people as different'.¹¹⁸ Brouard noted that the perception of AIDS as 'other' is still prevalent in contemporary public health debates.

Brouard was struck by the irony that state resources for AIDS programmes amongst LGBTI communities were not available either during or after apartheid. Brouard met Rina Venter (the last NP National Minister of Health) in the early 1990s and recalls that she made it clear

¹¹⁷ Hoard *et al* (eds) *Sex & Politics in South Africa*, especially Part 2: The Constitution.

¹¹⁸ Interview with Pierre Brouard.

that because AIDS was a minority issue the gay community needed to look after itself. This attitude, combined with the criminalisation of homosexuality, meant that state resources were not made available to gay communities. In the post-1994 period when the demography of AIDS shifted and people started claiming their rights and demanding responses from the ANC-led government, the gay community was again sidelined as a minority group. This continued marginalisation has resulted in a lack of basic information about HIV transmission and infection rates amongst gay communities in post-apartheid South Africa.¹¹⁹

Of the early years of the epidemic Brouard primarily recalls death: 'there was a lot of death – that's what I remember of those years ... The number of funerals one went to, the number of people who disappeared, it was just horrible'.¹²⁰ While the funerals continue, there are now options for people with AIDS which offer a longer life if regular and sustained access to ARVs can be maintained by the government.¹²¹ Brouard continued working at the Esselen Street clinic until 1997, later joining Crewe at the CSA in 1999. As the Deputy-Director of the CSA, Brouard continues to conceptualise and develop training methods and materials and to contribute to academic publications and other fora on topics such as psychosocial issues, gender, sexuality, human rights, testing, treatment and tertiary responses to HIV and AIDS.¹²² The work Brouard does now still involves the realities of AIDS-related deaths, but it also focuses on supporting and sustaining life and living.

¹¹⁹ In an ideal world, transmission and infection rates for people based on a variety of determining factors from economic security to geographic location, to age, sexual practice and ability would be available. This information could then guide responses to AIDS to ensure that programmes were suitably tailored to communities – and indeed the first National AIDS Plan adopted post-1994 went out of its way to ensure that multiple communities were included and identified, but not necessarily provided with appropriate programmes. For example, currently, as noted above, there is little information on lesbians and HIV or AIDS, so it is difficult to determine what kind of support lesbians might need. Thus there is a difference in constructing an epidemic in such a way that it focuses inappropriately on people defined as belonging to a particular group, and sensitively ensuring there is sufficient information and support for communities of people whose lives and sexual health needs may be context specific.

¹²⁰ Interview with Pierre Brouard.

¹²¹ The continued relevance of this sentiment was borne out by recent media reports that referred to survey findings which indicated 'that South Africans spend more time at funerals than at weddings or even doing their hair at salons'. See Nkosi, M., 'The Funerals that Cost Families Dear', BBC News, 26 November 2011 available at the BBC website at www.bbc.co.uk/news/magazine-15890662 (accessed January 2012). Note that the original survey that the media report refers to could not be located making it impossible to verify the statements in the report.

¹²² CSA website at www.csa.za.org/contact/67-management/2-pierre-brouard (accessed December 2011). See, for example, Brouard, P., 'Gender, Same-sex Sexuality and HIV/AIDS in South Africa: Practical Research Challenges and Solutions', in Reddy *et al*, *From Social Silence to Social Science*.

Conclusion

Personal and professional relationships and networks organised around sexual identity were important to the first responses to AIDS in South Africa in both medical and social spheres. Sexuality organisations had to take responsibility for addressing the AIDS epidemic in the face of government inaction, but much of this response was limited to specific sections of the gay community, and to specific geographic areas.

While AIDS did provide a point of mobilisation and support, race, class, gender, and sexuality divided gay communities in South Africa. The recollections of Sifris and Brouard show that in the realm of both organisational and individual experience, AIDS brought to the fore the intricate relationships between illness, ideologies, and (intimate) identities, in both their personal and public lives. Sifris and Brouard were active in both sexuality organisations and two key public health sites involved in addressing AIDS. Both men moved between a variety of communities – some hostile and some supportive. Their accounts of the time provide insights into the experiences of two gay men at the start of an epidemic ‘written on’ and around gay men’s bodies. Their stories show how even within government-aligned health care spaces, they were able to provide support and treatment to people, and to engage in, what were for the time, subversive activities. The different contexts and professional fields in which they found themselves mediated their individual experiences, but in both men’s case, the hegemonic AIDS narratives about homosexuality influenced and shaped their responses even as they challenged them.

Homophobic beliefs, conservatism, or any other invisible or unquestioned ideologies that influence understandings of epidemics and practical responses to them, have tangible repercussions. These repercussions may be evident in the lack of legal protection or in the emotional costs of prejudice and intolerance. Brouard, like Miller and Sifris, challenged hospitals and hospices to provide care for people with AIDS. Joburg Gen was often reluctant to admit people with AIDS, as it was seen as a waste of resources and of limited value for instructional purposes.¹²³ Nursing and other staff were often unwilling even to touch AIDS

¹²³ Oppenheimer & Bayer, *Shattered Dreams*, p. 31.

patients.¹²⁴ Even when places could be found for people it was difficult to get staff members to treat them with dignity; and many staff members did not 'deal well with gay men, young men, coming in infected and dying of this strange disease [where] dementia complicated the death process further'.¹²⁵

For the partners of the men who died the trauma of loss was aggravated by their lack of legal status or recognition as partners of the deceased. Brouard recalls counselling loving partners who were not able to claim the bodies of the deceased men. He witnessed both the deaths and the grief of survivors during this time.

Sifris challenged homophobic responses to gay men with AIDS, but did not necessarily challenge the dominant narrative that initially linked AIDS to being gay. Given that the professional and personal spaces he occupied bore out the narrative that gay men were the ones dying of AIDS, this is perhaps not surprising. Brouard worked within gay communities he most identified with, but his professional and personal spaces seemed to have presented a more complex narrative about AIDS and its association with sexual identity and broader identity politics.

The socio-political evocation of stereotypes, or constructions of gender, 'race', and sexual orientation - or any multitude and combination of other markers of identity - have long shaped experiences of health, ill health, or epidemics. This thesis has shown how conscious and unconscious assumptions about gender, 'race' and sexual orientation influenced the direction of research into AIDS, and how AIDS and people with AIDS were 'spoken about' and conceived of. It has argued that political expediency, prejudices, inherent suppositions about people and intolerance mediated practical responses to AIDS – whether those responses reinforced or challenged the initial assumptions. This chapter has shifted the focus from the meta-narratives and organisational responses discussed elsewhere, to the micro-narratives of individuals and their responses to the epidemic as individuals and as part of various communities. The chapter serves as a reminder of the intricate and intimate relationships between ideologies, illness and identities, but also that behind each AIDS avatar evoked in hegemonic narratives are complex, embodied people.

¹²⁴ Oppenheimer & Bayer, *Shattered Dreams*, pp. 32 – 36.

¹²⁵ Interview with Pierre Brouard.

CONCLUSION: 'THIS WHOLE WEIGHT OF MEANING'

Despite the hope for a new era of co-operation to address Acquired Immunodeficiency Syndrome (AIDS) in a democratic South Africa after 1994, by the mid-2000s optimism about government responses to AIDS had waned as Dr Manto Tshabalala-Msimang, then minister for health, became engaged in ongoing battles with activists and scientists over the governments' response to the disease. As the Zapiro cartoon below acutely observed, Tshabalala-Msimang frequently blamed the legacy of apartheid for the government's inaction in addressing Human Immunodeficiency Virus (HIV) and AIDS in South Africa (figure 33).



Fig. 33. Cartoon by political satirist Jonathan Shapiro – Zapiro (*Mail & Guardian*, 2005).

The difficulties inherent in unifying a fragmented apartheid health service into a new, co-ordinated health service cannot be ignored or underplayed, but these difficulties do not explain the post-1994 government responses to AIDS which continue to attract comment and criticism from a variety of quarters. In the urgency and immediacy of failed (or failing) government responses, the struggle for affordable antiretroviral drugs (ARVs), problems

with ARV roll-out, and ongoing crises in the public health sector, there has been little time, or inclination, to reflect on what the narratives about AIDS were during the early years of the epidemic, or what effect the constructions of 'race', gender, sexuality and conservative morality had on these narratives and subsequent responses to AIDS. Work on post-1994 government responses has, understandably, concentrated on the shifts in attitude between the post-1994 presidencies, or tried to make sense of Thabo Mbeki's views on the causes of AIDS, but have not necessarily been able to contextualise these shifts or views historically.¹

Quarraisha and Salim Abdool Karim suggest that the first post-apartheid government was 'faced with the urgent need for reconciliation and nation-building which took precedence over the need to accord AIDS the necessary priority and commitment', while the Mbeki era was epitomized 'by its litany of errors in AIDS policy and for its failure to rise to the challenges AIDS posed for South Africa'.² This analysis is emblematic of the narrative that is evoked in most retrospective assessments of government responses to AIDS, and is usually

¹ As indicated in the chapter on government responses to AIDS, see for example Butler, A., 'South Africa's HIV/AIDS Policy, 1994-2004: How Can It Be Explained', *African Affairs*, 104, 417, October 2005; Fletcher, H. K., 'Conflict, Contradiction and Crisis: An Analysis of the Politics of AIDS Policy in Post-Apartheid South Africa', MA Thesis, Rhodes University, 2008; Heywood, M., 'The Price of Denial', c.2004, available on the Southern African Regional Poverty Network website at www.sarpn.org.za/documents/d0001195/4The_Price_of_Denial-Mark_Heywood.pdf (accessed February 2011); Heywood, M., & Cornell, M., 'Human Rights and AIDS in South Africa: From Right Margin to Left Margin', *Health and Human Rights*, 2, 4, 1998; Johnson, K., 'The Politics of AIDS Policy Development and Implementation in Post-apartheid South Africa', *Africa Today*, 51,2, Winter, 2004 (accessed using JSTOR); Mbali, M., 'HIV/AIDS Policy-Making in Post-Apartheid South Africa', in Daniel, J., Habib, A., & Southall, R. (eds), *The State of the Nation: South Africa 2003 – 2004* (Cape Town, HSRC Press, 2003); Natrass, N., *The Moral Economy of AIDS in South Africa* (Cambridge, Cambridge University Press, 2004); Natrass, N., *Mortal Combat - AIDS Denialism and the Struggle for Antiretrovirals in South Africa* (Scottsville, University of KwaZulu-Natal Press, 2007); Posel, D., 'Sex, Death and the Fate of the Nation: Reflections on the Politicization of Sexuality in Post-Apartheid South Africa', *Africa*, 75, 2, 2005; Posel, D., 'Democracy in a Time of AIDS', *Interventions*, 7, 3, November 2005; Schneider, H., 'On the Fault-line: the Politics of AIDS Policy in Contemporary South Africa', *African Studies*, 61,1, 2002; Schneider, H., & Stein, J., 'Implementing AIDS Policy in Post-apartheid South Africa', *Social Science & Medicine*, 52,5, 2001; Schneider, H., & Fassin, D., 'Denial and Defiance: A Socio-political Analysis of AIDS in South Africa', *AIDS*, 16, 4, 2002, available at AIDS journal website at: http://journals.lww.com/aidsonline/Fulltext/2002/16004/Denial_and_defiance_a_socio_political_analysis_of.7.aspx (accessed February 2011); Shisana, O., & Zungu-Dirwayi, N., 'Government's Changing Responses to HIV/AIDS', in Everatt, D., & Maphai, V.(eds), *The Real State of the Nation: South Africa after 1990* (Interfund, Development Update, 4, 3, November 2003) and Van der Vliet, V., 'AIDS: Losing "The New Struggle"', *Daedalus*, 130, 1, Winter 2002 (accessed using JSTOR). While there are NGO and CSO responses to AIDS initiatives launched during Zuma's presidency (such as the testing campaign launched in 2010), there are, unsurprisingly, few overviews or academic analysis of the AIDS policy since Mbeki's departure in 2008.

² Abdool Karim, S.S., 'Introduction' in Abdool Karim, S.S & Abdool Karim, Q. (eds), *HIV/AIDS in South Africa*, (Cape Town, Cambridge University Press, 2008), p. 35.

followed by an acknowledgement of an apparent 'change of heart' in 2003, and a desperate and quiet hope for change under Jacob Zuma's presidency.

Being conscious of the changing political, medical, economic, and social responses to AIDS as they occur is undoubtedly vital in researching and understanding AIDS 'in the present'. However, responses in 'the present' are influenced, framed and informed by 'the past', therefore the historical contexts that have shaped narratives, responses, and the people who created and implemented them, need to be understood and analysed. As Virginia Berridge notes:

History, even of the present, is not a predictive discipline. Its strengths lie in its sense of process and of change over time, in its generalizing capacity to interweave and assess different forms of source material and theoretical perspectives, above all, in its scepticism about received opinion and what appears to be the norm.³

History as a discipline, and historians as a group, thus have significant contributions to make by bringing these strengths to bear on writing and analysing histories of AIDS in South Africa (AIDS 'in the past') in order to better understand AIDS 'in the present'. This thesis is one such contribution which has interwoven and assessed different sources relating to medico-scientific and political communities and elites, and tracked changing responses by these communities and elites to AIDS during the early years of the epidemic. It has done so while sceptically analysing received opinions both about the epidemic and about those who were living with HIV, and dying from AIDS-related illnesses.

The body of historical knowledge about responses to, and other histories of, AIDS needs to be continually added to, not only to strengthen a disciplinary canon but also to provide texture and nuance to existing normative retrospective assessments of government responses to AIDS. Beyond 'speaking history to power', histories of AIDS need to be written to speak truth to the power of social constructions and ideologies that artificially cast certain groups of people as 'other' or 'foreign', and in so doing attempt to remove collective responsibility for public and social problems by placing some people outside of 'the general

³ Berridge, V., 'Researching Contemporary History: AIDS', *History Workshop*, 38, 1994, p. 233.

public' or 'society'.⁴ This thesis has shown how ideas and fears about 'infected outsiders' – cast as such by any number of changing characteristics from geography to gender - have been evoked and reinforced, to varying degrees, throughout the period under discussion.

Reflecting on over twenty years of involvement in AIDS work in South Africa, Mary Crewe remarked that AIDS 'carries this whole weight of meaning [and] nobody has ever actually fully unpacked that for South Africans'.⁵ In common with observations made by Paula Treichler and Charles Rosenberg about AIDS in the USA, Crewe's observations indicate that AIDS in South Africa has always been about more than just its constituent scientific explanations, epidemiological analyses, and physical deaths – it has also been about the relationships between ideas, words, and actions.

As Treichler observed in 1987, 'the AIDS epidemic - with its genuine potential for global devastation - is simultaneously an epidemic of a transmissible lethal disease and an epidemic of meanings or signification'.⁶ Similarly, Rosenberg reflected that

... nothing marked the [AIDS] epidemic more starkly than its ability to evoke and reproduce pre-existing social values and attitudes. The diversity and complexity of reactions to AIDS has underlined the need to look carefully at the elusive process through which society constructs its response to disease.⁷

This thesis engages with these observations, which are still germane in contemporary South Africa, and contributes to unpacking the histories of AIDS in South Africa by identifying the meanings and signifiers associated with AIDS and by examining how pre-existing social values and attitudes were produced and reproduced in the face of the epidemic, particularly in relation to constructions of 'race', gender, and sexuality.

⁴ Howard Phillips stressed the importance of 'speaking history to power' in his opening address at the New Directions in the Histories of Health, Healing, and Medicine in African Contexts workshop, Midlands, UKZN, South Africa, 19 - 21 August 2012.

⁵ Interview with Mary Crewe, Centre for the Study of AIDS, University of Pretoria, Pretoria, South Africa, 8 February 2008.

⁶ Treichler, P., 'AIDS, Homophobia, and Biomedical Discourse: An Epidemic of Signification', *October*, 43, 1987 p. 32.

⁷ Rosenberg, C.E., *Explaining Epidemics and Other Studies in the History of Medicine* (Cambridge, Cambridge University Press, 1992) p. 258.

Between 1980 and 1995 narratives about, and responses to, AIDS were constructed against the backdrop of apartheid ideologies and anti-apartheid struggles. Apartheid ideologies and legislation influenced how elites in medico-scientific and political communities understood themselves and their roles as professionals, citizens, and political actors. Whether supporting apartheid or opposing it, political and medico-scientific elites and communities evoked, and often reproduced, pre-existing social values and attitudes influenced by apartheid ideology.

While the response to AIDS and the constructions of AIDS narratives were uniquely shaped by the specific historical context of South Africa during a period of political transition, they were also shaped by, and reproduced, pre-existing social values and attitudes present at regional and international levels. The hegemonic AIDS narrative from English-speaking countries like the USA and UK that posited the '4 H-Club' narrative reflected narratives about 'race', gender and sexuality forged in a complex history that resonated in South Africa and were easily adapted to 'local' conditions.

The history of AIDS in South Africa is not bound by geographic borders but is rather a story of relationships forged nationally, regionally, and internationally. As the thesis has shown, the political and medico-scientific communities and elites discussed and exchanged information with professionals, organisations, or communities; received support from them; or evoked international standards against which to measure their actions. The importance of the relationships and networks that existed between medico-scientific and political elites and communities has also been revealed as one of the 'elusive processes'. To understand responses to AIDS in South Africa is to understand relationships from the most intimate and private sexual relationships between people, to the intellectual and financial relationships between countries, governments, communities, NGOs, and international organisations.

The creation of AIDS avatars (which were little more than crass stereotypes) in the hegemonic AIDS narrative were, for the most part, unquestioned because local, regional and international socio-political contexts did not challenge the convenient short-hand of such stereotypes. Even as the hegemonic AIDS narratives evolved and became more cognisant of

human rights discourses, assumptions about, for example, 'homosexuality' and sex workers, were still evident at local, regional and international levels.

Similarly, assumptions about the unquestioned primacy of biomedical approaches to AIDS and the positioning of male heterosexuality and patriarchal masculinities as normative and not in need of interrogation, restricted and stifled research about and responses to AIDS. In terms of biomedical approaches to AIDS, the thesis reiterates the findings of Rosenberg and others that the 'history of AIDS illustrates ... our continuing dependence on medicine'.⁸ This thesis has shown that during the period under discussion AIDS was treated as only a 'medical' matter and it was doctors and scientists who primarily influenced the official narratives and responses in political communities.⁹

Alan Whiteside and Clem Sunter remarked in 2000 that 'AIDS is bad news and dealing with it means addressing many issues around male sexuality and power - not something South African males (of all races [sic]) are comfortable with'.¹⁰ Commenting on this observation Shula Marks observed 'perhaps the regional qualification should be omitted'.¹¹ In relation to male sexualities this thesis has shown how certain sexualities and powers remained 'invisible' in narratives about and responses to AIDS and that this was a feature across communities, across sources and over time. Understandings of gender, 'race' and sexuality continue to contribute to the 'weight of meaning' that AIDS has, and require continued unpacking if their burden on people (particularly womyn) is to be reduced.

⁸ Fee, E., & Fox, D.M.(eds), *AIDS: The Burdens of History* (Berkeley, University of California Press, 1988), p. 5; Rosenberg, C. E., 'Disease and Social Order in America: Perceptions and Expectations' in Fee & Fox, *AIDS: The Burdens of History*; and Grundlingh, L., 'The Nature and Development of HIV/AIDS Historiography', *Acta Academica*, 29, 2, August 1997.

⁹ This is not to suggest that medico-scientific interventions are not vitally important in addressing AIDS, but rather that they should form part of more comprehensive responses that locate and contextualise AIDS as a health concern related to more than just a lack of physical well-being. While there have, more recently, been ongoing efforts to understand and respond to AIDS at both inter- and intra- disciplinary levels, the primacy of medico-scientific narratives remains evident in contemporary discussions about, and responses to, AIDS. An example of a slightly more inter-disciplinary approach is the International AIDS Vaccine Initiative. The South African component, known as SAAVI, while still predominantly driven by the search for a biomedical response, has deliberately sought to work with health psychologists from Stellenbosch University. (private correspondence and conversations with author). For more on SAAVI see the website at South African AIDS Vaccine Initiative, www.saavi.org.za (accessed February 2011).

¹⁰ Whiteside, A., & Sunter, C., *AIDS: The Challenge for South Africa* (Cape Town, Human & Rousseau, 2001), p. 124.

¹¹ Marks, S., 'Review: Science, Social Science and Pseudo-Science in the HIV/AIDS Debate in Southern Africa', *Journal of Southern African Studies*, 33, 4, December, 2007, p. 863.

The thesis has also explored some of the 'elusive processes' through which medico-scientific and political elites and communities constructed their practical responses to AIDS through the creation of hegemonic narratives. Such narratives shaped generally ineffective responses to AIDS by the government, the African National Congress (ANC) in exile, progressive health movements, and sexuality activists. The thesis has also revealed the 'elusive processes' through which narratives and responses were contested and challenged. Despite being hegemonic, the responses and narratives were not monolithic and were at least partially contested.

The benefit of hindsight allows historians the opportunity to analyse how narratives and contexts influence states of knowledge and this should be acknowledged. While knowledge and information available about AIDS was often scarce or difficult to obtain in the early years of the epidemic, this does not detract from the importance of interrogating the mechanisms and processes that form and shape what knowledge is sought, how it is sought, and what the consequences of unreflexive, uncritical research are. If researchers do not critically engage with the disciplinary practices that shape how they do research and what knowledge results from it, they may get caught in a cycle of uncritical shared beliefs which can be replicated in epidemic after epidemic. As Gilbert Rist notes

every belief grows accustomed to temporary uncertainties, and even feeds off them; anyway, they do not challenge the social consensus. However much one may hesitate privately, it still seems that there is nothing else to be done, since everyone believes that everyone else believes. Shared beliefs thus gives rise to social constraints, expressed in the form of obligatory practices reinforcing commitment to the belief. This defines the circle within which the definition of problems and the ways of solving them, are inscribed.¹²

This thesis has made a contribution to writing a history of AIDS in South Africa and unpacking aspects of the histories of AIDS, but more histories need to be written. Louis Grundlingh suggested that historians have a 'professional obligation' to 'counter ... superficial [historical] interpretations of HIV/AIDS' and should apply themselves to constructing 'more

¹² Rist, G., *The History of Development – From Western Origins to Global Faith* (London, Zed Books, 2008), p. 254.

... complete' histories of AIDS.¹³ In addition to other medico-scientific and political elites and communities whose histories need to be written, this could be achieved by historians writing the histories of AIDS in relation to mining companies, trade unions, religious or faith-based communities, LGBTI communities, children, and international organisations, to name but a few. Using the Zapiro cartoon above as a starting point, historians could write histories of each interested 'body' (or sector) and their responses to AIDS, and examine the relationships and networks between them and how they changed over time.¹⁴ Pursuing these lines of enquiry will help further unpack the meaning of AIDS and lighten the weight of multiple meanings that continue to be so burdensome.

In 1994, Mrs B.M. Nzimande (ANC), reflected on HIV and AIDS interventions in South Africa

A whole host of factors such as the migrant labour system, political tension, cultural diversity, illiteracy and the fragmentation of curative and preventative health services hindered efforts to combat HIV infections and Aids [sic]. While the tragedy of Aids was growing and was well documented, its effects on the pressing need for health services and facilities was less established. All these factors placed us on a road to a worse scenario.¹⁵

Despite it being thirty years since the first AIDS cases, and close on twenty years since the first democratic elections, there have been so few deviations from that road that historians might usefully ask why this has been the case. Throughout the period under discussion the political rhetoric of all the ministers of health have included references to the 'importance', 'seriousness', and centrality of AIDS prevention programmes to the government. Even when there have been no comprehensive strategies or plans in place, government officials have created the impression of action by evoking the use of the word 'programme' as if to

¹³ Grundlingh, 'The Nature and Development of HIV/AIDS Historiography', p. 21.

¹⁴ Work that has been done in this regard by Mandisa Mbali, for example, includes Mbali, M., 'Gay AIDS Activism in South Africa Prior to 1994', in Reddy, V., Sandfort, T., and Rispel, L. (eds), *From Social Silence to Social Science – Same-Sex Sexuality, HIV & AIDS and Gender in South Africa* (Cape Town, HSRC Press, 2009); Mbali, M., 'The New Struggle': A History of AIDS Activism in South Africa, 1982 – 2003', PhD Thesis, University of Oxford, 2009; and Mbali, M., 'The Treatment Action Campaign and the history of rights-based, patient-driven HIV/AIDS activism in South Africa' in Jones, P., & Stokke, K. (eds), *Democratising Development: The Politics of Socio-economic Rights in South Africa* (Leiden, Martinus Nijhoff, 2005).

¹⁵ *Hansard* National Assembly, vol. 2, Thursday, 20 October 1994, col. 3458.

concretise the ethereal or reinforce the flimsy.¹⁶ Declarations of the importance of an issue though, did not (and still do not) necessarily translate into effective or efficient responses. Government responses to AIDS in South Africa reveal the massive gulf between political narratives (or, perhaps more accurately, political spin) and appropriate practical resolutions or responses to public health crises that would benefit people in the most socially just and equitable manner. The relationships between politics, polemic and practice continue to have real effects on the lives, and deaths, of people.

¹⁶ A search through the research notes made from Hansard revealed the frequency of the use of the term, and a more rigorous discourse analysis might be of interest. Examples of this use include: communication programme, information and guidance programme, liaison programme, AIDS-control programme, educational programme, programme of education, information programme, programme of sex education and AIDS education, National programme, the AIDS programme, AIDS combating programme, lifestyle programme, Department's AIDS programme, DoH's AIDS programme, prevention programme, surveillance programme and National AIDS programme.

APPENDICES

Information on HIV prevalence rates in South Africa drawn from the Department of Health 'The 2011 National Antenatal Sentinel HIV & Syphilis Prevalence Survey in South Africa', December 2012, available on the Department of Health website at www.doh.gov.za/docs/reports/2012/Antenatal_Sentinel_survey_Report2012_final.pdf (accessed December 2012).



Figure 2: The HIV prevalence trends among antenatal women, South Africa 1990 to 2011.

The estimates from 2008 are based on a different sample size to the previous years.

Information from '2011 National Antenatal Sentinel HIV & Syphilis Prevalence', p. 12.

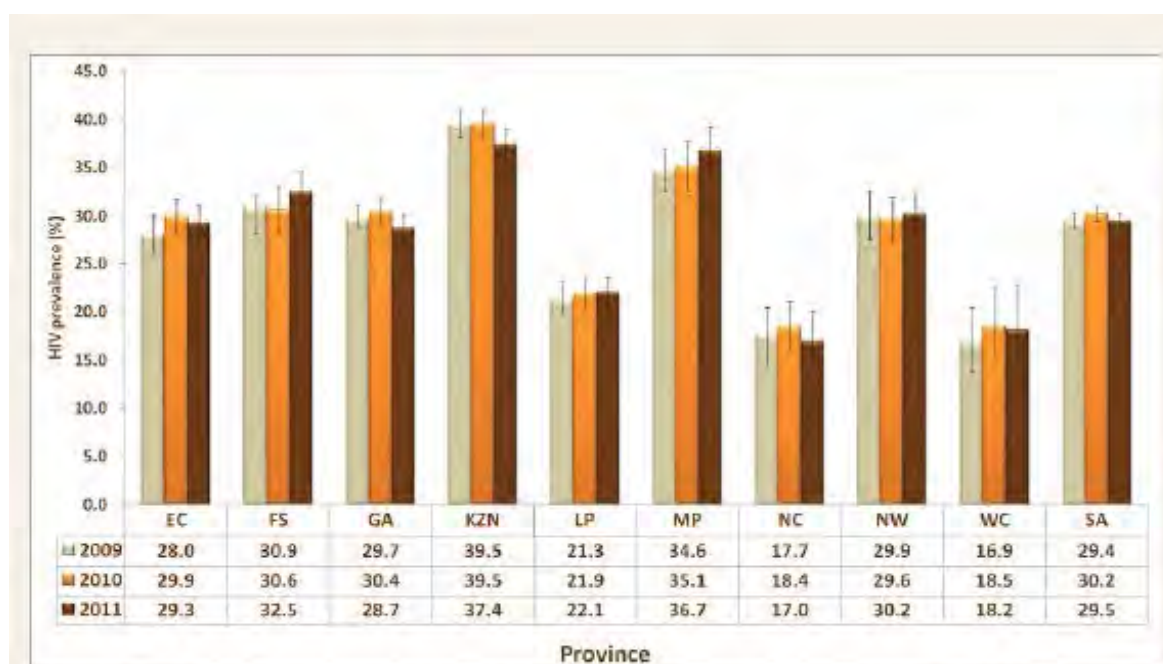


Figure 6. HIV prevalence trends among antenatal women by province, SA, 2009 to 2011.

Information from '2011 National Antenatal Sentinel HIV & Syphilis Prevalence', p. 15.

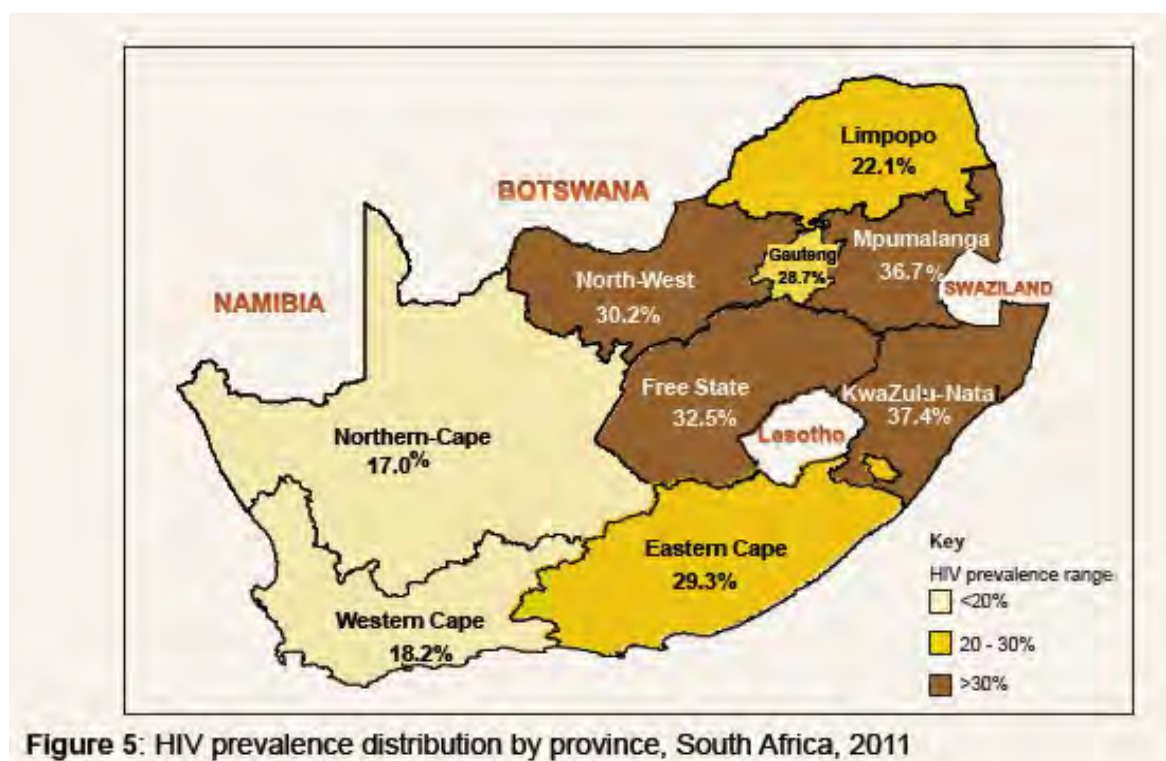


Table 25: Selected HIV estimates for South Africa, UNAIDS SPECTRUM, 2008-2011

Indicator	UNAIDS			
	2008	2009	2010	2011
Total HIV population (adults and children)	5 400 000 [5 100 000-5 700 000]	5 400 000 [5 200 000-5 700 000]	5 500 000 [5 200 000-5 800 000]	5 600 000 [5 300 000-5 900 000]
HIV+ adults (15+)	4 900 000 [4 700 000-5 200 000]	5 000 000 [4 700 000-5 300 000]	5 100 000 [4 800 000-5 300 000]	5 100 000 [4 900 000-5 400 000]
Adult (15-49) HIV prevalence (%)	17.2 [16.4-18.0]	17.2 [16.4-18.0]	17.9 [16.5-18.0]	17.3 [16.6-18.1]
Adult prevalence (15-24) female population (%)	13.1 [10.6-17.3]	12.6 [10.2-16.5]	12.2 9.915.9	11.9 9.715.5
Adult prevalence (15-24) Male population (%)	5.7 [4.4-8.1]	5.5 [4.3-7.8]	5.4 [4.2-7.5]	5.3 [4.1-7.4]
Adult HIV+ female population (15+)	2 800 000 [2 600 000-2 900 000]	2 800 000 [2 700 000-3 000 000]	2 800 000 [2 700 000-3 000 000]	2 900 000 [2 700 000-3 000 000]
HIV population (children <15)	450 000 [400 000-500 000]	460 000 [410 000-520 000]	460 000 [410 000-520 000]	460 000 [410 000-520 000]
Total annual AIDS deaths	380 000 [350 000 420 000]	340 000 [310 000 380 000]	300 000 [280 000 340 000]	270 000 [240 000-300 000]
AIDS orphans	1 900 000 [1 800 000-2 100 000]	2 000 000 [1 900 000-2 200 000]	2 100 000 [1 900 000-2 300 000]	2 100 000 [2 000 000-2 300 000]
Total number of new HIV infections	450 000 [420 000-490 000]	430 000 [390 000-470 000]	390 000 [360 000-440 000]	380 000 [350 000-420 000]
New infections (Children birth -14yrs)	66 000 [58 000-77 000]	57 000 [48 000-67 000]	30 000 [25 000-40 000]	29 000 [26 000-39 000]
Total need for ART among adults (15+)*	1 200 000 [1 100 000-1 300 000]	2 100 000 [2 000 000-2 200 000]	2 200 000 [2 100 000-2 300 000]	2 300 000 [2 000 000-2 200 000]
Children needing ART	220 000 [190 000-240 000]	220 000 [200 000-250 000]	270 000 [240 000-300 000]	260 000 [2 200 000-2 400 000]
Mothers receiving PMTCT (excluding sNVP)	-	-	250 000 [220 000-280 000]	240 000 [210 000-270 000]

* (CD4 350 starting 2009)

Information from '2011 National Antenatal Sentinel HIV & Syphilis Prevalence', p. 56.

AFRICAN NATIONAL CONGRESS

18.8.86

BASIC HEALTH POLICY GUIDELINESPreamble

Health care services under apartheid are totally unaccountable, racist, undemocratic, predominantly curative oriented, hospital-based and urban-biased. They therefore cannot equitably meet the health needs of the entire population. Diseases which were the scourge of 19th Century Europe are to this day still rampant amongst the black population. A precondition for the introduction of a democratic health care system lies with the eradication of the apartheid system, including an overhaul of the entire health system, in order to render it comprehensive and of meaningful service to the entire population of our country.

THE PLACE AND ROLE OF THE DEPARTMENT OF HEALTH

The Department of Health is part of the overall structures of the African National Congress, through which all health strategies for the well-being of our people shall be initiated and implemented. In the discharge of the ANC health strategies, the Department of Health shall always endeavour to:

- provide the highest and humane standard of health care possible to the membership of the movement.
- train health workers committed to the service of our National Liberation Struggle, and in the phase of national reconstruction and development. In this regard political and ideological training shall be a component part of training for health workers. Health workers shall be accountable individually and collectively to the community and shall adhere to professional ethics.
- involve and integrate itself with the progressive health struggles both inside South Africa and internationally.
- mobilise political and material support for our movement.
- isolate South Africa from all international health forums.

The Department of Health shall have the final word in all health and health related matters.

HEALTH POLICY GUIDELINES

The ANC Health Policy Guidelines shall reflect the content of the policy of the ANC as enshrined in the Freedom Charter, with particular emphasis on Primary Health Care strategies, which guarantee the attainment of health for all.

-2-

Furthermore, primary health care shall go hand-in-hand with other nationwide developmental programmes that seek to minimise the disparities in the living standards and conditions of our people. The application of the primary health care strategies shall at all times ensure the following measures:

PREVENTATIVE HEALTH CARE WHICH SHALL PROVIDE FOR:

- maternal child health care services
- expanded programme of immunisation
- nurseries and crèches near the work place
- encourage breast feeding
- protective clothing and measures for the workers

PROMOTIVE HEALTH CARE REORGANISED TOWARDS

- change of habits to promote healthy life-style
- national research on all socio-cultural and economic factors influencing health
- utilisation of wastes for production of biogas
- providing adequate and safe supply of drinking water, good housing, lighting, playing fields and social recreation centres
- improving environmental hygiene and sanitation
- land reclamation, water, soil and forest conservation
- proper disposal of air, water and chemical and nuclear waste.

CURATIVE HEALTH TO ENSURE:

- a high standard of health care for all
- standardisation of treatment
- provision of a nationwide list of essential drugs in order to prohibit the proliferation and distribution of dangerous drugs and drugs of doubtful efficacy
- systematic acquisition and distribution of medical supplies on an equitable basis
- national research with the aim of discarding harmful practices and integrating traditional healers and birth attendants into the national health service.

REHABILITATIVE HEALTH CARE ENCOMPASSING:

- child psychology and survival, to guarantee proper counselling and support in the field of child growth and development
- provision of services for the pensioned and the age

-3-

- comprehensive and community-based mental health care
- acquisition of expertise in surgical techniques, mechanical aids to minimise the degree of disability

HEALTH EDUCATION ORIENTATED AROUND:

- the homes, work places, institutions - from cognitive ages to literacy and adult education programmes
- teaching personal hygiene and public health, nutrition, first aid and civil defence
- popularising health care
- dissemination of information on health matters
- mobilising the membership around health issues.

INTERSECTORAL AND MULTIDISCIPLINARY APPROACH TO HEATH TO ENSURE:

- sharing of health information at all levels of the department and other sectors of the movement
- identification of assistances in the health field by all other sectors of the movement
- planning, implementation, supervision and evaluation of all health programmes at all levels of the department.

COMMUNITY PARTICIPATION BASED ON EPIDEMIOLOGICAL DATA THAT WILL:

- strengthen community-based programmes through campaigns led by task forces and brigades
- identify health programmes necessary for self reliance
- allow for a flexible approach by the community in determining health priorities for implementation
- encourage initiatives and strengthen community involvement and commitment.

TECHNICAL COOPERATION TO FACILITATE:

- good working relationship with other progressive health workers, organisations and countries
- utilisation of experience and expertise of other progressive health workers in the field of health
- international mobilisation for political and material support.

Copied from original document found in the University of Fort Hare's ANC Archive, ANC Lusaka Mission, pt.2, 20, 2.

Extract from:

ANC DEPARTMENT OF HEALTH

ANNUAL REPORT TO THE ECC FOR THE YEAR 1987

13. Internal work

...

b. On-going discussions are being held with health workers and trade unionists involved in health struggles at home. Discussions centre around mode of coordination between the department and the democratic health movement inside the country; mobilisation of health workers in general into the broad democratic health movement; issues concerning emergency services to victims of police and SADF harassment; the concept of Progressive Primary Health Care (PPHC) and a Nationalised Health Service for a future democratic South Africa; mobilisation of the international community in support of health struggles being waged in the country and the isolation of apartheid health organisations and individuals from international health forums. These meetings and discussions are gathering momentum and are drawing closer together our understanding of struggles in the health sector and the democratic health organisations at home.

Copied from original document found in the University of Fort Hare's ANC Archive, ANC Lusaka Mission, p2a, 41, 65, p.4.

HIV and AIDS in Southern Africa

Draft Maputo Statement

Introduction

This statement was prepared and agreed to by delegates at an International Conference on Health in Southern Africa held in Maputo, Mozambique in April 1990.

The conference acknowledged research which shows that human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS) is an established epidemic in South Africa and throughout Southern Africa.

The magnitude of the epidemic is increasing rapidly within the Southern African region. Recent research has shown that nearly 60 000 people are thought to be infected in South Africa alone. The number of people affected by this disease is expected to double every eight and a half months.

Delegates at the conference agreed that if no significant intervention is made within the next few months, there would be little chance of avoiding its disastrous consequences.

It was noted that the South African state response has been totally inadequate. Lessons drawn from throughout the world have emphasised the crucial role representative organisations have to play in combating this disease. These community-based organisations need to develop an appropriate strategy which will reach the many of our people.

The conference therefore made the

following recommendations as policy guidelines for developing programmes around AIDS and HIV infection:

An HIV campaign must have the following features:

- It must be nonstigmatising and avoid stereotyping individuals and groups.
- It must be founded upon community-based action. Political and other leadership must be involved.
- It must identify and address the social and political factors relating to the spread of the disease.

The political profile of HIV and AIDS must be raised

HIV/AIDS is a social disease and should not be approached in a narrow biomedical fashion. Economic, political and social factors are major determinants of the rate of development and extent of this epidemic.

Features of life in South Africa and Southern Africa facilitate its spread. Poverty, migrant labour, population relocation, homelessness, forced removals, unemployment, lack of education and poor housing play major parts in the development of this epidemic.

The health care system is fragmented and discriminatory. Little emphasis is placed on prevention and health promotion. Communities do not participate in promoting their health and health services.

The HIV campaign waged by the

state has been grossly inadequate. Communities have not been involved, nor have representative organisations been consulted. Too few funds have been allocated to HIV prevention and the care of people with HIV disease. The media and education campaigns have promoted fear, stigmatisation and discrimination.

Political organisations must play a leading role

Any attempt to deal with the HIV epidemic must be situated within the broader struggle for sociopolitical change. This will provide a context for preventive work amongst the broad group of people most affected by HIV infection.

Progressive organisations should inform their membership of the magnitude and importance of HIV infection. They should examine, analyse and respond to HIV with the support of their membership.

We can start by involving senior progressive political leadership within and outside South Africa. The African National Congress has a major role to play in this regard. The involvement of political leaders will help overcome suspicion and mistrust created by the South African state. A high public profile will raise awareness and stimulate appropriate action.

We need to involve worker, youth, women's, religious, political and other community-based organisations at all levels of work on HIV infection and

AIDS. We should assist these organisations to recognise the importance of this epidemic. Wherever possible, committees to develop a response to the epidemic and related problems should be formed within organisations and communities.

Change in personal politics is required

The HIV epidemic has revealed inadequacies in how we relate to one another. Sexism, victim-blaming and racial stereotyping decrease our ability to deal effectively with HIV infection at a grass-roots level. Discrimination against prostitutes, members of the gay community, injecting drug users and other marginalised groups should be overcome. Programmes to rectify these discriminatory forms of behaviour should be initiated as part of the response to HIV disease.

The rights of people with HIV disease, as with any other health condition, must be firmly recognised.

Demands of the South African state

The South African state has not displayed any genuine commitment to dealing with the problem facing the population. We need to develop a set of demands directed at the state so that it does not neglect its responsibilities. These will include:

- a) undertaking a serious preventive programme for HIV infection in the country. Adequate resources must be provided. Free condoms should be supplied throughout the country.
- b) committing itself to providing comprehensive preventive, promotive, counselling, support, hospital and community-based services.
- c) making available material and other infrastructural resources to community-based organisations involved in HIV campaign work.
- d) abolishing discriminatory, repressive and restrictive legislation such as that discriminating against gays, commercial sex workers and foreign migrant workers.

The progressive movement should be at the forefront of developing appropriate strategies and should demand the resources to achieve this. State resources

are ours and should be used as such.

Developing a community-based approach

A multisectoral community-based approach is needed to effectively tackle HIV infection. Communities must have control over activities and resources. Representative structures must ensure accountability.

We must acknowledge the importance of working with the unorganised and identify ways of facilitating their involvement and representation.

Broad programmes need to be translated into local-level activity. Safer sexual practices and behaviour change must be encouraged. Condoms must be made widely available and local educational materials and mechanisms developed.

Workers must be protected

We acknowledge the work undertaken by the trade unions in identifying and tackling the work-related problems associated with HIV infection. These include such issues as discrimination, testing without consent, denying medical and other benefits, and the lack of facilities for conducting appropriate worker-controlled educational programmes around HIV infection in the workplace.

We need to provide whatever assistance is required by the trade union movement in campaigning for employers and the state to fulfill their social responsibility to workers and the community at large.

Health workers

Health workers have a responsibility to care for people with HIV disease in a caring and nondiscriminatory way.

Adequate protection against the risk of HIV and other infections should be provided at all worksites.

Appropriate structures should be formed

An AIDS Task Force should be established. This must coordinate and promote HIV and AIDS work nationally in the progressive movement. It should develop a programme for preventing this infection from spreading and ensure that

appropriate services are put in place to provide care. It must demand resources from the state to achieve these goals. It will need to build on existing organisations and involve all AIDS interest groups. A democratic structure, including representatives of the progressive movement, must be formed within the Progressive Primary Health Care Network.

An interim committee set up at the conference has undertaken the following urgent programme of action:

- a) to set up a mid-1990 national conference on HIV and AIDS at which the National AIDS Task Force will be elected.
- b) to distribute this statement and consult with organisations about the development of an appropriate response to HIV and AIDS and the formation of a representative structure to take this forward.
- c) to draw in progressive political and community-based leadership in order to gain their support and involvement in urgent action to prevent the further spread of HIV infection.

Evaluation

The state programme needs to be examined and monitored in an ongoing way. We should reveal the weaknesses of such a campaign and articulate demands and alternative structures which will more directly address the prevention of this epidemic.

Our programmes need to be carefully and scientifically evaluated at regular intervals and modified accordingly.

Conclusion

South Africa and the whole Southern African region is facing a crisis over the HIV epidemic. Urgent action must be initiated immediately. The state programme is fundamentally limited and flawed. An alternative progressive campaign with the support of political and other representative organisations must be set up immediately.

An AIDS Task Force is proposed to take this urgent programme forward. Realistic objectives must be set, based on grassroots participation. The sociopolitical context of this disease must be acknowledged in all programmes. Safer sex must be promoted to protect the health of the community. □

Maputo, April 1990.

Yellow Hand Campaign - AIDS Information Launch Advert, December 1991.

SOWETAN Tuesday December 3 1991 Page 19



AIDS. Don't let it happen.

WHENEVER YOU SEE THIS HAND REMIND YOURSELF THAT YOU
HAVE THE POWER TO STOP AIDS HAPPENING TO YOURSELF.
YOUR FAMILY. YOUR COMMUNITY.
REMINDE YOURSELF THAT AIDS IS NOT A DISEASE THAT ONLY
HAPPENS TO OTHER PEOPLE IN OTHER PARTS OF THE WORLD.
IT'S HERE. AND WE ARE ALL AT RISK.
REMINDE YOURSELF TO GIVE PEOPLE WITH AIDS ALL THE
HELP AND SUPPORT YOU CAN.
THEN REMIND YOURSELF THAT AIDS WON'T HAPPEN TO THE
UNINFECTED IF WE START LEARNING ALL WE CAN ABOUT
HOW TO PREVENT IT.
IF WE STOP BEING AFRAID TO TALK ABOUT
OUR RELATIONSHIPS.
IF WE TAKE THE TIME TO TEACH OUR CHILDREN WHAT WE KNOW
AND MOST IMPORTANT OF ALL, IF WE STOP SAYING IT CAN'T
HAPPEN TO ME.

PLATJACARD 2004 111042

THE PLAIN AND SIMPLE TRUTH ABOUT AIDS.

On this page you will find a simple and practical guide which tells you how you can get AIDS, how you can't and how you can avoid it.

Some of the words used here may shock you because until now they have not been considered polite or acceptable in everyday conversation. But please understand that times have changed. Now that AIDS is here we can no longer be afraid to say them.

Because by discussing AIDS and by bringing relationships between men and women into the open we're taking the first step in making sure that AIDS doesn't happen. To us. To our families. To our community.

YOU CAN PREVENT AIDS BY:
 HAVING A LONG-STANDING RELATIONSHIP IN WHICH BOTH PARTNERS ARE FAITHFUL AND UNINFECTED WITH AIDS.
 HAVING SEX WHERE THE MAN'S PENIS DOES NOT ENTER HIS PARTNER.
 ALWAYS USING A CONDOM IN SHORT TERM OR CASUAL RELATIONSHIPS.

IF YOU'D LIKE TO KNOW MORE:
 IT'S NOT EASY TO TALK ABOUT SOMETHING SO PERSONAL. WE HOPE THAT BY TALKING SO OPENLY IN THIS AD WE HAVE HELPED YOU TO FEEL MORE COMFORTABLE WITH DISCUSSING THESE ISSUES. AT THE AIDS TRAINING AND INFORMATION CENTRES YOU'LL FIND A SYMPATHETIC EAR. OUR COUNSELLORS ARE TRAINED TO ANSWER WHATEVER QUESTIONS YOU MAY HAVE. AND IT'S ABSOLUTELY CONFIDENTIAL. PHONE OR VISIT NOW. TOGETHER WE CAN MAKE SURE THAT AIDS DOESN'T HAPPEN.

BLOEMFONTEIN : (051) 405 8544/28.
 CAPE TOWN : (021) 210 2682/5400.
 DURBAN : (031) 300 3104/3020.
 EAST LONDON : (0431) 34 2383.
 JOHANNESBURG : (011) 725 6710/27379
 HOTLINE.
 PIETERSBURG : (01521) 91 4962
 PORT ELIZABETH : (041) 506 1911/1415.
 PRETORIA : (012) 313 7988/7850.
 RICHARDS BAY : (0351) 3 111.

YOU CAN GET AIDS FROM:
 SEXUAL INTERCOURSE EITHER VAGINAL OR ANAL.
 SHARING NEEDLES FOR SELF INJECTION OF DRUGS.

YOU CANNOT GET AIDS FROM:
 CONTACT SPORT EG. SOCCER AND RUGBY.
 CROWDED VEHICLES.
 FOODS PREPARED BY AIDS INFECTED PERSONS.
 HUGGING AND HOLDING HANDS.
 MANICURES, PEDICURES AND WAXING.
 MASTURBATING.
 MOSQUITOES AND BED BUGS.
 NOBODY HAS GOT AIDS FROM ANY KIND OF KISSING.
 SHARING A BED.
 SHARING CROCKERY AND CUTLERY.
 SHARING THE COMMUNION CUP.
 SNEEZING, COUGHING AND PERSPIRATION.
 SWIMMING POOLS.
 TOILET SEATS.
 TODDLERS CANNOT GET AIDS FROM MIXING AND PLAYING TOGETHER.



AIDS. Don't let it happen.

Yellow Hand Campaign - AIDS Information Launch Advert, December 1991.

SOWETAN

Building the Nation



Parents, children and

AIDS

WHAT IS AIDS

AIDS is a condition in which our immune system, the system in our bodies that protects us from disease, breaks down. This means that eventually our bodies can no longer fight off illnesses they used to deal with easily, and after quite a long time, usually eight to 15 years, we die.

Aids stands for Acquired Immune Deficiency Syndrome. Acquired means it is something you get, rather than something you were born with. Immune means you can't get it. Deficiency means lack of being immune. And syndrome means a group of symptoms forming an illness.

Aids is caused by a tiny germ, a virus known as the Human Immune-Deficiency Virus, or HIV. There is no medicine, vaccine or antibiotic that can remove the virus once it is in our bodies, or protect our bodies from it. The virus seriously destroys the body's ability to protect itself, so that it becomes a bit like a soccer team without a goalie — there is nothing there to protect the goal, and the team is easily beaten.

The virus is contained in blood and in sexual fluids such as semen or vaginal fluids, so that the main way it is passed on is when people have sex. Sex with no protection, such as a condom, can allow the virus to pass into the partner's body. The virus can also be passed on by a pregnant mother to her baby, and when this happens the baby usually dies before it is two years old.

If we allow blood from an infected person to enter our bodies we will probably become infected with the virus too, so it is very important that doctors and dentists use clean, sterilised injection needles on every patient. Drug addicts who share needles and syringes are putting themselves at great risk.



*HIV is a very fierce germ
that attacks the
white blood cells themselves*

It used to be possible to get Aids through blood transfusions, but since 1985 all donated blood is tested for the virus. It is very unlikely now for the virus to be passed on this way. You cannot get Aids from donating blood either.

Once someone is infected it usually takes about three months before there are any signs of the infection in that person's blood. During this time, and for several years to come, an infected person is likely to be perfectly healthy. But all this time they are capable of infecting other people.

You can't tell if someone is infected. Because of this, it is wise always to take precautions against the virus. The best way to avoid the virus is to avoid having sex until you are married, and after that to remain faithful to your partner. If you do have sex, use a condom, because condoms reduce the risk for both partners.

If you avoid unsafe sex and injecting yourself with drugs it is impossible to get Aids. You cannot get it from ordinary everyday contact at school, from touching, from kissing (not even French kissing), from swimming in the same pool as an infected person, from lavatories, from sharing cups or glasses or a straw, or from having a bite of someone else's sandwich. You can't get it by donating blood.

People between the ages of two and 12 are almost never infected by the Aids virus, because they have not had sex. But they need, by the time they become teenagers, to know about the disease, and how to avoid it. Forewarned is forearmed.

Detail of AIDS Information Supplement in *The Sowetan*, c. 1991/2,
Part of the Yellow Hand Campaign.

You and your friends

ADOLESCENCE is a time when we are no longer children, but not quite adults either. Our bodies start to change, often quite alarmingly, and our emotions can swing from the pines to happiness and back again very quickly. It is really a trial period for adulthood, and we have to try out all sorts of different roles and choices to decide who and what we'll one day become.

Both girls and boys suddenly start growing taller, often develop spots and other skin problems, and both groups start to develop physically. It usually happens to girls first.

Our feelings, which are often intense, can swing so that something we felt very strongly about yesterday can be unimportant today. Suddenly we start to be attracted to members of the opposite sex, and become aware of strange reactions in our bodies when someone we fancy is near.

It is a time when we test ourselves and each other. We need to start to develop a feeling of being able to cope with our emotions and with the demands made on us by our families, our friends and our teachers.

It's important that we realise that because our feelings can change, we should not always do exactly what we feel like doing. Sometimes we must think with our heads, not our hearts.

We all want to be liked, to be loved, to be popular and be regarded as smart and attractive. But we may feel stupid, lonely, gangly, hairy, fat and unattractive. Boys may find their

voices are unreliable and squeak at important moments, making everyone laugh. It is very easy, when we feel unsure of ourselves, to fall in with what everybody else is doing, just to prove we are okay and acceptable.

Because we want to be regarded as smart, we sometimes do some unsmart, even dumb things. It is not smart to have sex with someone because we're scared they'll leave us or talk about us if we don't. It is rather dumb to take drugs or drink alcohol because we're scared our friends will reject us if we don't.

Being told it is normal to feel inferior, rejected and ugly doesn't help a lot. But there are tricks for coping with these feelings. For instance, if we feel inferior because we're useless at sport, we could focus on something we're good at, like photography or schoolwork. When we succeed at something it boosts our self-confidence, and once we start to believe in our own abilities, we're winning. Confidence is very attractive. Adolescents need to learn how to cope with conflict. If we feel anxious, distressed, angry or afraid, we often want to go out and DO something, like break something, punch someone, get drunk or do anything we know will "make them sorry".

We need to identify the feeling (angry, sad, bored), and then do something appropriate. If we're angry, for instance, instead of going out and getting drunk it would be better to go for a long walk, do some hard physical work, and then perhaps talk about it when all tempers have cooled.



You cannot
get AIDS
through
social contact

Detail of AIDS Information Supplement in *The Sowetan*, c. 1991/2 with Keith Haring-like illustrations.

Negotiation skills

As we grow older we get more freedom — and more responsibility. As a small child someone was always keeping an eye on us, making sure we were safe. But eventually we have to start taking charge of our own wellbeing and safety, and to do this we need to learn a variety of skills so we can cope with the demands of maturity and adulthood.

We need to learn how to assess a situation and the possible result of certain types of behaviour. We need to know how to make a decision that is best for us, and one that isn't too strongly influenced by our friends, especially if this influence could lead to our making the wrong decision.

When making decisions we should ask ourselves:

- What harmful effects could this decision have on me?
- What harm could this cause others, such as my girl/boyfriend or my parents? and
- What harm could this cause now or in the future?

Often we know what the right decision should be, but feel scared to make it in case our friends reject us. We might feel really silly if we refuse to smoke when everyone else is smoking, even though we don't really want to smoke.

People — adults and adolescents — are often unable to make the right decision because they feel inferior and unimportant, and because they have no sense of the future.

It is vital to develop a sense of our own importance, and this comes through confidence. We have to give ourselves a chance of a happy life, and should think about the things we would like to do and to achieve.

Drinking and its consequences, drugs, unplanned pregnancy or Aids can all spoil our chances for ever. We have to learn to say no.

Saying no is not easy. Sometimes we have to say it several times, loudly, to convince ourselves as well as others.

It can also be very hard when someone we love wants us to do something we feel we should not do. And sometimes it can feel as though our own bodies are betraying us. It is easy to think: If it feels this good it can't be wrong.

But sex has possible consequences: infection, pregnancy, guilt, a bad reputation, embarrassment, emptiness and disappointment in ourselves.

No sex means no guilt, no infection, no pregnancy, a possible feeling of pride. If the relationship should end, there will be no hang-ups when starting a new relationship.

Sometimes the arguments can be very persuasive. The best guide is: If you feel it is not right, don't do it.

What to say when your partner doesn't want to use a condom:

"It takes too long."

- You'll be turning me on every second.
- I love it when you take your time.
- What's the rush?
- I'll wait.

"Just this once."

- Only kids make decisions like that.
- I'm suddenly extremely sleepy.
- It only takes once.
- No way.

"It spoils the mood."

- We could always go to a good movie.
- It puts me in the mood.

"You won't catch anything from me."

- If you love me, respect my health.
- Condoms protect, love doesn't.
- I forgot to take the Pill.



Talk to your partner

Detail of AIDS Information Supplement in *The Sowetan*, c. 1991/2 encouraging heterosexual couples to negotiate sexual practices.

The Star



Meeting the challenge of

AIDS

THE LANGUAGE OF AIDS

AIDS is a pandemic (world-wide epidemic) which is going to affect everyone directly or indirectly. There is still no vaccine and no cure, so prevention is the only way to deal with it.

In South Africa 300 people a day are becoming infected, most of them heterosexual adults, many of them with children to support.

Aids stands for Acquired Immuno-Deficiency Syndrome, and is caused by a virus known as the Human Immuno-Deficiency Virus or HIV.

The disease was first diagnosed in America in the early 1980s, and the first two South African patients, both white homosexuals, were diagnosed in 1982.

At first most of the patients were homosexuals, but now the main way the virus is spreading is by heterosexual sex, that is, sex between men and women. It can also be spread from mothers to their unborn or newly born babies.

The virus enters the bloodstream and attacks the body's immune system — the system which protects the body against infections — and gradually destroys it. Once the immune system is destroyed, you have no protection against a series of opportunistic infections which healthy people easily fight off.

When you are first infected with the HIV virus you look and



feel well, and usually do not know the virus is in your body. But you are infectious and you can pass the virus on.

It usually takes about three months for antibodies to the virus to show up in your blood, and this period — when you are infectious but there are no signs of the virus in your blood — is known as the window period.

After about five to 10 years, when the body has little natural immunity left, you feel tired and get sick often, with illnesses such as thrush in the mouth, shingles, pneumonias, a rare skin cancer, or TB.

There is a drug called AZT which can delay the onset of symptoms and allow people to live full, active lives for longer. But its effect is temporary. It is also very expensive, costing more than R1 000 a month.

You are safe from Aids if you are involved in a long-term, faithful relationship with someone, or if you don't have sex, or if you masturbate.

Sex with an infected person al-

lows infected semen, vaginal fluids or blood, including menstrual blood, to enter the body.

Condoms act as a barrier and prevent the exchange of fluids. They are made of fine latex rubber and are very sensitive. It is safe and responsible to use condoms every time you have sex outside a long-term, faithful relationship.

WOMEN AND AIDS

THERE are more women in Africa who are HIV-positive than anywhere else. Although the number of women infected in South Africa is still fairly small, it is growing rapidly, with 140 of the 300 people testing positive every day in this country being women.

At first homosexual men were the group most at risk of becoming HIV-positive, but now the disease is spreading fast among heterosexual people. Heterosexual sex is now the main way to become infected. Passing the virus from infected mother to newborn baby will soon be the second most common transmission method.

Researchers believe that women are more vulnerable to the virus than men are, and are more likely than men to get infected if they have unprotected sex with an infected person.

Because there is no vaccine against Aids, you have to take responsibility for your own safety from this virus. This means taking the safe options and avoiding high risk behaviour.

Babies: Apart from being at risk of becoming HIV positive, women will also be affected by the epidemic because of the vulnerability of babies both in the womb and newly born. Some studies have shown babies born to HIV-positive women have approximately a 40 percent chance of being HIV positive too. Although they appear to be entirely normal at birth, they usually have many childhood infections before their first birthday, and invariably die by the age of three.

About 40 babies a day in South Africa are diagnosed HIV positive.

Health resources and care: Most people who develop Aids will have to be looked after at home. For many years HIV-positive people can lead normal lives and continue earning their living and supporting their dependents. But when they get sick they will need to be nursed. Because of the number of people who will be sick, most people will not be treated in hospitals.

Women are likely to have to bear the brunt of looking after Aids patients, and will need the support of everyone within the

neighbourhood and the community.

Finances: The epidemic is going to strike people of working age, who may be earning money to support themselves and their families.

Often both parents die, which implies that many children are left behind orphaned.

Women need to learn how to negotiate both within intimate relationships and beyond, to take responsibility for their own health and safety and those of their children, and work towards a society in which women can help make decisions.

ARE YOU AT RISK?

	No	Yes
1. Have you ever had sex with anyone?	0	1
2. Have you had sex with a prostitute or a sugar daddy?	0	2
3. Have you had more than one sexual partner?	0	2
4. Have you had sex with anyone who has already had sex with someone else?	0	2
5. Have you ever had a Sexually Transmitted Disease (STD)?	0	3
6. Do you intend to stay a virgin till you get married?	2	0
7. Do you intend to marry a virgin?	2	0
8. After marriage will you remain faithful?	3	0
9. Will you expect your wife/husband to be faithful to you?	3	0
10. Do you ever inject yourself with a dirty syringe?	0	4

SCORE:

0 You are not at risk.

1 You could be at risk.

2-25 You could be at risk of infection with HIV and of later developing Aids; the higher your score the greater your risk.

Estimated numbers of HIV - infected women



Detail of AIDS Information Supplement in *The Star*, c. 1991/2.

THE IMPACT ON THE ECONOMY

AIDS in South Africa is going to affect mainly young adults of working age, and very young children who may be infected or orphaned. This will have a major economic impact both on the overall economy of the country and on individuals in the community.

Although nearly 200 000 persons are already infected with HIV in South Africa, it is as difficult to predict accurately how many people will be infected in 1996 as it is to predict that year's gold price. The reason is that the rate of the pandemic's spread will eventually slow down, as it has in other countries. Also, many estimates of future numbers of HIV-infected persons ignore the impact preventive measures could have.

One area of the economy which will be seriously affected by Aids will be the health services. With the benefit of the experience of the pandemic painfully gained in other parts of the world, and particularly Africa, we know that this could be considerable. Many people already infected will present themselves to all levels of the health service with a variety of problems including pneumonias, cancers and tuberculosis. An increasing proportion of the health budget will have to be spent on people with Aids.

It is difficult to know exactly how Aids will affect business and industry, because the likely extent of the pandemic is not known. Economically active adults will become sick and die, but many will be replaceable from the large pool of unem-

ployed people. There will, however, be a big loss of skills, and the cost of retraining people will be considerable.

Testing employees for Aids, and Aids-testing job applicants, are not going to prevent Aids. The large amounts of money needed for repeated screening would be better used in long-term education of both employee and employer.

Aids is very much a family disease. Typically, the young husband becomes infected while away from home, and subsequently infects his wife. In turn the youngest born child is infected. Within a few years these three family members are either very sick or actually dead.

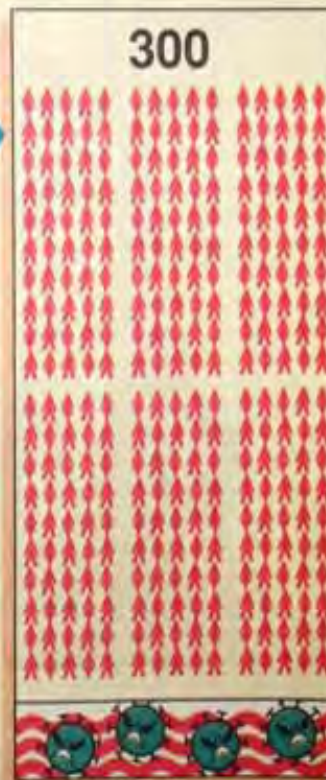
Apart from the immediate distress and loss, the family suffers because the long periods of illness and costs directly related to death take up a lot of the family resources. Older, orphaned children may not have anyone to look after them, or may not be able to continue their education.

If a small community is severely affected by Aids there may be a relatively high proportion of families affected either directly or indirectly. This may impose a huge burden on the community. In communities dependent on agriculture, the loss of key family members has already had an impact on the types of crops grown and general prosperity.

Insurance companies and medical aid societies have special problems. At the moment they are considering how best to address the very sensitive issues involved.



Number of new HIV infections in South Africa every day



Top daily causes of death in South Africa, compared with new HIV infections



Detail of AIDS Information Supplement in *The Star*, c. 1991/2.

WHEN YOU MEET A PERSON WITH AIDS

PEOPLE who are told they are HIV positive have to face a new and frightening future. They often react in similar ways to people with other life-threatening illnesses, such as cancer and heart disease, and may be angry and frightened. They may also refuse to believe the diagnosis.

The difference between illnesses such as cancer and Aids is Aids's link with sex, and the fact that you can get it from another person. Some people believe, wrongly, that nice people don't get Aids, and see the disease as a punishment for sleeping around, or homosexuality, or using drugs.

This stigma can play a major role in how a person with Aids responds to the news, and faces the future.

People with Aids may die in the end, but they have to learn to live with the disease for many years first, often with no symptoms at all. Their own attitude can make a difference to how long and how well they live. And their own attitude is affected by how other people treat them.

People with Aids — worried about their jobs, accommodation and links with family and friends — often keep the information secret. By not telling people they care for that they have the virus, they tend to isolate themselves, and often become desperately unhappy and lonely, which can make them sick.

When you first meet a person with Aids you are confronted by various beliefs and possible prejudices of your own. You may disapprove of his lifestyle, and you will probably be nervous of getting Aids from him if you touch him, kiss him or let him use your cups and plates.

All these feelings are picked up by the person with Aids, and can contribute to his physical and emotional distancing, and his sense of alienation.

But you can't get Aids by touching, by using lavatories a person with Aids has used, by sharing food and drink, by hugging or kissing, from swimming pools, by touching handles or doorknobs, working next to someone with Aids, from second-hand clothes, by giving blood, or by any ordinary social contact.

There are only three ways of getting Aids: through unprotected sex, through exchange of blood (via transfusions, or dirty injection needles), and from a mother to her unborn baby.

Social support is extremely important for people with Aids.

I HAVE AIDS

Please hug me



I can't make you sick

They are better able to live with their disease when they maintain or develop ties with supportive family, friends and the community. Social support systems help people with Aids maintain feelings of hopefulness, and also provide practical support.

It is vital that if you meet a person with Aids you examine your own feelings and emotional responses to that person and work out if they are valid. People with Aids are already angry, frightened and probably discriminated against. But they need a warm, caring and supportive environment, and must be treated with respect and compassion.

By being non-judgmental, caring and supportive, you can help a person with Aids not only to come to terms with the diagnosis, but also to live with it.

This Valentine's Day
say it with
a French letter.



This Valentine's day you may put your heart at risk. But don't risk your life. Play it safe, use a condom. To find out more about AIDS and safer sexual practices phone Life-Line AIDS Line toll-free 0800 012 322 or contact your nearest AIDS Training and Information Centre.



AIDS. Don't let it happen.

Yellow Hand Campaign - AIDS Information Adverts, c. 1991/2.



if you think you have an STD tell your sexual partner.

BIBLIOGRAPHY

PRIMARY SOURCES

Archives

African Studies Library (ASL), University of Cape Town

- BRB 309.16805 SOU, Andor, L.E., 'AIDS in Southern Africa' in *Southern African Update - A Bibliographic Survey*, 5, 2, October 1990.
- BRB 616.079 BOWE, Bowen, J.H., 'AIDS/HIV Infection: a select bibliography of articles in South African journals, 1988 – 1990', c. 1991.
- BRB 616.079 BOWE, Bowen, J.H., 'AIDS/HIV Infection, volume 2, 1990 – 1991', 1992.
- BRB 616.079 BOWE, Bowen, J.H., 'AIDS/HIV Infection, volume 3, 1991 – 1992', 1993.
- BRB 616.079 BOWE, Bowen, J.H., 'AIDS/HIV Infection, volume 4, 1992 – 1993', 1994.
- BRB 616.079 BOWE, Bowen, J.H., 'AIDS/HIV Infection, volume 5, 1993 – 1994', 1995.
- BRB 616.079 ESAU, Esau, F., 'AIDS: Literature Review 1980-1992', Cape Town, Southern Africa Labour & Development Research Unit, 1993.

GALA (Gay and Lesbian Archive / Gay and Lesbian Memory in Action), Wits University, Johannesburg, South Africa

Individual Collections

Margaret Auerbach (AM 2863)

Edwin Cameron (AM 2629)

Correspondence and Organisational Material, GLOW Newsletter *Glowletter*, June 1990.

HIV/AIDS Material, Correspondence, John Pegge, ASET, to Edwin Cameron, Centre for Applied Legal Studies, 29 October 1992.

Legal Opinion on Imported AIDS Educational Material for Gay Clients for ASET, 6 March 1993.

Steve de Gruchy (AM3016)

Derrick Fine (AM 2796)

Mark Gevisser (AM 2663)

Gerald Kraak (AM 2669)

Sheila Lapinsky (AM 2817)

Alfred Machela (AM 2622)

Barry McGeary (AM 2581)

Julia Nicol (AM 2846)

Simon Tseko Nkoli (AM 2623)

Lee Randall (AM 2805)
Ann Smith (AM 2697)
Peter Tatchell (AM 2715)
Ivan Toms (AM 2798)
Alan Velcich (AM 2657)

Collections for Organisations

(Note that some collections share call numbers)

AIDS Coalition to Unleash Power (ACTUP) Johannesburg (AM 2690)
AIDS Consortium Minutes B9.1.
AIDS Law Project (ALP) (AG 3077)
The AIDS Support and Education Trust (ASET) (AM 2974)
The Association of Bisexuals, Gays and Lesbians (ABIGALE) (AM 2802)
The Congress of Pink Democrats (AM 2626)
The Equality Foundation (AM 2688)
The Gay Association of South Africa (GASA) (AM 2975)
 "ACT-UP" Cape Town, Project report, c. 1989.
 Correspondence, Hilton-Barber Hayes, 'AIDS Awareness Campaign Press Kit',
 January 1988.
 Correspondence from Dr M. Popkiss to John Pegge, 13 & 15 March, 1989.
 Correspondence from Susan Hyde, AIDS Centre, SAIMR, to Diana, GASA, 1 June
 1989.
 Correspondence, John Pegge to Terry Mooney, 25 November 1989.
 Correspondence, John Pegge, GASA 6010, to Bob Webster, Hamilton AIDS Network
 for Dialogue and Support, 15 May, 1991.
 Correspondence from John Pegge to Jeff Neff (ACT-UP Los Angeles), 31 July 1991.
 Correspondence, John Pegge, GASA 6010, to Benjamin Hal, B M Switchboard, 16
 October, 1991.
 Media Scrap Books, 'Scrap Book Kept by Leon Eksteen', Leon Eksteen and Harris, S.,
 'Row brews over "moffie" posters', unknown newspaper, c. 1986.
 Media Scrap Books, 8, Author unknown, 'Gays angry over blood transfusion poster',
 The Citizen, 29 January 1986.
 News Release from Advisory Group on AIDS, 2 November 1987.
Gay and Lesbian Counselling (AM 2989)
Gay and Lesbian Organisation of Pretoria (GLO-P) (AM 2637)
Gay and Lesbian Organisation of the Witwatersrand (GLOW) (AM 2560)
International Lesbian and Gay Association (ILGA) (AM 2659)
Lesbians and Gays Against Oppression (LAGO) (AM 2801)
The Organisation of Lesbian and Gay Activists (OLGA) (AM 2846)
National Coalition for Gay and Lesbian Equality (NCGLE) (AM 2615)

The Triangle Project (AM 2974)

HIV and AIDS Information and Publications, AIDS Fact Sheet 13 'The AIDS Advisory Group?', c.1988.

HIV and AIDS Information and Publications, AIDS Fact Sheet 12 'Who Does What, and What Steps Have Been Taken in SA?', c.1988.

Health Economics & HIV/AIDS Research Division (HEARD Library, UKZN, Westville Campus, Durban, South Africa)

AIDS Analysis Africa, 1, 1, June/July 1990 to 6, 4, December 1995/January 1996.

ID: 1891, McKerrow, N., 'The South African Response to the HIV/AIDS Epidemic', Input report prepared for the Poverty and Inequality report, Greys Hospital, Pietermaritzburg, 1997.

Historical Papers, WITS University, Johannesburg, South Africa

Peter Soal Collection (A2683), Health File - Correspondence from W A Van Niekerk to P. G. Soal, Memorandum Regarding AIDS, c. 1988.

International Institute of Social History (IISH), Amsterdam, the Netherlands

BG V8/226, *As Surely as an A.K.*, (video, Solidarity Films, c.1989); 25 minutes.

BRO 833/10 Fol, Solomon Mahlangu Freedom College, Mazimbu & ANC Development Centre, Dakawa – ANC Progress Report 1982/1983.

Killie Campbell Library (KC), UKZN, Durban, South Africa

National Progressive Primary Health Care Network (NPPHCN) Papers

KCM 03/7/59/6.

KCM 03/7/59/7.

National Library of South Africa (NLSA)

AP.1988-593, Department of National Health and Population Development and the Advisory Group on AIDS, 'What you should know about AIDS', October 1986.

General Collection, AP 1990-229.

Cape Town General Collection (CTGC), SA Reports (SA Rpts)

Department of Health, Welfare and Pensions, Annual Reports 1982 - 1983.

Department of Health and Welfare Annual Report 1984.

National Department of Health and Population Development Annual Reports, 1985 – 1993.

Department of Health Annual Reports 1994 – 1995.

South African History Archive (SAHA), WITS University, Johannesburg, South Africa

National Medical and Dental Association (NAMDA) Collection (AL3182).

A1.1.6, incoming correspondence, Prof. A Du P Heyns to Dr P.N. Soni, 22 August 1990.

A1.3, Reports, Report for NAMDA S.Tvl Regional Meeting: NAMDA and Its Role in Combating the Spread of HIV Infection and AIDS, n.d.

A1.3.13, Report, NAMDA-ANC Meeting, 21 – 22 October 1989.

A1.3.16, NAMDA Annual Report 1989/90, Presidential Address, March 1990.

A1.3.16, 'NAMDA Annual Reports' particularly for 1987/88, 1988/89, and 1989/90.

A1.3.16 'NAMDA Annual Report 1989/90' presented at the 7th Annual General Meeting, 3 – 4 March 1990.

A1.4, NAMDA document, 'Why NAMDA?', c.1988/89.

A1.4, NAMDA Policy Statement pamphlet.

A1.4, NAMDA document, 'Why NAMDA Was Started', n.d.

A1.4, 'A Guide to the National Medical and Dental Association (NAMDA) and an Invitation to Join', 1986.

A1.4, NAMDA document, STVL NAMDA Branch, 'The Role of NAMDA in the Health Sector', 29 August 1989.

A1.5.1, NAMDA News, 'AIDS in South Africa– Progressive Perspectives', *NAMDA News*, c. June 1988.

A1.5.1, NAMDA News, 'AIDS, South Africa and NAMDA', NAMDA Southern Transvaal Newsletter, June 1988.

A1.5.1, NAMDA News, 'AIDS Series', NAMDA Southern Transvaal Newsletter, August 1988.

A1.5.1, NAMDA News, 'How many people must AIDS kill before we do something about it?', NAMDA Western Cape Medical Branch Newsletter, November 1988.

A1.5.1, NAMDA News, Steinberg, M., 'Some Pointers to an Effective Education Strategy for the Prevention of HIV Infection', NAMDA Southern Transvaal Newsletter, January 1989.

A1.5.1, NAMDA News, 'Delegation Meets Minister of Health', *NAMDA News*, 3, 2, June 1989.

A1.5.1, NAMDA News, 'Epidemiology of AIDS', *NAMDA News*, 3, 2, June 1989.

A1.6, NAMDA Press Statements, 'Press Statement on Burglary in P.E. Offices', 13 April 1988 and 'NAMDA Press Statement', 10 May 1989.

A1.8.1, 'NAMDA Conference Proceedings', 7th National Annual Conference, 1990.

- A1.8.1, Keynote Address by Mencer D. Edwards, Executive Director, National Minority AIDS Council, Washington, DC to the 6th Annual National Conference of the National Medical and Dental Association of South Africa, delivered May 12, 1989, Johannesburg, South Africa.
- A1.8.1 'NAMDA Conference Proceedings', 1985, 1986, 1987, 1989 & 1990.
- A1.8.2, 'NAMDA – ANC Meeting, 21 – 22 October 1989', NAMDA Special Bulletin 3, February 1990.
- A1.8.2, 'HIV-Infection and AIDS', NAMDA Special Bulletin 4, May 1990.
- A1.11, Correspondence, NAMDA AIDS Group, Johannesburg, to NAMDA members, c.1990.
- A1.11, Correspondence, NAMDA S. Tvl AIDS Group to NAMDA branches, Re.: Consultation on a Regional AIDS Programme by the S.Tvl AIDS Working Group of the PPHC', 17 January 1991.
- A1.11, NAMDA document, Liz Floyd, 'NAMDA: Our Contribution to the Fight Against AIDS', National Retreat, June 1991.
- A2.11, Abdullah, F., 'The Demand for a National health Service', 1987.
- A2.11, Buch, E., 'Health Services in the South African Homelands', c.1987.
- A2.11, Coovadia, H., and Marks, S., various National Health Service papers from NAMDA Annual Meeting 1987.
- A2.11, de Beer, C., 'The Health Sector - Definition, Description and Major Policy Debates', rough draft of discussion paper for joint ANC/COSATU Development Research Group (DRG) meeting, 4- 5 September c.1992.
- A2.11, de Beer, C., 'The Role of the Health Worker in South African Society', undated; Dommissie, J., 'A Future Glimpse Towards Health and Health-Care in Post-Apartheid South Africa', University of Pittsburgh Seminar, 1986.
- A2.11, Louw, G.M., 'Epidemiological Transition in the RSA - Implications for Primary Health Care', 1991.
- A2.11, Mji, D., 'The Struggle for Health: The Struggle for Democracy', Institute for Social Studies Amsterdam, December 1986.
- A2.11, Price, M., Steinberg, M., & de Beer, C., 'The New Constitution and Health', NAMDA Constitution Group, c.1983.
- A2.11, Author Unknown, 'The Health Sector: Policy Positions and Organisational Developments', Paper for DRG meeting 3 - 4 December, date unknown.
- A2.11, Variava, Y., 'A Perspective on Health Care in South Africa', date unknown.
- A2.11, Zwi, A., 'Piecing Together Health in the Homelands', Carnegie Conference Paper no. 187, UCT, (c.1983).
- B1.10.5, the OASSSA papers, thematic documents, 1990 - 1995: National AIDS Programme Proposed by the National Progressive Primary Health Care Network, 4 March 1991.
- B1.10.5, National Strategic Planning Workshop: PPHC AIDS Programme with CBDP: February 1992.
- B1.10.5, PPHC National AIDS Programme, February 1992.

- B1.10.5, The Political Agenda of AIDS: A Preliminary OASSSA Discussion Paper, undated.
- F1.7, PPHCN, Provisional Programme PPHCN AIDS Forum, 2nd Community AIDS Education Symposium, 29 & 30 November 1990.
- F1.8, Meeting the Challenge of AIDS, pamphlet, ANC Health Department, Lusaka, n.d.
- F1.10.1, the National Progressive Primary Health Care Network (NPPHCN) Papers, thematic documents, 1990 – 1992.
- G1.1.2, outgoing correspondence, SAHSSO pamphlet, c.1992.
- G1.2, SAHSSO minutes of meetings, Minutes of meeting of progressive organisations involved in AIDS work in preparation for the NACOSA conference, held on Monday, 19 October 1992.
- G1.8, SAHSSO Press Statements, Press statement issued by SAHSSO, WITS University, Sunday, 5 July 1992.

South African National Archive, Pretoria, South Africa

- BAO DJ6/3/3/475, vol. 18/178, memo from Director of Planning Services (Beplannings-dienste) to Director of Administration (Administrasie), Interdepartementele Komitee: VIGS-Bekamping, 7 March 1991.
- Interdepartmental Reports (D9/7 1-10).
- Interdepartmental Reports (D9/7 71-80).
- Interdepartmental Reports (D9/7 91-100).

University of Fort Hare Archive, Alice, South Africa

ANC Lusaka Mission (ALM)

- 105, 45, Joint Commission of Enquiry – Chief Representative's Office and the SOMAFCO Directorate East Africa – on the Resignation of Comrade Regina Nzo from the Health Team of the African National Congress, 4 December 1983.
- 105, 45, correspondence Lusaka Doctors to the Secretary General, 2 April 1984.
- 127, 236, Draft Health Secretariat Report to the 3rd Health Council Meeting, 29 July 1986.
- 127, 236, Paper to the 3rd Health Council Meeting, 29 July 1986, Macberry, H., 'The Spread of Communicable Diseases Amongst Our Communities in Exile, in Particular TB and STDs'.
- 160, 1, correspondence from Connie to the Treasury Department, 20 March 1982.
- 160, 1, correspondence from Manto Tshabalala to Doodles, 23 March 1983.
- 160, 1, correspondence from Doodles Gaboo, Regional Treasurer, to M. Tshabalala, Secretary for Health, 26 March 1982.
- 160, 1, correspondence from Sipho Mthembu to ANC Secretary General and others, 31 May 1982.
- 160, 1, correspondence from R.V. Nzo to M. Tshabalala, 6 September 1982.

160, 1, correspondence from Rica Hodgson to Alfred Nzo, 14 March 1983.

161, 3C, 'Plenary Session – Discussion of Scientific Papers', 29 July 1986.

Part 2, Additions (hereafter pt. 2 ad), 2, 7, 13, correspondence Latif to Mkangisa, 14 March 1990.

pt. 2 ad, 2, 7, 13, correspondence Refiloe Serote (Township AIDS Project) to Lungile, 22 May 1990.

pt. 2 ad, 7, 13, correspondence Lungile Makhanda to Prof. Harwarth, 17 July 1990.

pt. 2 ad, 6, 6, correspondence Hagggar to Health Secretariat, 24 August 1987.

pt. 2 ad, 6, 7, Health Department Circular to ALL A.N.C. (S.A) Health Teams, 26 November, 1980.

pt. 2 ad, 6, 8a, correspondence Katz to Education Secretary, 5 February 1987.

pt. 2 ad, 6, 8a, correspondence from Zakes Mokoena, Deputy Secretary for Health to All Departments, 20 September 1987

pt. 2 ad, 6, 9, correspondence, Ralph Mgijima to Mirjam Dahlgren, 27 January 1989.

pt. 2 ad, 6, 9, ANC Department of Health *ANC-SIDA Co-operation Progress Report, 1988-1989*.

pt. 2 ad, 6, 9, Recommendations of the 3rd Council Meeting of the A.N.C. Department of Education and Culture on "The Crèche and Prenatal Care", 14 – 18 August 1980.

pt. 2 ad, 6, 9, correspondence Naicker to Sachs, 23 April 1987.

pt. 2 ad, 6, 9, correspondence Mgijima to ANC Secretary General, Lusaka, 21 July 1988.

pt. 2 ad, 6, 9, correspondence Mgijima to ANC Secretary General, Lusaka, 21 July 1988.

pt. 2 ad, 6, 9, correspondence, Mirjam Dahlgren to Ralph Mgijima, 21 March 1989.

pt. 2 ad, 6, 9, correspondence, Mirjam Dahlgren to Ralph Mgijima, 5 April 1989.

pt. 2 ad, 6, 9, correspondence, Mirjam Dahlgren to Ralph Mgijima, 4 July 1989.

pt. 2 ad, 6, 9, correspondence Thorstensson to Mgijima, 1 August 1989.

pt. 2 ad, 6, 9, correspondence, Christina Larsson to Ralph Mgijima, 20 September 1989.

pt. 2 ad, 6, 9, correspondence between Mirjam Dahlgren and Ralph Mgijima, 29 June 1989, 30 June 1989 and 8 March 1990.

pt. 2 ad, 9, 30, correspondence Ralph Mgijima, Secretary for Health, to Heads of all RHT, 31 August 1989.

pt. 2 ad, 9, 30, correspondence Naicker, Nkobi and Mokoena to ANC HQ, 8 September 1989.

pt. 2 ad, 9, 30, Evaluation of Education and Information Project on STD/HIV/AIDS in the ANC Communities 89/90, Lusaka, 13-19 February 1990.

pt. 2 ad, 9, 30 correspondence, Lungile Makhanda to Comrade Alice , Head RHT, Harare, 9 March 1990.

pt. 2 ad, 9, 34, Memorandum to NPA-Oslo/Gunvor from NPA-Harare/Laila, 9 May 1990.

pt. 2 ad, 9, 30, correspondence Thami Magigwane to Health Secretariat, Lusaka, 4 June 1990.

pt. 2, 20, 2, African National Congress Basic Health Policy Guidelines, 18 August 1986.

- pt. 2 ad, 30, 24, Floyd, E., 'Draft Paper on HIV and AIDS in South Africa Today for CHISA Conference in Maputo', April 1990.
- pt. 2 ad, 30, 24, Paper for Maputo Conference – ANC Department of Health: Strategies for the control of AIDS in the African National Congress.
- pt. 2 ad, 30, 24, Mayford, Mkhulu and Mike, 'Report of Maputo Health and Welfare Conference (Apr 9-16 '90)', Harare, 3 May 1990.
- pt. 2 ad, 33, 1, Meeting of the Health Secretariat with the Clinic Staff of the Zambia Regional Health Team, 24 April 1987.
- pt. 2 ad, 33, 1, ANC Department of Health Report on Publicity and Information, 2 April 1987.
- pt. 2 ad, 33, 1, correspondence from Zakes Mokoena to James Stuart, Secretary ECC, 20 September 1987.
- pt. 2 ad, 33, 1, Minutes of meeting between ANC Department of Health and NOVIB, 5 November 1987.
- pt. 2 ad, 33, 2, Minutes: Health Secretariat Meeting with the NPA, Lusaka, 14 March, 1990.
- pt. 2 ad, 33, 2, Minutes of Meeting between H.S and NPA, 4 May 1990.
- pt. 2 ad, 33, 2, Project Proposal for an HIV/AIDS Workshop for the ANC
- pt. 2 ad, 9, 34, Memorandum to NPA-Oslo/Gunvor from NPA-Harare/Laila, 9 May 1990.
- pt. 2 ad, 33, 5, Minutes Meeting 3, Emmasdale Clinic Meetings, 11 November 1986.
- pt. 2 ad, 41, 63, ANC Department of Health Project Proposal, c. 1987.
- pt. 2 ad, 41, 64, Annual Regional Health Report East Africa from 1 January 1986 to 27 March 1987, p.2a.
- pt. 2 ad, 41, 65, ANC Department of Health Annual Report to the ECC for the Year 1987.
- pt. 2 ad, 41, 69, Report on the Meeting of the NEC on the State of Organisation of the Department, 19 February 1987.
- pt. 2 ad, 41, 69, Project Proposal for Urgent and Additional Transport for the Health Secretariat for ANC Community Health Programmes in Zambia, 2 May 1987.
- pt. 2 ad, 41, 69, ANC Department of Health Progress Report on the Work of the Department for the NEC, October 1987.
- pt. 2 ad, 41, 69, Education and Information Project on STD/HIV/AIDS in the ANC Communities, Lusaka, November 1989.
- pt. 2 ad, 41, 69, Summary of Report from the Health Secretariat, c. 1989
- pt. 2 ad, 41, 70, Clinic Report for Quarter Ending Dec. '86 for meeting held 1st – 5th April 1987.
- pt. 2 ad, 42, 89, Zambia Health Report – Period July – Aug-Sep.
- pt. 2 ad, 42, 89, 'Reorganising for a Healthier Revolutionary Movement', Report of ANC Health Department Seminar, 1987.
- pt. 2 ad, 42, 89 Report of Regional Health Team UK, October 1987.
- pt. 2 ad, 42, 102, Evaluation on the STD/HIV/AIDS Project – Questionnaire (sic), not dated but c. 1989/90.

pt. 2 ad, 42, 103, rapporteur's notes UK Regional Health Team Report and Zimbabwe Report, 10 October 1987, Tanzania and Zambia Report, 11 October 1987, and General Session, 12 October 1987.

pt. 2 ad, 42, 104, African National Congress Department of Health Seminar Report, 'Theme: Towards Comprehensive Intervention Strategies for the Prevention and Control of AIDS/HIV Infection'.

pt. 2, 64, c3, Paper by Chris Hani to the AIDS Workshop.

pt. 2, 64, c3, Key Note Speech by Secretary General – ANC HIV/AIDS Workshop.

pt. 2 ad, 64, 25, 'letters and AIDS Action'.

Solomon Mahlangu Freedom College, Director's Office & Health Department Records.

London Mission Records

Luthuli House Records

Personal Papers and Private Collections

Pierre Brouard – Private Collection

'Keep It Hot, Safe and Gay' pamphlet.

Mary Crewe – Personal Papers (MC-PP)

Correspondence (fax), M. Holmshaw to All Regional ATICS, 'Communication Campaign', 28 November 1991.

Author unknown, 'The Importance of Implementing an AIDS Programme in Primary Schools', 1992.

Author Unknown, press release 'AIDS Education Programme Begins with Challenge of Adolescence', 30 March 1992.

Press Release by Dr E H Venter MP, Minister of National Health and of Health Services and Welfare, 'Now There's Hope We Can Keep Our children AIDS-Free As They Move to Adulthood', 30 March 1992.

Jeanne Bestbier on behalf of the AIDS Unit, 'AIDS Unit Message on Schools Package Goes Out to Parents, Teachers and Teenagers', for first use 12.00 noon, 30 March 1992.

Jeanne Bestbier, statement, 'AIDS Unit Combats AIDS Ignorance with Education Programme for Teenagers', embargoed first use 30 March 1992, ref. number 13524/92/eb.

Hunt Lascar TBWA, AIDS Presentation, 21 April 1993.

Hunt Lascar TBWA, AIDS Strategy 1993/94 - part of the Presentation, 21 April 1993.

NACOSA, *A National AIDS Plan for South Africa, 1994 – 1995*, July 1994.

Michele Galloway – Private Collection

AIDS Bulletin, 1, 1, August 1992

AIDS Bulletin from 1993 to 1995, incomplete selection.

Dennis Sifris – Personal Papers

Speeches and presentations.

Government Publications

Admission of Persons to the Republic Regulation Act of 1972 (section 51)

Constitution of the Republic of South Africa 1983, South African government website at: www.info.gov.za/documents/constitution/83cons.htm (accessed January 2011).

Department of National Health and Population Development, *Health Trends in South Africa, 1992*, available from the Pádraig O'Malley digital archive on the Nelson Mandela Organisation website at www.nelsonmandela.org/omalley/index.php/site/g/03lv02167/04lv02218/05lv02244/06lv02254.htm (accessed July 2012).

Government Notice No. R.2439 of 30 October 1987, Regulation 17.

Government Notices, Department of Home Affairs, No. R. 2439, *Government Gazette*, vol. 268, no. 11014, Pretoria, 30 October 1987.

Health Act, 1977, No. R. 2438, *Government Gazette*, vol. 268, no. 11014, Pretoria, 30 October 1987.

Human Sciences Research Act 23 of 1968 (amended by the Human Sciences Research Amendment Act 99 of 1990), HSRC website at www.hsrc.ac.za (accessed July 2012).

Human Tissue Act no. 65, 1983 (assented to 20 May 1983), *Government Gazette*, vol. 216, no. 8734, notice no. 1162, Cape Town, 1 June 1983.

Poverty and Inequality in South Africa: Final Report, 13 May 1998, available at South African Government Information website at: www.info.gov.za/view/DownloadFileAction?id=70499 (accessed February 2011).

Republic of South Africa Constitution Act 110 of 1983, the South African government website at: www.info.gov.za/documents/constitution/83cons.htm (accessed January 2011).

Interviews and Correspondence

By Author

Interview with Quarraisha Abdool Karim, CAPRISA Offices, UKZN, Durban, South Africa, 19 November 2007.

Interview with Salim (Slim) Abdool Karim, CAPRISA Offices, UKZN, Durban, South Africa, 19 November 2007.

Interview with Virginia Berridge, Centre for History in Public Health, London School of Hygiene and Tropical Medicine, London, UK, 13 July 2010.

Interview with Pierre Brouard, Centre for the Study of AIDS, University of Pretoria, Pretoria, South Africa, 19 February 2008.

Interview with Edwin Cameron, WITS University, Johannesburg, South Africa, 7 February 2008.

Interview with Dawn Cavanagh, Rhodes University, Grahamstown, South Africa, 15 May 2007.

Interview with Mary Crewe, Centre for the Study of AIDS, University of Pretoria, Pretoria, South Africa, 8 February 2008.

Interview with Michele Galloway, Medical Research Council of South Africa Offices, Cape Town, 9 November 2007.

Interview with Janet Giddy, Giddy & Reid's Residence, Hillcrest, South Africa, 19 November 2007.

Interview with Hoosen M. 'Jerry' Coovadia, CAPRISA Offices, UKZN, Durban, South Africa, 20 November 2007.

Interview with Francie Lund, School of Population Studies and Development Studies Offices, UKZN, Durban, South Africa, 30 June 2011.

Hugh MacMillan, email correspondence with author, 4 February 2012.

Interview with Shaun Mellors, International HIV/AIDS Alliance, Brighton, UK, 08 September 2006.

Interview with Eleanor Preston-Whyte, Centre for HIV/AIDS Networking (HIVAN), UKZN, Durban, South Africa, 7 December 2006.

Interview with Steve Reid, Giddy & Reid's Residence, Hillcrest, South Africa, 19 November 2007.

Interview with Helen Schneider, WITS School of Public Medicine, Johannesburg, South Africa, 12 February 2008.

Interview with Rob Shell, University of Cape Town, Cape Town, South Africa, 8 May 2009.

Interview with Dennis Sifris, Sifris' medical practice, Melville, Gauteng, South Africa, 26 February 2008.

Interview with Vajradhara, Shantikula Buddhism and Meditation Centre, Johannesburg, South Africa, 22 February 2008. (RIP Vajradhara d. 18th November 2011).

Interview with Rina Venter, Venter's Residence, Pretoria, South Africa, 21 October 2011.

Interview with Alan Whiteside, HEARD Office, UKZN, Westville, South Africa, 20 November 2007.

Other

Larry Kramer, by Sarah Schulman, Interview no. 035, 15 November 2003, available at www.actuporalhistory.org/interviews/images/kramer.pdf (accessed December 2011).

Printed Primary Sources

Author Unknown, 'A Brief History of the National Medical and Dental Association (NAMDA)', *Critical Health*, 25, December 1988.

Critical Health, no. 31/32, August 1990.

Hippe, J.M., & Pedersen, A.W., *Health Care in an Exile Community – Report on health planning in the ANC*, The Norwegian Trade Union Research Centre, 1987.

Epidemiological Comments, 1989 – 1995

Küstner, H., 'Editorial', *Epidemiological Comments*, 10, 9, September 1983.

Küstner, H., 'AIDS: The 1979-Pandemic with Special Reference to South Africa', *Epidemiological Comments*, 14, 4, April 1987.

Küstner, H., 'The Practice of Epidemiology', *Epidemiological Comments*, 15, 7, July 1988.

Küstner, H., 'AIDS-Update, Part 1', *Epidemiological Comments*, 15, 8, August 1988.

Küstner, H., 'AIDS-Update, Part 2', *Epidemiological Comments*, 15, 9, September 1988.

Küstner, H., 'AIDS-Update, Part 3', *Epidemiological Comments*, 15, 12, December 1988.

Küstner, H., 'AIDS in South Africa', *Epidemiological Comments*, 17, 2, February 1990.

Küstner, H., 'The Truth About AIDS', *Epidemiological Comments*, 17, 3, March 1990.

Küstner, H., 'Update: AIDS in South Africa Since 1982 (as on 14 December 1990)', *Epidemiological Comments*, 17, 12, December 1990.

Küstner, H., 'First National HIV Survey of Women Attending Antenatal Clinics, South Africa, October/November 1990', *Epidemiological Comments*, 18, 2, February 1991.

Küstner, H., 'HIV Screening Results of Blood transfusion Services', *Epidemiological Comments*, 18, 4, April 1991.

Küstner, H., 'AIDS: The Threat to Children', *Epidemiological Comments*, 18, 5, May 1991.

Küstner, H., 'Second National Survey of Women Attending Antenatal Clinics, South Africa, October/November 1991', *Epidemiological Comments*, 19, 5, May 1992.

Küstner, H., 'Third National HIV Survey of Women Attending Antenatal Clinics, South Africa, October/November 1992', *Epidemiological Comments*, 20, 3, March 1993.

Küstner, H., 'Summary of AIDS Patients Reported to the Department of National Health and Population Development during the period April to September 1993', *Epidemiological Comments*, 20, 10, October 1993.

Küstner, H., 'Fourth national HIV survey of women attending antenatal clinics, South Africa, October/November 1993', *Epidemiological Comments*, 21, 4, April 1994.

Küstner, H., 'Fifth national HIV survey in women attending antenatal clinics of the public health services in South Africa, October/November 1994', *Epidemiological Comments*, 22, 4, April 1995.

Hansard, 1980 - 1995

Note: HA = House of Assembly; HD = House of Delegates; HR = House of Representatives;
NA = National Assembly

Hansard HA, vol. 105, Wednesday, 9 March 1983.
Hansard HA, vol. 105, Thursday, 10 March 1983.
Hansard HA, vol. 117, Wednesday, 6 June 1984.
Hansard HA, vol. 5, Tuesday, 12 March 1985.
Hansard HA, vol. 14, Friday, 20 February 1987.
Hansard HD, vol. 13, Monday, 15 June 1987.
Hansard HD, vol. 13, Wednesday, 17 June 1987.
Hansard HA, vol. 20, Tuesday, 23 June 1987.
Hansard HA, vol. 20, Tuesday, 28 July 1987.
Hansard HR, vol. 14, Wednesday, 5 August 1987.
Hansard HD, vol. 13, Monday, 10 August 1987.
Hansard HA, vol. 18, Wednesday, 19 August 1987.
Hansard HR, vol. 14, Tuesday, 1 September 1987.
Hansard HD, vol. 14, Wednesday, 2 September 1987.
Hansard HA, vol. 19, Wednesday, 2 September 1987.
Hansard HA, vol. 19, Thursday, 3 September 1987.
Hansard HA, vol. 3, Monday, 18 April 1988.
Hansard HA, vol. 3, Tuesday, 19 April 1988.
Hansard HR, vol. 3, Monday, 25 April 1988.
Hansard HD, vol. 3, Tuesday, 26 April 1988.
Hansard HR, vol. 3, Wednesday, 27 April 1988.
Hansard HR, vol. 4, Tuesday, 10 May 1988.
Hansard Joint Meeting, vol. 9, Monday, 20 February 1989.
Hansard Public Committee on Health, vol. 11, Tuesday, 18 April 1989.
Hansard Public Committee on Health, vol. 11, Wednesday, 19 April 1989.
Hansard HD, vol. 21, Thursday, 22 February 1990.
Hansard HA, vol. 21, Tuesday, 13 March 1990.
Hansard HA, vol. 21, Wednesday, 21 March 1990.
Hansard HA, vol. 17, Thursday, 22 March 1990.
Hansard HA, vol. 17, Friday, 23 March 1990.
Hansard HA, vol. 21, Thursday, 10 May 1990.
Hansard Extended Public Committee Meeting, vol. 19, Wednesday, 16 May 1990.
Hansard HR, vol. 19, Thursday, 17 May 1990.
Hansard HD, vol. 21, Friday, 18 May 1990.
Hansard HA, Extended Public Committee Meeting, vol. 23, Friday, 15 February 1991.
Hansard HA, vol. 29, Tuesday, 26 February 1991.

Hansard HA, vol. 29, Monday, 18 March 1991.
Hansard HA, vol. 29, Tuesday, 19 March 1991.
Hansard Public Committee on Provincial Affairs: Tvl, vol. 17, Tuesday, 26 March 1991.
Hansard Public Committee on Provincial Affairs: OFS, vol. 24, Wednesday, 27 March 1991.
Hansard HA, vol. 29, Tuesday, 9 April 1991.
Hansard HA, vol. 29, Wednesday, 10 April 1991.
Hansard Joint Meeting, vol. 25, Thursday, 11 April 1991.
Hansard HA, vol. 29, Friday, 12 April 1991.
Hansard HR, vol. 26, Monday, 13 May 1991.
Hansard HA, Extended Public Committee Meeting, vol. 26, Monday, 13 May 1991.
Hansard HR, Extended Public Committee Meeting, vol. 26, Tuesday, 14 May 1991.
Hansard HR, vol. 26, Tuesday, 14 May 1991.
Hansard HR, vol. 26, Monday, 20 May 1991.
Hansard HD, vol. 26, Monday, 20 May 1991.
Hansard HA, vol. 36, Tuesday, 4 February 1992.
Hansard HA, vol. 36, Monday, 10 February 1992.
Hansard HA, vol. 36, Wednesday, 18 March 1992.
Hansard HA, vol. 32, Tuesday, 24 March 1992.
Hansard HA, vol. 33, Monday, 27 April 1992.
Hansard HA, vol. 33, Tuesday, 28 April 1992.
Hansard HA, vol. 33, Monday, 11 May 1992.
Hansard HR, vol. 33, Monday, 11 May 1992.
Hansard HR, vol. 33, Tuesday, 12 May 1992.
Hansard HA, vol. 34, Monday, 18 May 1992.
Hansard Joint Meeting, vol. 35, Wednesday, 14 October 1992.
Hansard HA, vol. 45, Tuesday, 9 March 1993.
Hansard HA, Interpellations, Questions and Replies, vol. 45, Wednesday, 24 March 1993.
Hansard Extended Public Committee on Provincial Affairs: OFS, vol. 39, Tuesday, 6 April 1993.
Hansard Extended Public Committee Meeting, vol. 39, Wednesday, 7 April 1993.
Hansard Extended Public Committee Meeting, vol. 40, Monday, 26 April 1993.
Hansard HA, vol. 40, Friday, 30 April 1993.
Hansard HA, Extended Public Committee Meeting, vol. 39, Friday, 30 April 1993.
Hansard HA, Extended Public Committee Meeting, vol. 40, Friday, 30 April 1993.
Hansard HA, vol. 45, Wednesday, 5 May 1993.
Hansard HR, vol. 41, Monday, 24 May 1993.
Hansard HA, Interpellations, Questions & Replies, vol. 45, Thursday, 24 June 1993.
Hansard NA, Interpellations, Questions & Replies, vol. 3, Tuesday, 2 August 1994.
Hansard NA, vol. 2, Thursday, 20 October 1994.
Hansard NA, vol. 6, Monday, 19 June 1995.

Newspaper and Magazine Articles

Author unknown, 'South Africa: Battle won for HIV-positive soldiers', 11 November 2009 on PlusNews website at www.plusnews.org/Report.aspx?ReportId=86974 (accessed February 2010).

Author unknown, 'How arms dealer got its hooks into the ANC', *Mail & Guardian*, 19 January 2007 at <http://mg.co.za> (accessed June 2011).

Basson, A., Sole, S., & Brümmer, S., 'Arms probe reopened', *Mail & Guardian*, 20 March 2008 at <http://mg.co.za> (accessed June 2011).

Botha, H., 'Exit: Memories of the Early Years', *Exit* website at www.exit.co.za/frmArticle.aspx?art=41 (accessed December 2011).

Hayward, G., 'Exit @ 200: South Africa's Gay Newspaper', *Exit* website at www.exit.co.za/frmArticle.aspx?art=37 (accessed December 2011).

Meyer, J., 'The Aids Plan that Never Saw the Light of Day', IOL News website, 10 October 2004, available on the IOL website at www.iol.co.za/news/south-africa/the-aids-plan-that-never-saw-light-of-day-1.223704#.UBIzOaDhgSp (accessed April 2011).

Rubin, C., 'SA armour "used in Iraq"', *Mail & Guardian*, 30 June 2006 at <http://mg.co.za> (accessed June 2011).

SAPA, 'AIDS-Funds' (OB656), Johannesburg, 7 June 1992 available via the 'e-tools' portal for SAPA media releases at www.e-tools.co.za/newsbrief/1992/news9206.08 (accessed August 2012).

Sole, S., 'Sutcliffe's Achilles Heel?' *Mail & Guardian*, 1 June 2009 at <http://mg.co.za> (accessed June 2011).

'South Africa: Battle won for HIV-positive soldiers' 11 November 2009 on PlusNews at <http://www.plusnews.org/Report.aspx?ReportId=86974> (accessed February 2010).

South African Press Association (SAPA), 'AIDS-Lead-Funds'(OA633), Johannesburg, 7 June 1992 available via the 'e-tools' portal for SAPA media releases at www.e-tools.co.za/newsbrief/1992/news9206.08 (accessed August 2012).

Tolsi, N., 'Three horsemen visit Durban', *Mail & Guardian*, 16 October 2008 at <http://mg.co.za> (accessed June 2011).

South African Medical Journal (SAMJ), 1980 - 1995

Abdool Karim, Q., Abdool Karim, S.S., and Nkomokazi, J., 'Sexual Behaviour and Knowledge of AIDS Among Urban Black Mothers', *SAMJ*, 80, 7, 5 October 1991.

Abdool Karim, S.S., and Abdool Karim, Q., 'Changes in HIV Seroprevalence in a Rural Black Community in Kwazulu', *SAMJ*, 82, 6, 1 December 1992.

Abdool Karim, S.S., 'Traditional Healers and AIDS Prevention', *SAMJ*, 83, 6, 1 June 1993.

Ablin, R.J., & Gonder, M.J., 'Immunological abnormalities in South African homosexuals - a non-infectious co-factor?', *SAMJ*, 67, 2, 12 January 1985.

Advisory Group on AIDS, 'Update on AIDS: Number of Cases in the RSA and Abroad', *SAMJ*, 72, 1, 4 July 1987.

Advisory Group on AIDS, 'Official Announcement', *SAMJ*, 72, 5, 5 September 1987.

Advisory Group on AIDS, 'Update on AIDS: Heterosexual Spread of AIDS', *SAMJ*, 72, 5, 5 September 1987.

Advisory Group on AIDS, 'Advisory Group on AIDS: Activities During 1987', *SAMJ*, 73, 5, 5 March 1988.

Advisory Group on AIDS, 'Strategic Plan for the Containment of AIDS in South Africa' *SAMJ*, 73, 8, 16 April 1988.

Advisory Group on AIDS, 'AIDS - The Current Situation in the RSA', *SAMJ*, 74, 6, 17 September 1988.

Advisory Group on AIDS, 'Update: AIDS in RSA', *SAMJ*, 74, 11, 3 December 1988.

Advisory Group on AIDS, 'AIDS in the RSA', *SAMJ*, 75, 2, 21 January 1989.

AIDS Advisory Group, 'AIDS Advisory Group's first year', *SAMJ*, 69, 12, 7 June 1986.

AIDS Advisory Group, 'Update on AIDS from the Advisory Group on AIDS – Blood and blood products', *SAMJ*, 70, 3, 2 August 1986.

AIDS Advisory Group, 'Update on AIDS: Vital Need for Information from Private Practitioners', *SAMJ*, 70, 10, 8 November 1986.

AIDS Advisory Group, 'Consensus Statement on AIDS', *SAMJ*, 81, 3, 1 February 1992.

Allwood, C.W., Friedland, I.R., *et al* 'AIDS – the Baragwanath Experience: Part IV, Counselling and Ethical Issues', *SAMJ*, 82, 2, August 1992.

Anderson, R., Prozesky, O.W., Eftychis, H.A., *et al*, 'Immunological Abnormalities in South African Homosexual Men', *SAMJ*, 64, 4, 23 July 1983.

Author Unknown, 'Immunitetstekort en Homoseksualiteit', *SAMJ*, 61, 9, 27 February 1982.

Author Unknown, 'Acquired immunodeficiency syndrome (AIDS)', *SAMJ*, 63, 4, 22 January 1983.

Author Unknown, 'AIDS, Haemophiliacs and Haitians', *SAMJ*, 63, 8, 19 February 1983.

Author Unknown, 'The acquired immunodeficiency syndrome (AIDS) and blood products in haemophilia', *SAMJ*, 63, 8, 19 February 1983.

Author Unknown, 'Meer Oor VIGS', *SAMJ*, 64, 4, 23 July 1983.

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

Author Unknown, 'AIDS in children', *SAMJ*, 65, 15, 14 April 1984.

Author Unknown, 'AIDS and Blood Transfusion', *SAMJ*, 65, 25, 23 June 1984.

Author Unknown Retrovirus and AIDS, *SAMJ*, 66, 2, 14 July 1984.

Author Unknown, 'Kaposi's Sarcoma in Central Africa', *SAMJ*, 68, 5, 31 August 1985.

Author Unknown, 'Pitfalls in AIDS diagnosis', *SAMJ*, 68, 5, 31 August 1985.

Author Unknown, 'Prostitution and AIDS', *SAMJ*, 69, 1, 4 January 1986.

Author Unknown, 'African AIDS: A Bibliography', *SAMJ*, 69, 2, 18 January 1986.

Author Unknown, 'Slim Disease', *SAMJ*, 69, 8, 26 April 1986.

Author Unknown, 'Update on AIDS: HIV Antibody Testing', *SAMJ*, 70, 6, 13 September 1986.

Author Unknown, 'AIDS Pamphlet', *SAMJ*, 71, 4, 21 February 1987.

Author Unknown, 'Action Against AIDS', *SAMJ*, 71, 4, 21 February 1987.

Author Unknown, 'Prostitution and AIDS', *SAMJ*, 71, 5, 7 March 1987.

Author Unknown, 'AIDS and the RSA', *SAMJ*, 71, 12, 20 June 1987.

Author Unknown, 'Update on AIDS: Numbers of Cases in the RSA and Abroad', *SAMJ*, 72, 1, 4 July 1987.

Author Unknown, 'Statements made in the USA by the President of the National Medical and Dental Association (NAMDA) regarding the MASA and health services and conditions in the RSA', *SAMJ*, 72, 2, 18 July 1987.

Author Unknown, 'Conference on epidemiology in southern Africa', *SAMJ*, 72, 4, 15 August 1987.

Author Unknown, 'Always been a puzzle why AIDS became so common', *SAMJ*, 72, 3, 1 August 1987.

Author Unknown, 'MASA and NAMDA', *SAMJ*, 72, 5, 5 September 1987.

Author Unknown, 'MASA and NAMDA', *SAMJ*, 72, 6, 19 September 1987.

Author Unknown, 'MASA and NAMDA', *SAMJ*, 72, 9, 7 November 1987.

Author Unknown, '20th Century Catastrophe', in *Hospital Forum*, *SAMJ* Supplement, June 1989.

Author Unknown, 'Nuwe VIGS-Brosjyre', *SAMJ*, 76, 8, 21 October 1989.

Author Unknown, 'VIGS-virus sedert 1966 in Afrika', *SAMJ*, 76, 12, 16 December 1989.

Author Unknown, 'German Pharmaceutical Companies Donate R17 000 to AIDS Education', *SAMJ*, 77, 3, 3 February 1990.

Author Unknown, '7th Annual National NAMDA Conference', *SAMJ*, 77, 11, 2 June 1990.

Author Unknown, 'First AIDS Case in SA?', *SAMJ*, 78, 4, 18 August 1990.

Author Unknown, 'AIDS Conference Focuses on Women', *SAMJ*, 78, 1 December 1990.

Author Unknown, 'Women and AIDS', *SAMJ*, 79, 2, 19 January 1991.

Author Unknown, 'SAMJ News Note', *SAMJ*, 79, 4, 16 February 1991.

Author Unknown, 'Government Strategies in the fight against AIDS', *SAMJ*, 79, 8, 20 April 1991.

Author Unknown, 'First National HIV Survey Published', *SAMJ*, 79, 9, 4 May 1991.

Author Unknown, 'World AIDS Day 1991 – Sharing the Challenge', *SAMJ*, 80, 10, 16 November 1991.

Author Unknown, 'Toll-free AIDS helpline in eight SA languages', *SAMJ*, 81, 1, 4 January 1992.

Author Unknown, 'Why do Black Runners Do so Well?', *SAMJ*, 81, 10, 16 May 1992.

Author Unknown, 'Wellcome Seminar – AIDS in Perspective', *SAMJ*, 82, 3, September 1992.

Author Unknown, 'Where have all the venereologists gone?' *SAMJ*, 83, 1, January 1993.

Author Unknown, 'HIV-2 at Ga-Rankuwa Hospital', *SAMJ*, 83, 7, July 1993.

Author Unknown, 'The "Epidemic Snowball" of HIV Infection', *SAMJ*, 84, 4, April 1994.

Author Unknown, 'West African AIDS virus – HIV 2', *SAMJ*, 84, 8, August 1994.

Author Unknown, 'Latest Figures on HIV Pregnancies', *SAMJ*, 85, 7, July 1995.

Badenhorst, C.H., 'Privatisation and medicine', *SAMJ*, 73, 5, 5 March 1988.

Becker, W.B., 'HTLV-III Infection in the RSA', *SAMJ Supplement*, 70, 8, 11 October 1986.

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.

Benatar, S.R., 'Privatisation and Medicine', *SAMJ*, 72, 10, 21 November 1987.

Blecher, M.S., Steinberg, M., Pick, W., Hennink, M., and Durcan, N., 'AIDS – Knowledge, Attitudes and Practices among STD Clinic Attenders in the Cape Peninsula', *SAMJ*, 85, 12, 1 December 1995.

Bobat, R., Coovadia, H.M., & Windsor, I.M., 'Some early observations on HIV infection in children at King Edward VIII Hospital, Durban', *SAMJ*, 78, 9, 3 November 1990.

Bobat, R., Coutsoodis, A., Moodley, D., & Coovadia, H.M., 'Moving from AIDS to symptomatic HIV infection', *SAMJ*, 85, 6, 1 June 1995.

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

Bourne, D.E., 'Nomenclature in a Pigmentocracy – A Scientist's Dilemma', *SAMJ*, 76, 5, 2 September 1989.

Bradshaw, D., Dorrington, R.E., & Sitas, F., 'The Level of Mortality in South Africa in 1985 – What Does It Tell Us About Health?', *SAMJ*, 82, 4, October 1992.

Bradshaw, E., & Harington, J.S., 'The Changing Pattern of Cancer Mortality in South Africa, 1949 – 1979', *SAMJ*, 68, 7, 28 September 1985.

Brouard, P., 'Sustaining Safe Sex', *SAMJ*, 84, 8, August 1994.

Cameron, C.M., 'Serological tests for AIDS', *SAMJ*, 68, 13, 21 December 1985.

Cohen, P.L., 'Privatisation and medicine', *SAMJ*, 73, 5, 5 March 1988.

College of Medicine of South Africa, 'The case for a unitary health service', *SAMJ*, 77, 5, 3 March 1990.

Cowan, D., 'Privatisation and medicine', *SAMJ*, 74, 1, 2 July 1988.

Cowie, R.L., 'Health Risks Among White South African Goldminers', *SAMJ*, 82, 4, 1 October 1992.

De Beer, C., & Broomberg, J., 'Achieving health care for all', *SAMJ*, 78, 3, 4 August 1990.

De Miranda, D.S., Sher, R., Metz, J., Sifris, D., Lyons, S.F., & Schoub, B.D., 'Lack of evidence of HIV infection in drug abusers at present', *SAMJ*, 70, 12, 6 December 1986.

De Van Niekerk, J.P., 'Male Homosexuality', *SAMJ*, 82, 5, November 1992.

Du Toit, M., 'Wye steun vir VIGS-veldtog', *SAMJ*, 77, 1, 6 January 1990.

Editor, 'On the Buses', *SAMJ*, 80, 7, 5 October 1991.

Editor, 'Medicine - business or profession?', *SAMJ*, 81, 4, 15 February 1992.

Evian, C., 'Imagine', *SAMJ*, 81, 12, 20 June 1992.

- Evian, C., 'The Socio-economic Determinants of the AIDS Epidemic in South Africa – a Cycle of Poverty', *SAMJ*, 83, 9, September 1993.
- Evian, C., 'Rapid 'bedside' HIV tests and testing - useful but needs to be used with caution', *SAMJ*, 8, 4, April 1993.
- Evian, C., 'Consent for HIV testing', *SAMJ*, 83, 12, December 1993.
- Evian, C., 'AIDS and your response', *SAMJ*, 84, 3, March 1994.
- Evian, C.R., Ijsselmuiden, C.B., Padayachee, G.N., & Hurwitz, H.S., 'Qualitative evaluation of an AIDS health education poster', *SAMJ*, 78, 9, 3 November 1990.
- Evian, C., 'AIDS - a need for uniform terminology', *SAMJ*, 79, 4, 16 February 1991.
- Evian, C., de Beer, M., Crewe, M., Padayachee, G.N., & Hurwitz, H.S., 'Evaluation of an AIDS awareness campaign using city buses in Johannesburg', *SAMJ*, 80, 7, 5 October 1991.
- Ezekowitz, M.D., 'South Africa revisited - lessons to be learned from mistakes in American health care policy', *SAMJ*, 80, 6, 21 September 1991.
- Feinstein, F., 'Privatisation and medicine', *SAMJ*, 73, 5, 5 March 1988.
- Fleming, A.F., & Martin, D.J., 'National strategy for serological diagnosis of HIV infection', *SAMJ*, 83, 9, September 1993.
- Friedland, I.R., & Karstaedt, A.S., 'HIV-Related Ethics – Who Should Decide?', *SAMJ*, 79, 9, 4 May 1991.
- Friedland, I.R., & McIntyre, J.A., 'AIDS – the Baragwanath Experience: Part II, HIV Infection in Pregnancy and Childhood', *SAMJ*, 82, 2, August 1992.
- Friedland, I., & Snipelisky, M., 'Vertically Transmitted HIV-1 Infection in Children – A Report of 23 Cases', *SAMJ*, 79, 3, 2 February 1991.
- Friedman, S.Y., & Robertson, B.A., 'Human Immunodeficiency Virus Infection in Children – Prevalence and Psychosocial Impact', *SAMJ*, 78, 9, 3 November 1990.
- Gilder, S., 'A century of the Journal', *SAMJ*, 66, 7, 18 August 1984.
- Gledhill, R.F., Dessen, P.H., and Sneider, P., 'Antibody to HTLV-I in a Black South African with a Neurological Disorder Resembling Multiple Sclerosis', *SAMJ*, 75, 3, 4 February 1989.
- Govender, V., Bhana, R., Pillay, R., *et al*, 'Perceptions and Knowledge about AIDS among Family Planning Clinic Attenders in Johannesburg', *SAMJ*, 81, 2, 18 January 1992.
- Groeneveld, H., & Padayachee, N., 'A Stochastic Model for Medium-Term Estimation of the Prevalence of HIV Infection in a South African Heterosexual Population', *SAMJ*, 81, 2, 18 January 1992.
- Ijsselmuiden, C.B., Steinberg, M.H., Padayachee, G.N., Schoub, B.D., *et al*, 'AIDS and South Africa – Towards a Comprehensive Strategy', parts 1, 2 & 3, *SAMJ*, 73, 8, 16 April 1988.
- 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.

- Isaacs, G., & Miller, D., 'AIDS – Its Implications for South African Homosexuals and the Mediating Role of the Medical Practitioner', *SAMJ*, 68, 5, 31 August 1985.
- Kaplan, R., 'The Aversion Project - Psychiatric Abuses in the South African Defence Force During the Apartheid Era', *SAMJ*, 91, 3, March 2001.
- Keen, G.A., 'Privatisation and medicine', *SAMJ*, 73, 5, 5 March 1988.
- Klopper, J.M.L., 'AIDS – Report of an Epidemiological Seminar', *SAMJ*, 68, 8, 12 October 1985.
- Klopper, J.M.L., 'Privatisation', *SAMJ*, 72, 11, 5 December 1987.
- Klugman, K.P., Patel, J., Sischy, A., and McIntyre, J.A., 'Serological Markers of Sexually Transmitted Diseases Associated with HIV-1 Infection in Pregnant Black Women', *SAMJ*, 80, 5, 7 September 1991.
- Küstner, H.G.V., Swanevelder, J.P., & Van Middelkoop, A., 'National HIV Surveillance – South Africa, 1990 – 1992', *SAMJ*, 84, 4, April 1994.
- Lecatsas, G., *et al* 'HIV Seropositivity in east Caprivi, SWA/Namibia', *SAMJ*, 74, 11, 3 December 1988.
- Lee, T., Masobe, P., & Schneider, H., 'Proposals for the feasible management of tuberculosis in HIV-seropositive South Africans', *SAMJ*, 85, 2, February 1995.
- Lyons, S.F., Schoub, B.D., McGillivray, G.M., & Sher, R., 'Sero-epidemiology of HTLV-III Antibody in Southern Africa', *SAMJ*, 67, 24, 15 June 1985.
- Malan, M., 'AIDS in the USA and the RSA – an update', *SAMJ*, 70, 2, 19 July 1986.
- Marks, I.N., 'Perspectives in gastro-enterology', *SAMJ*, 72, 1, 4 July 1987.
- Martin, D.J., Tilley, J.F.G. *et al* 'AIDS Clinic – A Year On', *SAMJ*, 75, 8, 15 April 1989.
- Mathews, C., Kuhn, L., *et al* 'Knowledge, Attitudes and Beliefs about AIDS in Township School Students in Cape Town', *SAMJ*, 78, 9, 3 November 1990.
- Matondo, P., 'Perspectives on AIDS Control in Zambia', *SAMJ*, 83, 9, September 1993.
- Murray, J.F., 'History of the South African Institute for Medical Research', *SAMJ*, 37, 20 April 1963.
- Naylor, C.D., 'Privatisation of South African health services - are the underlying assumptions correct?', *SAMJ*, 72, 10, 21 November 1987.
- O'Farrell, N., 'South African AIDS' *SAMJ*, 72, 6, 19 September 1987.
- O'Farrell, N., & Windsor, I., 'Prevalence of HIV Antibody in Recurrent Attenders at a Sexually Transmitted Disease Clinic', *SAMJ*, 74, 3, 6 August 1988.
- Padayachee, N., Ijsselmuiden, C.B., & Hurwitz, H., 'Quality of condoms', *SAMJ*, 76, 3, 5 August 1989.
- 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.
- Potocnik, F., 'Successful Treatment of Hypersexuality in AIDS Dementia with Cyproterone Acetate', *SAMJ*, 81, 8, 18 April 1992.
- Prior, C.R.B., & Buckle, G.C., 'Blood Donors with Antibody to the Human Immunodeficiency Virus – the Natal Experience', *SAMJ*, 77, 12, 16 June 1990.

- 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.
- Ras, G.J., Simson, I.W., Anderson, R., Prozesky, O.W., & Hamersma, T., 'Acquired Immunodeficiency Syndrome – A Report of Two South African Cases', *SAMJ*, 64, 4, 23 July 1983.
- Ras, G.J., Eftychis, H.A., Anderson, R., & Van Der Walt, I., 'Mononuclear and polymorphonuclear leucocyte dysfunction in male homosexuals with the acquired immunodeficiency syndrome (AIDS)', *SAMJ*, 66, 21, 24 November 1984.
- Rolfe, M. 'HIV-2 and its Neurological Manifestations', *SAMJ*, 84, 8, August 1994.
- Roux, F.G., 'Privatisation and medicine', *SAMJ*, 73, 5, 5 March 1988.
- Schall, R., 'Statistical Analysis of HIV Prevalence', *SAMJ*, 77, 1, 6 January 1990.
- Schall, R., Padayachee, G.N., & Yach, D., 'The Case for HIV Surveillance in South Africa', *SAMJ*, 77, 7, 7 April 1990.
- Schall, R., 'On the Maximum Size of the AIDS Epidemic among the Heterosexual Black Population in South Africa', *SAMJ*, 78, 9, 3 November 1990.
- Schneider, H., & McIntyre, J., 'Is the 1993/4 AIDS programme budget adequate?', *SAMJ*, 84, 4, April 1994.
- Schoub, B.D., 'AIDS in South Africa – a time for action', *SAMJ*, 71, 11, 6 June 1987.
- Schoub, B.D., Smith, A.N., Lyons, S.F., Johnson, S., *et al*, 'Epidemiological Considerations of the Present Status and Future growth of the Acquired Immunodeficiency Syndrome Epidemic in South Africa', *SAMJ*, 74, 4, 20 August 1988.
- Schoub, B.D., 'AIDS in South Africa – into the Second Decade', *SAMJ*, 81, 2, 18 January 1992.
- Schulman, A., 'Privatisation and medicine', *SAMJ*, 73, 5, 5 March 1988.
- Sellers, S.L., 'Contraction of HIV Infection During Mutual Masturbation', *SAMJ*, 74, 4, 20 August 1988.
- Sher, R., 'AIDS in Johannesburg', *SAMJ*, 68, 2, 3 August 1985.
- Sher, R., 'AIDS and Related Conditions – Infection Control', *SAMJ*, 68, 12, 7 December 1985.
- Sher, R., 'Acquired Immune Deficiency Syndrome (AIDS) in the RSA', *SAMJ*, Supplement, 70, 8, 11 October 1986.
- Sher, R., 'HIV Infection in South Africa, 1982 – 1988 – A Review', *SAMJ*, 76, 7, 7 October 1989.
- Sher, R., Christie, G., & Zazayokwe, M., 'Fifth International AIDS Conference', *SAMJ*, 77, 3, 3 February 1990.
- Sher, R., & Metz, J., 'Third International AIDS Conference', *SAMJ*, 72, 6, 19 September 1987.
- Sifris, D., 'Serological test for AIDS', *SAMJ*, 69, 9, 26 April 1986.
- Spargo, C., Chricton, B., de Souza, M., Phoshoko, V., and Dansey, R.D., 'Awareness of AIDS Among Black Mineworkers', *SAMJ*, 80, 3, 3 August 1991.

- Spracklen, F.H.N., Whittaker, R.G., Becker, W.B., *et al*, 'The Acquired Immune Deficiency Syndrome and Related Complex - A Report of 2 Confirmed Cases in Cape Town with Comments on Human T-cell Lymphotropic Virus Type III Infections', *SAMJ*, 68, 2, 3 August 1985.
- Spracklen, F.H.N., 'AIDS: Prevention and Control', *SAMJ*, 74, 6, 17 September 1988.
- Stevens, H. & Boon, G., 'Prevalence of HIV Antibodies in Antenatal Clinic Attenders in Ciskei', *SAMJ*, 79, 5, 2 March 1991.
- Taylor, M.B., *et al* 'HIV Survey in Venda', *SAMJ*, 75, 7, 1 April 1989.
- Tshibangu, N., 'HIV Infection in Bophuthatswana: Epidemiological Surveillance 1987 - 1989', *SAMJ*, 83, 1, January 1993.
- Van Wyk, C., 'Follow-up on AIDS at Hottentots Holland Hospital', *SAMJ*, 83, 2, February 1993.
- Vos, G.H., & Brain, P., 'Race and Sex Differences in Walking Under Ladders in Durban', *SAMJ*, 58, 12, 20 September 1980.
- West, M.E., & Boonzaier, E.A., 'Population Groups, Politics and Medical Science', *SAMJ*, 76, 5, 2 September 1989.
- Wilkinson, R., 'Hepatitis B as a Sexually Transmitted Disease in a Black South African Population', *SAMJ*, 65, 24, 16 June 1984.
- Wilson, D., & Lavelle, S., 'AIDS Prevention in South Africa: A Perspective from other African Countries', *SAMJ*, 83, 9, September 1993.
- Ziefer, A., & Abramowitz, J.A., '*Pneumocystis carinii* pneumonia in HIV-Positive and HIV-Negative Patients', *SAMJ*, 76, 7, 7 October 1989.

Other Primary Sources

- ACT-UP (AIDS Coalition to Unleash Power) website at www.actupny.org (accessed December 2011).
- ACT-UP Oral History Project website at www.actuporalhistory.org (accessed December 2011).
- Afrika Grupperna* website at: www.afrikagrupperna.se/english (accessed July 2010).
- Alan Johnson, C., 'Off the Map – How HIV/AIDS Programming is Failing Same-Sex Practicing People in Africa', International Gay and Lesbian Human Rights Commission (IGLHRC), 2007, available on the SAFAIDS website at www.safaid.net/files/Off%20the%20Map.pdf (accessed December 2011).
- 'ANC Structures and Personnel, 1960 – 1994' on a cached copy of the ANC website at: www.anc.org.za/ancdocs/misc/trc2a.html (accessed August 2010).
- Anglo American website at www.angloamerican.co.za (accessed August 2011).
- 'Anglo American continues its global leadership in the fight against HIV/AIDS', 2 December 2009 at www.angloamerican.co.za/en/media/press-releases/2009/02-12-09.aspx (accessed August 2011).

AREPP – Theatre for Life see the organisation’s website at www.arepp.org.za (accessed September 2010).

Audit Bureau of Circulations of South Africa (ABC) see ABC website at www.abc.org.za (accessed November 2009).

AVAC (AIDS Vaccine Advocacy Coalition) website at www.avac.org/ht/d/sp/i/28226/pid/28226 (accessed June 2011).

AVERT website at: www.avert.org (accessed February 2011).

AVERT website, History of AIDS section at www.avert.org/aids-history87-92.htm (accessed May 2010).

Awareness Publishing Group at www.awarenesspublishing.co.za/writers.htm (accessed June 2011).

Brummer, D., 'Labour Migration and HIV/AIDS in Southern Africa', IOM (International Organization for Migration) Report, 2002, available on the Southern African Regional Poverty Network (SARPN) website at www.sarpn.org/documents/d0000572/P534_Labour_Migration_HIV.pdf (accessed January 2011).

Bunting, I., 'The Higher Education Landscape Under Apartheid' in Cloete, N., Maassen, P., Fehnel, R., *et al* (eds), *Transformation in Higher Education - Global Pressures and Local Realities*, Centre for Higher Education Transformation (CHET) available on the CHET website at http://chet.org.za/webfm_send/64 (accessed January 2012).

CAPRISA website at www.caprisa.org (accessed June 2011).

Centers for Disease Control and Prevention (CDC) website at www.cdc.gov (accessed May 2012).

Centre for the Study of AIDS (CSA) website at www.csa.za.org (accessed July 2012).

Charlotte Maxeke Johannesburg Academic Hospital website at www.johannesburghospital.org.za (accessed December 2011).

Columbia University Center for Bioethics website at www.cumc.columbia.edu/dept/bec/staff/stein.html (accessed May 2012).

Davie, L., 'Sizwe Hospital, 109 years later', 26 November 2004, on the City of Johannesburg website at www.joburgnews.co.za/2004/nov/nov26_sizwe.stm (accessed March 2012).

Department of Health 'The 2011 National Antenatal Sentinel HIV & Syphilis Prevalence Survey in South Africa', December 2012, available on the Department of Health website at www.doh.gov.za/docs/reports/2012/Antenatal_Sentinel_survey_Report_2012_final.pdf (accessed December 2012).

de Waal, A., Klot, J.F, Mahajan, M., Huber, D., Frerks, G., & M’Boup, S., ‘HIV/AIDS, Security and Conflict - New Realities, New Responses’ AIDS, Security and Conflict Initiative (ASCI), c. 2010 available on the ASCI website at http://asci.researchhub.ssrc.org/working-papers/HIV_AIDS,%20Security%20and%20Conflict.pdf (accessed December 2012).

‘Epidemiologic Notes and Reports Positive HTLV-III/LAV Antibody Results for Sexually Active Female Members of Social/Sexual Clubs – Minnesota’, *Morbidity and Mortality Weekly*

Report (MMWR), 35, 45, 14 November 1986 accessed via the CDC website at www.cdc.gov/mmwr/preview/mmwrhtml/00000819.htm (accessed May 2012).

Ethekekwini Hospital and Heart Centre see the website at www.ehnc.co.za/aboutus/index.htm (accessed June 2011).

Exit website at www.exit.co.za (accessed December 2011).

Federation of Physicians for Life website at www.euthanasia.com/belgium.html (accessed July 2012).

Gertrude H. Sergievsky Center website at www.cumc.columbia.edu/dept/sergievsky/fs/susser.html (accessed May 2012).

Goyer, K.C., *HIV/AIDS in Prison – Problems, Policies and Potential*, Institute for Security Studies, Monograph No. 79, February 2003, available on the ISS website at: www.issafrika.org/Pubs/Monographs/No79/Content.html (accessed January 2011).

Health Economics and HIV/AIDS Research Division (HEARD) website at www.heard.org.za (accessed July 2012).

Health-e News website at www.health-e.org.za (accessed December 2012).

Heywood, M., 'The Price of Denial', c.2004, available on the Southern African Regional Poverty Network website at [www.sarpn.org.za/documents/d0001195/4The Price of Denial-Mark Heywood.pdf](http://www.sarpn.org.za/documents/d0001195/4The%20Price%20of%20Denial-Mark%20Heywood.pdf) (accessed February 2011).

HIV Center for Clinical and Behavioral Studies at the New York State Psychiatric Institute and Columbia University website at www.hivcenternyc.org/people/zenastein-pb.html (accessed May 2012).

'HIV Testing in Pregnancy' on the AVERT website at: www.avert.org/hiv-testing-pregnancy.htm (accessed February 2011).

Hospital Association of South Africa (HASA) website www.hasa.co.za/about/director (accessed June 2011).

Human Rights Watch, *Report: South Africa - The State Response to Domestic Violence and Rape*, November 1995 available on the Human Rights website at www.hrw.org/legacy/reports/1995/Safricawm-02.htm (accessed August 2012).

Human Rights Watch Report, *"We'll Show You You're a Woman" Violence and Discrimination against Black Lesbians and Transgender Men in South Africa*, 2011 available on the Human Rights Watch website at <http://www.hrw.org/sites/default/files/reports/southafrica1211.pdf> (accessed December 2011).

Human Sciences Research Council (HSRC) website at www.hsrc.ac.za (accessed July 2012).

Hunt Lascar TBWA website www.tbwa.co.za (accessed February 2011).

International Planned Parenthood Federation website at www.ippf.org/en/Where/za.htm (accessed May 2012).

Johnson-Barker, B., 'Thirty Years of the MRC - A short general history of the South African Medical Research Council' available on the Medical Research Council website at www.mrc.ac.za/history/history.pdf (accessed July 2012).

Keith Haring Foundation website at www.haring.com (accessed July 2012).

Medical Research Council website at www.mrc.ac.za (accessed March 2012).

Michigan State University African Activist archive listing at: <http://africanactivist.msu.edu/organization.php?name=Africa+Groups'+Recruitment+Organisation> (accessed July 2010).

National Health Laboratory Service (NHLS) website at www.nhls.ac.za (accessed December 2011).

National Health Service (UK) information on haemophilia at its website at www.nhs.uk/conditions/haemophilia/Pages/Introduction.aspx (accessed October 2010).

National Health Service (NHS) UK website at www.nhs.uk/conditions/kaposi-sarcoma/Pages/Introduction.aspx (accessed May 2012).

Norwegian People's Aid (NPA) website at www.npaid.org (accessed August 2010).

NOVIB *Nederlandse Organisatie voor Internationale Ontwikkelingssamenwerking* (Netherlands Organization for International Development Cooperation website at www.oxfamnovib.nl/history.html (accessed May 2010).

Parliament of the Republic of South Africa website: www.parliament.gov.za/live/content.php?Category_ID=119 (accessed January 2010).

Physicians for Life website at www.physiciansforlife.org (accessed January 2010).

Poverty and Inequality in South Africa: Final Report, 13 May 1998, available at South African Government Information website at: www.info.gov.za/view/DownloadFileAction?id=70499 (accessed February 2011).

The Public Health Approach to STD Control, UNAIDS Technical Update, May 1998, at http://whqlibdoc.who.int/unaid/1998/a62393_eng.pdf (accessed 18 May 2010).

Reddy, E.S., *International Conferences, Seminars and Other Events against Apartheid, 1964-1994* on the ANC website at: www.anc.org.za/ancdocs/history/solidarity/conferences/conf.html (accessed June 2010).

Right to Care at www.righttocare.org/index.php?option=com_content&view=article&id=159&Itemid=235 (accessed June 2011).

School of Population and Development Studies, UKZN, website at <http://sds.ukzn.ac.za/default.php?2,4,8,4,0> (accessed February 2012).

Section 27, *A Background to Health Law and Human Rights in South Africa*, 2010 available on the Section 27 website at www.section27.org.za/wp-content/uploads/2010/04/Chapter1.pdf (accessed July 2012).

SIDA website at www.sida.se (accessed August 2010).

Simon Fraser University website at www.fhs.sfu.ca/portal_memberdata/msteinberg (accessed June 2011).

South African AIDS Vaccine Initiative (SAAVI) website at www.saavi.org.za (accessed February 2011).

South African Haemophilia Foundation/Suid-Afrikaanse Hemofilie-Stigting at www.haemophilia.org.za/Hem2.htm (accessed October 2010).

Southern African HIV Clinicians Society website at <http://sahivsoc.org> (accessed December 2011).

Southern African Regional Poverty Network (SARPN) website at www.sarpn.org (accessed January 2011).

'Statement on PEPFAR Funding to Fight HIV and AIDS in South Africa', 28 January 2010, available at the United States Diplomatic Mission to South Africa website available at <http://southafrica.usembassy.gov/press100128.html> (accessed December 2012).

TRC and the Commissions final report can be found on the Department of Justice website at <http://www.justice.gov.za/trc> (accessed September 2010).

The Truth and Reconciliation Commission of South Africa Report, 'Institutional Hearing: The Health Sector', vol. 4, ch. 5, 1998, available on the Department of Justice website at www.justice.gov.za/trc/report (accessed April 2011).

Truth and Reconciliation Commission, *Human Rights Violations – Health Sector Hearings*, Cape Town, 17 - 18 June 1997, transcripts available on the Department of Justice's website at www.justice.gov.za/trc/special/index.htm#hsh (accessed April 2011).

South African Press Association (SAPA), 'De Kock Amnesty hearings Scheduled for Next Week', Pretoria, 11 November 1990 at www.justice.gov.za/trc/media/1999/9911/p991111a.htm (accessed December 2010).

Statement by the Truth and Reconciliation Commission - Media Release, 10 November 1999 at www.justice.gov.za/trc//media/pr/1999/p991110.htm (accessed December 2010).

TRC Amnesty Hearing Transcript, Eugene Alexander de Kock, application number AM0066/96, 6 September 1999 at www.justice.gov.za/trc/amntrans/1999/99090616_pre_990906pt.htm (accessed December 2010).

TRC Amnesty Hearing Transcript, Andries van Heerden, application number AM3764/96, 23 October 2000 at www.justice.gov.za/trc/amntrans/2000/201023jb.htm (accessed December 2010).

Triangle Project website at www.triangle.org.za (accessed December 2011).

UNAIDS, AIDSInfo Country Fact Sheet - South Africa, available from the UNAIDS website at www.unaids.org/en/dataanalysis/tools/aidsinfo/countryfactsheets (accessed July 2012).

UNAIDS, *Sexually Transmitted Diseases: Policies and Principles for Prevention and Care*, UNAIDS Best Practice Collection, 1999, World Health Organisation (WHO) website at http://whqlibdoc.who.int/unaid/1997/UNAIDS_97.6.pdf (accessed 18 May 2010).

Van Zyl, M., de Gruchy, J., Lapinsky, S., Lewin, S., and Reid, G., 'The Aversion Project - Human Rights Abuses of Gays and Lesbians in the South African Defence Force by Health Workers during the Apartheid Era', report compiled on behalf of the Gay and Lesbian Archives (GALA), Health and Human Rights Project, Medical Research Council (MRC) and the National Coalition for Gay and Lesbian Equality, Cape Town, October 1999,

- available at the South African Medical Research Council website at www.mrc.ac.za/healthsystems/aversion.pdf (accessed December 2010).
- Wells, H., & Polders, L., 'HIV & Sexually Transmitted Infections (STIs) Among Gay and Lesbian people in Gauteng: Prevalence and Testing Practices', Research initiative of the Joint Working Group conducted by OUT LGBT Well-being in collaboration with the UNISA Centre for Applied Psychology, n.d. c.2004, available on the Southern Africa HIV and AIDS Information Dissemination Service (SAFAIDS) website at [www.saf aids.net/files/HIV and STD among Gays and Lesbians research findings.pdf](http://www.saf aids.net/files/HIV_and_STD_among_Gays_and_Lesbians_research_findings.pdf) (accessed December 2011).
- Who's Who Southern Africa at www.whoswhosa.co.za/clive-evian-5181 (accessed June 2011).
- World Federation of Doctors Who Respect Human Life website: www.euthanasia.com/belgium.html (accessed January 2010).
- World Health Organisation, *Progress in Reproductive Health*, 67, 2004, available on the WHO website at www.who.int/hrp/publications/progress67.pdf (accessed July 2012).

SECONDARY SOURCES

Books

- Abdool Karim, Q., & S. S. (eds), *HIV/AIDS in South Africa* (Cape Town, Cambridge University Press, 2008).
- Atkinson, D., *Going for Broke: the Fate of Farm Workers in Arid South Africa* (Cape Town, HSRC Press, 2007) available online from HSRC Press at www.hsrcpress.ac.za (accessed August 2012).
- Baldwin-Ragaven, L., de Gruchy, J., et al (eds), *An Ambulance of the Wrong Colour: Health Professionals, Human Rights and Ethics in South Africa* (Cape Town, University of Cape Town Press, 1999).
- Ballard, R., Valodia, I., and Habib, A. (eds), *Voices of Protest: Social Movements in Post-apartheid South Africa* (Durban, University of KwaZulu-Natal Press, 2006).
- Banton, M., *Racial Theories* (Cambridge, Cambridge University Press, 1998).
- Barnett, T., & Whiteside, A., *AIDS in the Twenty-first Century: Disease and Globalization* (Basingstoke, Palgrave Macmillan, 2002).
- Beinart, W., *Twentieth Century South Africa* (Oxford, Oxford University Press, 2001).
- Berridge, V., *AIDS in the UK: The Making of Policy, 1981 – 1994* (New York, Oxford University Press, 1996).
- Berridge, V., & Strong, P. (eds), *AIDS and Contemporary History* (Cambridge, Cambridge University Press, 2002).
- Brandt, A.M., *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880* (New York, Oxford University Press, 1987).

- Butchart, A., *The Anatomy of Power: European Constructions of the African Body* (London, Zed Books, 1998).
- Butler, J., *Bodies that Matter: On the Discursive Limits of 'Sex'* (London, Routledge, 1993).
- Butler, J., *Gender Trouble: Feminism and the Subversion of Identity* (New York, Routledge, 2006).
- Callaway, H., *Gender, Culture and Empire: European Women in Colonial Nigeria* (London, Macmillan, 1987).
- Cameron, E., *Witness to AIDS* (Cape Town, Tafelberg, 2005).
- Campbell, C., *Letting Them Die: Why HIV Prevention Programmes Fail* (Cape Town, Double Storey, 2003).
- Chirimuuta, R., C., & Chirimuuta, R.J., *AIDS, Africa and Racism* (London, Free Association Books, 1989).
- Cochrane, M., *When AIDS Began – San Francisco and the Making of an Epidemic* (New York, Routledge, 2004).
- Cock, J., *Colonels & Cadres: War and Gender in South Africa* (Cape Town, Oxford University Press, 1991).
- Comaroff, J. (ed), *Ethnography and the Historical Imagination* (Boulder, Westview Press, 1992).
- Crewe, M., *AIDS in South Africa – The Myth and the Reality* (Harmondsworth, Penguin, 1992).
- Cross, S., & Whiteside, A. (eds), *Facing Up to AIDS: The Socio-economic Impact in Southern Africa* (London, Macmillan, 1993).
- Cullinan, K. & Thom, A. (eds), *The Virus, Vitamins and Vegetables: the South African HIV/AIDS Mystery* (Auckland Park, Jacana, 2009).
- Daniel, J., Habib, A., & Southall, R. (eds), *The State of the Nation: South Africa 2003 – 2004* (Cape Town, HSRC Press, 2003).
- Davenport, T.R.H., *South Africa – A Modern History* (London, Macmillan, 1991).
- Deacon, H., Stephney, I., & Prosalendis, S., *Understanding HIV/AIDS Stigma - A Theoretical and Methodological Analysis* (Cape Town, HSRC Press, 2005).
- De Beer, C., *The South African Disease: Apartheid Health and Health Services* (Johannesburg, Southern African Research Service, 1984).
- De Waal, A., *AIDS and Power: Why There is No Political Crisis - Yet* (Cape Town, David Philip, 2006).
- De Waal, S., & Manion, A. (eds), *Pride – Protest and Celebration* (Johannesburg, Fanele, 2006).
- Denis, P., & Becker, C. (eds), *The HIV/AIDS Epidemic in Sub-Saharan Africa in a Historical Perspective*, English addition published online by the Senegalese Network "Law, Ethics, Health", October 2006 available on the website of the *Agence Universitaire de la Francophonie* at <http://rds.refer.sn/IMG/pdf/AIDSHISTORYALL.pdf> (accessed July 2009).
- Doka, K.J., *AIDS, Fear, and Society* (New York, Taylor and Francis, 1997).

- Dubow, S., *Scientific Racism in Modern South Africa* (Cambridge, Cambridge University Press, 1995).
- Dubow, S. (ed), *Science and Society in Southern Africa* (Manchester, Manchester University Press, 2000).
- Dubow, S., *A Commonwealth of Knowledge: Science, Sensibility and White South Africa 1820 – 2000* (Cape Town, Double Storey, 2006).
- Dyer, R., *White* (New York, Routledge, 1997).
- Elder, G., *Hostels, Sexuality, and the Apartheid Legacy: Malevolent Geographies* (Athens, Ohio University Press, 2003).
- Engel, J., *The Epidemic: A Global History of AIDS* (New York, Collins, 2006).
- Epstein, S., *Impure Science – AIDS, Activism, and the Politics of Knowledge* (Berkeley, University of California Press, 1996).
- Everatt, D., & Maphai, V. (eds), *The Real State of the Nation: South Africa after 1990* (Interfund, Development Update, 4, 3, November 2003).
- Farmer, P., *AIDS & Accusation: Haiti and the Geography of Blame* (Berkeley, University of California Press, 2006).
- Fassin, D., *When Bodies Remember: Experiences and Politics of AIDS in South Africa* (Berkeley, University of California Press, 2007).
- Fausto-Sterling, A., *Myths of Gender: Biological Theories about Women and Men* (New York, Basic Books, 1992).
- Fausto-Sterling, A., *Sexing the Body: Gender Politics and the Construction of Sexuality* (New York, Basic Books, 2000).
- Fee, E., & Fox, D.M. (eds), *AIDS: The Burdens of History* (Berkeley, University of California Press, 1988).
- Fee, E., & Fox, D.M. (eds), *AIDS: The Making of a Chronic Disease* (Berkeley, University of California Press, 1992).
- Feldman, D.A. (ed), *Global AIDS Policy* (Connecticut, Bergin & Garvey, 1994).
- Fourie, P., *The Political Management of HIV and AIDS in South Africa: One Burden Too Many?* (Basingstoke, Palgrave Macmillan, 2006).
- Gasa, N. (ed), *Women in South African History* (Cape Town, HSRC Press, 2007).
- Germond, P., and de Gruchy, S. (eds), *Aliens in the Household of God – Homosexuality and Christian Faith in South Africa* (Cape Town, David Philip, 1997).
- Gevisser, M., and Cameron, E. (eds), *Defiant Desire: Gay and Lesbian Lives in South Africa* (New York and London, Routledge, 1995).
- Gilman, S.L., *Difference and Pathology: Stereotypes of Sexuality, Race and Madness* (New York, Cornell University Press, 1985).
- Goudsmit, J., *Viral Sex: The Nature of AIDS* (Oxford, Oxford University Press, 1998).
- Grmek, M. D., *History of AIDS: Emergence and Origin of a Modern Pandemic* (Princeton, Princeton University Press, 1990).
- Halperin, D., & Timberg, C., *Tinderbox: How the West Sparked the AIDS Epidemic and How the World Can Finally Overcome It* (New York, Penguin Press, 2012).

- Harris, V., *Archives and Justice – A South African Perspective* (Chicago, Society of American Archivists, 2007).
- Hoad, N., Martin, K., and Reid, G. (eds), *Sex & Politics in South Africa* (Cape Town, Double Storey Books, 2005).
- Heywood, M., *From Disaster to Development: HIV and AIDS in Southern Africa* (Braamfontein, INTERFUND, 2004).
- Hunter, M., *Love in the Time of AIDS: Inequality, Gender, and Rights in South Africa* (Scottsville, University of KwaZulu-Natal Press, 2010).
- Hyam, R., *Empire and Sexuality: The British Experience* (Manchester, Manchester University Press, 1990).
- Iliffe, J., *The African AIDS Epidemic: A History* (Oxford, James Currey, 2006).
- Jochelson, K., *The Colour of Disease: Syphilis and Racism in South Africa, 1880-1950* (Basingstoke, Palgrave, 2001).
- Jones, P., & Stokke, K. (eds), *Democratising Development: The Politics of Socio-economic Rights in South Africa* (Leiden, Martinus Nijhoff, 2005).
- Judge, M., Manion, A., & De Waal, S. (eds), *To Have and To Hold: The Making of Same-Sex Marriage in South Africa* (Johannesburg, Fanele, 2008).
- Kark, S., *Promoting Community Health: from Pholela to Jerusalem* (Johannesburg, Wits University Press, 1999).
- Katz, E., *White Death: Silicosis on the Witwatersrand Gold Mines, 1886 – 1910* (Johannesburg, Wits University Press, 1994).
- Kauffman, K.D., & Lindauer, D.L. (eds), *AIDS and South Africa: The Social Expression of a Pandemic* (New York, Palgrave Macmillan, 2004).
- Klausen, S., *Race, Maternity and the Politics of Birth Control in South Africa, 1910-39* (Basingstoke, Macmillan, 2004).
- Kuntz, D., & Bachrach, S. (eds), *Deadly Medicine: Creating the Master Race* (Washington, University of North Carolina Press, 2004).
- Lawson, L., *Side Effects: The Story of Aids in South Africa* (Cape Town, Double Storey, 2008).
- Lindenbaum, G., & Lock, M. (eds), *Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life* (Berkeley, University of California Press, 1993).
- Lonsdale, J. (ed), *South Africa in Question* (Cambridge, Cambridge University Press, 1988).
- Luirink, B., *Moffies – Homo- en Lesboleven in het Zuiden van Afrika* (Amsterdam, Jan Mets, 1998).
- MacLeod, R., & Lewis, M. (eds), *Disease, Medicine and Empire: Perspectives of Western Medicine and the Experience of European Expansion* (London, Routledge, 1988).
- Manganyi, N.C., & du Toit, A. (eds), *Political Violence and the Struggle in South Africa* (London, Macmillan, 1990).
- Marais, H., *Buckling: the impact of AIDS in South Africa 2005* (Pretoria, University of Pretoria, 2005).
- Marks, S., *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession* (Johannesburg, Wits University Press, 1994).

- Marks, S., & Andersson, N., *Apartheid and Health: Report to the World Health Organisation* (Geneva, WHO Publications, 1983).
- Marks, S., & Engels, D. (eds), *Contesting Colonial Hegemony: State and Society in Africa and India* (London, British Academic Press, 1993).
- Marks, S., & Trapido, S. (eds), *The Politics of Race, Class & Nationalism in Twentieth Century South Africa* (London, Longman, 1987).
- Maylam, P., *South Africa's Racial Past – The History and Historiography of Racism, Segregation and Apartheid* (Aldershot, Ashgate, 2001).
- McCulloch, J., *Colonial Psychiatry and 'the African Mind'* (Cambridge, Cambridge University Press, 1995).
- McCulloch, J., *Asbestos Blues: Labour, Capital, Physicians and the State in South Africa* (Bloomington, Indiana University Press, 2002).
- Moodie, T. D., *The Rise of Afrikanerdom: Power, Apartheid, and the Afrikaner Civil Religion* (Berkeley, University of California Press, 1975).
- Morgan, R., and Wieringa, S. (eds), *Tommy Boys, Lesbian Men and Ancestral Wives: Female Same-Sex Practices in Africa* (Johannesburg, Jacana Press, 2005).
- Morgan, S. (ed), *The Feminist History Reader* (Abingdon, Routledge, 2006).
- Morrell, R. (ed), *Changing Men in Southern Africa* (Scottsville and London, University of Natal Press and Zed books, 2001).
- Mukudi Omwami, E., Commins, S., & Keller, E.J. (eds), *HIV/AIDS in Africa: Challenges & Impact* (Trenton, Africa World Press, 2008).
- Nattrass, N., *The Moral Economy of AIDS in South Africa* (Cambridge, Cambridge University Press, 2004).
- Nattrass, N., *Mortal Combat - AIDS Denialism and the Struggle for Antiretrovirals in South Africa* (Scottsville, University of KwaZulu-Natal Press, 2007).
- Ndinga-Muvumba, A., & Pharoah, R. (eds), *HIV/AIDS and Society in South Africa* (Scottsville, University of KwaZulu-Natal Press, 2008).
- Ngugi wa Thiong'o, *Moving the Centre: The Struggle for Cultural Freedoms* (London, James Currey, 1993).
- Nichter, M., & Lock, M. (eds), *New Horizons in Medical Anthropology: Essays in Honor of Charles Leslie* (London, Routledge, 2002).
- Obono, O. (ed), *A Tapestry of Human Sexuality in Africa* (Johannesburg, Fanele, 2010).
- O' Meara, D., *Forty Lost Years - The Apartheid State and the Politics of the National Party, 1948 - 1994* (Randburg, Raven Press, 1996).
- Omond, R., *The Apartheid Handbook: A Guide to South Africa's Everyday Racial Policies* (London, Penguin, 1985).
- O'Neill, M., *Prostitution and Feminism: Towards a Politics of Feeling* (Cambridge, Polity, 2001).
- Oppenheimer, G., & Bayer, R., *Shattered Dreams? : An Oral History of the South African AIDS Epidemic* (Oxford, Oxford University Press, 2007).

- Outshoorn, J. (ed), *The Politics of Prostitution: Women's Movements, Democratic States, and the Globalisation of Sex Commerce* (Cambridge, Cambridge University Press, 2004).
- Packard, R., *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Pietermaritzburg, University of Natal Press, 1990).
- Padayachee, V. (ed), *The Development Decade? Economic and Social Change in South Africa 1994-2004* (Cape Town, HSRC Press, 2006).
- Pierson, R., & Chaudhuri, N. (eds), *Nation, Empire, Colony: Historicizing Gender and Race* (Indiana, Indiana University Press, 1998).
- Pisani, E., *The Wisdom of Whores: Bureaucrats, Brothels and the Business of AIDS* (London, Granta, 2008).
- Poku, N., *AIDS in Africa: How the Poor are Dying* (Cambridge, Polity, 2005).
- Poku, N.K., & Whiteside, A. (eds), *The Political Economy of AIDS in Africa* (Aldershot, Ashgate, 2004).
- Posel, D., *The Making of Apartheid, 1948 - 1961* (Oxford, Oxford University Press, 1997).
- Quetel, C., *History of Syphilis* (Baltimore, Johns Hopkins University Press, 1990).
- Ranger, T., & Slack, P. (eds), *Epidemics and Ideas: Essays on the Historical Perception of Pestilence* (Cambridge, Cambridge University Press, 1992).
- Ranger, T., & Vaughan, O. (eds), *Legitimacy and the State in Twentieth-Century Africa: Essays in Honour of A.H.M. Kirk-Greene* (Basingstoke, Macmillan, 1993).
- Reddy, V., Sandfort, T., & Rispel, L. (eds), *From Social Silence to Social Science – Same-Sex Sexuality, HIV & AIDS and Gender in South Africa* (Cape Town, HSRC Press, 2009).
- Reid, G., & Walker, L. (eds), *Men Behaving Differently – South African Men Since 1994* (Cape Town, Double Storey Books, 2005).
- Rist, G., *The History of Development – From Western Origins to Global Faith* (London, Zed Books, 2008).
- Rosenberg, C. E., *Explaining Epidemics and Other Studies in the History of Medicine* (Cambridge, Cambridge University Press, 1992).
- Rupiya, M. (ed), *The Enemy Within – Southern African Militaries' Quarter-Century Battle with HIV and AIDS* (Pretoria, Institute for Security Studies, 2006).
- Sabatier, R., Aina, T., Ardila, P., et al, *Blaming Others: Prejudice, Race and Worldwide AIDS* (Washington, Panos, 1988).
- Scarpa, S., *Trafficking in Human Beings: Modern Slavery* (Oxford, Oxford University Press, 2008).
- Schiebinger, L. (ed), *Feminism and the Body* (New York, Oxford University Press, 2000).
- Seedat, A., *Crippling a Nation: Health in Apartheid South Africa* (London, International Defence and Aid Fund for Southern Africa, 1984).
- Shilts, R., *And the Band Played On: Politics, People and the AIDS Epidemic* (New York, Penguin, 1987).
- Sontag, S., *Illness as Metaphor and AIDS and Its Metaphors* (London, Penguin, 2002).
- Squire, C., *HIV in South Africa: Talking About the Big Thing* (Abingdon, Routledge, 2007).

- Steinberg, J., *Three-letter Plague: A Young Man's Journey Through a Great Epidemic* (Johannesburg, Jonathan Ball Publishers, 2008).
- Straker, G., *Faces in the Revolution: The Psychological Effects of Violence on Township Youth in South Africa* (Cape Town, David Philip, 1992).
- Stolten, H.E. (ed), *History and Present Day Politics – The Meaning of Collective Memory in South Africa* (Uppsala, Nordiska Afrikainstitutet, 2007).
- Susser, I., *AIDS, Sex, and Culture: Global Politics and Survival in Southern Africa* (Oxford, Wiley-Blackwell, 2009).
- Symanski, R., *The Immoral Landscape: Female Prostitution In Western Societies* (Toronto, Butterworths, 1981).
- Theodoulou, S.Z. (ed), *AIDS: The Politics and Policy of Disease* (Upper Saddle River, Prentice Hall, 1996).
- Thompson, L., *A History of South Africa* (London, Yale University Press, 1990).
- Thorbek, S., & Pattanaik, B. (eds), *Transnational Prostitution: Changing Patterns in a Global Context* (London, Zed Books, 2002).
- Treichler, P.A., *How to Have Theory in an Epidemic: Cultural Chronicles of AIDS* (Durham, Duke University Press, 1999).
- Tuana, N. (ed), *Feminism & Science* (Bloomington, Indiana University Press, 1989).
- Vaughan, M., *Curing their Ills: Colonial Power and African Illness* (Cambridge, Polity Press, 1991).
- Walker, C., *Women and Resistance in South Africa* (Cape Town, David Philip, 1991).
- Walker, L., Reid, G., & Cornell, M., *Waiting to Happen: HIV/AIDS in South Africa - The Bigger Picture*, (Cape Town, Double Storey, 2004).
- Walkowitz, J.R., *Prostitution and Victorian Society: Women, Class, and the State* (Cambridge, Cambridge University Press, 1980).
- Watney, S., *Practices of Freedom – Selected Writings on HIV/AIDS* (Durham, Duke University Press, 1994).
- Wells, J., *We Have Done with Pleading: The Women's 1913 Anti-Pass Campaign* (Johannesburg, Ravan Press, 1991).
- West, D.J., *Male Prostitution* (New York, Haworth Press, 1993).
- Whiteside, A. & Cross, S. (eds), *Facing Up to AIDS: The Socio-economic Impact of AIDS in Southern Africa* (London, Macmillan, 1993).
- Whiteside, A. (ed), *Implications of AIDS for Demography and Policy in Southern Africa* (Pietermaritzburg, University of Natal Press, 1998).
- Whiteside, A., *HIV/AIDS: A Very Short Introduction* (Oxford, Oxford University Press, 2008).
- Whiteside, A., & Sunter, C., *AIDS: The Challenge for South Africa* (Cape Town, Human & Rousseau, 2001).
- Wilton, T., *EnGendering AIDS: Deconstructing Sex, Text and Epidemic* (London, Sage, 1997).
- Wright M., Stein, Z., & Scandlyn, J. (eds), *Women's Health and Apartheid: The Health of Women and Children and the Future of Progressive Primary Health Care in Southern*

Africa : Proceedings of the Third Workshop of the Project on Poverty, Health, and the State in Southern Africa (New York, Columbia University, 1988).

Youde, J.R., *AIDS, South Africa, and the Politics of Knowledge* (Aldershot, Ashgate, 2007).

Journal Articles and Chapters

Abdool Karim, S.S., 'Introduction' in Abdool Karim, S.S & Abdool Karim, Q. (eds), *HIV/AIDS in South Africa* (New York, Cambridge University Press, 2008).

Abrahams, Y., 'Images of Sara Bartman – Sexuality, Race and Gender in Early Nineteenth-Century Britain' in Pierson, R., & Chaudhuri, N. (eds), *Nation, Empire, Colony: Historicizing Gender and Race* (Indiana, Indiana University Press, 1998).

Afolabi, M.O., 'Sexual Health Needs of People Living with HIV/AIDS in Osun State, Nigeria' in Obono, O. (ed), *A Tapestry of Human Sexuality in Africa* (Johannesburg, Fanele, 2010).

Aggleton, P., 'Researching Same-sex Sexuality and HIV Prevention' in Reddy, V., Sandfort, T., and Rispel, L. (eds), *From Social Silence to Social Science – Same-Sex Sexuality, HIV & AIDS and Gender in South Africa* (Cape Town, HSRC Press, 2009).

Ahlberg, B.M., 'Is There a Distinct African Sexuality? A Critical Response to Caldwell', *Africa*, 64, 2, 1994.

Altman, D., 'Transfiguring Sexual Identity: AIDS & the Contemporary Construction of Homosexuality: Comment', *Social Text*, 19/20, Autumn, 1988.

Angus Nicoll, A., Hughes, G., Donnelly, M., Livingstone, S., De Angelis, D., Fenton, K., Evans, B., Gill, N., & Catchpole, M., 'Assessing the Impact of National Anti-HIV Sexual Health Campaigns: Trends in the Transmission of HIV and Other Sexually Transmitted Infections in England', *Sexually Transmitted Infections*, 77, 4, August 2001 available on the *British Medical Journal* (BMJ) website at <http://sti.bmj.com/content/77/4/242.full> (accessed December 2011).

Bank, A., 'Of "Native Skulls" and Noble Caucasians: Phrenology in Colonial South Africa', *Journal of Southern African Studies*, 22, 3, 1996.

Bekker, L., 'Tribute - Des Martin', *Southern African Journal of HIV Medicine*, 8, 2, 2007, (via www.sajhivmed.org.za/index.php/sajhivmed/article/view/72/37, accessed December 2011).

Bell, S., 'The Politician, the Economist, and the Medical Professional: The Unholy Trinity of Apartheid in South Africa', *Undercurrent*, 3, 1, 2006.

Berridge, V., 'The Early Years of AIDS in the United Kingdom 1981–6: Historical Perspectives' in Ranger, T., & Slack, P. (eds), *Epidemics and Ideas: Essays on the Historical Perception of Pestilence* (Cambridge, Cambridge University Press, 1992).

Berridge, V., 'Researching Contemporary History: AIDS', *History Workshop*, 38, 1994.

Berridge, V., & Strong, P., 'Review Article: AIDS and the Relevance of History', *Social History of Medicine*, 4, 1, 1991.

Bibeau, G., & Pedersen, D., 'A Return to Scientific Racism in Medical Social Sciences: The Case of Sexuality and the AIDS Epidemic in Africa' in Nichter, M., & Lock, M. (eds), *New*

- Horizons in Medical Anthropology: Essays in Honor of Charles Leslie* (London, Routledge, 2002).
- Brandt, A.M., 'AIDS in Historical Perspective: Four Lessons from the History of Sexually Transmitted Diseases', *American Journal of Public Health*, 78, 4, April 1988.
- Braude, H.D., 'Colonialism, Biko and AIDS: Reflections on the Principle of Beneficence in South African Medical Ethics', *Social Science & Medicine*, 68, 11, June 2009.
- Brouard, P., 'Gender, Same-sex Sexuality and HIV/AIDS in South Africa: Practical Research Challenges and Solutions', in Reddy, V., Sandfort, T., and Rispel, L. (eds), *From Social Silence to Social Science – Same-Sex Sexuality, HIV & AIDS and Gender in South Africa* (Cape Town, HSRC Press, 2009).
- Brown, B., 'Facing the "Black Peril": The Politics of Population Control in South Africa', *Journal of Southern African Studies*, 13, 2, January 1987.
- Burke, G. & Richardson, P., 'The Profits of Death: A Comparative Study of Miners' Phthisis in Cornwall and the Transvaal, 1876-1918', *Journal of Southern African Studies*, 4, 2, April 1978.
- Burns, C., 'A Useable Past: The Search for "History in Chords"' in Stolten, H.E. (ed) *History and Present Day Politics – The Meaning of Collective Memory in South Africa* (Uppsala, Nordiska Afrikainstitutet, 2007).
- Butler, A., 'South Africa's HIV/AIDS Policy, 1994-2004: How Can It Be Explained', *African Affairs*, 104, 417, October 2005.
- Caldwell, J. & P. *et al*, 'The Cultural Context of High Fertility in Sub-Saharan Africa', *Population and Development Review*, 13, 3, 1987.
- Callaway, H., 'Purity and Exotica in Legitimizing the Empire. Cultural Constructions of Gender, Sexuality and Race', in Ranger, T., & Vaughan, O. (eds), *Legitimacy and the State in Twentieth-Century Africa: Essays in Honour of A.H.M. Kirk-Greene* (Basingstoke, Macmillan, 1993).
- Cameron, E., & Swanson, E., 'Public Health and Human Rights – The AIDS Crisis in South Africa', *South African Journal on Human Rights*, 8, 2, 1992.
- Campbell, C., 'Going Underground and Going After Women': Masculinity and HIV Transmission amongst Black Workers on the Gold Mines' in Morrell, R. (ed), *Changing Men in Southern Africa* (Scottsville and London, University of Natal Press and Zed books, 2001).
- Campbell, C., 'Selling Sex in the Time of AIDS: The Psycho-social Context of Condom Use by Sex Workers on a Southern African Mine', *Social Science & Medicine*, 50, 4, February 2000.
- Campbell, C., & Williams, B., 'Beyond the Biomedical and Behavioural: Towards an Integrated Approach to HIV Prevention in the Southern African Mining Industry', *Social Science & Medicine*, 48, 11, June 1999 (accessed using Science Direct).
- Carton, B., 'Historicising the Unspeakable. Legacies of Bad Death and Dangerous Sexuality in South Africa' in Denis, P., & Becker, C. (eds), *The HIV/AIDS Epidemic in Sub-Saharan Africa in a Historical Perspective*, English addition published online by the Senegalese

- Network "Law, Ethics, Health", October 2006 available on the website of the *Agence Universitaire de la Francophonie* at <http://rds.refer.sn/IMG/pdf/AIDSHISTORYALL.pdf> (accessed July 2009).
- Chirwa, W.C., 'Aliens and AIDS in Southern Africa: The Malawi-South Africa Debate', *African Affairs*, 97, 386, 1988.
- Chirwa, W.C., "'No TEBA...Forget TEBA": The Plight of Malawian Ex-migrant Workers to South Africa, 1988-1994', *International Migration Review*, 31, 3 Autumn, 1997 (accessed using JSTOR).
- Chirwa, W.C., 'The Malawi Government and South African Labour Recruiters, 1974-92', *The Journal of Modern African Studies*, 34, 4, December 1996 (accessed using JSTOR).
- Comaroff, J., 'The Diseased Heart of Africa: Medicine, Colonialism, and the Black Body' in Lindenbaum, G., & Lock, M. (eds), *Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life* (Berkeley, University of California Press, 1993).
- Comaroff, J., 'Medicine, Colonialism and the Black Body' in Comaroff, J. (ed), *Ethnography and the Historical Imagination* (Boulder, Westview Press, 1992).
- Conway, D., 'Queering Apartheid: The National Party's 1987 "Gay Rights" Election Campaign in Hillbrow', *Journal of Southern African Studies*, 35, 4, December 2009.
- Crush, J., 'Fortress South Africa and the Deconstruction of Apartheid's Migration Regime', *Geoforum*, 30, 1999, (accessed using Elsevier).
- Crush, J., Williams, B., Gouws, E., & Lurie, M., 'Migration and HIV/AIDS in South Africa', *Development Southern Africa*, 22, 3, September 2005 (accessed using Academic Search Premier).
- Curtin, P.D., 'The White Man's Grave: Image and Reality, 1780-1850', *Journal of British Studies*, 1, 1, November, 1961.
- Deacon, H., 'Racial Segregation and Medical Discourse in Nineteenth Century Cape Town', *Journal of Southern African Studies*, 22, 2, 1996.
- Delius, P., & Walker, L., 'AIDS in Context', *African Studies*, 61, 1, 2002.
- Delphy, C., 'Rethinking Sex and Gender', *Women's Studies International Forum*, 16, 1, January – February 1993.
- Denis, P., 'Towards a Social History of HIV/AIDS in Sub-Saharan Africa' in Denis, P., & Becker, C. (eds), *The HIV/AIDS Epidemic in Sub-Saharan Africa in a Historical Perspective*, English addition published online by the Senegalese Network "Law, Ethics, Health", October 2006 available on the website of the *Agence Universitaire de la Francophonie* at <http://rds.refer.sn/IMG/pdf/AIDSHISTORYALL.pdf> (accessed July 2009).
- Dolan, K.A., & Davis, P.W., 'Nuances and Shifts in Lesbian Women's Constructions of STI and HIV Vulnerability', *Social Science & Medicine*, 57, 1, July 2003.
- Doyle, P., 'The Demographic Impact of AIDS on the South African Population', in Whiteside, A. & Cross, S. (eds), *Facing Up to AIDS: The Socio-economic Impact of AIDS in Southern Africa* (London, Macmillan, 1993).
- Doyle, P., Mühr, T., Steinberg, M., & Broomberg, J., 'Towards Optimisation of the HIV Modelling Process in South Africa' in Whiteside, A. (ed), *Implications of AIDS for*

- Demography and Policy in Southern Africa* (Pietermaritzburg, University of Natal Press, 1998).
- Dubow, S., 'Afrikaner Nationalism, Apartheid and the Conceptualization of "Race"', *Journal of African History*, 33, 2, 1992.
- Dworkin, S. L., & Ehrhardt, A., 'Going Beyond "ABC" to Include "GEM": Critical Reflections on Progress in the HIV/AIDS Epidemic', *American Journal of Public Health*, 97, 1, January 2007.
- Echenberg, M., 'Historical Perspectives on HIV/AIDS: Lessons from South Africa and Senegal' in Denis, P., & Becker, C. (eds), *The HIV/AIDS Epidemic in Sub-Saharan Africa in a Historical Perspective*, English edition published online by the Senegalese Network "Law, Ethics, Health", October 2006 available on the website of the *Agence Universitaire de la Francophonie* at <http://rds.refer.sn/IMG/pdf/AIDSHISTORYALL.pdf> (accessed July 2009).
- Ellis, S., 'The ANC in Exile', *African Affairs*, 90, 360, July 1991.
- Ellis, S., 'Mbokodo: Security in ANC Camps, 1961-1990', *African Affairs*, 93, 371, April, 1994.
- Erlank, N., 'Gender and Masculinity in South African Nationalist Discourse, 1912-1950', *Feminist Studies*, 29, 3, 2003.
- Fanon, F., 'Medicine and Colonialism' in Fanon, F., *A Dying Colonialism* (New York, Grove Press, 1967).
- Fausto-Sterling, A., 'Gender, Race and Nation: The Comparative Anatomy of 'Hottentot' Women in Europe, 1815-1817' in Schiebinger, L. (ed), *Feminism and the Body* (New York, Oxford University Press, 2000).
- Fausto-Sterling, A., 'The Five Sexes: Why Male and Female are Not Enough', *The Sciences*, 33, 2, March/April 1993.
- Fausto-Sterling, A., 'The Five Sexes, Revisited', *The Sciences*, 40, 4, July/August 2000.
- Fee, E., & Fox, D.M., 'The Contemporary Historiography of AIDS', *Journal of Social History*, 23, 2, Winter, 1989.
- Fee, E., & Krieger, N., 'Understanding AIDS: Historical Interpretation and the Limits of Biomedical Individualism', *American Journal of Public Health*, 83, 10, 1993.
- Finlay, L., "'Outing" the Researcher: The Provenance, Process, and Practice of Reflexivity', *Qualitative Health Research*, 12, 4, April 2002.
- Fox-Genovese, E., 'Placing Women's History in History', *New Left Review*, 1/133, May-June 1982.
- Friedman, S., & Mottiar, S., 'Seeking the High Ground: The Treatment Action Campaign and the Politics of Morality' in Ballard, R., Habib, A., & Valodia, I., *Voices of Protest - Social Movements in Post-Apartheid South Africa* (Durban, University of KwaZulu-Natal Press, 2006).
- Gevisser, M., 'A Different Fight for Freedom: A History of South African Lesbian and Gay Organisation from the 1950s to the 1990s' in Gevisser, M., & Cameron, E. (eds), *Defiant Desire* (New York, Routledge 1995).

- Gilman, S.L., 'Black Bodies, White Bodies: Towards an Iconography of Female Sexuality in Late Nineteenth-Century Art, Medicine, and Literature', *Critical Inquiry*, 12, 1, 1985.
- Ginwala, F., 'Women and the African National Congress 1912-1943', *Agenda*, 8, 1990.
- Glick Schillers, N., Crystal, S., and Lewellen, D., 'Risky Business: The Cultural Construction of AIDS Risk Groups', *Social Science & Medicine*, 38, 10, May 1994.
- Gould, C., & Folb, P., 'The Role of Professionals in the South African Chemical and Biological Warfare Programme', *Minerva*, 40, 1, 2002.
- Grasswick, H.E. 'Individuals-in-Communities: The Search for a Feminist Model of Epistemic Subjects', *Hypatia*, 19, 3, Summer 2004.
- Grove, N.J., & Zwi, A.B., 'Our Health and Theirs: Forced Migration, Othering, and Public Health', *Social Science & Medicine*, 62, 8, April 2006, (accessed using Elsevier).
- Grundlingh, L., 'The Nature and Development of HIV/AIDS Historiography', *Acta Academica*, 29, 2, August 1997.
- 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.
- Grundlingh, L., 'Government Response to HIV/AIDS in South Africa as Reported in the Media, 1983-1994', *South African Historical Journal*, 45, 1, November 2001.
- Grundlingh, L., 'Challenges and Obstacles in Early HIV and AIDS Education in South Africa, 1989-1994', *Historia*, 54, 1, May 2009.
- Haas, P.M., 'Introduction: Epistemic Communities and International Policy Coordination', *International Organization*, 46, 1, Winter 1992.
- Hassim, S., 'Nationalism, Feminism and Autonomy: The ANC in Exile and the Question of Women', *Journal of Southern African Studies*, 30, 3, September 2004.
- Heald, S. 'The Power of Sex: Some Reflections on the Caldwell's "African Sexuality" Thesis', *Africa*, 65, 4, 1995.
- Heald, S., 'It's Never as Easy as ABC: Understandings of AIDS in Botswana', *African Journal of AIDS Research*, 1, 1, 2002.
- Hermann, A., 'Child Health Under Apartheid' in Wright M., Stein, Z., & Scandlyn, J, (eds.) *Women's Health and Apartheid: The Health of Women and Children and the Future of Progressive Primary Health Care in Southern Africa : Proceedings of the Third Workshop of the Project on Poverty, Health, and the State in Southern Africa* (New York, Columbia University, 1988).
- Heywood, M., & Cornell, M., 'Human Rights and AIDS in South Africa: From Right Margin to Left Margin', *Health and Human Rights*, 2, 4, 1998.
- Hodes, R., 'HIV/AIDS in South African Documentary Film, c. 1990 - 2000', *Journal of Southern African Studies*, 33, 1, March 2007.
- Horwitz, S., 'Migrancy and HIV/AIDS: A Historical Perspective', *South African Historical Journal*, 45, 1, November 2001.
- Hubbard, R., 'Science, Facts and Feminism' in Tuana, N. (ed), *Feminism & Science* (Bloomington, Indiana University Press, 1989).

- Hunter, M., 'Cultural Politics and Masculinities: Multiple-partners in Historical Perspectives in KwaZulu-Natal' in Reid, G., and Walker, L. (eds), *Men Behaving Differently – South African Men Since 1994* (Cape Town, Double Storey Books, 2005).
- Inhorn, M.C., & Whittle, K.L., 'Feminism Meets the "New" Epidemiologies: Toward an Appraisal of Antifeminist Biases in Epidemiological Research on Women's Health', *Social Science & Medicine*, 53, 5, September 2001.
- Jewkes, R., & Abrahams, N., 'The Epidemiology of Rape and Sexual Coercion in South Africa: An Overview', *Social Science & Medicine*, 55, 7, 2002.
- Johnson, K., 'The Politics of AIDS Policy Development and Implementation in Post-apartheid South Africa', *Africa Today*, 51, 2, Winter, 2004 (accessed using JSTOR).
- Jordon, P., 'The African National Congress: From Illegality to the Corridors of Power', *Review of African Political Economy*, 31, 100, special edition 'Two Cheers? South African Democracy's First Decade', June 2004.
- Kallings, L.O., 'Review Article: The First Postmodern Pandemic: 25 Years of HIV/AIDS', *Journal of Internal Medicine*, 263, 3, March 2008 (accessed using Academic Search Premier).
- Kaplan, R., 'The Aversion Project - Psychiatric Abuses in the South African Defence Force During the Apartheid Era', *South African Medical Journal*, 91, 3, March 2001.
- Kaplan, R. M., 'Treatment of Homosexuality during Apartheid - More Investigation is Needed into the Shameful Way Homosexuality was Treated', *British Medical Journal*, 329, 18-25 December 2004.
- Kippax, S., 'Understanding and Integrating the Structural and Biomedical Determinants of HIV Infection: A Way Forward for Prevention', *Current Opinion in HIV and AIDS*, 3, 4, July 2008.
- Klausen, S., 'For the Sake of Race: Eugenic Discourse of Feeble-mindedness and Motherhood in the South African Medical Record 1903 – 1926', *Journal of Southern African Studies*, 19, 3, 1993.
- Larson, A., 'The Social Epidemiology of Africa's AIDS Epidemic', *African Affairs*, 89, 354, 1990.
- Lawless, S., Kippax, S., & Crawford, J., 'Dirty, Diseased and Undeserving: The Positioning of HIV Positive Women', *Social Science & Medicine*, 43, 9, November 1996.
- Lodge, T., 'State of Exile: The African National Congress of South Africa, 1976-86', *Third World Quarterly*, 9, 1, January 1987.
- Lorimer, D., 'Nature, Racism and Late Victorian Science', *Canadian Journal of History*, 25, 3, 1990.
- Lubanga, N. 'Are the South African Nursing Organisations Silent Partners of Apartheid?' in Wright M., Stein, Z., & Scandlyn, J. (eds.), *Women's Health and Apartheid: The Health of Women and Children and the Future of Progressive Primary Health Care in Southern Africa : Proceedings of the Third Workshop of the Project on Poverty, Health, and the State in Southern Africa* (New York, Columbia University, 1988).
- Lurie, M., 'Migration and AIDS in Southern Africa: A Review', *South African Journal of Science*, 96, 6, June 2000 (accessed using SA ePublications).

- Lyons, T., & Israel, M., 'Women, Resistance and the Armed Struggle in Southern Africa', *African Studies Association of Australasia and the Pacific: Review and Newsletter*, 21, 1999.
- Malowany, M., 'Unfinished Agendas: Writing the History of Medicine of Sub-Saharan Africa', *African Affairs*, 99, 2000.
- Marks, S., 'Women's Health in South Africa' in Wright M., Stein, Z., & Scandlyn, J. (eds), *Women's Health and Apartheid: The Health of Women and Children and the Future of Progressive Primary Health Care in Southern Africa : Proceedings of the Third Workshop of the Project on Poverty, Health, and the State in Southern Africa* (New York, Columbia University, 1988).
- Marks, S., 'The Burdens of the Past' in Ndinga-Muvumba, A., & Pharoah, R. (eds), *HIV/AIDS and Society in South Africa* (Scottsville, University of KwaZulu-Natal Press, 2008).
- Marks, S., 'Review: Science, Social Science and Pseudo-Science in the HIV/AIDS Debate in Southern Africa', *Journal of Southern African Studies*, 33, 4, December 2007.
- Marks, S., 'An Epidemic Waiting to Happen? The Spread of HIV/AIDS in South Africa in Social and Historical Perspective', *African Studies*, 61, 1, 2002.
- Marks, S., 'South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics', *American Journal of Public Health*, 87, 3, March 1997.
- Marks, S., 'What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health?', *Social History of Medicine*, 10, 2, 1997.
- Marks, S. & Andersson, N., 'Disease of Apartheid' in Lonsdale, J. (ed), *South Africa in Question* (Cambridge, Cambridge University Press, 1988).
- Marks, S., & Andersson, N., 'Typhus and Social Control in South Africa, 1917-1950' in MacLeod, R., & Lewis, M. (eds), *Disease, Medicine and Empire: Perspectives of Western Medicine and the Experience of European Expansion* (London, Routledge, 1988).
- Marks, S., & Andersson, N., 'Women and Health in South Africa', *Canadian Women Studies*, 7, 1, 1986.
- Marks, S., & Andersson, N. 'Issues in the Political Economy of Health in Southern Africa', *Journal of Southern African Studies*, 13, 2, 1987.
- Marks, S., & Andersson, N., 'Apartheid and Health in the 1980s', *Social Science & Medicine*, 27, 7, 1988.
- Marks, S., & Andersson, N., 'The State, Class, and the Allocation of Health Resources in Southern Africa', *Social Science & Medicine*, 28, 5, 1989.
- Marshall, W.E., 'AIDS, Race and the Limits of Science', *Social Science & Medicine*, 60, 11, June 2005.
- Mbali, M., 'Gay AIDS Activism in South Africa Prior to 1994', in Reddy, V., Sandfort, T., and Rispel, L. (eds), *From Social Silence to Social Science – Same-Sex Sexuality, HIV & AIDS and Gender in South Africa* (Cape Town, HSRC Press, 2009).
- Mbali, M., 'HIV/AIDS Policy-Making in Post-Apartheid South Africa', in Daniel, J., Habib, A., & Southall, R. (eds), *The State of the Nation: South Africa 2003 – 2004* (Cape Town, HSRC Press, 2003).

- Mbali, M., 'The Treatment Action Campaign and the history of rights-based, patient-driven HIV/AIDS activism in South Africa' in Jones, P., & Stokke, K. (eds), *Democratising Development: The Politics of Socio-economic Rights in South Africa* (Leiden, Martinus Nijhoff, 2005).
- McCulloch, J., 'Counting the Cost: Gold Mining and Occupational Disease in Contemporary South Africa', *African Affairs*, 108, 431, April 2009.
- McCulloch, J., 'Asbestos, Lies and the State: Occupational Disease and South African Science', *African Studies*, 64, 2, 2005.
- Meintjes, S., 'The Women's Struggle for Equality During South Africa's Transition to Democracy', *Transformation*, 30, 1996.
- Mohamed, J. 'Epidemics and Public Health in Early Colonial Somaliland', *Social Science & Medicine*, 48, 4, February 1999.
- Morrell, R., 'Of Boys and Men: Masculinity and Gender in Southern African Studies', *Journal of Southern African Studies*, 24, 4, December 1998.
- Morrow, S., 'Dakawa Development Centre: An African National Congress Settlement in Tanzania, 1982-1992', *African Affairs*, 97, 389, October, 1998.
- Mtika, M.M., 'Political Economy, Labor Migration, and the AIDS Epidemic in Rural Malawi', *Social Science & Medicine*, 64, 12, June 2007 (accessed using Science Direct).
- Nattrass, N., 'The Crisis in South African Gold Mining', *World Development*, 23, 5, 1995.
- Ona Pela, A., & Platt, J.J., 'AIDS in Africa: Emerging Trends', *Social Science & Medicine*, 28, 1, 1989.
- Packard, R., 'The Healthy Reserve and the "Dressed Native": Discourses on Black Health and the Language of Legitimation in South Africa', *American Ethnologist*, 16, 4, November 1989.
- Packard, R., 'The Invention of the Tropical Worker: Medicine Research and the Quest for Central African Labour on the South African Gold Mines, 1903-36', *Journal of African History*, 34, 2, 1993.
- Packard, R., & Epstein, P., 'Epidemiologists, Social Scientists, and the Structure of Medical Research on AIDS in Africa', *Social Science & Medicine*, 33, 7, 1991.
- Packard, R., 'Tuberculosis and the Development of Industrial Health Policy on the Witwatersrand, 1902-1932', *Journal of Southern African Studies*, 13, 2, 1987.
- Packard, R.M., & Epstein, P., 'Medical Research on AIDS in Africa: A Historical Perspective' in Fee, E., & Fox, D.M. (eds), *AIDS: The Making of a Chronic Disease* (Berkeley, University of California Press, 1992).
- Padian, N.S., 'Editorial review: Prostitute Women and AIDS: Epidemiology', *AIDS*, 2, 6, December 1988 (abstract only accessed via RU Library link).
- Paneth, N., & Susser, M., 'A Conversation with Mervyn Susser', *Epidemiology*, 14, 6, November 2003 (accessed using JSTOR).
- Parnell, S., 'Creating Racial Privilege: The Origins of South African Public Health and Town Planning Legislation', *Journal of Southern African Studies*, 19, 3, 1993.

- Pegge, J.V., 'Living with Loss in the Best Way We Know How: AIDS and Gay Men in Cape Town' in Gevisser, M., and Cameron, E. (eds), *Defiant Desire: Gay and Lesbian Lives in South Africa* (New York and London, Routledge, 1995).
- Phatlane, S., 'Poverty and HIV/AIDS in Apartheid South Africa', *Social Identities*, 9, 1, March 2003.
- Pheterson, G., 'The Category "Prostitute" in Scientific Inquiry', *Journal of Sex Research*, 27, 3, August 1990.
- Phillips, H., 'AIDS in South Africa: An Historical Perspective', *Society*, 40, 4, May/June 2003.
- Phillips, H., 'AIDS in the Context of South Africa's Epidemic History: Preliminary Historical Thoughts', *South African Historical Journal*, 45, 1, November 2001.
- Phillips, H., 'HIV/AIDS in the Context of South Africa's Epidemic History' in Kauffman, K.D., & Lindauer, D.L. (eds), *AIDS and South Africa: The Social Expression of a Pandemic* (New York, Palgrave Macmillan, 2004).
- Pillow, W.S., 'Confession, Catharsis, or Cure? Rethinking the Uses of Reflexivity as Methodological Power in Qualitative research', *Qualitative Studies in Education*, 16, 2, 2003.
- Posel, D., 'What's in a Name? Racial Categorisations under Apartheid and their Afterlife', *Transformation*, 47, 2001.
- Posel, D., 'Sex, Death and the Fate of the Nation: Reflections on the Politicization of Sexuality in Post-Apartheid South Africa', *Africa*, 75, 2, 2005.
- Posel, D., 'Democracy in a Time of Aids', *Interventions*, 7, 3, November 2005.
- Preston-Whyte, E., 'Framing the South African Epidemic: A Social Science Perspective' in Padayachee, V. (ed), *The Development Decade? Economic and Social Change in South Africa 1994-2004* (Cape Town, HSRC Press, 2006).
- Price, M., 'Health Care as an Instrument of Apartheid Policy in South Africa', *Health Policy and Planning*, 1, 2, 1986.
- Prins, G., 'But what Was the Disease? The Present State of Health and Healing in African Studies', *Past and Present*, 124, August 1989.
- Rayner, M., 'From Biko to Wendy Orr: The Problem of Medical Accountability in Contexts of Political Violence and Torture', in Manganyi, N.C., & du Toit, A. (eds), *Political Violence and the Struggle in South Africa* (London, Macmillan, 1990).
- Robins, S., 'Sexual Politics and the Zuma Rape Trial', *Journal of Southern African Studies*, 34, 2, June 2008.
- Rosenberg, C. E., 'Disease and Social Order in America: Perceptions and Expectations' in Fee, E., & Fox, D.M. (eds), *AIDS: The Burdens of History* (Berkeley, University of California Press, 1988).
- Rosenberg, C.E., 'What Is an Epidemic? AIDS in Historical Perspective', *Daedalus*, 118, 2, Living with AIDS, Spring, 1989.
- Rosenberg, M.J., & Weiner, J.M., 'Prostitutes and AIDS: A Health Department Priority?', *American Journal of Public Health*, 78, 4, April 1988 (accessed using EBSCOhost).

- Sacks, V., 'Women and AIDS: An Analysis of Media Misrepresentations' *Social Science & Medicine*, 42, 1, January 1996.
- Sadie, Y., & Van Aardt, M., 'VIGS-Politiek in Suid-Afrika: 1987 – 1992', *Politikon*, 19, 3, December 1992.
- Saunders, C., 'Four Decades of South African Academic Historical Writing: A Personal Perspective' in Stolten, H.E. (ed), *History and Present Day Politics – The Meaning of Collective Memory in South Africa* (Uppsala, Nordiska Afrikainstitutet, 2007).
- Schneider, H., 'On the Fault-line: the Politics of AIDS Policy in Contemporary South Africa', *African Studies*, 61, 1, 2002.
- Schneider, H., & Stein, J., 'Implementing AIDS Policy in Post-apartheid South Africa', *Social Science & Medicine*, 52, 5, March 2001.
- Schneider, H., & Fassin, D., 'Denial and Defiance: A Socio-political Analysis of AIDS in South Africa', *AIDS*, 16, supp.4, 2002, available at AIDS Journal website at: http://journals.lww.com/aidsonline/Fulltext/2002/16004/Denial_and_defiance_a_socio_political_analysis_of.7.aspx (accessed February 2011).
- Seidman, S., 'Transfiguring Sexual Identity: AIDS & the Contemporary Construction of Homosexuality', *Social Text*, 19/20, Autumn, 1988.
- Shisana, O., & Zungu-Dirwayi, N., 'Government's Changing Responses to HIV/AIDS' in Everatt, D., & Maphai, V. (eds), *The Real State of the Nation: South Africa after 1990* (Interfund, *Development Update*, 4, 3, November 2003).
- Sifris, D., 'Tribute - Remembering Ruben Sher', *Southern African Journal of HIV Medicine*, 8, 3, 2007 available on the journal's website at www.sajhivmed.org.za/index.php/sajhivmed/issue/view/5 (accessed December 2011).
- Sitas, A., 'The Making of the "Comrades" Movement in Natal, 1985-1991', *Journal of Southern African Studies*, 18, 3, September, 1992.
- Stapleton, T.J & Maamoe, M., 'An Overview of the African National Congress Archives at the University of Fort Hare', *History in Africa*, 25, 1998.
- Stearns, P., 'The Forgotten Compass of Death: Apocalypse Then and Now in the Social History of South Africa', *Journal of Social History*, 37, 1, Autumn, 2003.
- Stein, J., 'HIV/AIDS Stigma: The Latest Dirty Secret', *African Journal of AIDS Research*, 2, 2, 2003.
- Stevenson, Jr., H.C., 'The Psychology of Sexual Racism and AIDS: An Ongoing Saga of Distrust and the "Sexual Other"', *Journal of Black Studies*, 25, 1, September, 1994.
- Stoler, A., 'Making Empire Respectable: The Politics of Race and Sexual Morality in 20th Century Colonial Cultures', *American Ethnologist*, 16, 4, 1989.
- Stolten, H.E., 'History in the New South Africa: An Introduction' in Stolten, H.E. (ed), *History and Present Day Politics – The Meaning of Collective Memory in South Africa* (Uppsala, Nordiska Afrikainstitutet, 2007).
- Susser, M., & Cherry, V.P., 'Health and Health Care Under Apartheid', *Journal of Public Health Policy*, 3, 4, December, 1982.

- Susser, M., 'Apartheid and the Causes of Death: Disentangling Ideology and Laws from Class and Race', *American Journal of Public Health*, 73, 5, May 1983 (accessed using JSTOR).
- Suttner, R., 'Culture(s) of the African National Congress of South Africa: Imprint of Exile Experiences', *Journal of Contemporary African Studies*, 21, 2, May 2003.
- Suttner, R., 'Women in the ANC-led Underground' in Gasa, N. (ed), *Women in South African History* (Cape Town, HSRC Press, 2007).
- Suttner, R., 'Masculinities in the African National Congress-led Liberation movement', *Kleio*, 37, 1, 2005.
- Swanson, M., 'The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1909', *Journal of African History*, 18, 3, 1977.
- Taitz, J. L., 'The Right to Health: Medical Treatment and Medical Law in South Africa', *South African Human Rights Yearbook*, 2, 1992 (accessed using HeinOnline).
- Tallis, V., 'Lesbians and AIDS', *Agenda*, 15, 1992.
- Treichler, P.A., 'AIDS and HIV Infection in the Third World: A First World Chronicle', in Fee, E., & Fox, D.M. (eds), *AIDS: The Making of a Chronic Disease* (Berkeley, University of California Press, 1992).
- Treichler, P., 'AIDS, Homophobia and Biomedical Discourse: An Epidemic of Signification', *October*, 43, Winter 1987.
- Tsampiras, C., 'Not So "Gay" After All: Constructing (Homo)sexuality in AIDS Research in the South African Medical Journal, 1980 - 1990', *South African Historical Journal*, 60, 3, September 2008.
- Tsampiras, C., 'Sex in a Time of Exile: An Examination of Sexual Health, AIDS, Gender and the ANC, 1980 – 1990', *South African Historical Journal*, 64, 3, 2012.
- Unterhalter, E., 'The Work of the Nation: Heroic Masculinity in South African Autobiographical Writing of the Anti-Apartheid Struggle', *The European Journal of Development Research*, 12, 2, 2000.
- Van der Vliet, V., 'AIDS: Losing "The New Struggle"', *Daedalus*, 130, 1, Winter 2002 (accessed using JSTOR).
- Van der Vliet, V., 'Apartheid and the Politics of AIDS' in Feldman, D.A. (ed), *Global AIDS Policy* (Connecticut, Bergin & Garvey, 1994).
- Van Heyningen, E., 'Review: Recent Research on the Social History of Medicine in Africa', *South African Historical Journal*, 45, 1, November 2001.
- Van Heyningen, E., 'Agents of Empire: The Medical Profession in the Cape Colony, 1880-1910', *Medical History*, 33, 4, 1989.
- Van Heyningen, E., 'The Social Evil in the Cape Colony 1868-1902', *Journal of Southern African Studies*, 10, 2, 1984.
- Van Niekerk, R., 'The Evolution of Health and Welfare Policies in South Africa: Inherited Institutions, Fiscal Restraint, and the Deracialization of Social Policy in the Post-Apartheid Era', *Journal of African American History*, 88, 4, Autumn, 2003.
- Van Rensburg, H.J.C., & Benatar, S.R., 'The Legacy of Apartheid Health and Health Care', *South African Journal of Sociology*, 24, 4, 1993.

- Vaughan, M., 'Health and Hegemony: Representations of Disease and the Creation of the Colonial Subject in Nyasaland' in Marks, S., & Engels, D. (eds), *Contesting Colonial Hegemony: State and Society in Africa and India* (London, British Academic Press, 1993).
- Visser, W., 'The Production of Literature on the "Red Peril" and "Total Onslaught" in Twentieth-Century South Africa', *Historia*, 49, 2, November 2004.
- Whiteside, A., De Waal, A., & Gebre-Tensae, T., 'AIDS, Security and the Military in Africa: A Sober Appraisal', *African Affairs*, 105, 419, 2006.
- Wilcox, A.J., & Stein, Z., 'A Conversation with Zena Stein', *Epidemiology*, 14, 4, July 2003 (accessed using JSTOR).
- Wilson, F., 'Minerals and Migrants: How the Mining Industry Has Shaped South Africa', *Daedalus*, 130, 1, Winter, 2001 (accessed using JSTOR).
- Youde, J., 'The Development of a Counter-Epistemic Community: AIDS, South Africa, and International Regimes', *International Relations*, 19, 4, December 2005, (accessed using JSTOR).
- Zwi, A., & Bachmayer, D., 'HIV and AIDS in South Africa: What is an Appropriate Public Health Response?', *Health Policy and Planning*, 5, 4, 1990.
- Zwi, A., Marks, S., & Andersson, N., 'Health, Apartheid and the Frontline States', *Social Science & Medicine*, 27, 7, 1988.

Unpublished Sources

- Barrell, H., 'Conscripts to their Age: African National Congress Operational Strategy, 1976-1986', (unpublished D.Phil thesis, St Antony's College, University of Oxford, 1993) available from SA History Online at: http://www.sahistory.org.za/pages/library-resources/thesis/barrel_thesis/index.htm (Accessed May 2010).
- Connelly, M., 'Rumours of War: De-constructing Media Discourses of HIV/AIDS in South Africa', MA Thesis, Rhodes University, 2002.
- Fletcher, H., 'Conflict, Contradiction and Crisis: An Analysis of the Politics of AIDS Policy in Post-Apartheid South Africa', MA Thesis, Rhodes University, 2008.
- Grundlingh, L., 'Neither Health Nor Education? An Historical Analysis of HIV/AIDS Education in South Africa, 1980s - 1990s', unpublished paper presented to RAU (now UJ) Sociology Seminar, 24 May 2002.
- Hodes, R., '*Siyayinqoba/Beat It!*: HIV/AIDS on South African Television c.1999-2006', PhD Thesis, University of Oxford, 2009.
- Li, X., 'Disjunctures within Conventional Knowledge of Black Male Homosexual Identity in Contemporary South Africa', MA Thesis, Rhodes University, 2009.
- Mbali, M., 'The New Struggle': A History of AIDS Activism in South Africa, 1982 – 2003', PhD Thesis, University of Oxford, 2009.
- Ruiters, M., 'Elite (Re-) Constructions of Coloured Identities in a Post-Apartheid South Africa: Assimilations and Bounded Transgressions', PhD Thesis, Rutgers University, 2006.

Shell, R. 'The Silent Revolution: the AIDS Pandemic and the Military in South Africa', paper presented at the Consolidating Democracy in South Africa conference, Umtata, South Africa, 18 - 20 August 1999, full copy available at the *Konrad Adenauer Stiftung* website at <http://www.kas.de/suedafrika/en/publications/5111> (accessed December 2010).

Shell, R.C.H., 'Trojan horses: HIV/AIDS and the military in Southern Africa, an epidemiological analysis with reference to Grahamstown and Port Elizabeth in the Eastern Cape, Conference paper presented in East London, July 1999.