Western science today is slowly consolidating around a particular construction of 'African AIDS', which elaborates on the colonialist mystifications of the past century. Debates about the conduct of vaccine trials in Africa constitute an especially dangerous form of neo-colonial ideology which masquerades as benevolent medical science and culturally sensitive medical ethics. The illusion of an Africa little changed since The Heart of Darkness pre-empts participation in debates on AIDS by African ethicists and philosophers, and makes it extremely difficult to sort out the legitimate voices in a discourse which occurs in a kind of middle ground between two cultures, a middle ground in which virtually the only audible speech is that which occurs within, or is translated into, the conceptual categories of the modern western episteme.

In this article, I want to investigate how western representations of the national and sexual cultures of post-colonial Africa direct the international AIDS research and policy agenda. Working from conference presentations and media reports on AIDS in Africa, I will link some of the apparently silly or innocuous assumptions made about Africans with the agenda of western science. In particular, I shall investigate how western inventions of Africa as poverty-stricken and as heterosexual set medical science on a genocidal course which masquerades as western altruism toward the client-state 'Other'.

A note on the terms employed here: in western discourse Africa, a continent of roughly 11.5 million square miles, is treated as a homogenous socio-political block. Yet this supposedly 'unknown' continent - unknown, that is, to its pale neighbours to the north - is, in fact, vastly more culturally, linguistically, religiously, and socially diverse than North America or Europe. Much political and social violence is accomplished by collapsing the many cultures of the African continent in the invention, 'Africa'. In order to problematize this western construction, 'Africa', I will employ the equivalent constructions 'North America' and 'Euro-America' to indicate the collection of relatively homogeneous northern administrative states as we appear to our southern neighbours. North Americans should take note of their discomfort at having their cultural space discursively reduced in this way.

The following are compressed versions of statements widely and frequently offered at scientific conferences on AIDS, and implicit or rendered almost verbatim in both the popular press and scientific literature on AIDS in Africa. I have chosen these particular statements as my 'texts' because they are
commonly used as if they ’go without saying’, requiring none of the usual kinds of justification (e.g. supporting data, argumentation) and receiving little challenge. ’Text One’ hinges on an implicit comparison with an unstated norm: the norm is taken to be us, but a closer examination suggests that two norms must be in force, since there appears to be little real difference between MS and them within the parameters suggested. ’Text Two’ argues on the basis of a plausible description, but uses that description to argue that ‘AIDS’ is a thing-in-itself whose detection can serve as a test of scientific advancement. ’Text Three’ exemplifies the mystification which lies at the heart of both classic Marxist and classic liberal economics: the confusion of biology (here, a viral infection) with historical specificities (here, colonialist underdevelopment) in an attempt to describe not only a material but, more importantly, a cultural difference between pre- and post-industrial societies.

INSKRIBING DIFFERENCE

Text One: ’Africans won’t use condoms.’ As if North American heterosexuals have taken up condom use in any significant numbers.

Text Two: ’Africa has such poor medical care that they can’t properly diagnose AIDS.’ Not only does this insult the many fine researchers and clinicians working in urban teaching hospitals as well as town clinics throughout Africa, but the claim of poor diagnosis is used as a rationale for inflating statistics on the incidence of AIDS in Africa. This issue is extremely complex, blurring the line between science and long-held cultural beliefs about race. The epidemiology of Human Immunodeficiency Virus (HIV) in Africa relies on tests and clinical definitions developed in the west, which assume a northern hemispheric distribution of pathogens (i.e. which assume that common cold and flu viruses are endemic, ordinary, and ’clean’ pathogens, but polio or malaria are exotic and ’filthy’). The epidemiology produced in the first five years of the epidemic was thus doubly flawed: clinical AIDS was haphazardly diagnosed because diagnosis relies on the identification of a ’difference’, yet the diagnostic ’differences’ of AIDS were based on the disease patterns in the north. The vaguer symptoms of AIDS (night sweats, weight loss, malaise, even thrush, diarrhoea, respiratory problems) are characteristic of any number of ailments common in equatorial areas (and in western inner cities, one might add). It isn’t so much that the medical facilities in Africa are flawed - although, much like western clinics for the uninsured, they can barely meet the general needs of the populations in their seriously underfunded systems - but that the definition of AIDS, especially the definition used before confirmatory tests were developed and refined two years ago, is problematic. Further, the HIV antibody test used in the early epidemiology cross-reacts consistently with the antibodies to malarial Plasmodium, which is common in equatorial Africa, resulting in huge numbers of false positive results. To make matters worse, there has been little medical investment in Africa (with notable exceptions where former colonial powers had an interest in solving problems in tropical medicine that were in the service of western needs) and certainly little basic research. Blood samples stored in Kinshasa, for example, which have
become the anchor for claims that AIDS began in Africa, have no patient history attached to them - this might as easily be the blood of Europeans, or of their sexual or injecting drug partners.\textsuperscript{3}

Text Three: ‘In Africa, AIDS is a disease of poverty.’ As if a lack of western-style industrialization, rather than a virus, were the cause of AIDS in Africa. Since evolutionism reared its ugly head in debates on AIDS, there has been persistent confusion between economic-evolutionist and biologic-evolutionist argumentation; yet both are united in their mapping of racial difference. Take, for example, the contribution of genetics to recent discussions of the racial parameters of the AIDS epidemic. There has always been ambivalence among geneticists about the significance of the genetic variation which produces pigmentation difference. Less than a century ago, mere colour was considered exactly correlated with moral and mental capacity; genetic logic is no less racist in its newer versions. Far from becoming more 'scientific' as technology improves the ability of geneticists to make fine distinctions, genetic logic continues reflexively to explain pre-existing cultural beliefs and thereby justify their administrative effects. The latest contribution of genetic logic to AIDS science is, typically enough, by psychologists, not geneticists: a symptom of the historical problem of genetics is its easy co-option by social scientists in need of biological back-up for arguments that would not otherwise hold water in the indigenous logic of their own discipline.

J. Philippe Rushton and Anthony F. Bogaert’s article in a 1989 issue of \textit{Social Science Medicine} applies sociobiology (the most prominent contemporary form of genetic logic) to argue that race per se, as a marker of genetically determined intelligence level, degree of sexual control, and social organization ought to be considered a risk factor in the transmission of HIV. Having 'established' the genetically linked lower intelligence of 'negroids' and accepted as agreed that 'within the constraints allowed by the total spectrum of cultural alternatives, people create norms and environments maximally compatible with their genotypes',\textsuperscript{4} Rushton and Bogaert argue that

Lowered levels of intelligence must also be considered a risk factor. Observation of contingent danger may be less, both in terms of acquiring the disease, and in transmitting it to others. There are many problems in Africa in educating people to avoid intercourse with prostitutes, or other at-risk behaviors such as scarification, tattooing, ear piercing, male or female circumcision, blood-brotherhood ceremonies, etc. In the U.S. it is becoming clear that drug addicts who actively seek out heroin with street 'brand names' such as 'death wish' and 'suicide' are not likely to readily modify their at-risk behavior. It is conservatively estimated that there are 100,000 addicts in New York alone who carry the AIDS virus, and in some samples, seroprevalence among Afro-Americans has soared to African proportions.\textsuperscript{5}

The problems begin with Rushton and Bogaert’s obvious unfamiliarity with even the most basic AIDS terminology - there is no such thing as an 'AIDS virus'; rather, the Human Immunodeficiency Virus (HIV) is the agent believed, in the context of an unclarified sequence of events, to result
sometimes in immune suppression, and sometimes, after seven years or more, in AIDS. One cannot, therefore, either 'acquire' AIDS or 'transmit' it. Further, their reference to 'African proportions' suggests that seroprevalence in Africa is higher than in the USA; this relies on a thoroughly misleading comparison between high incidence cities in Africa and the USA as a whole. (Sero-prevalence worldwide is a general function of the time of introduction of HIV to an area, the time of instigation of education, and, to a lesser extent, I would argue, variations in patterns of sexual practice, blood-screening, and needle-sharing.) Finally, Rushton and Bogaert rely on disputable claims about 'intelligence' and 'sexual promiscuity' and ignore the success of risk reduction programmes in dozens of African countries, not to mention the success of both drug-related and safe sex programmes in African-American communities in the USA.

Linking disease and poverty in a simple fashion leaves the way open to the unconscious reflex of westerners to situate poverty as well as disease in the context of racial/ethnic difference rather than in larger world-wide patterns of colonialism, capitalist statism, and a global economy increasingly in the control of supranational corporations. Fundamental 'difference' between Africa (and Africa's children among the urban poor) and Euro-Americans is maintained in a complex set of constructions: the race (black)/class (lower) construction of Africa is paired with a race (white)/sexuality (perversion) construction that identifies AIDS in North America and Europe as a disease of sexuality, unmediated by the effects of class and gender status on health care, information, and access to services.

The insidious, unifying theme reiterated in texts one to three is that disease and the interruption of disease in Africa are of a different type altogether from disease in North America and Europe, and that science, a logical system requiring western 'intelligence', can never be conducted by Africans. Disease in Africa is considered natural, conjured out of the primordial nought or caught from animals imagined to live side by side with Africans. In fact, the average laboratory technician in the USA lives in closer proximity with suspect "AIDS monkeys" than does anyone in an African town. The genocidal western fantasy of the essential economic/genetic and moral unviability of Africa combined with the idea of disease as natural selection enables the former colonial administrators to forget their complicity in the underdevelopment and exploitation that created the particular patterns of poverty that mark Africa today. The disease-as-nature trope parallels an evolutionary view of geopolitics: while conflict between the nuclear super-nations is depicted as grave, but rational and negotiable, civil and intranational conflicts in Africa are portrayed as frivolous, hopeless dramas of uncivilized tribal dispute. Western countries are said to be threatened by environmental pollution and nuclear war, problems created by and purportedly solvable through science and rationality. Africa is described by contrast as subject to acts of nature such as tropical disease and famine. In western eyes, Africa's problems can only be solved through civilizing forces - or, in the romantic version, through a withdrawal from civilization and a return to pristine 'tribal ways'.

NEW FORMATIONS
When the west found itself beset by a deadly little virus of unknown origin, it sought the source elsewhere; nothing of this sort, it was argued, could have arisen in the germ-free west. So the best research minds of the western world set off on a fantastic voyage in search of the source of AIDS. They went to Haiti and Zaire, because the first non-Euro-American cases were diagnosed in people from these countries; the fact that the particular individuals involved had lived for a long time in the USA and Belgium respectively was ignored. It never seemed to cross these researchers’ minds that the diagnosed individuals were more likely to have contracted HIV while living in Europe and the USA, where HIV infection was already well established.

The data collected by western researchers on seroprevalence in selected Central and East African countries proved equivocal; it turned out that the HIV antibody test developed in the USA could not distinguish between antibodies to HIV and antibodies to malaria, which is endemic in rural, equatorial Africa. Nevertheless, western media reports on data published in 1985 claimed universally that AIDS was devastating Africa. The image of wasting 'African AIDS bodies' fitted neatly into the pre-existing western image of a wasting continent peopled by victim-bodies of illness, poverty, famine. African nations have experienced uneven economic development in their post-colonial or post-revolutionary periods; however, the US mainstream media do not present successful developments, but instead portray Africa as a romantic tragedy in which poverty is so total, so basic, that there is nothing to be done to save the continent. Proposals to run HIV vaccine trials in Africa - trials which would never pass ethical muster in the west - are justified by invoking precisely this image of a dark continent perpetually on the brink of natural disaster. The typical western images of Africa present African lives as cheap; thus there is seen to be a numerical surplus of African research subjects (objects). In this curious calculus, the risk/benefit ratio which medical ethicists require should be demonstrated by researchers is one in which the risk to members of this vast, undifferentiated mass of people is falsely presented as minimal, and is further legitimated by pointing to the great benefits of vaccine trials to the unique, individuated peoples of the western world. Thus, western researchers argue that African trials are not only economically but also morally efficient. The reality, however, is that Africans won’t benefit from most medical advances, since on the one hand there is no profit in the African market for western drug companies, and on the other hand, at least under current HIV medicine practice, drugs are calibrated for diagnostic and treatment conditions in the north. African research subjects are thus constructed simultaneously as noble savages, helping science improve the lot of humanity, and as a sort of post-modern Agar plate, a halfway house between the animals conventionally used in drugs testing, and humans. Far from representing an advance in biomedical ethics, and despite its claim to cultural sensitivity, indeed to be rescuing Africa, scientific AIDS research relies today on marking some people as less than human and silencing them through a cacophony of soul-searching discourse.
CULTURALLY SENSITIVE ETHICS?

The Vth International AIDS Conference in Montreal\(^7\) saw the first public debate about the ethics of conducting vaccine trials on African citizens. During a major panel on ethics and AIDS human subject research, Nicholas A. Christakis, a new graduate of Harvard's joint MD-M.P.H. programme took great pains to define the problems of cross-cultural research programmes, especially in cultures like 'Africa' where concepts of 'personhood' and the relationship between the individual and society are different from those proposed by western, post-Nazi biomedical ethics. He argued, correctly, that 'where the notion of persons as individuals is not dominant, the consent process may shift from the individual to the family or to the community'.\(^8\) He notes, in line with past experience in treatment trials in Africa, that obtaining informed consent in this context may often involve working with community leaders, whose own interests in co-operating with researchers might be complex.\(^9\) But it is a mystification to situate these problems solely in supposedly fixed cultural differences between Africa and the west; for this ignores the reality that Africa has for centuries been negotiating the logic of western ethics; thus, for example, almost half of all Africans (that is to say, about 200 million people) profess some version of Christianity.\(^10\) Further, to mystify differences in social ethics by setting them on the slippery slope of evolutionism (however unconsciously that slippage may occur in western ethical discourse) short-circuits the obvious need to consult not only local political leaders, but the actual peers of western ethicists - African professors and theorists of African social ethics and theology, who can be easily located in their offices at the many major universities in the African states.

The romantic ideal of cultural sensitivity embraced by such as Christakis has to be seen, then, as the product of a specifically western discourse, which at its very best can only deal with local custom by interpolating it into a social ethics which can then be translated into the 'proper' western categories of informed consent, risk/benefit, etc. Anthropologists have long known what western medical ethicists have yet to realize, namely that one discourse may be offered to westerners (to defend, deflect, appease) while a quite different set of concerns may be articulated within the African nation/locality/culture. This should, however, hardly be new or startling. Neither the dual discourse competency of the dominated nor the local variations in social ethics and their relation to local systems of political power in Africa are any different in concept from the situation in the west, where, as feminist and African American theorists and activists have long argued, dominated communities are called upon to possess equal competence in the language of the white, patriarchal hegemony and in their own cultural vernaculars. (So, for instance, western ethics require that individuals from the 'community' sit on biomedical ethics review boards in the USA.) Western ethicists have recognized the power that accrues to research subjects via this dual discourse competence, and they fear that the involvement of African subjects in debates on the ethics of vaccine trials could, equally, disempower western scientists as the bearers of rationality, pitted against primitive and irrational 'others', both across the sea.
and inside our own borders. Thus there was not one single African theologian or ethicist invited to speak in Montreal about the conduct of current or future biomedical research into AIDS and HIV infection.

Though current medical ethics may constitute an advance over that of Nazi science, for example (though the USA conducted similarly if less spectacularly unethical researches on southern blacks), it is only so in situations where research subjects are perceived to be 'like us'. 'Cultural sensitivity' arguments are designed to interpolate the 'other' into 'us' long enough to allow 'us' to feel good about 'their' informed consent. The risk/benefit assessment demanded by western science in which the risk to the individual or her/his class must be less than the anticipated benefit to one or both, is said to exist in an analytically neutral space; yet it always rests on assumptions about the social value of the class in question, and on the evaluation and meaning of the cause of its exposure to the aetiologic agent. Classes deemed particularly 'prone' to an ailment such as AIDS, or to a 'risk behaviour', are seen to benefit more from a possible treatment or vaccine, but if those classes are in general terms socially devalued ('Africans'), the harm of their ailment is considered less than the harm of that ailment in more valued people ('the general population'). Scientists who conduct trials among socially devalued classes are thus seen to be taking less risk for more individual and social benefit.

The disavowal of the social and political economy of scientific research ignores the broader ethical obligations existing between nations in a world community, where, in fact, developing nations have no option but to refuse or to allow, but never to affect the theoretical framework of western science or to plead for a better place in the economic plan in which that science operates. A vaccine, and especially a vaccine for a disease easily avoided by good educational programmes, cheaply available condoms, and some additional investment in clinical sterilization techniques and universal blood-screening, may simply be too costly. An AIDS vaccine, even after the problems created by the trials are over (i.e. increased HIV transmission among the placebo group, potentially disrupted educational programmes resulting in decreased concern about safe sex among those outside the trial), only leaves Africans where they were before the epidemic. By contrast, investment in education, clinics, and health awareness has benefits that increase the general well-being of Africans - condoms mean lower sexually transmitted disease (STD) rates in general, improved clinical procedures reduce a variety of iatrogenic illnesses, and health awareness programmes create baseline knowledge and interest that other health-related programming can build on. Yet given international economic imbalances, the west believes it has more to gain by throwing its weight behind African vaccine trials - drug companies will get the profits, the future benefits of the knowledge gained (i.e. the possibility of using HIV vaccine as a model for other retroviral vaccines), and the political power that will surely accrue to those who control the administration of the vaccine for such a controversial disease.
The vaccine trials slated for Africa differ in significant ways from those slated for Britain and already under way in the USA, where in some cases noble researchers have injected themselves with trial vaccines. The trials in Britain and in the bodies of the researchers are Phase One and Phase Two trials, designed to determine whether the person taking the vaccine experiences any side-effects (Phase One) and what the exact dose and administration schedule should be (Phase Two). It is improbable that these vaccines will produce HIV-related illnesses, though there is a possibility that anyone who has been erroneously tested as free of HIV infection could become sick as a result of the response of the body to the vaccine. Because of the risk that the varying doses of vaccine administered in Phase One and Phase Two might not be effective, and indeed that they might make it impossible for subjects to respond to a future, more effective vaccine, the small numbers of subjects in these trials are chosen from the lowest risk groups in order to reduce the likelihood that they will subsequently be exposed to HIV. There is, however, great concern expressed that these noble, low-risk people might be falsely branded as 'carriers' should their blood be tested and found antibody positive as a result of the vaccine rather than as a result of infection proper. Subjects will thus be issued identification cards stating that their antibodies have come from vaccination.

The trials slated for Africa, by contrast, are Phase Three trials, designed to determine whether the vaccine actually works as a deterrent to HIV infection. In other words, under current plans the trials in Britain and the USA will determine whether the vaccine is harmful to British and American bodies. In Phase Three, African subjects will discover whether they have received enough vaccine to stay uninfected. Clearly, this scheduling of trials in Africa rests on two assumptions which reveal the complicity of science in actually making AIDS in Africa worse.

First, vaccine trials are based on the assumption that Africans will continue to be exposed to HIV in large numbers - you can’t test a vaccine’s effectiveness unless people are subsequently exposed to the agent. Barring mass inoculation with HIV of trial subjects, vaccine trials assume that ‘Africans won't use condoms’, and that risk reduction campaigns are destined to fail.

Secondly, the high risk involved in Phase Three vaccine trials is obscured by the widely promoted image that Africa and Africans are already lost to the HIV epidemic; thus we have seen the emergence of a new ethical concept of cataclysmic rights, according to which trials which don't quite pass ethical muster should be allowed as 'compassionate'. We must raise several questions here. First, existing epidemiological data certainly do not suggest that HIV is any more rampant in any African locale than in, say, San Francisco, Newark, Paris, or Amsterdam. Second, if all of Africa is dying of AIDS, as western news reports suggest, who is left to serve as trial subjects? Third, if preventive measures can be successful, as some African governments claim (and here, ethicists must explain where and why prevention works - if it works in the
Sodom of San Francisco, why not the Eden of Dar es Salaam?), then who benefits from the risks of the vaccine trials? Fourth, if some significant number of the HIV cases in African cities are attributable to poor blood-screening resulting from the low efficacy and high cost of the western-developed tests, are we funding vaccine trials instead of improved screening? Is the moderately high (and unavoidable) risk of receiving an HIV-infected blood transfusion to be another route of exposure to potential vaccine trial subjects? Finally, what provisions ensure that Africans - African societies as wholes - will actually be first to receive the vaccine, once developed? Here, the precise arguments about the problems in rural clinical practice - 'They can't properly diagnose AIDS in Africa' - come into play as alibi for not distributing the vaccine.  

The contradictory nature of the racist perceptions which construct the idea of Africa renders them all the more insidious. On the one hand, researchers who want to run Phase Three trials in Africa argue that 'AIDS' in Africa and 'AIDS' in the west are the same. On the other hand, epidemiologists argue that 'African AIDS' is something altogether different, with different modes of transmission having to do with dramatic differences in western and African sexual practices. The desire for a radical and incommensurable racial difference runs rampant here. Miscegenation fears, oddly enough, seem to lead some epidemiologists to argue in support of white homosexuality; thus one study of South African miners claimed that male-male relations in the migrant workforce were 'patron relationships' which, unlike white homosexuality, did not involve 'anal intercourse'. What is at play here is not only the desire that black and white blood should not mix in the issue of heterosexual union, but also that black and white homosexuality be different and not a possible source of sexual congress across racial divides. At the Global Impact of AIDS Conference in 1988, Alan Whiteside, an economist studying the HIV policies of the South African Ministry of Mining described the country's demographics in terms of 'white homosexuals' and 'foreigners and heterosexuals who are black'. 'Ironically,' he said, 'political isolation and apartheid may have slowed the spread of AIDS.' Although sympathetic towards miners and active in preventing discriminatory laws requiring the repatriation of seropositive miners, Whiteside argued that miners only bring HIV infections from home and do not acquire them in (black) South Africa.

The irony, of course, is that black miners may well acquire HIV in their male-only mining camps; and black 'nationals' who are gay are certainly also potentially at risk.  

But 'homosexuality' is only illegal under laws governing white conduct. Thus, white male-male relations are unlawful and black male-male relations invisible in the eyes of the South African government. In response to that situation, two entirely different television campaigns - not so different in strategy from campaigns in the USA, though the 'white' campaign was more overtly aimed at 'homosexuals' - have been produced in South Africa: the white campaign aims to reduce homosexual practice, while the black campaign promotes monogamy and the closing of family ranks against outsiders, the covert suggestion being that apartheid and monogamy might protect blacks from AIDS.

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The efforts of westerners meanwhile are focused on explaining the reasons for the apparent dominance of heterosexual transmission in the sub-Saharan continent overall, versus the apparent homosexual and injection drug transmission in northern Europe and North America (southern Europe claims transmission patterns more like those in Africa). The attribution of transmission routes, of course, depends on self-reports of homosexual behaviour, a social construction which varies, not surprisingly, according to these very same geographical clusters. Ironically, the concern of western researchers about possible heterosexual transmission in US citizens came from looking at early African data at a time when the available US data were particularly skimpy. The possibility of heterosexual transmission in the USA was dismissed at this point in 1984 because, scientists alleged, anal intercourse was the sole route of sexual spread, and, unlike African heterosexuals, Euro-American heterosexuals were not believed to engage in this 'primitive form of birth control'. No data were ever offered in support of this belief and no one mentioned that anal sex might actually be a pleasure indulged in by heterosexuals world-wide. Thus when apparent cases of 'heterosexual transmission' began occurring in the USA, the first explanation was a combination of prostitutes and anal sex - doctors alleged that (military) men had been infected with HIV through anal sex with prostitutes. One researcher told me that men had anal sex with prostitutes because their wives 'wouldn’t do it'.

In the early years of the epidemic, then, 'black'/'heterosexual' AIDS and 'white'/'homosexual' AIDS were banished to an imaginary space, 'Africa', and linked together, not through intimations of cross-racial/cross-preferential pairings, but through a metaphorical cross-inscription of bodies. US (white) homosexuals were said to have made of their bodies something of the order of the sewerage system of a Third World country - free running waste being a prominent western image of underdevelopment. African (black) heterosexuals were homosexualized through their allegedly greater practice of anal sex - anality being a chief western symbol of homosex.

The attempt here on the part of researchers was clearly to reconcile cultural anxieties and stereotypes with certain curiosities in their own data. Their efforts were directed towards explaining how in the west, and among whites, active homosexuals passed the virus to passive homosexuals, while in Africa and among prostitutes and among people of colour in the USA, women engaging in (anal) intercourse passed the virus to heterosexual men. The collision of homophobia and racism provided the anus with a curious but pivotal gender: the female anus was thought capable of doing what the male anus was not.

HIV prevalence and sexual practice studies in the mid-1980s quickly showed, however, that rates of anal intercourse amongst heterosexuals were little different from those among homosexuals - not so much because Africans engaged in it less than expected but because Euro-American heterosexuals engaged in it more. (In general, African sex lives were disappointingly ordinary, quashing both the hopes of scientific explanations of epidemiological differences and western racists' fantasies of exotic sexual otherness.) Scientists
quietly dropped the anal sex differential argument in favour of a theory that sexually active Africans are afflicted by genital ulcers which increase the potential for transmission of the virus from women to men. That theory was put forward in an attempt to explain why in Africa male to female seroprevalence ratios ranged from 2:1 to 1:1, while in northern and central Europe and North America, the ratios were between 7:1 and 9:1. This was taken to be evidence that in Europe and North America, AIDS is a 'gay disease' while in Africa it is 'heterosexual'. This is a perplexing form of 'new maths' in the age of sophisticated computer modelling. Paradoxically, of course, the African ratio of one to one suggested that Africans were more prone to Victorian heterosexual bonding, while the ratio of 7:1 among Europeans not only suggested promiscuity, but somehow intimated that the female 'I' was always the hapless victim of homosexual forays into heterosexual intercourse. The mediating feature of injection drug paraphernalia-sharing - which was in fact occurring both within homosexual and heterosexual relationship systems, and in groups where both sharing and pairing were not rigorously governed by sexual labels - was politely ignored (especially in African contexts), as was the continuing inability of some African countries to screen blood to western standards, and thus to gauge the range of people infected with HIV.

Conference visual aids during the era of blaming genital ulcers were never complete without pictures of diseased genitals - projected to six or eight feet high - to get over the point that the equipment of men and women in Africa is 'different'. What remained unspoken here was that those differences occur, not at the level of sexual, but of medical practice - at the level, that is, of the availability of STD health care services (which incidentally vary as much in the USA as they do in other countries). The implication of this STD-ulcer research was, however, once again that STD-infected individuals were somehow able to produce HIV *sui generis*. This continuing attempt to locate gender differentials between the USA and Africa in the bodies of self-reported heterosexuals (Africans) rather than in the social processes which create the economy of sexualities once again distorted both the demographics and the biology of HIV in Africa, and thus inhibited properly directed risk-reduction campaigns.

The persistent conflation of HIV with secondary factors in Africa - particularly its linking with poverty and sexuality - has, finally, led researchers to hunt for differences in heterosexual practices instead of recognizing the existence of male homosexuality in countries and cultures where male-male sex is practised under another name. In fact, a number of African cultures have longstanding, culturally specific structures of male-male sexual practice; yet there is inconsistent data on the existence of 'homosexuality' in Africa, largely because of the categories and stereotypes of western researchers who understand homosexuality as a preference or identity in western terms, rather than as a form of social or economic bond. The Zulu gay activist Alfred Machela has described the male-male sex structure widespread in his own and in geographically adjacent cultures. Male-male sex is part of a social/paramilitary bond of significant dimensions but is not considered 'homosexuality',

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a category which is taboo and recognized as a western or Arabic perversion. He suggests that when western researchers ask about the incidence of homosexuality in African nations, the governments' prudish 'not here' reply is a self-protective denial of European concepts of homosexuality rather than a denial of male-male sex practices, which remain unspoken or ritualized in social or economic bonds. As Gill Shepard has noted, there was a wide variety of homosexual roles and relations articulated in pre-colonial cultures. Many of these were subsequently banned by Christian, colonial governments, who condemned them as 'perversions' or 'primitive' seductions. For colonized peoples, denying homosexuality could be seen therefore as a means of evading the legal and moral sanctions of the administrative state. In some cases, the strength and values of homosexual relations were totally destroyed within colonized cultures. In other cases, as in Zulu culture, homosexual practices remain, but are doubly coded, in some contexts as perversions, in others as ritualized forms of male bonding.

As gay theorists have argued, gay identity and the notion of homosexuality are historically specific concepts in the west whose emergence coincided with the appearance of psychological explanations of sexuality. And indeed, current studies of sexual practice, launched world-wide in attempts to provide an epidemiological basis for HIV education, suggest boringly little difference in heterosexual and homosexual activities, in rates of partner change, or in acceptance of the new sexual practices of 'safer sex'. It is sexual identity and the relation between identity and 'risk' that vary so dramatically around the world. The social arrangements and meaning of sexual acts vary from city to city, country to country, era to era; yet the acts themselves remain more or less the same. Unfortunately, of course, the HIV virus follows the routes of particular acts, regardless of whether they are considered homosexual acts, acts of male dominance, sodomy irrespective of gender, acts of economic exchange, acts of romantic male bonding or of species perpetuation. The virus enters any given locale through an accident of history, and slowing down the transmission of HIV depends on understanding the exact interrelationship between sexual actors of whatever gender or sexuality, whatever national or political formations. The key question, then, is that of how to understand the interrelation of sexualities internationally; and we should address that question not as voyeurs or guardians of sexually overdetermined 'Others', but as equal participants in an economy of pleasures.

We should also understand what is at stake politically in current representations of 'Other' sexualities. Beneath the dramatic media accounts of Africa, for example, as a continent devastated by a virus lies the vision of a continent ripe for medical and scientific exploitation. Beyond the post-colonial and post-revolutionary administrations fighting for credibility and political survival on a global, western-defined stage are peoples interrelating and seeking pleasures in their bodies. Cultural organizing to fight HIV must work in micro-networks to enable people both to recognize the acts which allow transmission of HIV, and to sustain and resymbolize those cultural/sexual practices which prevent transmission. We must also understand the political and social difference between the western closet which circumscribes in order
to occlude deviance and the traditional cultures which articulate homosexualities into economic and social and religious bonds in order to sustain difference.

Internationally, AIDS is constructed through a deadly set of assumptions about cultural and political difference. AIDS is mapped directly on to pre-existing national and cultural formations. But HIV knows no geographical boundaries. HIV traces a geography unrecognized by governments intent on reducing sexualities which subvert economic production, thwart social control, or merely stand as politically embarrassing reminders of richly symbolic and less rigidly conformist ways of life, once characteristic of traditional culture, but now labelled as perverted and as a political liability by western discourse. HIV follows the lines of transportation created by capital investment and traces a geography of bodily pleasures that defy the medical cops who police every country's border - no matter how many tests they devise. The HIV epidemic poses a unique moral challenge and will re-form both the meaning of sexuality and the meaning of local and international co-operation.

The scientists, policy-makers, and media-makers have the power to produce masks of otherness which create discrimination against people with HIV and AIDS. They have the power to thwart prevention by allowing people to ignore the necessity of speaking about sexual practices, out of a false sense that HIV is somewhere else, in someone else's body. Local activists - as we slowly find each other through the improbable routes of international scientific conferences, ex-lovers, and FAX machines - will, however, transform the meaning of geographical boundaries. Though many of us will die in this epidemic, the network of survivors will form a new, supra-national community of resistance.

NOTES

1 This essay is an expanded version of my earlier 'Inventing African AIDS', *City Limits*, 363 (15-22 September 1988). I thank Professors Doris Somer and Andrew Parker for asking me to present an earlier version at their Nationalisms/Sexualities Conference at Harvard University in June 1989, and Eve K. Sedgewick for hosting a mini-conference around this work at Duke University in September 1989.

2 I am of course using Michel Foucault's periodization in *The Order of Things* (New York: Random House, 1970). V. Y. Mudimbe's excellent *The Invention of Africa: gnosis, philosophy, and the order of knowledge* (Bloomington Ind.: Indiana University Press, 1988) argues that movements parallel to those of Foucault and other twentieth-century French philosophers have been occurring in African philosophy, and, in fact, that some of these philosophers have begun the epistemological break Foucault struggled to imagine. Mudimbe also provides an excellent review of twentieth-century developments and problematics in African philosophy with careful attention to the local and international historical/political developments. For other works on AIDS and Africa from a cultural/critical perspective, see Paula A. Treichler, AIDS and HIV Infection in the Third World: a First World chronicle', in Remaking History, ed. Barbara Kruger and Phil Mariani (Seattle, Wash.: Bay Press, 1989) and Simon Watney, 'Missionary positions', in Critical Quarterly (Autumn 1989).


5 ibid., 1217.

6 For a more detailed discussion of the silencing effects of science as conceived during the colonial era, see Mudimbe, op. cit. Treichler takes this in a different direction to demonstrate the rhetorical manoeuvres that leave only the tiniest space for African contributions to discourse on Africa.

7 Held in June 1989. This is the major AIDS conference and attracts medical and social science researchers from around the world. The Montreal conference had over 10,000 attendees.


9 The Chirimuuta critique provides some history on the conflicting reasons for early co-operation of African governments and researchers with western AIDS researchers.

10 According to a 1984 World Bank study, cited in Mudimbe, 54. The forms of Christianity are multiple, sometimes syncretist with longstanding local religious beliefs and practices, sometimes virtually supplanting them. Nevertheless, it is quite bizarre to construct the radical difference between western and African worldview as if centuries of evangelism and colonialism have not left Africans well aware of the curious workings of a western ethics supposed to 'protect' unwitting 'Others'.

11 I learned that the 'ethical space' is not, and cannot be, 'objective' when I served as a theologian and a 'community' i.e. 'gay', person on an institutional review board for local, Boston-based AIDS research from 1983 to 1985. The nature of negotiating the demand that specific conditions be met, particularly regarding the content of informed consent, takes on an agonistic quality that is, and in AIDS treatment trial debates has consistently been, interpreted as political. The rise of community research initiatives - where community-based scientists and activists conduct their own trials under review board supervisions - are the culmination of this process.

12 See both Christakis, 'Responding to a pandemic: international interests in AIDS control', *Daedalus*, 118, 2 (Spring 1989), and Mariner and Gallo, op. cit.

13 There is uncertainty about what would constitute a successful vaccine, and a variety of approaches are currently implemented. Some attempt to prevent HIV infection occurring at all. Others try to disable the vaccine once it has attacked certain cells. Still others aim to prevent HIV replication or to slow it down enough to lengthen the time it takes for the immune system to be functionally affected. For a good review of current approaches, see Thomas J. Matthews and Dani P. Bolognesi, 'AIDS vaccines', *Scientific American*, 259, 4 (October 1988), 120-8.

14 This includes the possibility that the vaccine won't work and that people who become infected through vaccination, not having been aggressively educated about safe sex, will increase the total number of infected people. Further, the belief that a vaccine is around the corner may decrease people's willingness to practise safe sex. In addition, there are probable social effects - because widespread vaccine
trials will confuse testing programmes, border regulations may discriminate against Africans. Popular claims about having been vaccinated (like the folklore about men claiming to be sterile and therefore not needing to use condoms) may thwart the safe sex education programmes that will have to continue to take place until the entire world is vaccinated. This is an additional problem with the placebo controls: since it may be quite easy for trial subjects to get antibody testing, the placebo control subjects will be able easily to find out whether they have been vaccinated or not, which may change their behaviour.

15 Partly in response to demands by People With AIDS (PWA) activists to speed up treatment trials, several ethicists have developed the concept of 'cataclysmic rights', which argues that AIDS is so dramatic that individuals should be allowed to take unusually high risks in entering treatment trials. Several AIDS-related drugs have been 'fast tracked' and allowed into human trials before completing the usual round of preliminary trials; several drugs, including AZT, were widely released before completing trials, and data were collected on those people who took the drug. These are referred to as 'compassionate release' trials, and they result in data uncontrolled by traditional standards.

16 In addition, the early years of the HIV epidemic coincided with the discovery of serious hygiene problems and possible cross-infection through smallpox vaccination. A detailed understanding of the value or otherwise of the efforts to wipe out smallpox in Africa is only now emerging.

17 Alfred Machela has described the nascent gay culture of Soweto, and the ANC has in the past year embraced gay rights as part of the liberation programme, in acknowledgement of the variety of homosexualities indigenous to South Africa, and specific to post-colonial South Africa. A gay liberation and AIDS education project is now underway in Soweto: see Alfred Machela, 'The township project', paper presented at the First Non-Governmental Organization Conference and the Vth International AIDS Conference in Montreal, June 1989.