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Chronology and Causality in Africa's HIV Pandemic: The Production of History between the Laboratory and the Archive[1]

ABSTRACT

By 2018 approximately 32 million deaths worldwide had been attributed to HIV/AIDS. Yet the impact of the AIDS pandemic has been profoundly uneven. In the Global North HIV has been constructed as marginal; in much of Africa, it is pervasive and transformative, fundamentally reshaping local economies, civil society, state structures, and the continent's relations to the outside world. HIV is in reality a series of distinct epidemics, each with their own histories. In recent years scientists have challenged historians' understanding of HIV's chronology and patterns of transmission, providing alternate histories of the virus's origins, expansion, and resilience within mature epidemic settings. Epidemiologists and geneticists have realigned the temporal focus of archival and oral research, while conceptualizing change over time around moments of divergence, and focusing on historical episodes rather than process, and on diffusion over intensification. This paper analyses scientists' historical understanding of Sexually-Transmitted Infections, migration, and same-sex relationships, challenging narrow understandings of causality, and the assumption that the contexts of the recent past can be applied backwards to more distant periods. Reconstructing HIV's long history requires recognition of the evolving complexity of sex and marriage, morality and discretion, migrancy and displacement, ethnic and racial preconceptions, and locality and connection.

[1] Acknowledgements.

By the end of 2018 approximately 32 million deaths worldwide had been attributed to AIDS, and a further 38 million people were living with HIV. HIV/AIDS is one of the most significant pandemics in human history, with an impact that has extended far beyond its immediate demographic consequences. All infectious, fatal diseases reshape human relations, but the economic, political, and social effects of different pathogens vary depending on their mode of transmission, the nature of the symptoms they cause, and the duration of the illnesses they bring about. The depth of HIV's impact on societies around the world can be explained by the specific characteristics of the virus itself.

Because HIV is spread predominantly, though not exclusively, through sexual contact, it has contributed to the growing moralism of political discourse around the world.[2] Characterized by a long period of latency, the virus challenged systems of border control which had evolved to detect symptoms over a period of days rather than years, and encouraged the restriction of individual rights in the name of public health.[3] The identification of a series of specific behaviours or characteristics that increase the likelihood of infection has resulted in the identification of distinct risk groups. Within a year of the first cases of AIDS being recorded in 1981, the United States Centers for Disease Control

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[2] For one of many examples see Anthony Slagle, 'Scapegoating and Political Discourse: Representative Robert Dornan's Legislation of Morality through HIV/AIDS', in William Elwood (ed.), *Power in the Blood: A Handbook on AIDS, Politics, and Communication* (Mahwah, NJ: 1999).

[3] <http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/news/news/2015/09/population-movement-is-a-challenge-for-refugees-and-migrants-as-well-as-for-the-receiving-population/migration-and-health-key-issues> (accessed 27 Feb. 2020). For a long history of quarantine, showing that the medico-moral targeting of minority groups long predated HIV, see E. Tognotti, 'Lessons from the History of Quarantine, from Plague to Influenza', *Emerging Infectious Diseases*, xix (2013). Other infections characterized by long periods of latency, such as syphilis and tuberculosis, have also prompted the alteration of border control protocols in the past.

associated this seemingly new plague with the '4 H's - homosexuals, heroin users, hemophiliacs, and Haitians'. The realization that HIV was best controlled through openness and inclusion had by the 1990s shifted disease control rhetoric away from categorizations which promoted victimization. In recent years, however, as improvements in treatment led UNAIDS to imagine the eradication of the disease, attention has refocused on what are now described as 'particularly vulnerable' 'key population groups', 'men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners'. Awareness of higher risk has, in different regions and periods, been variously associated with vilification, uplift, and self-protection, in many cases generating new forms of civil society mobilisation.[4]

HIV's biological characteristics have above all influenced its history within Africa. Based on analysis of the evolution of the various sub-types of HIV, and of the genetic similarity of HIV to Simian immunodeficiency viruses (SIVs) commonly found among non-human primates, the scientific consensus today is that the global pandemic of AIDS can be traced back to several incidences of cross-species infection which occurred across western Africa during the early decades of the twentieth century.[5] Although it is common to think of AIDS as one disease, HIV is genetically diverse, split into two types, HIV-1 and the much rarer HIV-2, with HIV-1 again being split into four groups, M, N, O, and P. These types and groups vary greatly in terms of their transmissibility, disease progression, and treatment. Their diversity reflects their unique genetic origin, as each type and group emerged from a separate encounter between a human and non-human primate. It must be assumed that humans have become infected with SIV very many times in human history. One key question is why, in the early twentieth century, these initial infections did not remain localized within hunting communities, dying out within a decade or so. Significant debate exists about which

[4] <https://www.unaids.org/en/topic/key-populations> (accessed 20 February 2020).

[5] Jacques Pépin, *The Origin of AIDS* (Cambridge, 2011), 43–58.

factors were responsible for accelerating HIV's rate of transmission, and facilitating the dispersal of the virus, but it is agreed that by 1981 HIV had spread across the continent. The primary reason why Africa has suffered so deeply from AIDS is that the virus was so widely dispersed before any control measures could be introduced.[6]

Through the 1980s attention focused on East Africa, particularly those societies bordering Lake Victoria, but from the 1990s it became clear that the epicentre of the global pandemic lay in southern Africa. By 2000, a staggering 36 per cent of adults were infected in Botswana, while in South Africa 4.2 million people were living with the virus. AIDS put immense strain on the institution of the family across the region, heightened gender tensions, drew some societies into famine, and contributed to growing anxieties around witchcraft and to the rise of Pentecostalism. In political terms, the impact of the pandemic has been surprisingly muted across the continent, except in South Africa where it has been intrinsically linked to the legacy of Apartheid, and the failings of the African National Congress.[7]

HIV viewed as a pandemic is significant because of its global scale, the interconnections which linked the Cameroonian rainforest to Edinburgh and San Francisco; but a focus on the interlinkages suggests a shared history which perhaps obscures as much as it reveals. In the Global North, HIV has predominantly been viewed as a rare disease, which affects groups constructed as marginal.[8] In much of Africa HIV is pervasive, fundamentally shaping local economies, the nature of civil society, the structure of the state, and its relations to the outside world. Yet the African experience is not homogeneous. In some countries such as Mali, where fewer than 0.5 per cent of the population are HIV-positive, the disease is a

[6] John Iliffe, *The African AIDS Epidemic: A History* (London, 2006), 2.
[7] *Ibid*.; <http://data.unaids.org/pub/report/2000/2000_gr_en.pdf> (accessed 22 Feb. 2020).

[8] In 2017, HIV prevalence in the UK was 0.15 per cent.

carefully-monitored background risk. It is, then, crucial to think of HIV as a series of distinct epidemics, each with their own histories.

This in turn raises new questions, because the nature and purpose of history is not universally agreed. Specifically, scientific researchers seeking to understand the natural history of the virus bring with them tools of analysis and perspectives on causation which differ significantly from those of the academically-trained historian. While historians are hardly unaffected by presentism, scientists are particularly geared to focus on the origins of phenomena which they observe in the present.[9] Whereas historians are, notionally at least, committed to understanding the past on its own terms, scientists' perspective on the past is more likely to be reverse-chronological, working backwards with a narrow focus in the quest for direct, causal links. This approach is seen most clearly, and most beneficially, within the work of phylogenetic analysis. This methodology has transformed understanding of the dating of HIV's evolution, as scientists have tracked HIV's multiple genetic mutations over time, in the quest for the Most Recent Common Ancestor, or progenitor of viral lineages. This process, similar to the construction of a family tree, provides an invaluable map to the past (see Map 1). But it is a map with gaps and assumptions. The tissue samples which enable HIV's phylogenetic reconstruction reflect the patterns of previous medical research and treatment. Regions where no historic tissue samples have been stored are structurally marginalized within HIV's history, a problem which is not ignored by geneticists, but which has received less attention than might have been assumed. Despite these concerns, scientists' alternate approaches to the past require historians to think about their assumed primacy in the structuring of historical narratives. On what basis should HIV's evolution be periodized – should this be shaped by genetic or social change? Should scientists' movement from the

[9] See the collection of papers previewed in Alexandra Walsham, 'Introduction: Past and … Presentism', *Past & Present*, ccxxxiv (2017).

laboratory into the archive be welcomed, or viewed as a territorial threat? Why is collaboration between scientists and historians so rare; why are the skills and knowledge possessed by historians invisible or unappealing to the very large numbers of scientists interested in Africa's past?

This article examines three examples of how scientists' understanding of AIDS in Africa today has shaped the questions that have been asked about the virus's past. The first of these emerging trends is a growing tendency for medical scientists to engage with the colonial archive in their quest to understand the early evolution of the epidemic. The second is the capacity of phylogenetic analysis of HIV's dispersal to upset long-accepted assumptions about the dating of the virus's arrival in specific regions. The third is the recognition over the past fifteen years of men who have sex with men (MSM) as a highly significant source of new HIV infections within sub-Saharan Africa, raising the possibility that assumptions about the heterosexual nature of Africa's pandemic in the 1980s and 1990s were erroneous.

These case studies reflect the epidemiological construction of the history of HIV, focusing on the virus's origins, its expansion, and its resilience within mature epidemic settings. Their purpose is to demonstrate that AIDS itself has an evolving history, that its primary means of transmission has evolved over time, in response to social change. The case studies will also show that the history of a disease is inherently complex, and can be best understood from multiple disciplinary perspectives. The article focuses on the experience of Uganda, perhaps the most interesting country in the long history of the virus. It was in Uganda in the early 1980s that the world's first large-scale AIDS epidemic was identified, revealing that HIV could spread rapidly in rural communities through vaginal intercourse. Uganda's President Museveni was unusual in insisting from the beginning that 'we should not feed people on lies but facts, and use facts to produce fear and instil change in

behaviour.'[10] By 1992, Uganda's early commitment to public health information, the avoidance of stigma, and the creation of space for civil society activism, had facilitated a sharp decline in HIV prevalence, one of the earliest signs that AIDS' terrifying advance might be halted. Uganda's AIDS control model was adopted across the continent, but then in 2006 it was reported that Ugandan prevalence was increasing again, prompting new research into supposedly entrenched high-risk sexual cultures. Uganda's reputation for AIDS progressivism was further tarnished in 2009 with the tabling of the Anti-Homosexuality Bill. This bill, which proposed that the involvement of a HIV-positive person in a same-sex relationship should be a capital offence, highlighted the growing influence of a condemnatory evangelical Christianity within Ugandan public discourse.[11] Uganda's decades-long prominence within the world of AIDS stimulated the biomedical research which this article examines. It has also shaped the interests of historians working in Uganda since the late 1980s, and of the oral informants whose memories and conceptualizations of the past were inevitably influenced by contemporary networks of public health information of remarkable pervasiveness. The production of HIV's history has extended far beyond the archive and the laboratory.

I

In the Global North, AIDS has been feared but it has rarely been imagined as a mass epidemic. From the beginning, the disease has been associated with minorities. Some, such as

[10] Uganda Ministry of Health, John Iliffe papers, African Studies Centre Library, Cambridge (UMOHJIASCC), Unnumbered Section 13, Memos and Letters from ACP, S. Okware, 'Brief report and policy considerations on AIDS Control Programme for Minister of Health', 15 Apr. 1989.

[11] The bill was passed in modified form in 2013 but ruled invalid in 2014.

haemophiliacs, have been categorized as innocent victims. Others have been viewed less sympathetically, prompting references to a 'gay plague' in Los Angeles, New York, and San Francisco, and to heroin-users' sharing of needles making Edinburgh 'the AIDS capital of Europe'. In all cases, what was defined as the general population could distance itself from an infection associated with non-normative behaviours, whether this was medical negligence, anal sex, or unhygienic injection of illegal drugs.[12] By the mid-1980s, however, global scientific attention shifted focus, trying to comprehend how HIV was spreading so rapidly in African societies where blood transfusion, homosexuality, and heroin use appeared much less common than was the case in America and Europe. Africa's epidemic appeared unique, a mass outbreak spread predominantly through vaginal sexual intercourse. Given that the average risk of HIV transmission through vaginal intercourse is so low, researchers began to look for complicating factors which would increase the likelihood that exposure would lead to infection. A consensus quickly developed that HIV transmission was around eight times more likely during vaginal intercourse where an individual had a pre-existing ulcerative sexually-transmitted infection (STI). The recognition that genital sores resulting from STIs provide ideal entry points for HIV caused AIDS control programmes across Africa to adopt a broad-spectrum approach to improving sexual health..[13]

Within the past decade, biomedical researchers have revisited the topic of ulcerative STIs, but focusing on history rather than the present. Genital Ulcer Disease (GUD), a catch-

[12] Anna Alexandrova, *AIDS, Drugs, and Society* (New York, 2004), 98, 295.

[13] See, for example, R. Greenblatt *et al*., 'Genital Ulceration as a Risk Factor for Human Immunodeficiency Virus Infection', *AIDS*, ii (1988), 47–50; H. Ward and M. Rönn, 'Contribution of Sexually Transmitted Infections to the Sexual Transmission of HIV', *Current Opinion in HIV and AIDS*, v (2010), 305–10. For an historical perspective see R. Packard and P. Epstein. 'Epidemiologists, Social Scientists, and the Structure of Medical Research on AIDS in Africa', *Social Science & Medicine*, xxxiii (1991).

all term encompassing infections such as syphilis, herpes and chancroid, is now viewed by some scholars not only as a risk factor for new HIV infections today, but also as a possible explanation for HIV's unlikely survival and spread in the early decades of the twentieth century. In 2010 De Sousa *et al*. reported that '[o]ur review of the colonial medical literature established that GUD . . . peaked in the relevant cities [such as Kinshasa/Léopoldville], in the period 1910–35, with incidences 1.5–2.5 orders of magnitude higher than in mid 20th century, coinciding in time with the narrow timeframe of the emergence of epidemic HIV groups.'[14] This interpretation has been influential, and even where it has been questioned by other biomedical researchers, sceptical scientific commentary focused on the limited likelihood that a recorded GUD incidence which never exceeded 10 per cent in the early twentieth century could have had a transformative effect on HIV's fortunes, rather than on the methodology which underpinned the GUD thesis. Scientists' critiques, in other words, have accepted early colonial data at face value, but have used epidemiological modelling to query how significant the impact of GUD might have been. The way in which biomedical researchers seek, deploy, and critique data tends to generate specific, narrow kinds of historical explanations for the epidemic.[15]

It is hardly surprising that epidemiologists, whose understanding of the current HIV pandemic is shaped by aggregated disease incidence data, medical reports, and ethnographic

[14] J. de Sousa *et al*., 'High GUD Incidence in the Early 20 Century Created a Particularly Permissive Time Window for the Origin and Initial Spread of Epidemic HIV Strains', *PLOS ONE*, v (2010), e9936.

[15] For positive responses see, for example, Supriya.Mehta *et al*. 'Circumcision Status and Incident Herpes Simplex Virus Type 2 Infection, Genital Ulcer Disease, and HIV Infection', *AIDS*, xxvi (2012). For epidemiological criticism see N. Faria *et al*., 'The Early Spread and Epidemic Ignition of HIV-1 in Human Populations', *Science*, cccxlvi (2014). Disease incidence is usually reported as the number of new cases occurring within a period of time.

commentary, should also utilize such sources when their object of enquiry shifts to HIV's origins. Nor would it be surprising, as Giles-Vernick and colleagues have observed, if the sight of '[s]ome biomedical researchers digging away at HIV "origins" [working] in historians' hallowed grounds – the archives', provoked feelings of territoriality among historians.[16] Yet history is an eclectic discipline, and historians of Africa in particular have for decades drawn on concepts and methods developed within other academic traditions, most obviously anthropology, but also economics, geography, literary studies, and political science.[17] The microbiologist Jacques Pépin's recent book, *The Origin of AIDS*, for example, has been received positively by historians, who acknowledge the range and originality of his archival research.[18] But Pépin's most compelling contribution relates to the scale of French colonial medical campaigns against trypanosomiasis and other tropical diseases. His detailing of the remarkable frequency with which medical staff injected Africans using unsterilized or inadequately sterilized reusable syringes adds a new credibility to the thesis that the iatrogenic transmission of HIV via medical examination or treatment was key to the virus's early survival and dissemination.[19]

That De Sousa *et al*.'s thesis has been viewed with greater scepticism than reconstructions of iatrogenic, non-sexual risk relates to both the nature and the interpretation of sources. Colonial era medical staff commonly recorded how many injections they gave;

[16] T. Giles-Vernick *et al*., 'Social History, Biology, and the Emergence of HIV in Colonial Africa,' *The Journal of African History*, liv (2013), 16.

[17] Many leading Africanist historians have been trained or teach in other disciplines, as well as history, while numerous influential books within the African history canon have been produced by non-historians. For example, John Peel, *Ijeshas and Nigerians: The Incorporation of a Yoruba Kingdom* (Cambridge, 1983).

[18] Pépin, *Origin*.

[19] See William Schneider, *The History of Blood Transfusion in Africa* (Athens, OH, 2013).

lists of medical equipment, including numbers of syringes and needles as well as sterilization equipment also survive. Even if early-twentieth-century practitioners did not explicitly state that they used unsterilized syringes, their recording of the numbers of individual injections given per hour during campaigns indicate that adequate sterilization would have been impossible.[20] Indeed, the risks of unintentional infection may if anything be underestimated, given that one of the earliest medical campaigns in colonial Africa, the attempt to contain smallpox, sometimes used arm-to-arm inoculation (variolation). With medical personnel seeking to cover the entire population with no immunity against smallpox, and inoculating hundreds of people per day, this inherently non-sterile procedure would have been an ideal vehicle for the inadvertent medical transmission of HIV.[21] In comparison with iatrogenic transmission, with its carefully recorded, relatively unambiguous interventions, GUD is much less straightforward.

So how, then, did De Sousa *et al*. arrive at their figures for GUD incidence in colonial Congo? As Giles-Vernick and colleagues have observed, De Sousa *et al*.'s assumptions about the credibility of high GUD incidence rested in part on problematic assumptions that the nature and frequency of paid sex in early colonial Kinshasa were comparable to those recorded in twenty-first-century African cities. Given that urban scale and cash availability are so much greater today than a century ago in West Africa, and that qualitative evidence indicates that in the early colonial period women who were paid for sex commonly had a relatively limited clientele, the social foundations of the GUD epidemiological model seem

[20] See H. Welbourn, 'First impressions' (unpublished TS in the possession of the author, 1946). By the 1960s staff reusing the same needle during inoculation campaigns often used sterilization techniques inadequate for HIV transmission prevention. For example, Int. TNN, Kitala, Female [F], 3 Aug. 2004 (transcripts are in the possession of the author).

[21] J. Cook, 'Sleeping Sickness and Smallpox in the Uganda Protectorate', *Uganda Notes*, iii (1902), 9.

rather fragile.[22] But, crucially, it is also necessary to question the credibility of the GUD data itself. De Sousa *et al*. have constructed a time series by assiduously assembling numbers of cases of syphilis and other STIs in Kinshasa/Léopoldville between 1919 and 1958, and then dividing this total by the adult population of the city to arrive at an annual incidence. There are several major problems with De Sousa and colleagues' assumptions that incidence data from 1958 can be credibly compared with those from 1919. Examples from Uganda will be used to highlight the questions that must be asked of the data recorded in the Belgian Congo.

The most significant issue relates to the accuracy of diagnosis of syphilis, the most common genital ulcerative disease. Given the extensive evidence from other regions of Africa that diagnostic assumptions and techniques changed drastically over the course of the colonial period, there is reason to question De Sousa *et al*.'s assumption that the relative decline in the number of cases of syphilis recorded in Léopoldville's clinics indicated an absolute decline in syphilis prevalence among the urban population. Uganda is a valuable case study because the sources available for the analysis of its colonial-era 'epidemic' of syphilis are so extensive.[23] Few countries in colonial Africa had such a well-developed medical system, as a remarkable array of missionary hospitals and clinics were supplemented by an impressive secular network, headed by East Africa's major teaching and research hospital, Mulago. In part, this generous provision of healthcare was stimulated by what was believed to be a syphilis epidemic of unprecedented proportions, one that seemed to threaten not only the survival of the indigenous population, but also claims that colonization and

[22] Giles-Vernick *et al*., 'Social History', 22–3.

[23] See, for example, Shane Doyle, *Before HIV: Sexuality, Fertility and Mortality in East Africa, 1900–1980* (Oxford, 2013), 67–95; Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Cambridge, 1991), 130–6;

missionization were beneficial to Africans. Indeed, Mulago itself originated in 1912 as a specialist venereal disease unit.[24]

At the start of the twentieth century European doctors commonly claimed that the majority of Ugandans had been infected with a sexually-transmitted infection. A military venereologist sent to Uganda in 1908 reported that 'the entire population is in danger of being exterminated by syphilis in a very few years, or of being left a degenerate race fit for nothing.' Secular and mission doctors clashed over whether Christianity or 'civilization' were to blame, but all agreed, on the basis of very limited evidence, that the history of syphilis in Uganda was short, but dramatic. The relationship between diagnosis, data, and narrative was self-consciously purposive within Ugandan biomedicine from the beginning.[25] In 1922 the head of the Protestant medical mission in Uganda claimed that 66 per cent of mothers were currently or previously infected with syphilis, while the director of the colonial state's venereal disease program asserted that Uganda's STI prevalence was between 85 and 90 per cent. That year, however, Dr Lamont, a newly-arrived female STI specialist, was dismissed for protesting at the degrading nature of Uganda's STI program. A scandal erupted following the publicization of her claims that Uganda's regulations were 'far worse than any Contagious Diseases Acts ever in force in any country', that mass examinations of the public were so cursory that prevalence data had to be treated with scepticism, and that from her observation only 5 per cent of Ugandan women had an active STI. Questions were asked in parliament, and even though the Colonial Office forced a radical change in Ugandan policy, metropolitan medical and women's pressure groups thereafter monitored Uganda's STI laws and practices right through to the 1950s. In particular the campaigning group, the Association

[24] O. Arya, 'Organization of the Venereal Diseases and Treponematoses Service in Uganda,' *British Journal of Venereal Diseases*, xlix (1973), 134–8.

[25] 'Syphilis in Uganda', *British Medical Journal* (1908), 1022–3. See Vaughan, *Curing*, 129–54.

for Moral and Social Hygiene, immediately and publicly queried the STI incidence and prevalence data which had been accepted for years without reservation: 'the figures hitherto quoted (80-90%) are ridiculous.'[26] From the mid-1920s Uganda's main state hospital, Mulago, adopted more stringent diagnostic procedures, and made the use of laboratory testing in suspected STI cases compulsory.[27] In the years that followed, as Mulago took on the character of a medical school tied to Makerere, East Africa's first university, the research interests of its clinical staff often focused on syphilis, so that Uganda would become a global centre for the study of treponemal diseases.[28]

Thus in 1945 one of the first postgraduate theses based on Ugandan data found that statements by early specialists such as Albert Cook regarding the prevalence of syphilis 'seem to have been mere guesses'[29] The crucial step came with the appointment of Uganda's first fully-trained pathologist, Jack Davies, who in 1947 conducted a systematic re-examination of Mulago's autopsy reports from 1931 to 1946. He concluded that many cases of syphilis had been wrongly identified, and that while signs of previous syphilitic infection could be detected in 11.8 per cent of cases, this was a similar level to that reported in the USA, and far lower than estimates of prevalence in Uganda based on clinical signs or diagnostic tests. The following year Davies analysed neo-natal and infant deaths, finding that syphilis, previously blamed for most under-one mortality, was in fact of very minor

[26] Women's Library, 3AMS/D/49, Uganda 1908–54, J. Hope Reford to NCCVD, 22 Aug. 1922, Dr M. Lamont to Dr June Walker 1 Jan. 1922, and Alison Neilans, Association for Moral and Social Hygiene, n/d [1923].

[27] Weston Library, Oxford, MSS.Afr.s.1872(153A), Box xxxvi, East African Notes, A. Williams papers.

[28] For example, C. Hackett, 'On the Origin of the Human Treponematoses (Pinta, Yaws, Endemic Syphilis and Venereal Syphilis)', *Bulletin of the World Health Organisation*, xxix (1963).

[29] R. Billington, 'Neurosyphilis in Natives of East Africa' (Univ. of Cambridge PhD thesis, 1945), 29.

significance.[30] Davies would go on to conduct research of global importance in cancer and nutritional disease; it is a sign of his authority within Uganda's medical system that the medical department's annual report admitted in 1951 that, following retrospective re-evaluation, it 'must plead guilty to over-facile diagnosis of 'syphilis' and erroneous interpretation of hospital data in the past . . . it is evident that many other illnesses of childhood were in those days confused with syphilis.'[31] In 1955 more quantifiable evidence that syphilis had been grossly over-diagnosed in the past, even after the adoption of serological testing, emerged. A technical refinement of the Kahn laboratory test for suspected cases of syphilis saw the proportion of positive results fall from 50 to 20 per cent overnight.[32]

Moreover, the Ugandan example illustrates that colonial-era diagnostic practice was not only inconsistent over time, but also by sector. While Mulago self-consciously shed presumptions of African hypersexuality after the 1920s, in mission institutions and secular dispensaries syphilis remained something of a default diagnosis well into the post-war period. The government's annual medical report in 1950 observed that 'rural maternity centres probably diagnose syphilis too readily', and noted with sceptical concern that the recorded incidence of congenital syphilis in rural units was eight times higher than in the large urban hospitals, where staff had superior training and testing facilities.[33] As late as 1956 Uganda's

[30] J. Davies, 'Pathology of Central African Natives: Mulago Hospital Post Mortem Studies', *East African Medical Journal*, xxiv (1947); J. Davies, 'Causes of Death in African Children', *East African Medical Journal*, xxv (1948), 228.

[31] Uganda, *1951 Annual Medical Report* (Entebbe, 1952), 33–4.

[32] Uganda, *1955 Annual Medical Report* (Entebbe, 1956).

[33] Uganda, *1950 Annual Medical Report* (Entebbe, 1951), 17.

Director of Medical Services stated that 'there is no doubt that tertiary syphilis is erroneously diagnosed at dispensaries.'[34]

While problematic diagnostic practice at low-level clinics could be attributed to inadequate training, other explanations are required for mission hospital doctors' apparent systematic overdiagnosis of syphilis into the 1930s at least. Albert Cook, who had headed Mengo mission hospital in Kampala since 1897, wrote in 1931 that

> ten years ago, I should have replied with the utmost confidence that two out of every three Baganda mothers have had syphilis at one time or another in their lives and that the percentage of abortions or premature births in women showing active signs of syphilis is in the neighbourhood of 65%. Further experience has made one more cautious and especially the results of detailed observations elsewhere. To get at the exact results clinical work must be checked by laboratory findings.

Yet this apparent admission of past diagnostic misconception was offset by Cook's recording within this same report that 67 per cent of women attending church-run ante-natal clinics in Kampala over the past year had been diagnosed as having active or latent syphilis. In reality, Cook's quest for exactitude was rhetorical, and Protestant mission units continued to diagnose syphilis without testing for decades.[35] Unaffected by Uganda's secular shift to data-driven, critical diagnostic practice, missions' fixation with syphilis survived to independence. A highly-trained paediatrician noted in her memoirs that 'When I went out [as a medical

[34] Uganda, *1956 Annual Medical Report* (Entebbe, 1957).

[35] Birmingham University Library [BUL], CMS M/Y/A7 1931–5, A. Cook, 'Report of the Lady Coryndon Maternity Training School, Namirembe, 1931'. See M. Tuck, 'Syphilis, Sexuality, and Social Control: A History of Venereal Disease in Colonial Uganda' (Northwestern Univ. PhD thesis, 1997), 226, 285.

missionary] in 46 the first thing I was told was that c.80% of the population were syphilitic.' Her realization that most children diagnosed with syphilis instead suffered from malnutrition and a range of other ills helped propel her into government service.[36] In the mid-1950s this same doctor diagnosed 1.5 per cent of sick children who attended her secular child welfare clinics around Kampala as syphilitic; at the same time Nsambya Catholic hospital's children's clinic diagnosed 13 per cent of cases as having syphilis. In the secular system syphilis was only diagnosed in children with a positive Kahn test, x-ray, or physical signs unique to that disease. It is unlikely that Nsambya was so well-equipped, or, arguably, so particular. Catholic mission units still treated syphilis with bismuth in 1954, years after penicillin had been adopted by government clinics, with remarkable, and highly publicised, success.[37]

It seems then that De Sousa and colleagues' assumption that misdiagnosis was minimal and consistent over time is problematic. Further concerns are raised by their methodology for deriving GUD incidence rates, which involved their dividing the number of cases reported in Léopoldville's medical units by the city's adult population. As has been discussed above, the numerator (ie the number of infections) within this equation is of dubious reliability; but so too is the denominator (the population at risk). First, there are concerns about the accuracy of colonial-era population counts, due to the difficulty of identifying residents within informal settlements, city boundaries whose relevance declined over time due to peri-urban sprawl, and variation over time in the incentives which

[36] Welbourn, 'First impressions'.

[37] H. Welbourn, 'Infections among Baganda Children attending Child Welfare Clinics', *East African Medical Journal*, xxxi (1954), 323; Nsambya Hospital patient registers.

influenced individuals' self-categorization as children or adults.[38] Second, the supposition that patients examined at urban medical institutions in colonial Africa were all urban residents runs counter to what is considered one of the key characteristics of the African patient in the past, their mobility. As John Janzen's seminal work on health-seeking behaviours in the Congo has demonstrated, a culture of pragmatic experimentalism in relation to healing prompted the sick to travel often surprising distances. Patients who attended hospital in the colonial period sometime travelled for days from their rural homes to reach an institution which had been recommended to them. John Iliffe described a patient walking 160 km in 1928 to Toro Hospital in western Uganda, drawn by the fame of its staff.[39] A recent study of this same institution found that the average distance travelled to Toro Hospital between 1908 and 1949 averaged 20km, with one in four patients coming from more than a day's walk away. Crucially, the average distance travelled fluctuated significantly over time, rising by 3km between 1908 and 1923, and then falling by 7km between 1923 and 1948.[40] Within the city of Kampala, Mengo, Mulago, and Nsambya hospitals served as referral hospitals for a network of dispensaries and sub-hospitals, which extended far into the Ugandan countryside.[41] Given the extensive transport network which centred on colonial Léopoldville, and that the Belgian Congo's medical system became one of the most integrated and best funded in colonial Africa between the wars, it seems very likely that many

[38] Bruce Fetter, 'Decoding and Interpreting African Census Data: Vital Evidence from an Unsavory Witness', *Cahiers d'Études africaines* xxvii (1987).

[39] John Janzen with William Arkinstall, *The Quest for Therapy in Lower Zaire* (Berkeley, 1978), 154; John Iliffe, *East African Doctors*: *A History of the Modern Profession* (Cambridge, 1998), 49.

[40] Shane Doyle, Felix Meier zu Selhausen, and Jacob Weisdorf, 'The Blessing of Medicine? Patient Characteristics and Health Outcomes in a Ugandan Mission Hospital, 1908-1970', *Social History of Medicine* (2019).

[41] Doyle, *Before HIV*, 103.

patients who attended Léopoldville's hospitals were rural visitors, and that their relative numbers would have expanded over time. In other words, the apparent decline over time in what De Sousa *et al*. define as urban GUD incidence may, in part, have reflected a patient community whose character was increasingly rural and mobile.[42] This assumed decline is also likely, as in Uganda, to have been shaped by an increasing tendency amongst individuals to respond to suspected STI infection through self-medication or recourse to private practitioners, due to the socially uncomfortable nature of formal medical encounters arising from such conditions. By the 1950s it was common for medical reports to complain of 'the vast number of patients who treat themselves (by purchasing black-market sulphonamides) or are treated by unqualified practitioners.'[43] There are then a series of problems with the quality of the data relating to GUD in colonial Africa which make any attempt to construct a credible longitudinal narrative, or to propose a causal link to HIV's emergence, risky.

This example has been utilized because it highlights how the relationship between the evidence available from the past and the narratives that can be constructed using that evidence vary from one disciplinary perspective to another. Historians must engage critically with the work produced by medical researchers, where it has historical implications, and particularly where it relates directly to historical subjects and sources. Historical researchers have much to gain from biomedical approaches, given the depth of scientists' understanding of contemporary phenomena, and the rigour of the analytical tools they use to approach and

[42] N. Hunt, *A Colonial Lexicon: Of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham NC, 1999), 3–7; D. Gondola, *Tropical Cowboys: Westerns, Violence, and Masculinity in Kinshasa* (Bloomington IN, 2016), 35–7, 83; Emmanuel Capelle, *La Cité indigène de Léopoldville* (Léopoldville, 1947), 30, 59–61.

[43] Uganda, *Annual Report of the Medical Department, 1958* (2 vols., Entebbe, 1959), i, 26–7; Arya, 'Organization', 136–7; Wellcome Archive, A.3/1 PP/PRE, Dr. Evans' diary of 1953 visit to Uganda; Male Focus Group Discussion (FGD), Kisubi Kiwulwe, 4 Sept. 2004.

explain causation. But it is important to remember the necessary limits within which scientists have been schooled. Historians have been trained to evaluate the raw materials of the past, to consider the inherent biases and absences within the archive, and how these can be mitigated. It is the slow work of triangulation between multiple archives, and often oral testimonies, that enable historians to gauge the credibility of sources, and to seek to understand them from the perspective of the context within which they were created, deposited, and retained. In this case, detailed historical contextualization calls the quality of early colonial medical data into question which in turn undermines the reliability of the longitudinal narrative built on such evidence. But even if these data were unproblematic in themselves, dependence on such decontextualized sources still tends to motivate a particular form of historical narrative, framed by a quest for isolated cause and effect. Such an approach has a clarity which can be valuable, but it clashes with historians' sense of the complexity of interrelationships and the uncertainties of meaning which, for them, define early colonial Africa.

MAP 1: HIV'S EARLY EXPANSION TOWARDS UGANDA

II

Whereas epidemiologists have challenged historians of Africa to think more deeply about how they approach causation, and the utility of early twentieth-century sources, recent work by geneticists challenges historians to reconsider issues of timing and chronology. For decades it was assumed that the key moment in the emergence of East Africa's HIV epidemic was the mid to late 1970s, a time of economic crisis and socio-political instability. Scholars argued that the growth of urban unemployment and female poverty after the 1973 oil crisis created new high-risk sexual behaviours, including a rise in both commercial sex and short-

term relationships. In Uganda and Tanzania economic decline took an extreme form from the mid-1970s as a result of Idi Amin's expulsion of the Asian community and Julius Nyerere's villagization programme. Settlements sprang up along the international frontier and the shores of Lake Victoria (see Map 2), where quick money derived from a huge expansion in cross-border black-market trading created an ideal context for rapid sexual partner exchange. A further accelerator took the form of the social destabilization, rape and commercial sex work associated with the Uganda-Tanzania war of 1978-9.[44] Such a periodisation was of course logical, given that the region's AIDS epidemic was not formally identified until around 1985, and that the average incubation period for HIV is around a decade.[45] However, in 2009 Rebecca Gray and colleagues' phylogenetic analysis revealed that HIV-1 arrived and survived in the region long before the mid-1970s.[46] Subsequent studies by Yebra *et al*. and Grabowski *et al*. narrowed the entry point to around 1960 (range 1950-1968), and noted the epidemic first took hold in rural areas and involved significant cross-community transmission.[47]

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[44] For example, C. Obbo, 'HIV Transmission through Social and Geographical Networks in Uganda', *Social Science and Medicine*, xxxvi (1993), 949–55; J. Killewo, L. Dahlgren, and A. Sandström, 'Socio-geographical Patterns of HIV-1 Transmission in Kagera Region, Tanzania', *Social Science and Medicine*, xxxviii (1994).

[45] D. Serwadda *et al*., 'Slim Disease: A New Disease in Uganda and its Association with HTLV-III Infection', *Lancet*, viiicdlx (1985). Retrospectively it was recognized that the first cases were, however, observed around 1982.

[46] R. Gray *et al*., 'Spatial Phylodynamics of HIV-1 Epidemic Emergence in East Africa', *AIDS*, xxiii (2009), F9–F17.

[47] Gonzalo Yebra *et al*., 'Analysis of the History and Spread of HIV-1 in Uganda Using Phylodynamics', *The Journal of General Virology*, xcvi (2015); Mary Grabowski *et al*., 'The Role of Viral Introductions in Sustaining Community-Based HIV Epidemics in Rural Uganda: Evidence from Spatial Clustering, Phylogenetics, and Egocentric Transmission Models', *PLoS Medicine*, xi (2014), e1001610.

This new strand of research, which analyses DNA sequences to date divergence and recombination, transforms the historical imagining of HIV's arrival in East Africa and subsequent dispersal. The importance of the later 1970s and early 1980s is unquestioned, as the genetic evidence shows that these were the years when the virus spread rapidly. But the focus of historical attention must now broaden temporally to incorporate the 1950s and 1960s, an era of significant economic growth and, in Tanzania and Uganda, relative socio-political stability. Moreover, theoretical assumptions about HIV's dispersal must also change, relying less heavily on an image of the region's sexual culture defined by coercion, desperation, and urbanism. Instead it is necessary to explain how HIV might have entered Africa's Great Lakes region before the trucking economy had fully developed, how rural communities became nodes of infection, and how HIV spread from the villages of southern Buganda into the city of Kampala. New genetic work, then, has transformed historians' sense of periodization. However, historians' investigation of these new research directions calls into question some of the historical narratives that geneticists have formulated as they have sought to make sense of their genetic evidence. The genetic reconstructions provide a map for the spread of the virus, but it is a map without signposts. The genetic map tells us when and where change happened, but does not offer explanations for HIV's spread. This is then a particularly valuable opportunity for the exchange of expertise between scientists and historians, whether in collaboration or dialectically.

In the 1980s epidemiologists studying HIV's rapid dispersal across East Africa identified truck drivers as a major risk group, due to their reportedly frequent encounters with commercial sex workers: 'By September 1987 cases were reported all along the . . . truck stopping stations on the main highway to the sea.' 'The disease is spreading eastward along the Trans-African Highway, which handles considerable human traffic and interaction;

33% of long-distance truck drivers are infected.'[48] It is perhaps unsurprising that phylogeneticists working on HIV-1's century-long dispersal across the continent from south-east Cameroon's rainforest via Léopoldville/Kinshasa should focus on long-distance, rapid transport. Both Gray *et al*. and Yebra *et al*. suggest that the Trans-African Highway was the likely avenue for HIV's transfer from Kisangani in Eastern Congo to southern Uganda at some point in the 1950s and 1960s.[49] However, this hypothesis is based on an anachronistic understanding of regional patterns of transport and population movement. The Trans-African Highway, connecting Lagos on the west coast to Mombasa on the east, was only conceived in 1971, with construction starting in Congo/Zaire in 1975.[50] Roads did of course pre-exist the Highway's development, but the nature of travel was rather different before the 1970s. During the colonial period, for example, eastern Congo's trade was primarily westward-facing. Insofar as commerce with Uganda existed, this was predominantly local, border traffic. A significant truck route between Kisangani/Stanleyville and the Ugandan border did exist in the late colonial period, but this was largely focused on the purchasing of fish from small border markets for urban consumption in Congo's third city. The fish trade largely died after 1960, due to the turmoil that affected the Congo following independence, but eastern Congo's subsequent commercial reorientation towards Mombasa rather than Léopoldville/Kinshasa saw the rapid expansion of transborder trade, with coffee and rubber moving eastwards, and oil and other essential products being transported from Kenya. It

[48] Samuel Okware, 'Epidemic of AIDS in Uganda', *AIDS and Associated Cancers in Africa* (1988), 25–9; Samuel Okware, 'Towards a National AIDS-control Program in Uganda', *Western Journal of Medicine*, cxlvii (1987), 726.

[49] Gray *et al*., 'Spatial'; Yebra *et al*., 'Analysis'.

[50] *Review of The Implementation Status of The Trans African Highways and the Missing Links* (Stockholm, 2003).

seems that much of this trade still centred on points of exchange at small border markets, such as Katwe, Kasese, and Mahagi. Some through-traffic in the 1960s did exist, however, with trucks pressing on from Congo as far as Kampala, so there were multiple possible relay points connecting Ugandan and Congolese sexual networks, though evidence on their character and scale is extremely sparse.[51]

By contrast, two other forms of extremely large population movement are very well documented, and seem equally likely potential sources of HIV's eastward movement. First, the scale of voluntary migration from Burundi and especially Rwanda into Uganda during the colonial era is remarkable. Crucially, migration was concentrated within the kingdom of Buganda, the central region of Uganda where HIV initially emerged. The number of immigrants from Ruanda-Urundi resident in Buganda rose rapidly from 22,436 in 1921 to 354,363 in 1959.[52] These figures underestimate the overall level of population movement, because perhaps a third of all border crossings were circular in nature, with target migrants making repeated trips to Uganda, each lasting between six and eleven months.[53] This enormous migration was stimulated in part by the poverty and oppression suffered by Rwanda's Hutu agriculturalists, but consolidated by the opportunities which existed in Buganda. Here, unusually for colonial Africa, labour migration was not corralled into the

[51] A. O'Connor, *Railways and Development in Uganda* (Nairobi, 1965), 20, 80–2, 108–9.

[52] Uganda, *1921 Census Returns* (Entebbe, 1922); Uganda, *Uganda Census 1959: African Population* (Entebbe, 1960). Maryinez Lyons has noted how blaming Rwandans for importing HIV in the 1980s drew on decades-old tropes demonizing this immigrant group as 'disseminators of disease'. By contrast, this paper emphasizes Ugandans' affective relationships with outsiders. M. Lyons, 'Foreign Bodies: The History of Labor Migration as a Threat to Public Health in Uganda', in Paul Nugent and A. Asiwaju (eds.), African Boundaries: Barriers, Conduits and Opportunities (London, 1996).

[53] M. de Haas, 'Rural Livelihoods and Agricultural Commercialization in Colonial Uganda: Conjunctures of External Influences and Local Realities' (Univ. of Wageningen PhD thesis, 2017), 71–2.

mine or plantation, but was instead mostly dispersed within the indigenous, small-scale, cash-cropping farms of the Ganda. Migrants' relatively light labour requirements, high levels of personal freedom, and opportunities to shift from the status of labourer to tenant created a social movement that developed almost entirely without government control from either the Belgian or British authorities. By the middle decades of the twentieth century seventy-five per cent of migrants from Ruanda-Urundi worked on Ganda-owned land, and a third of Ganda households employed migrant labour.[54]

Hutu migration from Ruanda-Urundi slowed down in the 1950s, as the local economy expanded and local exchange rates shifted in Ruanda-Urundi's favour. But a second form of population movement provided an alternative route for HIV's entry into Uganda.[55] Rwanda's Hutu uprising which began in November 1959 would ultimately see perhaps 100,000 Tutsi refugees resettle within Uganda by 1964.[56] While this forced migration was initially contained to a large degree within refugee camps near the Rwandan border, over time many Tutsi were relocated to new camps within Buganda, or integrated and intermarried within local communities. By 1983 19,000 refugees were encamped in Rakai, the epicentre of Uganda's early HIV epidemic. Somewhere between 150,000 and 300,000 Tutsi were believed to have resettled outside of the camps in the decades that followed their exile.[57]

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[54] De Haas, 'Rural', 72–5; A. Richards, 'Methods of Settlement in Uganda,' in A. Richards (ed.), *A Study of Immigrant Labour in Buganda* (Cambridge, 1957).

[55] For another scenario see Jan Kuhanen '"Deadly Gonorrhoea": History, Collective Memory and Early HIV Epidemiology in East Central Africa', *African Journal of AIDS Research*, xiv (2015). For Congo-Rwanda traffic see Gillian Mathys, 'People on the Move: Frontiers, Borders, Mobility and History in the Lake Kivu Region, 19th-20th century' (Univ. of Gent PhD thesis, 2014), 303.

[56] The refugee crisis began after Uganda's 1959 census was taken.

[57] Katy Long, 'Rwanda's First Refugees: Tutsi Exile and International Response 1959–64', *Journal of Eastern African Studies*, vi (2012), 219–20; Jinmi Adisa, *The Comfort of Strangers: The Impact of Rwandan Refugees in*

There were then multiple routes by which the virus could have reached Buganda. But the arrival of HIV in a community does not automatically create an epidemic. The risk of transmission in any individual sexual encounter between two healthy people is relatively low. Classically, urban environments, with their denser populations, greater anonymity, and potentially more complex sexual networks, have been viewed as key to the survival and expansion of STI epidemics. By whatever route HIV reached southern Buganda, it is necessary to explain how this region whose population lived predominantly on small farms could play such a vital role in the global history of AIDS. One possibility is that iatrogenic (medical) transmission provided the crucial initial accelerator. Admittedly, the mass, coercive public health campaigns, involving millions of injections, which seem likely to have been crucial in the West African story of HIV's survival in the interwar period no longer characterised medical provision in the 1950s and 1960s, in Uganda at least.[58] Uganda's medical culture by this period was voluntarist, but while vast compulsory injection programmes were absent, its clinical services were extensive and very well used. As early as the 1930s, Buganda, Uganda's southern province, already had eleven hospitals, a higher density of provision than existed anywhere else in eastern Africa. By 1948 there were a total of 5,164,619 medical attendances at government institutions alone, an average of 1.07 per person. Injections were a preferred method of transmitting medication, from the perspective of patient and clinician alike. In addition, by the 1960s reports indicated that injectionists, sometimes off-duty medical staff, sometimes untrained entrepreneurs, were a popular source of biomedical intervention, due to their convenience and discretion. Such encounters were

Neighbouring Countries (Ibadan, 2013), 39–41. Refugees from eastern Congo in 1960–2 were less numerous and mostly confined to northern Uganda.

[58] Pépin, *Origin*, 103–17.

very unlikely to have involved the use of sterile equipment.[59] Blood transfusion, meanwhile, an inherently non-sterile procedure in the 1950s and 1960s, which almost guaranteed infection if blood was contaminated, became a relatively common procedure, albeit only in major hospitals.[60]

The possibility of iatrogenic transmission must not be ignored, but nor should the possible diffusion of the virus by unintentional medical interventions monopolise attention. It is necessary to acknowledge that Buganda during the middle decades of the twentieth century had developed complex sexual networks in rural as well as urban areas, that these networks were interlinked through both rural:urban and rural:rural population movement, and that sexual encounters between immigrants and host communities seemingly became much more common as the twentieth century progressed. Analysis of sexual networks in the 1920s and 1930s in West Africa, the era when HIV escaped from the rainforest, or Uganda during the 1970s and 1980s, the moment when infections seemingly accelerated, has tended to emphasise coercion, desperation, and sexual relationships skewed by locally-imbalanced sex ratios.[61] Sex work was certainly not absent from Uganda during the 1950s and 1960s, but these decades are remembered by informants primarily as a time of new forms of socialising, and growing openness and voluntaristic ethnic interaction.[62]

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[59] Doyle, *Before HIV*, 298; O. Arya and I. Phillips, 'Antibiotic Sensitivity of Gonococci and Treatment of Gonorrhoea in Uganda', *British Journal of Venereal Diseases*, xlvi (1970).

[60] Uganda, *Annual Report of the Ministry of Health, 1961–2* (Entebbe, 1963); 'Blood Donations', *The People*, 10 Feb. 1969, 5.

[61] Pépin, *Origin*, 91–3; G. Bond and J. Vincent, 'Living on the Edge: Changing Social Structures in the Context of AIDS', in H. Hansen and M. Twaddle (eds.), *Changing Uganda* (London, 1991).

[62] Int. BMJ, Kyankoole, Male (M), 29 Aug. 2004; Int. JS, Takajjunge, Masaka, M, 26 Aug. 2004.

By the 1950s, cultural obstacles to the formation of sexual relations between immigrants and the indigenous population of southern Uganda had largely broken down. High-status church marriage between Ganda and immigrants from areas such as Rwanda and Burundi was extremely unusual and would remain so throughout the colonial period, indicating that immigrants' low incomes and social status made them unattractive marriage partners. However, informal relationships were very common. A Catholic parish baptism register reveals that over the course of the colonial period 19 per cent of babies baptised had mixed parentage. It might have been expected that Ganda men would have sought additional opportunities to reproduce without the obligations to in-laws which intra-ethnic relationships involved. Yet in fact 55 per cent of all babies of mixed-ethnicity parentage had an immigrant father. It is then necessary to explain the growing attractiveness of both female and male immigrants as sexual and reproductive partners.[63]

Interviews with elderly male Ganda, who had been young men in the 1950s, revealed that the long-established acceptance of immigrant women as potential mothers of their children, had become overlaid with a growing interest in sexual experimentation. As it became known that immigrant women 'had different techniques of making love', men from rural villages began to plan urban visits in search of exotic sexual experiences.[64] Ganda men came to evaluate women from different ethnic groups according to their perceived beauty, ranking highest Tooro, Tutsi, and Ziba, who resided on direct and indirect trade routes from the Congo. When asked why men particularly sought out women from those ethnic groups, one recounted 'it was because of men's nature of admiration. You know men have a natural

[63] Kisubi Parish Baptism and Marriage Registers..

[64] For example, Int. RK, Takajjunge, M, 26 Aug. 2002

desire to make love to beautiful women.'[65] A focus group of male elders resident in Buganda's countryside discussed in detail other attractions of ethnic diversity:

> Q Where did they [sex workers] mostly came from in the 1950s?
>
> Respondent (R)1 There were Basoga, Banyoro…
>
> R2 Even Rwandese . . .
>
> R5 And the Batooro . . .
>
> Q Why do you think men visited these prostitutes? . . .
>
> R2 they had skills in sex, she would thrust and turn you in such a way you would lose yourself, yet with the wife at home such skills wouldn't be employed . . . (laughter)!...
>
> R4 Ahaa! Boy, you would tell your friends about the game so they could also go and play.

By the 1950s sex work was no longer confined to the city of Kampala, but had also become common in small trading centres in rural Buganda, such as Kalisizo and Nyendo. Life histories of Kampala sex workers revealed that some had begun receiving money for sex while living in one of the small settlements scattered across Buganda's countryside.[66] One informant from a village near Masaka, within the epicentre of Uganda's initial epidemic, remembered that after the Second World War, when he was young, sex workers 'were many also in the trading centres, though they would work in secret'. Again women from Tooro in

[65] A. Southall and Gutkind, *Townsmen in the Making: Kampala and its Suburbs* (Kampala, 1957),, 82–3; E. Hooper, *Slim: A Reporter's Own Story of AIDS in East Africa* (London, 1990), 40–1; Int. PLGS, Kitala, M, 2004.

[66] Male FGD, Bukoto, 24 Aug. 2004; Christine Obbo, 'Town Migration is Not for Women' (Univ. of Wisconsin-Madison PhD thesis, 1977), 111.

western Uganda were particularly sought after. 'Tooro girls looked so beautiful; their figures were very attractive.'[67] Surveys from the mid-twentieth century emphasised the exceptional mobility of Buganda's population. Urban men and women were reported as commonly maintaining spouses or long-term partners in both town and countryside.[68] A remarkable 88 per cent of rural householders of one village surveyed in the 1960s travelled at least once a month to Kampala, located 120 kilometres away.[69] And travel was not just a means of linking urban and rural sexual networks. Many male interviewees recounted how their occupations during the 1950s and 1960s had required them to regularly travel from their rural homes to other rural communities. Such travel was repeatedly associated with short-term sexual encounters. As one focus group member related: 'My wife left me because I was unfaithful to her, whenever I went for safari (a journey). Traveling to far places to work.' Another participant, discussing employment and sex during the 1950s, reported that 'Another reason for using prostitutes was due to the safaris where drivers would get them. For example, a driver would stop in places like Naluwere, then Mbiko, from there he stops in Ndeeba, then Lukaya Kinobi, Lyantonde etc.' These locations would become notorious during the 1980s as stopping points on the TransAfrican Highway with shockingly high HIV prevalence. In the 1950s, by contrast, they primarily served Buganda's local traffic.[70]

While Ganda men found immigrant women both physically attractive and skilled during intercourse, for Ganda women, it was knowledge of male immigrants' prioritization of foreplay that reportedly broke down ethnic barriers:

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[67] Int. IST, Kagezi, M, 21 August 2004.

[68] For example, LSE, A. Richards papers, 6/19, A. Richards, 'Kisozi village 1952'.

[69] M. Robbins and R. Pollnac, 'Drinking Patterns and Acculturation in Rural Buganda', *American Anthropologist*, lxxi (1969), 278–9.

[70] For example, Male FGD Bukoto, 24 Aug. 2004.

Q Were there cases were wives would fall in love with such people [migrant labourers].

R_2. Yes.

R_1. The labourers had their own system of doing it …

R_3. And the women would really enjoy…

R_2. Sometimes they would wait for the husband to travel away for work . . . and seduce the wife.[71]

The emphasis on a particular style of foreplay in the sexual culture of Rwanda and western Uganda, known as *kakyabali*, was believed by Ganda men to explain their wives' willingness to have affairs with labourers, a class of men previously despised for their low status and standards of hygiene. 'That is why Baganda women like westerners [ie men from Rwanda and neighbouring regions].' *Kakyabali* became the subject of gossip and song. As several Ganda men remembered with some bitterness: The labourers 'loved their masters' wives too much'. 'These servants later . . . went ahead to marry . . . sometimes our own wives. Sometimes these women would compose songs like "*Bwogoba Kayanda anga nange ngenda*" meaning "if you chase Kayanda [my servant], I'll leave with him".'[72]

[71] Male FGD, Kisubi Kiwulwe, 4 Sept. 2004.

[72] Male FGD Namitanga, 19 Aug. 2004; Female FGD, Takajunge, 26 Aug. 2004; Int. SKKG, Kabonera, Masaka District, 25 Aug. 2004, M; Int. SKJH, Takajunge, M, 26 Aug. 2004; Florence Muhanguzi, '"Sex is Sweet": Women from Low-income Contexts in Uganda Talk about Sexual Desire and Pleasure', *Reproductive Health Matters*, xxiii (2015); Guillermo Pérez, Brigitte Bagnol, and Concepción Aznar, 'Autoerotism, Homoerotism, and Foreplay in African Women Who Practice Labia Minora Elongation: a Review', *International Journal of Sexual Health*, xxvi (2014). *Kakyabali* was also known as Kigali-style, western jazz, and *kunyaza*.

The resentment of the cuckolded informant notwithstanding, immigrants from Rwanda and Burundi were not regarded at the time nor in local memory as being particularly promiscuous. In the early 1960s at Kampala's referral hospital, complications of advanced syphilis and gonorrhoea among the local Ganda were four times as frequent as among the Rwanda, and eight times higher compared to the Rundi. Informants' emphasis was typically on how immigrants, both male and female, became not only much more numerous, but also more attractive, over time.[73] By the 1950s many people in Buganda still preferred to marry within their own ethnic group, but previous scepticism about the merits of the outsider as a lover or partner had largely disappeared. Immigrants then were absorbed into a sexual culture which was itself changing as regular travel elongated sexual networks, and rapidly growing wealth facilitated the development of new patterns of rural socialization, shaped by nightclubs and bars. In rural Buganda in the 1960s 'People from different tribes, owners and tenants, neighbors, halfcastes, etc., normally drink in the same places . . . where gaiety and generosity are the prevailing norms.'[74] This was the distinctive environment where HIV was able to develop into a mass rural epidemic. As in southern Africa, the early dispersal of the virus in Eastern Africa may have been facilitated by large-scale, long-term migration as much as recurrent, short-term commercial traffic.[75]

MAP 2: BUGANDA IN ITS REGIONAL CONTEXT

[73] M. Hutt and A. Dulo, 'An Analysis of Diseases found in Adults of the Baganda and Banyarwanda/Rundi Tribes at Autopsy in 1964', *Makerere Medical Journal*, i (1966); Male FGD Kitala, 1 Sept. 2004.

[74] Robbins and Pollnac, 'Drinking', 281.

[75] See Karen Jochelson, Monyaola Mothibeli, and Jean-Patrick Leger, 'Human Immunodeficiency Virus and Migrant Labor in South Africa', *International Journal of Health Services*, xxi (1991).

III

In recent years a number of studies have identified men who have sex with men (MSM) as a significant risk group within Africa's maturing HIV epidemic.[76] Within Uganda, HIV prevalence among MSM in Kampala was, at 13.2 per cent, double the national average in 2009. Researchers found that 53 per cent of MSM in Kampala believed that they had been stigmatised by staff at STI clinics because of their orientation, with 18 per cent refusing to attend such clinics as a result. A remarkable 37 per cent reported that they had been blackmailed. Unsurprisingly, victimisation, rejection, and self-withdrawal had exposed MSM to higher risk of new infections. More than a fifth of MSM were infected with other STIs, making infection with HIV more likely. While the Ugandan population's awareness of most risk factors relating to HIV infection was extremely high, a striking 89 per cent of MSM had an incorrect understanding of the relative riskiness of receptive sex.[77] Across East Africa, the illegality of homosexuality has tended to reduce MSM's access to HIV prevention programmes in general, and has limited the availability of AIDS information targeted specifically at MSM.[78]

Coinciding with this increasing focus within epidemiological research on MSM, humanities and social science research has also been stimulated by governmental and religious persecution of homosexuality across Africa in recent decades. In Uganda,

[76] For a survey see N. Muraguri, M. Temmerman, and S. Geibel, 'A Decade of Research involving Men who have Sex with Men in Sub-Saharan Africa: Current Knowledge and Future Directions', *Sahata*, ix (2012).

[77] Wolfgang Hladik *et al*., 'HIV Infection among Men who have Sex with Men in Kampala, Uganda: A Respondent Driven Sampling Survey', *PloS one*, vii (2012).

[78] J. Okal *et al*., 'Social Context, Sexual Risk Perceptions and Stigma: HIV Vulnerability among Male Sex Workers in Mombasa', *Culture, Health, and Sexuality*, xi (2009).

homosexuality was identified as a key threat to morality by evangelical Christians in the late 1990s. In the years that followed a number of conservative political figures, including the president, blamed homosexuality for various social ills, from the breakdown of the family to the potential failure of Uganda's population to reproduce itself. Crucially, President Museveni and other critics identified homosexuality as 'un-African', blaming outsiders for its introduction.[79] These claims have prompted a number of scholars to seek to demonstrate the existence of indigenous homosexual cultures within Africa, while also noting the importance of distinguishing between homosexual acts and identities, the challenges arising from self-reporting and external labelling, and the complex history of stigmatization.[80]

Contemporary discrimination also provoked medical researchers, concerned with the neglect of MSM within contemporary AIDS programmes across Africa, to ask why 'the model of bidirectional heterosexual HIV transmission' had been so quickly accepted in Africa in the mid-1980s, with the result that 'Same-sex behaviour as a potentially relevant risk factor was measured in only 14 of 118 studies reported between 1984–2007.'[81] Of particular relevance to Uganda, Marc Epprecht has also queried why MSM have been marginalized within research on AIDS, given that in one of the first studies of the transmission of HIV within Uganda, Serwadda *et al*. in 1985 identified truck-stops on the TransAfrican Highway as major nodes of viral dispersal, where drivers engaged in both

[79] 'Uganda president: Homosexuals are "disgusting"', *CNN*, 25 Feb. 2014. See K. Cheney, 'Locating Neocolonialism, "Tradition", and Human Rights in Uganda's "Gay Death Penalty"', *African Studies Review*, lv (2012).

[80] H. Médard, 'L'Homosexualité au Buganda, une acculturation peut en cacher une autre', Hypothèses, iii (2000); R. Rao, 'Re-membering Mwanga: Same-sex Intimacy, Memory and Belonging in Postcolonial Uganda', *Journal of Eastern African Studies*, ix (2015).

[81] A. Smith *et al*., 'Men who have Sex with Men and HIV/AIDS in Sub-Saharan Africa', *The Lancet*, ccclxxiv, (2009).

heterosexual and homosexual short-term encounters. Epprecht argues that this early commitment to unbiased empirical observation was quickly lost, as research in Africa became constrained by assumptions that Africa, and its HIV epidemic, were fundamentally heterosexual. Researchers, it is suggested, did not look for evidence of homosexuality, due to self-censorship in a local context defined by aggressive neo-traditionalism, or a recurring failure to survey Uganda's ethnographic and historical record.[82]

Epprecht states that while Serwadda *et al*.'s paper has been cited on multiple occasions (706 times by 2018), no subsequent research followed up on the role of homosexuality within Uganda's emerging epidemic. The implication is that homosexual HIV infections were ignored or suppressed for two decades, before their significance was recognised again in the early 2000s. Epprecht has identified an issue of great historical and contemporary significance. It is, though, necessary to consider in more detail the history of homosexuality and same-sex relations before and during the HIV epidemic, as the appearance of continuity may be deceptive.

To engage first with Serwadda *et al*.'s foundational article, it is important to note that the authors themselves downplayed same-sex infection. Their article's abstract made no reference to homosexuality, and instead emphasised heterosexual infection. Their discussion asked 'why has slim disease suddenly become epidemic, among a rural population that does not seem to have the risk factors that Western patients have for AIDS. It would seem that slim disease is, indeed, recent and that it has spread because of heterosexual promiscuity,

[82] M. Epprecht, *Heterosexual Africa?: The History of an Idea from the Age of Exploration to the Age of AIDS* (Athens OH, 2008), 107–124; M. Epprecht, 'Slim Disease and the Science of Silence: The Erasure of Same-sex Sexuality in "African AIDS" Discourse, 1983-1988', *Jindal Global Law Review*, IV (2013), 195-6. See David Serwadda *et al*., 'Slim Disease: A New Disease in Uganda and its Association with HTLV-III Infection', *The Lancet*, cccxxvi (1985).

which is hard to document in a rural community. Prostitutes and travelling traders are potential sources of infection.' Of 15 Tanzanian traders tested for HIV as part of this Ugandan study, 10 were positive. While the statement that 'These traders admitted to both heterosexual and homosexual casual contacts' suggests that all ten were bisexual, the sentence can also be read as indicating that some of the traders were heterosexual, some bisexual, and some were homosexual. The latter possibility would seem to fit better with the arguments made within the article, which acknowledged homosexual as well as heterosexual transmission, but tended to focus on the much larger numbers of HIV-positive men and women in rural southern Buganda who were categorised as heterosexual.[83]

The second factor to consider is the evidence of entrenched bias. It is not in fact clear that Serwadda *et al.*'s recognition of same-sex transmission was intentionally suppressed. Their observations were, for example, referenced the following year in one of the most heavily-cited articles on AIDS in Africa, published by a group of scholars including James Curran, head of the CDC's HIV/AIDS division, Jonathan Mann, head of the WHO's HIV programme, and Peter Piot, who would become executive director of UNAIDS. This article in *Science* acknowledged that surveys indicated that while homosexual contact was implicated in 6 per cent of cases among migrants from Africa to Europe, within Africa 'AIDS patients rarely report a history of homosexual activity.' It was noted that the significance of this mode of transmission might be underestimated, given cultural reluctance to admit to same-sex encounters. However, from their analysis of a range of studies, they concluded that the evidence of predominantly heterosexual and iatrogenic transmission was overwhelming,

[83] Epprecht, *Heterosexual Africa*, 107–124; Epprecht, 'Slim Disease', 195–6; Serwadda *et al*., 'Slim Disease', 849–52. One of Serwadda's co-authors stated in 1988 that he was 'embarrassed' by the paper, and described the findings re homosexuality 'rather dubious'. Hooper, *Slim*, 347. AIDS was commonly referred to as 'slim' in Uganda, in reference to sufferers' wasting.

and that given the scarcity of resources and the rapid escalation in HIV prevalence, attention should focus on groups of demonstrated high risk, such as sex workers and recipients of blood donation.[84] Nor does it seem that the implications of Serwadda *et al*.'s findings were structurally ignored within Uganda. A 1986 Ministry of Health report discussed detailed interviews with forty-eight patients, twenty-three of whom were HIV-positive. All comprehensively denied any experience of homosexuality or anal sex. A more extensive study was commissioned the following year, with a questionnaire being delivered to all inpatients at fifteen major hospitals across Uganda, again recording both homosexual and anal sex. Neither were reported to be common. Of 559 HIV-positive respondents, three had had same-sex relations, and ten had had anal sex (highlighting that, of course, homosexual and anal sex are not synonymous). For 745 HIV-negative respondents the equivalent numbers were three and eight. Neither behaviour was found to be statistically associated with HIV infection. The possibility then must be considered that apparent rareness and limited risk caused the marginalisation of homosexuality within subsequent HIV research and interventions in Uganda, rather than wilful ignorance or assumptions about Africans' inherent heterosexuality. As the researchers involved in the 1987 study observed: 'Admitted homosexuality and admitted anal sex are rare in East Africa according to existing literature.

[84] T. Quinn *et al*., 'AIDS in Africa: An Epidemiologic Paradigm', *Science*, ccxxxiv (1986). Other studies from the late 1980s noted the extreme rarity with which homosexuality was mentioned by patients and the wider community. For example, N. Clumeck, P. Hermans, and S. De Wit, 'Some Epidemiological and Clinical Characteristics of African AIDS', *Recent Advances in AIDS and Kaposi's Sarcoma*, xxxviii (1987); A. Larson, 'Social Context of Human Immunodeficiency Virus Transmission in Africa: Historical and Cultural Bases of East and Central African Sexual Relations', *Reviews of Infectious Diseases*, xi (1989).

Our results are in accordance with this.' 'Homosexuality and intravenous drug abuse do not seem to be risk factors in this population.'[85]

It seems then that homosexuality was not universally ignored or censored in the years after Serwadda *et al.*'s paper. But given the prominence of MSM within patterns of HIV transmission today, it is necessary to consider the extent to which the focus on heterosexual transmission from the 1980s resulted in the destructive exclusion of MSM from HIV services which has been observed since the turn of the century. It is highly likely that the public association within Uganda of HIV with American homosexuality during the early years of the epidemic would have tended to encourage men who had sex with men to keep their sexuality and status private.[86] This culture of privacy, however, was not a new phenomenon. While previous studies of the history of homosexuality in Africa have tended to focus on demonstrating its existence, and its indigeneity, for the purposes of this paper attention should rather be devoted to popular responses to homosexuality.[87]

During the colonial and early postcolonial periods homosexuality was largely invisible within Uganda. Between 1938 and 1961, Buganda's provincial courts tried only two cases of sodomy, 0.1 per cent of all sexual crimes, and far fewer than, for example, cases relating to bestiality.[88] It seems that neither local communities, chiefs, nor police identified homosexuality as a significant threat to public morality during this era. Nor did the medical

[85] F. Kigozi, 'Sexual Behaviour', *Health Information Quarterly*, ii (1986): 11–20; S. Berkley *et al.*, 'Risk Factors Associated with HIV Infection in Uganda', *Journal of Infectious Diseases*, clx (1989).

[86] F. Bennett, 'AIDS as a Social Phenomenon', *Social Science and Medicine*, xxv (1987).

[87] Valuable surveys include Epprecht, *Heterosexual Africa*; N. Hoad, *African Intimacies: Race, Homosexuality and Globalization* (London, 2007); S. Murray and W. Roscoe, *Boy-Wives and Female Husbands: Studies of African Homosexualities* (New York, 1998). These discuss early ethnographic studies which referenced homosexuality across Uganda.

[88] SOAS archive, PPMS38/Perlman/Box 2, Court Records.

profession seek to regulate sexual normativity. References to same-sex relationships in medical reports and publications before the 1980s are extremely rare. One 1947 study of syphilis reported that anal sores were common among Ugandan men, yet this observation prompted no commentary about same-sex activity. In this era, it is more likely that such silence was suggestive of tolerance of, or uninterest in, homosexuality, rather than a desire to suppress or ignore non-heterosexual disease transmission. Only once was homosexuality referred to directly in this era in medical writing, and then only in passing. In the 1960s, researchers evaluating mental health among Makerere University students in Kampala noted that 'Homosexual problems were never seen as presenting problems but three African males [out of c.800 cases] referred because of anxiety related to study stress . . . admitted, during the course of the psychiatric examination, to occasional homosexual behaviour; none appeared to be socially or psychologically disturbed by their bisexual orientation.' Medical professionals may have accepted the prevailing clinical categorisation of homosexuality as a psychiatric 'problem', but pragmatically it was not treated as such since the subjects of study were comfortable in their identities. Even within indigenous medical cultures, what very limited evidence survives indicates that same-sex behaviours were viewed as a phenomenon that was situational or associated with the life-stage of adolescence. An oral informant, referring to the early twentieth-century practices of *baramansi* ritual healers, described several contexts where their interventions might be necessary: 'when the rains have failed to come . . . also when say like young boys go into the hills and play sex there and they get stuck together . . . [The healer] comes and prays to this goddess and you get freed.' Here, it was a complication, rather than the condition of homosexuality itself, that required a healer's intercession.[89]

[89] C. Hackett, 'Yaws and Venereal Disease in Uganda', *British Medical Journal*, ivcdlxxxix (1947), 88–90; G. German and O. Arya. 'Psychiatric Morbidity amongst a Uganda Student Population', *British Journal of*

Similarly, Uganda's press largely ignored homosexuality before the 1980s. This again was not because of a general prudishness, as local newspapers regularly described in salacious detail adultery, officials' use of sex workers, adults impregnating schoolgirls, and various other scandals.[90] Surveying the Ugandan press identified only one story where same-sex relations were implied, and even here the possibility remained that such relationships were unintended or unconsummated. 'Mary', a fourteen-year-old boy, 'whose appearance and style of dressing [was] very much feminine', was 'alleged to have been tricking men that he was a woman, and was being befriended, after which he would escape after getting whatever he wanted from his "boy-friend".' Although the story made clear that this case was not a one-off – 'Mary' was a member of a gang 'who taught him how to imitate women in order to earn his living' – its tone lacked the fear and distaste of Ugandan media coverage of MSM since the late 1990s. There was no sense that Ugandan morality was being corrupted by a grand conspiracy, the tone of this 1973 piece being largely matter of fact, and more amused than scandalized.[91]

References to MSM appear more frequently in the records of Uganda's Christian churches, but with nothing like the furious intensity of recent decades. Even the famous martyrdoms of Buganda's royal pages in 1886, which were categorised by contemporary missionaries as the result of young male converts' moral repugnance at the king's predatory

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Psychiatry, cxv (1969); Justin Willis Interviews, Int Nyoro28b, Kyesiiga, F, 30 Mar. 1998, <https://beta.ukdataservice.ac.uk/datacatalogue/studies/study?id=4169> (accessed 30 Nov. 2019). This informant came from Bunyoro, a society which neighbours and is closely related to Buganda.

[90] 'Who avails invitation cards to prostitutes?', *Obugagga Bwa Uganda*, 16 Jan. 1957, 6; 'White's wife gives birth to black twins', *Uganda Empya*, 4 Feb. 1957, 1; 'Superstar Prostitute', *Uganda Empya*, 28 Oct. 1957, 3.

[91] 'Man is woman', *Voice of Uganda*, 6 Aug. 1973. Four years of Uganda's newspapers were sampled from each decade of the twentieth century.

bisexuality, were increasingly referred to by allusion as the twentieth century progressed.[92] As Kevin Ward has observed, the annual commemoration of the martyrdoms at the Catholic and Protestant shrines at Namugongo during the 1970s and 1980s glossed over the issue of homosexuality.[93] Equally revealing is how the most significant incident relating to homosexuality from the entire colonial period was handled. An investigation into the cause of a riot at Buganda's leading boarding school, Budo, in 1942 identified a culture of 'subterranean' homosexuality, involving both British teachers and Ugandan schoolboys. Despite the existence of rigid laws against sodomy, and the Christian character of the school, the evidence of homosexuality was censored from the official government record, and kept from parents and key church figures.[94] In broad terms the official response to cases of suspected homosexuality before the 1980s was one of discretion. Religious hierarchies defended clergy and teachers accused of same-sex relations with their juniors, even in the face of seemingly strong evidence.[95] Church elites typically regarded homosexuality as a practice associated with contexts where heterosexuality was structurally obstructed, and

[92] For contemporary accounts see R. Ashe, *Two Kings of Uganda* (London, 1970 [1889]), 218; Letter from A. Mackay, *Church Missionary Intelligencer*, xi (June 1886), 888. Some colonial-era mission publications explicitly linked the martyrdoms and homosexuality. For example, J. Thoonen, *Black Martyrs* (London, 1941).

[93] K. Ward, 'Same-Sex Relations in Africa and the Debate on Homosexuality in East African Anglicanism', *Anglican Theological Review*, lxxxiv (2002), 89.

[94] BUL, CMS G3/A/7/e1, Bishop Stuart to 'The Mass Meeting of Budo Parents', 9 Dec. 1942; National Archives, CO/536/210/5 'Portions of the Report of the Board of Enquiry into Certain Disturbances at King's College, Budo, which have been deleted from the signed copies of the Report', n.d. [1943]. See C. Summers, '"Subterranean Evil" and "Tumultuous Riot" in Buganda: Authority and Alienation at King's College, Budo, 1942', *Journal of African History,* xlvii (2006).

[95] Church of Uganda Archives, Mukono [CUAM], BP/CUA-1, 151/891, Bishop to Governor, 30 Oct. 1952; CUAM, BP/CUA-1, 241/1380, Ernest to Bishop, 21 May 1954, and Mbarara College and High School, 1954.

quietly requested that boys in reformatory schools should not share beds, and that new prison inmates should not be put into cells with 'old lags'. Assessing non-elite opinion from this period is more difficult. Occasional documents in the church archives contain virulent attacks on individuals accused of homosexuality, but the view from above was that such allegations reflected personal malice, the result of schoolboy antagonism, nationalist conspiracy theories, or familial disputes.[96] In 1978, following the Lambeth Conference's resolution that homosexuality should be studied across the Anglican Communion, the Church of Uganda reflected on same-sex relationships, society, and theology. The consensus which was reached was that Lambeth's injunction to 'rejoice in diversity . . . is detestable', yet 'African problems such as ancestral veneration, polygamy, magic etc need our Church's immediate attention [more] than homosexuality.' 'Although homosexuality was not a pronounced problem, it was existent in prisons, schools, and among migrant labourers', and merited attention.[97]

It would be an exaggeration to suggest that Uganda before the 1980s was free of homophobia, but what evidence exists indicates that homosexuality was regarded as uncommon and insignificant. The latter assumption may of course support Epprecht's hypothesis that the role of homosexuality in Africa's AIDS epidemic was structurally marginalized from the beginning. Yet the peripheralization of MSM since the late 1990s relates precisely to their new visibility within Uganda. The emergence of international rights-based NGOs which sought to define and protect MSM as a discreet risk group, and create space for the expression of same-sex identities, coincided with, and stimulated, the rapid expansion of American Pentecostal Christianity. Pentecostalists' identification of a global

[96] CUAM, PS/CUA-6, 127/3, Minutes of the Board of Visitors' Meeting 6 Oct. 1976 at Kampiringisa Approved School; CUAM, BP/CUA-1, 151/891, Bishop to Prison Governor, 26 July 1953; CUAM, BP/CUA-1, 241/1380, Anon to Mr Rwatsika, 26 Mar. 1954; CUAM, BP/CUA-1, 153/898, S. Mulumba to Bishop Stuart, 26 July 1948.

[97] CUAM, General File/CUA-6, 131/3, Partners in Mission 1981.

conspiracy to turn Uganda gay fed into popular disquiet at the iniquities of development, and the social destabilization associated with human rights discourse. For President Museveni, growing public criticism of his regime's authoritarianism and corruption could be best countered by a new moral politics, that defined the normative family as the bedrock of the nation and, by extension, homosexuality as its antithesis.[98]

In earlier decades, by contrast, same-sex networks were assumed to be narrow and homosexuality was generally regarded as a relatively uncontroversial, private matter. As one informant recalled, there was no public interest in same-sex relationships, provided they were discreet, in the years before the AIDS epidemic. Same-sex behaviours were regarded as less serious than heterosexual; they carried connotations of play, or practice, unaffected by the implications of reproduction and bridewealth. MSM were seen as outside, but not fundamentally undermining, of kinship relations, and, it seems, they were typically viewed as performing homosexual acts rather than assuming and asserting homosexual identities. Crucially, at this time, there was no visible gay scene in Kampala.[99] It is likely that if, in the decades before the HIV epidemic was recognised, gay bars and clubs existed in Kampala in the numbers reported in the 2000s, then they would have been the subject of official intervention and press attention, and MSM might have been included in the extensive list of

[98] Lydia Boyd, *Preaching Prevention: Born-Again Christianity and the Moral Politics of AIDS in Uganda* (Athens OH, 2015); Patrick Awondo, Peter Geschiere, and Graeme Reid, 'Homophobic Africa? Toward A More Nuanced View', *African Studies Review*, lv (2012).

[99] Int. Anon, 5 Sept. 2018; S. Nyanzi, 'Queering Queer Africa', in Z. Matabeni (ed.), *Reclaiming Afrikan: Queer Perspectives on Sexual and Gender Identities* (Athlone SA, 2014). Epprecht's valuable work has also noted examples of cultural tolerance of private homosexuality. M. Epprecht, *Sexuality and Social Justice in Africa: Rethinking Homophobia and Forging Resistance* (London, 2013).

groups categorised as being at higher risk of STI infection.[100] It seems then that looking for continuities from Serwadda *et al*.'s research findings in 1985 and the intense concern about rising MSM HIV prevalence over the past ten to fifteen years may conceal as much as it reveals. Same-sex culture, as well as public and official attitudes relating to it, appear to have changed markedly since the late 1990s.

Conclusion

Much of this paper has reflected on non-historians' engagement with the past in relation to HIV. It has demonstrated the unique contribution that geneticists and other medical researchers can make. They have challenged historians' chronological frameworks, requiring a realignment of the temporal focus of qualitative archival and oral research. Their analyses of current policy and survey data highlight issues that have previously been neglected by historians, or that encourage a rethinking of historical change. Scientific researchers' writing about the past does though indicate the existence of significant disciplinary differences in how historical narratives are imagined and constructed. Geneticists' formulation of change over time has tended to be built around moments of divergence, heightening the focus on historical episodes rather than process, and on diffusion over intensification. They have also at times assumed that the contexts of the recent past can be applied backwards to more distant periods. Historians are hardly immune to such approaches; their interests are often demonstrably shaped by present concerns, they too have a known fixation with turning points, and many historical debates are structured around long-term versus short-term causality. Yet historians are trained to avoid reverse chronological methodologies, to encompass the dead ends and the long ways round within their

[100] See, for example, F. Bennett, 'The Social Determinants of Gonorrhoea in an East African Town', *East African Medical Journal*, xxxix (1962).

reconstruction of historical process, and to recognise that meanings and assumptions as well as structures change over time. Historians are trained to challenge rather than accept the limitations of evidence, to consider, for example, the implications of the availability of genetic material reflecting, to a large degree, the location of medical facilities. Historians' embeddedness in the past enables them to see that the accuracy of GUD diagnosis improved markedly over the twentieth century because of shifts in racial and moral assumptions, as well as improvements in technical capacity. Their awareness of the contexts within which communications were transformed over the twentieth century highlights that travel before the TransAfrican Highway was shaped not only by variations in infrastructure and technology, but also by differing social networks and patterns of trade.[101]

On one level, the arguments of this paper could be read as profoundly negative, an historian's guarding against the possibility of anachronism. Instead, what it seeks to argue is that HIV's emergence, dispersal, and resilience reflect the evolving complexity of African societies. Reconstructing HIV's long history involves stories of sex and marriage, morality and discretion, migrant labour and political displacement, ethnic and racial preconceptions, and locality and connection. The need to encompass and integrate very different scales of interaction, processes of change, and levels of analysis provides a reminder that while historians should take non-historians' interventions seriously, historians are best placed to explain how diseases have been shaped by past societies.

Multidisciplinary research is common within science; there exists no conceptual barrier to working across disciplines from scientists' perspectives. Practical obstacles, such as variation in the pace of research and funding barriers to collaboration, exist. But historians

[101] For similar discussion of the varying viewpoints of econometrists and historians, see G. Austin, 'The "Reversal of Fortune" Thesis and the Compression of History: Perspectives from African and Comparative Economic History', *Journal of International Development*, xx (2008).

perhaps also need to reflect on why our publications often fail to be seen by or to resonate with scholars working on the present. Search engines, digital cameras, and digitization programmes have made archival materials accessible to the non-historian as never before, certainly in Africa. This presents a new challenge for historians, requiring them to consider how effectively they engage with other disciplines, ensuring that the difficulties of interpreting archival sources are recognized beyond their own scholarly tradition. Historians need to become better at disseminating their methodology, as well as their findings, to a non-expert audience.

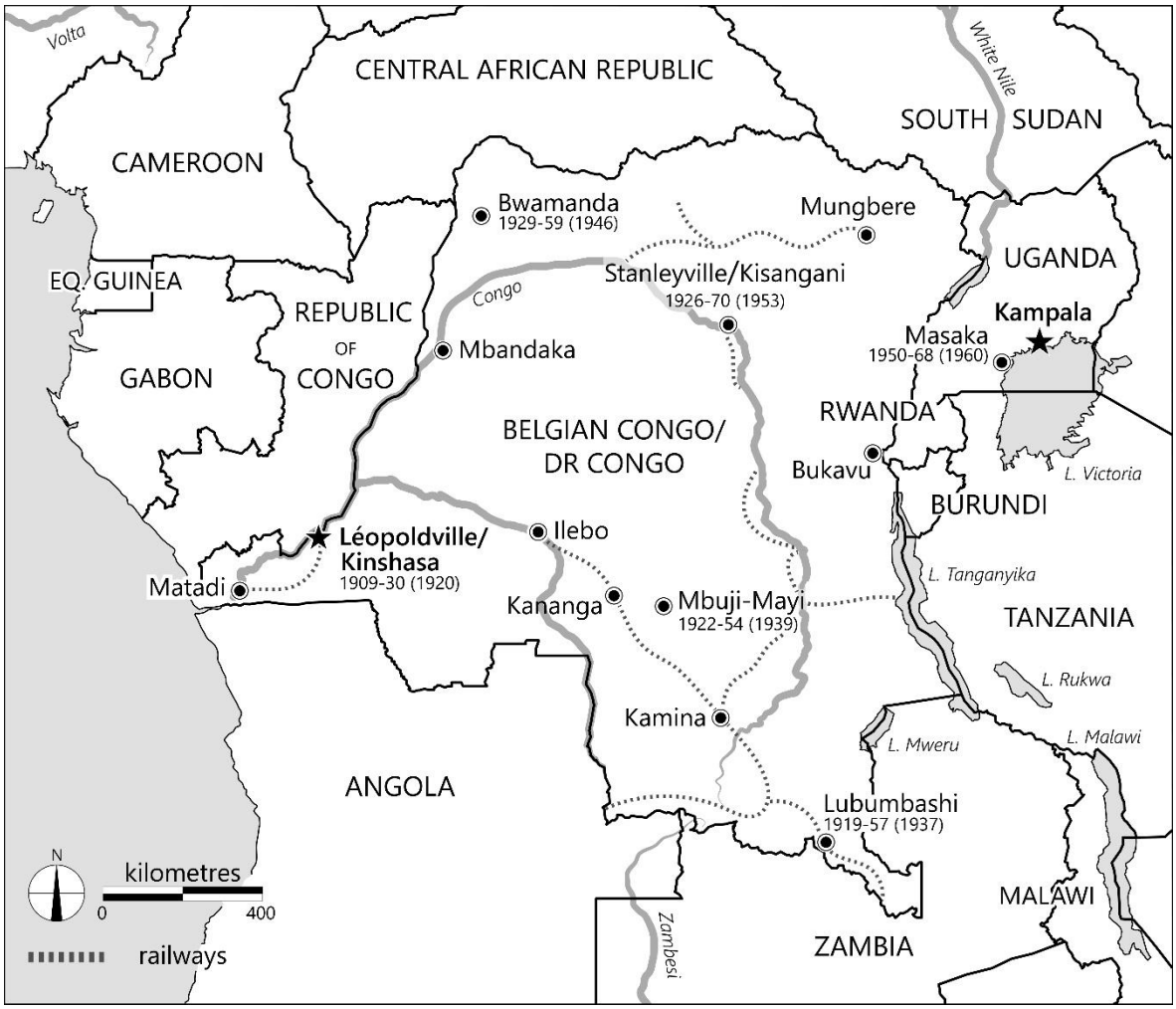
This paper has focused on the history of Uganda, indeed on one region, Buganda. This narrowness is inevitable, and necessary. Africa's pandemic consists of a series of interconnected local epidemics, each with its own distinct epidemiology, and each requiring detailed historical analysis. AIDS' impact on Africa has been regionally diverse, but across most of the continent it has been transformative. Its history is still in its infancy, but it can be anticipated that future histories of HIV will look far beyond epidemiology, to, for example, the relationship between the state, INGOs, and the subject; how the ubiquity of counselling and human rights discourse have shaped new notions of the self; and how marriage has in many societies increased in value and importance even as it reduced markedly in prevalence.[102] Perhaps most importantly, new research will examine how African states sought from the beginning to shape the historical representation of their HIV epidemics. In Uganda, as early as 1987, President Museveni asked of the country's AIDS experts a series of questions: 'What is the history of the disease? Who is responsible? What happened in

[102] Historical research might also build on insightful social science studies including H. Gilbert, 'Re-visioning Local Biologies: HIV-2 and the Pattern of Differential Valuation in Biomedical Research', *Medical Anthropology* xxxii (2013); Vinh-Kim Nguyen, *The Republic of Therapy: Triage and Sovereignty in West Africa's Time of AIDS* (Durham, N.C., 2010).

Uganda? . . . What lessons have we to learn from this killer disease?' For the Ugandan government, AIDS was both an existential threat and an historic opportunity. HIV offered this impoverished, vulnerable regime an international visibility, which it sought to turn to its, and its people's, advantage. Uganda's imaginative and comprehensive response to HIV would bring not only billions of dollars of donor aid in years to come, but an immediate place at the heart of global policymaking relating to AIDS. By 1989 Uganda had persuaded the WHO to develop a more favourable depiction of the country's role in the emergence of HIV, and clamped down on AIDS-focused journalism 'where we are not in a position to monitor and control the end product'. Here, the production of history was leveraged to enhance state sovereignty and national reconstruction.[103] It is the multifaceted nature of HIV's history, and history-making, that makes new, collaborative research so essential.

[103] UMOHJIASCC, 'Prevention of AIDS' VNNUMR. RGD Section 12, NCPA (extraordinary) meeting, HE the President, 10 July 1987; UMOHJIASCC, GCD 2/1, A. Ogola to MoH, minute, 5 June 1989; UMOHJIASCC, Unnumbered Section 13, Memos and Letters from ACP, S. Okware, Brief report and policy considerations on AIDS Control Programme for Minister of Health, 15 Apr. 1989. See also Iliffe, *Doctors*, 244.

MAP 1: HIV'S EARLY EXPANSION TOWARDS UGANDA[104]



[104] Map by Matilde Grimaldi. The map illustrates our partial understanding of the chronology of HIV's spread across Congo and Uganda. Locations where archived tissue samples permitted a calculation of a median estimate for the date of first infection (in parantheses), and the range of dates within which infection would have first occurred, have been included. So too have Congo's other major transport hubs, where samples have not survived. Faria *et al*., 'Early Spread'; Gonzalo Yebra *et al*., 'Analysis of the History and Spread of HIV-1 in Uganda Using Phylodynamics', *The Journal of General Virology*, xcvi (2015).

MAP 2: BUGANDA IN ITS REGIONAL CONTEXT[105]

[105] Map by Vincent Hiribarren.