Speaking to the Converted? Religion and the Politics of Gender in South African AIDS Discourse

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RESÜMEE

Marian Burchardt: Rede an die Konvertiten? Religion und Genderpolitik im AIDS-Diskurs in Südafrika

Die kirchlichen Hilfsgruppen, die sich in Südafrika mit der HIV-AIDS-Pandemie befassen, sind überwiegend weiblich. Der Aufsatz untersucht solche Gruppen im Kontext der Neukonfiguration des Verhältnisses zwischen Gender und Religion im Rahmen der Modernisierung. Auf der Basis einer in Kapstadt durchgeführten Feldforschung zeigt er das Potential von Religion – vor allem vom charismatischen Christentum – als Raum, in dem sich die sexuelle Genderdynamik transformieren kann. Die neuen Faith-Based Organisations schaffen Räume, in denen die Ungleichheiten von Männer- und Frauenmacht teilweise „neutralisiert" werden und Frauen auf der Basis gemeinsamer Erfahrungen in die Lage versetzt werden, bestehende religiöse Räume zu betreten und auszunützen.

Collective expressions of faith and shared religious practice are commonly known to gain salience as articulations of societal crisis and as collective attempts to cope with it. One of the perennial functions of religion in this context is that in fact it simultaneously operates along the lines of two distinct and yet intrinsically related logics: on the one hand, religions provides narratives of *continuity* and stability within the broader context of social anomie and suffering; on the other, in wrestling with social problems that command response, religions often – intentionally or as a side-effect – re-enforce *cultural change*. In this article I show that both logics are at work with regard to the impact of both religious practice and the non-religious practices of faith-based organisations on gender relations in confronting the AIDS epidemic in South Africa.

The significance of gender relations and identities for understanding the dynamics of

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South Africa's AIDS epidemic has long been acknowledged.[1] Being a sexually transmitted disease, intimate gender encounters as well as the norms, values and material constraints on the basis of which South African women and men engage in them are at the heart of the social arrangement that determines predominant epidemiological patterns. However, intimate relationships and sexual interactions have to be seen as enmeshed in and articulating the fundamentally gendered nature of relations of power and domination within the broader social world whose hierarchical ordering they express.[2] In this sense the concept of gender enlaces ideas of moral order – as a system of duties and obligations - with aspects of the division of labour, a fact that explains the perceived female responsibility of caring for the sick, for the millions of AIDS orphans, but also women's capacities to create new forms of solidarity and mobilize support networks.

While for a long time the religious response to the challenge of AIDS was either limited to discourses of sin or else was characterized by institutional inertia, during the past decade churches and other faith-based organizations have emerged as new major players within the South African AIDS industry.[3] Religious organizations are at the forefront in prevention campaigning and in organizing care for the diseased, and they are running countless support groups. This makes it worthwhile to explore how the construction of religious spaces as arenas for fighting AIDS affects and reconfigures gender relations, as well as how the practices of faith-based organizations resolve possible tensions between religiously defined gender-roles and the kind of gender-specific responses that the challenge of AIDS demands, in interaction with their followers.

In the first part of this article I review how sociological and anthropological research on HIV/AIDS in Africa has conceptualized the gender problematic. I will then locate the activities of faith-based organizations within the broader discourse on norms of intimacy, care and solidarity. After that, I discuss how faith-based organizations in Cape Town frame gender issues in their AIDS-related work. The article draws on nine months' field research in 2006 and points to some major tendencies within this ongoing and highly contested process.

1 B. Ingstad, The cultural construction of AIDS and its consequences for prevention in Botswana, in: Medical Anthropology Quarterly 4 (1990), 1, 28-40; more recently: J. Lonsdale, Conclusion, in: Journal of Religion in Africa 37 (2007), 1, 145-149.

2 P. Bourdieu, Masculine Domination, Stanford 2001.

3 On the interface of religion and HIV/AIDS in Africa see for example R. C. Garner, Safe sects? Dynamic religion and AIDS in South Africa, in: The Journal of Modern African Studies 38 (2000), 41-69; J. Pfeiffer, Condom social marketing, Pentecostalism, and structural adjustment in Mozambique: A clash of prevention messages, in: Medical Anthropology Quarterly 18 (2004), 1, 77-103; V. Agadjanian, Gender, religious involvement, and HIV/AIDS prevention in Mozambique, in: Social Science and Medicine 61 (2005), 1529-1539; with particular regard to East Africa F. Becker/ P. W. Geissler, Introduction. Searching for pathways in a landscape of death: Religion and AIDS in East Africa, in: Journal of Religion in Africa 37 (2007), 1, 1-15.

1 The Gender of an Epidemic

1.1 The Gender Perspective on AIDS: Why Does it Matter?

Support groups are one of the most significant organizational forms through which Africans living with HIV and AIDS are trying to deal with their precarious life circumstances. They emerged in the social climate of widespread stigmatization, anxiety and denial. In most cases these groups are small and relatively informal grass-roots initiatives or organizational appendices of NGOs. AIDS patients are recruited to such groups by word of mouth or referred to them through ties between local clinics and NGOs. In recent years South Africa has witnessed a massive proliferation of such initiatives. Their creation reflects the emergence of a nascent post-Apartheid civil society movement and signifies fundamental shifts in the way solidarity and care are organized.

However, something appeared to be different when in Cape Town back in September 2005 yet another such group was founded and given the name "Kululeka". The group was immediately known throughout the entire civil society landscape of Cape Town and beyond. Their members were invited to NGOs and other support groups to give talks about their project. The T-shirt carrying the Kululeka-logo could be spotted in various townships, and from the beginning the group became the subject of intense scholarly interest.[4] What was different? It was a men's support group. After more than a decade of public AIDS discourse in South Africa, the formation of "Kululeka" was celebrated as a pioneering act, providing a role model for further critical engagement of men with AIDS-related concerns. Asked why they found it necessary to form a support group for men, Kululeka members argued that men's concerns with HIV were very different from those of women, adding that although they did participate in mainstream mixed support groups before, they never felt comfortable to address their issues there.[5] But why then is there only one men's group in a sea of support groups that are overwhelmingly frequented by women?

The striking absence of men in support groups reflects the fact that a whole series of elements that form parts of culturally sanctioned models of masculinity are seemingly incompatible with the challenges posed by AIDS. The mere idea that men need support can be read as running counter to an ideal of masculinity that is based on notions of strength and independence. But in a more immediate sense, it prompts us to ask: Why did women form support groups in the first place? There are three possible answers: first, because there may be no men as husbands and partners in confronting AIDS-related issues in the household. Anthropological studies have argued that the combination of rural impoverishment, subsequent rural-urban migration, social mobility and economic

4 For an analysis of Kululeka as a laboratory of creating new male gender models see S. Robins, Sexual rights and sexual cultures: reflections on "the Zuma affair" and "new masculinities" in the new South Africa, in: Horizontes Antropológicos 12 (2006), 26, 149-183.

5 These views were articulated in the course of an action-research workshop, held in March 2006, in which I participated.

insecurity has led to a dissolution of traditional norms of family relationships. Single mothers raising children alone or in cooperation with grandparents seem to be the dominant household form in some metropolitan townships.[6] Secondly, if women are married and cohabitating with their husbands, husbands are usually not available for addressing AIDS-related issues, which would somehow imply communication about sexual practices. It has been argued that such talk would generally be subject to traditional moral restrictions and taboo. Yet the normative core of this taboo is less a conservative standard of decency than a masculine morality, which precludes the possibility of a debate that implicitly aims at reconfiguring gender relations. And thirdly, we can hypothesize that because of the continuing stigma that is attached to AIDS, the extended family can be partially ruled out as a source of practical and emotional support.[7] Under these circumstances, the formation of female-dominated support groups appears a logical outcome.

It has become clear that the case of Kululeka is highly indicative of the necessity to address gender relations and gender dynamics when analysing the struggle against HIV and AIDS in South Africa, for – against the mainstream of studies pointing to women's vulnerabilities – it also provides us with a sense of the particular precariousness of HIV-positive men in finding social support. However, the fundamental significance of gender divisions in combating HIV and AIDS clearly reaches beyond concerns with the unequal capacities of organizing support or problems with negotiating condom use. Yet there has been little in the way of systematic *theoretical* investigation into the multiple connections between gender and HIV/AIDS.

Within the existing literature on AIDS, there are three ways in which the role of gender has been addressed: the first is concerned with the implications of gendered patterns of blaming; the second way focuses on the impact and consequences of gender roles in sexual dynamics; a third line of argument addresses the unequal social consequences of HIV infection for women and men. I will briefly describe these approaches.

1.2 Patterns of Blame

Mary Douglas has argued that one of the most important societal reactions to risk is the attribution of blame.[8] Finding out who is responsible for a certain crisis is an active engagement with the social and natural world and appears as an almost natural corollary of thinking through a *nomos*, that is, a more or less coherent cognitive and normative order, in which objects and actions are classified in terms of causes and effects. However, if the critical condition appears to be an outcome of human action, blaming is tantamount to

6 F. Scorgie, Virginity testing and the politics of sexual responsibility. Implication for AIDS intervention, in: African Studies 61 (2002), 1, 55-75, p. 63.

7 For an overview on the sociological dimensions of AIDS stigma see A. A. Alonzo/ N. R. Reynolds, Stigma, HIV and AIDS: An exploration and elaboration of a stigma trajectory, in: Social Science and Medicine 41 (1995), 3, 303-315; on family solidarity in the context of stigma see H. Dilger, Leben mit AIDS. Krankheit, Tod und soziale Beziehungen in Afrika, Frankfurt/ M. 2005, 94 et seqq.; for the most influential sociological account on stigma, E. Goffman, Stigma: Notes on the Management of Spoiled Identity, Englewood Cliffs, N.J. 1963.

8 M. Douglas, Risk and Blame. Essays in Cultural Theory, London 1992.

opening up a moral discourse in the course of which particular social groups are held responsible for bringing the crisis about. Drawing on research in Botswana in the late eighties, Benedicte Ingstad was the first author to claim that in Africa AIDS overwhelmingly unfolds as a gendered epidemic.[9] According to her findings, the cultural construction of AIDS departed from ideas about the sexual anatomy of the female body, that is, from a framework in which the female body appears as particularly unclean, thereby potentially allowing diseases to arise. For Ingstad, this cultural construction of the female body was at the bottom of a pattern of blame that ultimately held women responsible for the spread of AIDS. Subsequent studies in various African countries produced further evidence for patterns that are largely based on the idea of a one-way transmission from women to men.[10]

With particular respect to South Africa, Leclerc-Madlala provides a fascinating account on how the blaming discourse of AIDS is borne from cultural concepts of pollution.[11] In her research into the current revival of virginity testing movements in KwaZulu Natal she found that long-established notions of pollution are generally associated with sexually active women. More precisely, pollution is a possibility that emerges from the fundamentally ambivalent character of the female reproductive biology that within the framework of folk theory comprises positive and negative valences: "The female body", Leclerc-Madlala points out, "is the acknowledged site of male sexual pleasure and the "nest" within which new members of the patrilineage are nourished and grow. (…) On the other hand, once women become sexually active, their bodies conjure up notions of danger, disease, and the ability to weaken men and bring all manner of misfortune to society."[12] It does not come as a surprise then that – at least under the circumstances of scant alternative knowledge – this model lends itself to blaming the spread of AIDS on women.

But blaming women for the spread of AIDS is not only inextricably connected to cultural definitions of the female body; it is also linked to the gender-specific norms of sexual morality. With particular regard to the sexual practices of unmarried youth, these norms are fundamentally characterized by a double-standard. Time and again, studies have shown that for young men – despite much prevention discourse – the norms of sexual conquest are pretty much alive.[13] Having multiple sexual partners testifies to indi-

9 B. Ingstad, The cultural construction of AIDS (fn 1).

10 See C. Obbo, HIV Transmission: Men are the solution, in: Population and Environment 14 (1993), 3, 211-243; L. Haram, The gendered epidemic: sexually transmitted diseases and AIDS among the Meru people of Northern Tanzania, in: S. Bergstrom/ G. Holmbee-Otlesen (eds.): Reproductive Health Research in Developing Countries (Sum. Report No. 4), Oslo 1996.

11 S. Leclerc-Madlala, Virginity testing. Managing sexuality in a maturing HIV/AIDS epidemic, in: Medical Anthropology Quarterly 15 (2001), 4, 533-552.

12 Ibid., 541.

13 C. Wood/R. Jewkes, 'Dangerous' love. Reflections on violence among Xhosa township youth, in: R. Morell (ed.): Changing Men in Southern Africa, Durban 2005, 317-336; C. A. Varga, Sexual decision-making and negotiation in the midst of AIDS: youth in KwaZulu Natal, South Africa, in: Health Transition Review, Supplement 3 to Vol. 7 (1997), 45-67.

vidual virility and bestows pride and honour to a man in the eyes of his male peers and girls alike. Male multiple partnering is a practice with such profound cultural plausibility that some young women reportedly assume that there is something wrong with their boyfriends if they do not court other women. Culturally accepted models of "successful masculinity" are thus revolving around "successes with women" and put a premium on them. These successes translate into prestige and later circulate as the quintessential currency in the process of establishing male peer hierarchies.[14] For young women and girls, on the other hand, the very same practices are thoroughly unthinkable and would expose them to everything from moral degradation to outright violence. Again, violating the moral norms of serial monogamy would generally be viewed as a moral transgression in the eyes of both young men and women. Thus, being faithful within an intimate and sexual relationship is a norm that solely applies to women. Within the same complex of moral rules what is expected from men is out of bounds for women.

It is important to note that transgressions of these norms typically provoke less severe consequences for men than for women because they are – in the gendered popular perspective – less severe in their nature. Whereas failing to live up to standards of successful masculinity might expose young men to ridicule, for women transgressions are often followed by social ostracism or violent retribution. In general, observing transgressions focuses on the actions of women, a fact that has important implications for patterns of blame for AIDS infection. Discussing findings from her research in Zaire, Schoepf writes: "When men are infected, *their wives* are suspected of infidelity. Where women are infected *they* are assumed to have had multiple partners."[15] The practical logic of blaming that is at work here appears to re-enact the perspective of masculine domination from which the moral norms are constructed, on the one hand, and a whole tradition of male concern with controlling female sexuality on the other.

These blaming patterns are also reinforced by the current revival of practices of virginity testing in the South African province of KwaZulu Natal. Virginity testing consists of the public inspection of the genitals of unmarried girls with the aim of restoring the moral norms of premarital chastity. It is usually carried out by older women and is governmentally sponsored through funds for the promotion of indigenous knowledge. Therefore the revival of virginity testing has to be located within the broader context of the "African Renaissance" agenda, which attempts to revive African traditions that have been lost "in the concerted onslaught of Christianity, colonialism and apartheid".[16] In their discussions of these movements, Scorgie and Leclerc-Madlala come to the conclusion that, although carried out by women, virginity testing serves as another contemporary reminder of a long history of social preoccupation with controlling female sexuality.[17] It squarely puts the responsibility for achieving abstinence on young women and girls, and

14 See Varga, Sexual decision-making (fn 13).
15 Quoted in Leclerc-Madlala, Virginity testing (fn 11), 546.
16 Ibid., 536.
17 Scorgie, Virginity testing (fn 6); Leclerc-Madlala, Virginity Testing (fn 11).

in doing so it helps to render invisible the male sexual responsibilities. It also conceals the whole paradoxical construction of the male prerogative to sexual agency and assumed female responsibility for averting sex. However, keeping in mind that the major rationale behind this revival is the concern with HIV/AIDS, it seems clear that responsibility for abstinence is easily translated into the responsibility and blame for the spread of AIDS.[18] In conclusion, gendered patterns of blaming AIDS result from a cultural construction of disease that conjoins ideas of a medicalized female body with an overall focus on female transgressions of moral norms of sexuality.

1.3 Twisted Entanglements: Gender and the Changing Order of Sexuality

The discussion of blaming patterns has already indicated the significance of sexuality for understanding the connections between gender relations and the struggle against AIDS. Another line of investigation seeks to understand more directly the implications of gender roles for contemporary sexual dynamics through exploring the cultural frameworks that set the parameters for sexual decision-making and that determine the cultural meaning of sexual encounters. Given the assumption of a pluralism of such cultural frameworks, this research strategy allows us to see that there is in fact not one but a multitude of gender relations. Each of these has its own implications for questions of AIDS prevention. Some pioneering work has been done by Preston-Whyte et al. in their study of "Survival sex and HIV/AIDS in an African city".[19] By comparatively analysing and characterizing the sexual dynamics in three townships with different economic backgrounds this study goes beyond the simplistic and Eurocentric dichotomy of romantic love and prostitution, thereby at least in theory permitting the construction of a differentiated typology of cultural frameworks of sex. Over decades anthropologists had gathered evidence that many sexual encounters in Southern African societies involved exchanges of gifts, money or services for sexual favours. While these practices certainly share some formal characteristics with commercial sex – namely the fact that they constitute social transactions – they nonetheless must not be conflated with prostitution. Preston-Whyte et al. argue that there is in fact a whole array of possible forms that transactional sex can assume. With regard to emotional involvement and their cultural legitimacy most of them have to be placed on a continuum that stretches from frameworks that locate sex within marriage or concepts of romantic love on the one hand to those of professionalized sex work at the other end of the continuum. A single mother, for example, may engage in multiple sexual relationships, which involve the exchange of consumer goods, emotional bonds, and some kinds of mutual obligation. One of her partners might be a long-distance truck driver who regularly covers her rent and the school fees of her children, and eventually they might even develop more exclusive conjugal bonds. Yet, notwithstanding the degree

18 Ibid., 67.

19 E. Preston-Whyte et al., Survival sex in an African city, in: R. Parker/R. M. Barbosa/ P. Aggleton (eds.): Framing the Sexual Subject. The Politics of Gender, Sexuality and Power, Berkeley 2000, 165-190.

to which the definitions of transactional sex differ, all can be explained by one pivotal variable: survival. Economic development and aspects of modernization appear to be a central factor in explaining the shifting significance of cultural frameworks of sex, thereby also affecting the possibilities for AIDS prevention.

Although there are some key differences between the various frameworks in terms of how they affect AIDS prevention, some generalizing conclusions are in order. Firstly, most studies agree that economic dependence combines with moral norms of female sexual availability to reduce or even minimize the power of women in sexual decision-making and negotiations.[20] This concerns timing, frequency, the kind of intercourse, and of course the question of condom use. Because of fear of rejection and stigmatization by their partners, women are often not in a position to enforce the use of condoms.[21] Under these circumstances many studies conclude that for women unsafe sex can actually represent a rational strategy; for it symbolizes intimacy, trust, and sexual legitimacy, and may even provide economic security.[22] Furthermore, women may choose not to use condoms, because on top of preventing HIV infection they also prevent pregnancy. Yet in cultural contexts, in which motherhood is central to the female gender role and in which there are scant effective moral barriers to premarital pregnancy, the expectation or desire to bear children is effectively tantamount to increased exposure to HIV infection.[23] Secondly, for men, condom use generally seems to signify reduced pleasure, and – more importantly – it symbolizes a fractured form of trust, or else promiscuity on the part their female partners. All these forms of resistance lead us to conclude that condom use will only be habitualized if resistance is confronted and dismantled though a process of negotiation. Now, whereas in *public campaigning interaction* many people have now quite literally come to learn the very meaning of the term 'sexual negotiation', its practice is often thwarted by the fact that there *is* no sexual communication in *private encounters*, and hence no negotiation.

What has become apparent from these remarks is that women and men in contemporary South Africa have to deal with a number of contradictive normative requirements with regard to gendered role expectations. Notwithstanding the historically unique discursivation of sexuality through AIDS discourse that I will address more in detail below, these contradictions reflect the ambivalent nature of colonial and post-colonial modernization. One important part of this process has been the creation of a post-Apartheid popular media culture.[24] Globally televised lifestyle models for which the acquisition of

20 Varga, Sexual decision-making (fn 13), for a contrary view B. G. Schoepf, International AIDS research in anthropology: Taking a critical perspective on the crisis, in: Annual Review of Anthropology 30 (2001), 335-361, see 346.

21 Varga, Sexual Decision-making (fn 13), 49.

22 Preston-Whyte, Survivalsex (fn 19).

23 Referring to the contradictory norms of child-bearing and HIV prevention, Preston-Whyte has coined the term „fertility conundrum"; see E. Preston-Whyte, Reproductive health and the condom dilemma: identifying situational barriers to HIV prevention in South Africa, in: J. Caldwell et al. (eds.): Resistances to Behavioural Change to Reduce HIV/AIDS Infection, Boston 1999, 139-155, p. 143.

24 M. Hunter, The materiality of everyday sex: Thinking beyond 'prostitution', in: African Studies 61 (2002), 1, 99-120, p. 113.

consumer goods such as cell phones, cars and fancy clothes are indispensable are now also celebrated by and promoted to young South Africans. At the same time, growing economic inequality within the recently liberated black population have made matching these aspirations largely impossible.[25] However, while the poor could not achieve the consumerist ingredients of "black coolness", gradual impoverishment also meant that for a lack of material resources to afford the traditional bride-wealth (*lobola*), they were no longer in the position to follow the traditional path of marriage and family life either. To the "new rich", in contrast, who could afford to follow the path of tradition, it appeared less and less attractive because of the new opportunities that their wealth afforded them on the market of sexual favours. The crucial point is that – unlike poor men – less endowed women can use sex as a bargaining point in interactions with men who enable them to fulfil their consumerist aspirations. According to Hunter, this has led to an increased salience of the cultural framework of transactional sex with three major consequences: first, it has reduced the relevance of marriage for setting the boundaries of legitimate manly behaviour; secondly, it has provided (some) women with strategic positions within which they can allocate their sexual capital to achieve higher status positions; and thirdly, it has rendered sexualities and related concepts of masculinity and femininity unstable.[26]

1.4 Who Cares? The Consequences of Infection

A third field of research on the interplay of gender and HIV/AIDS focuses on the unequal consequences the epidemic entails for women and men. The results of these investigations are unequivocal: despite the above-mentioned capacities of women to mobilize support their vulnerability to HIV infection is far greater.[27] Ethnographies of AIDS in various African countries have shown that infection of family members often multiplies women's obligations in terms of caring for the sick. If husbands are infected and fall ill, these obligations may also entail women having to look for additional household income through employment in the labour market. If women fall ill themselves, they generally face more severe forms of social and moral exclusion than men. Such reactions are derived from the gendered nature of stigmatizing discourse and the patterns of blame that I have addressed above. They include open rejections like being chased away from their family home to the more subtle forms of being silenced or discouraged from disclosing their status in order to avoid bringing shame upon the family.

In the context of a public discourse which links female sero-positivity to transgressions of gender-specific moral norms and which pejoratively describes HIV-positive women as

25 D. Posel, Die Kontroverse um HIV/Aids in Südafrika. Zur Politisierung von Sexualität nach der Apartheid, in: Peripherie 24 (2004), 93/94, 8-41.

26 Hunter, The materiality of everyday sex (fn 24).

27 For an overview on the relationships between gender, social inequality, and AIDS in South Africa see L. Gilbert/L. Walker, Treading the path of least resistance: HIV/AIDS and social inequalities – a South African case study, in: Social Science and Medicine 54 (2002), 1093-1110.

promiscuous, gender identity work tends to be subject to severe pressure. Interestingly, South African women seem to be exposed to the same kind of dilemmas that Laura Stanley has found to be typical for HIV-positive American middle class women.[28] These women have to confront a stigma that was issued on the basis of moral norms that are constitutive of their very own cultural milieu. An active engagement with this situation can basically assume two forms: firstly, women may be able to integrate their sero-positivity actively into their personal identities. They may develop a sense of solidarity with other HIV-positive people regardless of their social background, and by subjectively crossing the medical and moral boundaries from HIV-negative to positive, they may end up rejecting the AIDS stigma and the related moral framework altogether. On the other hand, an alternative strategy can consist in distancing oneself from the negative stereotypes by insisting on the distance between oneself and the group for which the stereotype was initially designed, thereby partially accepting the dominant moral framework and individually reinforcing an image of innocent victimhood. Given that in South Africa female sero-positivity continues to be strongly associated with promiscuous sexuality, women are in the same dilemma. From research into the experience of HIV and from my own analysis it became clear that confronting an HIV-positive diagnosis usually begins by answering the question: "Why me?" By insisting that – against the implications of the AIDS stigma – *they* have always been 'good' girls or 'good women' they implicitly accept the dominant definitions of how good women are meant to behave. By employing what Sobo calls the "rhetoric of the moral self" they align themselves with the moral standards of mainstream society as far as female sexuality is concerned.[29] However, in the case of South African women, such rhetoric of the moral self also implies a critique of dominant male assumptions about one-way transmission.

The reconstruction of morally upright womanhood is particularly important for being able to meet another norm, which is central to female gender roles and which HIV infection puts under stress: the responsibility for care. In numerous publications, Arlie Hochschild has described how social change affects the organization of care, and – by extension – the ways in which women cope with the cultural definitions of legitimate femininity.[30] At some point in their disease trajectories, HIV infection incapacitates women to care for their families. The burden of care is then usually passed on not to the husband but to other women within the extended family or to women from neighbourhood networks. In building up such networks, support groups – as described at the beginning of this article – have come to play a pivotal role. Significantly, the definition of these groups has changed over the years to include *infected* as well as *affected* people. To this extent,

28 L. D. Stanley, Transforming AIDS: the moral management of stigmatized identity, in: Anthropology and Medicine 6 (1999), 1, 103-123.

29 E. Sobo, Self-disclosure and self-construction among HIV positive people: the rhetorical use of stereotypes and sex, in: Anthropology and Medicine 4 (1997), 67-87.

30 See for example A. Hochschild, Global care chains and emotional surplus value, in: A. Giddens/ W. Hutton (eds.): On the Edge: Globalization and the New Millenium, London 2000, 130-146; A. Hochschild/ B. Ehrenreich (eds.), Global Woman: Nannies, Maids and Sex Workers in the New Economy, San Francisco and Los Angeles 2002.

support group-driven networks of care are organized to assist HIV-positive women as well as women whose husbands or other family members are infected.
For men, HIV infection results in some equally profound kind of identity conflicts, for being ill makes it impossible for them to play the role of the breadwinner for the family, or else it thwarts the dominant concepts of strong and sexually potent manhood. They become dependent on support and care. Whereas married men can still rely on their wives to fulfil this function, unmarried men are generally much less capable to mobilize the kind of solidarity networks that women manage to create. This begins with their general inability to disclose their status to male peers or employers and extends throughout their entire disease trajectory. While for women HIV infection adds another dimension to pre-existing experiences of dependence, to men it means dependence in an immediate and hitherto unknown sense and cuts right through their capacities to fulfil the masculine norms of strength and independence. HIV infection provides an ironic and tragic example of men inadvertently becoming victims of discourses of stigma that arose on the basis of masculine norms.
In discussing themes that on the basis of sociological AIDS literature appear to be central to the interplay HIV/AIDS and gender roles I have drawn attention in an ideal-typical fashion to some global tendencies, while there is in fact a whole array of different disease trajectories, each of which entails a number of sequences with different challenges. I have shown that the analysis of the gender-specific social construction of AIDS must be placed within a theoretical framework that sees the production of the gender/sex-nexus in the wider context of social reproduction and social change. In the following section I analyse how the social construction of gender roles in the struggle against HIV/AIDS is moderated by the engagement of religious organizations, and how this in turn affects the ambivalent position of AIDS-related practices between reproduction and change of existing gender arrangements.

2. Reconfiguring Gender Roles and Identities in the Struggle Against HIV/AIDS: The Significance of Religious Spaces

The religious concern with gender roles is probably as old as most religious traditions themselves. In traditional societies, in which extended families and kinship relations provided the primary means of social reproduction, religion served as the quintessential normative underpinning of patriarchal social order. Gender roles and the expectations they conveyed were embedded in religious morality that pervaded the social world. As far as this normative overlap of family, gender, and religious norms is concerned, the arrival of modernity was tantamount to a triple destabilization: a destabilization of family structures, of gender norms and of the power of religious institutions, norms, and worldviews.
Throughout the 20th century, much of the sociology of religion was devoted to describing and explaining the decline of religion in terms of a theory of secularization. While

relatively little attention was paid to addressing explicitly how gender relations were affected by this process, the changing patterns of family life were seen as reflecting the decreasing power of religious moral standards. However, with the undeniable return of new and not so new religious movements into the public arenas of modern and modernizing societies, the questionable legacy of enlightenment-born Western universalistic thought became more and more visible. The sociology of religion took a definite turn towards an increased recognition of religious revivals, thereby acknowledging that the theory of secularization had to be put into perspective.[31] Significantly, the new scholarly interest in these movements also opened up a new space for analysing the recurrent entanglements of gender and family values with religious discourse. Research into the Pentecostal revolution and into the advent of modern Islamism has plainly demonstrated that religious revivals are modern attempts to deal with the destabilizing consequences of modernization for gender relations.[32] So instead of merely dissolving them, modernity rather seems to provide the terrain in which the connections of gender and religion are being reconfigured.

The power of movements of religious revitalization has generally been interpreted as resulting from their abilities to cash in on scenarios of crisis and to promote such views.[33] They are seen as articulating a sense of modern uncertainty and insecurity and responding to such perceptions by demarcating moral boundaries against the world outside, by providing narratives of spiritual salvation, and by generating models of moral conduct for their adherents.[34] It is within this framework of analysis that the increasing religious concern with HIV/AIDS has to be placed. From a religious point of view, HIV/AIDS is not simply a health crisis. It rather combines a number of concerns, all of which figure prominently within modern religious discourse. Firstly, HIV/AIDS articulates concerns that touch the boundaries of life such as sexuality, conception, disease, suffering and death. Secondly, it touches fields of social regulation that point to both traditional and modern religious imaginations of transcendental orders such as sexuality and gender. In addition to that, the AIDS epidemic has posed the challenge of caring for diseased individuals. In a nutshell, HIV/AIDS provides crucial incentives for religious engagement.

According to most scholarly work on South African Christianity, Christian denominations fall into three broad categories: mainline denominations (including the Catholic, Anglican, Lutheran and Reformed Dutch Churches), Pentecostal and Charismatic churches, and African Indigenous Churches.[35] Most of Cape Town's faith-based organi-

31 As the most prominent example for this turn see J. Casanova, Public Religions in the Modern World, Chicago 1994.

32 For the case of Latin American Pentecostalism see E. E. Brusco, The Reformation of Machismo. Evangelical Conversion and Gender in Colombia, Austin 1995; for the case of modern Islamism, see M. Riesebrodt, Fundamentalismus, Säkularisierung und die Risiken der Moderne, in: H. Bielefeldt/ W. Heitmeyer (eds.): Politisierte Religion, Frankfurt/M. 1998, 67-90.

33 Riesebrodt, Fundamentalismus (fn 32).

34 On African charismatic Christianity as an articulation of economic crisis, see Hasu, this volume.

35 R. C. Garner, Safe sects (fn 3) p. 46. Cape Town has a sizeable Muslim population of various origins. This article, however focuses exclusively on the Christian religion.

zations (FBOs) have close organizational and financial ties to one of these churches. As organizational branches, they provide charitable, educational or other services to particular groups of the population. Other FBOs again are not related to any denomination in particular while having a strong ideological commitment to some religious movement.
In the following section I will discuss gender-related aspects of the discourses and practices of two Cape Town-based organizations belonging to the Pentecostal branch of Christianity that are chiefly concerned with HIV/AIDS. The first case illuminates the potential of religion as a space for transforming gendered sexual dynamics and identities (see 1.3). The second highlights the gender dynamics within faith-based support groups as spaces for mobilizing care and solidarity (see 1.4).

3. The Gender of Religious AIDS Discourse

3.1 Evangelical Gender Work and the Logic of Personal Transformation

Founded in 2000, the Living Hope Community Centre (LHCC) is an FBO which is not aligned to any church in particular but has a strong evangelical and Pentecostal orientation. The organization has grown steadily over the past couple of years to become one of the biggest FBOs in the Western Cape Province. Much of this growth is owed to the fact that LHCC has successfully tapped funds from the US-American PEPFAR initiative. Founded by President Bush in 2003, PEPFAR is now the single most important programme of bilateral cooperation in the struggle against AIDS. With a financial commitment of 15 billion US dollars, Bush set the ambitious goals of providing support for the prevention of 7 million new infections, support for the treatment of 2 million HIV-positive people, and support for care for 10 million people infected and affected by HIV/AIDS in 15 of the world's hardest-hit nations.[36] One of the most interesting – and also most widely criticized – aspects of this initiative is its commitment to abstinence-only programmes and its renewed emphasis on the involvement of FBOs. These aspects in particular, together with pre-existing close ties to various US-American evangelical denominations, provided the ground for LHCC's engagement with PEPFAR.
Characteristic for LHCC is that the missionary mandate precedes the concern with social issues such as HIV/AIDS. In interviews I conducted with LHCC employees, all spontaneously pointed out that their primary organizational and personal concern is religious by nature. Michael, one of their educators, plainly stated:[37]

> *AIDS aspect is not my main concern, to be honest – my main concern is getting them to get to know Christ and what the church says about lifestyles, about being abstinent and faithful, stick to one partner. Whatever we teach, we taught it through the scriptures. We don't focus on the social issues, we focus on the whole person, self-esteem, loving yourself, loving others, making the right choices.*

36 PEPFAR, Action for today, a foundation for tomorrow: The President's emergency plan for AIDS relief. Second Annual Report to Congress, Washington 2006, 3.
37 All names in this paragraph have been changed.

Instead of drawing on religious sources as ethical underpinnings of their educational and charitable practices, LHCC promotes an approach that places social engagement within the larger framework of mission as the ultimate point of reference or value of their activities. People should be faithful not because of AIDS but because of the scriptural foundation of this norm. In the course of the interviews, LHCC employees made frequent references to God's plan – God's plan for human life and how to live it in general, and his plan for their personal life in particular. This goes typically hand in hand with a strong rhetoric of vocation to enable others to make the experience of being saved. All LHCC employees underwent a personal conversion process whose result they depict in the popular evangelical idiom of 'having accepted Jesus Christ as their personal saviour'. From this point of view, averting the risks of HIV infection and the negative social consequences thereof appears as a secondary or collateral benefit of being saved and vice versa.

While the idea of personal transformation that is implicit in the evangelical concept of conversion is pertinent to the practices of Pentecostal organizations in general, it is of particular significance to HIV-positive people who join such groups, be it as employees, volunteers or otherwise. One of LHCCs peer counsellors found out that she was HIV-positive when she went for prenatal diagnostics, being pregnant with her second child.[38] Subsequently, she left her partner, focussing all her energies on raising her children and on her career in the field of social work. It was about two years ago that a friend took her to an evangelical crusade where – as she puts it – she "found God". The crusade also put her in touch with LHCC. What followed was a process of conversion that had profound implications not only for the way she is dealing with her HIV-infection but also for her gender identity. The following passage describes how her understanding of HIV was affected that process:

> *Doctors are not God, they just give you result of scientific exam but that's a lie. They tell you, you are gonna die. But you are still alive. They are not God. So why should I bother? They just use their machines. You never know, today CD4-count is low, maybe tomorrow it is up again. I was well treated but it is my understanding. You don't know what God is doing overnight. HIV doesn't exist in my blood that is what I believe.*

Maggie firmly believes that her life is eventually in the hands of God and takes the changing results of medical tests as evidence for that. The conversion, it appears, has resulted in a profound mistrust of medical definitions of HIV/AIDS, a development that is also reflected in the fact that she stopped taking anti-retroviral drugs in spite of receiving them free of charge on the basis of her medical cover. She symbolically removes her body from the medical machineries to put it in the hands of God.

38 HIV tests are routinely carried out as part of prenatal diagnostics with informed consent of the women. The results of these tests are still found to provide the most reliable basis for South African HIV statistics.

Parallel and in a remarkable analogy to this act of transfer, she removes her body from the hands of men by opting for a lifestyle of total abstinence. Asked whether she would be interested in marrying she simply states:

> *I don't care because Jesus is in my life. As long as I get in my promised land, that is all that concerns me. Marriage will come if God wants it. I don't think about it.*

This argument is consistent with the findings of other studies into the gender dynamics of Pentecostal Christianity in Africa and Latin America, which point out that conversion often comes to signify a process of purification in which the relation to men is symbolically and practically replaced by the relationship to Jesus Christ. In my understanding the case of Maggie allows for two conclusions: Firstly, FBOs can provide spaces in which the gendered power imbalances as they are expressed in sexual interactions are neutralized through the establishment of strong moral boundaries. Such moral boundaries are legitimised by scriptural norms and allow women to withdraw themselves from sexual encounters altogether. Secondly, such spaces allow for the generation of narratives of personal transformation with the conversion symbolically marking the beginning of a new life. The HIV infection itself assumes a new meaning: The biological contingencies of a medical condition are re-stabilised through the belief in the healing power of faith and everyday moral conduct that is mainly expressed through a re-configuration of gender-relations.

The creation of religious spaces that enable women to circumvent the hierarchical forms of gendered domination to which they are generally subjected can be seen to entail a *feminization* of such spheres. As I have already hinted, the same tendency can be observed by looking at the gender dynamics in HIV support groups. In the remainder of this section I will argue that for a number of reasons support group communication provides a particularly powerful field for observing the gender dynamics of the struggle against AIDS and that its analysis affords conclusions about the continuities and changes that this struggle can be expected to produce.

3.2 Protected Spheres of Femininity: Mobilizing Gendered Solidarity through Support Groups

The first HIV/AIDS support groups came into existence in the early years of the epidemic in the United States. In their initial stage, they were little more than informal gatherings of sick people, their friends and relatives, whose only concern was to break the silence. As Cindy Patton powerfully reminds us, they were about crafting a language of suffering and pain, for which there was no explanation at hand, and about giving expression to the experience of a disease about which there was only scant if any knowledge.[39] For the formation of these groups, two kinds of cultural resource were of paramount significance: firstly, the solidarity networks within the gay community that emerged as a result of the

39 C. Patton, Globalizing AIDS, Minneapolis 2002.

gay struggle for public recognition; and secondly, an elaborated culture of grassroots therapeutic relationships that was part of a flourishing civil society movement.

When the epidemic started to become a major social problem in South Africa in the beginning of the nineties, neither of these resources were at hand or relevant to Black South Africans, the hardest-hit group. But although the social, political and cultural context and the state of medical knowledge were totally different now, we could witness the emergence of a support group movement, which displays some remarkable resemblances to its Western precursor. Therefore, Patton, de Waal and others have argued that as an organizational expression of bottom-up self-help relationships, support groups must be seen as one of the most successful examples of the global dissemination of civil society responses to disease.[40]

Now, while by the middle of the nineties the body of medical knowledge on HIV/AIDS had considerably grown and South African prevention campaigning efforts slowly intensified, HIV/AIDS was overwhelmingly framed within discourses of danger, sin, and blame. South Africans' attitudes towards the disease and their interactions with AIDS patients were informed and continue to be informed by those discourses. Although practices of discrimination and stigmatization are now frequently scandalized through mass media, stigma keeps on pervading the social environment within which the subjective experience of HIV/AIDS is located. The emergence of support groups in South Africa has to be understood against this backdrop as a pivotal step in the struggle against AIDS as a whole. Within this process, some churches provided a pivotal cultural resource; for they appeared as spaces of unconditional solidarity.

It goes without saying that there are significant differences in the ways different churches deal with AIDS. Furthermore, religious discourse on AIDS has profoundly changed over time. The most important development that has taken place within the South African religious scene during the last fifteen years is that the unitary focus on the discourse of sin has gradually given way to strategies of 'ambivalent inclusion'. Whereas the connotations of HIV with promiscuous sexuality continue to occupy a prominent place with religious prevention discourse, there is now a much greater emphasis on *solidarity* with HIV-positive people. This turn is ideologically and organizationally reflected in the emergence of numerous religious support groups. In line with Ardener's theoretical suggestions concerning the relationships of women and space (see Gaitskell, this volume), I will argue that it is in and through these groups that South African women enter, appropriate, expand and exploit existing religious spaces on the basis of shared female experiences of family need and spiritual help.[41]

One of these groups is the Monwabisi support group. In 2004 Monwabisi, a former member of the ANC's military wing and now in his late thirties, embarked on a new project. With the financial and intellectual support of a US-American Baptist Commu-

40 Patton, Globalizing AIDS, fn 39; A. de Waal, A disaster with no name: the HIV/AIDS pandemic and the limits of governance, in: G. Ellison/ M. Parker/ C. Campbell (eds.): Learning from HIV and AIDS, Cambridge 2003, 238-267.

41 S. Ardener (ed.): Women and Spaces: Ground Rules and Social Maps, New York 1981.

nity, he started organizing workshops on HIV/AIDS with the help of some HIV-positive friends. Being a lay preacher in a small Pentecostal church and repelled by the hostile and in his view 'un-Christian' attitudes of many church officials and communities to PLWA, he felt compelled to set a better example of how 'real Christians' are meant to act. After his first steps as an AIDS activist, he became acquainted with the idea of support groups and decided to set up such a group himself.

The group meets every Saturday in a little community hall in Town Two, a relatively safe and settled neighbourhood in the township of Khayelitsha. People are recruited to the group by word of mouth and by flyers that members distribute during public functions or in other rather informal situations. Besides, once a month the group organizes awareness raising workshops with the aim of "reaching out" to the broader population of the Township and to become more widely known.

The regular group meetings appear rather informal in that there is no fixed agenda and no programme. The right to speak is organized through informally negotiated authority rather than through formal position. By contrast, workshop interaction is organized by a detailed programme and by fixed speaker positions. Monwabisi usually welcomes the audience and provides something resembling the emotional framework for the situation. He actually does what we could call *community making*. Other than him, there are usually two or three women from the support group who speak and provide expertise on a wide range of HIV-related issues. What is interesting and specific about the workshop discourse is that it covers a wide range of issues, from questions concerning modes of transmission, sexuality, and safer sex in particular, symptoms of AIDS and opportunistic infections, awareness of the difficult circumstances of PLWA, issues of discrimination and stigmatization, information about VCT, possibilities for treatment, the importance of treatment adherence, drug resistance and so on.

Furthermore, there are a number of ritual elements that give these workshops their specific structure. Usually there are common prayers at the beginning and at the end of the workshop, which mark the boundaries of the temporary spiritual community which people enter when participating in the workshop. One very central element in every meeting is the illness testimonials: an HIV positive person walks to the panel and shares her or his personal story with the other participants. These are typically the most powerful and emotionally intense moments of the whole workshop process. They are stories of illness, pain and suffering, but also often stories of immense personal tragedy, abuse and violence. After a person is finished her or his story, people line up in front of the speaker to hug her or him, thereby welcoming them as new members of the group.

As with almost any other of the groups I visited, members of the Monwabisi Support Group are overwhelmingly women. On a more general level, this can be explained by the fact that HIV infection has also more severe consequences for women than for men; hence the greater incentive for them to join support groups. As a consequence, many groups have been founded by women who have been verbally and physically abused, rejected or chased away from home by their husbands and partners. Or else such groups have been designed to cater for the specific needs of HIV-positive women. To that extent,

the formation of support groups can be seen as part of the female struggle for an emancipative life with HIV/AIDS.

But even more importantly, support groups appear to be more attractive to women because the implications of support group processes are perfectly reconcilable with main aspects of dominant female gender identities. First of all, the very practices of care, particularly of caring for the sick, are traditionally defined as belonging to female spheres. Whereas this definition did historically place severe restrictions on women's occupational and social mobility and continues to hold them responsible for caring for AIDS sufferers, it also enhances their capacity to mobilize networks of solidarity. Support groups are primary examples of such capacities. Although initially flowing from patriarchal concepts of the gendered division of labour, they provide them with a crucial kind of social capital from which they can benefit in moments of crisis. For most of its female members, the support group offered the chance of "getting out of the closet" and engaging in new cooperative personal relationships. Secondly, the idea of admitting weakness and the need for support is less at odds with cultural concepts of femininity than with the dominant models of masculinity. It is important to note that support groups not only provide opportunities for openness; they also establish openness about personal history and emotional experiences as an implicit expectation that sits rather uncomfortably with male notions of bravado and boldness.

Besides, we find that many women join support groups because of a lack of communication about their HIV status or about sexuality with their husbands, out of fear of the possible consequences thereof. One of the all too real possibilities is to be left alone, which for many women means being left with no income or other means of surviving. Economic dependence renders women vulnerable to such rejection and at the same time prevents them from resorting to similar responses in case their partners fall sick. Therefore, being left is generally of less concern for men than for women. If for such reasons women feel little inclination to address AIDS within the couple, joining support groups is often the only alternative way to express such concerns. Support groups often serve as alternative female spaces of communication and discourse on HIV/AIDS, thereby erecting moral barriers to male participation. One prominent subject of communication during the meetings of the Monwabisi group was sexual coercion, and – by extension – the concern with gender hierarchies and gender-based violence in general. It is hard to see how such communication could have unfolded in the presence of men with whom the female members had a less trustful relationship than with Monwabisi himself. One of the implicit principles that worked as the enabling grammar of group discourse was the absence of gendered power relations. Furthermore, at some point of the group process a greater involvement of men would have inevitably led to a confrontation of female and male concerns with HIV/AIDS, namely the issue of multiple partnering and the question of blame. It can with great plausibility be assumed that for these reasons many men dismiss the idea of joining such groups. After all, caring and support again appear as an essentially female business.

4. Conclusion

I have demonstrated that the struggle against HIV/AIDS in South Africa has given rise to a profound and very particular cultural 'problematisation' of gender relations. On a general level it has been observed that aggressive assertions of masculine domination, as revealed in research into sexual dynamics, is indicative of the destabilizing tendencies that the process of modernization entails for gender hierarchies. The struggle against HIV/AIDS seems to reinforce these tendencies in that it opens a number of social arenas in which the parameters of gender relations, gender identities and gendered subject positions are being re-negotiated and reconfigured. These arenas, such as prevention workshops and support groups for example, are social locales in which HIV-related gender issues can be articulated and addressed. But at the same time they have to be understood as responses to the epidemic that are themselves fundamentally gendered. As both case studies showed, by drawing upon and engaging with gendered properties of religious spaces women are capacitated to strengthen their scope for agency while at the same time reproducing the moral order, which delineates particular social domains and correlative identities as female or male.

I have identified sexuality, care and solidarity as the three most contested HIV-related aspects of social life, which are fundamentally shaped by gender relations. The very reorganization of these fields in turn can be expected to affect relations between women and men. Furthermore, the growing engagement of faith-based organizations with HIV/AIDS is due to the fact that the same concerns – sexuality, care, and solidarity – provide the symbolic resources that religious discourse uses to demarcate moral boundaries and to symbolize moral inclusion. In a recent commentary, John Lonsdale forebodingly remarked that "(I)f women are to have greater power in negotiating their sexual relations, if men are to learn new ways to 'grow', there is a large agenda pending in the reordering of gender relations."[42] The coming years will show whether progressive religion can be a means to this end.

42 Lonsdale, Conclusion (fn 1), 149.

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Abbreviations

ABC – Abstain, Be faithful, Condomize
AIDS – Acquired Immunodeficiency Syndrom
ANC – African National Congress
ARV – Anti-retrovirals
FBO – Faith-based organisation
HIV – Human Immunodeficiency Virus
KAP (-survey) – Knowledge, Attitudes, Practices
LHCC – Living Hope Community Centre
MSF – Médecins sans Frontières
NGO – Non-Governmental Organization
PLWA – Persons Living with AIDS
TAC – Treatment Action Campaign
VCT – Voluntary Counselling and Testing