

— **Special section on religion and antiretroviral therapy** —

## **Introduction — The redemptive moment: HIV treatments and the production of new religious spaces**

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### **Background**

The growing importance of religious influences in relation to the individual and social consequences of HIV and AIDS has increasingly been acknowledged by workers in the social sciences and humanities, including theology and religious studies (Becker & Geissler, 2007; Prince, Denis & Van Dijk, 2009). In recent years, HIV/AIDS studies in sub-Saharan Africa have often taken a broader view. Moving away from narrow interpretations that have informed much of the social sciences, in terms where medicalised and problem-oriented approaches were dominant, we notice a more explicit focus on HIV and AIDS as a lived reality, as a field of experiences and existential choices (Dilger & Luig, 2010).

Studying religion allows for a particular understanding of the presence of HIV in these terms. In religious groups in Africa, religious practices and ideologies are often central to how individuals, groups, and institutions engage with the disease. A rich field of religious mediations has emerged in which these experiences are being expressed. As other authors have argued as well (e.g. Bornstein, 2007; Chitando, 2007; Denis, 2009; Nguyen, 2009; Van Dijk, 2009), these religious mediations constitute new spaces where religious bodies have become active in HIV prevention, care and treatment, wherein room is being created for individual or collective practices of health, healing, consolation, support and mitigation.

This special section of *AJAR* highlights a multidisciplinary field that considers these emerging 'religious spaces' in the history of the HIV epidemic in Africa. This involves a variety of closely related angles and approaches informed particularly by the social sciences and theology. While there is a need to take stock of how, and in what ways, various religious formations so far have engaged with HIV and AIDS, and how this has been informed by their respective histories and traditions, an endeavour of this kind also needs to develop a common working language. Hence, the aims and objectives of this issue must face up to a dual challenge: How to create a better understanding of the new religious

spaces that current experiences of HIV and AIDS appear to be coproducing? And, is it possible to ensure that there is an informed as well as emphatic language that allows agnostic and theological sciences to talk about matters of life and death in a context of AIDS, which in many African societies people and institutions often express in terms of faith?

These questions are pertinent not only in view of the societal relevance of religious practices, institutions, and ideologies in the field of HIV and AIDS, but also because of the ways that these have become embedded in, challenge, or are confronted by specific social, cultural and political-economic contexts. Much as this is the general objective of this special section, studying the interactions between religion and HIV/AIDS will enhance the expertise of workers in both fields.

HIV/AIDS issues can be better understood and explored if the relevance of religion is acknowledged, and vice versa. The study of religion in Africa is taking new directions and, as highlighted here, is being sharpened by the many existential questions posed by an HIV epidemic. These questions are so fundamental and concerned with deep-seated anxieties, desires, hopes and fears that a reshaping of religious thought and praxis can be seen. Matters concerning the production of new 'theologies' of sexuality, the body, and health and healing in various religious traditions are part of this.

There is no question of being celebratory about the way that some religious traditions, particularly within Christianity, have lived through this process of reshaping religious thought, yet the rapid change that HIV and AIDS has created in the field of religion needs to be studied and problematised. Most of these changes are reflected in new institutional practices, in new ways of speaking about the religious self, as well as the ways in which religious traditions are now addressed in matters of sexuality, reproduction, intimacy and relationships. In other words, the emergence of HIV has been co-productive in the emergence of new religiosities (i.e. devotional life) that inform individual and social identities, and which consequently have a bearing on policies and

political and economic realities. The articles in this special section address this comparatively — with Christian, Islamic and African ritual practices<sup>1</sup> all being approached by a combination of agnostic and theological reflections in order to produce a balanced representation of this field.

This must be joined to analyses of how studying religion can enhance the study of HIV and AIDS in Africa. This would concern the cultural, moral and political responses that various (religious) actors in society have developed in relation to the disease and which give the HIV epidemic particular shape and meaning (Setel, 1999; Heald, 2003; Campbell, 2003; Dilger, 2005; Rödlach, 2006; Dilger & Luig, 2010).

While religion and HIV/AIDS issues may transform together, this process can be chiefly studied in the field of the current rollout of antiretroviral treatment (ART) on the continent. Life-prolonging as antiretroviral (ARV) drugs are, there are indications that the shaping of new religious spaces has acquired special significance as a result. Religious groups have become active in ART rollout, yet have been confronted (again) by a range of existential questions and concerns. These relate to notions of divine healing, the provision of medicines, health resources and access, ethics, and institution-building. Ideological contestations have emerged in some cases, whereby religious ideologies have questioned or contested the morality of ART rollout. Hence, the field of ART incites multidisciplinary understanding of the social positioning of religion, an enhancement of the study of religion, and the terms under which that takes places. Conversely, by studying religion, we realise how HIV/AIDS studies can be enhanced by including religious processes of meaning-making, legitimacy, morality and identity-formation and how these become crucial to understanding the efficacy of HIV treatment and care.

Taken together, these articles focus on two issues shaping individual and collective experiences and practices around HIV and AIDS in recent years: the relationship between religion and HIV/AIDS, and the growing availability of ART in wide parts of sub-Saharan Africa. We build on earlier studies that explored the processes of stigmatisation and the dynamics of gender and family relations (e.g. Meursing, 1997; Baylies & Bujra, 2000); the making of policies and programmes in the context of international funding priorities and mechanisms (e.g. Campbell, 2003; Booth, 2004); and the emergence of local aetiologies and healing practices in the context of HIV (e.g. Mogensen, 1995; Yamba, 1997). We suggest that these issues should be discussed in more detail as regards religious practices and perceptions emerging in relation to the HIV epidemic in sub-Saharan Africa, including the fairly recent introduction of ART.

The following section gives a brief overview of the larger field of HIV/AIDS research and how it relates to recent studies on religion and ART in Africa. Next, we describe how insights from these studies can be fruitful in formulating a notion of the time when 'religion met ART' and a new stage in the interaction between religion and the disease: namely 'the redemptive moment.' Medically, anthropologically and theologically engaging with concepts of 'life-prolonging' and the 'afterlife' has created a unique dynamic, variously explored by the authors in this special section.

## Overview of the study of religion and HIV/AIDS

Just as religious communities and organisations in sub-Saharan Africa were latecomers in responding to the HIV epidemic, researchers were initially reluctant to acknowledge the multiple ways in which religious faith and practices surrounding the disease are involved. While the centrality of religion in social life in Africa is not disputed, anthropological studies have long focused on other cultural factors, such as witchcraft or evil spirits, on which people's ideas and practices hinged (e.g. Mogensen, 1995; Yamba, 1997; Wolf, 2001). This approach was complemented by other studies in the social and political sciences which elucidated the broader economic and political processes underlying epidemiological patterns and explained the complex and highly contested forms of institutional response: that is, the politics and policies of HIV and AIDS (e.g. Poku & Whiteside, 2004; Patterson, 2006). It was only during the last decade that issues of religion have appeared on research agendas.

When religion was adopted as a subject in HIV/AIDS research in Africa, it was described with regard to its perceived negative impact on the interventions of HIV/AIDS programmes and the life situations of people living with HIV (for exceptions see Garner, 2000; Dilger, 2001). In many parts of sub-Saharan Africa, Christian religions have, with their discourse on HIV infection as a punishment from God, led to a conceptual dichotomy between 'good/pure' and 'bad/impure' Christians. In fact, during much of the 1990s the public representation of religious responses to HIV and AIDS was dominated by discourses on infection as a divine retribution for individual or collective failures to adhere to sanctioned models of conduct. Against this backdrop, people who are HIV-positive were mostly positioned as 'bad/impure' within religious discourse.

Likewise in Islamic contexts, HIV infection has mostly symbolised illicit sexual contact and deviance from divine instructions. As a corollary, some Christian churches and Islamic communities began promoting strict adherence to religious sexual teachings on premarital abstinence and fidelity in marriage as a form of HIV prevention. Researchers and HIV/AIDS activists have both criticised these religious responses to HIV because they contributed to stigma in many cases (Foster, 1996; Gruénais, 1999; Burchardt, 2010a). It is also possible, however, that such religious discourses have emerged as ways of translating the stigmas that prevailed in society at large in its own idiom.

Importantly, religious constructions of HIV and AIDS as a problem of sexuality and sexual relationships have illuminated the manifold ways in which religious beliefs and cosmologies are entangled with the forging of sexual ties, and some have pinpointed renewed claims to authority over sexual practices made by religious leaders in the name of the 'sacredness of sex.' These developments have engendered a new wave of studies on the articulations of sexuality with religious discourses and practices (Garner, 2000; Gusman, 2009; Parsitau, 2009). Much of this research ties in with broader questions about ways in which expressions of sexuality — as well as relationships of healing and care — are afforded particular spiritual significance within

the moralistic agendas and regimes of Pentecostal and evangelical Christianity (and partially concerning mainline churches) that are flourishing across sub-Saharan Africa. A few discrete dimensions of this are distinguished here.

*Sexuality, sin and healing: Christian responses to HIV/AIDS*  
First, in the wake of envisioning and imagining Christian discourse as HIV prevention, responses to the HIV epidemic have come to produce new forms of speaking about sexuality, complete with new vocabularies and registers through which things sexual can be addressed (Leclerc-Madlala, 2005; Christiansen, 2009). This has entailed reliance on inherited (if hitherto less emphatically promoted) Christian ideals as well as the partial adoption of public-health discourses championing notions of responsible sexuality and its discursive cognates (Burchardt, 2010b). Both developments seem to coalesce in what Becker & Geissler (2009) have termed 'the prescriptive turn in religious life,' in other words the notion that one of the prime preserves of religion is to enjoin followers and thereafter monitor behaviour change.

Second, there are specific ways in which HIV and AIDS has been incorporated into Pentecostal discourse and its moral constructions. If not always explicitly, the evangelical notion of 'being saved' was increasingly taken to include AIDS in the list of evils from which twice-born Christians are being delivered (Dilger, 2007; Christiansen, 2009; Gusman, 2009). Here, acquiring membership in a Pentecostal community through conversion is conceived to save individuals from the threat of AIDS illness, sometimes replacing the biomedical notion of sexual HIV transmission with the idea of 'immunity by faith' (Burchardt, 2010a). The most controversial issue in faith-based HIV prevention is invariably condom promotion, which many churches equate with promulgating sexual promiscuity (Parsitau, 2009). As a result, the focus is almost always, especially in the Pentecostal field, on preaching morals, sexual abstinence and fidelity. In various African countries, the emergence of this conservative public discourse on sexuality has been facilitated and reinforced by the building of international evangelical alliances, not least through the establishment of the United States President's Fund for AIDS Relief (PEPFAR) (Dilger, 2009; Gusman, 2009).

Third, we are faced with questions about the processes whereby people take up religious injunctions on having a sexual life, and then must collectively negotiate them in the context of often competing cultural orientations, or else reject them. For instance, some studies (e.g. Garner, 2000; Agadjanian, 2005) have compared mainline and Pentecostal churches regarding the influence of church teachings on HIV prevention and sexual practices, with contradictory results. Although religious discourses on sexual self-restraint may address both women and men alike, they may meet with a social reality in which sexual practices (just as the experience of HIV) are inserted into arrangements of domination that are profoundly gendered (Sadgrove, 2007; Burchardt, 2010b).

Fourth, religious thoughts and practices can be analysed in relation to practices of healing and mourning, as well as the building of (gender-specific) networks and communities

of support. Klaitz (1998 and 2005) has described how an apostolic church in urban Botswana shaped experiences and practices of grief and mourning among its followers, and that the church contributed essentially to its members' efforts to turn the experience from dying from the stigmatised disease into a 'good death.' In his study on a neo-Pentecostal church in urban Tanzania, Dilger (2007) emphasises that the church has become not only popular due to its proclaimed HIV/AIDS healings, but also because it has become a network of care and support for its mostly female followers in the context of urbanisation and modernisation processes. In a similar vein, Burchardt (2010b) argues that churches and faith-based organisations in urban South Africa have become social arenas in which gender constructions are renegotiated and reconfigured in relation to HIV. The notorious dominance of women in religious-based HIV/AIDS initiatives reflects larger processes whereby responses to HIV in the religious arena have reinforced the construction of separate gendered spheres.

#### *Moral decay and politicised HIV: Muslim experiences of HIV/AIDS*

To some extent, the above-mentioned prescriptive turn in religious life also became manifest in Islamic contexts, not only as a scholarly category or perspective but as a way in which people (re)constructed the significance of religion. Among Muslim youths in the Kenyan town of Kisumu, Svenson (2009) found a pervasive sense in which Islamic forms of facing HIV were constructed through the notion of 'following instructions.' He also highlighted the fundamental importance of religious scriptures to Muslim interpretations. The articles by Jack Ume Tocco and Amusa Saheed Balogun (this issue) show us that the role of the scriptures in grappling with HIV disease has gained renewed salience with the arrival of ART.

Drawing on research among Muslims in mainland Tanzania, however, Becker (2009) argued that Muslims' attitudes might be less influenced by rigid notions of sex than outside observers would generally expect, but more by the wider political context. This context has been shaped by longer processes of economic decline, resulting in mistrust of the state and its ability to generate progress, as well as perceptions of being sidelined in government politics. Muslims' ideas of their own marginalisation in the Tanzanian state have led to distrust or even the rejection of government messages, including ones about HIV prevention and control.

This reminds us that behavioural injunctions are rarely politically neutral recommendations but should be understood through the ideas of those promoting them. From a conceptual perspective, this implies that the influence of Islam on constructions of HIV and AIDS may have less to do with Islamic beliefs than with interpretations of the structural location of Muslims in society. Where Muslims' beliefs mattered, they do so in ways quite different from those found in Christian contexts. Again, on the basis of reference to the scriptures, as the virus was seen as being God's will (cf. Tocco and Balogun, this issue), Muslims have tended to accept HIV instead of demonising it. As a result, stigma and silence appear less a product of

shame than associated with the fact that there was no hope for people with AIDS-related illnesses before the arrival of ART (Becker, 2009).

In various Islamic contexts, HIV has been taken as a symbol for moral decay, epitomised in the loosening of gender segregation and as one in a series of concerns with sexuality, such as prostitution and the influences of tourism on sexual mores, as in the case of Zanzibar (Beckmann, 2009). Much of the condemning discourse on HIV in Islamic reformist movements seems to have constructed all this as a result of outside influences, somehow echoing discourses of moral superiority, which Van Dijk (2009) found to be reactivated in Pentecostal responses to HIV in Botswana. Interestingly, in Zanzibar, Muslim discourses of decay have been inscribed into narratives of intergenerational conflict, in which the older accuse the younger (Beckmann, 2009), while in Uganda Pentecostalism has seen the rise of a born-again 'Joseph generation' that holds the older generation responsible for the spread of HIV and consequently has become engaged in building a Christian country (Gusman, 2009). All this research demonstrates the need to explore the ways in which religion ties in with the larger social and political contexts and cultural sensibilities, on the basis of which meanings of HIV are collectively constructed.

#### *Challenges for future research*

While the relationship between religion and HIV/AIDS has been discussed in a number of recent publications and conferences (see the special issue of *Journal of Religion in Africa*, edited by Becker & Geissler, 2007, a volume by the same editors in 2009, and the special issue of *Africa Today*, edited by Prince, Denis & Van Dijk, 2009), a more holistic and comparative approach is required.

In particular, existing research has been characterised by a bias with regard to the work of Christian churches and organisations, with an emphasis on Pentecostal churches. The responses of former Christian mission churches as well as Muslim communities and organisations have rarely been discussed.

So far, more research has been done on African traditional religions, which have been analysed regarding the healing claims of witch-finders in the context of local power relations (Yamba, 1997), and in terms of their incorporation of HIV/AIDS into local disease categories that associate the illness with the non-observance of ritual prescriptions (Mogensen, 1995; Wolf, 2001; Heald, 2002; Green, 2003). Furthermore, some anthropological studies have shown how notions of purity and impurity have become contested with regard to mourning rituals and ritual cleansing practices for widows (e.g. Offe, 2004; Prince, 2007). They have also shown how these debates on purity and ritual have become implicated in local discussions pertaining to burials and the social and moral 'belonging' of (deceased) persons with HIV (Dilger, 2008). However, while several studies on traditional religion and HIV/AIDS were done *before* the introduction of ART, there is still a need to understand how the field has been (re)shaped by the growing presence of ARV medications and biomedical programmes in the context of transnational development/collaboration, especially in Africa.

Against this backdrop, a crucial question is: How does

the growing interest of international HIV/AIDS organisations and donors in the involvement of different faith-based organisations in HIV/AIDS responses affect these religious traditions? These recent developments in HIV treatment also pose new questions about religious perceptions and practices surrounding life, death and healing and the shifting nature of religious involvement in governance and international development policies. We suggest that the answers to these questions are intimately tied to the growing availability of ART in wide parts of sub-Saharan Africa and that the terms on which this treatment has been grafted onto wider therapeutic landscapes have engendered the production of new religious spaces. It is within these spaces that notions of life and its moralities are being negotiated and configured.

#### **ART in Africa<sup>2</sup>**

While an estimated 2.1 million people with HIV had access to ART in sub-Saharan Africa as of the end of 2009 (WHO, UNAIDS & UNICEF 2010), social-science research on the new medications has remained scarce. Initial concerns that cultural factors were presenting a major obstacle to the successful introduction of ART in African countries (cf. Tawfik, Kinoti & Chad Blain, 2002) were eventually modified with regard to the multiple structural obstacles that have hindered access to ART on the subcontinent. These obstacles include a lack of confidentiality at HIV-treatment centres as well as the long waiting times and costs arising for patients making regular visits (Hardon, Akurut, Comoro, Ekezie, Irunde, Gerrits *et al.*, 2007).

Other research has focused on the issue of medication adherence, which remains one of the major challenges for HIV-treatment programmes in sub-Saharan Africa. A study from Tanzania, conducted soon after the introduction of ART in the country, stated that only 21% of the participating ART users in 2005 achieved the necessary level of adherence (see also Irunde, Temu, Maridadi, Nsimba & Comoro, 2006, p. 174). A recent ethnographic study in Tanzania was more optimistic in this regard in that it showed that individuals living with HIV or AIDS, on average, "take more than 90% of prescribed doses of antiretroviral therapy" (Ware, Idoko, Kaaya, Biraro, Wyatt, Agbaji *et al.*, 2009, p. 40). Thus both studies reveal the need for social science and ethnographic research on the failures and shortcomings of ART programmes (see also Van der Geest & Hardon, 2006, p. 4).

Apart from focusing on issues of access and adherence, few publications have dealt with the way ART has become embedded in patients' social and family networks and how the treatment affects understandings of health, illness and healing. A study on the introduction of ART in Senegal (Desclaux, Lanièce, Ndoye & Taverne, 2004) provided first insights into the social effects of this treatment on patients and their families. In addition to discussing adherence and confidentiality, the authors interpret ART as a catalyst for social and family change due to a growing individualisation of ART patients and an increasing dissociation from their families. Other studies have focused on the way societal discussions about ART — and the treatment programmes that have been built around ART — have led to new forms and understandings of political activism and citizenship in

different African countries (e.g. Robins, 2004; Nguyen, 2005). Many of these studies have focused on the settings of healthcare and counselling.

In a seminal article, Nguyen (2005) subsumed the various practices, values and ideas that have emerged in the context of a globalised health response to HIV under the concept of therapeutic citizenship — a transnationalised form of biological citizenship that makes claims on the global economic and social order based on a ‘shared therapeutic predicament.’ According to Nguyen (2005, p. 125f), the social and cultural practices that have evolved in this context over the last 10 to 15 years have been organised around a complex set of ‘confessional technologies’ and processes of self-fashioning that are closely interwoven with internationally acclaimed forms of HIV/AIDS activism and essentially draw their legitimacy from the economic, political and biological inequalities that exist in a globalising world. Hence, this kind of citizenship may explain ‘exemplary adherence’ among some ART patients in West Africa (Nguyen, Ako, Niamba, Sylla & Tiendrébéogo, 2007).

Similarly, Burchardt (2009) explores how efforts in South Africa concerning treatment adherence tie into negotiations of subjectivity in the context of counselling and have engendered new sites of governmentality. Finally, an article by Whyte, Whyte & Kyaddondo (2010) demonstrates that the medical personnel of governmental and non-governmental institutions are playing a crucial and often difficult role as mediators between individual patients and their families, national health policies, and transnational donor organisations. In Uganda, the translation of ethical guidelines into the professional relationships of an ART programme had to be negotiated in relation to the moral commitments and obligations that the ‘entangled’ health workers (HIV-positive nurses) experienced with their patients and clients who were often members of the same community (Kyakuwa, 2009).

While interesting and innovative work has been done on the introduction of ART in recent years, few studies have addressed the way in which the availability of the life-prolonging drugs has affected individual and communal understandings of life, death, healing, and stigma in the context of HIV, and how such shifts are related to changes in family and community relations. In a study in Uganda, Mogensen (2010) focuses on the dynamics of disclosure in the context of ART and analyses how the decision to speak to third parties about one’s HIV infection is embedded in varying levels of sociality and moral commitment. Her research points to the need for in-depth ethnographic research that can highlight the variety and negotiability of people’s positions and practices in the context of family relations over the life course of individuals.

Mattes’s (in press) study on ART patients and their families in coastal Tanzania highlights that the ‘bio-power’ that is exerted on individual ARV users only partly contributes to producing a self-responsible patient in the sense of ‘therapeutic citizens’ as suggested by findings of Nguyen (2005) and Nguyen *et al.* (2007). Mattes (in press) shows how frictions implicated in the therapeutic process and the production of adherent patients are strongly influenced by perceived gender roles and economic constraints as well as

by the logics of traditional healing and people’s struggle to maintain mostly kinship-based networks of support.

#### *Incorporating the perspective of religion*

Building on earlier studies on ART as well as the existing literature on religion and HIV, this special section highlights the way HIV treatments have become entangled with religious perceptions and practices in various African countries; and how the HIV/AIDS-related activities of religious groups and organisations have become intertwined with the growing presence of faith-based organisations in the context of national and international HIV/AIDS work.

Specifically, we argue that the introduction of ART in sub-Saharan Africa has created a specific historical momentum that has challenged religious practices, ideas and thinking in unique ways, and has triggered the formation of new religious spaces. At the same time, religious practices and institutions — with their multiple local manifestations and transnational links — have shaped the implementation and appropriation of ARV medications by national authorities, health institutions, and the recipients of ART and their respective social and family networks.

As we argue in the following section, these mutually intertwined dynamics can be designated as the ‘redemptive moment’ in the larger history of the HIV epidemic in Africa. The use of the term ‘redemptive’ thereby fulfils the above-mentioned need to create a working language for the complex analytical challenges that the field of religion and ART presents. The term redemptive appeals not only to social scientists for whom the notion of redemption and the transitory nature of much of the excitement and hope that were connected to the introduction of ART seem to emerge so obviously from concrete empirical evidence. It may also be appealing for theologians and religious practitioners since ‘redemption’ indicates discursive regimes in which Christianity has become highly influential in providing for dominant themes, tropes, and manners of speech for soul-saving practices (i.e. far beyond Christianity’s own domain of influence). Thus, the term redemption, as creating a multidisciplinary common ground where insights can be shared, not only indicates this moment of hope and expectation, but also includes the manner in which certain forms of theological speech came to be at the forefront of public awareness and policymaking. We argue that this term will provide workers in both anthropology and theology with the analytical tool to speak conceptually to one another about changes and continuities. The next section explores in more detail how new faith, hope and expectation meet the predicaments of everyday African society.

#### **‘The redemptive moment’**

The introduction of ART in Africa has been closely linked to religious thinking and practice and, more specifically, to redemptory language and images, since the beginning.<sup>3</sup> While the HIV epidemic in Africa was seen as a development and security crisis in the late 1990s, the introduction of ART since the early 2000s has marked a new era in its history. This new era has triggered hopes and expectations among national, local, and international organisations and governments, and most of all among patients and

their families, that the uncountable experiences of loss and suffering of the 1980s and 1990s might soon become relics of the past. While Africa had been caught up in a 'state of abjection' by the globalising world order for many years, with the HIV epidemic being the most explicit marker of the continent's marginalised position in the globalised political economy (Comaroff, 2007), the introduction of ART seemed to indicate a reversal of this trend.

The anxieties and hopes that surrounded the introduction of ART in Africa were driven by treatment activists like the Treatment Action Campaign in South Africa which claimed the treatment of people with HIV or AIDS as a human right, thus challenging the status quo of the political, legal and moral world order. With the pressure of local activist groups, the foundation of new international bodies like the Global Fund and the PEPFAR initiative set up the institutional framework for this new era. Funds began to pour into African healthcare budgets in almost excessive amounts; new structures and frameworks were established to distribute medications and implement HIV-treatment regimes at an almost breathtaking pace; people with AIDS illnesses were rising from their sickbeds and returning to their normal social and family lives. 'From despair to hope' was the phrase used by Doctors without Borders in 2001<sup>4</sup> to summarise the situation of hope that characterised the situation in many African countries, and sustained by the successes of activist organisations as well as by policy shifts in the globalised framework of the HIV/AIDS response (on 'the Lazarus effect' see Simpson, this issue).

The almost miraculous nature of the arrival of ART in Africa was closely linked to the interventions of the United States government and its involvement with the religious field in Africa and beyond. Even the sternest critics of former President Bush, who was repeatedly linked to the evangelical field, acknowledged that the Bush administration's PEPFAR initiative saved millions of lives in Africa. Bono, the lead singer in the rock band U2 and one of the most outspoken HIV activists on the global scene, made this connection very clear in an NBC interview in 2005: "I think [Bush has] done an incredible job, his administration, on AIDS.... 250 000 Africans are on anti-viral drugs. They literally owe their lives to America. In one year that's been done."<sup>5</sup> Awareness of the special bond between the United States and Africa was increasingly instilled in the minds of ordinary people in Africa, as is exemplified in a quote by an American nurse who described her encounter in Uganda with a patient on ARV drugs: "Just today, a patient came up to me in the parking lot and said, 'Thank you, American.' I said, 'For what?' He said, 'For my medicine. You care if I live or die.'"<sup>6</sup>

In Africa, local processes of carving out religious spaces for dealing with and negotiating the consequences of HIV and AIDS are increasingly mediated through interconnections with globally operating regimes of development aid and humanitarian assistance (Prince, Denis & Van Dijk 2009). As religious communities presented themselves as being mobilised and proactive and were perceived as reliable, and most importantly, socially and morally embedded institutions in transnational policy domains, their role in donor-dominated development networks was enhanced. The

PEPFAR programme in particular (but also other donor initiatives) contributed to the generating of new opportunity structures for religious actors and new horizons for reasserting their positions in the public spheres of African countries. This research is firmly embedded in the emerging social-science discourses on religion and development that analyses these intersections and also seeks to disentangle the underlying secularist assumptions of development policy, discourse and practices (Bornstein, 2005; Deneulin & Bano, 2009).

#### *Religion and the global development framework: challenges and opportunities*

Much of the financial support provided for the implementation of ART in Africa has been channelled through the religious field. The decision to involve religious organisations in healthcare-provisioning should not come as a surprise as religious organisations — especially the former (Christian) mission organisations and also groups and actors from the Islamic field — have played a central role in healthcare provisioning over the last hundred years (Vaughan, 1991). However, the funds that have become available for the introduction of ART since the early 2000s have not only been allocated to established religious organisations, such as in Zambia where mainline Christian churches have been operating successfully in the field ART field for many years (see Patterson, this issue). The promises and hopes that were raised by the growing availability of HIV-treatment funds challenged the less-established religious organisations (such as the Pentecostal churches) and, in some cases, also Islamic organisations, to develop their own policies on HIV/AIDS and ART; to establish their own institutional arrangements and structures for the implementation of HIV-treatment programmes; and to deal with the preventative and care-related challenges of HIV and AIDS more consistently.

In this regard, the globalised HIV/AIDS response has created opportunities for a wide range of religious organisations to adopt responsibility in responding to the epidemic, and has helped them to adjust their language, practices and institutional arrangements to the expectations and standards of (mostly Western-driven and predominantly Christian) development frameworks and accountability structures (Dilger, 2009). Most importantly, the growing institutional engagement of religious organisations with HIV/AIDS-related activities has seemed to make up for the fact that religion was losing ground in one of its most traditional domains. Thus, the growing availability of biomedical treatment and the expected concurring medicalization of people's lives in the context of HIV, queries the (continued) relevance of religious actors in the field of healing: What role does religious healing play in a world where people's problems are being increasingly solved by the rapidly growing (mostly secularly defined) HIV/AIDS industry?

Why do we conceive of the dynamics described here as 'a moment'? From the start, ART in Africa has never been what it was hoped or expected to be. The PEPFAR initiative was criticised for a range of reasons, and not only for its preference for the involvement of religious actors in an HIV/

AIDS response and its explicit support of religious groups' often morally conservative agendas (Sadgrove, 2007). The comparative abundance of funds for HIV/AIDS-related treatment and infrastructure has also created overwhelming challenges for healthcare systems in Africa regarding absorbing available funds into the existing infrastructure. In some cases, the over-availability of resources for HIV and AIDS in comparison to other health problems has reinforced inequalities and conflicts within some health institutions where health staff had to compete for better working conditions and career opportunities (Sullivan, in press; Leusenkaamp, this issue).

While medicines adherence rates in some healthcare settings in Africa turned out to be high (Ware *et al.*, 2009), the new era of HIV treatment has not produced the medicalised, disciplined or responsible patients that a project of this size anticipated. Several articles in this special section demonstrate that religiously driven healing practices in many African countries continue to flourish and that bodies and people were not disciplined by the available biomedical treatment regimes in the ways envisaged (or at least hoped for) by national and international policymakers as well as local healthcare providers (e.g. the articles by Jack Ume Tocco and Benjamin Kobina Kwansa). Thus, along with the strong stigma that continues to surround an HIV-positive diagnosis and HIV-related illnesses, the bio-power that is exercised by rigid treatment regimens and transnationally funded healthcare interventions cannot be viewed independently of the social and moral priorities formulated by communities, families, religious organisations and leaders in relation to the disease. Religious ideas, experiences, moralities and practices continue to play an important role in the way patients, families and health personnel ascribe meaning to life, death and healing. Their behaviours and actions are shaped along with or in contestation of biomedical ideas, material circumstances, and HIV-treatment regimes that have come to configure the ART rollout in wide parts of sub-Saharan Africa (Dilger, in press).

It is becoming clear that the introduction of ART in Africa has become a story of hope, success, and opportunities as much as it has been shaped by anxieties, contradictions and conflict. Most importantly, the hopes and opportunities that were so closely implicated in the introduction of ART over the last few years are now being questioned by recent reports about decreasing funds and the non-sustainability of treatment programmes in the wake of the global financial crisis,<sup>7</sup> concerns that have been expressed in relation to the 'ART hype' in Africa since the beginning.

### **Themes of the articles in the special section**

This special section explores the diverse relationship between religious thinking, practices and organisations on the one hand, and the increasing availability of ARV medications on the other. The eight articles address these questions from an interdisciplinary (political science, theological, anthropological and historical) perspective in different regions of sub-Saharan Africa, with case studies from Botswana, Ghana, Nigeria, South Africa, Uganda and Zambia. While six of the articles are based on empirical research, all take into account the broad diversity

and historical contingencies that have shaped religious responses in relation to HIV treatments in recent years. The articles can be grouped thematically according to institutions, ideologies and practices, thus highlighting the different analytical and disciplinary perspectives of the contributions.

The articles by Amy Patterson, Alexander Leusenkaamp, and Stephen Muoki Joshua take an institutional perspective to explain how the reshaping of religious spaces in the era of biomedical treatment for HIV is being enabled and constrained by a variety of institutional interactions. These are taking place between religious actors, states and external donors, as well as within the religious field itself. These articles describe the multiple ways in which access to donor resources reveals and reconfigures the distribution of power between religious and state actors. Simultaneously, they provide a pervasive sense of the degrees to which donor organisations, both bilateral and multilateral, have reinserted themselves in the wake of ART programmes into the transversal networks of governance in Africa.

Amy Patterson's contribution starts with the observation that church involvement with HIV/AIDS and ART has differed strongly in Ghana and Zambia, in scope and over time. Her article explains these differences in a multilevel approach that takes into account how the specific shape of civil society, the state, and international relations influence church activities. She shows that the nature of church activities depends on their representation in the national HIV/AIDS policy arena but also on the place of HIV/AIDS on national policy agendas. Simultaneously, the power of church bodies is massively enhanced if, as in the case of Zambia, their access to funds is not mediated through the state but through direct interaction with donors. A fascinating account is offered of how the highly complex mosaics of church initiatives in both countries are constantly being reconfigured as a result of shifting political opportunities, and also how churches are striving to shape these opportunities themselves.

While Patterson provides a sense of the complexities of national scenarios, Stephen Muoki Joshua's article looks at the transformation of HIV treatment and care provided by one particular religious actor, namely the Roman Catholic Church in South Africa. He meticulously traces the rise of Catholic HIV/AIDS-treatment activism and internal debates in order to explore how the Church, within five years, not only became a pacesetter in offering HIV treatment and care, but also a catalyst in mobilising rights to HIV treatment. Intent on revealing the dramatic and contradictory nature of these interventions, Joshua argues that, as a result of their immense proportions, project activities around HIV treatment and care have increasingly overshadowed inherited religious activities at the parish level. While focusing on internal developments within the Roman Catholic Church, the article highlights how these have inevitably been shaped by the perceived need to take a stance within South Africa's controversial political discourse on HIV treatment and against the government's initial reluctance to develop an ART rollout programme.

Alexander Leusenkaamp highlights how the presence of religious organisations in ART rollout programmes in rural Uganda, especially Catholic Relief Services, has come to

produce new religious spaces within local governance networks. Here, the arrival of ART has been accompanied by an ever-closer alignment of donors and religious service organisations, precipitating the reinforced marginalisation of state actors. Emphasising the fact that religious service organisations operate under a bishop's authority, the article reminds us how strongly religious HIV/AIDS activities can be shaped by inherited church hierarchies even if the official responsibility for biomedical interventions lies with governmental agencies. In this sense, Leusenkamp's study provides a fascinating example of how official and formal organisation works as 'myth and ceremony' (Meyer & Rowan, 1977). The article draws attention to the built-in tensions between the logic of faith-based organisations on the one hand, and governmental claims to authority on the other. It also serves as an admirable example of the benefits of in-depth ethnographic research for unearthing how governance works at ground level.

The articles by Amusa Saheed Balogun and Lovemore Togarasei consider the significance of religious views, convictions, dogmas and ideologies that govern many of the institutional and practical relations that evolve around the rollout of ART. They explore, but at the same time coproduce, what can be called a theology of ART in the African context: Balogun for West African Islam, and Togarasei for southern African Christianity (Pentecostalism in particular). Neither article speaks from an agnostic position, but both are formulated from an engaged and committed point of view. They present an insider's view of how faith and conviction have come to terms with the availability of life-prolonging drugs in religious traditions, and how this can be related to what some have called their 'scriptural politics' (see Kastfelt, 2003). In a way, these articles situate themselves in the production of 'a theology of ART' (both Islamic and Christian) and offer the reader a view of how biomedical practices and treatments can be incorporated in systems of thought where the divine is believed to be the ultimate source of life and therefore of healing as well. The articles bespeak a theologisation (i.e. turning into theological speak) of biomedicine and present ways in which these practices acquire moral legitimacy in such traditions. Interestingly, they also show that this is never an uncontested process, much though both traditions mean to ensure that their views on these forms of life-prolonging treatment appear as well-grounded in the scriptures and dogma. There are dissenting voices, of course, and ART appears to have the capacity to make ideological differences appear sharper or else to put them in relief.

Balogun's contribution offers a detailed account of the Quranic texts and *hadith* that inform Islamic scholars and intellectuals in Nigeria of the terms under which bio-power is being reformulated, if not reinterpreted, as becoming acceptable to the ordinary believer. Most important is the ideological recognition that as everything comes from Allah, the divine has also sent a cure for every disease. ART is thus being ideologically shaped as a medicine God has sent, while God's 'cure' for AIDS has yet to be discovered through divine inspiration. This renders the textual and scriptural integration of ART into a system of Islamic dogma possible.

Togarasei similarly discusses the dogmatic development of the integration of ART into a Christian, in particular Pentecostal, ideological domain in Botswana. Again, notions about divine healing and the view that ART is not an ultimate cure therefore remain possible and are not contradictory. Togarasei demonstrates Pentecostal churches' ideological struggle in their attempt to come to terms with the fact that bio-medicine can indeed be life-prolonging, can avert imminent death, and yet does not contradict the healing power of the Holy Spirit in any fundamental way. Claims that prayer healing miraculously takes place are then theologically justified because 'through God, nothing is impossible.'

Finally, the remaining articles look at different religious practices and ideas that have shaped individual and collective experiences around ART in different parts of sub-Saharan Africa in recent years. The articles discuss how practices surrounding illness and healing have become embedded in the wider religious and political histories of specific localities. They illuminate the manifold struggles of patients, churches and believers in attempts to establish meaningful relations and practices in the wake of a primarily biomedical HIV/AIDS response. How religious practices shape the manufacturing of heterogeneous therapeutic strategies is also highlighted.

Jack Ume Tocco shows how the introduction of ART in northern Nigeria has been connected to a flourishing of Islamic healing practices and to recent political shifts in the country which, in turn, have been associated with the introduction of *sharia* law and a wider reorientation of society in the region. He argues that while the introduction of ART has challenged the religious authority of Islam and Islamic leaders, this challenge is being negotiated differently by different actors in society. While the Nigerian Supreme Council for Islamic Affairs fully endorses the national government's treatment guidelines for HIV/AIDS in its 2009 National Islamic Policy on HIV/AIDS, many Islamic traditional healers "stake their professional reputations on their ability to cure patients of their ills," including HIV and AIDS. This position is viewed critically by some of Tocco's (male) interviewees, some of whom state that the healers' claim for a cure is false. The contribution hints at the analytical difference to be drawn between 'medicine' and 'cure,' as well as the complex contestations of values and practices that shape Islamic perspectives on HIV and ART in Nigeria.

Benjamin Kobina Kwansa also addresses the issue of religious and medical authority in relation to ART and the way it is negotiated and contested by healers, patients, and religious and medical institutions in Ghana. He provides ample evidence that the behaviour of people with HIV or AIDS in Ghana is only partially shaped by religious prescriptions and frameworks, since people with HIV make context-dependent use of different spiritual therapies, including those offered by Pentecostal churches, traditional priests and Islamic healers. Kwansa argues that the negotiations and compromises people make in this wider context of medical pluralism are best understood through a pragmatic approach (Whyte, 1997) that analyses healing practices, first and foremost with regard to people's moral and social priorities, as well as the aspired outcome of spiritual healings, and less through the prescriptive



framework of institutions and authorities (as suggested by the notion of 'prescriptive turn'). This sheds light on social-science assumptions about beliefs that cannot be understood as a stable cognitive framework of reference for action but that are subject to negotiation and (shifting) experience.

Through a long-term study among Christian men in Zambia, the contribution by Anthony Simpson discusses the hope and excitement associated with the introduction of ART. While Simpson carried out his initial episode of field research among a cohort of students in a Catholic missionary boarding school during the early 1980s, he reinterviewed some of these men annually, between 2004 and 2009, to find out how their religious values and schooling had shaped their subsequent lives, including their sexual relations and attitudes towards HIV. His findings show that while most of the men had experience of HIV either through the loss of relatives or friends or by being infected themselves, religion played a varying and often contradictory role in the way the men dealt with these challenges. Especially during the early 2000s (i.e. before ART), HIV/AIDS was framed largely in a discourse about sin and the need to lead a morally upright life. From 2004 onwards, the men increasingly described religion as a source of hope and support for those with HIV infection. Continued secrecy around HIV in Zambia, however, shows that for these men religious education was of little help for cultivating health-seeking competencies, particularly those linked to openness (i.e. disclosure) — which are crucial in mediating access to health facilities, voluntary counselling and testing and ART. The article hints at the need to pay close attention to the multiple and often inconsistent meanings that religion has produced in relation to HIV and the way these meanings have shaped men's and women's gendered identities and experiences over an extended period of time.

Taken together, the articles emphasise the need to explore how religion has become intertwined with the evolving HIV epidemic in sub-Saharan Africa, and how HIV-treatment programmes and healthcare interventions are being established (or are being withdrawn) on the continent. There are not single forms of Islam, Christianity, or African traditional religions that have come to shape people's practices and experiences in the context of HIV and ART in uniform ways. Instead, the articles highlight the manifold articulations that internally differentiated and contested religious thoughts and practices offer with regard to disease, treatment and healing. This special section provides a unique perspective on the topical and theoretical challenges that will surely characterise research on ART in the coming years, especially studies focusing on the relationship between religion and HIV/AIDS in sub-Saharan Africa.

## Notes

- 1 Unfortunately, only one article in this special section deals explicitly with the relationship between African ritual practice and ART (see Benjamin Kwansa on Ghana).
- 2 The authors want to thank Dominik Mattes for providing information about some of the literature discussed in this section.

<sup>3</sup> However, it should be noted that religious organisations were strikingly absent when it came to challenging global and national power relations with regard to the introduction of ART in Africa.

<sup>4</sup> See: <<http://www.doctorswithoutborders.org/publications/alert/article.cfm?id=3319&cat=alert-article>>.

<sup>5</sup> Thus quoted on America.gov, a website produced by the US Department of States Bureau of International Information Programs (see: <<http://www.america.gov/st/washfile-english/2005/June/20050627175254sssillE0.3220789.html>>).

<sup>6</sup> See: <<http://www.nytimes.com/2010/05/10/world/africa/10aids.html?pagewanted=2>>.

<sup>7</sup> See: <<http://www.nytimes.com/2010/05/10/world/africa/10aids.html?pagewanted=2>>.

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