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Positive Muslims:

**A Critical Analysis of Muslim Aids Activism in Relation
to Women Living with HIV/Aids in Cape Town**

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Abstract

Title : *Positive Muslims: A Critical Analysis of Muslim Aids Activism in Relation to Women Living with HIV/Aids in Cape Town.*

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This research will critically analyse Muslim approaches to five women living with HIV/Aids in Cape Town focussing particularly on the approach of 'Positive Muslims' – an awareness-raising and support group for Muslims living with HIV/Aids. The central question of this thesis deals with the impact of the norms, values and practices of Cape Muslims on the approach of Positive Muslims to women living with HIV/Aids. It is suggested that while norms and values articulated in religious texts inform the ideological approach of the organisation, the actual practices of Cape Muslims have an even greater influence on the organisation's Aids prevention model. This is due the pragmatic approach adopted by Positive Muslims which recognises that the articulated norms and values do not always conform to the practices of Cape Muslims.

This conclusion is supported by the experiences of five Muslim women living with HIV/Aids whose life histories are captured in this thesis. The life histories reveal some of the important factors that impact on the identities of the informants. Factors such as poverty and violence appear to have the most significant impact on the lives of women taking precedence over factors such as religiosity and HIV status.

Ultimately it is suggested that Aids epidemic has forced us to accept that practices often differ from the expressed norms and values articulated by mainstream religious leaders. Furthermore, it forces us to acknowledge that certain religious practices which perpetuate gender inequality may make women vulnerable to HIV infection. These practices therefore have to be re-evaluated.

It is suggested however that the re-evaluation of religious practices should be initiated from within the particular society in which the practice occurs. External pressure on Muslims to change practices that perpetuate gender inequality may have a limited if not adverse effect.

Key Words : Cape Town, Islam, Muslim women, HIV/Aids, religion, culture, rights, gender, ethnography, activism

Date : 6 November 2003

Introduction

The vision which fuelled our struggle for freedom; the deployment of energies and resources; the unity and commitment to common goals – all these are needed if we are to bring AIDS under control.

Future generations will judge us on the adequacy of our response.

(Nelson Mandela 1997)

Acquired Immunodeficiency Syndrome (Aids) is a disease that has no respect for boundaries of class, race or religion. It has affected millions of people around the world and continues to destroy the lives of thousands more on a daily basis. Aids is therefore a crisis of bewildering proportions. Since the first time it was detected in June 1981 by the Centre for Disease Control (CDC) in the United States, the epidemic has widened its circle and is no longer an individual, national or regional matter. There is furthermore hardly a sphere of human concern that has escaped unscathed from its devastating impact. Today, every facet of society, including law, medicine, politics and religion, is implicated in issues arising out of Aids.

In South Africa, the Human Immunodeficiency Virus (HIV) which ultimately results in Aids, represents one of the greatest threats to the country's future with 5 million men, women and children infected by the end of 2001 and as many as 1 750 new infections occurring on a daily basis (UNAIDS 2002: 190). While the first cases of Aids were identified in South Africa in 1982 amongst homosexual men, the majority of HIV transmissions in South Africa today occur

heterosexually (Partnership Against Aids Briefing Pack 1998: 3). Socio-economic inequalities as well as political factors have played, and continue to play a substantial role in the spread of HIV/Aids, resulting in the poorer black communities being more vulnerable to HIV infection than other groups.

Women between the ages of 15 and 49 make up the majority of those infected with HIV/Aids and have been identified as the most vulnerable group in terms of contracting HIV.¹ Besides the physiological factors that increase the risk of infection for women, it has been argued that they also have little or no power over their bodies and sexual lives. This powerlessness is reinforced by social, cultural and economic inequalities (Albertyn 2000: 1). The failure to recognise that gender relations not only underlie women's particular vulnerability but also limit women's attempts to protect themselves, has contributed to the rapid spread of HIV/Aids across Africa (Baylies 2000: 1). As a result, this thesis examines the question of gender relations and its link to the spread of HIV/Aids amongst Muslim women in Cape Town, South Africa. More specifically, this thesis will focus on the approach adopted by *Positive Muslims*, an organisation formed in June 2000 to raise awareness and provide support for Muslims living with HIV/Aids in Cape Town. The approach adopted by Positive Muslims in dealing with gender relations amongst Muslims in Cape Town, is examined in relation to in-depth interviews conducted with five HIV positive women who form part of the Positive Muslims support group.

¹ According to UNAIDS latest statistics on South Africa, 2.7 million women are HIV positive.

The central question that this thesis attempts to answer is: how have the norms, values and practices associated with Cape Muslims impacted on the response of *Positive Muslims* towards five Muslim women living with HIV/Aids in Cape Town? This question involves a critical analysis of Positive Muslims as an organisation, its approaches to HIV/Aids and the norms and values that influence its responses. Furthermore it involves exploring the relationship between Muslim women's vulnerability to HIV infection on the one hand, and religious and cultural practices that impact on gender equality on the other. This exploration will include an analysis of the way in which norms and values articulated by Muslims at a discursive level differ from or are similar to the practices carried out by Muslims at a practical level. The central question will be examined within the gender, rights and HIV/Aids framework which forms part of the culture/rights debate.

The role of religion and culture in shaping the individual and community response to HIV/Aids has been particularly interesting since it has had a substantial impact on the level of awareness as well as the type of response to the disease. It has been suggested that faith-based communities exert a powerful influence on the priorities of society and the policies of national leadership (Faith in Action, Durban 2002).

There are primarily two recurring themes that permeate through the orthodox Islamic discourse on Aids from the early 1980's until today: the first is that Aids is

a curse from God to punish those who have engaged in immoral sexual behaviour. The second theme proposes that the only way to effectively deal with the Aids epidemic is to return to the moral way of life prescribed in religious texts such as the Qur'an.

The adoption of these two themes by Muslims in Cape Town has had a devastating effect on its members who are living with HIV/Aids. HIV positive Muslims who form part of the various Muslim communities in Cape Town have refused to reveal their status to religious leaders as well as fellow Muslims fearing rejection, isolation and in some instances violent threats. Certain members of religious organisations have threatened Muslims who have publicly disclosed their HIV status. Faghmeda Miller, an HIV positive Aids activist and the first Muslim woman to publicly disclose her HIV status is one such individual who was threatened. Miller, who is one of the founding members of Positive Muslims, states in a television interview (Emmett 2001):

My problem was with the head of the Muslim community, which we call the Muslim Judicial Council (MJC) and other bodies. They didn't feel happy that I disclosed because according to them I am a woman and women are supposed to keep quiet. And secondly...they said...you know...some of them, I won't say who, some of them said I should be stoned to death because they believed, they still believe, some of them, that it's a curse from God, and because of that I should have been stoned to death. But I didn't stop there. I carried on telling people about my HIV status.

Miller's statement provides a critical insight into the experiences of Muslim women living with HIV/Aids in Cape Town for two reasons. Firstly, she argues that certain religious leaders affiliated to the MJC believe that women are 'supposed to keep quiet.' This reflects the unequal position of women in Muslim society and the consequent need to silence women, especially women who want to talk openly about issues involving sexuality and reproductive health - issues that make religious leaders uncomfortable. Secondly, the belief that Miller should be stoned to death is based on the idea that Aids is a curse from God - a curse directed against people who engage in sexually immoral behaviour. The logic (or lack thereof) is that since stoning to death is a punishment usually associated with adultery, and adultery is regarded as a form of immoral sexual behaviour, then the punishment for being HIV positive and for committing adultery should be the same. According to these religious leaders therefore, if you are HIV positive you must be sexually immoral and therefore you must be stoned to death.

Miller is one of a few brave individuals who have publicly declared their HIV status. She, together with other HIV positive Muslims, has challenged the orthodox approach to HIV/Aids and has provided an alternative voice to mainstream Muslim religious leadership. While orthodox religious institutions continue to preach uncompassionate morality, progressive Muslim organisations such as Positive Muslims have provided HIV positive people with the necessary support and counselling they require. In theory, progressive Muslims embrace differences of opinion on issues of religious belief and practice and believe in a

society where justice, equity and compassion go hand in hand with democracy, tolerance and individual liberties (Fatah 2000). At the heart of progressive Islam lies the belief that 'every human life, female and male, Muslim and non-Muslim, rich or poor, "Northern or "Southern," has exactly the same intrinsic worth (Safi 2003: 3).' Furthermore, a progressive Muslim is one who is committed to social justice, gender equality and pluralism (Safi 2003: 3).

The motivation for writing this thesis is two-fold. Firstly, the writer aims to expose and delegitimise certain Islamic cultural and religious practices that impact on gender equality. Secondly, to demonstrate that the gendered power relations evident amongst certain Muslims in Cape Town have to be challenged in order to effectively deal with the spread of HIV/Aids in that region.

Chapter Outline

The central question of this thesis, namely, how have the norms, values and practices associated with Cape Muslims impacted on the approach of Positive Muslims towards women living with HIV/Aids, is answered in five chapters. A conclusion will then be provided in the final chapter.

In chapter one, a broad overview of Aids, Islam and Muslims is provided. The impact of the Aids epidemic on South Africans, particularly women, as well as a brief history of Muslims in South Africa is explored. In addition, gender relations

in Muslim communities and the vulnerability of Muslims, particularly women, to HIV infection is also discussed.

Chapter two expands on the framework of the thesis by exploring the culture/rights debate in the context of HIV/Aids. An analysis of the relationship between Muslims and the South African Bill of Rights is furthermore provided. Tensions between the right to religious freedom on the one hand, and the Bill of Rights on the other, is also discussed.

Chapter three explores Muslim approaches to HIV/Aids and more particularly, Positive Muslims' approach to women living with HIV/Aids. A detailed ethnography of Positive Muslims is provided and their approach to women living with HIV/Aids is compared to one other Muslim Aids prevention organisation.

In chapter four the life histories of Muslim women living with HIV/Aids will be related through in-depth interviews conducted with these women. While the discussions in these interviews will feature throughout the thesis, this chapter will specifically be dedicated to providing these women with the platform to relate their life histories.

The relationship between women's vulnerability to HIV infection and religious practices that impact on gender equality is discussed in chapter five. Issues such as polygamous marriages and Islamic laws affecting women's economic

independence are critically analysed. Links are then drawn between these practices, and the impact it has on women's vulnerability to HIV infection. This discussion takes place in the context of the literature on gender, rights and HIV/Aids.

In the final chapter, concluding remarks are provided together with my reflections and impressions on the significance of this thesis in the context of HIV/Aids activism.

Approach to this Thesis

My approach to this thesis is in many ways connected to the fact that I strongly identify with progressive Muslim values. As one of the founder members of Positive Muslims and its Director for two and a half years, I have had first hand experience of Muslim responses to HIV/Aids. As a Black South African man, I feel that I have a responsibility to play a part in the struggle for equality, justice and human rights for women since the struggle for gender equality cannot be regarded as a women's struggle anymore than the battle against racism is a battle belonging only to Blacks. While the disempowerment of and discrimination against women may physically and legally be a women's problem, morally and theologically it is very much that of men. It is also essential that my own response to HIV/Aids does not simply reinforce the paternalistic role of men as responsible for women. Rather, I see myself as *equally* responsible *with* women.

My approach to this thesis was both enhanced and complicated by the fact that I wrote in my capacity as activist and researcher. At one level I was able to relate experiences, appreciate underlying issues and understand situations better because I have been an activist. My activist experience therefore enhanced my ability to write this thesis. On the other hand, this first hand experience limited my capacity to play the role of researcher since I not only passively listened to the informants, but used what they said to develop the services provided by Positive Muslims. So for example, while I was interviewing the five HIV positive informants and passively listening to their stories as a researcher, I also actively listened to them in my capacity as an activist and followed up on the difficulties they related during these interviews. Since it was practically impossible to separate my dual identity I embraced my activist/researcher position and used it both as an instrument of theoretical analysis and practical activism. While in certain instances it was difficult to maintain an optimal balance between these two positions, in most instances the theoretical analysis complemented and enhanced my activism.

One of the most striking ways in which my position as researcher enhanced my activism, was during my interviews with the five informants. Due to the fact that I had always interacted with the support group members in my capacity as Director of Positive Muslims, I was only aware of the immediate difficulties they were dealing with and attempted to assist them by focussing on these difficulties. As a result, I knew very little about the members except that they required

medication or they had no income for example. When I started asking them questions about their childhood and the circumstances surrounding the discovery of their HIV status, I began to better understand them as individuals but also began to notice things I had not seen before. I realised for example that women in marriages were as vulnerable to HIV infection as women who were unmarried. This had a tremendous impact on the way I personally began to approach the issue of HIV/Aids and in some ways has changed the focus of our awareness campaigns. If I had therefore not written this thesis and conducted interviews with members, I would not have realised that there was a strong connection between marriage and vulnerability to HIV infection. This is one of the significant ways in which a theoretical analysis of the interviews impacted on and complemented practical activist programmes.

The interviews with informants also affected my relationships with them. In some instances, I developed closer bonds with informants because I was better able to understand what motivated them to act in certain ways. One informant's relationship with her family impacted heavily on her self-confidence for example. When I understood this, I was better able to appreciate why she was reluctant to speak in meetings and subsequently always encouraged her to give her opinion on a particular matter. In other instances my relationship with informants was negatively affected. I realised that some informants were happy to take from the support group but were unwilling to give anything back. As a result, I became less willing to give of myself to satisfy their demands and began to ask more of

them. This did not go down well in one particular case. My relationship with this informant was therefore unilaterally ended by her.

My relationship with fellow activists was not affected in any significant way as a result of writing this thesis. However, one senior executive member alluded to people using Positive Muslims as a means of advancing their own careers. I'm not sure whether the member was referring to me but I could certainly be accused of personally benefiting from the organisation. Since my involvement in Positive Muslims I have been fortunate enough to travel to several countries and have received scholarships to advance my studies. There is no doubt that my involvement in Positive Muslims has advanced my career. It is probably inevitable that some will see this thesis as an example of a man exploiting the lives of women and an organisation to advance his own interests. However, I believe that those who worked side by side with me at Positive Muslims will understand that this thesis is simply a means of advancing organisational interests above any individual benefits.

Having presented my ideas and beliefs at a number of conferences and seminars on HIV/Aids locally and abroad, some participants have confronted me afterwards with both positive and negative comments. After my poster presentation at the International Aids Conference in Barcelona (July 2002), two Saudi doctors approached me in a gentle but firm manner questioning why I had painted such a negative and controversial picture of Islam and Muslims in my

presentation. They were particularly unimpressed by the fact that I had criticised polygynous marriages and suggested that I focus on the more 'positive' elements of polygyny.

In contrast to this experience, I have also been praised and congratulated on my critical and controversial presentations. On one or two occasions, some even commented on my 'bravery' as a man - particularly as a Muslim man - challenging the orthodox religious traditions in such an open and honest manner. The strange thing about both the positive and negative feedback I received was the fact that people thought I was being controversial. It was strange because I don't like being controversial. I prefer not to be controversial. But controversy seems to follow me wherever I go, or rather whenever I open my mouth! I remember that as a member of the Islamic Society at the University of Cape Town, I was constantly reprimanded and called to tribunals for things I said at public meetings of the organisation. Many Muslim men and women students were horrified by the fact that I suggested that women be allowed to give the Friday lecture at mosque for example. I honestly didn't think that I was being controversial - just logical.

Besides being accused of being controversial, I've also been accused of being brave. When I think of brave people in the context of HIV/Aids, I think of Zackie Achmat from the Treatment Action Campaign, Faghmeda Miller, and Nkosi Johnson. I am not brave or remarkable as any of these people are. I have never

seen my activism as an act of bravery but rather as an act owed to people living with HIV/Aids. My activism is based in some ways on the obligation owed by those who are fortunate to those who are not. I grew up in a privileged middle class home, was fortunate to have parents who had money and sent me to university. I therefore cannot understand how people can refer to what I do as bravery. It is an obligation, a duty. It is not bravery. All of us who are privileged owe this duty to those around us who are not. It's as simple as that.

For me, this thesis forms part of my duty as a privileged man to give expression to those voices who continue to be marginalised. However, not everyone was convinced that writing this thesis was the best way to give effect to this duty. Besides the general challenges one faces in writing a thesis, I was also challenged by the following questions posed by a feminist friend and former colleague, Claire Mathonsi: what makes you think that you, as a man, is able to give expression to the voices of marginalised women? Should you not concentrate on empowering these women to write their own life histories? Are you not simply reinforcing paternalistic notions of men as the protectors of women? How is this thesis actually going to help these women after you're done exploiting them and claiming all the glory for yourself?

These are hard questions that were posed to me and that I kept on asking myself while I was writing this thesis. The reality is that, as a man, I will never be able to fully and completely understand the hardship and challenges faced by women,

let alone HIV positive women. While this may restrict or impede my ability to give full effect to the voices of marginalised women, I cannot sit back and do nothing. Perhaps I should have spent more time empowering these women to write their own life histories. Perhaps I should have taken time to assist Faghmeda Miller for example in developing her manuscript. By failing to do so, am I profiting off the hardships and misery she has experienced by concentrating on this thesis instead? I came to realise that while I will certainly benefit from writing this thesis in many ways, the primary motivation and aim of this thesis was to advance the interests of Positive Muslims. My interest in writing this thesis is therefore more organisational than individual. As a result, I have justified writing this thesis as opposed to assisting these women to write their own life histories, because I believe that this thesis will do more for the advancement of HIV positive women generally. By critically analysing Positive Muslims in this thesis, it is hoped that the organisation will function more optimally thereby providing better and more efficient services to women living with HIV/Aids. Strengthening the capacity of Positive Muslims will ensure that the interests of HIV positive women are directly advanced. My decision to write this thesis is therefore a conscious choice to assist HIV positive women generally through the strengthening of the organisational framework of Positive Muslims.

If, as I claim, this thesis will assist HIV positive women generally, how does it purport to do so? Firstly, I do not pretend that this thesis is going to solve all the problems faced by HIV positive Muslim women. What I hope it will do is

strengthen the organisational capacity of Positive Muslims to assist these women through a critical analysis of the organisation. Secondly, I have always made it clear that this thesis includes the life histories of five individual HIV positive Muslim women. These women are not necessarily representative of all Muslim women in Cape Town. As a result, these interviews do not therefore provide the reader with a window into the lives of HIV positive Muslim women generally. What it does is to provide the basis for a careful and contextualised analysis of their specific life histories. This analysis has assisted in identifying challenges faced by these women and more importantly has become the basis for direct action taken by Positive Muslims to assist these women in dealing with the diverse range of challenges they face.

Ultimately, I continue to struggle with the hard questions posed to me and doubt that my answers will satisfy all. As I struggle along writing this thesis, I hope that it contributes in some ways to the debates Muslim Aids activists and activists from other faiths have to deal with on a daily basis. This thesis represents a small but important step in my obligation towards the marginalised.

Chapter One

Aids, Islam and Muslims in South Africa: An Overview

It is not sufficient to say that we must return to Islam. We must specify which Islam: That of Abu Dharr or that of Marwan, the ruler... One is the Islam of Caliphate, of the palace, and of the rulers. The other is the Islam of the people, of the exploited, and of the poor.

(‘Ali Shari’ati, cited in Esack, 2003)

1.1 Introduction

This chapter aims to firstly, provide a brief overview of the devastating impact of HIV/Aids on South Africa as well as discuss the current debates in the HIV/Aids sector. Secondly, the history and composition of the Muslim community will be looked at, and finally, submissions will be made with respect to the vulnerability of Muslims to HIV infection.

1.1.1 Defining HIV/Aids

The history of stigma and discrimination surrounding HIV/Aids even extends to the definition of the virus and the syndrome which was not without controversy. When Aids was first detected amongst homosexual men in New York and San Francisco, the disease was labelled as the ‘gay plague’ or ‘gay cancer’

(Jennings, no date provided) and by epidemiologists as 'Gay-Related Immune Deficiency' or GRID (Hunt, no date provided). This led to the stigmatization and alienation of gay people. Despite the change in name, the disease continues to result in stigmatization and alienation of people living with it.

The first public record of the HIV/AIDS phenomenon was contained in the Morbidity and Mortality Weekly Report (MMWR) of 5 June 1981 (Whiteside and Sunter 2000: 1). The Report recorded a few clusters of diseases which had previously been extremely rare. These diseases were subsequently more frequently observed and were ultimately labelled as Acquired Immunodeficiency Syndrome or 'Aids.'

The disease is 'acquired' because it is not spread through casual contact like the flu virus. The virus attacks a person's immune system rendering it deficient. Aids then finally presents itself as multiple diseases that result from immune system failure and is therefore regarded as a syndrome.

Once the syndrome was identified, the virus that caused Aids was later isolated and labelled as 'HIV' or human immunodeficiency virus. There are various strains of HIV with HIV-1 being the dominant strain in Southern Africa (Whiteside and Sunter 2000:2).

1.1.2 Muslim Theories on the Origin of Aids: The Green Monkey vs God

The dominant theory on the origin of Aids suggests that HIV is a virus that crossed the species barrier from the African Green Monkey into humans (Whiteside and Sunter 2000: 6). Hunters who killed monkeys could easily have been infected by monkey blood that came into contact with cuts in their hands (Whiteside and Sunter 2000: 6). The spread of diseases from animals to humans is not unique to HIV since tick-borne Congo fever and Severe Acute Respiratory Syndrome (SARS) are other examples of such a phenomenon.

While Muslim organisations such as Positive Muslims support the dominant theory on the origin of Aids, counter theories have also been put forward by Muslim Aids dissidents. The Nation of Islam, an American organisation, argues for example that Aids is a disease manufactured by the United States (Muhammad, no date provided). Other theories by Muslims such as Malik Badri, a psychologist based in Malaysia, suggest that Aids originated from homosexual activity. He argues that the green monkey theory was constructed by 'Americans in order to avoid the obvious fact that the mutation might have taken place in the insulted, germ-ridden rectums of San Francisco receiving homosexuals...(Badri 1997: XIX)'

In a survey of fifty three mosques in the Western Cape region, Ashraf Mohammed (1999) discovered that more than two thirds of religious leaders who

filled in his questionnaire believed that Aids was a curse from God. This belief held by the majority of religious leaders in the Western Cape at that time, is also reflected on websites of prominent Muslim organisations. The Muslim Judicial Council (MJC), a clerical body based in Cape Town, has not officially put forward any theories on the origin of Aids, but has a copy of an article entitled 'Aids: Stigmatize or Show Mercy?' on its website (www.mjc.org.za). The article suggests that Aids is a curse from God. The article states that:

It is true and unopen (sic) to debate amongst Muslims that Allah the Almighty has on occasion punished various tribes of people for their wrongful behaviour. 'So We sent (plagues) on them: Wholesale Death, Locusts, Lice, Frogs, and Blood: Signs openly self-explained: but they were steeped in arrogance, - a people given to sin.' (Al-A'raaf: 133)

This paragraph equates Aids with a punishment for wrongful or sinful behaviour but then goes on to contradict itself by stating that 'Muslims are also taught not to judge others.' These contradictions are typical responses by confused religious leaders who attempt to justify their belief that Aids is a curse from God.

The Jamiat-ul-Ulama, an organisation of Muslim clerics based in Johannesburg, is more blunt about their theory on the origin of Aids. In an article by Chida (no date provided) published on their website (www.jamiat.org.za), the writer argues:

'If lewdness exists among people and then appears as a common and open practice, plagues and NEW DISEASES which did not exist before will spread among them (Ibn Maajah; Al Hakim)' That warning of the Rasulullah (Sallallaahu Alayhi Wasallam) has now come true in the form of Aids.

The writer on this occasion quotes a prophetic tradition (hadith) from the prophet of Islam, Prophet Mohammed, also referred to as 'Rasulullah' – the prophet of Allah. This saying is used to justify the writer's theory that Aids is a curse from God for engaging in sexually immoral behaviour.

The previous writer listed on the Muslim Judicial Council website, quoted directly from the Qur'an to justify her position. This is common practice amongst Muslims who often use and quote religious texts as a means of justifying their position on Aids or any other issue facing Muslims. Ebrahim Moosa (2003: 122), a South African academic who lectured at the University of Cape Town and is currently an associate professor at Duke University in the United States, argues that 'this desire to find justification in the past, in a text or practice of a founder, suggests that Muslims can act confidently in the present only if the matter in question was already prefigured in the past.' This approach, he argues, is the 'sign of a profound lack of dynamism among the contemporary adherents of the tradition.' Moosa's arguments appear to be relevant in the context of HIV/Aids where individuals and organisations seem to rely heavily on the text as a guide or as a justification for their approach to people living with HIV/Aids. The reality, according to Farid Esack (Interview: Rondebosch, 19 April 2003), one of the

founder members of Positive Muslims, is that 'Muslims give the image of being stuck to the text.' Muslims may therefore refer to the text or the past in order to justify their present actions, but, according to Esack, their actions are more dependent on their 'class position, money, gender and economic interests' than the text itself. Muslims are therefore not only defined by their faith, but through a number of other social and individual criteria. Their approaches to HIV/Aids are ultimately based on an intersection of these criteria. It is suggested further on in this thesis that while it may appear that Muslim responses to HIV/Aids are intrinsically connected to the way in which Muslims approach religious texts, the reality is that, more often than not, the text is simply used as a pretext for responding to people living with HIV/Aids.

The positions adopted by Muslim organisations such as the MJC appear to be exactly the same as the positions adopted by certain Muslim men in Cape Town. In a study conducted by Yoesri Toefy (2002) on behalf of the Human Sciences Research Council (HSRC), he discovered in group interviews with eight Muslim men, that the primary explanation for the cause of Aids was an 'immoral lifestyle.' One of his participants in one of his focus groups stated:

I mean, from what I know, there are a few ways in which you can contract the disease (HIV/Aids). Your lifestyle, if you are homosexual, whatever the case... whatever your sexual lifestyle is, which are some of the causes. Blood transfusions as well. I don't think it's any single sort of trigger causes you to get Aids. I think that the origin of the diseases is a mystery. But, one factor that

obviously, which I firmly believe that it's contributing to it's spread, more than anything else, is probably sexual promiscuity. Because from that you have babies more with it inheriting from their parents. So, that's probably the biggest single contributing factor I suppose. But if you look at the bigger picture, morality is in fact the biggest, or rather immorality, is the biggest contributing factor. And you cannot say that it isn't. You can't. But I always think that mainly focus on Aids/HIV, you know. I think for every action there will be a reaction. I have no idea how (disease originates or)... Or where it comes from... or homosexuality... I've got no idea. But I think that something must be responsible.

While Toefy (2002) realises that the opinions expressed in this focus group may not be the opinions of the majority of Muslim men in Cape Town, he concluded, based on his own personal experience as a researcher and former member of the Muslim Judicial Council (MJC), that these opinions were 'in all likelihood' the dominant opinion amongst Muslim men (Toefy 2003). In the second part of his study which involved the analysis of opinions of seven Muslim women in Durban, he found that the women's opinions on the origin of Aids were exactly the same as the opinions of the men in Cape Town. One of the female group participants indicated that:

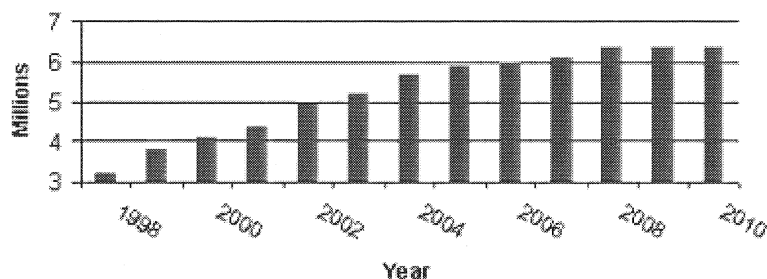
I think its something sent from God and I think you know we shall all live with it because maybe God has sent something down like pain because of all the sins in the world, must be something like that that's why there's no cure for it.

These opinions expressed by certain Muslim men and women between the ages of nineteen and sixty-four are a major cause for concern and a reflection of the deep seated ignorance on HIV/Aids prevalent amongst Muslims in Toefy's focus groups. The fact that these opinions are reinforced by religious leaders makes it exceptionally difficult for an organisation such as Positive Muslims to raise a sufficient level of awareness about HIV/Aids amongst Muslims. These opinions also contribute to the vulnerability of Muslims to HIV infection since they continue to believe that they are not susceptible to HIV infection as long as they live a 'good moral life.'

1.2 The Aids Epidemic in South Africa

In 1982, the first two South African Aids cases were identified amongst white homosexual men (Whiteside and Sunter 2000: 47). However, by July 1991, the number of heterosexually transmitted cases equalled the number of homosexual cases. Today the majority of HIV infections are amongst heterosexual women followed by heterosexual men (UNAIDS 2002: 190). While in 1990, the first antenatal survey conducted in South Africa found that 0.8% of women attending state clinics were HIV positive, by the end of 2001 the prevalence rate for South Africa as a whole was 20.1% (UNAIDS 2002: 190). The graph below projects the total number of HIV positive South Africans up to 2010.

Graph 1: Total number of projected HIV infected South Africans



Source: HIV Management Solutions (no date provided).

South Africa has experienced one of the fastest growth rates of the Aids epidemic. Since the primary mode of HIV transmission is penetrative heterosexual sex, assumptions have been made that South Africans engage in more sexual activity than residents of other countries (Whiteside and Sunter 2000: 59). Religious communities have often argued that sexual promiscuity and immorality are the primary causes of HIV infection. One Muslim commentator argues that 'A sexual holocaust called Aids is wreaking havoc in Sub-Saharan Africa (El Kassem, no date provided).'

However, no statistics are available to support the belief that South Africans are more sexually promiscuous than citizens from other countries. One company that attempted to determine the level of sexual activity in various countries carried out a survey in 2002. The Durex Global Survey covered 22 countries and a total of 50 000 respondents. While the survey may not be the most scientific because of its commercial background, it is suggested that biases contained in

the survey are probably consistent across the countries that have been sampled (Whiteside and Sunter 2000: 59). The highlights of the survey are contained in

Table 1:

Table 1: Sexual behaviour in selected countries

Country	% of unsafe sexual encounters	Average number of episodes of sexual intercourse per annum
USA	35	138
Britain	39	149
Denmark	49	152
Thailand	23	112
Germany	29	147
South Africa	31	146

Source: Durex Global Sex Survey (2002).

The survey clearly shows that South Africans seem to be engaging in approximately the same levels of sexual activity as residents of other countries. The belief therefore held by Muslim commentators that sexual promiscuity is the primary cause of the spread of Aids is false. If this were true, then Denmark would have far higher HIV infection rates than South Africa because Danes engage in more sexual activity and have a higher percentage of unsafe sexual encounters. The Danish HIV infection rate at the end of 2001 was 0.2% (UNAIDS 2002: 194) compared to South Africa's rate of 20.1% (UNAIDS 2002: 190).

1.2.1 The Impact of HIV/Aids on South Africans

A decrease in the life-span of South Africans will inevitably have dire consequences for the country at a social and economic level. At the moment South Africa is at the beginning of the Aids epidemic which is projected to peak in 2010 (Whiteside and Sunter 2000: 85). Predictions about its current and future impact are therefore difficult to accurately determine.

The Centre for Health Policy conducted a study in 1991 on the possible impact of Aids on South Africa. The study found that the most immediate impact would be felt in the public health sector. In the longer term, the epidemic would have an impact on economic growth. The general conclusion was that while the overall impact of the epidemic would be a sustainable one for the South African economy for 15 years, 'the problem is still a *desperately serious* one for our society (Centre for Health Policy 1991: 71).'

In a more recent report compiled by the Human Sciences Research Council (HSRC) presented to Parliament in February 2003, it was projected that 375 670 South Africans are expected to die as a result of Aids in 2003 (Mail & Guardian 2003). This is an increase of more than 30% from the estimated Aids-related deaths in 2000. The report also found that most HIV positive people are African women.

1.2.2 Current Debates

Besides the continuous presence of Aids dissidents who argue that HIV does not cause Aids, various debates in the HIV/Aids sector relating to intellectual property rights of pharmaceutical companies, governmental obligations and Aids trials continue to make headlines. The battle between the South African government and non-governmental organisations such as the Treatment Action Campaign (TAC) appears to dominate the Aids debate.

One of the main reasons why Aids activists as well as organisations such as the Congress of South African Trade Unions (COSATU) and the South African Communist Party (SACP) are currently unhappy with Government relates to Government's failure to sign the National HIV/Aids Treatment Plan negotiated at the National Economic Development and Labour Council (Nedlac) talks in 2002 (Achmat 2003). The plan envisages making anti-retroviral drugs available to all Aids patients who need them.

Since these organisations believe that Government and the business sector appear to be dragging their feet regarding the signing, the organisations have announced plans to embark on mass action to pressure Government into signing the Treatment Plan (The Cape Times, 10 February 2003). The first form of mass action took place on 14 February 2003 during the opening of Parliament in Cape Town. Approximately 10 000 people marched to Parliament to demand that the

HIV/Aids Treatment Plan be implemented (The Independent UK, 15 February 2003).

After several protests, petitions and civil disobedience campaigns, it appears as if government has finally acknowledged the value of anti-retroviral therapy. On 8 August 2003, Cabinet announced that it had instructed the Department of Health to develop a plan to roll-out anti-retroviral treatment by September 2003 (Sunday Times, 10 August 2003). Aids activists have welcomed Cabinet's decision and have urged government to follow through with their promise (Cape Argus, 11 August 2003).

1.3 Muslims in South Africa

Based on the 1996 population census, it is estimated that there are approximately 553 717 Muslims (1.36% of the South African population) living in South Africa (Haferburg 2000: 33). This figure is relatively close to the figure estimated by the United States Department of State which puts Muslims at 1.5% of the population in 2002 (International Religious Freedom Report 2002).

The largest number of Muslims are found in the Western Cape (263 913) making up 6.67% of the total provincial population. In Kwa-Zulu Natal 1.51% of the total provincial population is Muslim while in Gauteng 1.47% of the total provincial population is Muslim (Haferburg 2000: 33).

1.3.1 On Being a Muslim

When I arrived at Newark Airport in New York on my way from Canada to South Africa in July 2003, I was politely escorted by a customs official to a waiting room. My passport and ticket were carefully placed into a clear, thick plastic bag. The bag was sealed as if the contents were evidence from a crime scene and handed to the suspicious customs official waiting to escort me to the interrogation room. As I sat watching what looked like a Spanish soap opera on the wall-mounted television, I was summoned by a third, more senior looking official who asked me a couple of questions about where I was coming from and where I was on my way to.

When I told him that I was South African, he asked me where my parents were from. And when I informed him that my parents were also South African, he enquired about my grandparents' origin. When I mentioned that they were originally from India, the customs official looked up at me and probably thought that he was onto something. He then wanted to know whether they came from the part of India which is near to the Pakistani border or whether they were from the part of India that had subsequently become Pakistan. I was taken aback by his question but was more impressed with his geographical knowledge. I would be surprised if George W. Bush knew as much about the Indo-Pak subcontinent as this customs official.

To be honest, I wasn't sure whether my grandparents' village was near the Pakistani border or not, so I simply said that they were from the South of India. The customs official seemed disappointed by my response and eventually released me. I was subsequently stopped by another official and was not allowed to board my flight until security had officially removed me from their system as a 'security threat.'

It seemed obvious that the U.S. customs official had taken a special interest in me because I look Arab and have an Arabic name. More importantly, he 'knew' that I was Muslim and wanted to establish this by connecting me in some way to a Muslim country like Pakistan. If we therefore applied the customs official's definition of what a Muslim is, we would focus specifically on what the person looked like. In other words, a Muslim would be defined according to his or her race and ethnicity.

In South Africa and in Cape Town specifically, the U.S. customs definition cannot be applied since Muslim society consists of white, black, Indian and coloured Muslims, amongst others.¹ One can therefore never tell whether someone is Muslim based simply on the way they look. In Cape Town, it has become even harder to determine whether someone can be identified as Cape Muslim due to an increase in marriages between Muslims and non-Muslims (Bangstad 2001: 2). As a result, it has been argued by Bangstad (2001) that one cannot really define

¹ In 2002 I happened to appear before a Muslim magistrate in Cape Town due to a traffic violation. The magistrate had a Chinese ethnic background and looked Chinese.

or determine what the characteristics of a Cape Muslim are. He therefore finds: 'Based on my research material from the Cape Muslim community of Mekaar, I suggest that Cape Muslim identities must rather be seen as palimpsest identities: fractured, fragmented and implicated in the hybrid social formations from which they arise (Bangstad 2001: 19).'

The obvious question that remains is: can we talk of a single Cape Muslim community or a Cape Muslim identity with specific norms or social values? On the one hand, it is impossible to argue that Cape Muslims adhere to specific norms and values which ultimately form the basis of their homogenous identity. This becomes particularly evident during the interviews with the five informants where one observes that practices amongst Muslims do not always conform with the norms and values articulated in religious texts or by religious leaders. On the other hand, Positive Muslims claims to provide a service to a particular community with a particular identity in Cape Town. If it is impossible to identify this community through its norms and values, how can the organisation claim to raise awareness and provide support to members of this community? At an organisational level, the answer is simple: anyone who claims to be a Muslim and who is HIV positive will be assisted. At an ideological level, the answer is more complex. It is suggested that Bangstad's observation that the Cape Muslim identity is 'fractured' and 'fragmented' is correct and that it is virtually impossible to come to a definite conclusion about who and what is a Cape Muslim. The answer is constantly evolving and is based on a combination of the norms and

values found in religious texts, the interpretation of those texts by religious leaders, and the actual practices of Cape Muslims.

At Positive Muslims, when someone walks into the office and asks for assistance, we may at times be suspicious about whether the person is HIV positive, but have never questioned whether the person is Muslim because of their race or ethnicity. There is an assumption that only Muslims will seek assistance from a Muslim organisation especially when the organisation is called 'Positive Muslims.' This assumption is of course highly flawed since one of our partner Muslim organisations, the *South African National Zakah Fund (SANZAF)* who is meant to provide Muslims with food parcels and other financial assistance, is bombarded with requests for support from Muslims as well as poverty stricken individuals from other faiths. Since Positive Muslims largely limits its support to counselling services, it is assumed that the organisation only attracts Muslims who are HIV positive. Anyone who therefore says that they are Muslim is for all intents and purposes regarded as Muslim by the organisation. The same broad definition is applied to Muslims in this thesis.

1.3.2 History and Composition of Muslims in South Africa

Historically, Islam's entry into South Africa came in two waves. The first group of Muslims arrived in the Cape shortly after 1652 as labourers, exiles and political prisoners of the Dutch colonialists (Esack 1999). These Muslims were from the

colonies of Java and Malaysia. Despite severe repression of Islam by the Dutch authorities, Islamic practices and teaching continued (Moosa 1995). This was primarily due to the early founders of Islam at the Cape such as Sheikh Yusuf of Macassar (d. 1699) and Tuang Guru (d. 1807) who are considered as having consolidated the Islamic presence in South Africa (Mukadam 1990: 27).

The second wave of Muslims was brought to South Africa by the British Colonial powers as indentured labourers from India. Their arrival in 1860 was due to the British requiring cheap labour to work on the sugar cane fields in Natal. The majority of indentured labourers were Hindu. However, large numbers of Muslim merchants from India soon followed establishing businesses, mosques and religious schools (Mukadam 1990: 27).

The development and growth of Islam in South Africa therefore stems from a twofold historical process. The banishment of prisoners and slaves from the Malaysian Archipelago to the Cape in the 1660's and the arrival of Indian labourers and immigrants in the 1800's, set the historical context for Muslims in South Africa. Islam was subsequently embraced by sectors of the indigenous African population making the composition of Muslims in South Africa fairly diverse.

1.3.3 Contemporary Cape Muslims: Challenging Religious Authority

Today, Muslims in the Cape consist of all races as a result of conversions to Islam and marriages between people from different racial and ethnic backgrounds (Bangstad 2001: 2). The Cape Malay population however, continues to comprise of the majority of Muslims in this region. Since the profile of Muslims in the Cape has changed and evolved over the past few years, the approach to religious authority appears to have changed as well. The change in the racial and ethnic profile of Muslims in the Cape together with 'increased access to higher religious education and increased exposure to the diversity of local and global Islamic discourses as a result of general societal democratisation and processes of globalisation, leads to increased contestation over religious authority in Cape Muslim communities' (Bangstad 2003: 1). While the 'contestation over religious authority' has been an ongoing issue in the Cape for several decades, Bangstad (2003: 6) argues that this trend appears to be increasing. More significantly, challenges to traditional religious authority has also opened up the possibility of more women taking positions of leadership in Muslim communities (Bangstad 2003: 2).

Furthermore, challenges to religious authority is particularly evident in the HIV/Aids debate where religious leaders are publicly challenged by Muslim Aids activists on the question of Islam and Aids. The challenge by Aids activists, in particular, Positive Muslims, against the authoritarian or conservative approach

to Islam and Aids is in many ways a challenge based on the principles of 'Progressive Islam.' A definition and declaration of 'progressive Islam' is provided by the Progressive Muslim Network, a group of academics and activists from various parts of the world, including Cape Town, who communicate primarily via their website and internet discussion forum:

Progressive Islam is that understanding of Islam and its sources which comes from and is shaped within a commitment to transform society from an unjust one where people are mere objects of exploitation by governments, socio-economic institutions and unequal relationships. The new society will be a just one where people are the subjects of history, the shapers of their own destiny in the full awareness that all of humankind is in a state of returning to God and that the universe was created a sign of God's presence.

www.progressivemuslims.com/index2.html

The authors acknowledge that there are some difficulties with this definition but it appears to be the most comprehensive and encompassing definition of this relatively new phenomenon. It should however be noted that progressive Muslims are still very much on the margins of Cape Muslim society where conservative and even fundamentalist Muslims have more prominent voices.

1.3.4 Gender Relations amongst Muslims in South Africa

The history of the struggle for gender equality amongst Muslims in South Africa is intrinsically connected to the history of Islamic resurgence (Shaikh 1996: 25). Two significant developments played a crucial role in stimulating Islamic resurgence in South Africa. The first involved the Iranian revolution in the 1970's which saw a resurgence of Islamic movements. One of the significant aspects of these movements was its willingness to take on the issue of women's education and empowerment (Esack 1992). The second development was the escalation of the national struggle against apartheid, particularly in the late 1980's (Tayob 1990). These developments which involved issues of human rights, liberation and justice, were logically extended to the issue of women's rights (Esack 1992).

In South Africa, the wave of Islamic resurgence manifested in the formation of the Muslim Youth Movement (MYM) in 1970 – an organisation that located Islam within the socio-political context of South Africa and that worked towards gender equality (Tayob 1990). The organisation challenged the religious leadership ('ulama) and their belief that they had exclusive access to understanding and interpreting the Qur'an and other sources of religious knowledge (Tayob 1990). At the same time, the MYM placed the issue of gender equality firmly on the agenda. According to Shaikh (1996: 30) however, the organisation's approach to gender equality was often patronising and usually articulated 'in fairly

conservative terms by men,' implying that women were still not afforded the same powers and rights as men.

In contemporary Muslim society, the gender debate has increased intensively. The South African Law Commission's (SALC) Discussion Paper on Islamic Marriages (2002) has fuelled this debate culminating in diverse views being expressed by various Muslim organisations and individuals. In submissions made to the Commission, the issue of women's rights within Islamic marriages was continuously raised by respondents. It is argued that the submissions to the Commission are in many ways statements relating to gender equality.

Submissions made by organisations such as The Islamic Unity Convention (IUC) rejected the Discussion Paper in its totality arguing that the Commission was selective in the authority it used to place restrictions on polygamous marriages (SALC 2002: 8). A number of organisations and individuals were strongly opposed to the fact that Islamic law was made subject to the limitations imposed by the Constitution.² It is however submitted that their arguments about Constitutional limitations masked their resentment towards the Commission who had adopted positions that were inclined towards establishing gender equality within Islamic marriages.

² Some of the organisations opposed to the Law Commission's proposals included the *Association of Accountants and Lawyers for Islamic Law*, *Murabitun* and *Institute of Islamic Shari'ah Studies*.

This submission is based on the fact that a number of opponents to the Discussion Paper listed the age of consent for marriage and the restrictions placed on polygamous marriages as particularly objectionable. Both these issues relate specifically to women, since women may be forced to marry at a young age and may also become part of a polygamous marriage without their knowledge or consent.

Furthermore, a detailed study of 600 divorce records amongst Muslims in the Western Cape revealed that 76.2% of the applicants were women (Toefy 2002: 41). The significant number of women initiating formal divorce proceedings according to Toefy (2002: 132), is a reflection of 'several changing social and cultural factors in the community.' Toefy argues that the primary factor bringing about social and cultural change is the advent of the 'New South Africa' and its associated transformation in legislation favouring the rights of women. The most common reasons for divorce given by women divorce applicants were infidelity, drug abuse and physical abuse. This can be compared to the most common reasons given by male applicants which were incompatibility, infidelity and abandonment. The high rate of divorce proceedings being initiated by women is therefore a strong indication of the gender discrimination faced by Muslim women in marriages as well as an indicator that more women are taking greater control of their lives. Toefy (2002: 145) interprets the reasons provided for initiating divorce proceedings as a sign that women show a 'lack in confidence in the divorce procedure.'

From my experience and from others in the field, if a woman has a range of complaints, she will list the ones that will assist her to obtain a speedy divorce and stay away from reasons that need interpretation and excessive explanation. Males do not display the same reservations because they are confident in obtaining the divorce decree whatever reasons they give.

Women are therefore not only subject to violence and abuse during marriage, but are subjected to secondary victimisation by Muslim bodies that oversee divorce proceedings. This secondary victimization occurs when men are granted divorces without having to provide detailed reasons, while women undergo extensive questioning and have to provide substantial reasons before their divorce is granted. The changes that the Law Commission wants to introduce aims to assist in the eradication of secondary victimisation. Organisations and individuals who object to the changes being introduced by the Law Commission, in many ways want to maintain control over the lives of women through religious leaders and organisations who oversee divorce proceedings. Despite the criticism of the Commission, progressive Muslim organisations such as the Muslim Youth Movement (MYM) were largely in favour of the Discussion Paper. One person who made a submission goes even further than the Commission on the issue of consent by proxy. She argues that if consent to marry by proxy is given by a woman the consent has to be in writing and include a test to determine the HIV status of both parties (SALC 2002: 11). These measures are suggested as a means of protecting women before and during the marriage process and are a reflection of the pro-equality advocates in the gender debate.

Furthermore, in a joint submission by Ittigaadun-Nisa and The Women's Institute for Leadership and Democracy they argue that 'legislation enforcing and enacting the principles expounded in the Holy Qur'an will accord Muslim women their rights and security against oppression and injustice (SALC 2002: 20).' Ultimately, the arguments put forward in these submissions are a reflection of the current gender debates amongst Muslims.

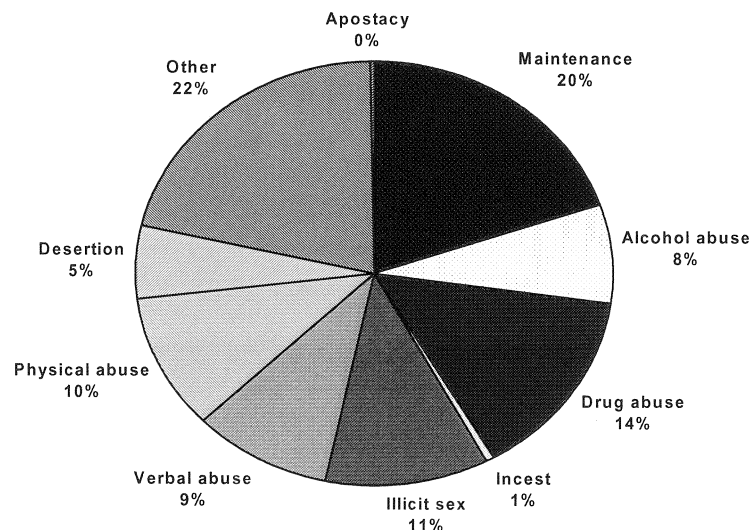
More recently, a letter to the editor of a popular Cape Town Muslim newspaper, *Muslim Views*, suggested that violence against women stems from the fact that men are unable to control their 'biological sex drive' (Martheze 2003). The writer went on to argue that men cannot be blamed when they 'sometimes misinterpret the signals' sent out by women who dress like 'sex workers.' While these opinions continue to find their way into the pages of local Muslim publications, there appear to be strong opposing voices reflected in these publications as well (Muslim Views, March 2003).

1.3.5 The Vulnerability of Muslims to HIV Infection

An analysis of 3 959 client counselling sessions at the Muslim Judicial Council (MJC) based in Athlone, Cape Town, for the period 1 January to 31 December 1993 revealed some startling results (Mohammed 1997: 36). There were 297 (8%) cases of alcohol abuse, 569 (14%) cases of drug abuse, 25 (1%) cases of incest, 412 (10%) cases of physical abuse, 371 (9%) cases of verbal abuse, 781

(20%) cases of lack of maintenance, 216 (5%) cases of desertion and 441 (11%) cases of illicit sexual activity. These figures indicate that Muslims in the Cape are highly susceptible to HIV infection since there is a direct link between sexual activity with multiple partners and Aids. The graph below illustrates the type of cases dealt with by the MJC in 1993. The categories were formulated by Mohammed (1997):

Graph 2: Types of cases dealt with by the MJC in 1993



While these figures fail to indicate what percentage of cases was committed by men or women, in a presentation by the researcher of this study, he indicated that the 'overwhelming majority' of illicit sex cases were perpetrated by men (Mohammed, 2003). All the cases of physical and verbal abuse, incest, desertion, drug and alcohol abuse as well as failure to pay maintenance, were committed by men against their wives.

These results are confirmed in a later study by Toefy (2002: 145) who states that the primary reasons why women initiate divorce proceedings are infidelity, drug abuse and physical abuse. Table 2 below, lists the reasons for divorce cited by divorce applicants in Toefy's study:

Table 2: Reasons for divorce

Reason for Divorce	Male	Female	Total
Infidelity - Spouse	25 (20.8%)	95 (79.2%)	120
Drug abuse - Spouse	7 (8.0%)	81 (92.0%)	88
Incompatibility	31 (45.6%)	37 (54.4%)	68
Physical abuse - Victim	9 (13.8%)	56 (86.2%)	65
Abandonment	10 (22.2%)	35 (77.8%)	45
Other spouse	10 (25.6%)	29 (74.4%)	39
Financial support problems	0 (0%)	30 (100.0%)	30
Alcohol abuse	5 (20.8%)	19 (79.2%)	24
In-laws	10 (43.5%)	13 (56.5%)	23
Apostasy	8 (38.1%)	13 (61.9%)	21
Basic unhappiness	8 (40.0%)	12 (60.0%)	20
Religiosity	6 (42.9%)	8 (57.1%)	14
Communication	7 (58.3%)	5 (41.7%)	12
Infidelity - Self	3 (30.0%)	7 (70.0%)	10
Financial problems	1 (11.1%)	8 (88.9%)	9
Sexual difficulties	2 (28.6%)	5 (71.4%)	7
Incarceration	1 (20.0%)	4 (80.0%)	5
Total	143 (23.8%)	456 (76.2%)	600

Source: Toefy (2002: 145)

The table above, which is made up of categories formulated by Toefy himself, illustrates that 95 out of 456 women (20.83%) who apply for divorce are in marriages in which their husbands are unfaithful. When combining the two

categories of infidelity formulated by Toefy, it becomes evident that a total of 130 out of 600 cases (21.6%) involved infidelity. This figure of 21.6% can be compared to the 11% of cases discovered in Mohammed's study in 1993. While the two studies used different categories, it can be concluded that the number of divorce cases involving infidelity has almost doubled from 1993 to 1999.

Physical abuse of women by men made up 12.28% of cases (56 out of 456 cases). This can be compared to 10% of cases in 1993 (Mohammed 1993). The increase in cases of physical abuse and infidelity are clear indications of the increased vulnerability of women to HIV infection.

Another significant trend discovered by Toefy (2002: 151) relates to the 'community practice of "forcing" couples to get married when the female falls pregnant.' These marriages, also known as 'shotgun' marriages involves situations where couples who would probably not have wanted to get married, end up doing so 'due to the insistence of the families "to make things right (Toefy 2002: 151)."' A staggering 57% of all couples who applied for divorce had entered into marriage as a result of premarital pregnancy (Toefy 2002: 122). The largest percentage of these couples was in the 25 to 29 year old age group. One of the HIV positive women I interviewed also became a victim of a 'shotgun marriage' when she fell pregnant while at high school at the age of nineteen. During our interview (Najma Salie, Observatory, 24 April 2003), she stated that:

I had to leave school because I was pregnant and got married and was very, very happy at the time. I think that the reason for getting married was because I was scared because I didn't want to be alone. The first thing my mother said was, 'what's people going to think and what are they going to say? And, 'how can you do that?' So I said that I'm going to get married. So it's like if I get married then everything will be like... you can't say anything. But it wasn't the best decision even though I was happy at that time.

The figures put forward by Toefy suggest that a significant number of Muslim men and women engage in sexual activity before marriage. This is verified in Mohammed's (1999) survey which confirms that 88.4% of religious leaders in the Western Cape have performed 'shotgun' marriages. As a result, the high levels of sexual activity outside marriage increases the risk of HIV infection. What is of greater concern is the fact that no contraceptives are used, resulting in pregnancies, and ultimately in 'shotgun' marriages. According to Toefy (2002: 151-152), premarital pregnant women are 'generally younger, lack economic resources and preparation for marriage, and have a short period of courtship.'

The conclusion that can be drawn from the findings by Mohammed (1997) and Toefy (2002) is that Muslim women in marital relationships appear to be particularly vulnerable to HIV infection due to their husbands engaging in sexual activity outside marriage. In cases where women are unaware of their husband's extra-marital sexual behaviour, these women are put at risk of contracting HIV since married couples would most likely engage in sexual activity without the use

of condoms. Even in cases where women are aware of their husband's sexual affairs outside marriage, they have little control over sexual relations and may be forced into having sex against their will (Klugman 2000: 146). In a Ugandan study conducted by Carpenter et al (1997), it was found that women aged thirteen to nineteen who were HIV positive were twice as likely to be married as those who were negative. According to Baylies (2000: 11) the particular vulnerability of young married women follows from 'the way that desire for children makes protection problematic, the fact that men tend to have more partners in the early years of marriage, and that husbands may be particularly prone to wander during their wife's pregnancy or in the first post-partum months.'

These married women are furthermore subjected to physical abuse which made up 10% of divorce cases in 1993 and 12.28% of divorce cases in 1999. According to feminist lawyer and academic, Albertyn (2000: 7), violence against women and girls in South Africa generally, 'plays a major role in the spread of HIV.' Women are unable to negotiate or control coercive and violent sex making them particularly vulnerable to Aids. During the interviews I conducted with five HIV positive women, one of the informants indicated that she had been raped by her husband who she later discovered was HIV positive. According to Sumaya Ismail (Observatory, 2 May 2003), '... there were many times when I didn't want to sleep with him and then he beat me so that I slept with him.'

Participants in Toefy's (2002) female focus group in Durban also appear to agree that HIV/Aids is connected to violence against women. One of the participants stated that:

I think we can do that (prevent the spread of HIV) by educating the males to have more respect... for women and to the mothers of humanity. Because in the most cases males incline to abuse the women folk. So whenever I have that opportunity, whether it's in a wedding function, or you know religious service, I always make use of the opportunity, and I firmly believe it helps to remind people of... of the importance of women in this world. And it's clearly stated in the Koran, for example, where Allah says, and when you... when you live with your women, do it in the most loveable, and respectable manner.

The cases of desertion (5%) and maintenance (20%) in Mohammed's (1997) study provide some insight into the economic dependence of women on men and the failure of men to provide for the economic maintenance of their wives and children as stipulated in Islamic law (Keller 1994, 542). The dependence of women on men for economic support adds to their level of vulnerability to HIV infection since women may be forced to engage in sexual acts in exchange for economic support for themselves and their children (Albertyn 2000: 10).

1.4 Conclusion

Muslims in the Cape come from diverse racial, ethnic and cultural backgrounds. Some are religious while others are not, depending on their relationship to Islam and what they understand by Islam. In certain cases one may even distinguish between Islam, the religion, and Muslims, the people - who may or may not adhere to the religion. In other words, there is usually a difference between what people say about who they are and what they actually do. So 'Islam' may be a body of literature or a set of precepts Muslims think they ought to identify with but perhaps it's not the most relevant reference in their daily lives.

Muslims are therefore not homogenous in terms of who and what they are but also in the way they approach Islam. The difference in approach to Islam is also evident in the diverse approach to people living with HIV/Aids. These different approaches are clearly captured in the literature of the more conservative Muslim Judicial Council (MJC) and the progressive Positive Muslims. Despite the distinct differences in approach, there is a sense that all Muslims are vulnerable to HIV/Aids. The combination of economic dependence, marital status, violence and gender intertwine to create a complex web of vulnerability. While this thesis focuses specifically on the vulnerability of women, it is essential that men's vulnerability to HIV infection not be neglected. Forman (1999) argues that the Aids epidemic is driven by men, given that men are both liable to contract and transmit the virus. Therefore, if women are at risk from current sexual norms,

due to gender power imbalances resulting from ideologies of masculinity, so too are men (Baylies 2000: 21). Men therefore have to be included in any initiative that aims to challenge the imbalances in gender power relations.

As a result, it is essential that the issue of gender equality and more specifically, gender violence amongst Muslims in the Cape be adequately addressed since it appears as if the current values and norms held by Muslims in the Cape in relation to gender power relations create an environment for the spread of HIV/Aids. Failure to address this issue could have a devastating impact on Muslims in this region.

Chapter Two

The Culture/Rights Debate in the Context of HIV/Aids

Religion and human freedom have not always been natural allies. Religious institutions have frequently acted in prejudice, intolerance and persecution against those who have violated their rites and injunctions.

(Charles Villa-Vacencio 1999)

2.1 Introduction

The struggles and tensions that exist between religion and culture, on the one hand and a universal notion of human rights on the other, is essentially a struggle to ensure that people enjoy the same rights within their diverse communities, while respecting the cultural autonomy of those communities (An-Nai'm 2002: 1). As An-Nai'm (2002: 1) puts it: 'how is the inherent tension between these two competing claims (universal human rights and cultural autonomy) or entitlements to be mediated, for instance, by respecting the integrity of a community without permitting it to practise discrimination against women or minorities?' Furthermore, is such mediation meant to work in the same way in all communities or should culture and religion make a difference? These difficult questions are complicated even further when one introduces the HIV/Aids epidemic. If a cultural or religious practice violates the universal right to gender equality and makes women vulnerable to HIV infection, should these practices be

discarded in the name of human rights or maintained based on the principle of cultural and religious autonomy?

These are just some of the complex questions that have to be addressed when examining religious and cultural practices that impact on a Muslim woman's right to gender equality and bodily integrity.

Falk (1990: 44) notes that until recently, most human rights specialists have taken an, 'all-or-nothing' view of the relevance of culture. Some have argued in favour of a standard universal approach to human rights, while others believe that culture should be used as a guide to moral behaviour.

Universalists believe that international human rights such as the right to equality and freedom of religion are and must be the same everywhere (Steiner and Alston 2000: 366). According to Kantian moral theory, every individual stripped of their cultural differences and beliefs would ultimately come to the same conclusion about what human rights are (Rentlen 1988: 349). For advocates of universalism such as Higgins (cited in Harris 1998: 626-627), 'individuals everywhere want the same essential things: to have sufficient food and shelter; to be able to speak freely; to practise their own religion or to abstain from religious belief; to feel that their person is not threatened by the state; to know that they will not be tortured, or detained without charge, and that, if charged, they will have a fair trial.'

Cultural relativists, on the other hand, believe that one's understanding of human rights is intrinsically linked to one's cultural context (Steiner and Alston 2000: 366). Notions of what is right and wrong therefore have different meanings for different people depending on their underlying culture. Furthermore, Wilson (1997: 6) states that 'anthropological critiques of human nature, being based on the socially constructed nature of the "person," inherently imply a rejection of the category "individual" which is fundamental to human rights law.' As a result, relativists argue that the formulation of human rights by universalists is too heavily grounded in the rights of the individual and therefore fails to respond to the diversity of legal systems.

The term 'culture' is often used broadly moving beyond traditional practices to include political and religious beliefs (An-Na'im 1992: 43). Many anthropologists refer to 'culture' as knowledge that is learned or acquired (culture is not genetically transmitted) and shared (cultural knowledge is shared to some degree by more than one individual) (Wynn 1994: 151). Furthermore, according to Young (cited in Barry 2001: 269), culture 'includes the symbols, meanings, habitual comportments, stories and so on through which people express their experience and communicate with one another.' Cultural relativism has therefore been defined by Winthrop (1991: 235) in the anthropological context as, 'the ethical principle that behaviour must be judged in terms of the values indigenous to a culture, rather than through alien or ostensibly universal standards of judgment.'

According to Wilson (1997: 3) both relativism and universalism have something to offer to anthropologists and particularly the ethnographer, since, 'universalism makes comparison possible, and yet relativism grants precedence to immediate contexts and engenders a sensitivity to diversity.'

The culture/rights debate therefore provides a suitable framework for discussing the inherent tensions between religious norms and values articulated in the Qur'an and hadith, and the practical realities faced by Muslim women living with HIV/Aids. This framework allows one to explore the articulated norms and values on the one hand, and practices of Cape Muslims on the other and to illustrate how practices do not often conform to the expressed norms and values.

2.2 The South African Context

In the South African Muslim context, finding a balance between the universalist and relativist positions have been difficult since the majority of Muslims believe that Islamic customary law is the most important source of law (at least theoretically) (An-Na'im 1999: 47). Cultural and religious practices that discriminate against women and which offend international human rights norms therefore continue despite the existence of international conventions and external pressure to eradicate such practices. As early as 1954, the United Nations General Assembly adopted a resolution calling on member states to eliminate customs, ancient laws and practices contrary to the Universal Declaration of

Human Rights affecting the rights of women (Butegwa 2002: 114). In addition, Article 5 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) calls on states to take appropriate measures to 'modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women (United Nations, CEDAW, Article 5).'

The African Charter on Human and People's Rights is another international instrument that imposes a duty on states to promote and ensure through teaching, education and publication the respect of the rights and freedoms contained in the Charter (United Nations, ACHPR). Implicit in this obligation is the duty for states to modify cultural and religious practices through education. These international instruments have been ratified by several countries including South Africa. Despite this ratification, cultural and religious practices that discriminate against women continue to take place.

In South Africa, the universal notion of human rights is contained in the Constitution, while Islamic cultural and religious customary laws and practices are not codified in any legislative Act. Instead, Muslim religious and cultural practices are derived primarily from the Qur'an and sunnah (Prophetic precedent) which are then interpreted and applied by religious leaders. Some attempts have

been made by the South African Law Commission (SALC) to codify the laws relating to Islamic marriages (SALC 2002). This process has not been completed and is currently under discussion.

While it could be argued that both the rights contained in the Constitution and religious and customary law contained in religious texts are subject to interpretation, it is important to note who the interpreters are. The application of the Bill of Rights is determined by a panel of judges consisting of both men and women in the Constitutional Court whereas Islamic law in South Africa is interpreted by religious leaders, all of whom are men. Thijssen (1984: 19) referring to the interpreters of Islamic law states that '(women) are confronted with local religious leaders who, in some cases, have little more schooling than the ordinary believer. Thus what the women are facing - and challenging - is not necessarily religion according to the letter of the Koran, but rather religion as it is explained at the local level.' This is particularly true of religious leaders in Cape Town, who according to a survey conducted by Mohammed (1999), often have a very basic educational background. Mohammed's survey of forty three religious leaders across the Western Cape, revealed that 30% had not graduated from high school.

Furthermore, while the Constitution was developed through negotiations and discussion by men and women, most Muslims believe that the Qur'an is the word of God. For Muslims this implies that the word of God as interpreted by a

religious leader will always outweigh the opinion of a judge who basis his/her decision on a text drawn up by mere mortals.

While it may appear from the above discussion that the fate of Muslim women lies in a text written more than 1400 years ago which is interpreted predominantly by men, the reality is that the text and its interpreters are constantly being challenged by Muslim scholars who approach and interpret the text differently. These challenges are sometimes based on a universal rights discourse. The conflict between proponents of a universal notion of human rights, on the one hand, and cultural relativists on the other, is therefore not only a conflict that exists between external Western protagonists of human rights and Muslim cultural relativists. It is a conflict that is taking place amongst Muslims themselves.

2.3 Human Rights in the Context of Religious and Cultural Practices

An idealistic and limited view of human rights is put forward by Cranston (1967: 52) who maintains that a human right is something of which, no person may be deprived of without violating principles of justice. He believes that there are certain acts that should never be committed and certain freedoms that should never be violated. According to Deng (1990: 261), human rights ought to be viewed as something that is universally inherent in the very notion of humanity.

He argues that believing otherwise would be a contradiction in terms. Any true human right must satisfy at least four requirements:

- (1) It must be possessed by all human beings and only by human beings.
- (2) The right must be possessed equally by all human beings.
- (3) A right that is connected to one's status or relationship such as that of a parent or president does not qualify.
- (4) The right should be assertable against the whole world.

Kwenda (1999) points out however, that to assume that the humanity of all persons is an agreed fact is idealistic and conflicts with reality: 'humanity has been and continues to be a contested asset, the only variable over time being the degree of vulgarity in the expressive forms the contest took.' There is furthermore an objection to the liberal concept that one has human rights simply because one is human, and that human rights entail claims that the individual can make against the state and society as a whole. Instead, it has been suggested that each continent or religious tradition generates its own concept of human rights (Howard 1990: 159). The theme that emerges is that religious traditions and cultures are compatible with human rights, but with a religious and cultural understanding of human rights. Human rights are then ultimately located within the context of the religious or cultural tradition and not within the Western norms embodied in the International Charter of Human Rights as well as the South African Bill of Rights (Silk 1990: 290). According to Merry (1997: 28), this approach was historically supported by anthropologists who resisted the notion of

a universal standard of human rights because they believed that the 'concept of human rights is an artefact of Western cultural traditions raised to the status of global normativity.'

Understanding human rights as something that is relative to religious and cultural practices may be problematic. Firstly, this approach can be used as an excuse to justify practices that violate the International Charter, and secondly, it has been argued that there can be no basis for international protection if each society can determine its own list of human rights (Silk 1990: 291). Chanock (2000: 15) argues furthermore that 'rights discourses in which culture is invoked as an argument against universalism now largely belong to rulers, not those who may need rights protected, who talk in terms of wrongs and needs, not rights and culture.' On the other hand, cultural relativism provides us with the ability to challenge the presumed universality of standards that actually belong to only one culture (Renteln 1988: 58). Furthermore, enforcing an international set of human rights that is culturally and religiously insensitive is just as problematic. Article 17 of the Universal Declaration of Human Rights provides for example, that everyone has the right to own property alone as well as in association with others. The values underlying this right can hardly be seen to be universal according to Zvobgo since it attempts to impose a capitalist understanding of property ownership on people (Zvobgo cited in Renteln 1988). A compromise or balance between universal notions of human rights and the relativity of cultures therefore needs to be reached.

With respect to the relationship between culture and human rights, Deng believes that every culture has humanitarian ideals or principles that could contribute to the redefinition and promotion of universal standards of human rights (1990: 262). The same can be said of the relationship between human rights and religion since both culture and religion can be invoked interchangeably or in combination (An-Na'im 1994: 167). In addition, it is argued that even though the term and the concept of 'human rights' is not perceived to be traditional in religious thought, it is nevertheless central to religious thought and practice (Swidler 1982: vii).

Charles Villa-Vicencio believes however that religion and human rights have not always been natural allies. Religious institutions, according to Villa-Vicencio, 'have frequently acted in prejudice, intolerance and persecution against those who have violated their rites and injunctions (unpublished paper).' However, he also believes that religion can function as 'a means of resistance' in that it can be used to enforce universal notions of human rights.

2.4 Muslim Approaches to Human Rights

Ann Elizabeth Mayer asserts that there is no common definition of human rights from an Islamic perspective (1991: 11). Muslims have divergent views on what human rights are, ranging from the complete acceptance of the International Declaration of Human Rights (Antonius 1994: 17), to the total rejection of the

concept of human rights as a construct 'promoted by financiers and academics (Ahmed 1998: 4).' The unsettled nature of the relationship between Islamic law and legal instruments such as the South African Bill of Rights has repercussions in the area of human rights. Muslims who adopt a more conservative approach to Islamic law associate human rights concepts with Christian and Western traditions, which they consider to be alien to and therefore incompatible with Islam. Muslims who reject human rights norms argue for the substitution of Islamic human rights based on the Qur'an and *hadith* (Prophetic sayings) literature (Ahmed 1998).

However, one also finds Muslims who believe that the Islamic tradition, interpreted in an enlightened and progressive spirit, is broadly or even entirely congruent with the principles of modern international human rights standards. They base their beliefs on the fact that Islam should not be treated as a 'static entity embodied in texts with fixed meanings, but as a phenomenon that is constantly evolving and that manifests itself in the lives and conduct of Muslims (Mayer 1990: 135).' Cultural relativism nevertheless continues to have a presence in Islamic circles because of the strong aversion to Western standards of almost anything.

In South Africa, there are broadly speaking three approaches to the Constitution and its Bill of Rights: firstly, there are Muslims who associate the Bill of Rights and human rights concepts with the Western, Christian tradition, which they

consider to be incompatible with Islam. These Muslims argue for the substitution of what they perceive to be a Western understanding of human rights with Islamic rights based on the Qur'an and *hadith* (Ahmed 1998). The universality of human rights is particularly challenged by these Islamist groups who claim that their religious belief 'requires the establishment of a "theocratic" state to enforce their vision of the sacred law (An-Na'im 1996: 338).'

Secondly, there are Muslims who argue that Islam is completely compatible with the principles contained in the Bill of Rights and universal human rights more generally. They base their beliefs on the fact that Islam should not be treated as static but as 'an evolving phenomenon' that can be interpreted and re-interpreted depending on one's socio-historical context (Mayer 1990: 153). Some commentators (Hassan 1996: 370-371) have even gone so far as to argue that:

...I believe that the Qur'an is *the* Magna Carta of human rights and that a large part of its concern is to free human beings from the bondage of traditionalism, authoritarianism (religious, political, economic, or any other), tribalism, racism, sexism, slavery or anything else that prohibits or inhibits human beings from actualizing the Qur'anic vision of human destiny embodied in the classic proclamation: Towards Allah is thy limit.

Thirdly, and more recently, authors such as Safi (2001: 16) have argued for the development of a tradition of human rights rooted in an 'Islamic worldview'. In the South African context, this would imply tolerance, but not necessarily

acceptance, of the Bill of Rights. Furthermore, it would include the development of a set of rights rooted in the 'moral/religious commitments of Muslims.' Safi (2001: 17) argues that:

This can be achieved not through an imposition of a human rights tradition evolved in an alien culture, but by appealing to the conception of human dignity embedded in the Qur'anic text, and by employing the concept of reciprocity which lies at the core of the Qur'anic notion of justice.

These three approaches reflect broadly how Muslims have made sense of a universal notion of human rights. There are however instances where Muslims may find themselves straddled between two or more of these approaches. For instance, while Muslims may have no problem with the universal right to own property, therefore understanding universal notions of property rights as compatible with Islam, they may however be opposed to women being afforded the same rights as men, therefore understanding universal notions of women's rights as incompatible with Islam.

The common thread between these three positions is that Muslims are unable to neither conceive nor accept a system of rights that excludes Islam since religious belief is intimately connected to every facet of life for Muslims (Witte 1996: XXXIII). Therefore, despite the conflicts that exist between Islam and human rights, An-Na'im (1996) argues that the two must not only be reconciled but must support each other.

2.5 Religion, Rights and HIV/Aids in South Africa

The South African Constitution in s 31(2) limits the right of persons to enjoy and practice their religion and culture to the extent that it cannot be inconsistent with the Bill of Rights. All cultural and religious practices must therefore be tested against the Constitution. Nhlapo (2000: 144) questions the purpose of this test and argues that s 31(2) can be interpreted to imply that any cultural variation that is unfamiliar to the value system imposed by the Constitution is unacceptable. Ebrahim Moosa (2000: 133) is also critical of this provision of the Constitution and argues that:

What the Constitution does is to retain the fiction of sovereignty of religion, whereas the logic of modernity and capitalism had long eroded this in practice. It retains the pretence of this sovereignty by the invocation of the freedom of religion rhetoric, but in reality it is a freedom which finds its limits in the logic of the state. The problematic part of this kind of constitutional formulation is that it creates the expectation of religious freedom, but in effect allows the state to interfere with religion.

Moosa's dissatisfaction with the Constitution's approach to religious freedom is demonstrated in a Constitutional Court case in which a Christian education institution sued the Minister of Education for not allowing it to practise corporal punishment which it believes is sanctioned in the Bible. In *Christian Education*

South Africa v Minister of Education,¹ the Constitutional Court found that religious communities could not use the freedom of religion provision as a means of continuing to practice 'constitutionally offensive group practices' such as corporal punishment (De Waal et al 2001: 291).

Moosa's observation that the Constitution allows the state via the courts to interfere with religious practices is therefore correct. However, despite Moosa's criticism, the court's approach in *Christian Education* appears to be the better approach since it gives people the right to practice their religion to the extent that it does not harm anyone else. If Moosa's approach were adopted instead so that the State could not interfere with religious freedom, oppressive and humiliating practices such as corporal punishment could be justified through religion.

Chanock (2000: 16), who would in all likelihood agree with the Constitutional Court judgment, believes that religion and culture have been used by rulers 'to mask a defence of local privilege.' Christian schools who therefore insist on their right to enforce corporal punishment despite the prohibition contained in the Bill of Rights, are, according to Chanock, invoking religion as an argument against a universal notion of human rights to protect their own privileges. Furthermore, the claim that rights are the product of Western culture, should not automatically dispose of the question of the desirability of rights being universal according to Chanock. This assertion is supported by An-Na'im and Hammond (2002: 17)

¹ 2000 (4) SA 757 (CC).

who argue that just because the origin of an idea is Western, does not mean that it cannot achieve universal acceptance. They cite the European model of the nation state as an example of an institution that originated in Europe but which is now accepted by many societies throughout the world. There is therefore little reason why the currently dominant versions of culture in parts of Africa, which discriminate against women, should remain unchanged and unchallenged in light of the universal notion of human rights. The important question which Chanock (2000: 20) poses and which is also found in Positive Muslims' response to religious practices is: 'there are features of African cultures which do not conform to the universalist version of rights rhetoric, particularly in relation to gender discrimination in property ownership and marriage. Should these be protected on the grounds of cultural inviolability, from the kinds of political and cultural struggles over property and gender which have been and are a feature of Western politics?'

Nhlapo (2000), who argues that the rights movement is intolerant of competing world-views, has two responses to this question. Firstly, he does not deny that the language of culture may indeed mask a defence of privilege at certain times. Secondly, he is wary of the approach which only sees privilege when it comes to dealing with African culture. Nhlapo compares the inability of women to conduct religious ceremonies at a Western church with the practices of polygamy and lobola in Africa, and concludes that both African and Western cultures have

elements of rights violations. It is therefore incorrect to argue that African culture alone masks a defence of privilege.

For Nhlapo (2000: 147), culture talk involves more than just a defence of local privilege: the very upholding of one's dignity requires a defence of one's culture, particularly of the points of difference in it. It is from this point of view, he argues, that a rights critique of this same local culture represents no more than a culture-bound Western assault on local dignity. The best way of deploying the human dignity test according to Nhlapo, would be to realise that there are many conceptions of human dignity that are distinctly African. Therefore, where a woman indicates that she feels 'valued' by having her husband's family negotiate lobola with her father, Nhlapo argues that we should be reluctant to dismiss her beliefs, substituting our own beliefs about her situation. Nhlapo (2000: 147) concludes by suggesting that where it cannot be conclusively shown that an African cultural practice is worse than a competing Western practice, the 'decision to prefer the one over the other should not depend on an assertion of the general moral superiority of the value system of a particular group in society.'

Nhlapo therefore suggests that in the South African context, the Constitutional value system should not be the basis for deciding between two conflicting cultural practices. Instead, the notion of human dignity may be a more appropriate tool for deciding on whether a certain practice should be permitted or not.

The complex nature of the culture/rights debate captured in the above discussion is complicated even further by the introduction of HIV/Aids. Can Nhlapo's argument, which favours lobola, still have any merit if the practice of lobola, according to the feminist lawyer Cathy Albertyn (2000: 7), has been linked not only to patriarchal attitudes of 'ownership' of women, but also to increased violence and hence vulnerability to HIV/Aids?

Albertyn's argument is premised on the fundamental assumption that (1) if changing sexual behaviour is at the core of reducing HIV infection, and (2) if changing sexual behaviour requires changes to the socio-economic power relations in society, then addressing the Aids epidemic is directly connected to addressing gender inequality at all levels. Since the practice of lobola contributes to gender inequality, Albertyn concludes that the practice therefore also contributes to women's vulnerability to HIV infection. While the link between cultural practices such as lobola and HIV infection may appear to be contrived, Albertyn argues that we need to understand that gender relations, that is, relations between men and women, are synonymous with power relations in which women are unequal to men. It has also been argued by Heise and Elias (1995: 931) in the context of developing countries in Africa that 'women's vulnerability to HIV infection derives from their low status in society.' The 'key to understanding the sources of women's vulnerability' in developing countries for Hamlin and Reid (1991: 3), is to therefore understand the link between powerlessness and the risk of HIV infection. This means 'understanding men's

relative power and women's relative powerlessness (Albertyn 2000: 3).¹ Ultimately, Albertyn argues that it is the intersection of culture, poverty and gender which makes women particularly vulnerable to HIV infection.

In the context of the culture/rights debate, negotiating the rights of women within a religious or cultural society can be extremely complex. One of the difficulties raised by An-Na'im and Hammond (2002: 34) is: 'Since different cultures embody varied moral views, would it not be a form of cultural imperialism to use the standards of one culture to judge another?' Furthermore, in attempting to convince Muslims that the Constitution's approach to gender equality is in the best interests of women, one has to understand that most Muslims believe the Qur'an to be the word of God (Esack 2002). If a Constitutional provision, derived from Western notions of human rights, differs with the Qur'an, it differs with God's word – despite the fact that God's word is usually interpreted by men. Muslims would therefore be inclined to continue with unconstitutional practices that discriminate against women.

Any attempt by an external body or group to change the cultural and religious practices of Muslims based on a rights discourse would therefore almost certainly be rejected. Muslims would simply perceive these organisations as a threat to their religious convictions and dismiss the attempts to empower women as a Western ideal that is foreign to Islamic norms and values.

An-Na'im and Hammond (2000: 17) suggest that the best way to introduce the universal notion of human rights within a particular cultural or religious society is through cultural transformation. This transformation involves the local legitimization of international standards through internal mechanisms that have been developed or are already present within a society. In other words, in order to introduce universal notions of human rights to protect Muslim women from being treated unequally to men, An-Na'im and Hammond suggest that Muslims who believe in universal human rights are the best people to introduce these notions. Muslims would therefore be more open to accepting universal notions of human rights if (1) these rights are expressed in a culturally sensitive manner and (2) are conveyed by Muslims themselves. Wilson (1997: 23), who locates his writing within a comparative anthropology of rights, supports this approach. He argues that human rights should be located within social struggles since 'rights are embedded in local normative orders and yet are caught within webs of power and meaning which extend beyond the local (Wilson 1997: 23).'

It is submitted that while this approach makes a lot of sense in the context of Muslims Aids activism in Cape Town, the door to external intervention should not be completely closed. Certain situations may warrant the intervention by 'outsiders' who should attempt to seek the support of Muslims who share their beliefs and values. The test for deciding upon intervention should be the best interests of the society or community who may be affected by the intervention.

Using human rights as a tool for cultural transformation has many benefits but also many challenges. One of the benefits of using human rights is the ability to mobilize and unite groups around issues such as gender and HIV/Aids (Butegwa 2002: 118). In the area of HIV/Aids, a range of first-generation rights such as dignity, equality and security could all be used as a broader call for sexual and reproductive rights (Albertyn 2000: 14). However, rights campaigns require resources, a careful framing of the issues and broad-based support.

Another difficulty with using rights as a tool for transformation according to Albertyn, is the fact that in certain instances rights can create a gap between 'elite' rights activists and grassroots struggles. This occurs when rights becomes an end in themselves and are framed in a language that fails to capture the lived experiences of women, or people living with HIV/Aids.

Rights can also fail to deal with an issue such as Aids at a societal level, instead focussing on individual problems (Albertyn 2000). The individualization of rights could result in individuals living with HIV/Aids being seen as the problem or as different from people who are HIV negative. Albertyn therefore suggests that it may be preferable to link HIV/Aids to socio-economic issues of poverty and inequality rather than individual discrimination.

Ultimately, using human rights as a tool for cultural and religious transformation 'lies as much in our capacity to use them strategically as it does in the norms and values they espouse (Albertyn 2000: 16).'

2.6 Conclusion

It is essential that the tensions inherent in the culture/rights debate are acknowledged and negotiated, rather than overlooked or suppressed. This becomes even more important in the face of the Aids epidemic which forces societies to re-evaluate their cultural and religious practices. It is suggested however that the re-evaluation of cultural and religious practices should be initiated from within the particular society in which the practice occurs. External pressure on Muslims to change practices that perpetuate gender inequality may have a limited if not adverse effect. Even though I may support this approach in the context of Muslim Aids activism at some levels, I do believe that exceptions to the rule should remain open to allow for external intervention.

While it is essential to ensure that cultural and religious practices that discriminate against women are transformed, care should be taken to avoid being labelled as a cultural imperialist by using the standards of one culture to judge another. Furthermore, using rights as a tool for cultural and religious transformation has the ability to mobilize groups of people, but may also result in individualizing problems and creating gaps between organisations and

grassroots activism. Careful planning and strategy is therefore essential when individuals and organisations challenge cultural and religious practices based on a universal rights discourse. Ultimately, despite the perceived difficulties that exist between Islam and human rights in relation to gender equality and HIV/Aids, it is essential that the two be reconciled since Muslims cannot conceive nor accept a system of rights which excludes religion.

Chapter Three

Muslim Aids Activism: An Ethnography of *Positive Muslims*

While judgementalism and homophobia are often seen as inherent in the religious mindset and while we walk a difficult line between being rooted within the Muslim community on the one hand and being seen as promoting promiscuity on the other, we are convinced that there is no alternative to an organization such as ours for the Muslim community. There have been a few more conservative voices around the pandemic, although these responses are invariably inadequate and even they have often reluctantly acknowledged that our voice is the only relevant one. Thus, while there is a threat of a backlash, the sheer need for an organization like ours will ensure its survival and growth.

(Introducing Positive Muslims, 17 June 2003)

3.1 Introduction

Muslim attitudes towards women living with HIV/Aids vary considerably. Attempts have been made by researchers to evaluate the knowledge and attitudes of Muslim clerics towards people living with HIV/Aids through questionnaires and interviews (Mohammed 1997 and Ahmed 1999). Despite these attempts to discuss the impact of HIV/Aids on Muslims, the available literature fails to analyse the impact of HIV/Aids on Muslim women specifically. This gap in the discussion is a serious oversight since women are more vulnerable to HIV infection than men. In addition, current literature on Aids and

Muslims focuses primarily on the *impact* of Aids and the vulnerability of Muslims to Aids. There is little discussion on Muslim *approaches* to HIV/Aids since Muslim Aids organisations such as Positive Muslims were only formed after the publication of the above literature.

The approaches of Muslim organisations to women living with HIV/Aids can essentially be divided into two groups. The first group, which consists of the majority of organisations, approach HIV/Aids from a cultural relativist perspective. Their Aids prevention model and approach to the rights of women living with HIV/Aids is intrinsically linked to their cultural context. Furthermore, there is a tendency to model their approach around the norms and values articulated in religious texts even if these norms and values are inconsistent with current practices. The organisations that make up this group are clerical bodies such as the Jamiatul Ulama, a conservative clerical body based in Gauteng, and the Muslim Judicial Council (MJC), and organisations such as Islamic Careline and the Islamic Medical Association (IMA).

The second group of Muslim organisations have adopted an ideological approach to HIV/Aids which can best be described as a hybrid of the universalist and relativist approaches. These organisations focus primarily on the practices of Cape Muslims - as opposed to the norms and values derived from religious texts - in formulating their approach to Aids prevention. The text-based norms and values do however play an important role in guiding the progressive Muslim

ideology of these organisations. The common factor in this hybrid approach is the commitment of both progressive Islam and universalism to the transformation of society from an unjust to a just society. The Muslim Youth Movement (MYM) and Positive Muslims are organisations who fit into this group.

This chapter will first provide a brief overview of Islamic Careline which was formed by the Jamiatul Ulama and the Islamic Medical Association. The central focus of this chapter however is on Positive Muslims. An in-depth ethnography of the organisation will be provided focussing on the formation of this organisation, their approach to women living with HIV/Aids and the people involved in Positive Muslims.

3.2 Islamic Careline

The *Islamic Medical Association* (IMA) together with the *Jamiatul-Ulama*, joined to form the *Muslim Aids Committee* (MAC) and a subsidiary group called *Islamic Careline* in September 1996 (MAC Report 2001). These groups focus primarily on educating Muslims about the spread of HIV/Aids through pamphlets and a call-in telephone advice service. The telephone service receives calls from Muslims who are experiencing all kinds of difficulties and not simply from Muslims who are HIV positive. With respect to HIV/Aids education specifically, they claim in their pamphlets that 'Islam is the cure (MAC pamphlet, no date provided).' They argue furthermore, that 'Aids is primarily an ethical and moral problem,' that can only be eradicated by strongly discouraging sexual promiscuity

and by encouraging those who have contracted HIV 'to promote and maintain (an) Islamic lifestyle and repent for their past actions (MAC pamphlet).'

According to the MAC Report (June 2001), their Aids programme enjoyed a 'remarkable success.' One of the successes noted in the report is that they received numerous requests to reprint and distribute their pamphlets both nationally and internationally. Furthermore, their report also refers to the 'positive responses' received in relation to a workshop manual developed by the organisation which is used to train care providers who assist people living with HIV/Aids. This workshop manual (no date provided) contains comprehensive information on HIV/Aids including a section entitled: 'Is Aids a Punishment from Allah for the Immorality that is Rampant in Society?' In this section, the manual states:

Those stricken by it (Aids) due to their indulgence in immoral and illicit deeds and who pay no heed to it are most definitely subjected to the punishment and wrath of Allah.

The next paragraph in the manual goes on to ask: 'if this is so, how does one explain the disease affecting innocent children and people not involved in immorality, through blood transfusion etc?' The answer to this question follows:

These people will not be classified as those being punished by Allah, but rather as suffering from the evil prevailing in society due to the wave of immorality and

sexual permissiveness engulfing them. This is due to the fact that the consequence of the evil doers is not restricted only to them but affects society as a whole. The innocent are not spared, with the ultimate judgment resting in the hands of Allah. For these innocent people, it is hoped that the disease becomes a means of kaffarah (atonement) and elevation of their stages in the Aakhirah (afterlife).

These paragraphs provide some insight into the thinking (or lack thereof) behind Islamic Careline's approach to people living with HIV/Aids. Their approach to Aids prevention and to the rights of people living with HIV/Aids is intrinsically connected to their cultural and religious constructions of guilt and innocence. While the 'innocent children' will be spared from God's wrath, the 'guilty' and 'immoral' will be subjected to the punishment and wrath of God. By implication, the rights of 'guilty' HIV positive individuals to equal treatment is therefore restricted because of the manner in which they contracted the virus. The Islamic Careline approach appears to rely heavily on a literal interpretation of the norms and values articulated in religious texts and less on the realities of Muslim practices. And so the question that remains is: how do these religious constructions of innocence and guilt derived from the norms and values articulated in religious texts, impact on Islamic Careline's response to HIV positive women?

During an interview with Faghmeda Miller (Cape Town, September 2001) for an article on Muslim responses to HIV/Aids (Ahmed 2002), she stated that she had

received a number of complaints relating to the judgmental way in which the Islamic Careline treats Muslims who are HIV positive. Callers to Islamic Careline have allegedly been asked how they contracted HIV and have been preached to as opposed to being listened to. Furthermore, in an interview with Farida Mohammed (Johannesburg, August 2001) for the same article, she complained bitterly about the manner in which she was treated at a MAC workshop. She was invited to be a speaker at a women's day workshop organised by MAC and alleges that she was treated 'differently' to other guests on the panel. She also believes that her speech was cut short by organisers just as she was about to criticise the Muslim community for their prejudicial attitudes towards Muslim women living with HIV.

This is however not surprising considering the fact that the Islamic Medical Association (IMA), one of the founding members of MAC, advocates the Malik Badri (1997) approach when it comes to dealing with HIV/Aids prevention. Badri's 'Islamic' approach to resolving the Aids crisis is premised on his belief that Aids is a punishment from God unto those who have transgressed the sexual mores of Muslim society. His approach comes across as being retributive and judgmental and would therefore alienate those who are searching for help as opposed to attracting them and making them feel comfortable.¹

¹ In this regard, see Alan F Fleming et al *The Global Impact of Aids* (1988) 216 as well as Tony Barnett et al *Aids in Africa* (1992) 45 in which it is argued that the influence of religion on an Aids prevention model can be destructive if not implemented properly.

In some ways however, Badri is correct when he argues that a Western model of Aids prevention will be inappropriate in an Islamic context. He says that the 'mismatched transplantation of any preventative model from one culture to another, even if it is successful in the original culture, can be as dangerous as the mismatched transplant of human organs (Badri 1997: 183).'

Organisations such as MAC and Islamic Careline have therefore attempted to respond to Badri's concerns: what they essentially want to do is to extract certain norms and values articulated in religious texts, interpret it, and mould it into an Aids prevention model for Muslims. However, it is submitted that if one's interpretation of Islam is based on principles of inequality and judgmentalism, that those principles are invariably going to filter into an Aids prevention model developed in the name of this Islam. Furthermore, if religious norms and values are used exclusively as the basis of one's approach to HIV/Aids prevention without considering the actual practices of Muslims, then this approach ignores reality.

MAC's attitude towards Muslim women living with HIV, such as Farida Mohammed, have therefore been determined firstly, by their aversion to Western culture, morals and ethics and secondly, by a need to replace the Western model of Aids prevention with something more Islamic. In essence, this approach to HIV positive women is reactionary and defensive. It is reactionary because it considers Western culture to be in direct conflict with Islamic culture – the

reaction is therefore to instinctively reject anything Western believing that whatever is Western is un-Islamic. The approach is also defensive because by rejecting the Western model of Aids prevention, a void is created. Since there is no thought out response to Aids prevention because of the void left by the rejection of the Western model, Muslims respond defensively by arguing that the norms and values articulated in the Qur'an and *hadith* (prophetic precedent) are sufficient guides to developing an Aids prevention model. This approach ultimately amounts to sophisticated versions of what has been preached for centuries.

While it appears as if Islamic Careline's approach to the Aids pandemic is based on conservative interpretations of norms and values contained in religious texts, the reality is that the text is often discarded when their counsellors are confronted with people living with HIV/Aids. When I called Islamic Careline for example, pretending to be a gay Muslim man who had contracted HIV through homosexual sex, the counsellor was rather supportive and understanding and indicated that she would not judge me. So while the organisation's pamphlets contain references to Qur'anic verses that condemn adulterers, the verses are not used as the basis for counselling and support. Farid Esack (Cape Town, 19 April 2003) criticises Islamic Careline's approach to Aids prevention by arguing that:

There is an enormous inconsistency between their text and their spirit. They come with texts that are cut and dry...they come with texts that say 'punish the adulterers'...and at the same time, when the HIV positive person comes to them,

they only invoke the compassionate mindset. There is still a judgmental mindset, but they still talk nicely to the person. But if their text were to have rule over them, they should have told that person 'do you know that you don't have a right to be alive? Do you know that you should have been stoned to death? If it's a gay person, do you know that a wall should have been thrown over you? But they don't ever do any of those things. So there is in fact a huge gap between their text fundamentalisms and their real person that comes out when those people come to them. They are the inconsistent ones...you can even call them the hypocritical ones. We only don't call them hypocritical because they aren't even aware of the inconsistencies between their theology and their real responses. And so that is why when we confront them with a compassionate approach, they don't have an answer for it because at a gut level they know that they're wrong.

The inconsistency between Islamic Careline's 'text and spirit' is clearly reflected in their manuals and pamphlets which at one level refers to Qur'anic verses condemning adulterers, but at another level, uses the language of care and compassion when dealing with people living with HIV/Aids. Unfortunately, it appears as if this inconsistent approach adopted by Islamic Careline is also reflective of the general Muslim approach towards HIV positive people. This approach will now be contrasted with the approach adopted by Positive Muslims.

3.3 Positive Muslims

It's around 09h30 when a woman in her late thirties walks into the Positive Muslims office in Observatory. She looks slightly nervous as she walks up to the front desk where Farahneez, the office administrator, is making copies of the agenda for a meeting later that day. I'm seated in the waiting room and feel tempted to assist this woman since Farahneez is occupied. However, I remind myself that I'm simply here to observe what's happening in the office.

While I'm pretending to read a magazine, I overhear Farahneez explaining to the woman how Positive Muslims can assist her. Farahneez indicates that she will call someone to talk to her shortly and asks the woman to be seated in the meantime. I continue to casually stare at the pages of the magazine until Rehana, the current acting-director of Positive Muslims, accompanied by Farahneez, introduces herself to the woman and invites her into the privacy of an adjacent office.

While Farahneez returns to her work, I decide to explore what's going on in the other two offices. I meet Soekayna in the passageway and we start chatting about a meeting she recently had with a guidance counsellor based at a Muslim school in Cape Town. As the awareness and education officer of Positive Muslims, Soekayna is responsible for arranging workshops with school kids. After pulling together a workshop of about twenty young Muslim women in

grades ten and eleven from various Muslim and non-Muslim schools in Cape Town, she received a complaint from one of the Muslim schools. Two workshop participants from one of the Muslim schools had complained in their report of the workshop to their guidance counsellor, that the issue of Islam and HIV/Aids had not been sufficiently discussed. After meeting with the guidance counsellor and explaining that Islam had been incorporated into all of the discussion modules, the counsellor appeared to be somewhat satisfied with her explanation.

Our conversation is interrupted when two of the Positive Muslims support group members want to show us what they've been up to in the meeting room at the back of the office. Soekayna has to rush off to a meeting, so I follow the two men to the meeting room where they've been busy making Aids ribbons, beads and other arts and crafts. The fruits of their labour are a result of a project initiated by Rehana and the HIV positive support group members who are exploring various ways of empowering themselves.

I hear the door bell ring and realise that Mohammed, Rukia, Farid and Faghmeda, who are all members of the executive committee, have arrived for our meeting. Looking at the length of the agenda, it seems as if it's going to be another long meeting...

The above description of a typical morning at the Positive Muslims office provides the reader with a short glimpse into the daily work that members of the

organisation are involved in. The formation of Positive Muslims, an awareness-raising and support group for Muslims living with HIV/Aids, in Cape Town in July 2000, has been an important step in the development of a comprehensive Aids prevention model in this region. The group's founding members decided on its formation despite the existence of the Muslim Aids Committee (MAC) in Gauteng, because it firstly, wanted to move away from the Malik Badri approach to Aids prevention, and secondly, wanted to place more emphasis on dealing with people who had already been infected with HIV.

Positive Muslims is currently the only Muslim organisation in Southern Africa that specifically provides counselling and support services to people living with HIV/Aids. Islamic Careline's services focus primarily on marital problems. While this makes Positive Muslims a unique organisation, it is also a sad reflection of Muslim responses and approaches to the Aids epidemic.

The following discussion will provide an in-depth ethnography of Positive Muslims, focussing on its formation, the principles and values that it has adopted and the people involved in the organisation. Since I was one of the founding members of Positive Muslims and continue to remain a member of the organisation, the discussion will inevitably take on a personal tone. In addition, the views and experiences of other members, which have been captured through interviews, will also feature prominently in this discussion.

3.3.1 The Formation of Positive Muslims

While initially having decided to write a mini-thesis on sex and sexuality in Islam for my Bachelor of Arts (Honours) thesis at the University of Cape Town (UCT) in 1999, I was later convinced by Prof. Farid Esack to focus on HIV/Aids. Esack, a Commissioner for Gender Equality at the time as well as a trustee for the Treatment Action Campaign, felt that the issue of HIV/Aids had been seriously neglected amongst Muslims in South Africa. He wanted to write a book on developing a theology of compassion in response to the Aids epidemic, and as his research assistant at the time, thought that it would be a good idea for me to start conducting background research on Islam and Aids.

After working on some research for Esack, I decided to write my thesis on the impact of HIV/Aids on Muslims in the Cape by conducting interviews with religious leaders and Muslims living with HIV/Aids as well as doing a literature review. The only HIV positive Muslim that I had heard of and that was willing to allow me to interview her was Faghmeda Miller. Miller had been infected with HIV in 1993 and had appeared on numerous radio and television interviews.

When I first met her at her brother's house in Belhar, Cape Town, I was struck by how small she was. Despite her small stature she impressed me with her openness about what had happened to her, how her husband had unknowingly infected her, and how she has had to cope with his death, with her own HIV

status and with the prejudice she experienced within her community. Miller indicated that she was keen to start a support group for Muslims living with HIV/Aids since she wanted to make contact with other Muslims who were HIV positive. I suspected that her need to make contact with other HIV positive Muslims was in some ways due to her own loneliness. Even though she was involved in a Christian based support group at the time, she indicated that there were certain experiences that were unique to Muslims and that being in a support group for Muslims living with HIV/Aids would help her deal with her status. In addition, the burden of being known as the only Muslim living with HIV/Aids and being constantly asked to conduct interviews and give talks as a result thereof, must have been particularly difficult. According to Faghmeda Miller (Ruiterwagt, 19 April 2003):

For me I think it was important to be around people of your own religion where you can discuss what the Qur'an says about certain diseases and stuff like that. Because I still had this belief that it was a curse and it was a sin. And only when I learnt from these Christian people that you know, they believed it wasn't a sin or a curse, I realised our Qur'an surely must also say something about it. And I started to feel very much out of place being surrounded by people of other faiths and not my own faith. And I just wanted to get out of there and maybe start my own group...

At the same time, Esack and I re-thought the usefulness of his own work on developing a theology of compassion without providing concrete support around HIV/Aids and assistance to those living with it.

I was desperate to help Miller and therefore set up a meeting with Esack to discuss the possibility of forming a support group for HIV positive Muslims. Upon reflection, it seems as if my own reasons for wanting to help were partly selfish and partly altruistic. Having been involved in a number of student and community based organisations including the Islamic Society (UCT), the Students' Representative Council (UCT) and the District Six Beneficiary Trust, I had always derived a great sense of personal fulfilment and accomplishment from being involved in these organisations. By becoming involved in a support group for HIV positive Muslims, I guess I was hoping that my selfish need to feel some sense of fulfilment and accomplishment would be satisfied. This need stemmed from an emptiness I discovered that same year after realising that I belonged to about eighteen different organisations simultaneously. I had become a bit of an organisational junky wanting to take on as many causes as I possibly could to fill the emptiness or void that existed in my life.

At an altruistic level, I felt a very basic but profound need to help. As a result I arranged a meeting between Esack, Miller and myself sometime towards the end of 1999. We discussed what we intended to do over some burgers and chips at a fast food outlet in Rondebosch East and decided to get the Muslim Youth

Movement (MYM) involved. Esack's suggestion to form part of the MYM was essentially to provide us with some sort of organisational support and infrastructure since the organisation we hoped to establish was a rather fragile group at the time. Furthermore, Esack wanted to locate the organisation within the framework of progressive Islam which goes beyond providing charity to Muslims but includes privileging the marginalised (Farid Esack, Rondebosch, 19 April 2003). Both Esack and I had also been involved with the MYM at various levels and felt comfortable with their progressive values and principles. We were also friends with Dr Nisaar Dawood, the secretary of the MYM at that stage and thought that his involvement would be important in an initiative such as this. Miller was happy to go along with Esack's suggestions since she had no organisational experience and was simply happy that someone was taking an interest in her idea. While Miller provided the idea and inspiration for the establishment of a support group, Esack's training as a theologian and vast activist experience guided the realisation of Miller's idea. My involvement was more supportive at that stage, organising meetings and liaising between Esack and Miller.

Our meetings in January and February 2000 with the MYM Western Cape branch members Yusuf Gamielien (chairperson), Mohammed Groenewald (regional secretary) and Dr Nisaar Dawood (national secretary) were successful. It was at our second meeting at the MYM office in Rylands, Cape Town that Esack suggested 'Positive Muslims' as the name for this organisation. The name

reflected the fact that the organisation consisted of people who were HIV positive and provided support to HIV positive Muslims. At the same time, the name reflected our approach to dealing with HIV/Aids - we would adopt a 'positive' and progressive approach to people living with HIV/Aids.

The interim structure of the organisation consisted of an executive which was made up of the three MYM members listed above together with Esack, Miller and myself. In addition, Miller suggested that her brother, Fasli Miller, also be co-opted onto the executive structure. Fasli had been very supportive of his sister and she believed that he could play an important supportive role in the organisation. In an interview with Faghmeda Miller (Ruiterwagt, 19 April 2003) she says that 'I think for me it was em, how can I say, I've never been out on my own doing something. One of them (her siblings) were always with me and for me it was maybe just a habit , you know, that they must be there. But after a while, when he (Fasli) resigned I was actually happy without telling (laughs). I was happy because I also realised that, you know, I cannot carry on expecting them to be there for me all the time... but I realised that this was like, I can say, my organisation and not his and he had no place in it really.'

The second tier of Positive Muslims consisted of a volunteer base that would specifically be chosen for membership from amongst existing MYM members as well as friends and colleagues of the current members of the executive. The reason for this selective membership policy, suggested by Esack, was due to the

fact that Positive Muslims would be dealing with extremely sensitive issues. As a result, we did not want to open up the organisation at that vulnerable stage to people who may have differed with us on our approach to Muslims living with HIV/Aids. It was therefore essentially a strategic move to maintain close control of the organisation and its members and to prevent destructive and disruptive forces from negatively influencing our aims and objectives. The selective membership policy eventually turned out to be a major strength in the development of a solid volunteer base for Positive Muslims.

The aims and objectives of the organisation which was work-shopped at the third and subsequent meetings of Positive Muslims held in Esack's flat, was firstly, to raise awareness about HIV/Aids amongst Muslims and secondly, to provide support to Muslims living with HIV/Aids. We debated and discussed the levels of support we were willing to give but always maintained that any Muslim with HIV/Aids, irrespective of how they contracted it, would be assisted. The rationale for adopting a non-judgmental approach was in many ways based on the belief that we needed to acknowledge the social reality that Muslims were engaging in sexual activity outside the permissible boundaries imposed by Islamic law.

Positive Muslims was officially launched in June 2000 after the MYM National Executive decided to endorse the organisation (Al Qalam, July 2000). While we had an excellent relationship with members of the MYM, those of us on the Positive Muslims executive who were not members of the MYM felt frustrated at

the slow pace at which the MYM bureaucracy worked. We had for example requested that a separate bank account be opened for Positive Muslims in March 2000, but by July 2000 nothing had been done. After a number of administrative difficulties, Miller, her brother, Esack and myself decided that Positive Muslims should operate independently from the MYM. In a letter to the MYM, we indicated that while we would like the MYM members to remain part of the executive of Positive Muslims, we could no longer be affiliated with the MYM as an organisation since we desperately wanted to implement our aims and objectives as soon as possible. We felt that the MYM as an organisation was holding up this process.

This decision did not go down well with certain MYM members while others believed that it was in the best interests of Positive Muslims to move ahead independently of the MYM. The organisation grew rapidly after this set back with the recruitment of various professionals including two psychologists, namely, Wiedaad Dollie and Rehana Kader. They were recruited after an initial meeting with the existing executive members. Faghmeda Miller, Kader and Dollie worked quickly to develop plans to set up a support group while Esack, Faslief Miller and I worked on the awareness and education aspects of the organisation. At the same time, I was appointed as the convenor of Positive Muslims which involved overseeing the entire development of the organisation. Being the youngest member of the organisation at the age of twenty-four by at least ten years, I was

both excited at the possibility of leading this dynamic organisation and overwhelmed by the responsibility this entailed.

My first major challenge as the convenor occurred close to the end of 2000. Esack received an e-mail from Yusuf Gamieldien, the chairperson of the MYM in the Western Cape indicating that Faghmeda Miller and he had decided to start their own HIV/Aids organisation based at the MYM office in Rylands, Cape Town. Esack and I were both shocked at this sudden and unexpected move. I immediately went to see Fasli Miller to determine what his thoughts were on the matter. He believed that due to Faghmeda Miller's desperate financial situation, she had been lured to work for the MYM who promised to pay her. Fasli Miller also indicated that because Faghmeda Miller had no organisational experience, she was probably unaware of the implications of her actions in joining Gamieldien.

It became evident later on that Gamieldien had been acting in his personal capacity using the MYM's name to legitimate his actions. When the MYM's national chairperson, Na'eem Jeenah came to hear about this, Gamieldien was reprimanded. Soon afterwards, Gamieldien resigned as chairperson of the MYM Western Cape branch. Faghmeda Miller returned to Positive Muslims and once again committed herself to the organisation. To have lost Faghmeda Miller at such an early stage in the formation of Positive Muslims would have been disastrous. Miller was the only member of the executive who was HIV positive and she therefore added a sense of credibility to the organisation. Furthermore,

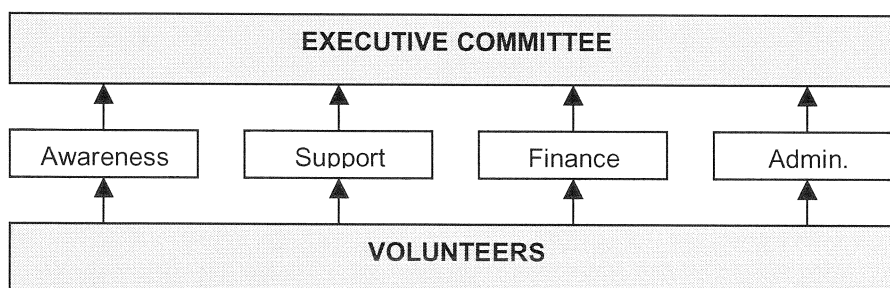
she had first hand knowledge and experience of how to provide support to people living with HIV/Aids which was central to setting up a support group.

The setting up and formation of Positive Muslims from the time the idea was first mooted in late 1999 to December 2000, was probably the most challenging time for me as the head of the organisation. Besides having to deal with setting up an organisational structure, I had to constantly ensure that members remained motivated and that they followed through with projects assigned to them. Trying to achieve all of this while completing my second year of law at the University of Cape Town was exceptionally stressful. In addition, we had to deal with pockets of resistance from religious leaders and individuals. Resistance ranged from being pushed aside outside mosques while trying to hand out pamphlets on Muslims and Aids, to having my credibility challenged by religious leaders. Despite these minor instances of resistance, we were never seriously challenged and were often invited by the local Muslim radio stations to talk about Aids. Muslims who called into these radio programmes were always polite when asking questions and never challenged the organisation's motivations. However, the primary difficulty remained getting Muslim religious leaders involved in Aids prevention activities. A meeting with the Muslim Judicial Council (MJC) which appeared promising, ultimately resulted in nothing concrete being followed up. In certain talks I delivered, I often compared the response of religious leaders to an incident I experienced while protesting at a Treatment Action Campaign picket in Mowbray along the Main Road. While toy-toying and singing outside a

Medicines Control Council meeting taking place at the Groote Schuur Hospital in Mowbray, a minibus taxi pulled up in front of the demonstrators. The 'gaartjie' who collects the money from passengers, leaned out of the taxi and shouted in Afrikaans 'As julle ophou naai, sal julle nie Aids kry nie! (If you stop fucking around, you won't get Aids!).' At the time we simply laughed off this character but after some reflection, I realised that our religious leadership often responded to HIV/Aids in this manner. They would shout profanities from the sidelines and then move off without ever seriously engaging in the real issues. The challenge to get religious leaders involved continues to concern us.

Esack's assistance and guidance played a central role in the survival of the organisation during this critical period. Ultimately, it was the combined effort of the entire executive who sacrificed several hours a week to pull things together. By the end of December 2000 the structure of Positive Muslims had evolved into a more organised set up. The executive committee who lead the organisation, consisted of four sub-committees namely, (1) education and awareness, (2) support and counselling, (3) finance and funding and (4) administration.

Diagram 1: Structure of Positive Muslims



As volunteer members came and went, the executive committee and structure was modified to adapt to these changes. While the awareness and support sub-committees remained unchanged, the finance sub-committee changed into finance and funding while the administration sub-committee was abandoned. In its place, a research sub-committee was established to start looking at conducting research with respect to HIV/Aids, Islam and Muslims. By July 2001, the executive committee consisted of the following people: (1) Mohammed Adam, the head of department of psychology at the University of the Western Cape oversaw the research sub-committee; (2) Rukia Cornelius, a business woman at the time and now a personal assistant to Zackie Achmat at the Treatment Action Campaign (TAC), dealt with awareness and education as well as finance; (3) Farid Esack, a Commissioner for Gender Equality at the time and now a professor of religion and ethics at Xavier University, saw to the funding requirements of the organisation; (4) Rehana Kader, a clinical psychologist at Lentegour Hospital at the time and currently a fulltime employee of Positive Muslims, headed the support group; (5) Faghmeda Miller, who is unemployed, assisted Kader with the facilitation of the support group. Finally, I was the convenor of Positive Muslims and had to oversee the running of all the sub-committees. The volunteers who were not part of the executive committee worked within one of the four sub-committees. This structure was slightly modified but generally remained the same until January 2003.

3.3.2 The Transformation of Positive Muslims

Despite the challenges faced by Positive Muslims during its infancy, the organisation continued to grow rapidly as a voluntary based organisation for the next two and a half years until December 2002. Positive Muslims was featured in several television and radio programmes as well as newspaper articles. The support group for Muslims living with HIV/Aids was considerably strengthened by the presence of Rehana Kader who used her skills as a psychologist at the Lentegour Psychiatric Hospital to run the group with the assistance of Faghmeda Miller.

The awareness and education committee of Positive Muslims, initiated by myself and later taken over by Rukia Cornelius, conducted approximately eighty workshops by December 2002. The workshops focussed primarily on educating and empowering Muslim girls and women and were conducted in school classrooms, community halls and mosques (Al Qalam, August 2001). Our decision to focus primarily on Muslim women was due to three reasons: firstly, we knew that based on UNAIDS statistics, more women than men were infected with HIV in South Africa. This was confirmed when we noticed that most of our HIV positive support group members were women. Secondly, because the majority of volunteers and executive members were women, there was a tendency to focus more strongly on women's issues. This decision was fully supported by the men involved in the organisation. Finally, due to limited

resources, we believed that it would simply be more strategic to focus on women as opposed to both men and women.

Our strong focus on women was recognised by the national Department of Health who invited Positive Muslims to form part of the Women in Partnership Against Aids (WIPA) group. The group plays an advisory role to the Minister of Health as well as to the national Department of Health and consists of various representatives of community based organisations across South Africa.

Our partnership with the Western Cape provincial Department of Health allowed us to secure limited funding which was used to inform, educate and empower thirty Muslim women from various regions in the Western Cape on the issues of Aids, Islam and gender. The workshop was spread across three days and covered issues ranging from the epidemiology of HIV/Aids to Muslim approaches to HIV/Aids. The workshops started in October 2001 and consisted of Muslim women from outside Cape Town such as Stellenbosch, Strand and Worcester as well as from the Cape Town suburbs such as Bo-Kaap, Grassy Park and Athlone. All the women selected to participate in the workshop were involved in community based organisations. These workshops which were jointly facilitated by the Department of Health and Positive Muslims, aimed to raise awareness about HIV/Aids and to empower women to educate others about the Aids epidemic. Many of these women, particularly those from Worcester and Strand

subsequently went back to their organisations to start discussion and education groups. They also referred HIV positive clients to Positive Muslims.

While we received limited funding for specific projects from the Department of Health, the rest of our funding came from individual Muslims themselves. We had taken a decision to make Muslims financially and socially responsible for HIV/Aids by soliciting individuals for financial support instead of seeking funding from donor organisations. The process of visiting individuals and asking them to fill in debit order forms was excruciating and time consuming. After a few months of constantly harassing people we ended up with debit orders worth approximately R2000 per month. This money was used to cover the most basic expenses while we used Esack's flat as our office and meeting place. Due to Esack's commitment as a lecturer in the United States he often travelled for several weeks at a time leaving his flat available for our organisational use. There were also several occasions when Positive Muslims could not cover its monthly expenses and had to borrow money from executive members.

One of these occasions took place during a particularly challenging time for Positive Muslims in August 2001, a little over one year since our launch in July 2000 (Muslim Views, September 2001). While we had dealt with the death of one of our members before, the death of two members in the same week impacted on us at various levels. Both members who died were women between the ages of forty and fifty. Emotionally, it was exceptionally difficult to handle the

deaths of these women. One of the women in particular, was the soul of the support group who played an important role in helping her fellow members in the group, always offering advice and assistance. On 14 February 2001, six months before her death, she, her husband and myself appeared on a SAfm radio show hosted by Nancy Richards. Using the name 'Leila' as her alias, she said:

I mean, we've been trying to do whatever is good in our lives, religious-wise, social-wise; we try not to hurt others. But, as my husband says, maybe our Creator put everything out in our life, so through his encouragement I gradually came to accept it. This is now our lot; we've got to deal with it.

The support group members as well as Kader, the support group facilitator, were hit particularly hard by these deaths. As a result, the support group fell apart with members failing to attend support group meetings for up to three months after Leila's death. In an interview with Kader (Observatory, 23 April 2003) she stated that Leila's death was 'very very difficult for everybody in the support group... because obviously it makes people face their own death. People refused to come to the support group and would make all kinds of excuses.'

It took a substantial amount of work on the part of Kader and Miller to get people back to the support group. However, Leila's husband who was also HIV positive, refused to return to the group. According to Kader '(Leila's husband) was extremely angry and it was almost difficult for him to deal with the anger so he

projected it onto the support group or onto myself... almost blaming us for Leila's death.'

At a financial level, Positive Muslims had taken a decision to pay for funeral costs of members whose families were unable to do so. We believed that it was important to ensure that people who died due to Aids related illnesses had exactly the same funeral as any other Muslim person. With the death of our first member for example, we ensured his funeral was like any other and paid for all costs including the flowers that went onto his grave. Muslim custom also stipulates that the body must be washed and wrapped in cloth before it is buried. The act of washing the body is performed by one or more *toekamandis* who are usually elderly women and men who have had informal and formal training from other experienced *toekamandis* to perform the rituals associated with preparing the body for burial. Only male *toekamandis* are allowed to deal with male bodies and female *toekamandis* with female bodies. However, in the case of people living with HIV/Aids, the *toekamandis* or a religious leader would usually take the corpse to a hospital and hose it down while wearing thick, rubber suits as protective clothing (Ahmed 1999: 29). When we could not find a *toekamandi* who was willing to wash the body of our first member who passed away, we decided to do it ourselves. Mohammed Groenewald (MYM regional secretary), Esack and I washed the body while being instructed by a *toekmandi* who told us what to do but who refused to touch the body himself. Our aim was simply to ensure that the funerals of Muslims living with HIV/Aids were normalised. We therefore

refused to allow bodies to be removed from homes and to be hosed down in hospitals.

Funerals became more and more common as the months went by. We subsequently buried Leila's husband as well as a six year old boy who liked to be called 'Saddam.' The death of Saddam impacted heavily on Kader who was unable to run the support group for several weeks after his death. While the distinct possibility of death constantly surrounded us, when it actually happened, members of Positive Muslims often suffered at a very personal level. Kader (Observatory, 23 April 2003) indicated that although her training as a psychologist had helped her to enforce the boundary between her clients and herself, 'the only time where the boundary was really overstepped was in Saddam's case. And that *really* had an impact on me... I couldn't see this child suffering like this and that's where I overstepped boundaries, I broke all frameworks, I broke all boundaries and that had a significant impact on my life.'

The combination of (1) the severe impact of deaths on our membership, (2) constant financial pressure, (3) the voluntary nature of the organisation and (4) the continuous growth of Positive Muslims, made us realise that we needed to introduce significant changes in order to ensure the survival of Positive Muslims. Fortunately, certain members of the organisation had been featured in a documentary called 'Body and Soul' which was screened locally as well as in certain parts of Europe. The documentary was seen by Novib Oxfam, an

organisation based in The Netherlands that funded various projects across Africa. As a result, we were contacted by Novib in August 2002 who agreed to provide substantial funding for Positive Muslims for three years. With the financial resources at our disposal, we could employ people on a full-time basis to provide comprehensive services to people living with HIV/Aids.

At the same time, I announced that I could no longer act as the convenor of Positive Muslims since after getting married in September 2002 I would be relocating to Beaufort West. The election of a new leader for the organisation became quite a contentious issue since no one in the executive was willing to replace me. After some negotiation, it was decided that Farid Esack would be employed as an Acting Director for six months from January 2003 to June 2003, during which time he would develop Rehana Kader to initially take over as the Acting Director of Positive Muslims in July 2003 and finally as Director in January 2004. From July to December 2003, Esack would act as a consultant to the organisation. In addition, an administrator and an education officer were also employed. The executive structure was maintained to develop organisational policy and as a means of holding the employed staff accountable.

Currently, Positive Muslims rents a house with a reception area, three offices and a meeting room in Observatory, Cape Town. Since July 2003 two offices are occupied by full-time staff members Rehana Kader in her capacity as Acting Director and Soekayna DaSilva as the awareness and education officer. The

third office, which used to be occupied by Farid Esack from January to June 2003, is now used by our interns. The organisation has thus far received two requests from students to work as interns at Positive Muslims on a completely voluntary basis. The first intern currently working at the office is Junaid Sirat, who has completed his pre-med studies and has been accepted at Eastern Virginia Medical School in the United States of America. He decided to take a year off to, in his words, 'explore the world' before starting medical school. Our second intern, Nesrin Atakan, a sociology student from the Vrije Universiteit in Amsterdam in The Netherlands is expected to arrive towards the end of 2003. She would like to explore the experiences of Muslims in Cape Town living with HIV/Aids for her Masters thesis. The interns provide various support services at the office ranging from answering the phones to assisting in planning workshops. At the same time, they are assisted by Positive Muslims staff and volunteers with their own projects which usually focus on Islam and HIV/Aids.

The relaxed setting of the meeting room is ideal for staff meetings as well as the long executive meetings. More importantly, the meeting room was designed with the best interests of the HIV positive support group members in mind since this is also their support group meeting room. For larger gatherings, the organisation rents the Observatory community hall which is situated about two hundred meters from the office.

When the office first opened, several HIV positive clients dropped into the office on a daily basis simply to chat or to work on their arts and crafts projects. This project was designed to provide unemployed clients with an opportunity to develop new skills by making various beaded and glass ornaments and products. The products, such as Aids ribbons and glass vases, would then be sold at community events such as school fairs or at conferences at which Positive Muslims had its own booth. Unfortunately, it became difficult for staff members to manage the clients who dropped into the office and concentrate on their own work at the same time. There were also incidences when clients stole items from the office. This situation was eventually sorted out by limiting the times during which clients could visit the office or by setting up appointments with office staff. At the same time we tried to instil the belief in our clients that the office belonged to them since it appeared as if they had not taken ownership of the office.

The transformation of Positive Muslims from a voluntary based organisation for two and a half years from July 2000 to December 2002, to a funded organisation from January 2003 to present, is a remarkable accomplishment. Despite the fact that certain restructuring challenges remain, the transition from a voluntary to a funded organisation went relatively smoothly. Thus far several projects have been initiated including a prevalence study on Muslim HIV infection rates.

While many changes have taken place, the mission and vision of Positive Muslims developed in Esack's flat in April 2000, remains the same. It is the firm

belief in the principles developed in our mission statement that influenced our approach to people living with HIV/Aids. Furthermore, our mission statement set us apart from all other Muslim organisations working on HIV/Aids issues.

3.3.3 The Approach of Positive Muslims

Positive Muslims has always been committed to providing support to Muslims living with HIV/Aids, irrespective of how they contracted the virus. This is reflected in the Mission statement (www.positivemuslims.org.za) which includes the following objectives:

- We believe that a non-judgmental approach should be adopted when dealing with people who are HIV positive. Our concerns are not related to how one became infected; instead we believe that those who are HIV positive must be accepted as they are.
- Our primary focus is to provide support for those who have already been affected and to educate our communities so as to prevent the spread of HIV/Aids. Our approach to prevention includes, but is not limited to, abstinence from sex outside marriage, faithfulness during a relationship and the use of condoms in appropriate circumstances.

The approach adopted by Positive Muslims to Aids prevention, is at a superficial level, similar to the Islamic Medical Association of Uganda's 'A-B-C' approach and includes abstinence, being faithful and the use of condoms. There is

furthermore no discrimination with regard to the support services offered based on how one acquired the virus, or on the basis of one's sexuality. As a result, Positive Muslims currently has members, among others, who have acquired HIV through homosexual sex as well as by engaging in heterosexual sex outside and within marriage. The members who disclosed how they contracted HIV did so voluntarily without ever being asked to do so.

At an ideological level, the Mission Statement is based on progressive Islamic values which place issues of social justice, gender equality and pluralism at the centre of the organisation's work. There is also a strong commitment to transform society from an unjust one in which HIV positive Muslims are marginalised to a just and compassionate society. As a result, Positive Muslims' approach to the rights of Muslims living with HIV/Aids is based on the norms and values espoused by progressive Islam. While this approach may appear to lean towards cultural relativism because it is connected to a cultural and religious context, it would be more correct to argue that the organisation's approach to the rights of HIV positive Muslims is a hybrid of both the universalist and relativist discourses.

Positive Muslims focuses heavily on ensuring that all HIV positive Muslims, irrespective of how they contracted the virus, are treated equally. If we adopted a purely cultural relativist approach to HIV positive Muslims, it would be difficult to justify guaranteeing the rights of homosexual Muslims living with HIV/Aids for

example, since mainstream Muslim norms and values portray homosexuality as sinful and anti-Islamic. On the other hand, if we adopted a purely universalist approach to the rights of HIV positive Muslims, we would be unable for example, to assert Muslim values such as communitarianism since it may contradict or conflict with the universal rights discourse which focuses on individual rights.

Positive Muslims has therefore adopted an ideological approach which is a hybrid of the universalist and relativist approaches. The common factor in this hybrid approach is the commitment of both progressive Islam and universalism to the transformation of society from an unjust to a just society. Furthermore, in addition to relying on a progressive interpretation of the norms and values articulated in religious texts, Positive Muslims places significant importance on the actual practices of Cape Muslims in formulating an Aids prevention model. In other words, the organisation accepts that Muslim practices often differ from religious norms and values and therefore believe that the approach to Aids prevention should centre on the actual practices of Cape Muslims. As a result, Positive Muslims would deal with single women who have contracted HIV through sex, for example, by acknowledging this issue and including it in the prevention programme as opposed to dealing with the issue as a violation of religious norms and values. This does not mean that the norms and values relating to sexual behaviour are abandoned and that it has no influence on the organisation's approach. Instead of being treated as the immutable fundamental

basis of Aids prevention, it is simply considered in relation to the actual practices of Cape Muslims and thereby put into perspective.

If one therefore goes back to the central question posed in the introductory chapter of this thesis, namely: how have the norms, values and practices associated with Cape Muslims impacted on the approach of *Positive Muslims* towards Muslims living with HIV/Aids? It now becomes evident, that the *practices* of Cape Muslims appear to have a greater impact on the approach of Positive Muslims to people living with HIV/Aids than the actual *norms* and *values*. In other words, the approach of the organisation reflects the practical needs and circumstances of Muslims by focussing on their practices and lived experiences as opposed to the narrow norms and values articulated by clerics which focus on how Muslims ought to live their lives. Nevertheless, norms and values articulated in religious texts continue to influence and impact on the organisation's ideological approach to HIV/Aids. These norms and values are however substantially different from the norms and values articulated by organisations such as MAC, since Positive Muslims bases its ideological approach on a progressive Islamic interpretation of the text.

The approach adopted by Positive Muslims can be contrasted with the purely cultural relativist approach of the Muslim Aids Committee (MAC) who, at an ideological level, distinguishes between how one contracted HIV/Aids by developing categories of 'innocent' and 'guilty.' The strong relativist tone of their

slogan, 'Islam is the cure,' attempts to convey the idea that a purely Islamic approach to HIV/Aids prevention is the best way to stop the spread of HIV/Aids amongst Muslims. There is also an aversion to Western Aids prevention models which would for example be sympathetic to the idea of safe sex outside marriage. MAC bases its Aids prevention model on an orthodox interpretation of the articulated norms and values found in the Qur'an and *hadith* literature. At an ideological level, they fail to take the actual practices of Muslims into consideration and therefore approach HIV/Aids in a manner which is devoid of reality.

When we formulated the Mission Statement for Positive Muslims, we did not consciously decide to adopt a hybrid universalist-relativist rights approach. In fact, my categorization of the organisation's ideological approach is slightly contrived and is probably more a reflection of my desperation to fit our approach into some sort of model than a true description of an approach we have formally adopted.

Our approach to people living with HIV/Aids has however always been based on progressive Muslim values. As progressive Muslims, we were always committed to values of social justice, gender equality and pluralism. However, at a grassroots level, Muslims are unfamiliar with the concept of 'progressive Islam' and therefore it was important to modify the language of this rights approach to suit our Muslim audience. Verses from the Qur'an and *hadith* literature which

espoused the norms and values of tolerance and compassion and which were in line with the progressive Muslim approach were therefore used in our Mission Statement. A Positive Muslims pamphlet entitled 'HIV, Aids and Islam' lists various *hadith* (sayings attributed to the Prophet Muhammed) including 'Allah shows compassion only to those of His servants who are compassionate' and 'A visit to a sick person is only complete when you have put your hand on his forehead and asked him how he is.' The Mission Statement also includes a *hadith* which states that 'My mercy overcomes my anger.' This particular *hadith* is used to reinforce the philosophy of Positive Muslims which is to develop 'a theology of compassion; a way of reading the Qur'an and understanding the sunnah (prophetic precedent) that focuses on Allah who cares deeply about all the creation...'

According to Esack, there are two reasons why these particular religious texts are invoked in Positive Muslims literature. Firstly, the use of religious texts is meant to acknowledge the centrality of the text in Muslim lives since, according to Esack (Rosebank, 20 April 2003), 'texts have throughout the history of Islamic writings focussed as the anchor upon which you build heterodoxies and orthodoxies... and so you are locating yourself within a particular discourse when you are doing this.' Secondly, he argues that 'we do believe that the spirit of the text is very supportive and that when you place a text like that at the beginning you are conveying a certain sense to those who pick it up, and then they also can

see where you stand...and so it is invoking the text in support of a particular position of ours.'

The difficult verses in the Qur'an which spoke of punishment and retribution were therefore set aside for the time being. We had tacitly agreed to focus on the verses which spoke of God as a compassionate being and to leave the verses dealing with punishment and retribution to organisations such as the Muslim Aids Committee (MAC). MAC's pamphlets are filled with Qur'anic verses such as 'Nor come near to adultery: for it is a shameful deed and an evil, opening the road to other evils.' MAC also quotes a Qur'anic verse which it argues deals with homosexuality: 'What! Of All the creatures, do you approach males and leave the spouses whom your Lord has created for you?'

In developing its ideological approach to dealing with people living with HIV/Aids, Positive Muslims is as 'culpable' as MAC in using specific religious texts to justify their respective positions. Esack (Rosebank, 20 April 2003) however argues that 'texts are always invariably used as pretexts...and there is no apology for it. The question that we need to ask is: how valid are our pretexts? So how valid is your desperation to be compassionate? How valid is your need to find a space for the marginalised?'

Esack therefore argues that while both MAC and Positive Muslims use the text as a pretext to justify their respective approaches to HIV/Aids, the pretext upon

which Positive Muslims approaches HIV/Aids is more valid. Furthermore, he believes that organisations such as MAC are inconsistent in their theological and lived out responses to HIV/Aids because they do not have the 'intellectual ability and the courage to make the connections' that Positive Muslims is making.

Our decision to develop what we referred to as a 'theology of compassion,' a term first coined by Esack, was motivated by our need to develop an approach to HIV/Aids that was rooted in Islam (and Islamic texts) but at the same time to distance ourselves from the patriarchal values associated with traditional Islam. In some ways, the need to base our approach on religious texts was also a result of our insecurity as an organisation. As Moosa (2003: 122) points out, we were attempting to justify our approach to people living with HIV/Aids by using religious texts because 'the greater the vintage of authority, the more persuasive the argument will sound to folks, even if the rationale of the argument and its substance make no sense at all.' Essentially, in order to gain legitimacy and to convince our Muslim audience that our approach was the better one, we had to cite religious texts in our literature. After all, organisations such as MAC based their approach to people living with HIV/Aids on the Qur'an. As Kugle (2003: 202) correctly points out: 'We do not come to the text naively.' Instead, every interpreter approaches the text with his or her own preconceptions, prejudices and experiences. Consequently, while MAC's prejudicial approach to the text is based on their condemnation of adulterers and homosexuals, Positive Muslims'

need to find a space for the marginalised on the one hand, and our insecurities on the other, causes us to engage in a different selective reading of the text.

Negotiating between verses which spoke of certain acts as 'evil' and providing support to people who had contracted HIV as a result of these 'evil' acts, was and remains exceptionally challenging. The challenge however, only operates at an academic level when attempting to reconcile conflicting texts and analysing what they mean and then what they really mean. At a practical level, support services are provided without getting caught up in the text. We simply provide support in whatever form we can to people living with HIV/Aids, irrespective of how they contracted the virus.

There was however one occasion in which we were hesitant to provide someone with support. A man who had raped his daughter and who was HIV positive, requested assistance from us. His children were unwilling to care for him and his wife was no longer willing to deal with his violent outbursts. While we were initially hesitant to provide support to this man because of our disgust felt towards rapists, after some discussion we realised that he probably required more help than most of our support group members. Rehana Kader who managed this case, held several counselling sessions with this person and his family. Reflecting on this case subsequently, Kader (Observatory, 23 April 2003) stated that 'my first reaction was... this man needs assistance, he needs help because he is HIV positive and there is a dynamic of sexual abuse here. So if we are not

going to assist him he will probably go on raping other people, other children and he's going to spread the virus, so we needed to get to the core, to the root of the problem and not just treat the symptom of what was going on.'

While the approach adopted by Positive Muslims continues to be developed at an ideological level, members of the organisation have already adopted a progressive Islamic approach when dealing with Muslims who are HIV positive at a practical level. This is reflected in the non-judgmental and compassionate support we aim to provide to all Muslims who are HIV positive, irrespective of how they contracted the virus.

It must be noted however, that despite the non-judgmental approach adopted by Positive Muslims, certain HIV positive Muslims refuse to join the organisation because of scepticism and fear. A few months after the formation of Positive Muslims for example, Faghmeda Miller and I met with a religious leader who was HIV positive. While he indicated that he was happy to assist us, the religious leader never attended any meetings, workshops or discussions we subsequently invited him to. We suspected that his unwillingness to play a role in the organisation had to do with his fear of meeting other Muslims who would recognise him as a religious leader. Furthermore, we believed that he was also unwilling to place his trust in and be associated with an organisation such as Positive Muslims - an organisation which had been around for a few months and which had little credibility amongst mainstream Muslims.

At the same time, our approach has also alienated us from other Muslim individuals and organisations, particularly from the clergy. They differ with our approach to assist all Muslims who are HIV positive and cannot accept that we promote condoms as part of our prevention strategy. In meetings with members of the Muslim Judicial Council (MJC), the issue of promoting condoms was a particular point of contention. The MJC believes that by promoting condoms one also promotes promiscuous sexual activity. Furthermore, they argue that condoms are not 100% safe and therefore even if condoms are promoted, it would not help prevent the spread of HIV/Aids. As a result, the MJC believes that abstinence from sex until marriage is the only solution to the problem. Our approach aims to deal with the reality that Muslims are engaging in sexual activity outside marriage - a reality that has ironically been researched and documented using statistics derived from MJC marriage counselling records.

While the Mission Statement of Positive Muslims and its approach to HIV/Aids is the most progressive and non-judgmental approach to people living with HIV/Aids in the Muslim context, it has however firstly, failed to encourage certain HIV positive Muslims to join, and secondly, alienated the religious leadership. Despite these setbacks, Positive Muslims remains committed to the idea of developing an Aids prevention model based on progressive Islamic values and continues to use this approach when dealing with Muslims who are HIV positive.

3.3.4 The People who Make up Positive Muslims

While it seems understandable that Faghmeda Miller, an HIV positive person, would want to join an organisation such as Positive Muslims, it has always been difficult for people to understand why a heterosexual, twenty-four year old (at the time) man, who is HIV negative would want to get involved in this organisation. As a result, many people assume that I am either gay or HIV positive. While delivering a talk at the progressive Claremont Main Road Mosque in Cape Town on World Aids Day in 2001, a friend and colleague sitting in the female section of the mosque overheard one woman telling another, 'Oh, I didn't know that he was gay.' On another funny occasion, a friend called me up to tell me that his cousin had seen me on TV talking about HIV/Aids. His cousin wanted to know when I had died of Aids.

The assumption that if you're a man involved in HIV/Aids activism you must be gay, HIV positive or dead has in many ways discouraged men from becoming involved in Positive Muslims. Approximately four fifths of our members are women despite our appeal for more men to get involved. Women members are therefore the driving force behind Positive Muslims since they manage and co-ordinate the majority of projects that have been established.

One of the most important (women) leaders in Positive Muslims is Rehana Kader. Kader, who is a clinical psychologist and started off as a volunteer in

2001, now works as the full-time psychologist for the support group. She has also been earmarked by the executive committee to take over the Directorship of Positive Muslims in January 2004. Farid Esack was employed as the Acting Director will be developing Kader's leadership skills during his Acting Directorship which started in January 2003 and will end in December 2003. While Kader has had extensive work experience as a psychologist, she has had little training in managing an organisation. It is therefore hoped that she will use 2003 to develop and enhance her management and leadership skills.

In an interview with Kader (Observatory, 23 April 2003) she indicated that her first contact with someone who was HIV positive was when she worked at a drug rehabilitation centre for Muslim men in 2000. While she was able to counsel the twenty one year old HIV positive Muslim with respect to his drug addiction, she had no knowledge about HIV/Aids. She desperately tried calling various Muslim organisations for assistance, but discovered that there were no support structures for Muslims living with HIV/Aids. Kader (Observatory, 23 April 2003) stated that 'this was a shocking reality for me...I had heard about Aids and read about it in the newspapers but it wasn't a reality for me until one of my clients was HIV positive.'

She continued asking colleagues and friends about Muslim support structures for people living with HIV/Aids until she eventually met up with Farid Esack who introduced her to Positive Muslims. Before getting involved with Positive

Muslims, Kader indicated that she had no experience working in a Muslim organisation. In fact she indicated that she 'clearly stayed away' from Muslim organisations since she found them to be 'conservative' and 'orthodox' and 'it didn't feel right to be part of those organisations.' Her attraction to Positive Muslims was based on the fact that it approached issues very differently compared to other Muslim organisations. According to Kader (Observatory, 23 April 2003), 'it was the acceptance of who I am as I am' and the fact that existing members of Positive Muslims gave her a 'very different understanding of Islam,' that made her get involved in the organisation.

Kader's approach to her faith goes deeper than simply following the rituals that have been prescribed by religious texts. She believes that her own life experiences have shaped her approach to Islam: 'I have a very strong sense of not judging people' which she believes has influenced her approach to her faith and her work. There have however been moments when she doubted her faith and felt angry towards God. One of these occasions was when six year old Saddam passed away. She remembers asking: 'How could you, how could you allow people to suffer like this?' The impact of Saddam's death in June 2002 affected Kader profoundly. It was also the only time Kader remembers doubting whether she should remain part of Positive Muslims. For Kader (Observatory, 23 April 2003), 'it was a personal loss for me, it wasn't just another PWA (person living with Aids) that had died.' She describes this life-changing experience as follows:

The pain and the last days of his life was, was really difficult, to see this child almost like withering away, not being able to walk and to see the fear in this child's eyes, the fact that he couldn't eat, it was just too painful, it was like *absolutely* painful for me to see a child going through *such* kind of pain...and the hopelessness and the helplessness that I couldn't do anything, I couldn't get this child medication, I was angry at the hospital, I was angry at the system, I was angry at the country, I was angry at the government, I was just...thinking it, it's so murderous, it was so inhumane to see this child... there was a lot of anger, there was a lot of anger in me... anger that I couldn't do enough, I was just so helpless. It was almost like I wish I could do something to not let this child die...

The pain and anger Kader experienced pushed her to a point where she felt that she did not want to expose herself to further emotional distress as a Positive Muslims volunteer. However, after some consideration she realised that she could not allow Saddam's memory to fade by allowing other children to suffer the same fate that he did. She believes that 'Saddam is the torch that lights my life and that makes me go on...he has given me more motivation and inspiration to continue and to see that things do change...'

Kader's role in Positive Muslims has changed dramatically since she first became involved as the support group psychologist. She initially thought that she would simply apply her clinical knowledge of psychology that she was familiar with, but quickly realised 'that this is a very different support group' that she was running. Kader therefore felt that she needed to modify the clinical principles that she was

familiar with to cope with the realities faced by support group members. She believes that 'more and more my role changed as a clinical psychologist to almost like a community psychologist.' This involved adapting her role as the facilitator of a support group to include lobbying and advocating for policy changes in her capacity as an executive member. Kader stated that during her two years as a volunteer she picked up valuable management and planning skills which would later equip her to take up her current position in Positive Muslims and be identified by the executive as the future Director of the organisation.

While Kader had no hesitation in taking up the full-time psychologist position, she was uncertain about her capacity to take over as the Director of Positive Muslims because she states that 'I never saw myself being in that role.' She always preferred being in the background and related an incident in which she decided not to attend a meeting that had been set up between the executive of Positive Muslims and the Muslim Judicial Council (MJC). Her decision not to attend, which was supported by some executive members for strategic reasons, was that Kader refuses to wear a headscarf. If she had walked into a meeting with the MJC without her headscarf, we suspected that the three Sheikhs who met with us would have been unwilling to listen to our suggestions. While I argued that Kader should attend the meeting dressed as she pleased, my argument was outvoted for strategic reasons.

The headscarf issue is a very sensitive one for Kader who believes that she is expected to dress a certain way simply because she is a woman. This expectation to dress a certain way is not only limited to Muslim thinking since at a conference she attended in Zambia in April 2002 she was confronted by one of the Christian participants who said 'Oh, they said a Muslim person is coming and I expected somebody with a scarf (Rehana Kader, Observatory, 23 April 2003).' The perception by Muslims and non-Muslims alike that the head of a Muslim organisation should be wearing a scarf if she is a woman, acts like a 'barrier' according to Kader, which forces her to work twice as hard when attempting to convey her point of view. Even within the Positive Muslims workplace setting, Kader also feels that her authority is sometimes undermined by the two women staff members since they respond more enthusiastically to Esack's authority. While Kader attributes the undermining of her authority to her belief that Esack is a powerful leadership figure, she also suspects that it has to do with the fact that she is a woman.

Despite the organisation's adoption of progressive Muslim values at an ideological level, it is evident that these values which has a strong gender justice component, has not filtered down to all our employees and members. Kader's experiences are therefore important in that they show the incongruity between the progressive norms and values we have adopted at an ideological level, and our inability to translate these norms and values into practice. It highlights the fact that as we struggle to challenge the orthodox norms and values articulated

by religious leaders outside our office, we continue, at some levels, to hold on to these orthodox notions of gender inside our office. Furthermore, it is interesting to note that Kader's experiences of gender bias inside the Positive Muslims office at least, are as a result of actions by women staff members. She never indicated that she was treated differently because of her gender by any male employees or male members. Outside the office, Kader related experiences of gender bias on the part of both men and women based primarily on the way she dressed.

Kader's own marginalisation as a woman due to her unwillingness to conform to mainstream Muslim thinking led to certain forms of isolation and discrimination within Muslim society. Kader therefore sees some parallels between her own marginalisation and the marginalisation of people living with HIV/Aids because according to her, 'there is a sense of not belonging.' While it may simply be easier to conform to mainstream Muslim thinking, Kader believes that if she were to change her approach 'then I'm not true to myself.' Furthermore, Kader states that 'Positive Muslims is giving me that space to explore my identity and normalising who I am...'

While Kader had little organisational experience before joining Positive Muslims, Esack had been involved in several organisations before helping to establish Positive Muslims. Most notably, he was a founding member of the 'Call of Islam,' a Muslim anti-apartheid organisation who worked closely with the African National Congress (ANC) and the United Democratic Front (UDF). Esack's

history in anti-apartheid activism is captured in two of his books, namely 'Qur'an, Liberation and Pluralism' and 'On Being a Muslim.' Raised in Bonteheuwel, a coloured township on the Cape Flats, Esack was raised solely by his mother after his father abandoned him and his five brothers when he was three weeks old.

Esack's entire life appears to have been a struggle against injustice - the injustice of poverty, racism and sexism. Getting involved in the setting up of Positive Muslims therefore appears to simply be a continuation of his struggle against injustice. However, after his involvement in a number of Muslim structures, he had taken a conscious decision not to get involved in Muslim organisations. He had lost a number of friends and made a few enemies during his involvement in Muslim organisations because of misunderstandings in certain instances and also because of his own mistakes in other instances. As a result, Esack's decision to get involved in a Muslim structure such as Positive Muslims after a number of years of absence from Muslim politics was significant. In an interview with Esack (Rondebosch, 19 April 2003), he indicated that there were two reasons why he became involved in Positive Muslims: firstly, there was an immediate need to 'reach out' despite his own anxiety about getting involved in Muslim issues. This need to do something about HIV/Aids in the Muslim context was far greater than his need to remain at a safe distance from Muslim issues. Secondly, he realised that the Aids epidemic was something that the majority of Muslims were not interested in, and so there was enough 'safe space' to set up Positive Muslims without getting caught up in Muslim politics.

Having been instrumental in the setting up and development of Positive Muslims over the past three years, Esack has 'mixed feelings' about his future role in the organisation. He believes that over the next two years he needs to take more of a back seat and allow others to take over since 'you can't own a project and make it your life' because you may begin to 'feed off' this project. Ultimately, he believes that the organisation has done well since its inception and believes that it has and will continue to play an important role in contributing towards social justice.

Besides Farid Esack, Faghmeda Miller and Rehana Kader, there are several other key figures involved in Positive Muslims. On the Executive structure, Mohammed Adam and Rukia Cornelius play an integral part in the running of the organisation. Adam and Cornelius have both been members of Positive Muslims since early 2001 and have served on the Executive since then. Adam has a background in community psychology and is currently heading the Department of Psychology at the University of the Western Cape. He has primarily been responsible for managing the research conducted by Positive Muslims but has also contributed significantly in the support group by assisting Rehana Kader with certain HIV positive members. At an organisational level, Adam has served as the chairperson of the Psychological Society of South Africa (Western Cape) and has also been involved with the Surrey Estate Civic Association where he currently resides. Adam comes from a small town in the Northern Cape called Calvinia, and has in some ways retained his sense of community and a bit of his

conservatism. When we put up a poster in the reception area of the Positive Muslims office advising people to use condoms, Adam suggested that the poster be moved to the back of the office. His reasoning was that if religious leaders were to visit us at the office, they may not be too impressed by the fact that we are openly promoting condoms. His suggestion, which was supported by Faghmeda Miller, was outvoted. The poster therefore remains on the wall in the reception area.

Rukia Cornelius is an energetic and hardworking activist in every sense of the word. From the moment she became involved in Positive Muslims, she attended every focus group, workshop and meeting giving of herself completely. While we were all initially very impressed with Cornelius' ability to attend every meeting, we realised that she needed to focus her energies on a specific project. She was put in charge of the awareness and education focus group and managed to pull off some amazing work. Cornelius had no organisational experience before joining Positive Muslims but was an astute business person who owned a successful fast food franchise. Her business skills together with the skills she acquired at Positive Muslims therefore came in handy when she was offered the position of Zackie Achmat's personal assistant at the Treatment Action Campaign. Cornelius currently plays an integral part in the Treatment Action Campaign and has unfortunately not been able to be as active as she wishes to be in Positive Muslims. Despite this, she continues to contribute substantially at an Executive level.

Two other important individuals who joined Positive Muslims in January 2003 are Farahneez Hassiem and Soekayna Da Silva. While Hassiem started working for Positive Muslims for the first time in January 2003, Da Silva had been a volunteer for Positive Muslims before her appointment as the awareness and education officer. Da Silva worked in the corporate sector for several years and had some difficulty in adjusting to the pace and style with which things are done at a non-governmental organisation level. However, she has grown substantially since her initial appointment and has managed to organise several important workshops and meetings.

Hassiem was appointed as the administrator of Positive Muslims but has since then also taken on other job titles during the course of her employment. Besides managing the office environment and being the front desk person for the organisation, Hassiem has also been trained to take over the accounting needs of the office while being supervised by a finance committee.

The management philosophy at Positive Muslims is to continuously empower the staff members. For this reason, all staff members have the opportunity to undergo training related to their work at the expense of the organisation. Thus far, all staff has taken up this offer and has attended various courses in management, report writing and conflict resolution at the University of Cape Town's winter school.

One of the important things that both Hassiem and Da Silva bring to an organisation like Positive Muslims is the fact that they have strong roots in the Cape Town Muslim communities and are in contact and form part of traditional Muslim groups. Da Silva for example belongs to a Muslim women's group that meets to pray and reflect on their spirituality and connection to God. As a result, Da Silva pointed out that many of the leadership figures in Positive Muslims were not connected to 'ordinary' Muslims and that it appeared as if the organisation was only regarded as a Muslim organisation because it served Muslim clients. When Da Silva for example, organised a prayer meeting of Muslim women at the Positive Muslims office as part of her awareness work, none of the Executive members attended this meeting. While I cannot speak for other members, Da Silva's observations regarding the disconnectedness to the 'ordinary' Muslim is certainly true in my case. I would therefore neglect to attend a prayer meeting (but would certainly be available for a workshop) because of my inability or unwillingness to engage in more spiritually related activities. While I'm sure that there may be deep and profound reasons for my own behaviour and attitude in this regard (which cannot and probably should not be explored here), I do believe that Da Silva's observations are in all likelihood correct and therefore have to be addressed. This particular issue was raised at an Executive meeting on 16 August 2003, but could not be thoroughly discussed due to time constraints. It was however stated at this meeting, that the issue needs to be raised at another forum comprising general members as well.

3.4 Conclusion

While organisations such as Islamic Careline base their ideological approach on religious and cultural constructions of innocence and guilt, Positive Muslims' approach to women living with HIV/Aids is premised on progressive Islamic values of social justice, gender equality and pluralism. This progressive Muslim approach is based on the practices of Cape Muslims as opposed to the norms and values articulated by clerics and is conveyed to Muslims at a grassroots level by using religious texts that advocate principles of social justice.

Muslims who seek assistance from Positive Muslims are provided with equal treatment, irrespective of how they contracted the virus. While this may also be true at some levels for Islamic Careline, the primary difference between Positive Muslims and Islamic Careline lies in the former organisation's courage to challenge and confront religious texts that discriminate against women and that perpetuates social injustice. There is furthermore a direct connection between the religious texts relied upon by Positive Muslims and the kind of action that it takes at a practical level. Positive Muslims has also recognised that Muslim women are the most vulnerable group to contracting HIV within Muslim society. As a result specific programmes aimed at empowering women to negotiate their sexuality have been initiated and carried out.

The people involved in Positive Muslims have a strong connection to the philosophy of the organisation, which is essentially to develop a theology of compassion, that is, a way of reading the Qur'an and *hadith* in a manner that focuses on God as a compassionate being. However, there are serious examples of situations where our ideological approach has not filtered through sufficiently to our employees. It appears as if our need for a compassionate God in the face of a crippling Aids epidemic is intrinsically connected to our own personal needs as members of Positive Muslims. It is this need that drives us to push the accepted boundaries and to challenge the norms and values of traditional Muslims.

Ultimately, Positive Muslims has become more than just an organisation that raises awareness and provides support to Muslims living with HIV/Aids. As much as we have shaped the history of the organisation, it has also shaped our lives in profound ways.

Chapter Four

Marginalised Voices: HIV Positive Women Speak Out

I thought to myself, I'll just try and live normal. I don't want people... I don't want them to be scared. I don't want them to change towards me. I don't want to lose people. I want to be myself. I know people...

(Najma Salie, Observatory, 24 April 2003)

4.1 Introduction

Muslim women living with HIV/Aids are in all likelihood the most marginalised people within Muslim societies. Their marginalisation stems from the fact that they are HIV positive and that they are women. This chapter aims to make their voices heard. The women's life histories that have been recorded in this thesis are all members of the Positive Muslims support group facilitated by Rehana Kader. According to Kader (Observatory, 23 April 2003):

The background that these people are coming from who are in the support group... life has always been a struggle, things have always been difficult, so it's almost like you're conditioned that no matter what you do, life is never going to be better for you. So it's almost like let me stay stuck in this situation. It takes a lot to get out of that. It takes a lot of resilience... an inner kind of strength to move on. And people don't have those kind of resources to build that inner

resilience. And the fact that they're positive has a huge impact on how they see life.

Five of the primary issues raised during support group sessions according to Kader (Observatory, 23 April 2003), are stigma, poverty, sexual relationships, death and inaccessibility of medication. All the support group members who disclosed their HIV status suffered some form of stigma which eventually lead to isolation from families and society. This isolation is also felt in instances where support group members develop relationships with individuals who are HIV negative. Kader related a case in which a woman member of her support group developed a relationship with a man who was HIV negative. The support group member had difficulty telling her partner about her HIV status and brought him to Kader's house so that she could tell him. After Kader informed him about the support group member's HIV status and offered to provide him with counselling services, he left and never returned.

Poverty is one of the biggest problems affecting support group members who often highlight this as the most immediate problem affecting them. The high levels of unemployment and poverty amongst support group members makes 'HIV/Aids a secondary issue' according to Kader (Observatory, 23 April 2003). The lack of medication and medical care which partially results from the poverty further exacerbates the problem. Furthermore, health care workers are also seen to be uncaring and unwilling to assist people who are HIV positive.

Two of the primary issues affecting women support group members specifically are their roles as caregivers and their reproductive health. Kader (Observatory, 23 April 2003) states that 'most of the time women forfeit their own health at the expense of taking care of everybody else.' The women become so involved in taking care of their husbands and children who are HIV positive, that they often neglect themselves. This is clearly reflected in Faghmeda Miller's unpublished manuscript which describes how she ignored her own pain, fever and lack of sleep to care for her husband:

While we waited for the ambulance, I dressed him (her husband) and then (he) laid down again, ignoring everyone again. By then I was so tired but would not leave his side even though my mother-in-law advised me to sleep for a while. Even his grandmother's sister told me to go sleep, but I was somehow just scared to leave my husband alone.

The other issue that women struggle with is their inability to have children once they are HIV positive. This often affects them most if they are young and unmarried.

Many of the problems raised in the support group are reflected in the interviews with informants. In addition, the informants also reveal aspects of their lives that have not been discussed in support group meetings. Some support group members are also highly critical of the level of support offered by Positive Muslims.

4.2 Life History Research

Five HIV positive Muslim women were interviewed in order to gain some insight into their lives as Muslim women and as Muslim women living with HIV/Aids. Four of these women could be classified as Cape Malay, three of whom form part of the working class, while one forms part of the lower middle class. The fifth woman is a refugee from Somalia who lives in Cape Town. All five women live in the Cape Flats region.

Open-ended, unstructured and semi-structured questions were used during the interviews which took place over five weeks. In-depth questions around how the informants responded when they were told that they were HIV positive, why they have chosen to speak out or remain silent about their status and their experiences of discrimination and acceptance as HIV positive Muslim women by fellow Muslims were examined. In addition, the role that religion played in their lives was also discussed in relation to their HIV status.

The in-depth interviews were used to record the life histories of these women. The life history is inherently selective but deliberately so, told from the women's own point of view. The women's life history offers the possibility of examining the impact of religion, culture, gender power relations and HIV/Aids on her life. The interviews were conducted in English and Afrikaans by myself and were recorded on audiotape with the permission of the informants. Three of the informants were

interviewed at the Positive Muslims office in Observatory, while the interviews with Faghmeda Miller were conducted at her home in Ruiterswag and the interviews with Bilquees Abrahams (not her real name) were conducted at a friend's home in Cravenby. I also provided all the informants, excluding Faghmeda Miller, with transport money as well as a small stipend for food. The money was given to each informant after our interview sessions.

My own relationship with the five informants varied from being close friends with one of the informants to only meeting an informant for the first time during our interviews. Faghmeda and I had been friends and colleagues for nearly four years. While we have had some difficult moments together, we remained close friends throughout this time. Her life story has always fascinated me and was in many ways, the basis for starting Positive Muslims. During our interview sessions, Faghmeda shared some very private and personal moments with me which she asked to be excluded from this thesis. As a result, the life history depicted below is a slightly incomplete one. It should also be noted that during our second and most in-depth interview, Faghmeda indicated that she was feeling depressed for reasons that can once again not be revealed. Her state of mind at the time has therefore influenced her responses to my questions. In addition to the transcript of my interviews with Faghmeda, I also quote extensively from Faghmeda's manuscript which she hopes to publish at a later date.

Faghmeda currently lives with her mother in a small one bedroom house situated at the back of her eldest brother's home in Ruitervagt. She is thirty-five years old.

I've known Najma Salie (not her real name) since 2001 when she attended a barbeque organised by Positive Muslims for its support group members. Since then, I've met with her at a few Positive Muslims events but had never engaged in a serious conversation with her until our interviews at the Positive Muslims office (Najma Salie, Observatory, 24 April 2003).

Najma has decided to remain anonymous since she has not disclosed her HIV status publicly. As a result, Najma was weary of providing me with specific details about her childhood and background fearing that someone may recognise her if they were to read this thesis. Furthermore, I found it rather challenging to interview her since she was soft spoken and had to be asked several questions about a particular event before one could get a complete picture of the event. While her answers were usually short, she was forthcoming.

My interviews with Gadija Mohammed (not her real name) were particularly challenging since Gadija did not speak English very well and therefore misunderstood a few of my questions. For instance, when I asked her about her childhood, she started talking about her child who was HIV positive.

Furthermore, she appeared reluctant to reveal information about herself fearing that someone may identify her. She was also the most difficult informant to arrange interviews with since she tended to forget about appointments and could not attend certain interview sessions due to her deteriorating health.

I first met Gadija after receiving a frantic call from her sometime during early 2001. She indicated that she was a refugee from Somalia and that both her and her six year old son was HIV positive. After Faghmeda and I met with Gadija and her son Saddam, who passed away in June 2002, Gadija joined Positive Muslims and has been a support group member ever since.

The interviews with Gadija were conducted at the Positive Muslims office (Observatory, 31 May 2003). Gadija currently shares a house with other Somalian refugees in a predominantly Muslim neighbourhood in Cape Town.

Besides Faghmeda Miller, Bilquees Abrahams (not her real name) was the first member of the Positive Muslims support group. Faghmeda and I initially met her in June 2000 just after her second son was born. Bilquees was twenty two at the time.

Since then, I have seen Bilquees at certain Positive Muslim functions but have had little interaction with her. This is primarily due to the fact that strict

boundaries are maintained between the support group and volunteer members for purposes of confidentiality.

I interviewed Bilquees at a friend's house (Cravenby, 30 May 2003) since she was not willing to be interviewed at her own home or at the Positive Muslims office. While I understood that she felt uncomfortable being interviewed at her own home, the reasons for not wanting to be interviewed at the Positive Muslims office were initially unclear. These reasons became evident as the interview progressed.

Bilquees currently lives with her two children in a small wooden structure often referred to as a 'wendy house,' behind her mother's home.

I met Sumaya Ismail (not her real name) for the first time at our initial interview at the Positive Muslims office (Observatory, 2 May 2003). She had joined the support group in March 2003 and volunteered to participate in this research project after being briefed about it by Rehana Kader in an earlier support group session.

Sumaya's life history is significantly different from the other life histories recorded in this paper since she converted from Christianity to Islam in February 2003 just after her husband, who was Muslim, passed away as a result of full blown Aids in

that same month. Her relationship with God and Islam therefore takes on a fairly unique form in relation to the other informants.

Our interview was conducted in Afrikaans and was translated by myself into English. Certain words and phrases will be kept in Afrikaans with an explanation of what they mean in parentheses.

The women's life histories are discussed under various themes which flowed throughout the interviews. Substantial extracts taken from the transcripts are quoted below. In addition, selected passages from the transcripts are attached in the annexure to this thesis.

4.3 Common Themes

While every informant was unique in their own way, there were many similarities between them. The age of the five informants ranged from twenty five to forty years with a mean age of thirty two years. Four of the informants could be classified as coloured or having a Cape Malay ethnic identity and one as black or African. This can be attributed to the fact that the overwhelming majority of Muslims living in the Western Cape are Cape Malay. Two informants were still married at the time of the interviews although both of them were separated from their husbands for different reasons. Bilquees was separated from her husband because he was serving a prison sentence while Gadija was separated from her

husband because of socio-economic reasons. Two of the informants were widowed while one informant was divorced.

None of the informants had tertiary level education. Gadija and Faghmeda are the only informants who completed the equivalent of matric (grade 12), while Bilquees and Najma left school in grade 11 when they fell pregnant. Sumaya left school at the age of fifteen after she was raped.

As a result, there were several common themes that emerged from the interviews with informants. The following common themes are used as a basis for discussing the life histories of these women: (1) childhood, (2) family, (3) relationships, (4) socio-economic background, (5) method of infection, (6) religious beliefs, (7) sexual violence, (8) support services and (9) fulfilling dreams.

4.3.1 Childhood

While four of the informants came from the Cape Flats region their childhoods differed fairly significantly. Faghmeda Miller was born in Bellville, Cape Town, the third youngest of four children. A few days after her birth she contracted bronchitis which has affected her health ever since. She states that, 'It was only when I became a teenager, then it affected me. In fact my mom said I was a hyperactive child. I could never sit still.'

Due to her poor health, she developed blockages of her ears and was unable to hear people speak. Her hearing disability made her different from family and friends, which according to Faghmeda, caused her to realise 'that people can actually be very cruel. If you are different, they treat you differently as well... I wanted to be treated normally like everyone else.' Her desperation to be treated 'normally' is something that continues to resonate strongly with Faghmeda since she believes that she is now treated differently by family and friends because of her HIV status. She relates how her hearing disability impacted on her:

My family would make fun of me, (laughs) by standing behind me and shouting at me and teasing me. But I didn't find it funny. For me it wasn't nice asking people to repeat what they were saying and at the end I just thought of withdrawing. I just kept quiet and tried to listen to what other people were saying by reading their lips. I didn't even realise that I was doing lip reading since it just became a habit to look at their mouths.

Faghmeda's hearing disability impacted on her at three levels: firstly, she became self conscious of her disability and her 'differentness' because family members kept on teasing her. Secondly, she withdrew from conversations and took on a more passive role by carefully listening to what people were saying. Her withdrawal also meant that she never really took centre stage during discussions and became shy and introverted. Thirdly, Faghmeda showed resilience by adapting her method of communication. She taught herself how to

lip read and was able to remain a part of conversations, even though she took on a more passive role.

Her hearing disability impacted on her friendships as well since she refers to her younger self as a 'tomboy' who 'never played with girls.' She stated that she preferred playing with boys because, 'the girls would always talk about each other while the boys didn't do that. They accepted you for what you were. I never played games with girls. When I became a young girl (laughs) I didn't play with the boys anymore.'

Faghmeda's decision not to play with girls because 'girls would always talk about each other' clearly shows how her hearing disability impacted on her choice of friends. Since Faghmeda appeared to be the subject of discussion amongst the girl children, she decided to play with the boys instead. At the same time, there is also the possibility that Faghmeda may have been rejected by the girls because of her disability. Instead of withdrawing completely from the playground, Faghmeda decided to go out and make friends with boys. Once again, this shows her resilience in overcoming discrimination and her ability to adapt in challenging situations. It is also interesting to note that Faghmeda stopped playing with boys when she became a 'young girl,' that is, when she started menstruating. Within the community in which Faghmeda was raised it appears as if it was acceptable for girls to play with boys until the girls reached

puberty. Faghmeda therefore stopped playing with boys and began playing with her sister instead.

While Faghmeda indicated that she, 'wanted to be treated normally like everyone else,' Najma Salie constantly emphasised how 'normal' she was throughout our interviews. Najma was born in Cape Town and has lived there for thirty one years. Below are a few examples of how Najma used the word 'normal' during our interviews:

- I grew up as any normal Muslim girl, went to school, went to Muslim school, came home and like most children who are naughty, I was also naughty and I went out and then I got pregnant and got married.
- We had a normal Muslim house. Not very, very strict but a normal, like a normal routine. We must be in the house before *Maghrib* (prayers performed just after sunset) and we must go to Muslim school and we must go to school as well. But not strict.
- I was a normal child and I loved sports. I never had expensive things. I was normal and I always accepted what I have. But I grew up and had a child.
- I was a normal wife, normal mother...
- I'll just try and have a normal life so that I can look after myself.

In some instances the word 'normal' is synonymous with 'ordinary,' but in other instances, I believe that Najma attempts to emphasise the normality of her life. At some levels she believes that she lives a normal, ordinary existence, while at another level, she sounds like she is trying to convince herself that she can lead an ordinary life as an HIV positive person. In fact, all Najma ever wanted is to be 'a normal wife, (and a) normal mother.'

Najma has five brothers and continues to live with her parents. She is divorced and has one child who is HIV negative. During our interview she described some of the things she used to do as a child. One the games she played were called 'huisie-huisie' or 'house-house.' She indicated that:

I played the mother in *huisie-huisie*. The children had to listen to what I told them (laughs) like clean and do this and that...I also told them how to dress and what to put on. The boy (who played the father) would sit around... just sit there.

The games Najma played as a child is fairly well-known and common games played by children in the Cape Flats region. One game in particular called 'huisie-huisie' draws on the stereotypical roles of men and women in their capacities as fathers and mothers respectively. Najma indicated that she played the role of the mother and that her playmates, which played the roles of her children, had to listen to what she told them to do. The male child who played the father just sat around and did nothing. Najma and her friends appear to have imitated their parents when playing this game. At the same time, her

understanding of the roles of men and women were also shaped and influenced through this game.

Najma's schooling experience also differed substantially from Faghmeda's since she states that she was a 'popular girl' at school. However, due to the school boycotts during the early 1980's her attitude towards school changed:

When I went to high school I think everything changed. My friends changed, the school changed, it was the boycotts. And my interest in things wasn't there any longer. I failed twice (laughs) because I wasn't there on school with my mind and it was like you come and you go whenever you want. It was only afterwards when the boycott was finished that you had to sit and concentrate and listen to the teacher. And by that time we weren't really interested in school. So I didn't finish school. I went up to standard nine (grade 11). And what also happened was, I had a child.

While Najma indicated that she was popular at school, which I would usually associate with being extroverted, she came across as being shy and introverted. During our interviews she spoke softly and had to be encouraged to elaborate on answers. My interviewing experience with Sumaya Ismail however, was quite the opposite.

At the beginning of the interview I asked Sumaya, a forty-year old mother of two sons, to tell me a bit about herself. Before I could even finish the question, she

began speaking and continued for about ten minutes. It appeared as if she was almost desperate to tell her story to someone since she had kept it in for so long:

I grew up in Retreat and I have two children. The one is five, the other is eighteen. My eldest one doesn't stay with me. He stays with my aunty who is Muslim. He stays there with her. The small one stays with me alone in the house. My mummy stays near to me in the main road in (deleted to protect Sumaya's identity).

I went to... (deleted to protect Sumaya's identity) primary school in Retreat and so in 1979 I stopped going to school, so I went to work at... (deleted to protect Sumaya's identity). I left school because I was raped and so I stopped going to school. I was fifteen (starts crying).

When Sumaya started crying, I decided not to pursue any further questions related to her childhood since this was obviously too traumatic for her to talk about. She was also more interested in relating her recent experiences since she discovered that she was HIV positive three months before our initial interview. I was able to establish in subsequent interviews that Sumaya's traumatic childhood impacted significantly on her during adulthood.

This was also true for Bilquees Abrahams, a mother of two sons who was born in Cape Town in 1978. Bilquees was the youngest informant at twenty five years. She indicated that she was the eldest daughter and had three younger sisters.

According to Bilquees, 'For all these years it was only me and my mother and my sisters living alone. Five years ago we met this man Abdul (not his real name), our step father. Since then, our lives have been threatened by Abdul and we became scared and have no control over our lives.'

While her mother and biological father never married, her stepfather who had served a lengthy prison sentence for rape, in many ways became the father figure for Bilquees. Before he came into their lives, Bilquees described her years in school as a lonely experience without any friends or companions. She also stated that, 'we were very poor and most of the kids at school were middle class. I always had to go to school without food or without fruit because there was no money for that.'

The poverty in which Bilquees grew up in had a substantial impact on her at school and was still very evident when I spoke to her during our interviews. She continues to live in fairly poor conditions and struggles to find food on a daily basis. While I sympathised and tried to understand the difficult circumstances in which Bilquees grew up in, I was also careful not to believe everything she told me because of previous interactions with her. Bilquees had in the past exaggerated her poverty stricken conditions as a means of evoking sympathy and as a way of soliciting charity from individuals, Positive Muslims and other organisations. One of our partner organisations, the South African National Zakah Fund (SANZAF), a charity organisation that assists poverty stricken

individuals such as Bilquees, refused to support her after having provided support to her for a few months. They believed that she was manipulating their food parcel system by selling the food she received and then requesting more food parcels claiming that the food they provided her with was insufficient. There were also many more incidents involving Bilquees that made me and others suspicious of her actual circumstances.

Bilquees continued to talk about her experiences of childhood and related the moment she decided she wanted to have a child:

In grade eleven, I thought to myself that I'm big now and I'm always the loser at home and I get nothing right or I don't get what I want or what I need. And in grade eleven I just started thinking that maybe a child will make me happier and maybe I could communicate with my child. And Allah *hoe ta'allah* (Allah the almighty) gave it to me and He gave me a child and I was pregnant in grade eleven. I left school and had part-time jobs so that I could feed my baby and give my kids all the things that I didn't have.

It is interesting to note that Bilquees wanted to have a child while she was still in school while Najma, who also fell pregnant in grade eleven, was not engaging in sexual activity in order to fall pregnant. Bilquees' reasons for wanting a child appear to be firstly, to make her happier because she never got what she wanted, secondly, to be able to communicate with the child, and thirdly, to give her child everything she never had. Bilquees had clearly not thought through her

reasons for wanting a child and created a greater burden for herself. Her subsequent decisions combined with her personal living conditions which were beyond her control continued to create further difficulties for her:

My baby was growing and growing, he was two years old and then I met this boy. He said to me that he would marry me and he promised me very big things and I fell for it because there wasn't someone in my life that really told me all this stuff. I went out with him for two years and I was pregnant again. The day that I gave birth, he was getting married (to someone else).

Bilquees appeared to have realised that her decision to have her first child made things harder for her. When her second partner came along and promised her 'very big things' which I interpreted as financial security, her decision making ability was blurred because she desperately needed financial support for her child and herself. In this instance, her need for financial security which was promised to her by her second partner also resulted in her becoming HIV positive.

Gadija Mohammed's childhood and life history is remarkably different from the four informants described above. She grew up in Mogadishu, Somalia and was born in 1973. She described what her life was like in Somalia:

At that time life was alright. We didn't have a problem at home. We had our own house. My father used to work in Italy. My father used to have nice job. He was

a chef. He used to get paid lots of money. He's the one who built our house. He used to live a good life because he used to give the people *sadaqa* (Arabic word for 'charity'). Our house was like a mosque. The people used to come and complain to my father about their problems. My father passed away. He died with a good heart. I'm just like my father. I want to be just like my father.

But the war started in 1991 I think. Then from that time there was no school, no hope, no nothing just fighting. I saw some of my friends moving to South Africa. They said that I should go to South Africa because if you go to South Africa you can get an education and a job.

Gadija realised later on that her move to South Africa would not be as easy as she had anticipated. While her middle class childhood appeared to have been fairly pleasant since she completed her schooling and was about to embark on tertiary level education, the situation changed drastically at the start of the conflict in Somalia. Her choices became severely limited because of the political situation in her native country.

The childhoods of the five informants provide the reader with an insight into the challenges they faced as girl children. More than that, it gives one an understanding of how those challenges may have shaped their choices and decisions in later life.

4.3.2 Family

For some informants, such as Faghmeda Miller, her family played an important role in providing her with support, while for others such as Bilquees Abrahams, her family was the last place she would seek assistance from. By exploring the informants' relationships with their families, I hope to understand the impact that these relationships have had and continue to have on the informants.

While Faghmeda Miller indicated that she had a difficult childhood due to her hearing disability and that her family contributed to the difficulties she experienced by mocking her, she remains fairly close to her family. Faghmeda has two brothers and one sister. She referred to her eldest brother as her 'hero' because of his involvement in various sporting codes such as weight lifting and karate. Faghmeda stated that she really admired her brother and also started karate classes because he was doing it. Her eldest brother is six years older than her, followed by her sister Najma, herself and then her youngest brother, Fasli. She also has a close relationship with her sister who is 'very protective' over her. One example of her sister's protective nature is portrayed in the following account:

I remember one time at high school, one of the girls teased me and my sister stood up for me. I said to her afterwards that she embarrassed me and that I could look after myself (laughs). But she has always been over protective and worried about me.

Faghmeda stated that while she has had a 'good relationship' with her youngest brother Fasli, she thinks that he likes to 'act as if he is the eldest member of the family (laughs).' According to Faghmeda, Fasli is also 'protective' over her. It becomes evident when talking to Faghmeda that she understands and interprets her family's 'protectiveness' as more of a form of control than a concern for her well-being. It is also interesting to note that Faghmeda never refers to herself as 'HIV positive' or as 'a person living with HIV/Aids' but rather talks about her HIV infection as 'what I have now.' In the paragraph below she once again refers to 'what I have.'

My mother and I have never seen eye to eye. I was closer to my late father. I could easily talk to him about anything whereas my mom was not necessarily distant towards me, but we just never seemed to click. I think I am more like my late father. I am quieter. I would rather listen than talk. My mom and my sister are the same. They can talk you to death (laughs). I've been living with my mom all my life. Because of what I have makes things worse now. For my mother, my life has ended. And she will often tell me that I must prepare for death. She won't say it exactly that way, but that's what she means.

On the one hand, Faghmeda chooses to avoid labelling herself as a person living with HIV/Aids by choosing language such as, 'Because of what I have makes things worse' instead of, 'Because I am HIV positive it makes things worse.' On the other hand, Faghmeda's mother appears to constantly remind her of her mortality by telling her that she needs to 'prepare for death.' This has led to an

ongoing conflict between Faghmeda and her mother. This conflict is exacerbated by the fact that she has lost her father who she was closer to. She stated that, 'when I lost my late father, I lost a great deal of myself, because I was just very close to my father and often now, when I talk about him I would cry (laughs), so I better stop talking (laughs).'

Faghmeda's relationship with her father was distinctly different from Najma Salie's relationship with her father. Due to his line of work, which Najma asked me to delete from the transcript to protect his identity, her father was away from home for long periods. She believed that his absence from home caused her to become distant towards him. She believes that, 'if I had grown up with him... I think it would have been different.'

Najma believed that her father's absence due to his work commitments played an important role in her upbringing. Had her 'religious' and 'strict' father been around things might have turned out differently for her. During the discussion on Najma's childhood she indicated that because she was 'naughty' she became pregnant. As a result, she believes that if her father had been around while she was growing up, she might not have turned out to be so 'naughty' and may therefore not have become pregnant. Najma connects her father's religiosity to his strictness implying that the more religious he became in later life, the stricter he became as well.

In addition to her parents whom she and her daughter continue to live with, she also has five brothers. She indicated that while she was close to her brothers when they were younger, once they had married her relationship with them changed. Najma stated that she was unable to ask her brothers to do anything for her indicating that their relationship was strained. Her family remains unaware of her HIV status.

Sumaya Ismail's family is well aware of her HIV status and revealed it to them shortly after her husband died of Aids related illnesses. I attempted to ask in-depth questions about Sumaya's family and childhood to get a more complete picture of her life. She would tend to start off by talking about the subject I enquired about, but the conversation would ultimately turn to her husband. I realised that her HIV status which was intimately connected to her husband was still fresh in her mind and that she needed and wanted to talk about these issues more than anything else. As a result, I decided to frame my questions around her HIV status and her husband but attempted to throw in one or two questions about other issues such as her family. She indicated that her parents had a good relationship towards each other and 'played a huge role' in her life. At one stage however, her mother was hospitalised due to a 'nervous breakdown.' She also stated that she was forty years old and the eldest child in her family. She had two younger brothers. According to Sumaya, her brothers were supportive of her when they discovered she was HIV positive. Sumaya appears to come from a family who was caring and compassionate and who was accepting of her HIV

status. This played an important role in her ability to deal with the trauma of her husband's sudden death and the discovery that she was HIV positive.

Both Sumaya and her mother suffered from 'nervous breakdowns' and had to be hospitalised. While Sumaya simply cites exhaustion and depression as the cause of her mother's breakdown, no detail is provided to ascertain what led to her mother's depression and exhaustion. In Sumaya's case, I discovered that her breakdown resulted from the constant abuse she suffered at the hands of her husband which is discussed in the next section.

Bilquees Abrahams describes the inability to connect with her mother as 'a wall (that has been) built and the wall is still standing.' She says further that 'there isn't a mother to daughter relationship really.' Bilquees admitted however that, 'sometimes she does help me out and sometimes I do talk to her but I don't know when because she's got her own problems.' Her mother and sisters are aware of her HIV status. Bilquees indicated that her mother needed to look after her two younger sisters as well as her husband who had been released from prison and was unemployed. She explained that the reason for the rift between her and her mother was due to the fact that she had to act as the 'breadwinner' in her house. She also indicated that there was no relationship between her and her sisters and added that, 'I try my utmost to live in the Islamic way.'

Bilquees came across as being angry when she spoke to me about her family and particularly about her mother. She blames the way she was raised for her inability to communicate with her mother and sisters. Bilquees appeared to be particularly angry about the fact that her mother forced her to take on the role of breadwinner for her two children and had to look for food herself. Bilquees therefore believes that her mother is responsible for supporting her and her two children while she is unemployed. During our interviews, Bilquees attempted to paint a picture of herself as a poor destitute victim of circumstance. In addition, she believed that because of her condition, her family, particularly her mother, should support her. What was also interesting was that Bilquees attempted to emphasise how religious she was throughout our interviews. This aspect is discussed further below.

Gadija Mohammed also emphasised her religiosity throughout our interviews but in a more subtle manner. She had come from a fairly religious family in Somalia and indicated that children were beaten from the age of seven if they did not pray. As a young girl Gadija was very close to her father until he passed away. Her mother is the only family member who is still alive. She indicated that she had not seen her mother for eight years and wanted to desperately visit Somalia. However, she stated that, 'you can't go with empty hands.'

Gadija's relationship with her mother remains strong despite the fact that they have not seen each other for eight years. Her relationship with her mother can

also be contrasted with Bilquees' relationship with her mother. While Bilquees expects financial support from her mother, Gadija feels guilty that she is unable to send her mother any money. On the other hand, while Bilquees has disclosed her HIV status to her mother, Gadija has not.

Besides her mother, Gadija also had two brothers who both passed away in 2001. Gadija's family has fallen apart since the start of the war in Somalia. Her son subsequently died of Aids related illnesses and her husband continues to be separated from her because of his employment commitments. As she struggles to hang onto what is left in her life, Gadija stated that she continued to have faith in God and remained strong.

4.3.3 Relationships

The relationships between the five informants and their respective sexual partners reveal a great deal about the women and the context in which they live. In four out of five cases, their relationships with their male partners led to them contracting HIV/Aids. The type of relationship that the women were engaged in differed substantially from one another. While some women were married to their partners at the time of their infection, others were not. There were also two reported cases of violence within the marital relationship.

In the most serious reported case, Sumaya Ismail believed that her husband, who is now deceased, knew he was infecting her with HIV/Aids when he raped her. She stated that:

He always said to me that he would leave me with something but I had no idea what he meant by it. I had no idea what he meant by that. I could have had myself checked out by a doctor and to say that if it is like that then... I could have left him and then his family could have been angry with me but I cannot live with a man that has given me that. And for me I feel that he knew he had it or... he can't say that he didn't know he had it because why did he never want to go to the doctor?

Sumaya provided details of some of the violent sexual experiences that she had to endure at the hands of her husband:

And there were many times when I didn't want to sleep with him and then he beat me so that I slept with him. He hit me like this... he hit me to hospital (Sumaya lifts up the leg of her pants and shows me a scar that stretches from the back of her knee down to her ankle across her calf). This is how he hit me with an *aapstert* (the word 'aapstert' literally translates into 'monkey's tail' which is essentially a whip). My doctor at Victoria Hospital wanted to make a case against him. He believed that he could sleep with me whenever he wanted. This was his attitude. This was his attitude.

I attempted to ascertain whether Sumaya's husband may have been influenced by the Islamic norms and values associated with a Muslim man's sexual rights over his wife. Sheikh Abdurraghiem Sallie (1993: 16), a prominent Sheikh from Cape Town, argues that a wife has to obey her husband's request for sex at any time, except when, (1) the husband refuses to support her; (2) the husband is guilty of an extra-marital relationship; (3) the wife is menstruating; (4) a doctor has advised the wife not to engage in sexual activity for medical reasons; (5) the husband and wife are both performing pilgrimage.

If the wife refuses to engage in sexual intercourse with her husband and the above exceptions do not apply, then Sallie (1988: 145) argues that the husband is not under any obligation to provide financial support to his wife as long as she refuses to have sex with him. This 'right' given to a man over his wife is rooted in prophetic precedent and does not extend to the woman and her sexual needs.

According to Sumaya, her husband was not religious at all and his actions were therefore not necessarily based on any Islamic norms and values. She stated that:

He never prayed or went to mosque on a Friday. His mother and father lived a very reckless life those years so I won't blame him for going in and out of jail because his father abused his mother a lot. His father also beat his mother a lot and so his mother began to drink and he grew up with his grandmother. Anyone could walk in and out of the house to sleep there because his mother was drunk and his father was drunk. So you can say it was like a liquor house. And there

wasn't respect. And so he went to jail quite young. From school he went to a reformatory and out of reformatory he went to jail. And when he got out of jail, he wasn't out long and then he saw the mother is still in that line. She continued to drink and so on. The mother also turned Muslim for the father.

From Sumaya's description of her husband's background, it appears as if there was no connection between his violent behaviour and the fact that he was Muslim. His violent behaviour appears to have a greater connection to the social conditions and everyday poverty and violence experienced in coloured areas. Sumaya went on to explain why she thought her husband became such a violent person. She believed that, 'he grew up in the wrong environment.'

Sumaya also indicated that she continued to stay with her husband because she believed he could change his life and that if she left him, he would probably end up in jail. It is interesting to note that Sumaya was willing to put up with her husband's violence and abuse hoping that he would change. Despite the fact that he raped her and beat her, she continued to support him. Even though Sumaya stated that she would have left him had she known he was HIV positive, she later on changes her mind:

My husband was lying there and I thought you're lying there and you gave me this sickness. And he still asked me *tamaaf* (Cape Malay word for 'forgiveness'). And I said to him, I gave you *tamaaf* a long time ago. Because I knew that you are not going to make it and I knew you won't come home. But I knew Allah will

take you just like that while you're lying there. But Allah still granted you a chance to ask me for *tamaaf*. And he asked me for *tamaaf*.

And so he asked me if he comes out of the hospital will I take him back? So I said, 'well it's no use that I push you away, I must take you back because you're still my husband. According to Allah, you and I are not yet divorced.

Sumaya would therefore have continued looking after her husband if he had been discharged from hospital despite the fact that he had raped her and infected her with HIV. I had great difficulty understanding why anyone would do this to themselves. Sumaya later explained that she thought her husband had been cursed and that this curse had caused him to act in the manner that he did. This issue is discussed further below.

Another informant who had also experienced violence in her marital relationship was Najma Abrahams. She explained that her decision to marry her husband after falling pregnant in high school was firstly, fear of being alone and secondly, because of 'what people (are) going to think.' Najma indicated that she was happy for about five years until her husband started abusing drugs and alcohol:

What happened was that my husband started to drink and gamble and he just... I can't put my finger on what I did wrong. I always think about that. And he started to smoke mandrax and drink more. He didn't pay the bills and went out with his friends... we lived like... he didn't exist, I didn't exist. What happened

was, he was violent when I decided I didn't want to be with him. That was the time he always used to be so violent. And there was times when he hit me. But that wasn't in the beginning, it was only afterwards.

Najma also believed that because she was unable to save her marriage, she was somehow responsible. She kept on asking herself what she did wrong for her marriage to have ended the way it did. The guilt she carried from the failure of her marriage caused her to steer clear of long-term relationships. Instead she had a few boyfriends, and was eventually infected by a man she met after her divorce. After she became infected, Najma said that her attitude towards relationships with men changed drastically. In one of her relationships she decided to tell her partner that she was HIV positive. His response was: 'Wat moet ek doen met 'n siek vrou? (What must I do with a sick woman?)'

While Najma believed that staying away from relationships with men would be best for her and for men generally, she also acknowledged that she would probably be treated differently to someone like Faghmeda Miller because of the way in which she contracted the virus. Since Faghmeda contracted HIV/Aids from her husband, Muslims were more accepting of her. Najma, on the other hand, contracted HIV/Aids from her boyfriend in a casual relationship, and therefore believed that Muslims would not welcome her with open arms.

I also asked Najma whether it would be easier to tell people about her HIV status if she had contracted HIV the way Faghmeda had, that is, within marriage. She

replied: 'I would say that it would have been easier. Yes, it would have been.' It therefore appears that the way in which she contracted HIV/Aids remains the biggest obstacle for Najma to telling her parents, friends and family about her HIV status. While many Muslims engage in sex before marriage, the stigma attached to such behaviour remains significant, especially for women. There is a clear divide between the norms and values articulated by Muslims at a theological level that is, abstinence from sex before marriage, and the sexual practices engaged in by Muslims at a realistic level. It is important to note though, that Muslims who have sex before marriage are only stigmatized when their actions lead to consequences that cannot be hidden such as pregnancy or HIV infection. In the other words, practices that conflict with the established Islamic norms and values, such as pre-marital sex, are tolerated as long as the practices are not committed openly and as long as there are no visible consequences resulting from the practices. So for example, when Najma became pregnant in high school, which is clear evidence that she was engaging in sex before marriage, her mother's first concern was what were the people going to say. Her mother's concern related to the embarrassment the pregnancy would cause the family and not so much to the fact that her daughter was engaging in sexual activity outside marriage. In order to minimize the damage, Najma simply married the man she was sleeping with to make the pregnancy more acceptable. It is doubtful whether Najma would have been forced to marry her boyfriend if her mother discovered that she was having sex but that she was not pregnant. The act of marriage was therefore used as a means of hiding the

consequences of sex outside marriage, namely pregnancy. If Najma had not become pregnant, her sexual relationship may have been tacitly accepted as long as she was not caught and there was some hope that she would marry her boyfriend at a later stage in their relationship.

The criteria for tacitly accepting sex outside marriage are different for men and women. While women must not get caught *and* ensure that they marry their boyfriend, men must simply make sure that they are not caught. For men, the obligation to marry the woman that you are sleeping with is not as strong as the unmarried pregnant woman's obligation to marry the man.

With HIV/Aids, the situation changes dramatically. While a clear sign of sex before marriage, such as pregnancy, could be fixed through marriage, contracting HIV/Aids as a result of sex before marriage is different. This sign cannot be fixed through marriage.

Essentially, this is the dilemma that Najma faces in her struggle to hide the sign that she has engaged in sex outside marriage. It appears as if her problem is not so much that she is HIV positive, but that she became HIV positive through sex outside marriage. In some ways therefore, Faghmeda Miller's public disclosure of her HIV status is more acceptable to Muslims since she contracted the virus within the articulated norms and values associated with Muslims in the Cape. Faghmeda indicated that she was a virgin until her wedding day.

Faghmeda's sexual experiences and relationship with her partner differs substantially from Najma and Sumaya's experiences. She appears to have a much more idealistic understanding of love, sex and relationships which is reflected in her diary. Faghmeda has kept a diary of the last few years of her life which she has written up as a manuscript, hoping to have it published as a book someday. She shared a copy of her manuscript with me. The opening paragraphs of her manuscript reveal Faghmeda's fascination with weddings. I have quoted the first paragraph of her manuscript below:

As a child, the third youngest of four children, I have often dreamt of only one thing. While other's dreamt of touring the world, going places, or even meeting their dream prince, I only dreamt of having the most beautiful wedding ever without even thinking who the groom would be.

I found Faghmeda's fascination with weddings to be rather interesting since I had never heard her speak or write about anything in such an intense manner. At some levels I suspect that all Faghmeda really wanted was to be an ordinary, inconspicuous woman who had a husband and some kids and who attended fancy wedding ceremonies. She's not particularly interested in travelling or exploring new places as she says in the opening paragraph of her manuscript, but is content with living a middle class existence. However, her HIV status has forced her to move beyond the white picket fence fairytale that she had imagined for herself as a child. And sometimes, it becomes difficult to deal with the

challenges that this unexpected intrusion brings with it. During our interview, I asked Faghmeda about her fascination with weddings:

I think for me the fascination is the dress of the bride itself, not the family or the food or whatever. Just to look at the dress the whole time and I thought I'd make up my own fairytale while I'm sitting there watching this bride (laughs). But even for me when I visualised my own wedding, I never thought of who the husband would be or where I would stay or nothing. For me it was just the dress itself, what I would look like. Although I looked junk on my own day (laughs) but okay.

While Faghmeda clearly had a fascination with wedding ceremonies which she talks and writes about at length, she says nothing about her own wedding ceremony in her manuscript except that 'My "childhood dream" was finally fulfilled, making me one of the happiest women ever.' When I asked her why she had neglected to talk about her own wedding, she replied: 'Maybe it was too painful...'

I can certainly understand why this must be painful since ironically, it was her childhood dream of being in a beautiful wedding gown that eventually resulted in Faghmeda becoming HIV positive. Her husband who was HIV positive and who subsequently passed away as a result of full blown Aids infected her. Her husband Junaid, who was a Malawian national, was not aware that he was HIV positive and therefore unknowingly infected her, according to Faghmeda. At our interview, Faghmeda did not feel up to talking about her marriage and the ordeal

she subsequently went through. I have therefore compiled extracts from her manuscript to convey some of the difficulties she experienced during her seven months of marriage. It should be noted that shortly after her marriage she moved to Malawi with her husband to stay with his family. The extracts refer specifically to the sixth month of her marriage while in Malawi, during which time Junaid became critically ill:

During our sixth month of marriage, Junaid became seriously ill. Though he was attending clinic on a regular basis for tuberculosis, there was nothing really wrong with him, so when he started with nightly perspiration, I believed it was due to the tuberculosis. Then he started to lose weight and simply wouldn't eat at all.

When he asked me to bath him, I stated that he could do it the next day when better, but he insisted that I did it and I then with the help of our houseboy, carried him to the bathroom where I gave him his last bath. Just as I was drying him, I realised that he was busy dirtying himself and he apologised saying that it was an accident and he then started crying, asking me why he's so weak and why he could not heal on his own as always and I had no answer to his questions. Instead I cried with him and washed him again. I then told him that I do not see my taking care of him as a burden as I know what it feels like to be ill, yet not knowing what is really wrong with him. By then he had developed tiny sores in his mouth and his scalp and moustache were filled with what looked like dandruff to me and he asked me to remove it for him.

Next to this last typed sentence, Faghmeda inserted the following words in her own handwriting: 'I now know it was dry skin peeling off.' After this insertion, the typed sentences continued to describe their last night together. Faghmeda went on to explain how Junaid's condition worsened during the night and how his family had rushed him to the local hospital where he stayed for one night before passing away:

...his stomach started running again and he asked for the houseboy to get a pan. For more than half an hour his stomach troubled him and in the end I almost had no paper left, thinking of the long night ahead so instead I used a cloth to wash him. Just after the diarrhoea stopped, the nurses removed his drips and I thought it odd, but said nothing as surely they knew best. By then his skin colour was almost yellowish. Again he told me to go sleep, but I never intended to sleep and just kept my eyes on him. While still doing so, he smiled at me and that was the last time he did so. When I came to my senses, I was waking up from a light sleep. The first thing I noticed was that the houseboy was fast asleep and so was everyone else in the room and my husband was rolling his head from side to side and at intervals would stare up straight at the ceiling as if he was looking at someone. At first I did not immediately realise what was happening, but the second I did, I jumped from the bed calling his name and at the same time reaching for his mother and gave her one wild shake, shouting at her to get a doctor as her son was dying. Why I needed a doctor I don't know, but I just called at her to get one. I then lifted his head in my arms, cradled it, asking him not to leave me alone, but his eyes just rolled from side to side and then white foam came from his mouth and then he was no more. I could not do

or say anything, but still held him close to me until the nurse came in and took me away, but I wouldn't leave. Instead of saying the usual prayer to him, I stared and stared at him until the nurse covered his face. Then only did I react, shouting "No" and pulled the blanket back and yelled at him, asking him what am I supposed to tell his kids (from his previous marriage) and my parents. When the nurse took me in her arms I cried only once and pushed her away and covered his face, prayed at his side and walked out of the room. I vaguely remember the nurse telling me to wait for transport to take me home, but I just kept on walking until I reached the main road leading to our house.

Faghmeda returned to South Africa shortly afterwards and discovered that she was HIV positive after being tested at Tygerberg Hospital in Cape Town. An entry in her diary dated '19/01/95: Thursday' described her anguish as she waited for the two weeks before her test results would be made known to her:

How am I going to survive the two weeks before the doctor calls with the results? What if it turns out to be positive, what am I going to do then? However, whatever the results may be, either way, I just have to put my trust and faith in The Almighty as surely He alone knows best. I'll just have to wait, alone in silence.

The fact that Faghmeda constantly states that she has put her faith in God, indicates that her faith plays a central role in her life and tends to weave in and out of her manuscript. This aspect of her life is explored further below.

While Faghmeda decided to 'wait alone, in silence' before revealing her HIV status to her family, Bilquees decided to tell her family immediately. However, she neglected to inform the man who infected her and who was also the father of her second child. Based on our discussion, it appears as if her reasons for refusing to inform him were firstly, that he had promised to marry her before she became pregnant but abandoned her shortly after finding out about the pregnancy. Secondly, on the day she gave birth to their son, the father of her second child married another woman. Thirdly, she was afraid that if she were to tell him that she was HIV positive, he would 'point a finger at me and say to me that I'm the one and I know that I wasn't the one that was sleeping around.'

Although Bilquees is convinced that the father of her second child is the one who infected her, she cannot understand why his wife, who she continues to communicate with, told her that they were both negative. She then suggests that she may have contracted the virus while she was pregnant which would imply that she had engaged in sexual activity with someone after her break-up with the father of her second child. However, Bilquees clearly indicated that before her husband, she had only had sex with the fathers of her two children and that the father of her first child was negative.

Whether Bilquees is telling the truth or not about her sexual activity is irrelevant. The point is that no one appears too concerned about taking responsibility for the consequences of their actions. On the one hand, the father of Bilquees' second child marries a woman on the day his son is born and fails to take responsibility

for his newborn child. On the other hand, Bilquees fails to inform the father of her second child about her HIV status. The resultant consequences are frightening. The father of her second child, who may be HIV positive, could now infect his new wife and their child. Furthermore, because no support was provided for Bilquees' child, she decided to marry another man who was temporarily able to support her and her children. Bilquees has informed her husband about the fact that she is HIV positive and they resort to using condoms when having sex.

However, at the time of the interview, Bilquees' husband had been imprisoned for five months and she was once again left without any kind of financial support.

She stated that:

Actually I'm struggling because my husband is in jail for a previous crime. It is against the law because it was with dagga (cannabis). And I decided to get married and he helped me a lot although the children are not his. He gave me things that nobody else could have given me, even my own parents. He spent money on my kids. He's now in jail but he's still writing to them and they still know him as a father because they call him daddy.

Bilquees is heavily dependent on her husband for her survival and her decision to marry him appears to be motivated to some extent by economic reasons. This is demonstrated in the paragraph above where she tends to gloss over the fact that he is serving a prison sentence and focuses on his support of her and her

children. According to Bilquees, her husband is aware of her HIV status, and fully supports her. Bilquees appears to have finally found someone who she believes will be able to support and care for her. The fact that her husband has been imprisoned for selling drugs does not seem to bother Bilquees too much. She appears to be willing to overlook all his faults as long as he is able to secure her and her children's economic survival.

Gadija Mohammed also struggles to ensure her economic survival and is to some extent dependent on her husband as well. When Gadija discovered she was HIV positive, she decided to separate from her husband. She explained how her relationship with her husband changed when she discovered that she and her child were HIV positive but that her husband was negative. Later, Gadija decided to move to Cape Town to look for work.

Her relationship with her husband appears to have some similarity to the relationship between Bilquees and her husband due to the economic dependence of both women on their respective husbands. Due to Gadija's level of religiosity, I would argue that in her case, she believed that her husband had an Islamic duty to financially support her. Cape Town based Sheikh Abdurraghiem Sallie (1995: 64-65) argues in one of his books that a husband has a duty to support his wife. This is substantiated by Saalih ibn Ghanim al-Sadlaan, a professor from the College of Shari'ah at Muhammad ibn Saud Islamic University in Riyadh (cited in Ali 2003: 173) who argues that:

The woman is naturally conditioned and created by Allah to perform the functions of pregnancy, giving birth, and taking care of the internal affairs of the house. Man, on the other hand has been endowed with more physical strength and clearer thought and he is, therefore, more befitting to be the leader of the household and the one responsible for providing the means of livelihood, protecting the family and bringing about security and continuance in the family.

The opinions put forward by Sallie and al-Sadlaan reflect the articulated norms and values that are meant to be followed by Muslim men. However, the reality is that in both Bilquees' and Gadija's cases, their husbands were unable to financially support them. Once again, this example reflects the divide between the articulated norms and values associated with the Muslim husband's duty to support his wife and the practices that actually occur at the ground level.

While both Sallie and al-Sadlaan state that because a husband supports his wife financially, he is entitled to certain economic and sexual rights over her, they fail to deal with the situation where the husband is unable to provide for his wife. In other words, can one argue that because a husband has failed to support his wife that he no longer has any rights over her? Even though this type of argument is flawed because it is premised on the belief that a husband has rights over his wife if he is able to support her, it also highlights the gaps in the thinking processes of religious leaders. A more in-depth discussion about the rights and obligations of men and women will be discussed in Chapter five.

4.3.4 Socio-economic Background

Before becoming infected with HIV, three of the informants could be classified as coming from working class backgrounds while Faghmeda and Gadija could be seen as coming from lower middle class homes. Since infection, four of the informants can now be classified as working class, while Faghmeda remains classified as lower middle class. The change in Gadija's economic situation can be attributed to her refugee status at one level, but also due to the restrictions placed on her by her HIV status. Gadija mentioned for example that she was unable to work in a place situated too far away from where she receives her medication.

Based on the above information, it is possible to argue that most Muslim women living with HIV/Aids in the Positive Muslims support group come from lower socio-economic backgrounds and usually have relatively low levels of education. In Bilquees' case for example, I would argue that her HIV infection is in many ways connected to the poverty stricken conditions in which she lives. According to Bilquees, she became infected by the father of her second child who, 'promised me very big things and I fell for it.' This statement acknowledges that Bilquees engaged in sexual relations with the father of her second child hoping for some sort of financial support and commitment. Her own level of poverty may have been a factor in her decision to engage in sexual activity with this man. Furthermore, her decision to marry her husband was also partially motivated by

economic reasons. She stated that, 'He helped me quite a lot. He gave me things that nobody else could have given me, even my own parents. He spent money on my kids.'

The struggle to survive as a woman living with HIV/Aids appears to be exceptionally difficult for some and more manageable for others. The difference between the women who survive and the women who struggle is in many ways related to their socio-economic conditions and more specifically, their financial resources. Women such as Faghmeda and Najma coped well with their HIV status compared to the other informants. In my opinion, this is attributed to Faghmeda's lower middle class status which is based on the area in which she lives, the fact that she owns a vehicle, receives financial compensation for her work at Positive Muslims as well as financial support from her brothers. Najma on the other hand, comes from a working class background but earns a regular income and lives with her parents who support her and her daughter. As a result, both Faghmeda and Najma have limited but sufficient financial resources to survive and can therefore deal more adequately with their HIV status.

The other three informants have little or no family support because of various circumstances. In addition, two of them have no work at all. Even though Sumaya has a job which is similar to that of Najma's, she does not have the financial support from her family to sustain her and her two sons. Sumaya, together with Bilquees and Gadija therefore appear to be unable to cope with

their HIV status in large measure due to their poor financial situation. It is therefore evident that socio-economic status plays a substantial role in women's vulnerability to HIV infection as well as in women's ability to cope effectively once infected with HIV/Aids.

As a result, in certain instances, the women's HIV status was not as central to their identities as the socio-economic conditions under which they lived. This was confirmed by Rehana Kader (Observatory, 23 April 2003) who also observed that poverty, as opposed to HIV status, was the primary concern for many support group members. The possible reason for women focusing on their socio-economic conditions as opposed to their HIV status may be due to the immediacy of the impact of poverty on their daily lives. The lack of food or money has immediate consequences whereas HIV/Aids takes many months and sometimes years to manifest as a problem.

4.3.5 Method of HIV Infection

Four of the informants were infected through sexual activity, while Gadija was infected through a blood transfusion outside South Africa. Since sexual activity is the most common mode of transmission of HIV, these results are to be expected. Najma described how after her marriage she had a few boyfriends and that after having sex with one of them, she became HIV positive.

For Najma, her decision to have sex with her boyfriend who was also married at the time was based on her need for 'somebody to be there.' This need developed after her failed marriage and unfortunately led to Najma becoming infected with HIV. She also described how she found out about her HIV status at a clinic she attended and that no counselling services were provided. Najma's experience of being told about her HIV status was very similar to Sumaya's experience. Sumaya also described how she was informed about her status without any counselling or support services.

The lack of care and empathy on the part of health professionals in both Sumaya and Najma's cases appear to be a common experience amongst the five informants. Bilquees and Faghmeda were the only two informants who received counselling. The lack of care appears to be across the board in that health professionals treated informants similarly irrespective of how they became infected.

One of the significant trends I noticed was that two of the four women infected through sex were infected by their husbands, while the other two were infected by their boyfriends. Based on these case studies, it appears as if married women are just as vulnerable to HIV infection as single women. This is fairly significant considering that religious leaders see marriage as a means of protecting Muslims from HIV infection. In a controversial paper delivered by Amina Wadud, a Muslim feminist scholar, at the Second International Muslim

Religious Leaders Consultation on HIV/Aids in Kuala Lumpur (May 2003), she argues that, besides children:

The other group that is of concern here are monogamous wives. Especially in the context of Islam, where a Muslim wife is not only expected to be, but defined in terms of her being unconditionally sexually available to her husband. Properly fulfilling this role of wife is fatal to some women, with estimates as high as 80%. That is 80% of the heterosexual women with Aids are monogamous and have only ever had sex with their husbands. What does a theological premise 'laa taqrabuna al-zinah' (do not approach adultery) avail these women? How has Islam in particular assisted them towards living a life of dignity and how has it prevented them from experiences of dignity and worth, un-stigmatized by our ostrich theology and law?

According to Wadud's (2003) research and experience with Muslim women living in Nairobi, 80% of the HIV positive women she met were infected by their husbands. It therefore appears that Muslim women in marriages may be even more vulnerable to HIV infection than unmarried women in certain countries. Furthermore, Positive Muslims awareness campaigns have in the past usually targeted single women since we assumed that married women would not be as vulnerable to HIV infection as single women. The awareness campaigns would therefore need to be reconsidered in light of these case studies.

It is also important to note that the sexual activity which led to the four informants becoming HIV positive was not consensual in all cases. While it could be assumed, based on the interviews, that sex was consensual in Faghmeda and Najma's cases, it is certain that sex was not consensual in Sumaya's case. Sumaya indicated during her interview that her husband forced her to engage in sexual activity against her will. She stated that, '... there were many times when I didn't want to sleep with him and then he beat me so that I slept with him.'

In Bilquees' case, it appears as if sexual activity was legally consensual but that her motivation for engaging in the sexual act was to escape her poverty stricken conditions by securing financial benefits. In other words, it seems as if Bilquees would not have engaged in sexual activity with the father of her second child if she knew that he would not marry her and provide her and her child with financial support.

Bilquees' decision to engage in sexual activity in exchange for financial support appears to occur fairly often amongst women in her position. According to Albertyn (2001: 5):

The intersection of poverty (or economic inequality), culture (or social inequality), and gender in increasing vulnerability to HIV is illustrated by the reality that poor women may resort to bartering sex for survival. This not only occurs under the rubric of commercial sex work, but also in other forms of 'bartering' behaviour that are not seen as 'sex work.' Here women form sexual relationships to ensure

food and maintenance for themselves and their families. Thus, in many societies men provide women with desired goods in return for sexual access on a one-off, short-or long-term basis. Sex may also be traded for a job, permit, or promotion in the employment sphere, and for marks or fees in the educational sphere. Most of this sex is unsafe because women risk loss of economic support from men by insisting on safer sex.

To conclude that sexual activity is the primary cause of HIV infection is therefore a rather simplistic way of approaching and understanding the spread of HIV/Aids. The reality is that women engage in sexual activity for various reasons and it is essential that these reasons be considered when formulating a comprehensive response to HIV/Aids prevention.

4.3.6 Religious Beliefs

Religion played a central role in the lives of two of the informants and a less important but significant role amongst the rest of the informants. For Faghmeda and Gadija, God was a central figure in their lives that they constantly referred to in relation to their HIV status and their very well-being. These two women believed that God had caused them to become infected with HIV/Aids as a test of their faith in Him. In her manuscript, Faghmeda often consults with God before taking important decisions such as disclosing her status on a local Muslim radio station.

During our interview, Faghmeda and I had an in-depth discussion about her faith and her relationship with God. She however asked that all her comments about her relationship with God be excluded from this paper. Faghmeda indicated that she had never told anyone about her relationship with God before and would prefer it if the discussion between her and I remained confidential. She did however give me permission to quote from her manuscript which often makes reference to God. It is important to note that Faghmeda is a deeply religious person which manifests itself at a basic external level, for example in the way she dresses, as well as at an internal level, with respect to the way in which she rationalises her HIV status.

From the day she went for an HIV test Faghmeda believed that she needed to 'put my trust and my faith in The Almighty as surely He alone knows best.' The phrase 'Allah knows best' is often quoted by Muslims during times of uncertainty and difficulty. When Faghmeda received the results of her test two weeks later, she writes:

Oh my Lord, how could Thou punish me like this, what have I done to have angered Thee? I am so hurt, angry, confused and even feel betrayed by my late husband. How could he have done such a thing to me? Oh no! I have shamed my family, how are they ever going to forgive me!!

Faghmeda's initial response to her HIV status is one of shock and anger believing that she had been punished by God. She also expresses anger

towards God since her next diary entry states: 'During the night I did nothing but cried and begged to The Almighty to forgive me for being so angry at HIM.' Her initial anger towards her husband is also rationalised in terms of her faith in that two days later she writes: 'I do not hate him (Junaid) for infecting me as who am I to judge as God alone can do that.'

Her faith in God, before she knew about her HIV status, turns into anger towards God when she finds that she is HIV positive. Faghmeda then turns to God again asking Him to forgive her for being angry towards Him. During our interview Faghmeda indicated that the only time she ever felt angry towards God was when she found out about her status. Even though she had a difficult childhood and her husband died seven months after they were married, Faghmeda never once felt any anger towards God. Her consciousness of God and His impact on her life is therefore heightened as a result of her HIV status. For a while, God is the only one she can confide in about her HIV status. Even when she eventually tells her parents about the fact that she is HIV positive she consults with God before doing so:

God is Great and Merciful indeed. I've finally managed to build up the courage to tell my parents earlier tonight. Of course I first performed a prayer, asking The Almighty to give me the strength and courage and also that my parents should be helpful and understanding. However, I turned back three times as the tears just would not stop, but managed to get it right the fourth time.

Faghmeda's parents reinforce the centrality of God in their response to her. According to Faghmeda her parents told her that she should accept her HIV status since it comes from God and that He, 'has better plans for us, testing us all the time...'

For Faghmeda and her family God is an interventionist God who is both responsible for bringing happiness and sadness in their lives. The fact that Faghmeda has contracted HIV is attributed to God's will and His 'plans for us.' It is also seen as a 'test' of faith which can only be passed if one's faith remains strong. God is therefore used as a means of rationalising and making sense of the unknown that comes with being HIV positive. More than this, God is ultimately seen as the source of the virus which has been given to Faghmeda for a specific reason. While this reason is not particularly clear, the family hopes that it will unfold over time.

Ultimately Faghmeda ascribes her strength to her faith, the support of her family and her own resilience. She believes that her continued existence lies completely in God's hands. During our interview she stated '...at times I do feel like that, that I can just die and get it over with. But, then again I know that it's not Allah's wish yet. So I just need to make *sabar* (strive for patience)...'

Sumaya described similar feelings to Faghmeda with respect to death and dying. She stated that, 'Sometimes I feel very depressed and that's why I want to take

my own life. And then I think about my children... Allah doesn't want it like that... that I must take my own life. I must manage my life.' Both women indicated that there were times when they felt like dying. However, they both believed that God did not want them to die just yet. However, this is where the similarity between Faghmeda and Sumaya ends. While Faghmeda described herself as religious, at the time of our interview (Observatory, 2 May 2003) Sumaya had recently converted to Islam from Christianity and knew very little about her new faith.

Sumaya's decision to convert appears to be influenced primarily by the fact that her eldest son decided to convert for reasons that are not particularly clear. From her statements, it seems as if her son had been influenced by Muslims who were living with her at the time her husband passed away. She does however mention that she wanted to convert to Islam at one stage during her marriage but that her husband's abusive behaviour caused her to hold onto her Christian identity. She indicated that, 'I said to him you're Muslim but you need to have respect for me before I accept the *deen*.' For Sumaya, converting to Islam or becoming Muslim is associated much more with developing a new identity than subscribing to a new religious ideology. She stated after deciding to convert to Islam for example, 'so we decided we wanted to live that kind of life.'

Sumaya's understanding and appreciation of her new religious identity can be sharply contrasted with Gadija's religiosity. Like Faghmeda, Gadija considered herself to be 'very religious.' Both women manifested physical signs of their

religious beliefs by wearing head scarves for example. Gadija even wore a loose-fitting Arab garment and avoided eye contact as well as physical contact, such as shaking hands, with men. She ascribes her religiosity to her strict upbringing: 'The house we grew up in was strict. In our family, from seven years they start to teach you. If you don't pray and fast they won't give you food.'

She went on to describe her level of religiosity by indicating that she did not like to greet men by shaking their hands and that she prayed more than the obligatory five times a day. She stated that:

I have a strong relationship with God because if you do the things Allah loves, Allah will help you even more. When you get some problem you don't have to ask why does Allah punish me like this, because there are many innocent people who get heart attacks or cancer or something like that. Because even if you get something good, you don't have to only say *shukran* (thank you) to Allah (then). You must also say when you see something bad from Allah, you must (say) *Alhamdulillah* (glory be to Allah) because good and bad comes from Allah.

Gadija's relationship with God appears to operate at both an internal and external level. Externally, she dresses in traditional Arab clothing and maintains a physical distance between herself and men. At a theoretical level these practices are meant to be adhered to by all Muslims. The underlying norms and values of these practices which calls for (1) women and men to dress modestly and (2) for the separation of the sexes, is to prevent men and women from engaging in

sexual activity outside marriage. In the Western Cape today, there are relatively few women and men who would adhere to this practice in the strict way in which it is articulated in religious texts. For example, at an extravagant wedding of a man from the United Arab Emirates and a local Cape Town woman at the International Convention Centre in Cape Town (August 2003), the man's family insisted that the male and female guests be separated. The women's family from the Cape agreed to this condition. However, at the wedding an argument erupted when a group of Cape men wanted to sit in the women's section due to a lack of space in the male section of the hall. All the Cape men and women I spoke to who attended the wedding were upset that the group of men could not sit with their family in the female section. The problem was that the overwhelming majority of Cape Muslim weddings allowed for men and women to sit together. While I would argue that this was certainly not the case twenty years ago, the separation of sexes rule - at wedding ceremonies at least - had been eroded allowing for men and women to sit at the same tables. I would argue that the separation of sexes rule has been eroded to such an extent that the traditional norms and values of Muslims in the Cape in relation to this rule has become somewhat alien to them. In other words, if Cape Muslims arrived at a wedding ceremony where men and women had to sit separately, they would probably find this practice to be strange and alien to their accepted norms and values.

Gadija's adherence to the separation of sexes rule is therefore in all likelihood, a result of her conservative Islamic upbringing in Somalia since none of the other women I interviewed expressed similar beliefs or values. Besides this external manifestation of her religious beliefs, her relationship with God also manifests at an internal or spiritual level. She indicated that she prayed more than the obligatory five times per day because 'if you're not praying, there is no more relationship with God.' Gadija's 'strong relationship with God' as she describes it, is in some ways connected to her HIV status. She believed that if she followed God's commands, He would help her deal with the challenges she faced as a woman living with HIV/Aids. Gadija's belief that 'good and bad' comes from God prompted me to ask her whether she believed, as some Muslims do, that Aids is a curse from God. She responded as follows:

You mustn't believe those who say it's punishment from Allah. What about these other diseases? These people with cancer die before people who are HIV positive. It's more (about) forgiveness. It's not punishment because I know I'm innocent and can say, I can even swear *wallahi* (on Allah's name).

When the man sleeps with many women I don't know what to say. But, I can say, when the man sleeps with lots of women... sometimes when you see the innocent people having HIV and the people who are doing something wrong they are HIV positive... I don't know what to say for that. I have no answer at the moment. But for me I think it's not good to see (Aids) as a punishment from God.

While Gadija indicated that she believed Aids was not a punishment from God and adopted somewhat of a non-judgmental attitude, she later talks about a friend of hers who died of Aids related illnesses in a fairly critical manner:

In 2002 I was really dying and I was just preparing myself (to die) because my CD-4 count was low. I lost my friend, she's got two children. When she started the medication she was not even praying or doing anything. I think she was Christian. The medication couldn't help her but for me they say your virus is going down...

God knows, she was my friend and she used to tell me she was Muslim but I don't know. She became a Christian later on. She changed. And when she changed, she started to have a boyfriend and children outside marriage. She was not praying. She used to go to the church and then she was not praying. And God, He did get angry with her. She prayed to someone else like a God and God maybe get angry with her because if God get angry with you, medicine cannot help you.

Gadija compared herself to a friend who was HIV positive and who used the same medication as she did but who subsequently died. While Gadija does not directly attribute her improved health to her Islamic beliefs and faith in God, she does indicate that because her friend became Christian, God was 'angry with her' causing her to die despite the fact that she was using the same medication. Gadija therefore distinguishes herself from her friend by emphasising her friend's lack of faith in a Muslim God and her friend's decision to have a boyfriend and

have children out of wedlock. Even though Gadija indicated earlier on in our interview that she did not believe Aids was a curse from God, she contradicts herself by insinuating that her friend was not saved by God because of the lifestyle she led. Furthermore, the medication that both Gadija and her friend used appeared to only help Gadija. Besides insinuating that her friend died because she led an existence which was contrary to the norms and values associated with being Muslim, Gadija also displays a hint of religious arrogance by assuming that no other religious beliefs are valid other than her own understanding of Islam.

While Gadija, followed by Faghmeda, expressed a strong belief in Islamic norms and values, for the other three informants, religion played a less central role in their lives. They admit to not praying all the time or failing to conform to the traditional dress code associated with being a Muslim woman. Najma, for example states that, '... I don't follow everything, but I am conscious you know. I must say my *dua's* (short prayer). And I love my religion.'

When I asked Najma whether she felt any anger towards God since she discovered she was HIV positive, she stated that she was not angry with God but more 'disappointed' in herself. She indicated that. 'I don't make my *salaah* (prayers) but I would always say *alhamdulillah* (glory be to Allah) and *shukurallah* (thanks be to Allah) things like that also helps me.'

Najma's disappointment in herself stems primarily from her belief that she has violated the norms and values relating to sexual behaviour for Muslims. Her inability or unwillingness to follow these norms is what led Najma, in her mind, to become HIV positive:

To follow the *sunnah* (Prophetic precedent) and the Qur'an I think it will save me from this world. So even if you follow it or if you get infected it will be easier for you. I would say if I followed (the Qur'an and sunnah) before my status it would have made things easier. But now, following it now would also make my life easy like after death.

While Najma does not attribute her HIV status to God's will, she does believe that if she had followed her religious beliefs more closely, 'it would have made things easier.' This statement prompted me to ask her whether she believed Aids was a curse from God:

Where it comes in about Aids is a curse, I would say it's almost like a *balah* (curse). I would say I didn't listen to my parents and I would say that if Allah didn't want it. If Allah could have stopped this, then it would have stopped. So if I would have listened to them it would have been different.

Najma believes that Aids is a *balah*, an Arabic word that literally means a 'trial' or a 'test' but which is used synonymously with the word 'curse' by Cape Muslims. This *balah* is seen by Najma as resulting from a failure to listen to her parents.

She therefore draws a connection between (1) God's power to decide who gets infected or not (2) the failure to listen to her parents, and (3) the belief that Aids is a *balah* or curse. While Najma steers away from the belief that Aids is a curse from God, she believes that her failure to follow her parents' advice resulted in her receiving a *balah* in the form of Aids. It appears as if this *balah* stems from her parents. At the same time she stated that, 'If Allah could have stopped this, then it would have stopped.'

Najma's confusion with respect to the relationship between Aids and God is a result of the general inability of Muslims to understand and deal with the intricacies of religion and Aids. However, I believe that as a member of the Positive Muslims support group, Najma's inclination towards the belief that Aids is a curse should have been dealt with by Positive Muslims. It should have been made clear to Najma that Aids is not a curse. Positive Muslims must therefore take responsibility for not adequately dealing with this misconception amongst its support group members.

Bilquees on the other hand was very clear in her understanding of the relationship between Aids and God. She stated that:

I think this disease comes from Allah and Allah will not give somebody an illness that will be a burden to them. And I don't think it's a burden. It's only that some people are actually ignorant about Aids. Because I'm sitting with the virus and I'm surviving. So can the others also. But I don't think it's a curse or anything

wrong, it's an illness that comes from God and I accepted it and I'm living normally. It's just a virus that's in your blood. That's what I believe.

It should be noted however, that the understanding about Aids and God that Bilquees held at the time of our interview, was not always clear. She stated that when she was first informed about her HIV status, her understanding of HIV/Aids was limited. After the nurse informed Bilquees that she was positive, she asked the nurse: 'What's that? We Muslims don't get Aids or don't get infected.'

When talking about her relationship with God, I often got the impression that Bilquees was exaggerating her level of religiosity thinking that this was what I as the interviewer wanted to hear. She indicated for example that: '(God) is the only friend I've got while my husband is not there and my kids are away or they are sleeping. Allah *hoe ta'allah* (Allah the Almighty) is there and He guides me and that's why I'm still surviving with the *koederat* (mercy) of Allah.'

Since I had never known Bilquees to be religious, I was surprised by her comments. She went on to say that God played a 'big role' in her life and that He was the first person she would think of when she woke up. Furthermore, she indicated that:

I have always felt this way about Allah because I grew up... I would say that I grew up in a mosque... that's the way I will say it. And although I don't wear a scarf or... (because I wear) a pants or jeans that doesn't say that I'm not doing

my deeds. I'm not showing people because only me and the man above knows what is going on inside of me.

When Bilquees stated that she 'grew up in a mosque' implying that her house was a very religious one, it became blatantly obvious that she was exaggerating her level of religiosity. Earlier on she indicated that her mother raised her alone after her father abandoned them and was never really around to look after her. Having also met Bilquees' mother and having spoken to her personally, I found it difficult to believe that Bilquees grew up in an orthodox Muslim home. I was therefore forced to conclude that her comments about her relationship with God were in all likelihood not an expression of her true convictions and that she was merely telling me what she thought I wanted to hear.

Bilquees also referred to her husband's religiosity saying that, 'He grew up in an Islamic house... very strict and they were punished to do *salaah* (prayer) and they were punished to go to Muslim school.' I was unable to verify whether this was true or not due to the fact that her husband had been imprisoned for the possession of cannabis.

Despite the fact that three of the informants were not particularly religious, there was no doubt that religion played a strong role in shaping their identities. Arabic religious terms were often used throughout their conversations with me. Even Sumaya, who had only converted to Islam three months before our interview, used religious terms such as 'deen' and 'wakeel,' Arabic words for 'faith' and

'guardian' respectively. She also had religious ornaments such as *rakams*³ in her home. The *rakams* usually serve three purposes: firstly, to show visitors that they are entering a Muslim home, secondly, to bless and protect the home, and thirdly, it is used for decorative purposes. At some levels therefore, Sumaya's husband identified himself as a Muslim even though he consumed alcohol and drugs and never prayed. Sumaya also mentioned that she would have converted to Islam a long time ago if her husband, who she saw as Muslim, treated her well. It should also be noted that her husband was buried according to Muslim rituals.

As a result, for three of the informants, Islam was seen primarily as a means of determining their individual and group identities. While this was true for Faghmeda and Gadija as well, they also related to Islam as a religious tradition that needed to be strictly adhered to. However, it should be noted that despite the informants' religious convictions and the centrality of God in rationalising their HIV status, there was little evidence to suggest that the stronger their religious conviction the better they were able to cope with their HIV status. Gadija for example, who was arguably the most religious informant, was having the greatest difficulty in coping with her situation. Najma, on the other hand, was far less religious, but appeared to cope well with her HIV status.

³ *Rakams* are verses of the Qur'an that are usually painted onto a canvass. The canvass is then framed and hung onto walls inside one's home for decorative purposes.

Furthermore, their religious beliefs were still not as central to the informants' identities as their poverty or the violence they experienced in their lives. In fact, in certain cases, I would argue that their religious beliefs had little if any impact or influence in shaping their identities when compared to their socio-economic conditions living on the Cape Flats.

4.3.7 Sexual Violence

In a statement delivered by Bertil Lindblad (2003), Deputy Director of UNAIDS at the Forty-Seventh Session of the Commission on the Status of Women, she indicated that:

The varied forms of violence against women, and the economic dependence which makes violent situations harder to escape from, fuel the spread of HIV. Between 10 and 50 per cent of women worldwide report physical abuse by their partners. The fear of intimidation prevents the risk of contracting HIV from being discussed and worse, results in HIV infection. In a number of countries, HIV-positive women were found to be 10 times more likely to have experienced male violence than those that are HIV-negative.

Two of the informants related incidences of sexual violence prior to becoming infected with HIV. Najma started being physically abused by her husband a few years after they were married. She said that, 'What happened was, he was

violent when I decided I didn't want to be with him. That was the time he always used to be so violent. And there were times when he hit me.'

Sumaya also related a number of sexually violent experiences in her life including being forced to engage in sexual activity with her husband and being raped at the age of fifteen. In addition to these incidents, she stated that:

...he cuts my hair short or he beats me in the road and then when the *jongens* (guys who stand on the street corners) want to interfere and the *jongens* say you can't do that to her and then he says I slept with the *jongens*. Then the *jongens* say, no man, this wife of yours works you mustn't do this to her. He beats me and gives me a blue eye and then I can't go and work... holes in my head... all these knocks on my head are because of the way he beat me.

Furthermore, Sumaya believes that her husband knew that he was HIV positive and purposefully infected her with HIV. During our interview she said that: 'he always said to me that he would leave me with something but I had no idea what he meant by it. I had no idea what he meant by that...'

Sexual violence therefore plays a significant role in making women vulnerable to HIV infection and can in some instances, such as Sumaya's, be the very cause of HIV infection. Since sexual violence is cited in 12.28% of cases (56 out of 456 cases) in which Muslim women applied for divorce (Toefy 2002), there is a high probability that many of these women may be HIV positive.

I asked Sumaya how she dealt with the many incidences of sexual violence she faced in her life. Her response was completely unexpected:

I'm going to be honest with you (starts crying). Sometimes if I have a Rand on me, then I say they should buy me a slow-boat (cannabis). Then someone makes me a slow-boat, then I smoke and then... it's almost as if it makes my mind a little at ease. Then they say I mustn't do that. So I say to them they don't understand me, they don't know how I feel. And I also smoked mandrax, smoked buttons (mandrax) (cries), yes, but that's before my husband died, it's when my husband abused me. And then he beats me and then I walk away from the house and I smoke myself drunk. And then I think when I get back then you can do what you want... I'm in another vibe man. And I feel strong and I'm not scared of you. That's why I say he drove me to these things... things that I didn't want to do with my life.

Besides the fact that sexual violence was the root cause of Sumaya's HIV infection, it also had other serious consequences. The constant violence she faced led her to drug abuse in order to escape the inevitable beatings and rapes she had to endure. There was also an economic element to the abuse which became evident as Sumaya recalled what happened to her:

He would give me money, and then... he works and then he gives me money, and he just walks out then he comes back and then he wants exactly the same amount of money. I can't tell him that I bought a bread or I bought that, I can buy

nothing with his money. I must keep his money just like that until he gets back and then I must give him his money back.

The extent of control Sumaya's husband exerted over her therefore included, sexual, physical, social and economic control. While Sumaya acknowledges that she had been physically abused, she fails to understand that when her husband forced her to have sex with him that this amounted to sexual abuse as well. She states that, 'My husband drank a lot and abused me a lot... not sexual abuse but physical abuse.'

As a result, Sumaya is unaware that the sexual violence she experienced was wrong both morally and legally. Instead, she believed that when her husband forced her to have sex that this did not amount to any form of abuse. There is nothing to suggest that Sumaya's husband acted from any religious basis or that she accepted his sexual 'rights' over her because this was his right as a Muslim man. However, strangely enough, Sumaya believed that there was a link between her husband's violent behaviour and Islam. She believed that a *doekoem* or bad spell had been placed on her and her husband by his religious Muslim sister:

I never believed in Muslims who put things behind *rakams*. So one day he and I cleaned the place and we found silver papers behind the *rakam*. And it wasn't written with Muslim writing. So I said to him, 'whether you want to beat me or you don't want to beat me but I'm just going to tell you how I feel.' So I said to

him, 'you know it looks like your sister planted something here by us in this house. This must be why we fight with each other. You must fight with me and I must run away with you. We don't understand each other and then this week we understand each other very well and then you give me your wages. And then suddenly it just happens again... we fight again and you beat me.'

So I said to her (Sumaya's sister-in-law) you came to cast a *doekoem* (bad spell) here. So she said to me, 'Allah is my *doekoem*.' So I said, 'Allah is your *doekoem* but you cast a *doekoem* on the other side of Allah and Allah will get you.' I believe that it's these silver papers that made me and my husband fight so much. His sister didn't like me.

He used to beat me and then later I would go to him again. But I don't know what played a role there. And I mean he sent me to the hospital. I spent three weeks in hospital and he never came to see me once. And when I got out of hospital, so my social worker said to me I should not go back to mummy, I should go back to my house to see how he reacts towards me. And I mean, this thing (her husband) was not even shocked. I sit there and then he throws the wine into my face and I do nothing to him. So I thought, is it the devil that's working on you or must you just be like this with me?

Sumaya believed that her husband's violent behaviour resulted from a *doekoem* or evil curse that was placed on him by his sister. According to Sumaya, her sister-in-law disliked both her and her husband due to some dispute over property and therefore planted pieces of silver paper with white powder and

unidentifiable writing behind the *rakams* and on top of the door. These pieces of silver paper were what caused Sumaya's husband to treat her in the violent manner that she described above. Sumaya mentioned furthermore, that her sister-in-law is a 'child of Allah' and a religious Muslim who prays everyday.

One can therefore conclude that in Sumaya's mind, her religious Muslim sister-in-law is the cause of her husband's behaviour which ultimately led to her becoming infected with HIV. Sumaya's denial of her husband's culpability and the form of abuse he subjected her to appeared to extend well beyond his death.

In developing a Muslim Aids prevention strategy, every effort must therefore be made to ensure that awareness and education programmes deal with issues of sexual violence. This will help to ensure that women are more empowered to deal with sexually violent experiences which will inevitably assist in reducing the vulnerability of women to HIV infection.

4.3.8 Support Services

As was stated above, all the informants belonged to the Positive Muslims support group. While three informants indicated a general satisfaction with the services they received, two informants were particularly unhappy with the extent to which assistance was offered. Bilquees and Gadija praised Positive Muslims for

assisting them in the past but complained bitterly about the support group's capacity to deal with their current difficulties.

Bilquees desperately required money to cover all her living expenses including food, water, electricity and school fees for her children. Her situation had become even more desperate since her husband was imprisoned for possession of cannabis. Bilquees indicated that she was unable to find any work because she had no money for transport to search for jobs. She spoke about the way the level of support she received had changed since she initially became a member:

Positive Muslims helped me a lot with giving me advice and if there were problems, I could always pick up the phone and call Rehana or Faghmeda. But as the years go, we've met some new members... things have changed. Because, I don't know if it's because the support group gets bigger or what, but the support that I used to get isn't there anymore. If I'm hungry and I phone my psychologist Rehana and I talk to her and say to her, this is my problem, here's no food... I don't know what to do... my kids are crying here, we are hungry. What must I tell them? How can I explain to them that I don't have? Then she will say to me, Bilquees, I think we must make an appointment for over four days or over two weeks and then I'll see her. And I mean, that's wrong because she said to us in the beginning, we are here to help you people. If you need help just call us. Faghmeda is always the one that I can call or that I can talk to because she understands my situation. But Rehana, she's Indian, and she lives the opposite life that I'm living. I'm living in poor (conditions) and she's living in a warm house with food. She can go to a hot shower or hot bath. Here we must

live without electricity and for me it's quite heart sore because I thought that they are my family and my friends and my brothers and my sisters but they're not there to help me the way... not the way that I want to but the way that I need it.

Gadija, on the other hand, wanted Positive Muslims to assist her in ensuring that her supply of anti-retroviral medication was not taken away because she had moved outside the geographical boundaries of the drug trial area. She indicated that the doctors running the drug trial had convened a meeting and decided that she would not be eligible for free medication if she moved outside the drug trial area. In addition, Gadija wanted Positive Muslims to employ her for at least two days a week so that she would earn an income to pay for her rent and other living expenses:

I've been trying to ask for (help from) Positive Muslims but God help them now because nobody helps me. I don't like to speak behind them but I already speak to them in front of them. I told them, they wanted to stop my medication.⁴ It's the only time I need their (Positive Muslims) help. I can survive through other things but (there are) things which I cannot stay without such as the medication. I came to ask for assistance from Positive Muslims. It is the only time I need help. I know you already helped me a lot before.

⁴ Gadija is currently a recipient of an anti-retroviral drug programme in which she receives free HIV/Aids medication. One of the conditions of the programme is that Gadija reside in a specific area. Unfortunately, she has moved out of the designated area resulting in her ineligibility to participate in the anti-retroviral programme.

Both Bilquees and Gadija had legitimate problems which impacted severely on their physical health and mental well-being but which according to them, was not being adequately addressed by the support group. After Bilquees and Gadija raised these difficulties during our interviews, I asked that Rehana Kader intervene in her capacity as the support group co-ordinator. In a meeting convened by Positive Muslims to discuss the difficulties raised by the two informants (Observatory, 20 June 2003), it was revealed that while official policy stipulated that support should be limited to serving the psychological needs of support group members, Kader had gone beyond these limitations because of the desperate situations members found themselves in. The Positive Muslims executive committee was well aware of Kader's efforts to secure food parcels from other organisations for example, and had endorsed and even encouraged expanding support services to include assisting support group members financially.

However, the situation had become untenable since more and more demands were being placed on the organisation to provide support in areas that had not been budgeted or planned for. Resources were therefore stretched to capacity and the increasing demands of certain support group members could not be met. Discussions were therefore held with support group members (Observatory, 22 June 2003) to look at ways of addressing the challenges that they were facing while at the same time explaining the limitations of the organisation in providing support. At this meeting it was discovered that Gadija's problems relating to

medication had in fact been dealt with by Kader and that anti-retroviral drugs had been secured after Kader visited the doctors who were running the drug trial. Bilquees on the other hand, continued to attack Kader's capacity to run the support group during our meeting (Observatory, 22 June 2003). When all the other support group members defended Kader and started accusing Bilquees of not doing enough to solve her own problems, she lashed out at them and stormed out of the meeting.

While no immediate solutions were proposed at that initial meeting, it became clear that the problem was not so much with Kader and her capacity to run the support group, but with certain individual members themselves. Certain members of the support group had become highly dependent on Positive Muslims and began to make demands which could simply not be met. At the same time Positive Muslims had contributed to the dependency of members on the organisation by giving in to demands which were outside the scope of the organisation's mandate. While discussions with support group members will continue, we foresee having to take tough decisions with respect to the level of support that can be provided to members in the future. Furthermore, processes have been put in place to restructure the support group to prevent incidents such as these from occurring in the future.

On the other hand, there were many positive comments made about the level of support received from Positive Muslims by other informants such as Najma. She indicated that:

For me it was nice to know that there are people that are compassionate about my status and they understand Aids. It was like I met new friends irrespective of my status, irrespective if they know. I'm happy to be with them even though I don't see them everyday, I know there are people out there. It makes a difference. For me it's like if I have to lose all the people outside or in front of me, I know there will be other people there for me.

Najma's comments about the support group reflected the majority of the respondents' views. The primary difference between Najma on the one hand, and Bilquees and Gadija on the other, was the fact that Bilquees and Gadija had been members of the support group shortly after it was initiated while Najma joined the group a few months later. As a result I suspect that because we were very new at running a support group, and because we were looking after the interests of two or three people only, we had much more time and energy to dedicate to the needs of our small support group. When the group expanded, our capacity to offer the same level of support that we offered initially was diminished. Bilquees and Gadija may therefore feel as if we are no longer paying the same amount of attention to their needs as we did before. This is of course correct since we simply do not have the capacity to offer them the same level of

support as before. As a result, this issue will have to be discussed with the aggrieved support group members and resolved as quickly as possible.

4.3.9 Fulfilling Dreams

When I first met Faghmeda in 1999 she indicated that she had three wishes: one was to start a support group for Muslims, the second was to go on pilgrimage (hajj) and the third was to publish her manuscript. While her first two wishes have been fulfilled, the manuscript is currently being looked at by potential publishers. During our interview, Faghmeda indicated that she also wanted to establish a hospice for Muslims since she had come across a number of HIV positive Muslims who had been rejected by their families and had nowhere to go. I asked Faghmeda whether she was happy that she had accomplished so much in a relatively short space of time. She indicated that she was very unhappy and that she felt as if there was 'something missing' in her life. She also expressed feelings of guilt for not being able to help all those who were HIV positive and had been rejected by their families.

After a long conversation with Faghmeda she eventually told me why she was really depressed but asked that this also be excluded from my thesis. By the end of our second interview I came to realise that Faghmeda had still not fully come to terms with her HIV status since she was first diagnosed in January 1995. More specifically, I'm not sure that she was ready to publicly disclose her status

on a Cape Muslim radio station in November 1996. After the radio interview was completed, Faghmeda described how she felt in one of her diary entries:

I somehow expected my family to call, but I guess I was expecting too much. Nevertheless, one would think that I now should feel on top of the world, instead I now feel lonelier than ever! I'm sitting all alone in my room, writing in my diary and crying my heart out, wishing suddenly I could have someone to tell me that life would soon be okay and that they all love me. Well I do not know what I've really expected, but surely not the feeling of loneliness.

As a result, Faghmeda continues to grapple with the challenge of managing her HIV status at a personal level on the one hand, and portraying an image of control and courage at a public level, on the other. The difficulty is that there is no clear line between her public and her private lives in that the one impacts on the other. Any decision that Faghmeda therefore takes regarding her HIV status, is in her mind, intimately connected to how the public will respond to her decision. More importantly, Faghmeda is concerned about how God will respond to her decision. The centrality of God in her decision making processes is clearly reflected in her private discussions with me as well as in her manuscript.

While Faghmeda continues to remain optimistic about her future and committed to her faith, she remains empty and unfulfilled. Her attempt to fill this emptiness through her work with HIV positive Muslims has helped to some extent. Her faith and the support of certain family and friends have also assisted her in this

regard. However, it seems that the emptiness will continue since nothing can ever replace her 'childhood dream.'

Najma on the other hand appeared to be dealing with her HIV status relatively well. At the end of our interview I asked Najma whether she had anything that she wanted to add to our conversation. She indicated that 'I wish that so many people could attend workshops and know about the virus so that people can understand what the virus is about.' For Najma, I believe that it was important for people to 'understand what the virus is about' so that they were better able to understand her. While she believed that Muslims would be more accepting of her if they knew more about HIV/Aids, she also acknowledged that she would be treated differently to someone like Faghmeda Miller because of the way in which she contracted the virus. Since Faghmeda contracted HIV/Aids from her husband, Muslims were more accepting of her. Najma, on the other hand, contracted HIV/Aids from her boyfriend through casual sex, and therefore believed that Muslims would not be as accepting of her. It therefore appears as if Najma's challenge is not so much that she has to live with HIV/Aids, but that she has to live with the fact that she became HIV positive through sex outside marriage. In addition, Najma lives with her secret in silence and indicated that she would probably not tell any of her friends or family about her HIV status.

For Sumaya the future seemed rather bleak. She believed that all she had to live for were her children:

If I think back then I think, I'm now forty. See where my life ends. There could have been a future for me, but I don't even look forward to a future. What must I do with a future? I just want to live for me and my children. And if I live nicely for me and my children then...

I found Sumaya to be an open and honest informant who was willing to reveal all aspects of her life, including the fact that she used drugs as a means of coping with the trauma she experienced throughout her marriage. In the concluding moments of our interview, I asked her if she wanted to add anything to what she had already said. She stated that she was proud of the fact that she worked and could therefore be independent. It appeared that despite the adversity Sumaya faced, she believed that something better would eventually come from her experiences. The issue that troubled her the most was not her HIV status, but the way her husband treated her. His unrelenting violence and abuse left deep scars on Sumaya at both a physical and psychological level.

As the youngest of all my informants, Bilquees, who is now twenty five, believed that her life would improve despite the fact that she is HIV positive, has two small children to look after, a husband in prison, endless financial problems and a step father who torments her. The only dream that she holds on to is that her husband will be released from prison and take her away from where she currently lives to provide her with the life that she has always wanted. Bilquees stated that, 'for me my mind is on... to take a big step and to get myself out of

there and to live the life that I want to live and to look to the future and never look back. For me, my dream is now to get my own house...'

In terms of where she sees herself in five years, Bilquees also appeared to be the most optimistic of all the informants. She believed that, 'in five years I see myself in my own office. Mainly to become a social worker because that's what I want to start to do is to go to schools and give talks and tell them that I am available at all times. A good job for me for the future will brighten my future.'

While her plans for turning her life around were admirable, it appeared as if Bilquees had not taken any steps to ensure that these plans or dreams would be fulfilled. She was relying solely and completely on her husband to rescue her from her current existence. Until he is released from prison, Bilquees hopes to rely heavily on Positive Muslims to provide her with financial support. While it had been communicated to Bilquees that Positive Muslims would only be able to offer psychological support as well as assistance in the form of empowering its support group members with various skills, Bilquees was adamant that Positive Muslims needed to provide her with financial support as well.

Bilquees ended our interview with the following words: 'I would say to all women out there, in South Africa, be aware and don't go after sweet talks because sweet talks can give you HIV and try to be protective at all times... at all times take

condoms with you. You must accept what God gives you because I accept it and I know which way I'm going to go when I die.'

While Bilquees was optimistic about her future, Gadija continued to be plagued with difficulties. One of the challenges she faced everyday was trying to deal with the death of her six year old son who died of Aids:

My child became sick. When he fell sick I really wanted to kill myself but this was not good because I'm Muslim. But *Alhamdulillah* (glory be to Allah) then I contacted Positive Muslims. They did a lot because if you don't have place to sleep and you have a sick child then nobody wants to help you. It was really a difficult time and I want to thank Positive Muslims.

As she continued to deal with the struggle of coping with her son's death, at the same time Gadija had her own daily struggles she faced. She reflected on some of these struggles and spoke about how her HIV status impacted on the way she lived her life. Gadija concluded our final interview with a message to people living with HIV/Aids: 'Surely I wanted to say something about the people living with HIV. The people living with HIV always think bad (thoughts) and they're always thinking they are going to die. They mustn't think about that because even if you're not HIV (positive) you are going to die.'

4.4 Conclusion

One of the constant themes that flowed throughout my discussions with the five informants was how little their HIV status actually impacted on them directly. Sumaya, for example, was more concerned about the abuse she suffered, while Bilquees was struggling to feed herself and her children. Gadija's concerns related to finding a job in order to survive. Many of these problems existed before these women became HIV positive and were in some instances exacerbated by their HIV status. As a result their hopes and dreams for the future have been shaped by their past experiences but have also been severely limited by their HIV status.

While it may be tempting to apply the lessons learnt from the life histories of the five informants to all Muslim women living with HIV/Aids in Cape Town, it must be noted that these women cannot be seen as representative of the entire Cape Town Muslim population. Conclusions drawn from the experiences of these five informants must therefore be seen within the limitations of this study.

Despite the limitations of this paper however, some of the common themes that have been drawn from the life histories provide us with important insights into the daily struggles of women living with HIV/Aids. A woman's socio-economic status is an important factor in determining her vulnerability to HIV infection as well as her ability to function effectively once infected with HIV/Aids. Poorer women are

more likely to be coerced into engaging in sexual practices that put them at risk of contracting HIV. Furthermore, once infected, women from lower socio-economic classes have greater difficulty in coping with HIV/Aids.

Sexual violence however cuts across all classes making women from both lower and middle income groups vulnerable to HIV infection. Amongst the informants, incidences of sexual violence took place primarily during marriage. In one situation, sexual violence was the primary factor in causing HIV infection. Therefore concluding that sex is the primary mode of transmission of HIV is an over simplification of a complex issue. Not all women who engage in sexual activity and become infected with HIV/Aids do so consensually. It is suggested that in at least two out of the four cases of HIV infection involving sexual intercourse amongst informants, women were forced or coerced into having sex against their will.

Islam played an important role in shaping the individual and social identities of informants. However, the religious beliefs of informants and their relationship with God appeared to have a limited impact in assisting them to cope effectively with HIV/Aids. Gadija, for example, who was arguably the staunchest Muslim amongst the informants, was also the most traumatised by her HIV infection. Najma, who was not as religious as Gadija, appeared to cope well with her status.

It has become evident that factors such as the informant's socio-economic background and history of sexual violence were important in determining their vulnerability to HIV infection and their ability to subsequently cope with their HIV status once infected. These factors were also the primary factors that shaped the identities of these women more so than their religious beliefs or HIV status.

While the informant's religious beliefs did not appear to have a direct or substantial impact on their vulnerability to HIV infection and their ability to cope with their HIV status, its influence in the lives of informants remains significant. As a result, it may be important to examine the religious beliefs of informants in relation to the factors that have directly impacted on their vulnerability to HIV/Aids namely, socio-economic background and sexual violence. This issue will be examined in greater detail in the next chapter.

Chapter Five

Practices that Impact on Women's Vulnerability to HIV/Aids

Men are the protectors and maintainers of women, because God has preferred some of them over others, and because they support them from their means. Therefore the righteous women are devoutly obedient and guard in their husbands' absence what God would have them guard. As to those women on whose part you fear ill-conduct admonish them, refuse to share their beds and beat them but if they return again to obedience seek not means against them for God is the most high, Great above you.

(The Qur'an, 4:34)

5.1 Introduction

Muslims believe that the Qur'an is the word of God and the central text in the Islamic tradition. They experience the Qur'an as 'God's living presence (Stowasser 1998: 32).' According to Esack (2001: 195), Muslims argue that 'It (the Qur'an) is God speaking, not merely to Muhammad in seventh-century Arabia, but for all eternity and to all humanity.' The words of the Qur'an can therefore not be ascribed to anyone but God Himself. Therefore, whenever a Qur'anic verse is cited which suggests that women be beaten if they disobey their husbands, Muslims generally associate this position with God's will and as a result, may feel obligated to follow this position.

Hadith, on the other hand is presented as being 'distinct from the Qur'an' and incorporates 'the Prophet's own deeds, speech, and silence in the presence of others while they were doing something (indicating approval)... (Esack 2002: 111-112).' During the classical period of Islam, the *hadith* became the sole bases for determining the *sunnah* or socio-religious precedent. Today however, the *sunnah* has been elevated to the level of a source of religio-legal authority (Esack 2002: 113).

As a result, we find that religious leaders use the words of the Prophet in addition to Qur'anic verses to establish laws and social practices. Sheikh Abdurraghiem Sallie (1993: 17), a prominent religious leader in Cape Town and the author of twenty eight books on Islam, quotes the following saying attributed to the Prophet to justify his belief that women are obligated to engage in sexual relations with their husband:

When a man calls his wife to bed and she refuses to go, causing him to go and sleep while he (the husband) is angry with her, then the angels curse her (throughout the night) until he awakes the following morning.

The Qur'an and *sunnah* have therefore been used to justify practices that perpetuate gender inequality such as beating women when they are disobedient and forcing them to engage in sexual activity with their husbands. While these practices are always qualified by certain conditions, they nevertheless continue to exist and are accepted as God's will or attributed to the words or actions of the

Prophet. However, it should be noted that when jurists or Islamic scholars argue a specific position based on the Qur'an or *sunnah*, it continues to remain *their* interpretation of the Qur'an and *sunnah* since as Ali (2003: 167) points out, there is a recognition on the part of jurists of their inability 'to fully comprehend and implement God's revealed law.' At the same time, Muslims do not always follow the norms, values or practices contained in the Qur'an and *sunnah* as is evident from the interviews with the five informants. As a result, when religious leaders invoke texts to assert a practice which perpetuates gender inequality, Muslims will not necessarily feel obligated to follow this practice.

This chapter will therefore focus on religious texts that impact on gender equality recognizing that practices advocated in the text are not always followed by Muslims or selectively followed in certain instances. More specifically, the relationship between women's vulnerability to HIV infection and religious texts that impact on gender equality is discussed. The approach of local religious leaders in Cape Town towards issues such as polygynous marriages and Islamic laws affecting women's economic independence are critically analysed. Links are then drawn between these approaches, and the impact it has on women's vulnerability to HIV infection. This discussion takes place in the context of the literature on gender, rights and HIV/Aids.

5.2 Relationship between Religious Practices and Women's Vulnerability

Four specific practices which find their basis in religious texts and which are practised in varying degrees amongst Muslims in Cape Town will be examined. Some of these practices are expressly sanctioned by local religious leaders in Cape Town while others are tacitly approved.

It is important to note though that even if a practice contained in the Qur'an or *sunnah* is sanctioned and reinforced by religious leaders, the distinct possibility remains that Muslims may not follow this practice. Polygynous marriages are a case in point. While the Qur'an and *sunnah* expressly provide men with the right to marry up to four women if they fulfil certain criteria, and religious leaders generally support a man's right to do so, most Muslim men prefer to have a monogamous marriage based on my observations. As a result, not all the practices discussed below are necessarily followed by all Muslims or even a large percentage of Muslims. However, the practices continue to remain a part of the norms and values articulated in religious texts as interpreted by many, if not most, religious leaders in Cape Town.

It is submitted that these practices, as articulated in religious texts and interpreted by religious leaders, perpetuate gender inequality thereby potentially contributing to the spread of HIV/Aids amongst Muslim women. These practices are discussed below:

5.2.1 A Woman's Obligation to Sexually Satisfy her Husband

In his book on divorce, Capetonian Sheikh Abdurraghiem Sallie (1993: 16) argues that a wife has to obey her husband's request for sex at any time, except when:

- (1) the husband refuses to support her;
- (2) the husband is guilty of an extra-marital relationship;
- (3) the wife is menstruating;
- (4) a doctor has advised the wife not to engage in sexual activity for medical reasons;
- (5) the husband and wife are both performing pilgrimage.

If the wife refuses to engage in sexual intercourse with her husband and the above exceptions do not apply, then Sallie (1988: 145) argues that the husband is not under any obligation to provide financial support to his wife as long as she refuses to have sex with him. This 'right' given to a man over his wife is rooted in prophetic precedent and does not extend to the woman and her sexual needs. In fact, Sallie (1988: 86) argues that:

N.B. If a particular wife has need for sexual relations more than what the husband is able to provide her in order to keep her chaste, then it is necessary for the husband to divorce the wife. If he is unable to cover her sexually less she

should go and seek her requirements from somewhere else which is Haraam (forbidden).

Sallie's opinion is echoed by Siddiqi (1993: 45) who argues that a man may stipulate in his marriage contract that his wife 'shall not refuse sexual intercourse with him and shall not use his property and possessions except by his permission.' Furthermore, according to Fatima Umar Naseef (1999: 202), a female scholar whose book on women in Islam is published by the International Islamic Committee for Woman and Child in Cairo, a wife is required to satisfy her husband's desire for sexual intercourse. According to Naseef, who also quotes the same prophetic saying as Sallie (1993), 'She has no right to abstain except for a reasonable cause or legal prohibition. Indeed, the tradition of the Prophet (S)⁵ has confirmed and emphasised this important duty through various narrations.'

Feminist scholar, Amina Wadud (2003) comments on this practice in the context of HIV/Aids:

According to *Shari'ah* (Islamic law) if a Muslim man desires intercourse with his wife, she must comply. If she does not, she is guilty of *nushuz*, recalcitrance. A wife who is *nashizah* is no longer eligible for *nafaqah*: maintenance or financial support. In addition, in various degrees of interpretation and application, the Qur'an asserts that the husband of such a woman may beat her. In the face of

⁵ The '(S)' denotes 'sallallah alayhi wassallam' or 'peace be upon him.'

this, the vast majority of Muslim wives, those with gentle husbands, husbands of polygyny: open or secret, husbands of violence and abuse, upright husbands of moral standing and husbands of Aids, open their legs to their men as they are not only expected, but commanded to do by that which is most popularly understood as 'Islam'. Women turn towards men who have contracted Aids and open their legs to their own death and destruction. It matters little if the men have contracted Aids by either legal and moral or illegal and immoral means. By legal and moral means, I refer to the husband who has contracted Aids by marrying younger more sexually virile women as confirmation of their masculine sexuality and then turn to the demure and compliant wife of longer standing.

Wadud's arguments which were presented at the Second International Muslim Religious Leaders Consultation on HIV/Aids, Kuala Lumpur (20 May 2003), caused an uproar amongst many participants who stormed out of the conference. About twenty delegates walked out in protest and later issued a statement. According to Jasbant Singh (21 May 2003), a reporter for Associated Press, the statement indicated that, 'Her vicious and venomous attack to Islam is unfounded and unsubstantiated... Amina Wadud's blasphemy against the Holy Quran and Islam are an echo of an unethical anti-Islam agenda to demonize Islam.' After the walkout, about fifty delegates, led by Positive Muslims representatives Farid Esack and Rehana Kader, signed a petition supporting Wadud's right to make the comments.

The belief that a man has a God given right to engage in sexual intercourse with his wife whenever he wishes is therefore a very real belief that continues to be justified and portrayed as prophetic precedent. Whether the statements attributed to the Prophet are correct or not is beyond the scope of this study. What is of great concern is that these statements may be used by Muslim men to force their wives to engage in sexual intercourse against their will. In other words, these prophetic statements may be used to justify marital rape.

During one of my interviews with Sumaya (Observatory, 2 May 2003), she indicated that her husband believed that he could sleep with her whenever he wanted. She stated that, 'And there were many times when I didn't want to sleep with him and then he beat me so that I slept with him.' While it would be difficult to prove that her husband's motivation to force her to have sex was based on his religious beliefs, it is possible to argue that women who are forced to have sex have little if any choice in the matter. The exceptions to the rule that men are allowed to have sex with their wives at any time provided by Sallie (1993: 16), is therefore of no help to women. In Sumaya's situation for example, she would never have been able to argue that because her husband does not support her, he cannot have sex with her. This may in all likelihood have angered him further, causing him to beat and rape her.

In reality the exceptions to the husband's right to sex is highly flawed and almost impossible to implement successfully. Women are in many instances unaware

that their husbands are involved in extra-marital affairs for example and therefore cannot invoke the exception. Even if a woman is aware of her husband's illicit sexual behaviour, Islamic law stipulates that four male witnesses testify to actually seeing the man engaging in sexual activity with another woman.⁶ The exceptions therefore do little to protect the woman's right to bodily integrity. Furthermore, even if the exceptions were properly enforceable, the mere fact that a husband is given a right to have sex with his wife violates her right to dignity and bodily integrity.

Women have little or no control over their sexuality in relationships where men believe they have a God given right to have sex with their wives whenever they wish. These women are therefore highly susceptible to sexual abuse and HIV infection. This submission is confirmed when one looks at Toefy's (2002) analysis of divorce statistics which indicate that 20.83% of Muslim women who apply for divorce cite their husband's infidelity as the reason for the divorce application. If these men are engaging in extra-marital affairs and at the same time force their wives to have sex, the possibility of the wife becoming HIV positive is greatly increased. There can be no doubt that the religiously sanctioned practice of forcing women to engage in sex with their husbands greatly increases the woman's risk of HIV infection.

⁶ Section 8(b) of the Offence of Zina Ordinance 1979 in Pakistan states that: 'at least four Muslim male witnesses about whom the court is satisfied having regard to the requirements of "tazkiyyah al-shuhud" that they are truthful persons and abstain from major sins (kabair), given eye witnesses of the act of penetration necessary to the offence...' cited in Ali op cit 106.

5.2.2 The Qur'an as a Legitimation of Gender Violence

The Qur'an and *sunnah* contain statements which both affirm and deny gender equality (Esack 2001: 192). *Surah* 219 of the Qur'an, states: 'And whosoever does good deeds, whether male or female and he (or she) they shall enter the garden and shall not be dealt with unjustly.' While this verse deals with men and women on equal terms, there are also many verses which perpetuate gender inequality. The Qur'anic verse which causes the most discomfort and embarrassment for Muslims who advocate gender justice is the verse which permits men to beat their wives if they are disobedient. The Qur'an has a specific word for female disobedience, namely, '*nushuz*,' which is defined as 'confronting the husband in act or word (Al-Ghazali cited in Esack 2001: 201). Asad (1980: 109) also defines '*nushuz*' as 'a wife's "ill-will" (which) implies a deliberate, persistent breach of her marital obligations.'

An obedient wife, according to Naseef (1999:197) who quotes Sayyed Qutb, 'means that the wife is willingly obedient, she chooses to be obedient, she loves to be obedient and she wishes to succeed in being so; she does not obey simply because she is forced and obliged to do so.' Acts of disobedience by a wife according to Sallie (1988: 145-146) includes refusing to have sex with her husband and leaving his house without obtaining his permission.

Three steps are suggested for dealing with a disobedient wife, namely, (1) admonish them, (2) refuse to share their beds and (3) beat them. These steps have been intensely debated and discussed by feminist writers such as Wadud (1992), Mernissi (1986) and Shaikh (1997) who use *hadith* such as, 'Never beat God's handmaidens' to down play the Qur'anic legitimation of gender violence. Even Muslim legal scholars such as Keller (1994: 541) attempt to sugar coat the Qur'anic verse that allows a man to beat a disobedient wife by stating that, 'he may hit her, but not in a way that injures her, meaning he may not break bones, wound her, or cause blood to flow.'

While it cannot be proven that the cases of gender violence perpetrated by 12.28% of men against their wives in Toefy's (2002) study is in anyway related to the Qur'anic verses permitting gender violence, it is evident that violence against women is permitted by the Qur'an if women are continuously disobedient to their husbands. This disobedience, according to Naseef (1999), Keller (1994) and Sallie (1988), includes refusing to engage in sexual intercourse with their husbands. Not only are women therefore forced to engage in sexual intercourse with their husbands, they may be beaten if they refuse to do so and may also be denied financial support from their husbands for as long as they refuse his sexual advances (Sallie 1988: 145).

According to Albertyn (2000), a woman's vulnerability to HIV infection is intrinsically connected to the lack of control over her body and her sexual life.

This lack of control is supported and reinforced by her socio-economic inequality. Furthermore, Klugman (2000: 146-147) argues that in African cultures, 'If a husband initiates sex, his wife may not refuse him; the same applies in relationships outside of marriage. This makes it impossible for women to protect themselves from HIV/Aids by initiating non-penetrative sex... or insisting on fidelity or condom use. Women are... also products of this culture and may themselves have internalized ideas of manhood that make it appropriate for men to have many partners and to manage sexual relations while they accept their partner's dominance and remain faithful.'

While women in Muslim marriages may be legally compelled to have sex with their husbands, in practice women often refuse to engage in sex with their husbands. Klugman's statement cannot therefore be generally applied. However, his observation that women have become products of their culture is certainly correct in some instances since certain Muslim women, such as Naseef (1999), have defended a man's right to engage in sexual intercourse with their wives.

Violence against women plays a substantial role in the spread of HIV/Aids with both men and women coming to accept coercive or violent sex as 'normal.' This is evident from my interview with Sumaya (Observatory, 2 May 2003) whose husband believed that he had a right to have sex with her whenever he wanted. Furthermore, Sumaya also appeared to believe that her husband's 'right' to have

sex with her was acceptable since she did not classify his violent behaviour as sexual abuse. She stated that, 'My husband drank a lot and abused me a lot... not sexual abuse but physical abuse.' Her inability to see her husband's sexually violent behaviour as a form of sexual abuse confirms Klugman's (2000) argument that many women have become products of a sexually violent culture, believing that men have a right to have sex with them.

5.2.3 Impact of Inheritance Laws on Women's Economic Independence

According to Islamic law, Muslim women are allowed to own and alienate property without their husband's permission and therefore have control over moveable and immoveable property in their ownership (Naseef 1999). While this implies that women are theoretically afforded the same rights as men with respect to the ownership of property, they remain unequal in relation to Islamic laws of inheritance.

The inequality in the shares inherited by men and women occur at two basic levels. Firstly, when a wife dies leaving behind a husband with no children, the husband is entitled to one-half of the estate. When a husband dies leaving behind a wife with no children, the wife is entitled to one quarter of the estate (Keller 1994). Secondly, when a parent of a girl-child and a boy-child dies, the boy-child is given double the share of the girl-child (Sallie 1995).

Several reasons are provided for the inequality in the distribution of shares between men and women. The most commonly quoted reason by orthodox clerics is that because men are solely responsible for providing women with financial support, men have to be given a greater share of the inheritance (Sallie 1995). Sheikh Abdurraghiem Sallie (1995: 64-65) in his book on inheritance provides the following example:

Let us take the situation of a man who has died leaving behind only two children, a boy and a girl and they are both standing on the threshold of holy matrimony. Their deceased father has left behind, for example, R3 000,00. According to Islamic law, the girl will receive one share and the boy will receive a double share. The one share of the girl will amount to R1 000,00 while the double share of the boy will amount to R2 000,00. As I have said before, they are both about to get married.

The boy is going to get married to a particular girl and lets say, for argument's sake, the dowry is R2 000,00. He will have no inheritance money left because the dowry is exactly the same as the inheritance. Besides the R2 000,00 as dowry he is still compelled to provide his wife with nafaqah (support) of:

1. sukna (house)
2. nafaqah of ta-am (food)
3. nafaqah of sharab (drink)

His sister, on the contrary, has received from her late father an inheritance of R1000,00. Let us assume that the dowry she will receive is also R2 000,00. It now means that she will have in her possession R3 000,00. She is not any under

obligation to spend any of this money, irrespective of other amounts she might have in her possession because it is now compulsory on her husband to provide her with nafaqah. For as long as she is under her husband's wing, her money will increase, while in the case of her brother and her husband, their money will decrease. What she has received from her late father as inheritance will remain in tact and it will grow if she invests it. What her brother has received from his father has already been exhausted.

From the above example, we can ask: Who is in a better financial position? Who has more wealth, the boy or the girl? Thus, Muslims categorically state, that it is only Islam that has enhanced the status of a Muslim woman and are proud to say that no other religion has looked after the interests of women on this spacious earth of Allah the way Islam has done.

Sallie's (1995) example is a typical argument used by Muslim apologists to justify the unequal treatment of women with respect to inheritance laws. There are two major problems with his argument:

Firstly, Sallie (1995) assumes that women want to be looked after and cared for by their fathers, brothers and husbands. There is also an assumption that men want to look after women. These assumptions about the roles of men and women are often based on 'biological determinism (Ali 2003: 173).' According to Saalih ibn Ghanim al-Sadlaan, a professor from the College of Shari'ah at Muhammad ibn Saud Islamic University in Riyadh (cited in Ali 2003: 173):

The woman is naturally conditioned and created by Allah to perform the functions of pregnancy, giving birth, and taking care of the internal affairs of the house. Man, on the other hand has been endowed with more physical strength and clearer thought and he is, therefore, more befitting to be the leader of the household and the one responsible for providing the means of livelihood, protecting the family and bringing about security and continuance in the family.

While the assumptions about the roles of men and women may be correct in certain instances, the reality is that many women work and are either sole breadwinners or contribute significantly to the household. On the other hand, not all men are willing or capable of looking after their wives, sisters or daughters.

Secondly, even if Sallie (1995) is correct in his assumption that men are the natural caretakers of women, what were to happen if the man responsible for his wife failed or was unable to look after her? During my interview with Bilquees (Cravenby, 30 May 2003), she indicated that her husband was in prison, her father had abandoned them, her stepfather was violent and abusive, and her sons were under five years old. In her situation, there is clearly no male person to take care and look after her. Sallie's (1995) example is therefore highly flawed and cannot be applied to real life situations.

Despite the flaws in Sallie's arguments, his approach to inheritance laws has a significant influence on the congregants of the mosque where he preaches in Bo-Kaap. As a law student, it was often assumed that because I was on my way to

becoming a lawyer, I could answer any legal questions thrown my way (free-of-charge of course). I was therefore often asked to draw up contracts and wills. A Bo-Kaap resident who also attended Sallie's mosque approached me to draw up a will for him. His eldest son was not the most reliable character, according to the father while his youngest daughter was very responsible. He wanted to divide his estate according to Islamic law and had heard from one of Sallie's lectures that his son should receive double the amount of his daughter.

However, the man was clearly disturbed by his son's inability to manage the estate and would have preferred his daughter to deal with things after his death. He was therefore relieved when I suggested that he make his daughter the executor of the estate so that she could continue to manage the estate. I also suggested that he divide his estate equally between his children, but he was not willing to go against what he understood to be Islamic law. He also indicated that because his son was married he needed to look after his wife. Since his daughter was unmarried, he believed that she did not have the same financial responsibilities as her brother. As a compromise, clauses were inserted into the will giving his daughter control over the estate as well as a right to live in the property until she married. The son could therefore not sell the property for example without the express permission of the daughter.

This personal observation aims to illustrate the tension between the norms and values contained in Islamic legal texts and the realities faced by Muslims in their

daily lives. While the Islamic law of inheritance is premised on andocentric notions of male superiority and control over women, there are several striking examples of the utter incompetence of men to manage their own lives let alone the lives of women around them. Islamic laws of inheritance are therefore completely out of touch with the realities that Muslims face when confronted with irresponsible sons and capable daughters. If these discriminatory inheritance laws are consistently advocated and applied, women will inevitably end up with the short end of the stick. Ultimately I believe that laws based on the andocentric notion that men are the caretakers of women, may lead to women being economically dependent on men. Women are therefore left extremely vulnerable when their well-being is dependent on the assumption that men are willing and capable to care for them.

The link between discriminatory inheritance laws and women's vulnerability to HIV/Aids takes place at two levels. Firstly, the direct economic impact that it has on women may in fact contribute to their vulnerability by making them economically dependent on men. If a woman is economically dependent on her husband for example, she may be forced to engage in sexual activity to ensure support for herself and her children (Albertyn 2000).

Secondly, Islamic inheritance laws perpetuate the stereotypical roles of men as providers and women as economically dependent on men. These stereotypes may contribute to normalising the belief that men are the 'maintainers' (in the

words of the Qur'an) of women at both an economic and physical level. The economic control given to men over women allows men to force their wives to engage in sexual intercourse with them. As a result, the inheritance laws contribute to the belief that men are entitled to have sex with their wives at anytime in exchange for providing their wives with financial support.

5.2.4 Polygynous Marriages

According to the Qur'an (4: 3), a man may marry up to four women if he is able to treat them justly whereas a woman may only be married to one man. Debates continue on whether the Qur'anic text allowing polygynous relationships are relevant today since the Qur'anic verse relating to polygyny was revealed in a specific context. Apologists who have attempted to justify polygynous relationships in the context of human and women's rights, have argued that the Qur'anic verse does not create an obligation on men to marry more than one woman, but rather a 'qualified right' to be exercised under 'controlled' circumstances (Al-Hibri cited in Ali 2000: 74).

This paper is not too concerned with the debate around the acceptability of polygynous marriages but will rather focus on whether polygynous relationships, as they are currently practised in Cape Town, make Muslim women vulnerable to HIV infection. It is common cause that where one person engages in sexual intercourse with a number of partners, the chances of contracting HIV are greatly

increased (Granich and Merman 1999). The Islamic Medical Association of South Africa (IMA) has however argued that women in polygynous relationships are protected from contracting HIV as long as all the partners involved in the relationship are HIV negative (IMA Workshop, Cape Town, June 2000). They refer to the relationship as a 'closed circle' that protects everyone inside the circle.

Although this argument may be theoretically correct, the reality is that women in polygynous relationships may stand a greater chance of contracting HIV than women in monogamous relationships for the following reasons:

Firstly, men who decide to take on an additional partner(s) do not usually consult with their first partner believing that they do not require the permission of the first wife. According to Sallie (1988), 'it is Sunnah (recommended) to seek a wife's permission but not Fard (required).' He gives the example of a man who is married to a 'sickly' wife who is unable to perform her 'wifely duties.' In this situation, Sallie (1988: 82) argues that 'If he wishes (to marry another wife), he can ask her for her permission as an act of courtesy, but should she refuse, then no consideration is given to her refusal.' The first wife is therefore often unaware that her husband has married someone else and usually finds out subsequently. This practice results in the first wife being unable to negotiate her sexuality and places her at risk of contracting HIV if the second wife is HIV positive.

Secondly, one may argue that the first wife in a polygynous relationship is in exactly the same position as a woman in a monogamous relationship since her partner may engage in sexual activity outside marriage without her knowledge as well. A woman in a monogamous relationship would therefore be at the same risk of contracting HIV as a woman in a polygynous relationship. The substantial difference however, is that religious leaders sanction polygynous relationships and often support men in their belief that they do not require the first wife's permission. The institutionalisation and acceptance of polygyny is what therefore makes women in polygynous relationships more vulnerable than women whose husbands are unfaithful. For example, since men believe that their polygynous marriages are legitimate and Islamically acceptable, there is less likelihood of men using condoms when they engage in sex with their wives than when they are having an affair. The wives of the men in a polygynous marriage are therefore at greater risk of HIV infection than the wife of man who is having an affair.

Thirdly, when Mohammed (1999) asked forty three religious leaders in the Western Cape, 'Do you think that the first wife (in a polygynous marriage) has the right to deny conjugal rights to her husband until he produces the results of an Aids test after he marries a second wife?' the response was alarming. While 58% (25) of religious leaders indicated that the wife does have a right to deny conjugal rights in this situation, 28% (12) of the respondents indicated that she did not, while 14% (6) claimed that they did not know. The fact that a total of

42% (18) of religious leaders would not inform a woman seeking advice in this situation that she may deny her husband his conjugal rights is utterly disturbing. What is of even greater concern is that 95% of the very same religious leaders who filled in the survey questionnaire believed that Aids is a deadly disease (Mohammed 1999). As a result, at least 95% of the twelve respondents who indicated that a wife cannot refuse to have sex with her husband, would prefer that the wife become infected with HIV and die than deny her husband sex. Women in polygynous marriages are therefore at greater risk of HIV infection since a significant percentage of religious leaders believe that women in these marriages have no say over their sexual lives even if they may be at risk of contracting HIV.

Furthermore, if one partner in a polygynous relationship contracts HIV, it is highly probable that every other partner will eventually contract HIV since it is unlikely that condoms will be used in these relationships. A man who has four wives and becomes HIV positive will infect more women than a man who has one wife. In a polygynous marriage, more women are susceptible to HIV infection than in a monogamous relationship. Consequently, more children born from mothers who are HIV positive may also be affected.

Regulation of polygynous marriages through the registration of the marriage does not exist. If a religious body practises some form of regulation, it is inadequate to monitor polygynous relationships effectively. Even if religious leaders apply the

laws surrounding polygynous marriages strictly, there is still no guarantee that women will be protected. Where for example, a man and his first wife was married by Sheikh X, the man would often marry a second woman with the assistance of Sheikh Y who may be completely unaware of the first marriage. Women who enter polygynous unions knowingly or unknowingly can therefore not be protected from the possibility of HIV infection.

In situations where women are financially dependent on men, they may have no choice but to accept their husband's decision to marry another woman. The woman's ability to negotiate her sexuality is therefore restricted causing her to be more vulnerable to contracting HIV.

It therefore follows that women in polygynous marriages stand a greater chance of HIV infection when compared to women in monogamous relationships. The fact that a man is not under any obligation to request permission from his wife to marry a second woman greatly restricts her ability to negotiate her sexuality. Furthermore, the sanctification of polygynous marriages by religious leaders combined with their belief, in certain cases, that a woman cannot withhold sex if her husband refuses to take an HIV test, causes her to be more susceptible to HIV infection.

5.3 Challenging Religious Practices

Since it has been established that certain religious beliefs and practices, as interpreted by religious leaders in Cape Town, are discriminatory towards Muslim women and may contribute to making them vulnerable to HIV infection, the question that remains is: what can be done to challenge these practices in order to reduce the negative impact it has on women? Modernist, post-modernist and progressive Muslims as well as feminist scholars have approached this question from both a theological and jurisprudential perspective by reinterpreting religious texts or by analysing Islamic jurisprudence in its socio-historical context. Ali (2003: 183) argues for example, that while Islamic jurisprudence contains 'deeply patriarchal and discriminatory elements,' an analysis of these elements will reveal serious flaws which cannot be Divine. As a result, the immutability with which Islamic laws relating to women are treated is slowly being eroded by powerful arguments presented by scholars such as Ali, Esack, Moosa, Shaikh, Wadud and many others. In doing so, these scholars have begun the frustratingly slow process of challenging the gendered power relations prevalent in Muslim society.

At an ideological level, Positive Muslims has latched on to the complex arguments presented by progressive Muslim scholars and have attempted to give expression to these arguments at a practical level. This is evident in the organisation's literature as well as in the way it deals with women living with

HIV/Aids. In an interview with Positive Muslims in July 2003 for the *Muslim Views* newspaper, a spokesperson for Positive Muslims argued that:

'What Muslims fail to understand is that Aids has very little to do with sex, despite the fact that sex is the primary mode of transmission. Aids has far more to do with issues such as gendered power relations within society,' says Rehana Kader, Acting Director of Positive Muslims. She adds, 'We should stop preaching about how to lead a more moral lifestyle and start talking about how we can change religious and cultural practices that may contribute to a society where men believe they have control over women, and where women are victims of sexual violence.'

It is hard to measure whether the approach adopted by Positive Muslims in the *Muslim Views* (July 2003) article for example, is having a real impact on changing the mindset of Muslims in Cape Town. As a result, it would be naïve to believe that one newspaper article or even one organisation for that matter, is able to transform religious and cultural practices within Muslim society. Instead, a long-term coherent strategy has to be devised aimed at carefully challenging religious practices that may contribute to women's vulnerability. Furthermore, both women and men have to be empowered and made aware of the potential connection between religious practices and women's vulnerability to HIV infection.

At some levels, this process has already begun. In a Muslim Youth Movement (MYM) workshop on the South African Law Commission's Issue Paper, calls were made for compulsory HIV testing to be included in future legislation involving Muslim marriages generally and polygynous marriages specifically (Al Qalam December, 2002). This call signals a fundamental shift in Muslim attitudes towards religious and cultural practices in the context of HIV/Aids. Furthermore, the basis for this shift appears to stem from the realisation and acknowledgement that Muslim women are at risk of HIV infection in polygynous marriages.

While proposed legislation regulating Islamic marriages has been influential in forcing Muslims to re-evaluate their positions on certain Islamic practices, it remains to be seen whether the law is the most appropriate instrument to influence Muslim responses to religious and cultural practices that impact on women's vulnerability to HIV infection. Pieterse (2000) argues that the influence of the law on cultural and religious practices is limited. He believes that cultural practices should be changed from within the culture and should not be subject to pressure from the outside. Although Pieterse's argument can be justified in some instances, it would be difficult to protect a Muslim man's 'right' to have sex with his wife whenever he wishes. Do we stand back and wait for Muslim society to re-evaluate this right or should the law step in and interfere with this right because it violates a woman's dignity and bodily integrity?

Perhaps the answer lies somewhere in between. While it is essential that the law intervene in cases where women's rights are violated, it is also important to recognise that the law cannot and has never been the 'sole agent of social change (Albertyn 2000: 27).' Legal strategies should always form part of wider social, political and educational strategies according to Albertyn (2000). As a result, organisations such as Positive Muslims and the Muslim Youth Movement together with individual academics and Muslim leaders in the gender, religious, legal and HIV/Aids fields, have to work in partnership at various levels to ensure social change.

In conclusion, religious and cultural practices that prevent women from taking control of their sexuality must be challenged and re-evaluated in light of the Aids epidemic. Failure to do so will result in the continuous marginalisation of women making them more vulnerable to HIV infection. Although it has been argued that Islamic culture may have kept the Aids epidemic at bay in Muslim regions (Tastemain and Coles 1993), this argument falls flat in light of the evidence suggesting that religious practices may in fact increase women's vulnerability to HIV infection.

Conclusion

...asserting women's rights will never be limited to the realm of women. It will necessarily change the way men behave and the way both women and men perceive sexuality.

(Scott Siraj Al-Haqq Kugle 2003: 228)

Kugle's (2003) article which tackles the issue of homosexuality in Islam, amongst other things, provides examples of how Islam and Islamic practices have changed over the centuries. During the early history of Islam, 'Muslims assumed that the Qur'an demanded the political rule of a monarch... (and took) for granted that slavery was a legal and useful social institution (Kugle 2003: 226).' These oppressive beliefs and practices, which were deeply ingrained in Muslim society and Islamic law, were eventually discarded in the interests of social justice. As a result, there is some hope that in decades to come, practices that discriminate against women and beliefs that deny sexual diversity will also be discarded in the interests of social justice.

Until then, the need for organisations such as Positive Muslims remains critically important for contemporary Muslims. Its importance extends beyond the HIV/Aids issue in that the organisation also provides a platform for discussion and debate around sexuality, gender power relations and social justice. Since the organisation was first established in June 2000, the founding members were committed to raising awareness and providing non-judgmental and compassionate support to Muslims living with HIV/Aids. As a result, the

organisation developed what is referred to as a 'theology of compassion' - a way of reading and understanding religious texts in a manner that focuses on God as a compassionate being. This theology was and continues to be based on progressive Islamic principles. Progressive Islam relies on the norms and values articulated in religious texts which support the transformation of society from an unjust one in which HIV positive Muslims are marginalised to a just and compassionate society. As a result, Positive Muslims' approach to the rights of Muslims living with HIV/Aids is based on the norms and values articulated by religious texts and interpreted by progressive Muslims. While this approach may appear to lean towards cultural relativism due to its connection to a cultural and religious context, it would be more correct to argue that the organisation's approach to the rights of HIV positive Muslims is a hybrid of both the universalist and relativist discourses. The common factor in this hybrid approach is the commitment of both progressive Islam and universalism to the transformation of society from an unjust to a just society.

In addition to relying on the norms and values articulated in religious texts to formulate its ideological approach, Positive Muslims relies heavily on the practices of Cape Muslims in formulating its Aids prevention model. The organisation acknowledges that Muslim practices often differ from articulated norms and values and therefore places significant value on these practices.

An answer to the central question posed in the introductory chapter of this thesis namely, how have the norms, values and practices of Cape Muslims impacted on the approach of Positive Muslims to five women living with HIV/Aids, can now be attempted. At an ideological level, Positive Muslims relies on the norms and values articulated in religious texts to formulate its approach to HIV/Aids. It does this through a progressive Islamic interpretation of the text by focusing on norms and values which conform to and are supportive of the ideals of social justice, gender equality and pluralism. These norms and values relied upon by Positive Muslims can be distinguished from the narrow set of norms and values articulated by many traditional religious leaders in the Cape.

At a grass-roots level Positive Muslims relies more heavily on the practices of Cape Muslims in formulating its Aids prevention model since the organisation acknowledges that Muslim practices often differ from articulated norms and values.

One could therefore argue that the practices of Cape Muslims have had a more significant impact on the practical approach of Positive Muslims to women living with HIV/Aids than the actual norms and values espoused by Cape Muslims. This can be attributed to Positive Muslims' pragmatic and realistic approach to HIV/Aids prevention. The norms and values however continue to shape and influence Positive Muslims' approach at an ideological level.

The central question of this thesis is located within the framework of the culture/rights debate. This debate allows for a discussion of the inherent tensions between religious norms and values articulated in the Qur'an and *hadith*, and the practical realities faced by Muslim women living with HIV/Aids. This framework also allows one to explore the articulated norms and values on the one hand, and practices of Cape Muslims on the other and to illustrate how practices often do not conform to the expressed norms and values. However, it is important to note that my categorization of Positive Muslims' ideological approach in the context of this framework is slightly contrived. I attempted to firstly give a name to the organisation's approach by drawing on various human rights theories and then secondly, tried to fit this approach into the culture/rights framework. My desperation to develop a theoretical category for the organisation's work should therefore be seen for what it is and not be confused with the very practical approach the organisation uses in its daily functioning.

While the organisation largely adopts a pragmatic approach to Aids prevention, there are inevitably moments when we are confronted by ideological issues that cause tensions between Positive Muslims activists and mainstream Cape Muslim culture. One of the most striking examples relates to Rehana Kader, a senior executive member and the psychologist running the support group. Kader is unwilling to conform to the dress code imposed upon her by mainstream Muslim culture and refuses to wear a head scarf. This has caused difficulties on a number of occasions according to Kader since she has been excluded from a

meeting with religious leaders and has also been forced to work hard to ensure that her view points are acknowledged. These tensions between Positive Muslims activists and mainstream Muslim norms and values manifest in a number of ways and impact to some extent on the legitimacy of the organisation within broader Muslim society. Questions have therefore been raised about whether Positive Muslims is in fact a Muslim organisation or merely a Muslim organisation by name.

Questions have also been raised about the 'Muslimness' of the five women informants whose life histories are depicted in this thesis. After my presentation at the South African Aids Conference (Durban, August 2003) on certain experiences related to me by the informants, I was asked whether given the fact that some of these women used drugs and had sex outside marriage, they were good examples of Muslims. The implication was that if these women were indeed 'good Muslims' - whatever that means - they would not have been infected with HIV. This assertion is of course utterly ridiculous since my findings suggest that all Muslim women, irrespective of their level of religiosity, are potentially vulnerable to HIV infection. In fact, the 'Muslimness' of the women had very little to do with their experiences of living with HIV/Aids. Issues such as poverty, sexual violence and socio-economic conditions had a far greater impact on their vulnerability to HIV infection as well as their ability to subsequently cope with their infection. Vulnerability to HIV infection was directly connected to the women's economic circumstances, which also affected the way in which they

were able to subsequently cope with their HIV status. Poorer women were more likely to be forced or coerced into engaging in sexual practices which put them at risk of HIV infection. It was discovered that in at least two out of the four cases of HIV infection involving sexual intercourse amongst informants, women were forced or coerced into having sex. Their socio-economic conditions and experiences of sexual violence therefore defined their identities more significantly than their religious affiliations.

Consequently, issues of poverty and violence were far more important to these women than their HIV status. The reason why women focussed on their poverty stricken conditions for example as opposed to their HIV status was in all likelihood due to the immediacy of the impact of poverty on their daily lives. The lack of food or money has immediate consequences whereas HIV/Aids takes many months and sometimes years to manifest as a problem.

While it could not be shown that the five informants were more vulnerable to HIV infection because of specific religious or cultural practices, it has been argued at a theoretical level at least, that certain religious beliefs and practices that discriminate against women may potentially cause them to be vulnerable to HIV infection. The beliefs and practices that have been identified affected a woman's ability to negotiate her sexuality and made her economically dependent on men. There is no doubt that women who are economically dependent on men and are unable to negotiate their sexuality are at greater risk of HIV infection than women

who are economically independent and have control over their bodies. As a result, religious practices which discriminate against women have to be re-evaluated in light of the Aids epidemic.

It is suggested however that the re-evaluation of religious practices should be initiated from within the particular society in which the practice occurs. External pressure on Muslims to change practices that perpetuate gender inequality may have a limited if not adverse effect.

Positive Muslims has attempted to initiate this debate at an academic level through workshops and discussion forums and at the same time aims to meet the daily practical needs of these women. Fulfilling the immediate expectations of the informants has not however been satisfactory in all cases. While most of the informants were happy with the level of support they received, two informants were dissatisfied with the extent to which their needs were being met. Their unhappiness was a combination of the limited capacity of the organisation to meet all their needs and unwillingness on the part of some members to see to their own needs. As a result, Positive Muslims has initiated an enquiry into the needs of support group members as well as developing clearer boundaries to determine what the acceptable and unacceptable levels of support are.

In addition to challenges related to the needs of the informants, several other challenges continue to impact on the organisation. One of the primary

challenges remains getting Muslim religious leaders involved in HIV/Aids awareness programmes. The tendency of religious leaders to oversimplify the Aids epidemic as a moral issue is a reflection of the general Muslim population's attitude to HIV/Aids and more specifically to people living with the virus. These attitudes and beliefs are constantly challenged by Positive Muslims through its awareness campaigns.

Ultimately, Aids presents us with a unique opportunity to re-evaluate the accepted norms and values articulated in religious texts and their relationship to the actual practices of Muslims. The epidemic has also forced us to accept that practices often differ from the expressed norms and values of mainstream religious leadership. In order to develop an effective Aids prevention model for Cape Muslims, the actual practices of Muslims have to be understood and dealt with instead of insisting that Muslims conform to a set of norms and values which have little relevance and meaning in their lives.

We have a duty to respond with creativity and compassion to those who have been marginalised and who seek protection from stigma and discrimination - for they are of us and we are of them.

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