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Gender, Health and Change in South Africa:

Three Ways of Working with Men and Boys for Gender Justice

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Structured Summary

Introduction: This article addresses the question of how to “think about” and to “do” gender change in the context of HIV and public health interventions in South Africa. The issue of gender has been closely intertwined with the HIV epidemic in Southern Africa since the beginning of the epidemic. The need for more gender equitable practices and relationships has been a central theme of the response to the crisis. While much of this work has focused on efforts to reduce the uneven impact of HIV has on women and girls, there have also been important interventions with men and boys around gender and HIV. This article synthesizes findings from research projects with three such interventions.

Methods: The findings presented here are drawn from three separate research projects conducted in South Africa in the last 10 years. The first was an ethnographic research project with the Khululeka Men’s Support Group in Cape Town. The second was an independent program evaluation of the “One Man Can” campaign that was commissioned by Sonke Gender Justice, a gender transformation NGO in South Africa. The third project was a qualitative process evaluation of a trial that used male lay health workers to provide support and care to pregnant and postpartum women who were enrolled in a PMTCT program.

Results: Gender and gender change were understood and promoted in contrasting ways across the three case studies. In the case of Khululeka, HIV-positive men were encouraged to become “better men” within the context of existing gender norms by doing things that would protect their health and allow them to achieve socially valued roles as strong family leaders and financial providers. They began with a conventional HIV support group model but adapted it to better suit local gender norms around masculinity. In Sonke’s One Man Can (OMC) campaign, the focus was on the ways men and women could address the underlying gender inequities in their families and communities. Participants were encouraged to raise their awareness and critical understanding of gender-related rights issues and mobilize for progressive gender change. Sonke staff struggled, however, to find ways of sustaining the changes they witnessed in OMC workshops and an ideological tension persisted between “culture talk” and “rights talk” about gender. Finally, in the PMTCT program, men were recruited to serve as lay counselors for HIV-positive pregnant women. By carefully training and supporting men in the daily practice of providing care for these women, male counselors developed trusting relationships, offered effective services, and in general, undertook a form of gender-transformed practice that exceeded much of what was observed in the other two case studies.

Discussion: There are many potential paths to gender transformation, and the HIV epidemic in Southern Africa has operated as a powerful catalyst for exploring and pursuing some of these

paths. In the process, however, a number of political and conceptual limitations of gender transformation work emerged. There is a need to find ways of thinking about and acting on gender that isn't over-determined by the logics of public health and biomedicine. There is also a need to complement ideological arguments for "gender transformation" with more embodied opportunities for transformed gendered practice.

Résumé

This article presents three case studies on the question of gender, health and change. It describes findings from research projects on interventions working with men and boys in south Africa on issues of HIV, public health and gender. Each case study examines the underlying theories of masculinity, gender and gender change at work in these interventions and assesses the forms and impacts of these interventions. The article concludes with a reflection of the political and conceptual limitations of gender transformation work undertaken in the context of HIV, and on the need to complement ideological arguments for "gender transformation" with more embodied opportunities for transformed gendered practice.

Keywords

HIV; gender transformation; social change; South Africa; practice theory

I. Introduction: Questioning Men

A few years ago, in a public health course at the University of Cape Town, I began a two-hour class lecture on men, HIV and gender transformation in South Africa with a slide that asked a simple question: "Can Men Change?". This question was meant to elicit some brief, initial discussion about the assumptions class members held about men, masculinity and the question of how gendered patterns of thought and practice might change – or be changed – over time. This simple question, however, provoked an animated and extended discussion among class members. Many had a visceral reaction to the question, answering it, at least initially, in the negative.

An hour later, the class was still engaged in intense debate about this opening question. The conversation had moved, however, from a rather pessimistic discussion about whether there was hope for gender transformation among men, to a richer and more productive analysis of the kinds of questions we ask about men, health and change. For example, "Can men change?" seemed like a sensible – and urgent – question for most class members, one underpinned by beliefs that men, individually and as a group, desperately needed to "change their ways", but probably would not or could not. The question, "can women change?", however, did not make much sense to the class. They argued that women "were not the problem", and that society needed to change, not women. In the process, assumptions about the "pathology" of masculinity, the framing of (all) men as (potential) perpetrators, and the moral virtue and victimhood of women were revealed. So too were very different ideas about how change should happen for each group – individual behavior change by men versus social and structural change for women.

We interrogated other kinds of questions as well, such as “can Black men change?”, “can gay men change?”, “can people change?”, and “how do men change?” revealing in the process the ways numerous unspoken assumptions about race, sexuality, gender, psychology and biology shape how we think about men and the question of gender change. What this impromptu discussion ultimately revealed was how narrow and confining many of our ways of thinking about men, women and change were and how much we needed both clearer theories of gender change as well as more thoughtful models of interventions for promoting this change.

This article addresses the question of how to better “think about” and “do” gender change with men and boys by comparing and contrasting findings from three different research projects on gender and HIV that I have conducted in the last 10 years in South Africa. Each of the projects was conducted with men from similar social and economic backgrounds, and was focused on understanding the ways medical and public health interventions for HIV have thought about and addressed gender and gender change. In each of these case studies, I identify some of the underlying theories of masculinity, gender and gender change at work and examine the forms of intervention that were deployed to promote these changes. The article concludes with a reflection on the differing models of gender and change in each project, and an argument that research and intervention for men, masculinity and gender transformation has too often privileged ideological critique as the primary mechanism for gender change, neglecting in the process the critical role of both individual practice and broader material and structural contexts.

II. Masculinity, Change and HIV/AIDS in Southern Africa

The question of gender has been at the forefront of analysis and intervention in the HIV/AIDS epidemic in Southern Africa. Women, for example, have long been recognized as bearing the greatest HIV-related burden, both in terms of prevalence as well as caring and labour obligations within families (Heidari et al., 2013). It is also widely accepted that gender inequities have fuelled, and continue to drive the epidemic, with gender-based violence, inability to negotiate sexual practices, and the dilemmas of “transactional sex” seen as key drivers of the epidemic (Dunkle et al., 2004; Dworkin/Ehrhardt, 2007 ; Jewkes/Morrell, 2010). The gender-focused response to HIV in Southern Africa has also been shaped by the histories of gay and lesbian activism around HIV in the global North as well as a strong feminist movement in South Africa. These movements have put gender-related aspects of HIV front and center on the national agenda.

In the gender analysis of HIV, the question of men and masculinities has also been the subject of urgent analysis and intervention. Researchers have considered how masculine norms legitimize certain kinds of sexual and social practice (Hunter, 2010 ; Leclerc-Madlala, 1997 ; Wyrod, 2011), how contexts of racial oppression and economic marginalization have shaped men’s violence against women, children and each other (Dworkin et al., 2012 ; Ouzgane/Morrell, 2005), and how local beliefs about “manly” behavior make it difficult for men to access HIV prevention, treatment and care, leading, in turn, to worse outcomes for men along the “HIV cascade” (Dageid et al., 2012 ; Harrison et al., 2006 ; Shand et al., 2014 ; Skovdal et al., 2011).

Many of these analyses of gender and HIV in Southern Africa draw, either implicitly or explicitly, on ideas of “hegemonic masculinity” (Connell, 2005), generally understood to be the theory that every society constructs and then socializes men into a widely accepted model of the “ideal man”, to which all men inevitably strive towards and compare themselves. The debates in the academic literature on hegemonic masculinity have been extensive and have led to rich models of hegemonic masculinity that address the impact of different spatial levels (*e.g.* local versus globalized masculinities), the role of gender hierarchies among men and between men and women in maintaining male hegemonic ideals, and the ways in which these idealized constructions of manhood are embodied and change over time (Connell/Messerschmidt, 2005).

In the field of public health research and development work around gender and HIV, however, a much more simple model of hegemonic masculinity tends to operate, one that asserts that hegemonic and patriarchal beliefs – often framed as “cultural” or “traditional” – about manhood are pervasive and largely unchanging in Southern African communities. There has been a great deal of work in these fields on the ways in which these gender norms and practices structure the risk for HIV, but much less attention to the question of how these norms and practices might change or be changed. Though there is important evidence emerging from some projects about “what works” when engaging men and boys in gender change (Barker et al., 2007; Lippman et al., 2013; Peacock/Barker, 2012), there is less research on “how change happens”. There is also not a lot of research on how the HIV epidemic has acted as a catalyst or a barrier (or both) to changes in gender norms and practices among men. The case studies that follow draw on my previous research on these questions of men and gender change and attempt to synthesize some lessons about the various ways change happens, and the ways in which these changes have been shaped by the HIV/AIDS epidemic.

III. Harnessing Hegemonic Masculinities to Therapeutic Regime(n)s

My first research project on men and HIV was an ethnographic study between 2003 and 2007 of the Khululeka Men’s Support Group, a men’s HIV support group in a Xhosa-speaking community in Cape Town (Colvin et al., 2010; Viitanen/Colvin, 2015). Khululeka was founded by Phumzile Nywagi, an HIV treatment activist who had grown weary of participating in the national protests over HIV denialism (Kalichman, 2009) and wanted to concentrate instead on the problems of HIV in his local family and community. At this level of analysis, Phumzile understood the problem of HIV to be primarily a “problem of men”. Men were framed as the primary drivers of HIV transmission as a result of their presumed reckless, promiscuous and sometimes violent sexual behaviour. Phumzile argued that this behaviour was in turn shaped by local and hegemonic forms of masculinity that privileged physical dominance, emotional reticence, and patriarchal forms of power within couples, families and communities.

At the same time, however, Phumzile recognized that these hegemonic forms of masculinity did a disservice to men, and especially HIV-positive men, by making it more difficult for them to practice safer sex with their partners and less likely for them to seek HIV testing, treatment and care. He also believed that men did in fact have ways of speaking with each

other about their problems and providing emotional support but that the design of most HIV services and programs made this kind of mutual support among men difficult. Phumzile said, for example, that many men complained that existing HIV support groups were open to both men and women, and were in fact dominated quantitatively and qualitatively by women. Men argued that local cultural norms precluded them from speaking about illness, vulnerability and sexuality in front of women and so they chose not to attend.

Phumzile therefore designed Khululeka as a “safe space” for HIV-positive men to come together and provide information and support to each other in an environment that would not challenge these existing gender norms but would instead be “gender-sensitive” to men’s perspectives. The group met every Saturday for open-ended discussions among members. They also ran a series of awareness-raising and community mobilization events in surrounding communities (though rarely in their own community). They borrowed elements of the classic HIV support group model (Dageid, 2014; Visser/Mundell, 2008) but also changed this model in ways that better suited their members. Their Saturday morning discussions, for example, focused less on expressing emotional vulnerabilities and providing support, and more on active problem solving of challenges facing the members. In many cases, men described to the group in significant detail the emotional difficulties they were having with their sexual partners. Rather than probing about the psychological dynamics of a couple’s relationship or challenging the underlying assumptions or values in these stories, however, the other members offered practical advice for what to say to their partners and how to resolve these conflicts.

They also used the support group space as a way to develop new forms of mutual accountability that were also shaped by local norms of masculinity. At the beginning of each meeting, for example, members would each write their latest CD4 count and their next clinic appointment date on a large whiteboard at the front of the room. Members who did not have an appointment scheduled, or whose CD4 counts had dropped, were challenged by the group to “do better” and “catch up” to the other members. Similarly, when members were found to have been drinking, using drugs, or engaging in unsafe sex, the other members would chastise them, reminding them that “to be a real man” and remain strong, they needed to consistently take their treatment and protect their health. In the process, members drew a distinction between the more toxic aspects of local forms of masculinity like excessive drinking and the more positive aspects of those same gender norms such as being a strong household head and a consistent financial provider.

Despite the more competitive and disciplinary tone of these meetings, however, the relationships between Khululeka members were generally very friendly and supportive. Many told me that they felt more supported and accepted by the other group members than by their families or friends. In many ways, the work that they were doing cut against conventional gendered norms and practices for men in their community. They had more opportunities in the group to speak about their emotional and physical challenges than they would have normally had. And they reflected on, and resisted, the more costly facets of local hegemonic masculinity, embracing those parts that better supported their health and their relationships.

These changes, however, were not generally guided by an ideological desire to “change men” or challenge hegemonic masculinity but rather by two other imperatives: to help men reclaim a more conventional masculine identity that had been damaged by HIV, and to help HIV-positive men stay healthy and alive. Khululeka thus mobilized some elements of local and accepted norms of masculinity to enable more positive and health-producing effects for its members, without directly challenging the overall complex of gendered norms and practices within their community. When some of the changes men were asked to undertake really pushed against these prevailing norms – such as only having one sexual partner or not drinking alcohol – Phumzile and others would often use the existential threat of HIV to motivate men, arguing that while such things might not be “manly”, they were necessary to keep men and their partners and families alive.

IV. Ideological Challenges to Hegemonic Masculinities

The second research project I undertook to better understand this intersection of men, HIV and gender change came from a distinctly different angle. Not long after my project with Khululeka was finished in 2007, I was commissioned by a large South African NGO, Sonke Gender Justice, to conduct an external evaluation of its national “One Man Can” (OMC) campaign. The OMC campaign was Sonke’s flagship project at the time and was meant to promote a nationwide program of gender transformation work that engaged men and boys to build a more gender equitable society (Dworkin et al., 2013).

For Sonke and others, “gender transformative” interventions are distinct from “gender neutral” ones (that do not account for gender) and “gender sensitive” ones (that accommodate local gender norms). Gender transformation aims instead for transforming the patterns of thought, relationship and practice that underlie patriarchal and unjust forms of gender (Barker et al., 2007). In its portfolio of programs, Sonke works to achieve this deeper gender transformation by working at multiple levels – from local community mobilizing through to international policy advocacy – and on a wide range of gender-related health and human rights issues including HIV, gender-based violence, refugees and occupational health (van den Berg et al., 2013).

The “One Man Can” campaign reflected this layered, multi-issue approach by working at individual, community and national levels and addressing a number of urgent health and social issues shaped by gender. At the heart of the campaign was a series of workshop sessions with male and female participants who were recruited by local community-based organizations (CBOs) that partnered with Sonke in the communities it worked. Each workshop session was organized around a particular gender-related issue. Participants were encouraged to not only learn about and discuss this issue with each other, but to also critically reflect on their own perspectives, and identify areas in which their own beliefs and practices conflicted with presumably more broadly accepted cultural and political norms such as equality, fairness, dignity, respect, tolerance and non-violence. At the end of the series of workshops, participants were recruited to form local “community action teams” (CATs) that would continue to meet regularly and identify gender justice-related issues in their communities and address them through a range of interventions.

In my evaluation of this campaign (Colvin et al., 2009), I noted a number of successes of the OMC campaign as well as a range of challenges it confronted as it worked to transform gender relations across the country. A key dynamic in these workshops was the ways in which local constructions of the “cultural”, the “traditional”, and the “Western” were central to how people imagined, narrated and performed their own gender norms. This intense and naturalizing discourse about what “local culture” was (and was not) was usually contrasted with how people imagined and spoke about the “human rights” discourse. This is a reprise of the distinction Mamdani (2000) has made in other contexts between “culture talk” and “rights talk”. For both participants and facilitators in these OMC workshops, rights and culture were usually taken as given, reified as distinct ways of being in the world that usually sat in antagonistic relationship to each other. A major task of OMC workshop facilitators was to promote a solidly human rights-grounded view of gender while not pushing too hard against what participants felt was a pervasive and all-powerful cultural context.

Not surprisingly, this was often a long and difficult process. Workshop facilitators and program managers acknowledged that lasting gender change was not likely to happen quickly. They also understood that providing information, raising awareness and encouraging dialogue and critical self-reflection were not likely, on their own, to result in fundamental shifts in gender hierarchies. They expressed frustration, however, at the lack of sustainability and depth of some of the small but encouraging changes they had witnessed in their workshops and community action teams. Their efforts did provide an opportunity for local residents to come together, discuss issues, and work towards greater gender equity but it is unclear how much of a broader impact they are likely to have or how these campaigns can be sustained over time.

Sonke’s efforts in the broader areas of policy and legislative change, improved law enforcement, and other structural interventions have grown over the last 10 years. And it has had a significant impact in the country in simply promoting the meaningful inclusion of men and boys in feminist-grounded gender transformation work. Throughout this time, the OMC campaign has largely remained focused on building platforms at the community level for sustained ideological reflection and critique of existing gender norms and practices. It remains an important, but somewhat ambivalent area of work for the organization, where questions of how to drive and sustain changes in gender norms and practices remain urgent and open.

V. Gender Transformation through Transformed Practice

Khululeka harnessed what its members saw as positive aspects of hegemonic masculinity, as well as HIV’s existential threat, to promote gender change among its members. Sonke developed a critical feminist project that includes men and boys in the long-term transformation of unjust gender relations by encouraging self-reflection and ideological critique of gender inequities. The third project I want to describe comes at issues of men, change and HIV again from a very different angle. It reveals a surprising path towards gender transformation, one not anticipated in the work of Khululeka or Sonke.

The research project was a qualitative process evaluation of an intervention designed to strengthen the prevention-of-mother-to-child transmission (PMTCT) of HIV in the Free State Province, South Africa. It was undertaken between 2010 and 2013. The core of this intervention was the addition of lay health workers (LHWs, or “counselors” hereafter) to the staff of primary health care clinics that offered PMTCT and other HIV services. These counselors were supposed to improve the continuity and quality of care for pregnant women with HIV. They did this by working closely with clinic staff, women, and their families throughout the antenatal period and the PMTCT process (which involves testing mothers, initiating them on treatment, treating the baby with antiretrovirals, and encouraging safe breastfeeding).

Unlike most LHW programs in South Africa, however – and almost unheard of among PMTCT programs – about half of the counselors recruited for this PMTCT project were local men from the same community. Many of them had little education and had previously worked in low-paying service or manual labour jobs. The project designers had initially recruited and trained these men largely on the principle that they had no reason to discriminate against male applicants. In doing so, they explicitly pushed against conventional gender norms that argue that women would never feel comfortable with a male counselor and that these men would never be able to work effectively with pregnant women in their communities. Their decision to include men, however, was not intended primarily as an act of gender transformation per se, but was guided by principles of fairness, non-discrimination and the social constructedness – and thus changeability – of gender. My role in the process evaluation of this program was to understand how the lay health worker program operated on a day-to-day basis. It was in this context that I came to learn about what happened when these male counselors were trained and integrated into the program.

What happened was in many ways remarkable. These men were trained, along with the female counselors, to provide individual HIV and pregnancy counseling to women, to run educational talks in the waiting rooms, and to conduct door-to-door outreach in their communities encouraging pregnant women to get tested and come in for HIV care. The training sessions I observed made some reference to their position as men and the ways local cultural norms might complicate their work. For the most part, though, the training was technically focused and broadly “gender neutral” in its approach.

The male counselors I spoke with said that, at first, they were very nervous about speaking with women about their pregnancies, about reproductive and sexual health, and about HIV. The perceived cultural prohibitions on these kinds of conversations were powerful and they did not have an analogous model of talking openly with women about sex that they could draw from in their own experience. They reported, however, that the training they received and the support and materials they had access to via the NGO running the project, prepared them well for this work. Most of the female patients we spoke with described good and trusting relationships with the male counselors. They said they trusted their knowledge and believed the counselors would keep their information confidential. And they felt comfortable enough to ask questions and speak about some very sensitive reproductive health issues, issues that they had never before discussed with another man.

The women were not immediately comfortable with the male counselors. They described some initial hesitation and discomfort, as well as some amusing tests of embodied knowledge they developed to determine if these young men really did understand how women's bodies worked. Feigning ignorance, they asked the male counselors, for example, what a particular vaginal discharge might indicate, or what tenderness in their breasts could be caused by. Male counselors passed these tests by either having the correct answer at hand, or admitting that they did not know, but then pursuing answers via their supervisors or female colleagues. In the end, there was widespread acceptance of and support for these male counselors among both the pregnant women and the clinic staff that we spoke with.

The program did have some gender-related complications, but ironically, these complications more often came from the male partners of pregnant women. Some of these partners became suspicious that the male counselors were trying to form relationships with the women at the clinic. At one point, counselors, both male and female, had to stop sending reminder text messages to their patients in order to avoid this kind of suspicion. For the most part, however, the integration of these young, under-employed men from the community in the PMTCT program was an unexpected success.

Of course, in many aspects of both their personal and professional lives, "traditional" gender roles and practices persisted for these men. Male counselors were often, and only half-jokingly, referred to as "doctor" by clinic staff while female counselors never were. Some male counselors were criticized for excessive drinking on the weekends and for acts of intimate partner violence. But the fact remained that this group of men, who had very little exposure to explicit notions of gender transformation or gender-related human rights, and who reinforced in many ways locally hegemonic forms of masculinity, also enthusiastically, and effectively, took on a radically new form of intimate, caring labour for women in their community. This was an outcome that would have likely seemed entirely improbable to the members of Khululeka or the participants and facilitators of Sonke's OMC workshops. Male counselors did, of course, gain a number of advantages from their work. They received a salary along with the social status of their new roles and a sense of accomplishment and purpose as HIV activists. But these advantages do not seem sufficient on their own to fully explain the type of "gender transformation" that happened through their participation in the PMTCT program.

VI. Lessons Learned and Conclusion

This article has reviewed some insights from three different health research and intervention projects that have engaged in various ways with men, health and the question of gender change. In the case of Khululeka, HIV-positive men were encouraged to counter some of the more socially and physically damaging aspects of dominant masculine thought and practice in order to better maintain their health and adherence to their HIV treatment. They worked to become "better men" within the context of existing gender norms by doing the things that would allow them to reclaim the socially valued roles of strong family leaders and financial providers that HIV had taken from them. They took the conventional HIV support group model and adapted it to better suit the ways men in their context were comfortable communicating with each other. And they used the power of biomedical forms of therapeutic

management and self governance (Nguyen et al., 2007), along with the existential threat of HIV, to encourage members to undertake some practices that more directly challenged hegemonic gender norms.

In Sonke's One Man Can campaign, the focus shifted from men drawing on existing gender norms to live more successfully with HIV to the ways men, women and communities could address the underlying gender inequities that are the focus of Sonke's gender transformation agenda. Individuals, couples, community action teams (CATs), and communities were encouraged to raise their awareness and critical understanding of gender-related rights issues and develop strategies for countering gender injustices through both individual and community-level mobilization and change. A special focus was made on directly involving men and boys in this work as part of a broader goal, grounded in feminist politics, to transform gendered norms, practices, and relationships. OMC facilitators and Sonke staff struggled to find ways of sustaining and deepening the gains made in workshops and CATs, however, and an ideological and practical impasse persisted in some of their work between "culture talk" and "rights talk".

Finally, in the PMTCT program, men were recruited to serve as lay health workers, or counselors, in a PMTCT program serving HIV-positive pregnant women. The focus of this program was not on gender transformation for men but rather on HIV prevention for women and their children. The program managers shared many of the feminist gender transformative perspectives of Sonke's staff, but understood their work as informed by these values rather than being focused on achieving gender transformation as a program objective. However, by including and supporting men in the daily practice of caring for pregnant, HIV-positive women, male counselors learned how to provide care for and develop trusting relationships with women in the PMTCT clinic. In doing so, the program managed to elicit a form of gender-transformed practice that would have far exceeded the ambitions of many of the Khululeka members and Sonke staff. These changes may not have impacted all areas of these men's lives, or lasted beyond the life of the program, but they do provide an indication of another pathway through which gender change might happen.

The purpose of comparing and contrasting these three different approaches to the question of men, health and gender change is not to argue for the superiority of one mode over the other. Nor is this an exhaustive list of the possible ways in which changes in gendered thought, practice and relationship might be promoted. I haven't paid attention here to the power of legal routes of redress, the impact of efforts to transform institutional culture, and the role of structural interventions at the political and economic levels to build a more justly gendered world. It is also important to note that the changes I have reported across these various projects are fairly small scale and short term. None of the projects were able to determine how durable, broad or deep-going the observed changes might have been.

However, there are a couple lessons that I think are worth extracting from these cases. The first involves the complicated relationship in each of these case studies between the HIV epidemic – and public health challenges in South Africa more generally – and the politics and practices of gender transformation work. In these examples, HIV is much more than just the setting for an examination of gender change. Powerful assumptions about HIV, public

health, responsibility, culpability, authority, and the ability to control the physical, social and political bodies of men and women (Scheper-Hughes/Lock, 1987) all permeate the thinking and doing about gender in these cases. The HIV epidemic – and the global biomedical and political response to HIV – have also offered a great number of tools, resources, and opportunities to work towards gender change. The case studies in this paper have offered examples of the ways the existential threat of HIV, the biomedical tools of antiretroviral treatment, the biopolitical techniques of self-management and resonsibilisation, and the human rights discourses of treatment access and gender justice, have opened up a space to challenge all those involved to think and do gender differently. And there is a belief, cutting across these case studies, that if we don't think and do gender differently, we won't make any progress against HIV, or the many other health problems faced in the region.

While HIV has highlighted the role of gender and made gender change an urgent priority, it has also, however, sometimes limited how that change might be imagined. I have noticed, for example, how arguments for the importance of gender transformation often ultimately circle back to HIV (or some other public health problem). It is as if the (primary) motivation for gender change is understood to be the reduction of HIV prevalence and the improvement of the public's health. The implied corollary is that if HIV were no longer a problem, or were no longer driven by gender-related causes, then the project of gender transformation would become less urgent. In many cases, when deep conflicts around values, ethics and politics come to the surface in conversations, the medical logics or existential threats of HIV are often used to sidestep these harder-to-resolve issues. In these cases, resorting to the threat of HIV or to legal and biomedical rationalities used to frame HIV become a way of avoiding harder discussions of the persisting social and political contradictions around gender that remain unresolved in the country. Thus, while a health- and HIV -centric approach to gender has catalyzed many useful interventions, it has, at the same time, narrowed the social and political imagination of what gender transformation might mean.

The second lesson I want to develop from these cases involves the relationship between critique and practice in gender change. Despite my alignment with the feminist politics of the gender transformation agenda, I do think that the "ideological challenge" approach has been over-represented in thinking and doing about gender transformation in South Africa. Sonke's approach of critical awareness-raising, reflection and community mobilization in its OMC campaign is one of the more common approaches to gender activism in the country, along with efforts to "empower" women and girls and better enforce the country's already progressive gender laws and policies. Sonke's efforts in all of these areas are thoughtful, creative, and already building an evidence base for their effectiveness (Dworkin et al., 2015; Small et al., 2013).

It would be worth paying renewed attention, however, to the ways that new forms of practice, especially ones that are not explicitly focused on gender transformation, may themselves have profound gender transformative effects. The male PMTCT counselors in the Free State Province were certainly aware of the ways their work challenged local gender norms, but it seemed they undertook this work, and developed novel forms of gendered caring labour, in spite of this fact, rather than because of it. It was their daily health-related work with women, in their role as PMTCT counselors and HIV activists, undertaken in the

clinic and NGO spaces, that led to new forms of gendered relation, thought and action. In a way, their practice as HIV activists – which is how many of them understood their work – led indirectly to new and progressive forms of gendered practice.

In a similar vein, the members of Khululeka challenged gender norms in their communities not primarily as gender activists but as HIV-positive men who were struggling to not only stay alive but to achieve accepted forms of masculine success in their families and communities. By highlighting positive elements of local gender norms and embracing biomedical techniques of responsabilised self-management (*e.g.* careful monitoring of CD4 counts), they were able to in turn open up new, more positive, if still somewhat limiting, ways of being men.

In more general theoretical terms, this is nothing more than an argument for closer attention to the role of practice (Blue et al., 2016; Bourdieu, 1977; Ortner, 2006) in relation to men, women, health and gender change. Paying more attention to this domain of gender change allows us to think in more complex ways about how change can be triggered, what kinds of agency men and women might exercise, and how these changes might be supported and sustained. Many current approaches to gender change, in theory and in interventions, give women and men either far too much or far too little credit for being able to enact changes in gendered practice and thought. Women are too often either expected to be powerless (and wait for structural change) or to become empowered (through force of will or provision of education or resources). Men are too often constructed as either pathologically-oriented towards perpetration, or expected as individuals to simply ignore, resist or overturn prevailing patriarchal gender norms. The tools for gender change are usually either sought in the realm of either individual beliefs or external structural forces and resources. A theory of gender transformation informed by a more meso-level theory of practice would offer a useful complement to these approaches.

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