Research papers

God will look after us: Africans, HIV and religion in Milton Keynes

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ABSTRACT

This paper examines how black migrant Africans in Middle England make sense of religion, in particular Christianity, in their daily lives when faced with a life-threatening condition, namely, the human immuno-deficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS). The movement of the African HIV epidemic to the sub-urban English home counties, where services are still in their infancy, presents a challenge to service providers as well as those Africans who are living with HIV. In 2003, interviews were conducted with a sample of 22 Africans living with HIV, most of whom reported that they relied on inner strength supplied by their Christian faith in coping with HIV. Despite the importance of faith in the management of daily life within the context of a positive HIV diagnosis, the church was simultaneously construed as a threatening space marked by lack of confidentiality, and a site for the generation of stigma. Faith leaders ($n = 20$) took part in discussions and stressed their limited capacity in dealing with HIV-related issues within their congregations. Faith leaders expressed a willingness to work in partnership with statutory providers and be recognised as equal partners in the fight against HIV stigma, and wished for their capacity to be developed to support those who were living with HIV.

Keywords: African migrants, HIV, religion

Introduction

There has been very little academic research focusing on the role of religion in the management of a positive HIV diagnosis amongst African populations resident in Britain. American-based studies indicate that religious influences play an important role in coping with HIV (Simoni and Ortiz, 2003). Religiosity was found to have both positive and negative outcomes in alleviating HIV-related distress amongst African-American mothers (Prado *et al*, 2004). Limited research has been conducted in the UK, exclusively examining the role of faith communities' responses to HIV and how individuals use their faith to cope with HIV in their lives. Data from the 2001 National Census show that the majority (72%) of the British population, including black Africans, reported that they were Christians (www.statistics.gov.uk/cci/nugget.asp?id=293). Census data also show Africans as very religious, with only 2%

reporting no religion at all. Although not exclusively focusing on religion, the dominance of Christianity is reported in surveys with Africans in the UK affected by HIV (Positively Women, 1994; Weatherburn *et al*, 2003; Doyal and Anderson, 2004, Sadler *et al*, 2005). Health needs assessment surveys of the general African population in the home counties show that most African respondents reported that they were Christians (Chinouya *et al*, 2003a,b; Chinouya, 2004). An extensive community-based study of sexual health and lifestyles amongst Africans in England found more than 90% of respondents identifying themselves as having a religion (Sadler *et al*, 2005). More than 50% of males and 60% of females reported regular attendance at services more than once a week. There is evidence that prayer has been used in the management of HIV (Chinouya and Davidson, 2003). Religion

played an important part in adherence to medical regimes, with more women (56%) than men (44%) reporting that religion played a part in taking medication as prescribed (Chinouya and Davidson, 2003). Most Africans affected by HIV in England are drawn from sub-Saharan multifaith communities dominated by Christianity, such as Zimbabwe and Uganda.

Christianity, a complex religious tradition, taking as its starting point the belief in Jesus Christ as the saviour of humankind from sin (Musopole, 1998), has been embraced by diverse African cultures. Some African scholars argue that Christianity is an 'imported religion' in Africa which needed to be, and has been in various degrees, indigenised (Amanze, 1998; Musopole, 1998). A Malawian model based on *Nzeru Nzamuntu* (wisdom for humanity) includes an African epistemology which connects human beings to God and one another (Musopole, 1998). The mixing of Christian beliefs with African (indigenous) cultures, social and political circumstances has resulted in a hybridisation of Christianity. For example, in Botswana, Tswana people have reshaped Christianity to meet their emotional needs for faith healing, use of traditional medicines, divination and veneration of the ancestors, while remaining identifiably Christian in doctrine and faith (Amanze, 1998). The church also mutates to address the challenges faced by communities. In responding to the increasing numbers of people living with HIV within the community, Dr Bakare, Bishop of Manicaland in Zimbabwe, argues that the church sees itself as the Body of Christ, which can be construed as suffering from HIV and AIDS (Chinouya *et al*, 2005). According to Bakare, the doctrine of incarnation provides a basis for the church to be a healing place for people who are living with HIV. However, according to Southern Africa HIV and AIDS Information Dissemination Services (SAfAIDS, 2001), some people believe that too few faith-based organisations have developed positive responses to HIV/AIDS, with statements by some religious leaders leading to stigmatisation and guilt. Reverend Dr Hans Ucko in the foreword to a recent Christian Aid report (Huggins *et al*, 2004, p. i) asserts that 'in many religions, leaders and others are uncomfortable sitting at the side of a person or family with HIV or AIDS because this means facing issues of sexuality around which there is much insecurity, defensiveness and aversion'. Proposals in this report addressed to UK churches include the recommendation that faith leaders should work ecumenically to 'promote positive messages about HIV care [and that] HIV prevention and non-discrimination should be emphasised in their advocacy, policy and campaigning work' (Huggins *et al*, 2004, p. i).

In the UK, 60% of new diagnoses in 2001 and over 80% of heterosexually acquired cases were recorded as probably acquired abroad, mainly in sub-Saharan Africa (Department of Health, 2003). As of 2003, 12 553 black African people were living with diagnosed HIV infection and using services in England, 57% of whom lived in London (Department of Health, 2005). The lives of Africans in England who are infected with HIV, compared to their non-African HIV-positive counterparts, are impacted by social vulnerability characterised by poor housing, poverty and unresolved immigration concerns (Weatherburn *et al*, 2003). The struggle for economic survival is often compounded by the need to support globalised families amidst restrictions on the entitlement to take on formal employment due to immigration regulations (O'Keefe and Chinouya, 2004). Racism and stigmatisation are part of their lives (Dodds *et al*, 2004). The articulation of these compounded worldly sufferings with the experience of religion, in particular Christianity, amongst this population, is the central concern of this paper.

While the African settlement pattern has been concentrated in London and other major cities, suburbanisation is now taking place, with vibrant communities becoming established along road, rail and air routes accessible from the major conurbations. One such place of settlement is in Milton Keynes, a new town, the location for this research, within an hour's travel by rail or road from London. New towns were established in the second half of the 20th century, 1967 in the case of Milton Keynes, to provide deliberately planned environments for the overspill populations of expanding cities. Milton Keynes continues to be one of the four fastest-growing population nodes in England. The rapid African settlement in the context of the disproportionate presence of HIV infection within this population has prompted public health planners to attempt to identify the extent of the sexual health problems this population experiences. The findings on religion reported here emerged from a health needs assessment of this sort. We took the view that it is not possible to understand health needs unless those needs are located against the background of the ordinary lives that people lead, including their economic and social circumstances. Participation in religious activities is one such aspect of ordinary life for many Africans. This paper explores how faith leaders perceive their role in HIV prevention and how Africans living with HIV harness their Christian faith in coping with the virus in this new town. Although in the last census, black Africans constituted 1.3% of the total population in Milton Keynes, they feature significantly (71%) in reported HIV statistics (Milton Keynes Primary Care Trust, 2004).

Method

This study was conducted as part of a quantitative and qualitative needs assessment exercise commissioned by Milton Keynes Social Services Department in 2003 (Chinouya *et al*, 2003). Using a survey questionnaire with the general African population and interviews with a subsample of people infected with HIV, the exercise aimed to explore the health and social care needs of black Africans in the town. Focus group discussions were also held with faith leaders. The findings presented in this report are part of the exercise, with a special emphasis on how religion played a part in the lives of those who were living with HIV.

The Local Research Ethics Committee in Milton Keynes granted ethical approval, and the participants were recruited while attending HIV consultation clinics at the hospital. Semi-structured interviews took place in 2003, and concentrated on coping with HIV, religion, service utilisation and family life. The interviews were undertaken by one male and one female interviewer, each interviewer matched for the sex of the participants. To preserve confidentiality, each person was interviewed separately in one of the clinic consultation rooms. All interviews were tape recorded and transcribed verbatim. The data were anonymised to preserve confidentiality. Interviews were analysed using the thematic framework method, where themes were generated and narratives grouped into these themes (Ritchie and Spencer, 1993).

The focus group method was chosen to ascertain the views and experiences of faith leaders. This approach gave participants an opportunity to take part in the process of talking out loud in a safe space among their peers, about sensitive topics, and to explore the variety of views held in an environment that enabled participants to learn from one another. The group focused on the faith leaders' beliefs about HIV and how HIV was affecting their congregations; the role of religion in supporting those living with HIV; faith and sexual health issues, gender as well as gender relations within faith community settings. One of the authors of this paper (MC) led the audiotaped focus group discussion. Data from the group discussion were transcribed and also analysed using the thematic framework, in particular assessing the challenges faced by the faith leaders in addressing HIV issues within their faith groups.

Sample

The study sample consisted of 22 persons with heterosexually contracted HIV, who described themselves as Africans living with HIV and accessing HIV treatment at the general hospital's department of genito-urinary medicine (GUM), a leading centre for the HIV diagnosis and treatment. The sample was composed of women (17) and men (5). Most ($n = 16$) of the respondents reported that they were born in Zimbabwe, with the rest drawn from Ghana ($n = 2$), Uganda ($n = 1$), Somalia ($n = 2$) and Malawi ($n = 1$). The age of the respondents ranged from 22 to 50 years. All the respondents were on anti-HIV treatment medication. It should be stressed that the representativeness of this sample of all HIV-positive Africans in Milton Keynes remains unknown.

Posters were displayed at the GUM clinic with a summary of the study and how one could take part. Nurses and doctors who specialised in HIV treatment and care were also briefed and given information about the study, and asked by the researchers to pass on the information to potential respondents as they attended their routine HIV consultations. As the researchers were stationed in the GUM clinic on dates agreed with the nurses and doctors, HIV-positive Africans who wanted to take part approached the researchers and either gave their contact details for interview at a later date or were interviewed on the same day.

In addition, 20 faith leaders, most of them men ($n = 18$), were engaged in a focus group discussion. The leaders were drawn from Christian ($n = 18$) and Muslim faiths ($n = 2$), and were part of the interfaith group in Milton Keynes. Participants were recruited via a multifaith group that was attended by a faith leader who was on the steering group for this study. He brought members of the group together to discuss issues faced in addressing HIV-related concerns in their communities. This experience showed that it is extremely important to have persons who are 'well connected' with the targeted research community in research steering groups, as they are able to connect researchers with the various sections of the target population.

Findings

Four themes were identified from the data provided by the HIV-positive participants who took part in the interviews: getting a chronic illness, Christianity and coping strategies, support from God without telling others, and religion and sexual health. The focus group with faith leaders provided a further three themes: the role of the faith leader and the church/mosque, the lack of recognition by statutory providers, and talking about sexual behaviour in church. Each of these themes is discussed below.

Getting a chronic Illness

The onset of an illness, especially one that is not evidently self-limiting, fractures the general expectations of long life, exposing the individual to threats to self-identity and biographical disruptions (Bury 1982, 1997). According to Bury (1982) the consequence of an illness becomes evident with disruptions in the normal flows in everyday life. Of respondents living with HIV, nearly all (n = 19) reported that they first became concerned about their health after a persistent illness that disrupted their everyday lives, in particular work and attending college. For example:

> 'I had difficulties in breathing ... I could not go to work.' (male)

Their narratives show that to manage these experiences, most respondents tried to deal with the illness, which as yet did not have a label, at home, using medicines from the chemist shop or some which their friends recommended. As the illness became unbearable, they often required the attention of medical staff, in most cases at the hospital.

When presenting for treatment at the hospital, half the sample of men and women who were living with HIV said that they were immediately hospitalised (n = 11). Hospital medical personnel offered an HIV test to patients who were admitted to hospital or attending outpatient departments. Not realising that they could be HIV positive, some participants perceived this offer of a test, and the subsequent informed consent for the test that was coupled with counselling, as part of routine hospital procedures and reported being 'surprised' by the label given to the underlying cause of their illness. One female noted:

> 'I did not know that I was HIV ...'

This element of surprise came despite the counselling and information from the medical staff that the outcome of the test could be a positive diagnosis. Some respondents (n = 2) had presented their symptoms previously to their general practitioners (GP). The GPs were construed by these respondents as 'slow' to respond to suspected HIV infections:

> 'My GP told me that having continuous diarrhoea does not mean that you are HIV.' (female)

Some participants became suspicious that they could be HIV positive after they overheard gossip, or through 'the bush telephone', that their current partner had had an intimate relationship with someone who had since died with suspected AIDS symptoms. Such gossip often prompted them to go for testing to find out their own status.

Whichever way they had become aware of their status, nearly all respondents reported that they were 'surprised'. Making sense of the significance of an illness (Bury, 1997) against a background of HIV as a stigmatised condition often led to a wide range of negative feelings. Feelings associated with sadness were reported, such as:

> 'feeling down' (male)

or:

> 'crying ... I was alone and no one to talk to.' (female)

Some noted:

> 'I did not want to be HIV and why me?' (female)

Although they had described these negative psychological feelings around the time of diagnosis, nearly all 22 respondents reported that they had a limited number of people they could discuss their feelings and thoughts with, outside the hospital staff. The isolating experiences related to living in this new town were more severe because of living outside a major conurbation where services are more highly developed. When the research was conducted, there were no social support systems in place, such as a support group, for people living with HIV. Turning to religion to find answers and comfort about their illness became very important.

Christianity and coping strategies

Reflecting the needs assessment survey sample, most HIV-positive African participants (n = 20) reported that they were Christians. Few were Muslim (n = 2). Nearly all the respondents (n = 18) reported that they had strong faith and regularly attended a place of worship once a week. Despite attending a place of worship regularly, very few (n = 2) reported that they had disclosed their HIV-positive status to people in their congregations and/or their faith leaders.

Participants were asked during the interviews if they had disclosed to their faith leaders that they were infected with HIV. Only two respondents reported that they had. In these two cases, the decision to tell the leader was due to what they identified as 'unbearable depression' brought about by the significance of the disability and their inability to disclose their diagnosis and discuss their condition with friends and family members. The female respondent thought that she was dying when she received the diagnosis, and disclosure to a church leader was:

> '... a wish to prepare the soul for life after death.'

The text of a male who had disclosed to his faith leader was loaded with accounts of a 'near death experience' and a pressing need 'for repentance'. However, after disclosure to the priest and gaining access to medical treatments, he experienced what he referred to as 'the Lazarus effect' brought about by an improvement in his health. The improvement in his health was

compared with the biblical experiences of Lazarus who rose from the dead.

This resurrection experience had costs attached: the respondent, with improved health and *now* a hidden condition, had no control over the way the faith leader was handling the information about the positive diagnosis. One participant construed the preaching from the pulpit as deliberately targeting their own HIV diagnosis. Although the two participants had confided to their faith leaders, there were limits to what they could discuss with these leaders, as they positioned themselves and their HIV diagnosis in relation to the role that faith leaders have, as moral guardians. Faith leaders provided important forms of support related to prayers and visits. Issues related to sexual health, including HIV, were taboo subjects because:

> 'you don't talk about HIV in the church.' (female)

There were various other reasons why the majority had not disclosed to their faith leaders. This is how one male participant put it:

> 'I am not dying yet ... the pills are working.'

Some of the participants reported that aside from the medical professionals, they had not told anyone of their positive diagnosis and subsequently they had no one in their daily lives they could talk to about HIV. The lack of opportunities to discuss issues related to HIV were, in part, related to lack of disclosure of HIV to others in their social networks.

Support from God without telling others

Although most of the participants had not disclosed their diagnosis to their faith leaders, they perceived themselves as having a very strong relationship with God. This relationship was very important for physical and emotional wellbeing. This is how one female participant described this relationship:

> 'I am strong. My belief is making me strong. God is helping me. I have medicine but God is helping me. Through prayer, I can talk to someone. Because I don't talk to anyone I talk to God ... if I was not a Christian I would have killed myself ... when I pray and read the Bible I get hope to live.'

The significance of the relationship with God with respect to emotional and physical wellbeing was reported as being bound up with the opportunity to be more honest, as some of the participants reported that they could 'pour their hearts' out to God without the risk of breach of confidentiality, to which people are prone. Personal disclosure to God of living with HIV was easier in the privacy of prayer. Others asserted that when they prayed, God answered them. The success of medical treatments in improving their lives was a 'living testimony' for most of the respondents. Some reported that they were praying and asking God to:

> '... make the HIV diagnosis disappear and be cured and that would be a testimony.'

Religion and sexual health

Sexual health is a broad concept that includes physical and mental health as well as freedom from disease and discrimination (Department of Health, 2001). For purposes of this study, the discussion will focus on condom use, as this is one way that individuals can protect themselves and others from sexually transmitted infections, including HIV. Participants were asked about condom use. Some ($n = 3$) of the respondents reported non-condom use. The supermarket price of condoms was mentioned as a hindrance. However, this may have been an excuse as there were free condoms at the clinic where the interviews were held. Subsequently, non-use of condoms and the fear of (re)contracting HIV from a partner whose status was (un)known were often, according to one female:

> 'left to the will of God.'

The will of God was interpreted as having worked in their favour, as two respondents reported that despite having repeated unprotected sex with their partners, their partners had not contracted HIV. This was:

> '... a mystery ... a testimony about God's power.' (male)

The views from faith leaders

The role of the faith leader and the church/mosque

Faith leaders were asked about their perceptions regarding the extent to which HIV had affected their congregations in England, and Milton Keynes in particular. There was a general lack of full knowledge about the extent to which HIV was affecting African communities in England or in the locality. However, most faith leaders appeared informed about the ways in which HIV had affected the sub-Saharan African continent. They used words such as 'devastation', 'catastrophe' and 'terrible' to describe the African continent situation. Some perceived that faith-based organisations in Africa had been more proactive, and had joined in the fight against HIV/AIDS in comparison with those in England.

Parts of the discussion focused on whether, as faith leaders, they had played any significant role in the fight against HIV/AIDS in the home counties. They stressed that the church/mosque, like many other institutions, was facing the dilemma of how to deal with the crisis in

the most appropriate way, considering the core work or responsibility of the church in keeping high and healthy moral standards in society. They pointed out that finances, human resources and capacity within their faith-based organisations were very limited and hence they were unable to effectively join those organisations fighting stigma and discrimination and help promote messages that encourage safer sex from the pulpit or other settings.

Some participants argued that the church/mosque had not done much in the fight against HIV/AIDS because it had tended to remain within the traditional ambit of condemning sexual activities outside marriage as 'ill behaviour', or 'sexual promiscuity' associated with the spread of HIV. This led to a cultural environment within the church that militated against openness. Some faith leaders argued during the discussion:

> '... if we are dealing with culture ... it's time the church moved and changed ... it's time to get out of this bondage.'

Others questioned the lack of drive amongst the faith leaders in engaging with the government's initiatives. During the discussions they challenged one another using words such as:

> 'go to the council and ask for help ... they will say you are not qualified.'

It was reported that some Africa-based faith organisations had taken the initiative and approached their local council for help and support in doing work within the community on HIV education. However, in this new town they, the faith leaders, thought that even if they wanted to be proactive, in practice this was highly problematic as they faced the problem of lack of recognition by statutory providers. Faith leaders referred to statutory providers as 'governments'.

Lack of recognition by statutory providers

Faith leaders argued that 'governments' had not yet recognised faith leaders as able partners in the fight against HIV/AIDS. The word 'governments' was used to refer to statutory providers including social services and primary care trusts. There was a perception that governments behaved as though they believed that they could provide solutions to many 'national crises', including the HIV/AIDS crisis, without partnership with faith-based organisations. Being ignored by governments was a problem, as leaders commented:

> 'in our communities we have ways of dealing with it [HIV/AIDS].'

There was, however, no agreement on the ways they dealt with HIV in their 'communities', although the strategies included prayers, pastoral support and offering advice on local services, and writing letters of support.

The lack of recognition has hampered the efforts of governments to distribute resources, in particular to faith-based organisations. Thus, without recognition, faith leaders and their organisations had not been able to access resources from governments to sponsor programmes that would increase HIV awareness, provide support, and fight discrimination and stigmatisation.

Many faith leaders emphasised that any work on HIV/AIDS that they had been engaged in was construed by the governments as part of the faith leaders' religious duties. This work did not get any recognition as being part and parcel of a public health programme and hence they questioned:

> 'who picks up the pieces when the social services offices are closed?'

Picking up the pieces included pastoral support during the times when statutory providers were closed for the weekend and public holidays. These were the times when some of their flock could not access support, and this duty fell on religious leaders who felt a moral responsibility to their communities as and when need arose. This work, which fell under the category 'God's work', was often undocumented and lacked coordination within these faith-based agencies. It also emerged during the discussion that much of the HIV work done by individual faith leaders was very much informed by a leader's efforts to engage themselves at their own discretion with programmes devoted to the fight against HIV/AIDS, as there was no direct and coherent support from their church or mosque hierarchies and the 'governments'.

Talking about sexual behaviour in church

Discussions about sexual behaviour, prevention and working with marginalised communities are some of the difficult areas that are faced by many faith-based agencies (SAfAIDS, 2001). HIV as a sexually contracted infection has profound implications for talking about sexual health. Faith leaders were engaged in a discussion regarding partnership work with health promotion agencies, in particular talking about prevention within the church/mosque settings. Some argued that religious teachings that placed emphasis on 'holiness and other things' made it difficult to talk about sexual health within the church. Subsequently they argued:

> 'we don't preach about it [sex and HIV] ... we are not social workers ... there are attitudes you should expect from a social worker and from a pastor.'

Some argued that they did not talk about sexual health because that was not their professional responsibility. When asked 'are you comfortable to talk about sex within the church or mosque?', there was a general consensus that although they did not talk about sexual

health in the church or mosque, they would be interested in building their capacity to support their congregation on sexual health matters, including HIV. Faith leaders argued that the church was well fitted to talk about sexual health, as its objective was to promote a better spiritual lifestyle, to help people stay away from sexually transmitted infections. In addition it was suggested that one way of engaging the community in sexual health discussion was to bring sexual health specialists to give talks to their congregation on the subject. This would require the development of partnership work with those who are skilled in the subject of sexual health.

Discussion

Religion involves a set of symbols, integrated in culture, involving feelings of reverence or awe, and linked to rituals or ceremonies by a community of believers (Giddens, 1989). Classical sociologists argue about a possible functional role of religion in society. By attributing socially created values and norms to the activities of supernatural forces such as god(s) (Feuerbach, 1957), religion might be an 'opium of the people', offering happiness after death, or operate to enable an 'oppressed' group to live with their difficulties (Marx, 1963, p. 41). On this view, it offers genuine rewards for people in difficulty, without engaging them in contesting the social and economic structures that are causally implicated in the difficulties they experience. Much social science of modernisation anticipated that secularisation would accompany economic and social development. With increasing knowledge-based efficacy, human beings were expected to develop confidence about relying on themselves rather than depending on some supposed external or transcendent power to which was attributed control over decisive aspects of life. In contrast to theories of religion emphasising knowledge, which predicted that as life became more science based, non-scientific creeds would erode, Durkheim (1915) argued that cohesion-producing cult rather than creed is the hallmark of religion. Collective religious practice binds members into a community (Durkheim, 1915). On this view, religion would change, but not disappear as long as individuals were effectively bound to one another. Hence, religion was coterminous with social capital and collections of individuals not so bound together would suffer from moral confusion, rootlessness, and the inability to co-operate or act on moral consensus. Durkheim's analysis is a key point of reference within the sociology of medicine to begin to understand social factors impacting on mental health. Characteristic of secularisation is the systematic disengagement of institutions from the control of

religious bodies. This separation of media, education and healthcare facilities from religious control is evident in modern societies. In addition, faith groups vie for religious affiliation, with none exercising a monopoly on a given territory. Where disengagement occurs and/or there is a plurality of faith groups in a given space, religion is less crucial as a direct provider of information and service provision in respect of the health of the population. Where education and health institutions have not been developed as robust independent service providers, religious bodies may be the key gatekeepers to essential elements of human capital formation. This is so in many parts of Africa. On one point social scientists agree: sacred wisdom, to be found in artefacts such as the Koran, the Bible, the Vedas, or within oral tradition, is marked by information and mandatory prescriptions about health:

> Sacred stories, histories, song and dance shape the emotions so that pride, humiliation, indignation and solidarity attach to specific role models. Members are praised and blamed accordingly. Much of the role structure is related to health. Tight rules about gender, personal and communal hygiene, the treatment of pregnant and menstruating women, when to have sex and with whom and how, what people are allowed to eat, and the use of intoxicating substances are taken in with mother's milk and the local language. (O'Keefe, 1995, pp. 52–3)

Since stigma involves moral judgements of spoiled identity shared by a community including the person stigmatised (Goffman, 1963), it is not surprising that faith communities are crucibles within which stigma is forged and reproduced. The great challenge for faith communities with respect to HIV is whether they have the resilience to be able to continue to provide valuable resources for participants while finding ways to disrupt the stigmatising processes fuelled by the faith itself. Much recent anthropology gives weight to religion as a site for the construction of meaning. In one of the very rare studies of African religion in the UK, such an exploration of meaning centres on religious participation as a mechanism for accessing spiritual power that gives participants what they see as extra resources to pursue their goals. The author examines transformations of meaning over generations and finds that access to much valued spiritual power can be maintained while gender norms are changed dramatically (Harris, 2002).

Large and rapid changes to the demographic profile of the UK have led to a call for concerted focus on the medical needs of immigrants (Khan and Ghosh, 2005). This will require an extensive research effort to find out what those needs are. In our view, that will require an imaginative and creative approach. The findings reported here are in line with the claim that the research agenda in respect of HIV and sexual behaviour amongst African migrant communities in

the UK is in need of important shifts of focus and method (Kesby *et al*, 2003). Kesby and colleagues have pointed to the importance, *inter alia*, of using social science evidence bases and methods, especially qualitative methods, to explore the underlying social factors that shape patterns of belief, attitude and behaviour, including poverty and gender. Such developments would enable an understanding of health risk against a background of sexual decision making as relational. Kesby and colleagues call on researchers to try to understand behaviour in the context of structures and constraints within and against which individuals and communities deploy discursive practices interactively. Their comments on gender point to the ways in which power relations operate within a web of meanings regarding love, pleasure, trust, sex and so on, which are unstable and require active buy-in by participants if they are to continue to operate hegemonically, i.e. to pass as 'natural'. Faith communities can be explored using these insights. This is especially so with respect to those who are seropositive participants.

Our findings suggest that participation in religious activities by those affected by HIV provides forms of empowerment that are contradictory and unstable. Participants are subject to stigma within the church, but actively reproduce this themselves. While their church membership does provide a communal framework of the sort indicated by functionalists, the framework is neither as tight nor as coherent as such theories might indicate. Religion provides comfort, not least through opportunities used for creative conversation with the imputed deity that is experienced as empowering, but within meaning frames that reproduce stigma. Hence, participation in public practice continues to consign this empowering conversation to invisible private spaces within which disclosure is not punished.

Our findings also throw down a serious gauntlet to commissioners of service provision who should ensure that planning in respect of African communities is evidence based. The Department of Health's (2005) prevention framework for HIV and AIDS in the African communities calls for work with African community-based organisations, including faith communities. In our sample, faith leaders expressed interest in being involved this work, indicated their willingness to identify gaps in their knowledge and skills, and recognised that there are significant challenges to their interpretation of the requirements of sexual morality. If they are to be so involved, it is essential that an action-research programme be put into place to develop the capacity of faith leaders to promote the sexual wellbeing within their community and counter the stigma currently attached to HIV.

There are limitations with this study. First, the service user participants who were interviewed were recruited at a clinic within the two-month period of this research. It is likely that people who were recruited at the clinic during this time could have been different from those who were not attending clinics. Second, this study does not explore potential differentiation amongst the respondents regarding church, denomination, sect membership within Christianity or presence of syncretic elements of African indigenous provenance within the religious discourse. Third, the respondents were not differentiated with regard to national, regional or tribal diversity. Fourth, because the numbers of HIV respondents and faith leaders from a Muslim background were so small, we have not commented on their specific contributions and have confined our discussion to those who identified as Christian. However, this sample of clinic attendees did raise important points about services in this town regarding the importance of partnership work between statutory providers and faith communities in coping with a life-threatening condition. The research has shown how some people turned to religion to cope with a stigmatised condition. Although they had limited contact with support services, Africans living with HIV were in regular contact with religious institutions. Faith leaders were the first port of call, but were less aware and engaged with the needs of this population than they would wish to be. They were not seen as able to maintain confidentiality regarding a positive diagnosis. Creation of safe spaces that promote the disclosure of HIV through capacity building of religious institutions is one way of getting involved with HIV and AIDS programmes. Our discussion of the complexity of the use that believers were making of private space for conversation with God, against the background of the significance of the role of churches in policing intimate sexual norms, suggests that it would not be an easy task for church leaders to contribute to the destabilisation of the perceived stigmatising hegemony which prevails within faith communities. Nevertheless, faith leaders indicated sufficient ambivalence about their role with respect to moral teaching to leave openings for stigmatising hegemony to be challenged. Faith leaders also showed their limited capacity within the context of limited overt support from the local authorities as well as senior members in churches and mosques.

SAfAIDS (2001) suggests that personal experiences of knowing someone living with HIV, advocacy and offering support to those who are living with HIV are some of the ways in which faith communities can become involved in HIV/AIDS advocacy. There are indications that participation in faith communities provided emotional support to people living with HIV, without explicit, expressed engagement in the provision of this support by the clergy and other members of the congregation. Building the capacity of faith communities to be able to respond to the

unspoken needs of people living with HIV should be enhanced through partnership work with the local primary care trust health promotion teams, other statutory providers, and HIV voluntary agencies. It was also suggested that specialists in HIV and health promotion could be invited into churches to provide specialist services.

Conclusion

This small-scale investigation points to the presence of religious practice as a mediating factor, which those affected by HIV use to manage their conditions. Hence, we place as a marker that religious practice should be included as a topic within the emerging research landscape for HIV amongst African communities in the UK. This research should be informed by the proposed agenda outlined by Kesby *et al* (2003). Our research has pointed to the complex and contradictory experience of the relationships of persons living with HIV and faith communities. Although their faith provided support and hope in times of crisis, the church composed of individuals was seen as a threatening place for handling delicate information about one's HIV status. Importantly, statutory providers and faith leaders need to work in partnership. Building the capacity of faith leaders to help fight stigma and offer support to those who are living with HIV should be prioritised.

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