

Religious participation and HIV-disclosure rationales among people living with HIV/AIDS in rural Swaziland

Robin Root

Department of Sociology and Anthropology, Box 4-255, Baruch College, The City University of New York, One Bernard Baruch Way, New York, New York 10010, United States

Author's e-mail: robin.root@baruch.cuny.edu

Despite the cultural salience of Christianity in many parts of Africa and the expansion of antiretroviral treatment, few studies have examined experiences of religious participation among HIV-positive individuals. Correspondingly, most studies of HIV self-disclosure in sub-Saharan Africa focus primarily on disclosure to sexual partners. Addressing both concerns, the central concern of this article is HIV self-disclosure in church settings, where disclosure rationales functioned as a key heuristic to explore experience of HIV-positivity, religiosity, and church participation. Given 39.2% antenatal HIV prevalence in Swaziland — the highest in the world — and an estimated 6 500 local congregations, this article draws on a medical anthropological project in Swaziland to investigate experiences of church participation among HIV-positive individuals. The data were derived from semi-structured interviews with 28 HIV-positive individuals across three domains: 1) pre- and post-diagnosis religiosity; 2) HIV stigma and support in church settings; and 3) decisions around HIV disclosure. Field research and open-ended interviews with individuals close to people living with HIV, health personnel, and pastors provided important contextual data. A grounded theory analysis showed that HIV disclosure in church settings is a highly reflexive process, mediated by subjective religiosity, the social dynamics of church networks, and broader structural vulnerabilities. Church participation often entailed significant stigma, which negatively affected self-disclosure and help-seeking practices; however, a rhetoric of 'courage' emerged to describe individuals who voluntarily disclosed their HIV-positive status. Pastors and pastors' wives were key protagonists in disclosure strategies. A church-based defense of the meaning of personhood for people living with HIV was among the most important findings. Given that congregations in much of Africa are predominantly female, and because women comprised the majority of the sample, the study productively problematised church settings as sites of analysis where gender, poverty, and religion intersect disease epidemiology in ways that may have untapped programmatic implications.

Keywords: anthropology, church, gender, grounded theory, religion, socio-cultural aspects, stigma, sub-Saharan Africa, women

Introduction

Despite estimates that religious organisations manage between 30% and 70% of medical assets in Africa (Thomas, Schmid, Gwele, Ngubo, & Cochrane, 2006) and notwithstanding the expansion of Christian networks across much of Africa (Bediako, 1995; Anderson, 2000; Meyer, 2004), peer-reviewed studies of faith-based responses to HIV and AIDS do not yet reflect the magnitude of activity on the ground (Woldehanna, Ringheim, Murphy, Gibson, Odyniec, Clérisimé *et al.*, 2005). However, an emergent body of literature from the fields of sociology, theology, and clinical medicine suggests the salience of religiosity, religious participation, and religious institutions to individuals and communities facing multiple vulnerabilities in Africa. This article aims to contribute to this project by drawing on data from a medical anthropological project in rural Swaziland to explore the social, spiritual, and strategic meanings of religious intensification and participation among people living with HIV (PLHIV).

With a 39.2% antenatal HIV prevalence (National Emergency Response Council on HIV/AIDS [NERCHA], 2008), 33-year average life expectancy (Attawell, Ogunlayi & Mndzebele, 2009), and a situation in which 34% of children under age 18 are living with neither parent (Central Statistical Office & Macro International, 2008), the Kingdom of Swaziland has witnessed an estimated 350% growth in registered church organisations since the mid 1990s (Pan African Christian AIDS Network [PACANet], 2008). Dire in the extreme, the epidemic in Swaziland provides a compelling epidemiological and socio-cultural environment for examining religion and HIV, which has relevance beyond its borders, such as in Lesotho and KwaZulu-Natal Province, South Africa. Indicators for those locations demonstrate similar hyper endemic conditions (Commission on HIV/AIDS and Governance in Africa, 2008), while religious organisations have been shown to play important public health roles (Cochrane, De Gruchy, Germond, Jones, Gunderson, Matimelo *et al.*, 2006).

Swaziland's 'Second National Multisectoral HIV and AIDS Strategic Plan 2006–2008' proposes a signifi-

cantly scaled-up response to the epidemic that takes to task communities that “lack initiative and tend to look up to government, development partners and civil society organisations to bring them relief” (NERCHA, 2006, p. 56). Assessments of community lassitude, however, may overlook the informal and ad-hoc efforts made by national church associations, dioceses, and local congregations to alleviate the multiple vulnerabilities that households suffer. With approximately one local congregation per 172 Swazi citizens versus one HIV testing and counseling facility per 8 080 persons, and one antiretroviral treatment (ART) site per approximately 45 400 persons, the institutional saturation of churches in Swaziland suggests evidence of a potentially vital untapped religious health asset. A concept developed by the The African Religious Health Assets Programme (ARHAP), an international research collaboration based in South Africa, religious health assets (RHA) provide a means of theorising the tangible and intangible assets that religious institutions and religious activities bring to the public health enterprise in sub-Saharan Africa (Cochrane, 2006).

In light of the centrality of Christian organisations to Swazi society, especially to women, I begin by describing the meanings of religiosity to the HIV-positive participants in the study and their experiences of church-based social networks. Critical to this analysis are participant reports regarding whether and how church leaders talked about HIV/AIDS to their congregations. These two foci — the subjective and social experiences of religious participation — provide the foundation for the central concern of this article: HIV-positive individuals’ decisions concerning voluntary self-disclosure in church settings.

Though some studies have examined aspects of HIV-disclosure patterns in Africa (e.g. Hutchinson, Mahlalela & Yukich, 2007), the rationales behind these patterns (i.e. the practices, settings, and perceived responses to self-disclosure) remain largely unknown. Such insights are essential because despite the public health valence of HIV-disclosure dynamics, little research exists on modes of disclosure in non-Western contexts (Norman, Chopra & Kadiyala, 2007), with most studies of self-disclosure in sub-Saharan Africa limited to decisions regarding disclosure to sexual partners (Miller & Rubin, 2007). To begin to redress these gaps, HIV-disclosure decisions functioned here as a key heuristic to explore aspects of HIV-positivity and religiosity. Given women’s proportionately large representation in Swazi congregations, and because the study sample was predominantly female, the analysis speaks most saliently (albeit not exclusively) to experiences of HIV-positivity, religiosity, and church participation among HIV-positive women. The overall aim of the article is thus two-fold: 1) to demonstrate the ‘situatedness’ of HIV-disclosure rationales as part of an assemblage of an HIV-positive individual’s experiences (including stigma, support, and health practices), which religiosity and religious participation mediate; 2) to substantiate local church congregations as distinctive sites of social-scientific and public-health analysis, where socio-cultural and structural processes intersect disease epidemiology.

Background

A former British protectorate, Swaziland is a small landlocked country bordered by South Africa and Mozambique. The only contemporary absolute monarchy in Africa, it is an ethnically homogenous nation, populated almost entirely by Swazis. Christian and ‘traditional’ practices in governance, religion, and medicine are integral features of social and political life. The kingdom’s head of state, King Mswati III, holds supreme executive, legislative and judicial powers, and presides over dual modern and traditional systems of governance (World Bank, 2008). Approximately 70% of Swaziland’s population practices subsistence agriculture and lives below the poverty line (Whiteside, Andrade, Arrehag, Dlamini, Ginindza & Parikh, 2006). Registering a Gini Index of 50.4, Swaziland is considered one of the most economically unequal societies in the world, ranking 141 among 177 nations (UNDP, 2007).

In addition to economic disparities, gender inequality remains stark in Swaziland (UNICEF, 2003). Prior to the adoption of a new constitution in 2006, Swazi women were deemed minors who required the permission of a male relative to own property or to open a bank account (IRIN, 2005). Yet despite new constitutional provisions, Swazi girls and women continue to be vulnerable in terms of customary law, pertaining, for example, to ritualised abductions, forced marriage, and having no right of consent in marital issues (Dube & Magagula, 2007). In a report on an initiative to grant women the right to refuse participation in socio-cultural practices, a Swazi judge was quoted as saying that “animals have more rights and freedoms than a woman here” (cited in Lucas, 2005, p. 62).

The extent to which socio-cultural, economic, and legal inequalities in Swaziland produce gendered vulnerabilities to HIV has been identified as a key concern (Daly, 2001). Swazi females become infected at an earlier age than men, and approximately one in three women age 15–49 years, compared with one in five men, is HIV-positive (Central Statistical Office & Macro International, 2007). To date, the government has conveyed contradictory messages over its concern that cultural practices exacerbate a risk of exposure to HIV. In 2001, the King reinstated traditional chastity vows for young unmarried women (*umcwasho*) as a culture-specific mode of HIV prevention intended to prohibit men from having sex with unmarried women under age 18; however, he breached his own ban a few weeks later by selecting a 17-year-old wife at the annual reed dance (*umhlanga*) (Democratic Underground, 2004). When the King revoked the ban altogether, in 2005, critics censured his failure to address the entrenched cultural drivers of HIV risk (IRIN, 2005).

In contrast to royal vacillations, the government’s ‘Second National Multisectoral HIV and AIDS Strategic Plan 2006–2008’ asserts that the “abuse of power by men through condoning socio-cultural practices that promote their dominance contributes to the vulnerability of women and children” (NERCHA, 2006, p. 46). Given the 49% HIV prevalence among Swazi women ages 25–29 years (Central Statistical Office & Macro International, 2008), and because women constitute the majority of church-goers in Swaziland,

local congregations have been identified as ready portals to highly vulnerable segments of the population. In 2002, following a United Nations report identifying Swazi churches as 'valuable pulpits' from which to reach young women, the United Nations Children Fund (UNICEF) partnered with the Swaziland Council of Churches to provide adolescent women with education in the areas of HIV/AIDS and human-rights, delivered through religious leaders and church-based networks (Hall, 2002). Religious institutional leadership was also demonstrated by the Swaziland National Church Forum when it issued the first formal denouncement of HIV stigma and discrimination nearly a decade before the Swazi government did the same (see Swaziland Ministry of Health and Social Welfare, 2008). As a national coordinating body of churches, the Swaziland National Church Forum was established in 1998 with the express intent of organising church-based responses to HIV/AIDS. The forum was subsequently profiled by UNAIDS (2006) as a best-practice community response to the HIV epidemic in Swaziland. Eventually recognising the integral role of religious institutions and leaders in HIV/AIDS-related programming, the government's draft strategy on combating HIV/AIDS-related stigma and discrimination identified churches as important settings for targeted interventions (Swaziland Ministry of Health and Social Welfare, 2008).

Study design and methods

The data were drawn from a medical anthropological project in rural northern Swaziland. Descriptive qualitative and focused ethnographic methods were used to explore HIV/AIDS-related stigma and the role that religiosity and church participation may play in the lives of PLHIV. The benefits of a descriptive, qualitative research design lie in the combination of qualitative methods — including semi-structured and in-depth interviews, which can help to elicit holistic and nuanced accounts of illness experiences (Eckhardt, Mott & Andrew, 2006). A similar design was used by Greeff, Phetlhu, Makoae, Dlamini, Holzemer, Naidoo *et al.* (2008) in a study of HIV-related stigma among PLHIV in five African countries, including Swaziland. In light of these methodological strengths, to better understand experiences of HIV-positivity and religiosity, the semi-structured interview questionnaire (Table 2) used in this study was designed to collect qualitative data across three domains: 1) pre- and post-HIV-diagnosis religious intensity; 2) perceptions of church-based HIV stigma and/or support in church settings; and 3) decisions around HIV-self-disclosure in church settings. Open-ended interview schedules worked from the semi-structured questionnaire but entailed considerably longer responses and/or meaningful tangents to some of the questions.

The second methodology, ethnography, has been described as an essential epistemology for situating research on religion and HIV/AIDS in the lived experiences of individuals and communities (Adogame, 2007). Ethnography is also an integral feature of the ARHAP research design (ARHAP, 2009). In an analysis of coping strategies among South African women with HIV or AIDS, Dageid & Duckert (2008, p. 184) defined focused ethnographic methods as a "time-limited, exploratory

study of a particular phenomenon [to collect] meaningful in-context data." In the study here, focused ethnographic methods of data collection entailed the researcher's attendance at church services, observations at the local HIV-testing and treatment health centre, and residence on a Swazi homestead. Each of these domains of ethnographic observation involved social interactions that yielded additional insights to inform the analysis.

Sampling strategy

Data collection occurred over nine weeks, between July 2005 and August 2006. The point of access was through a small foreign missionary organisation that had been active in the community some years prior. Its director continued to be well integrated in the traditional structures of the community and assisted in securing permission for the author's research from the local tribal council and other persons of status. Because the organisation did not maintain an office with staff in the community, and because the author (after being introduced to key persons) subsequently resided on a Swazi homestead and moved about independently, there was not an apparent association that would have shaped participant responses in any discernible or systematic way. Moreover, the questionnaire was designed so that questions concerning religiosity and religious participation were subsets of a broader inquiry into experiences of HIV-positivity, thereby minimising perceptions of proselytising intent.

Interviews were audio recorded and conducted anonymously, the majority occurring in Swati with the assistance of a Swazi translator. Interview audio was transcribed with the assistance of a research assistant in the United States. Consonant with the primacy of oral over written communication in Swazi society, consent procedures were explained and consent was provided orally before each interview commenced. The research procedures were approved before research commenced by Baruch College's Human Research Protections Program, City University of New York (USA).

The study used a strategy of purposive sampling of individuals who currently participated in local congregations, in order to explore diverse aspects of church participation. Most participants were accessed through an HIV-support group and a government health facility that provided HIV counseling, testing, and low-cost ART. Thirty-two individuals were asked to participate in the study; one person declined. The remaining 31 participants were comprised of 28 HIV-positive individuals (23 females and five males) who completed the semi-structured interview questionnaire and three persons (one HIV-positive; two HIV-negative) who were interviewed by adapting the semi-structured questionnaire. For example, it was preferable to conduct the interview with the HIV-positive individual in an open-ended format, as that person was a church leader who offered particularly compelling insights on the question of religiosity, religious participation, and HIV/AIDS. The two presumably HIV-negative participants were interviewed because, like many Swazis, they bore close witness to HIV-positive individuals' experiences of religion and HIV/AIDS in ways

that enhanced the analysis. The first of these respondents was a young woman had lost a close friend to AIDS and who felt that a Christian identity might have saved her from parental pressures to abandon ART. The second was a mother whose adult daughter was HIV-positive. The daughter reportedly began attending church after being diagnosed, yet despite encouragement from her congregation to go to the health centre, where free ART was provided, she would not. It was a church-based social network, moreover, that the mother said encouraged its HIV-positive congregants to do likewise. Both interviews significantly enhanced the analysis.

Sample characteristics

The majority of participants were females ($n = 23$) and the remainder males ($n = 5$) (Table 1). As a result, the findings are particularly illustrative of women's experiences. Given that the majority of pastors in Swaziland are male and because there are Swazi men who attend church and suffer from HIV/AIDS and poverty as well, data from male participants were retained in the analysis. The age range of the participants was 22 to 'over 60' years old; individuals ages 46 years and older constituted the largest group (43%), followed by those ages 22–35 years (39%) and 36–45 years (18%). All of the participants identified themselves as Christian, with the exception of one woman, a traditional healer, who attended church only at the urging of her adult children, as they feared that her ancestral calling to be a healer was a form of demonic possession.

Differentiating the religious experiences of individuals of different denominations has posed repeated challenges for scholars in Africa, in large part because categorical distinctions do not capture the complexity of many African church movements (Anderson, 2001; Meyer, 2004). Possible associations between denominational affiliation and HIV-related beliefs and practices are nonetheless an important line of inquiry (see, for example, Agadjanian, 2005). So, while the study sample was insufficient for a stratified analysis of such data, asking that participants identify the denomination of their congregation helped to signal the diversity of church settings. Thus, half the sample reported participation in Zionist congregations, which are uneasily categorised in much of the literature as African independent or indigenous churches (AICs) (for an excellent discussion, see Anderson, 2001). AICs have been described as sites where scriptural interpretation and religious practices generally reflect the distinctive histories, contemporary challenges, and socio-cultural particulars of the southern African region (Grundmann, 2006). Nearly 40% of the sample participated in what are loosely categorised in Swaziland as evangelical, Pentecostal or Pentecostal Charismatic (PCC) congregations. According to Meyer (2004, p. 452), African PCCs are often characterised by an emphasis on the concept of a 'Holy Spirit,' which manifests in cultural practices, for example, of prayer healing and prophesying. Last, one individual in the sample attended a mainline (Roman Catholic) congregation; a denomination referred to in the literature on Christianity in Africa as a historical or mission church rooted in more Western Christian traditions (Gifford, 2008).

Discussion

Participants' responses to the structured portion of the questionnaire were tabulated to produce descriptive statistics of key indicators (Table 2). However, only by situating these results in the contents of open-ended answers could the 'lived significance' of these numbers be interpreted. Thus, the field research and interviews with key informants provided important contextual data. Use of grounded theory analysis, "the making of credible inductive arguments for phenomena situated within a context of discovery" (Miller & Fredericks, 1999, p. 549), has been described as a productive approach for an emergent theory of religious health assets (ARHAP, 2006). The grounded theory analysis of qualitative data presented here generated a conceptual framework to help explain HIV-disclosure rationales in church settings in terms of a highly reflexive process (see Figure 1) — a process mediated by the subjective meanings of religiosity and HIV-positivity and the social dynamics of local congregations. Disclosure decision-making, however, must be situated within the broader structural and socio-cultural vulnerabilities that imperil individual wellbeing and community health in Swaziland. I now turn to an analysis of themes in order to demonstrate the significance of religiosity and church participation to participants' HIV-disclosure rationales and the downstream effects on several vital HIV-related health practices.

Religiosity and HIV-positivity: subjective meanings and practices

Clinical research among individuals with HIV infection has demonstrated diverse experiences of religious participation, faith, and spirituality as salient features of being HIV-positive (Pargament, McCarthy, Shah, Ano, Tarakeshwar, Wachholtz *et al.*, 2004). Of particular interest has been the extent to which religious intensification and spirituality are associated with better health outcomes, as some studies have suggested (e.g. Carrico,

Table 1: Characteristics of the participants ($n = 28$ HIV-positive individuals, average age 39.5 years)

	<i>n</i>	%*
Females	23	82
Males	5	18
Age distribution (years):		
22–35	11	39.3
36–45	5	17.9
46–'over 60'	12	42.9
Marital status:		
Married	16	57.1
Widowed	1	3.6
Single	4	14.3
Unknown	7	25
Church denomination:		
African Independent Churches (Zion and Jericho)	14	50
Pentecostal	11	39.2
Roman Catholic	1	3.5
Did not know	1	3.5
Missing data	1	3.5

*Percentages have been rounded in the text.

Table 2: Examination of religious intensity and church experience among the participants who were current church attendees ($n = 28$ HIV-positive individuals)

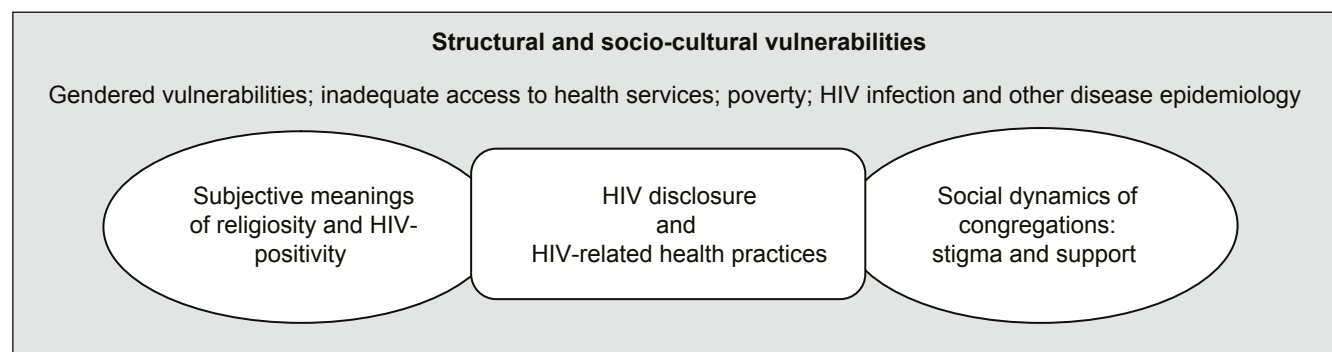
Semi-structured interview questions	'Yes' <i>n</i> (%*)	'No' <i>n</i> (%*)
Did you begin attending church after your HIV diagnosis? (If yes, why?)	7 (25)	21 (75)
Have your religious beliefs changed since your diagnosis? (If yes, did you 'repent'?)	14 (50) 7 (25)	14 (50)
Has your attendance at church increased since diagnosis? (If yes, why?)	13 (46.4)	15 (53.6)
Do people in your church know you are HIV-positive? (If yes, did you disclose or was there gossip? What was the reaction?)	12 (42.9)	16 (57.1)
Did you tell the pastor your status? (If yes, what was his/her reaction?)	11** (39.3)	17 (60.8)
Does your pastor talk about HIV and AIDS in sermons? (If yes, what does he/she say?)	22 (78.6)	6 (21.4)
Do you feel people stigmatise you at church?	†	
Do you receive help from church members, spiritually or materially (for example, with food)?	‡	

*Percentages have been rounded in the text.

**Three disclosures were made to a pastor's wife.

†Without disclosure of HIV status to church members, a participant may not have experienced or perceived HIV-related stigma. As a result, reports of 'no stigma' did not produce a meaningful metric of whether stigma was a discrete feature of church experience. Responses to open-ended questions about fear of disclosure provided better experiential data.

‡Some participants had not disclosed their HIV status to church members, therefore tabulation of whether the participants had received church support was not a meaningful metric. Open-ended responses provided more illustrative detail of the kinds of support and the conditions under which church support was provided.

**Figure 1:** Religiosity, HIV-positivity, and HIV-disclosure rationale in church settings

Ironson, Antoni, Lechner, Durán, Kumar & Schneiderman, 2006; Yi, Mrus, Wade, Ho, Hornung, Cotton *et al.*, 2006). Recognising the need to assess quality of life among PLHIV cross-culturally, the World Health Organization piloted a quality-of-life (QoL) instrument to determine meaningful indicators for individuals with HIV infection (see WHOQOL-HIV Group, 2003). The six-site international study found that the impact of a diagnosis of HIV/AIDS on individuals' QoL was most acute in terms of physical wellbeing, and among psycho-social-spiritual and environmental parameters as well. Therefore, a new domain name — spirituality, religion, and personal beliefs (SRPB) — was subsequently added to the instrument to capture the importance of a sense of meaning and purpose, forgiveness, and spiritual connections among PLHIV, and the role of spirituality in dealing with uncertainty, suffering, sickness

or dying.

Data from this study helped to identify and situate the socio-cultural aspects of some of these QoL variables. Participants' descriptions of their religious sentiments and practices evinced diverse motivations and meanings as regards church participation. Seven of the participants (25%) began attending church services either while they were sick or after their HIV diagnosis and a higher percentage (46%) reported making a greater effort to attend church services post-diagnosis. Indexing other changes in religiosity, 14 individuals (50%) felt that their religious beliefs had become more intense post-diagnosis, including seven who said they had 'repented.' To repent was described by the former director of the Swaziland National Church Forum as a *'believer's choice to turn away from sin after being born again, [which] continuously happens throughout the lifetime*

of the believer, as they grow to know God and themselves better in light of this new relationship' (pers. comm., Bongani Langa, 8 June 2009). Being 'born again,' the director explained, can be said to precede repentance, as '*an act of allowing Christ's forgiveness, His love and His promises to be part of your life/inheritance.*' (For an exegesis of 'born again' conversions in Ghana, see Meyer, 1998.) Because participants drew most often on the phrase 'I repented' to register these subjective shifts, I use the term 'repented' rather than 'born again' in the analysis.

The intensification of religious sentiments as part of the protracted suffering of being HIV-positive in a highly vulnerable context reflects the findings of a five-country study of HIV stigma and coping strategies, which included Swaziland; the majority of the respondents said that "faith in God was central to what kept them going" (Makoae, Greeff, Phetlu, Uys, Naidoo, Kohi *et al.*, 2008, p. 141). Among Ugandan church movements, Mogensen (2002) reported that 'being saved' could likewise entail personal religious transformations that influence how individuals deal with adversity and suffering. The experiences of religious intensification reported in this study took various forms, some more discursively subjective than others. For instance, one woman, age 50, whose husband had five wives and who she said had died of AIDS, attended church prior to her own diagnosis but decided to repent after discovering she was HIV-positive. She felt a desire to do God's will, she said, and not her own; this meant deepening her religious practices by praying in the morning and before she slept, until the time she dies, and by attending church, even when she feels sick. The decision to repent by a 47-year-old woman followed after the deaths of five of her ten children and her own HIV diagnosis had left her distraught. Another participant, a 38-year-old woman with three children, had repented after being diagnosed with HIV, '*Because even at the hospital, they tell me that I shouldn't be sad, that I should be happy.*' Intensifying her religious attachments helped her to achieve this aim, exemplifying an overlap in one's experiences of hospital and church settings, discussed further below.

The few peer-reviewed studies on religiosity and being HIV-positive that have been conducted have sampled primarily from populations in the United States and tend to conceptualise religiosity as a response to the 'existential' challenges of an HIV diagnosis (Cotton, Tsevat, Szaflarski, Kudel, Sherman, Feinberg *et al.*, 2006). Adogame (2007) has pointed up the shortcomings of psychologistic models in capturing the dynamic roles of religious institutions and church participation, as these mediate the experience of HIV and AIDS in much of Africa. Becker & Geissler (2007, p. 2) have similarly theorised the complexity of examining religion and HIV-related suffering in East Africa, writing that "people and communities affected by the virus range far and wide in their search for explanations, calling upon their knowledge of politics, commerce and international relations as well as diverse views of health and healing." The conceptual limits of a reductive framework are perhaps most pronounced in terms of a failure to situate experiences of religiosity and HIV-positivity in specific ethno-cultural contexts. This is a particularly high-stakes oversight given the significance of church participation to women across much of Africa, who

comprise 90% of African congregations and for whom churches often constitute the only form of female non-kin association (Taylor, 2006).

A handful of published studies has described the emotional and material benefits of church participation and religious intensification among HIV-positive women, such as in rural South Africa (i.e. Dageid & Duckert, 2008) and Mozambique (i.e. Agadjanian & Menjivar, 2008), and of the potential of church resources in southern Africa to incubate African Christian women's 'hidden discourses' (Haddad, 2006). Accounts of the solace and support that church participation occasionally provided to the participants in this study echo those findings. For instance, a 33-year-old woman with six children, one of whom had died, attributed her decision to repent and join a local congregation to the compassion she had received from a fellow churchwoman who had cradled her sick child. After the respondent's child died, the parishioner took up the traumatic burden of bringing the body to the mortuary — a profoundly compassionate gesture that superseded the stigma the respondent felt from other church members. This support was all the more significant because the woman had recently given birth again, and, intimating ongoing rape, said she knew that she should not become pregnant given her HIV-positive status, but that the infant's father had come to her family's homestead for sex and refused to use a condom. Asked whether she had reported him to the police, the woman said her family would like to do so but that they had insufficient funds for bus fare to go to the police station; however, the author's translator speculated that the family more likely feared going to the authorities.

Such traumatic reports highlight the importance of situating religious intensification in locale-specific contexts: in this case, an environment not only of poverty and gender inequality but of sexual violence as well. A report on the rate of sexual violence towards female children in Swaziland revealed that one in three young women (ages 13–24) had experienced sexual violence as a child (Reza, Breiding, Blanton, Mercy, Dahlberg, Anderson & Bamrah, 2007). In a study of the meanings of 'being saved' in Tanzania, Dilger (2007, p. 63) emphasised the critical and under-examined role of local congregations in providing a range of social, spiritual, and ideological resources that could help individuals, especially women, to face multiple vulnerabilities in their "local life-worlds." In Swaziland, diverse practices that may exacerbate the vulnerabilities facing women in their local life-worlds include wife inheritance (*kungena*), polygamy (*sitsembu*), and male sexual (*kulamuta*) and reproductive (*kuhlanta*) entitlement to wives' younger sisters (Whiteside *et al.*, 2006). Moreover, these are practices that constitute the homestead (*umuti*) as an organising principle of Swazi life.

As extended family compounds where patriarchal and polygynous arrangements structure social, sexual, and material relationships (Kuper, 1986), homesteads emerged in this study as a key variable in ascertaining the significance of religious participation to many women for whom home was a nexus of HIV-related vulnerabilities. In the context of these socio-cultural vulnerabilities, for some participants, the occasional material, social, and/or spiritual

support they received from church members had triggered a deeper sense of religiosity. Thus, for a 30-year-old female participant, feeling a closer relationship with Christ assuaged the stigma and alienation she suffered at her homestead. Plagued with sores and diarrhea, she was consigned to sleep in separate quarters; her sisters often diminished her, spurning the value of her voice in domestic affairs with such comments as, *'Why should we listen to you? You are HIV-positive.'* After commencing ART, her obvious symptoms of sickness diminished, and she was accepted back by her family. Nonetheless, the significance of her religiosity did not subside. In the next section, I turn from the subjective meanings of religiosity among PLHIV amid dire structural deprivations in their local life-worlds to the social relations that constitute local congregations as distinctive sites of HIV/AIDS-related decision-making, most saliently an HIV-positive disclosure.

Self-disclosure: navigating stigma, strategising support

A stigmatising moralism has marked the history of many religiously based responses to HIV/AIDS (Chikwendu, 2004). Indeed, the linking of infidelity, promiscuity, and HIV infection by religious authorities has been a powerful driver of HIV-related stigma in many areas of the world and remains a significant challenge. The small number of peer-reviewed studies that have explored these issues have pointed up the importance of situating the topic of religion and HIV/AIDS in specific locales. Thus, though a survey by Zou, Yamanaka, John, Watt, Ostermann & Thielman (2009) among parishioners in Tanzania found a strong association between religious beliefs and shame-related HIV stigma, Regnerus & Salinas (2007) found scant empirical evidence between religious affiliation and HIV-related stigma in sub-Saharan Africa. In Uganda, denominational organisations have been described as proactive partners in early government initiatives to address HIV/AIDS (Denis, 2003; Otolok-Tanga, Atuyambe, Murphy, Ringheim & Woldehanna, 2007). Such divergent accounts of faith-based discourses of, and engagement with, HIV and AIDS likely reflect an enormous variability in religious institutional responses to the epidemic. The studies also highlight the shortage of research on the supportive roles that religious organisations might play in the daily lives of HIV-positive individuals and affected families (Agadjanian & Sen, 2007).

Conceptualising local congregations as examples of 'social capital' that mediate the structural and behavioural risks associated with HIV in Mozambique, Agadjanian & Menjivar (2008) provided one of the first analyses of the importance of informal communication around HIV/AIDS among congregants. Yet little is known of experience of local church participation among individuals who know they are HIV-positive, whether involving stigma, support, and/or informal communication about HIV/AIDS. Given the parallel paucity of research on disclosure decision-making in sub-Saharan Africa (Miller & Rubin, 2007), here participants' HIV-disclosure rationales served as a heuristic to investigate: 1) the social dynamics among parishioners, between pastors and parishioners, and unexpectedly, between pastors' wives and parishioners; and 2) the dynamics concerning stigma and support that were integral

to PLHIV experiences of religious participation and which were foremost in many respondents' disclosure decisions.

Participants' reports of actively wrestling with the question of self-disclosure evidenced the intensity of perceived HIV stigma in church settings, simultaneous gestures of care and support, and the salient role that pastors played in the participants' 'imaginings' of disclosure pathways. Similar to Zou *et al.*'s (2009) survey of church-goers in Tanzania, which found that about 84.2% of the sample, when asked to speculate, said they would disclose to their pastor or congregation if they found out they were HIV-positive, in this study, 11 individuals (39%) who knew they were HIV-positive said that they had disclosed to their pastors. Three of these disclosures were made to pastors' wives. In various combinations, the pastors had prayed for the person who had disclosed, praised their courage to seek HIV testing, visited the respondent at their homestead, and/or emphasised that an HIV diagnosis was not the end of life. Such reports of pastors' constructive responses contrast with those described by Dageid & Duckert (2008) in South Africa, where some individuals recounted incidents of HIV-positive women being ostracised by their congregations and accused by church leaders of spirit possession. While no respondent from this study reported moral exorcisions or any other overt stigmatisation on the part of pastors, to the extent that some pastors were reportedly silent on the subject of HIV/AIDS, as six (21.4%) respondents indicated, they arguably missed opportunities to combat stigma. Also, by advocating fidelity and exhorting the dangers of promiscuity, even when these warnings were intended as part of a cautionary message that also may have included calls for compassion, the pastors may have unwittingly exacerbated HIV stigma.

Reports by participants who had disclosed to their pastor and received encouraging feedback, and that still others desired to do so, suggested a trend on the part of some church leaders to provide a safer context for disclosure than has existed in the past. In interviews with key respondents, Swazi church leaders were often described as a general cohort in need of HIV/AIDS health education and stigma-reduction interventions. With almost no peer-reviewed research available on pastors' HIV discourses in Africa, data from this study includes firsthand reports from participants about whether and in what ways pastors spoke about HIV/AIDS. A significant finding was the frequency (79%) with which pastors referenced HIV/AIDS during church sermons, at times in coded terms such as 'sickness' and 'disease.' The frequency of these reports contrasts with findings by Agadjanian & Menjivar (2008), in Mozambique, where HIV/AIDS was mentioned only occasionally during church sermons and was limited largely to calls for premarital sexual abstinence and fidelity. It is significant that while the pastors described in this study were said to convey similar conservative HIV/AIDS messages, these were often part of a pronounced rhetoric of caution and care that, to varying degrees, also advocated HIV testing, denounced HIV-stigma, promoted care and support, and advised congregants to 'be faithful' to their ART regimen. In this respect, pastors who encouraged parishioners to seek HIV testing and admonished HIV-related stigma suggested an

important constructive 'indoctrinating' presence, to borrow a phrase from Garner's (2000) work on religious ideologies and participation and HIV-risk behaviours. However, participants also said that pastors very often endorsed the efficacy of spiritual healing for the treatment of AIDS.

Illustrating this broad spectrum of HIV/AIDS content, by participants' accounts, pastors said that *'those who haven't got the disease should take extra care of themselves, and avoid sleeping around'* and *'youth should take care because AIDS is out there, and it kills.'* Shifting from a preventative content to stigma versus support, pastors reportedly called for parishioners *'to care for the sick.'* Even more pointed, the pastor of one respondent directed congregants to take care of their neighbours by *'always checking on them, seeing what's happening, because if that person gets sick you can help them; sometimes that person will be bedridden, and not able to go to the hospital to get the tablets [antiretrovirals]; so then you can go.'* Others said that their pastors had exhorted parishioners to *'take care of everyone, even those who were poor, and not to insult those who were HIV-positive, but to care for them as well.'* Asked if people heeded her pastor's compassionate directives, a respondent answered that it was hard to know since you *'can't see a person's heart.'* Moving into the domains of HIV testing and treatment, the pastor of a 33-year-old woman had advocated both HIV testing and treatment, and tasked church members with taking care of those who were HIV-positive. The participant said there were women in her congregation who did in fact tend to the unwell: *'Like, if you are [HIV-]positive, the little these women have, they spend on oranges or bananas for you, and help you with anything that you need to be helped with.'*

Some responses suggested that church participation did at times alleviate the chronic social and physical vulnerabilities women faced and thereby provided an incentive to disclose. Witnessing such assistance, some participants actively weighed fear of stigma against the rewards of support, whether spiritual or material, realising that access to that support might require them to express their needs through disclosure — either to pastors or other parishioners. A 23-year-old woman with HIV infection, whose 3-year-old daughter was also on ART, struggled with this perceived trade-off as she deliberated whether to disclose to her pastor. She and her child suffered significant stigma both at home and in her congregation. She described how a fellow parishioner had approached her, telling her that everyone at church feared she would infect *'all of us'* with the sores on her face. She protested that the infection came from *'inside'* her, that it wasn't itself contagious, and that all she had to do was go to the hospital to get treated. Fortunately, other parishioners offered support and donated clothing. Overall, the participant said, her belief in the power of prayer was strong, her pastor's prayer in particular, so much so that despite the stigmatising attitudes of some parishioners, she wished her pastor could *'tell the whole congregation'* of her predicament. That way, she explained, if she failed to show up at church services one Sunday the congregation would note her absence, know that she was sick with her baby, and could offer up prayers on her behalf: *'Because I'm not dead; I'm sick.'* However, she lamented that she lacked

the requisite 'courage' to disclose to her pastor, hence she could not reap the full material or spiritual benefits of support from her congregation. Other respondents expressed similar concerns: that disclosure to church leaders meant they might be referenced during church services. Even good intentions could incur negative repercussions, as when a pastor's wife, who was also a rural health motivator whom the author interviewed, gave permission to a TV station to interview the participant as part of a segment on HIV education. The pastor's wife saw the interview as an opportunity to support positive living among HIV-positive persons; however, the interviewee's husband and family were enraged. To avoid her being thrown off the homestead and left destitute, the pastor's wife and the participant met with the family and supplicated for forgiveness, and so she was permitted to remain.

In a study of the patterns, reasons, and reactions to HIV disclosure among PLHIV in India, Chandra, Deepthivarma & Manjula (2003, p. 211) distinguished disclosure without consent from voluntary self-disclosure, which itself could take two forms: as a "positive desirable act" or a decision to disclose because the person felt there was no choice but to do so. Respondents here characterised self-disclosure, when it was a 'positive desirable act,' as an act of 'courage.' In an analysis of HIV disclosure in five African countries, including Swaziland, Greeff *et al.* (2008, p. 315) reported a similar discourse, noting that disclosure "requires a lot of courage." Two participants in this study, both of whom had disclosed their HIV status to church members, conjured courage as a significant feature of their disclosure experiences. The first was a 36-year-old woman with six children who said that fellow parishioners had praised her for her courage; her pastor commended her as well, and said her disclosure might encourage those who feared to test to do so. The disclosure experience of a second participant, a 50-year-old woman, intimated why courage would be associated with the act. Having cut her hand during a church project, she requested a Band-Aid; aware that the exchange of bodily fluids posed a risk of HIV infection to others, she warned those present not to touch her blood, as she'd just learned she was HIV-positive. Her disclosure was initially met with laughter, since they thought no one would dare declare a positive status in such an outright fashion. Asked their reaction once they realised she was serious, she said they did 'nothing.' She was of the view that *'Swazis, they are hard like stones. They do not want to know or tell the truth.'* But God, she said, had helped her not to be a stone and gave her courage as well, so that she could reach out to those who appeared sick and fearful, encouraging them to get tested.

Ntsimane (2006) has highlighted the importance of creating safe spaces for self-disclosure in South Africa and recommended strategies for doing so. A process of ascertaining the "defined relational contexts" within which disclosure happens (or not) may be particularly relevant to disclosure pathways in sub-Saharan Africa (Miller & Rubin, 2007, p. 587). To the extent that congregations constitute defined, albeit dynamic, relational contexts, 12 of the participants (43%) felt that people in their congregation knew they were HIV-positive, a few of whom had voluntarily

disclosed their status. Sixteen individuals (57%) surmised that their congregations were not cognisant of the participant's HIV-positive status, or that only those whom they had told knew. A 49-year-old man had elected not to disclose because nurses at the hospital had advised him to tell no one except those with whom he was closest. A 34-year-old woman said she had shared news of her HIV diagnosis with only those church members who knew her, and they responded by expressing gratitude that she trusted them enough to share the information. Parishioners had always been kind to her, she said, even before she started ART and was sick. This generosity, however, co-existed with the stigma perpetuated by others who alleged that those who had HIV were persons who *'do not take care of themselves,'* a colloquialism meaning they had many sexual partners.

The participants who indicated they had not disclosed were asked two questions: Why had the participant elected not to disclose? And, did the participant fear repercussions if they did disclose? A 47-year-old woman decided not to disclose to anyone at church because *'after telling them that you are positive, they make fun of you.'* Even selecting who to voluntarily disclose to could unleash stigma later. After a 55-year-old man shared news of his HIV status to some church members, he explained *'the rumours are now spreading.'* Others, however, speculated that disclosing would incur no negative repercussions. According to one woman, nothing bad would happen because her pastor encouraged parishioners to get tested for HIV, adding that *'being tested doesn't mean they have to be stigmatised or anything.'* One participant, a young woman, challenged the very basis of the interview question itself, about why she had elected not to disclose: *'Why would I?'* The presumptive value of self-disclosure implicit in much HIV-disclosure research was neither a given nor self-evident in her experience.

To underscore the young woman's point, a report of HIV-disclosure decisions among PLHIV and their nurses in five countries in Africa (see Greeff *et al.*, 2008) recommended that healthcare providers be aware that self-disclosure is not always productive for PLHIV. In this study, some individuals had selectively voluntarily disclosed to church members because they felt it was productive and important to do so. For example, one woman, who at the start of the interview called to her HIV support group a few metres away to remind her of her age (51 years), maintained that her fellow parishioners did not know her positive status. However, she qualified, some members were in fact aware of her HIV-positive status because she reached out to those who appeared sick, encouraging them to go to the hospital, telling them that she herself had gotten help there: a coded communication in church settings between individuals who know they are HIV-positive and those who are possibly HIV-positive, which was mentioned by participants on more than one occasion.

Unfortunately, reports of church-based support did not negate the stigmatising discourses of sin and immorality associated with conservative religious ideologies, or the invidious effects of gossiping described by some participants. The question of how others came to know of their HIV-positive status if participants themselves had not

disclosed yielded a range of stigmatising processes in the social networks of congregations. Gossip, mockery, and avoidance were common indicators of stigma. The participants' reports suggested that the HIV-related stigma, alienation, and hostility that plague broader Swazi society festered in church settings as well (Root, 2009). Asked what parishioners said when they spoke about people with HIV, a 33-year-old woman with two children, one of whom had died, replied, *'They say that person is ready for death.'* Some participants voiced concerns not only of the demoralising impact of insults and alienation, but of the insalubrious effects of stigma on emotional and physical wellbeing. Mean-spirited reactions, explained one woman, might cause a feeling of sadness; there were unkind persons who *'if you tell them, they tend to laugh back at you, and then that can destroy you and make you more sick.'* She wanted to disclose to the church members who did show compassion and she described her pastor as supportive of HIV-positive persons. However, as much as she desired access to their support, she said she lacked sufficient 'courage' to face down others' derision.

Participants' contrasting reports of stigma, silence, and support points up the difficulties that researchers face in identifying and interpreting disclosure patterns in Africa. These challenges are all the more complex in settings where a language for discussing stigma appears non-existent, as reported by Hartwig, Kissioki & Hartwig (2006) in a study of HIV stigma among church leaders in Tanzania. One of the most important findings of the study here was an emergent dynamic whereby congregants debated the morality of stigmatising those with HIV; social dynamics that suggest a potential for mainstreaming an HIV-positive status. According to one woman, whereas congregants used to speak ill of individuals who were infected, *'Now they do not, because now everyone is affected, even if not infected.'* The pastor of another participant exhorted parishioners not to stigmatise those with HIV and to *'take care of that person like any other person, and to treat that person like any other person.'* The 47-year-old woman explained that although scorn and gossip were still operative, there were other situations in which a parishioner would step forward and chastise a church member who gossiped about a person with HIV by saying: *'No, you shouldn't say that because you might also be HIV-positive.'* A similar dynamic of interpersonal resistance to HIV stigma in church settings was apparent in the account of the woman who had disclosed her HIV-positive status after cutting her finger and warning others not to touch her blood. She felt she was treated well by those parishioners who knew she was HIV-positive. However, in a conversation with one of those persons, the fellow parishioner had said: *'It was not good to tell people you are HIV-positive.'* The woman rejoined that, on the contrary, speaking aloud about being HIV-positive was the right thing to do because it might help others who were at risk or similarly afflicted.

A church-based defense of the meaning of personhood as it applied to being HIV-positive was among the study's most meaningful findings since the social dynamics among progressive parishioners on a regular basis could function as critical levers of change in attitudes and health practices.

Thus, where Agadjanian & Menjivar (2008) identified religious involvement as an important informal resource that individuals could draw upon both to navigate HIV-related risks and uncertainties, the casual conversations among HIV-positive parishioners in this study intimated the potential of church settings to pointedly challenge HIV stigma, raise awareness of high rates of infection amid reports of intractable denial, and provide critical HIV health-seeking support. The contextual details of such dynamics, for example, whether they transpire independent of messages from church leaders, originate from those who have disclosed their HIV-positive status, draw in HIV-positive persons over time, or exert a meaningful ripple effect beyond church contexts are phenomena deserving further research. I now turn to a discussion of the possible impact of religiosity and religious participation on HIV-related health practices as suggested by data of this study.

HIV disclosure in church settings: a portal to HIV-related health practices

HIV-related stigma and discrimination constitute significant obstacles to the successful implementation of HIV and AIDS programmes in many parts of the world (Parker & Aggleton, 2003), often burdening individual decisions to test, disclose a positive status, or to adhere to treatment (Ware, Wyatt & Tugenberg, 2006; Wolfe, Weiser, Bangsberg, Thior, Makhema, Dickinson *et al.*, 2006). Though not extensive, research in the United States has also demonstrated diverse associations between religion and HIV-related health behaviours that may affect quality of life and survival among PLHIV (e.g. Ironson, Solomon, Balbin, O'Cleirigh, George, Kumar *et al.*, 2002). A study of religiosity and treatment adherence among a predominantly African-American sample, for example, found that religious practices, including church attendance, Bible reading, and prayer, were positively associated with treatment compliance, whereas certain religious beliefs, for instance that AIDS is a punishment from God, were negatively correlated with treatment adherence (Parsons, Cruise, Davenport & Jones, 2006). Yet, despite the institutional expansion and cultural salience of Christianity in much of Africa, and the marshalling of resources to rollout and scale up ART programmes, similar studies of HIV-positivity, religiosity, and HIV-related health practices are lacking. A comparatively larger number (though still small) of published studies has investigated religiosity and HIV prevention, however. Among Ghanaian women, Takyi (2001) found that religious affiliation was significantly correlated with knowledge of HIV prevention, but not with specific protective behaviours, such as condom use. In rural Malawi, Trinitapoli & Regnerus (2006) found that married men who belonged to Pentecostal churches reported lower levels of both HIV-sexual-risk behaviours and perceived risk of infection, and that men who regularly attended religious services were less likely to report extramarital sexual partners and demonstrated lower levels of perceived risk.

While the study reported here was not designed to explore HIV-preventative risk behaviours, to the extent that religious intensification could be experienced as a discrete act of risk reduction, evangelical Christianity may provide a feeling of having a means of dealing with fears of contracting HIV.

The mistaken belief among some women that marrying a 'Christian' man would protect them from infection, concerned the director of an HIV/AIDS support group. Repentance was appealing to one young woman, for example, who was married to a soldier, because '*there are many diseases out there.*' Christian marriages were limited to one man and one woman, a spouse, she explained, whereas polygamy could entail many. Asked whether the assumed protective benefits were negated if men replaced many wives with many girlfriends, the woman replied that should sickness find its way into her marital union, '*at the gates of heaven, God would know*' which spouse had sinned and which had not, and only the latter would be permitted entry. Religious intensification seemed to have the secondary benefit of reducing the participant's risk of an afterlife in hell should the first level of sexual HIV-risk mitigation fail.

In addition to the HIV-related knowledge that church participation at times provided, this study identified an additional faith-based resource: one that originated within and extended beyond church walls, and which could be of critically undocumented importance to comprehensive HIV/AIDS programming. Pastors' wives were, on at least three occasions, repositories of HIV disclosure and/or intermediaries between husbands and wives around issues of HIV. A pastor's wife described how she leveraged her simultaneous role as a rural health motivator when women confided in her their HIV-positive status and a husband's reluctance to be tested for HIV. Without disclosing that the man's wife had spoken with her, she would visit the woman's homestead and in her role as a rural health provider educate the husband about the benefits of testing in hopes that he would elect to test. Use of such indirect disclosure pathways supports Miller & Rubin's (2007) findings in Kenya that intermediaries, indirectness, and church pastors may play critical, distinctive roles in HIV-disclosure strategies in sub-Saharan Africa. Should similar dynamics hold in Swaziland, programmes that provide HIV/AIDS training to Swazi pastors might benefit by including pastors' wives as well. Importantly, though, if the brokering done by pastors' spouses in Swaziland is productive precisely because of its circuitous nature, then alternative forms of empowerment and HIV education may be more effective to preserve its hidden dynamics.

Besides the communication that transpired between some respondents and their church leaders, reports that church members encouraged one another to seek HIV testing and treatment testified to the subjective experience of church participation as one of shared sickness and suffering, and to the potential of church-based social networks to shape important HIV-related health behaviours. The mother of an adult daughter with HIV expressed frustration that her daughter refused to seek treatment from the health centre that provided free ART and that she continued to consult a traditional healer. She lamented the numerous instances of HIV-related stigma that her daughter suffered. On the homestead, family members refused to eat food that the daughter had prepared. In the community, the mother would not allow her daughter '*anywhere near the bore hole*' for fear that her constant scratching, '*as if her body itches all over,*' might trigger stigma. In contrast, members of her daughter's

church had encouraged her, and all those who appeared to be HIV-positive in the congregation, to go to the health centre for help. However, despite having tested HIV-positive four years earlier, the woman's daughter reportedly had yet to return for treatment.

The question of how religious intensification might strategically impact HIV-related health practices emerged in an interview with a Swazi university student who said she was HIV-negative. She grew up in the community where the study was conducted and returned home on school breaks to stay with her mother, a nurse. The student had lost a close friend to AIDS after her friend's mother, frustrated that there appeared to be no improvement in her daughter's health after one month on ART, insisted that she take Chinese herbs rather than adhere to an ART regimen. The author interviewed a female pastor who reported a similar case of a young woman with HIV who died after her parents had told her to *'put aside the tablets,'* as antiretroviral medications are often referred to. The student had *'repented'* around the time of her friend's dying. She explained that one advantage of claiming a Christian identity was that it positioned a person to resist such pressures. These can arise, for example, on a public bus where another passenger may see you have open sores, she said, and instruct you to go to a traditional healer. Asked whether her friend's painful dying and near total abandonment by school friends had intensified her own religiosity, the student's response triangulated a Christian identity, AIDS-related suffering, and pressures relating to health-seeking practices in Swaziland:

'It made me even more aware of the situation [in Swaziland] because she was not a Christian, and she suffered a lot. If you become sick and you are not a Christian...like, they take you to a traditional healer.... If you are sick, you go anywhere that you hear you will get help, because you are suffering. But if you are a Christian, even if I am suffering, I can tell those [who pressure me] — No I don't want to go to a traditional healer, because I know where I stand.'

Asked where she would go if she fell sick with AIDS, the young woman replied: *'The hospital. And if I can't get help there, then I will have to die.'* If Christian repentance empowers adherents to resist pressures to seek traditional healing services, a stance emboldened by pastor exhortations of traditional healing observed in Mozambique as well (Pfeiffer, 2005) and as part of Pentecostal church discourses in Ghana (Meyer, 1998), a Christian identity might be an important, albeit complex, public-health resource outside standard HIV-treatment literacy campaigns.

Religiosity appeared to have an impact on HIV-related practices in other ways as well. The 50-year-old woman who had boldly declared her positivity at the church gathering (described above) was asked to speculate on why people were reluctant to be tested for HIV, especially given the relative accessibility of low-cost treatment: *'They just don't believe in Jesus, so that's why they are scared; they have little faith.'* The participant's response arguably appropriated the rhetoric of religiousness that has fueled some of the most stigmatising claims — tying HIV infection with sinful-

ness. Instead, the quality of *'faithfulness'* she conjured was subjective rather than ideological, inspired by an individual's courage not just to disclose and face stigma, but the courage to be tested for HIV in the first place. An important downside to the linking of religious faith and HIV-related health practices, however, was the very common belief that spiritual healing can, if one has a deep and abiding faith, cure a person with HIV infection, independent of ART.

Participants' reports often evidenced church settings as sites that spawned substantive communication, and confusion, around clinical aspects of HIV testing and treatment. There were those who had actively reflected on the potential of their own disclosure to encourage others to seek testing and treatment; in Chandra *et al.*'s (2003, p. 212) terms, an *"other-focused"* disclosure, motivated by a sense of responsibility to others, based on one's own HIV status. For example, one participant wished to disclose because she felt that by doing so she could at last convince those who denied the empirical reality of HIV-related diseases of its existence. Another respondent, a church leader, felt strongly that self-disclosure would convince the skeptics in his church of the benefits of HIV testing and treatment. At the same time, he feared parishioners would declare him a moral fraud, requiring that he forsake his current mission to leverage church services as opportunities to regularly advocate HIV testing and treatment and goodwill towards HIV-positive persons. Advised by a clinic counselor not to *'confess'* his HIV status until *'the right time comes,'* the man had reluctantly resolved: *'God is the only one who is going to give me the date when I will tell.'*

Instances of using the HIV-positive self, or having it used, as a form of empirical proof of HIV disease could be a wrenching experience. A 41-year-old woman whose pastor decried HIV stigma and encouraged parishioners to keep taking *'the tablets'* provided by the clinic, had elected to tell her pastor's wife after the participant had tested HIV-positive. The woman had no control, however, over gossip that spread news of her HIV-positive status. She was upset by the avoidance and whispering perpetrated by some parishioners. There were individuals, she said, who would come up and say, *'Oh, I've heard from so-and-so that you are HIV-positive,'* to which she would answer, *'Yes, I am HIV-positive.'* Asked whether parishioners heeded the pastor's words to care for those were sick, she said that some did and some did not. In fact, she explained, when HIV-positive parishioners or HIV-positive members of her community ran into each other in the city, they would look after each other, for example, by retrieving medications if the person was unable to return to the clinic for refills. Agadjanian & Menjivar (2008) likewise reported the importance of parishioners' exchanges around HIV/AIDS outside of formal religious setting, where interactions could provide more constructive, candid, and personalised counsel about HIV risks, especially in rural and semi-rural areas. In this study, the participants similarly described casual and unstructured communication; however, because they knew they were HIV-positive, the content of their encounters revealed the strategic deployment of church-based networks outside of church settings in order to clinically manage one's infection, take care of other PLHIV,

and circumvent church-based stigma — exchanges that demonstrated the significance of off-site encounters to provide PLHIV with targeted PLHIV-specific content.

The potential disadvantages of informal conversation around HIV/AIDS, however, especially in a context of high stigma, were evident in this woman's accounts of simultaneous church-based stigma and support. Eventually, after beginning ART, she said she appeared much healthier; so much so that some parishioners, incredulous with her seeming recovery, resumed speaking with her: *'They think that the people who told them I am HIV-positive were lying [about the initial HIV diagnosis] because I am back to my old self.'* While it was fortunate that the participant felt less isolated as a result of treatment, her story put into relief the vexed intersection between perceptions about HIV diagnosis/treatment and the intractable denial of AIDS which transpires both inside and beyond church walls. By investigating these subjective and social processes in a distinctive setting, the data showed the potential of qualitative research to identify untapped sites of proactive interventions that may flow outward into other critical settings, such as homesteads and schools.

Limitations of the study

In light of the small-scale exploratory nature of this study, the findings cannot be generalised to all congregants and congregations in Swaziland. Where future research stratified by church category and urban/rural location should aim to shed light on potentially important differences, the aim of this study was to provide a starting point by analysing experience of HIV-positivity and religiosity regardless of denomination. Selection bias likely occurred as purposive sampling was of individuals who were currently attending church. As a result, those for whom becoming HIV-positive led to a cessation of church attendance, for example because of illness, shame or church-based stigma, were not accessed. Finally, focused studies of church participation among males, and of men's decisions not to attend church, are very much needed, especially if, as these findings suggest, pastors and parishioners are sharing critical HIV-related health information that is not otherwise available on a regular and reliable basis elsewhere in the community. Last, all the HIV-positive participants were on ART, with the exception of one individual who appeared to be under medical supervision to determine when to initiate treatment. It is impossible to know if treatment statuses mediated the responses in any systematic way. Whether such a sample is predisposed to disclosure, or alternatively, more likely to conceal an HIV status, may be an important aspect of disclosure practices, meriting future research.

Conclusions

By examining the meanings of religious intensification and church participation among people with HIV, this study helped to illuminate experiences of HIV-positivity in one of the most institutionally and geographically ubiquitous, as well as gender-relevant, institutions in Swaziland. The findings on the subjective meanings of religiosity and

HIV-positivity, perceptions of church-based stigma and/or support from pastors and parishioners, and individuals' decisions around HIV disclosure have productively problematised church settings in the context of HIV/AIDS. The resulting conceptual framework elucidates HIV-disclosure rationales in church settings as a matrix of subjective meanings and social dynamics; rationales that were, in turn, situated within broader vulnerabilities and often tied to other HIV-related health practices.

Individuals who deployed religious resources (including identities, relationships, practices and physical sites) did so often as a means of navigating deeply entrenched socio-cultural and structural threats to their wellbeing. Homesteads, in particular, emerged as a critical variable in assessing the significance of church participation to many of the women for whom home was a nexus of HIV-related vulnerabilities. The occasional social support that participants received, and the brief respite that church participation offered from homestead alienation and hostilities, testified to the potential importance of church participation in these women's daily lives. Moreover, to the extent that a Christian identity may provide Swazi women with a culturally legitimate means to circumvent polygamy in favour of an ostensibly 'safer' marriage to a presumably Christian man, relationships between women's subjective religiosity and HIV-risk perceptions may bear on HIV-risk practices, which warrants further research. This is especially so since it may be an urgent matter to disabuse women of the unlikely HIV-prevention benefits of such practices.

Participants' reports of the complex social dynamics among congregants adumbrated the possible implications of religious attachments with respect to other HIV-related health practices as well. As social networks, congregations constituted institutional mechanisms by which these individuals were continually exposed to disparate perspectives regarding HIV prevention, treatment, stigma, and support. In light of reports that pastors deployed the power of the pulpit to create environments conducive to proactive shifts in the perceptions and experiences of PLHIV, church settings may be a significantly under-leveraged health asset. Evidence of such proactive shifts was apparent in frequent attributions of 'courage' to individuals who elected to disclose an HIV-positive status, either because they had demonstrated courage or because the respondent felt that they lacked it; this may constitute a seed of anti-HIV-stigma, which church participation could nurture if supported by outside resources, including partnering church congregations with support groups and health centres. Voluntary disclosure, however, was deemed courageous precisely because of the HIV-related stigma perpetrated by some parishioners. Regardless, disclosure was often conjured as a highly prized gesture, in part because of the material, social, and spiritual support that public knowledge of one's HIV status could elicit. The unpredictability of parishioners' responses to self-disclosure pointed up the challenges that PLHIV face as they wrestle with disclosure decisions rendered in church settings — decisions that were often contingent on pastors' use of the pulpit to encourage support for the sick, and on the composition of the congregation itself as networks of people who might be both antagonistic and compassionate

towards PLHIV.

Eliciting and situating the range of HIV-positive parishioner experiences helped to conceptualise the roles that churches, as social institutions with normative authority, and local congregations, as primary social networks, can play in mitigating multiple vulnerabilities, but also in exacerbating HIV stigma. Taken together, the data evidence congregations as distinct social sites where gendered roles and other socio-cultural processes intersect poverty and HIV epidemiology. The findings also demonstrate the heuristic valence of HIV-disclosure rationales to offer a better understanding of HIV-related stigma and health practices. In light of the broad-based significance of church participation to individuals' wellbeing and community health in many areas of Africa, the research demonstrates the programmatic imperative too often overlooked in conventional social-scientific and public-health research of church-based HIV/AIDS initiatives as part of comprehensive HIV/AIDS-related policies.

Acknowledgements — The author would like to acknowledge The Research Foundation at The City University of New York, which has provided annual grants for the project since 2005. The author would also like to express gratitude to Alan Whiteside, Michael and Robin Pratt, Ann and Wendy Root, and Bongani Langa for their generous mentoring, sponsoring, and comprehensive support. I am appreciative as well of the manuscript reviewers, as their comments significantly contributed to the final product. Above all, the author is indebted to the individuals who participated in the study, whom the author hopes will benefit sooner rather than later from the research.

The author — Robin Root (MPH, PhD) has conducted theoretical and applied research in the field of medical anthropology, examining the interface between cultural anthropology, political economy, and public health. Using ethnographic and formal qualitative research methods, her work aims to shed light on how individuals negotiate diverse risks to survive. Her prior research in Malaysia documented the impact of Islamic revivalism, HIV/AIDS, and economic development on perceptions of risks of infection and moral risks. Her current work in southern Africa problematizes socio-religious institutions, social networks and social identities as sites of social-scientific and public-health analysis. She is currently an associate professor in the Department of Sociology and Anthropology at the City University of New York.

References

- Adogame, A. (2007) HIV/AIDS support and African Pentecostalism: the case of the Redeemed Christian Church of God (RCCG). *Journal of Health Psychology* 12, pp. 475–484.
- Agadjanian, V. (2005) Gender, religious involvement, and HIV/AIDS prevention in Mozambique. *Social Science and Medicine* 61, pp. 1529–1539.
- Agadjanian, V. & Menjivar, C. (2008) Talking about the 'epidemic of the millennium': religion, informal communication, and HIV/AIDS in sub-Saharan Africa. *Social Problems* 55(3), pp. 301–321.
- Agadjanian, V. & Sen, S. (2007) Promises and challenges of faith-based AIDS care and support in Mozambique. *American Journal of Public Health* 97, pp. 362–366.
- Anderson, A. (2000) The Gospel and African religion. *International Review of Mission* 89(354), pp. 373–384.
- Anderson, A. (2001) Stretching the definitions? Pneumatology and 'syncretism' in African Pentecostalism. *Journal of Pentecostal Theology* 10(1), pp. 98–119.
- ARHAP (2006) *Appreciating Assets: The Contribution of Religion to Universal Access in Africa*. Report for the World Health Organization. Cape Town, South Africa, African Religious Health Assets Programme (ARHAP).
- ARHAP (2009) 'The African Religious Health Assets Programme.' African Religious Health Assets Programme (ARHAP) website, University of Cape Town, Cape Town, South Africa. Available at: <<http://www.arhap.uct.ac.za/index.php>> [Accessed 19 April 2009].
- Attawell, K., Ogunlayi, M. & Mndzebele, A. (2009) *UNAIDS Second Independent Evaluation 2002–2008. Country Visit to Swaziland, Summary Report, 12–23 January 2009*. Available at: <http://data.unaids.org/pub/BaseDocument/2009/20090426_sie_countrysummaryreport_swaziland_en.pdf> [Accessed 5 June 2009].
- Becker, F. & Geissler, P.W. (2007) Searching for pathways in a landscape of death: religion and AIDS in East Africa. *Journal of Religion in Africa* 37, pp. 1–15.
- Bediako, K. (1995) *Christianity in Africa: The Renewal of a Non-Western Religion*. Edinburgh, Edinburgh University Press, and Maryknoll, New York, Orbis Press.
- Carrico, A.W., Ironson, G., Antoni, M.H., Lechner, S.C., Durán, R.E., Kumar, M. & Schneiderman, N. (2006) A path model of the effects of spirituality on depressive symptoms and 24-hourly-free cortisol in HIV-positive persons. *Journal of Psychosomatic Research* 61(1), pp. 51–58.
- Central Statistical Office [Swaziland] & Macro International (2007) *2006/2007 Swaziland Demographic and Health Survey (SDHS), Swaziland HIV Fact Sheet*. Mbabane, Swaziland, Central Statistical Office and Macro International Inc. Available at: <http://www.measuredhs.com/pubs/pub_details.cfm?ID=770&srchTp=advanced> [Accessed 30 June 2008].
- Central Statistical Office [Swaziland] & Macro International (2008) *Swaziland Demographic and Health Survey, 2006/2007*. Mbabane, Swaziland, Central Statistical Office and Macro International Inc. Available at: <http://www.measuredhs.com/pubs/pub_details.cfm?ID=769> [Accessed 30 June 2008].
- Chandra, P.S., Deepthivarma, S. & Manjula, V. (2003) Disclosure of HIV infection in south India: patterns, reasons and reactions. *AIDS Care* 15(2), pp. 207–215.
- Chikwendu, E. (2004) Faith-based organisations in anti-HIV/AIDS work among African youth and women. *Dialectical Anthropology* 28(3/4), pp. 307–327.
- Cochrane, J. (2006) Religion, public health and a church for the 21st century. *International Review of Mission* 95(376/377), pp. 59–72.
- Cochrane, J., De Gruchy, S., Germond, P., Jones, D., Gunderson, G., Matimelo, S., Molapo, S., McFarland, D., Olivier, J., Reilly, T. & Mwiche, M. (2006) *Mapping, assessing, and aligning religious health assets for HIV/AIDS treatment, care, and prevention — Lesotho and Zambia*. Presentation at the 16th International AIDS Conference, Toronto, Canada, 13–18 August. *International Conference on AIDS 2006*; Abstract No. ThLB0408.
- Commission on HIV/AIDS and Governance in Africa (2008) *Securing Our Future: Report of the Commission on HIV/AIDS and Governance in Africa*. New York, Commission on HIV/AIDS and Governance in Africa/United Nations Economic Commission for Africa. Available at: <<http://www.uneca.org/chga/report/CHGARreport.pdf>>.
- Cotton, S., Tsevat, J., Szaflarski, M., Kudel, I., Sherman, S.N., Feinberg, J., Leonard, A.C. & Holmes, W.C. (2006) Changes in religiousness and spirituality attributed to HIV/AIDS. *Journal of General Internal Medicine* 21(supplement), pp. S14–S20.
- Dageid, W. & Duckert, F. (2008) Balancing between normality and social death: black, rural, South African women coping with HIV/AIDS. *Qualitative Health Research* 18(2), pp. 182–195.

- Daly, J.L. (2001) AIDS in Swaziland: the battle from within. *African Studies Review* 44(1), pp. 21–35.
- Democratic Underground (2004) 'Swazi king reveals new bride to the nation.' Online posting, 3 September 2003. Available at: http://www.democraticunderground.com/discuss/duboard.php?az=view_all&address=116x1146.
- Denis, P. (2003) Sexuality and AIDS in South Africa. *Journal of Theology for Southern Africa* 115, pp. 63–77.
- Dilger, H. (2007) Healing the wounds of modernity: salvation, community and care in a neo-Pentecostal church in Dar es Salaam, Tanzania. *Journal of Religion in Africa* 37, pp. 59–88.
- Dube, B. & Magagula, A. (2007) *The Law and Legal Research in Swaziland*. New York, Globalex: Hauser Global Law School Program at New York University School of Law.
- Eckhardt, R., Mott, S. & Andrew, S. (2006) Culture and communication: identifying and overcoming the barriers in caring for non-English-speaking German patients. *Diversity in Health and Social Care* 3(1), pp. 19–25.
- Garner, R. (2000) Safe sects? Dynamic religion and AIDS in South Africa. *The Journal of Modern African Studies* 38(1), pp. 41–69.
- Gifford, P. (2008) Trajectories in African Christianity. *International Journal for the Study of the Christian Church* 8(4), pp. 275–289.
- Greff, M., Phetlhu, R., Makoae, L., Dlamini, P., Holzemer, W., Naidoo, J., Kohi, T., Uys, L. & Chirwa, M. (2008) Disclosure of HIV status: experiences and perceptions of persons living with HIV/AIDS and nurses involved in their care in Africa. *Qualitative Health Research* 18(3), pp. 311–324.
- Grundmann, C. (2006) Heaven below here and now! The Zionist churches in southern Africa. *International Journal for the Study of the Christian Church* 6(3), pp. 256–269.
- Haddad, B. (2006) 'Living it out': Faith resources and sites as critical to participatory learning with rural South African women. *Journal of Feminist Studies in Religion* 22(1), pp. 135–154.
- Hall, J. (2002) 'Churches in Swaziland take on new roles to combat HIV/AIDS.' *Femnet News*, 1 May 2002. Available at: <http://www.allbusiness.com/africa/427811-1.html> [Accessed 13 July 2008].
- Hartwig, K.A., Kissioki, S. & Hartwig, C.D. (2006) Church leaders confront HIV/AIDS and stigma: a case study from Tanzania. *Journal of Community and Applied Social Psychology* 16, pp. 492–497.
- Hutchinson, P.L., Mahlalela, X. & Yukich, J. (2007) Mass media, stigma, and disclosure of HIV-test results: multilevel analyses in the Eastern Cape, South Africa. *AIDS Education and Prevention* 19(6), pp. 489–510.
- IRIN (2005) 'The role of women stirs debate at the reed dance.' *IRIN Humanitarian News and Analysis*, online report, 30 August 2005. Available at: <http://www.irinnews.org/report.aspx?reportid=56096> [Accessed 22 June 2009].
- Ironson, G., Solomon, G., Balbin, E., O'Cleirigh, C., George, A., Kumar, M., Larson, D. & Woods, T.E. (2002) Spirituality and religiousness are associated with long survival, health behaviors, less distress, and lower cortisol in people living with HIV/AIDS: the IWORSHIP scale, its validity and reliability. *Annals of Behavioral Medicine* 24(1), pp. 34–48.
- Kuper, H. (1986) *The Swazi: A South African Kingdom*. New York, Holt, Rinehart and Winston.
- Lucas, N. (2005) The women's movement in Swaziland: Look how far we've come! *OPENSOURCE* 1(1), pp. 62–63 (a publication of the Open Society Initiative of Southern Africa [OSISA], Johannesburg, South Africa). Available at: http://www.osisa.org/publications/OPENSOURCE_1_1 [Accessed 29 June 2008].
- Makoae, L., Greff, M., Phetlhu, R., Uys, L., Naidoo, J., Kohi, T., Dlamini, P., Chirwa, M. & Holzemer, W. (2008) Coping with HIV-related stigma in five African countries. *Journal of the Association of Nurses in AIDS Care* 19(2), pp. 137–146.
- Meyer, B. (1998) 'Make a complete break with the past': Memory and postcolonial modernity in Ghanaian Pentecostal discourse. In: Webner, R. (ed.) *Memory and the Post Colony*. London, Zed Books.
- Meyer, B. (2004) Christianity in Africa: from African Independent to Pentecostal-Charismatic churches. *Annual Review of Anthropology* 33(1), pp. 447–474.
- Miller, A.N. & Rubin, D.L. (2007) Factors leading to self-disclosure of a positive HIV diagnosis in Nairobi, Kenya: people living with HIV/AIDS in the Sub-Saharan. *Qualitative Health Research* 17(5), pp. 586–598.
- Miller, S.I. & Fredericks, M. (1999) How does grounded theory explain? *Qualitative Health Research* 9(4), pp. 538–551.
- Ministry of Health and Social Welfare [Swaziland] (2008) *Draft National Strategy for HIV/AIDS-Related Stigma and Discrimination*. Mbabane, Swaziland, Ministry of Health and Social Welfare.
- Mogensen, H. (2002) The resilience of juok: confronting suffering in Eastern Uganda. *Africa* 72(3), pp. 420–436.
- National Emergency Response Council on HIV/AIDS (NERCHA) (2006) *The Second National Multisectoral HIV and AIDS Strategic Plan 2006–2008*. Mbabane, Swaziland, Government of the Kingdom of Swaziland. Available at: <http://www.nercha.org.sz/public.html?frameload=100> [Accessed 15 July 2008].
- National Emergency Response Council on HIV/AIDS (NERCHA) (2008) *Monitoring the Declaration of Commitment on HIV/AIDS (UNGASS). Swaziland Country Report, January 2008*. Mbabane, Swaziland, the Government of the Kingdom of Swaziland. Available at: http://data.unaids.org/pub/Report/2008/swaziland_2008_country_progress_report_en.pdf.
- Norman, A., Chopra, M. & Kadiyala, S. (2007) Factors related to HIV disclosure in two South African communities. *American Journal of Public Health* 97(10), pp. 1775–1781.
- Ntsimane, R. (2006) To disclose or not to disclose: an appraisal of the memory box project as a safe space for disclosure of HIV-positive status. *Journal of Theology for Southern Africa* 125, pp. 7–20.
- Otolok-Tanga, E., Atuyambe, L., Murphy, C., Ringheim, K. & Woldehanna, S. (2007) Examining the actions of faith-based organisations and their influence on HIV/AIDS-related stigma: a case study of Uganda. *African Health Sciences* 7(1), pp. 55–60.
- Pan African Christian AIDS Network (PACANet) (2008) *Situational Analysis: Swaziland Report*. Available at: http://www.pacanet.net/index.php?option=com_docman&task=cat_view&gid=23&Itemid=40.
- Pargament, K.I., McCarthy, S., Shah, P., Ano, G., Tarakeshwar, N., Wachholtz, A., Serrine, N., Vasconcelles, E., Murray-Swank, N., Locher, A. & Duggan, J. (2004) Religion and HIV: a review of the literature and clinical implications. *Southern Medical Journal* 97(12), pp. 1201–1209.
- Parker, R. & Aggleton, P. (2003) HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. *Social Science and Medicine* 57(1), pp. 13–24.
- Parsons, S.K., Cruise, P.L., Davenport, W.M. & Jones, V. (2006) Religious beliefs, practices and treatment adherence among individuals with HIV in the southern United States. *AIDS Patient Care and STDs* 20(2), pp. 97–111.
- Pfeiffer, J. (2005) Commodity fetishism: the Holy Spirit, and the turn to Pentecostal and African Independent Churches in Central Mozambique. *Culture, Medicine and Psychiatry* 29(3), pp. 255–283.
- Regnerus, M.D. & Salinas, V. (2007) Religious affiliation and AIDS-based discrimination in sub-Saharan Africa. *Review of Religious Research* 48(4), pp. 385–400.
- Reza, A., Breiding, M., Blanton, C., Mercy, J., Dahlberg, L., Anderson, M. & Bamrah, S. (2007) *Violence against children in Swaziland: Findings from a natural survey on violence against children in Swaziland, 15 May–16 June 2007*. Atlanta, Georgia,

- Centers for Disease Control and Prevention, and Swaziland United Nations Children's Fund.
- Root, R. (2009) Situating experiences of HIV-related stigma in Swaziland. *Global Public Health* (forthcoming).
- Takyi, B.K. (2003) Religion and women's health in Ghana: insights into HIV/AIDS preventive and protective behavior. *Social Science and Medicine* 56(6), pp. 1221–1234.
- Taylor, N. (2006) *Working Together? Challenges and Opportunities for International Development Agencies and the Church in the Response to AIDS in Africa*. Tearfund HIV and AIDS Briefing Paper No. 7. Middlesex, UK, Tearfund.
- Thomas, L., Schmid, B., Gwele, M., Ngubo, R. & Cochrane, J.R. (2006) *'Let us embrace': The Role and Significance of an Integrated Faith-based Initiative for HIV and AIDS*. Cape Town, South Africa, African Religious Health Assets Programme.
- Trinitapoli, J. & Regnerus, M.D. (2006) Religion and HIV-risk behaviors among married men: initial results from a study in rural sub-Saharan Africa. *Journal for the Scientific Study of Religion* 45(4), pp. 505–528.
- UNAIDS (2006) *Helping Ourselves: Community Responses to AIDS in Swaziland*. UNAIDS Best Practice Collection, UNAIDS/06.22E. Geneva, UNAIDS.
- UNDP (2007) *Swaziland: 2007/2008 Human Development Report*. New York, United Nations Development Programme (UNDP). Available at: <http://hdrstats.undp.org/en/indicators/147.html> [Accessed 22 June 2009].
- UNICEF (2003) *Facing the Future Together: Country Report of the United Nations Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa*. UNICEF/HQ01-0287. New York, United Nations Children's Fund (UNICEF).
- Ware, N.C., Wyatt, M.A. & Tugenberg, T. (2006) Social relationships, stigma and adherence to antiretroviral therapy for HIV/AIDS. *AIDS Care* 18(8), pp. 904–910.
- Whiteside, A., Andrade, C., Arrehag, L., Dlamini, S., Ginindza, T. & Parikh, A. (2006) *The Socio-Economic Impact of HIV/AIDS in Swaziland*. Mbabane, Swaziland, National Emergency Response Council on HIV/AIDS (NERCHA) and Health Economics and HIV/AIDS Research Division.
- WHOQOL-HIV Group (2003) Preliminary development of the World Health Organization's quality-of-life HIV instrument (WHOQOL-HIV): analysis of the pilot version. *Social Science and Medicine* 57(7), pp. 1259–1275.
- Woldehanna, S., Ringheim, K., Murphy, C., Gibson, J., Odyniec, B., Clérismé, C., et al. (2005) *Faith in Action: Examining the Role of Faith-based Organizations in Addressing HIV/AIDS. A Multi-Country, Key Informant Survey*. Washington, D.C., Global Health Council.
- Wolfe, W., Weiser, S., Bangsberg, D., Thior, I., Makhema, J., Dickinson, D., Mompati, K. & Marlink, R. (2006) Effects of HIV-related stigma among an early sample of patients receiving antiretroviral therapy in Botswana. *AIDS Care* 18(8), pp. 931–933.
- World Bank (2008) *International Bank for Reconstruction and Development, Interim Strategy Note: A Framework for Scaling Up Support for the Kingdom of Swaziland for the Period 04/2008–04/2010*. 26 February 2008. Document of the World Bank, Report No. 42059-SZ, Southern Africa Country Department 1, Africa Region.
- Yi, M.S., Mrus, J.M., Wade, T.J., Ho, M.L., Hornung, R.W., Cotton, S., Peterman, A.H., Puchalski, C.M. & Tsevat, J. (2006) Religion, spirituality, and depressive symptoms in patients with HIV/AIDS. *Journal of General Internal Medicine* 21(supplement 5), pp. S21–S27.
- Zou, J., Yamanaka, Y., John, M., Watt, M., Ostermann, J. & Thielman, N. (2009) Religion and HIV in Tanzania: influence of religious beliefs on HIV stigma, disclosure, and treatment attitudes. *BMC Public Health* 9(75) doi:10.1186/1471-2458-9-75 (published online 4 March 2009).