ATTITUDES OF CHURCH LEADERS TOWARDS CONGREGANTS TAKING ANTIRETROVIRAL THERAPY IN VHEMBE DISTRICT, LIMPOPO, SOUTH AFRICA

By

MKATEKO MARIA CHAUKE

(Student no: 33927219)

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Supervisor: Dr T.R. Netangaheni

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DECLARATION

I, Mkateko Maria Chauke, hereby declare that '**Attitudes of church leaders towards congregants taking antiretroviral therapy in Vhembe District, Limpopo, South Africa**" is my individual work and all the sources that I used or accessed have been indicated and acknowledged by means of a complete reference list.

Signed ______________ Date: 29 October 2023

Mkateko Maria Chauke

DEDICATION

I dedicate this dissertation to my parents posthumously, Mr. Mudungwazi John Hlongwane and Mrs. Tsatsawani Lydia Mathonsi-Hlongwane. They stood by me throughout my research and encouraged me to have a profession to take care of myself.

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ABSTRACT

Purpose: The study aimed at exploring church leaders' attitudes towards congregants who are taking antiretroviral therapy in the Vhembe District.

Research Design: A qualitative research approach with an exploratory, descriptive design was used.

Setting: The proposed research was conducted in the Vhembe District of Limpopo Province.

Population: The study population was church leaders and congregants of registered churches registered in the Vhembe District.

Sampling: The non-probability purposive sampling was used to select church leaders and congregants. The sample size was determined by data saturation.

Data collection and analysis methods: In-depth semi-structured interviews were utilised to collect data. Thematic analysis was done using Tesch's eight steps.

Results: A total of 30 participants, consisting of 24 church congregants and six church leaders participated. From the thematic analysis, church leaders' attitudes were positive and negative. Positive attitudes included encouragement, while negative attitudes included judgemental attitudes, lack of acceptance and faith- based healing versus taking antiretroviral therapy. Stigma and discrimination took the form of labelling and exclusion and participants recommended information sharing and involvement of the Department of Health in training.

Conclusion: HIV and AIDS awareness campaigns are necessary to impart the church leaders with information.

Keywords: Exploring, Attitudes, Church leaders, Congregants, Anti-retroviral therapy

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
DoH	Department of Health
FBOs	Faith Based Organisations
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
NGOs	Non-Governmental Organisations
PHC	Primary Health Care
PLWHA	People Living with HIV and AIDS
SDG	Sustainable Development Goals
SSA	Sub-Saharan Africa
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNISA	University of South Africa
WHO	World Health Organisation

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CHAPTER 1

ORIENTATION OF THE STUDY

1.1 Introduction and Background of the Study

The prevention and management of the Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) is still a worldwide challenge despite people having access to Antiretroviral Treatment (ART). This prevention and management of HIV and AIDS respectively forms part of the Sustainable Development Goals (SDG) by the United Nations (World Health Organisation (WHO), 2020). There is still inadequate conformity to ART despite its increased access for the reduction of AIDS-related mortalities among people living with HIV and AIDS (PLWHA) in the world (UNAIDS, 2019); (WHO, 2020).

South Africa has the largest ART programme of all in the world, with an estimated 7.7 million PLWHA as beneficiaries (WHO, 2020). Although South Africa is progressing positively in the trial and viral suppression quest toward achieving the UNAIDS 90-90-90 targets, the country continues to struggle to control the spread of the epidemic (WHO, 2020); (Avert, 2020). Various studies conducted in South Africa identified some contributory factors of non-adherence to ART among PLWHA (Kheswa, 2018:100). These factors include fear of disclosure, educational level, religion, inadequate social support, underdeveloped health provider-patient relationships and residing outside of home (Adeniyi et al., 2018:175). To address the above problems of the community, it is necessary to implement various interventions such as forging collaboration between the healthcare services and facilities with religious institutions and Faith Based Organisations (FBOs) to accelerate awareness on prevention and treatment of HIV and AIDS (Jobson et al., 2019: 81). The role of religious/spiritual institutions and their leaders is to assist congregants living with HIV to manage their overall wellbeing. Such importance was illustrated in many studies to ensure that PLWHA continue with their treatment despite care by healers (Arrey, Bilsen, Lacor, & Deschepper, 2018:22).

Kruger, Greeff and Letsosa (2018:10) observed that religious leaders can significantly contribute to reaching and empowering communities. Empowerment by church

leaders includes educating on the avoidance of risk, offering physical and spiritual support to the infected and affected members, combating HIV and AIDS stigmatisation and discrimination and encouraging those on treatment to continue administering their ART (Kruger et al., 2018:10).

Religious leaders in the country also experience relationship challenges with caregivers when supporting PLWHA (Arrey et al., 2018: 23). According to Kheswa (2018:101), religious practices have contributed to poor ART adherence in some communities in South Africa. For example, some patients have stopped ingesting ART due to religious beliefs. The cessation of ART by PLWHA through religious beliefs and practices has an adverse impact on their health and wellbeing (Kheswa, 2018:101). Furthermore, these beliefs are oppositional to strategies the South African government implemented to improve the quality of life for all its citizens (South African National AIDS Council, 2018).

According to Dzansi, Tomu and Chipps (2020:13), the substitution of ART with religious practices has resulted in the deaths of some PLWHA. Their religious beliefs cause them to discontinue ART in exchange for beliefs including attendance of prayer camps and sessions of fasting for deliverance. Various religious leaders have been reported to have discouraged congregants from using ART, encouraging them to use other religion-based remedies such as water instead (Kruger et al., 2018:10). Such discouragement to take ART are a form of stigma and discrimination against PLWHA among labelling them as immoral and having to atone for their sins (Kruger et al., 2018:10). Regrettably, these acts by religious leaders are negligent and result in experiences of debility, dizziness and nausea for some PLWHA (Dzansi et al., 2020:13).

It is, therefore, imperative for church leaders to understand HIV infection and ART administration as well as the dangers of defaulting ART. For this reason, the researcher intends to explore the attitudes of church leaders toward congregants taking ART in the Vhembe District.

1.2 Problem Statement

The researcher is an employee of the Department of Health in one of the Vhembe District Primary Healthcare (PHC) facilities in Limpopo Province. During daily nursing

care activities, the researcher has observed an increase in the number of PLWHA who have discontinued their ART intake, indicating religious beliefs and practices as reasons for non-adherence to the treatment. However, the truth and authenticity of such non-adherence to ART cannot be confirmed without scientific inquiry. Mabunda, Ngamasana, Babalola, Zunza, and Nyasulu (2019:14) highlighted that Limpopo Province, with an estimated ART adherence rate of approximately 61%, is regarded as one of the South African Provinces struggling with ART adherence. Meanwhile, non-adherence to ART exposes PLWHA to less effective viral suppression, exposing the patient's immediate health to an increased risk of permanent resistance to ART. Furthermore, breastfeeding mothers subject their infant babies to HIV infection, increasing the HIV mortality rate and new HIV infections in the community when ART is discontinued (South African National AIDS Council, 2018).

The researcher intended to establish whether or not church leaders in the Vhembe District influence or prevent PLWHA from continuing with the treatment. Discontinuation of ART creates health challenges for PLWHA that have the potential to increase both the mortality rate and new HIV infections in Vhembe District. Hence, hindrances to ART should be investigated (Health e-News Report, 2019). Furthermore, exploring the attitudes of church leaders towards PLWHA and the importance of ART adherence could assist in determining the factors contributing to non-adherence of ART within the Municipality.

1.3 Rationale of the Study

The researcher sought to explore church leaders' attitudes towards congregants taking ART in the Vhembe District. The investigation was prompted by the high ART defaulter rate of PLWHA, indicating the reason for defaulting treatment was religious. Such religious reasons included practices such as fasting and cleansing that induced vomiting and drinking of herbal concoctions.

1.4 Research Purpose

The study was aimed at describing the attitudes of church leaders towards congregants taking antiretroviral therapy in Vhembe district, Limpopo, South Africa.

1.5 Research Objectives

The research objectives of this study are:

- To explore the attitudes of church leaders towards congregants who are taking antiretroviral therapy in Vhembe District
- To describe the stigma and discrimination experienced by congregants who are taking antiretroviral therapy in Vhembe District
- To describe recommendation measures to address attitudes of church leaders towards congregants taking antiretroviral therapy

1.6 Research Questions

The following research questions were addressed:

- What are the attitudes of church leaders towards congregants who are taking antiretroviral therapy in the Vhembe District?
- What form of stigma and discrimination is experienced by congregants taking antiretroviral therapy in Vhembe District?
- What measures can be taken to address the attitudes of church leaders toward congregants taking antiretroviral therapy?

1.7 Significance of the Study

The study aimed to determine church leaders' attitudes toward congregants taking ART in the Vhembe District of Limpopo Province. The study's outcome can be applied by the management of the Limpopo Provincial Department of Health to make recommendations to the National Department of Health regarding the planning of overall strategies to prevent new HIV infections through 100% viral suppression in PLWHA who are taking ART. Furthermore, the proposed study could assist in health promotion and prevention strategies as needed by church leaders in helping and supporting the parish in their quest to improve adherence to ART.

The study outcomes could further assist in determining the health promotion needs of religious organisations regarding HIV, AIDS and ART. Development of support and collaborative strategies between the Provincial Department of Health and faith-based organisations (FBOs) will be aided. The research outcome will assist future researchers in furthering their investigation and developing additional ways to manage the influence of the church community in HIV-related matters.

1.8 Research Process

The qualitative research approach espouses several research designs, namely, ethnography, grounded theory and case studies (Creswell, 2020:216). An explorative, descriptive design was used to explore the attitudes of church leaders towards congregants who are taking ART in the Vhembe District.

Explorative design further provided the researcher with flexibility and adaptations during data collection, which enabled possibilities to explore and explain the phenomenon of church leaders' attitudes towards PLWHA. Exploratory research designs are, at most, inductive due to their attempt to build data collection instead of testing existing theories (Creswell, 2020:216). On the other hand, the descriptive research design was used to observe, describe, and record responses by the church leaders and congregants attending the selected churches, thus increasing the researcher's understanding of the church leaders' attitudes towards PLWHA taking ART in the Vhembe District.

The study explored the attitudes of church leaders towards congregants who are taking antiretroviral therapy, which renders exploratory and descriptive research design appropriate in the Vhembe District.

A semi-structured interview guide was used to conduct interviews with 30 church leaders and congregants aged 18 years and above. The church leaders were purposively selected from designated churches under Malamulele Pastors Forum in Collins Chabane Local Municipality in Vhembe District. This study's research design and data collection method were based on the stated research objectives. The researcher was interested in discovering how much knowledge the church leaders and congregants have about these attitudes towards congregants taking antiretroviral therapy in Vhembe District.

About 30 participants were interviewed at the three (3) churches. Each interview lasted for about 10-35 minutes. The researcher requested approval from the Collins Chabane Local Municipality and Malamulele Pastors Forum to conduct interviews at the three churches in Malamulele Township, Madonsi Boltman B village and Madonsi A. Structured interview guides were used to facilitate the interview process.

1.9 Research Assumption

The research had assumptions or knowledge claims:

- The church leaders know that their attitudes towards congregants taking antiretroviral therapy have a negative influence on them continuing to take ART, but they do not want to change to a positive attitude.
- The participants will feel comfortable discussing these attitudes and their influence during the interviews.
- The participants will provide their recommendations to address these attitudes of church leaders.

The current study considered qualitative interpretivism assumptions in which six (6) concepts of the Health Belief Model (HBM) will be described in relation to the attitudes of church leaders toward congregants taking antiretroviral therapy. The six concepts, perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and perceived self-efficacy, were appropriate to conceptualise the study results. The concepts of HBM form a scientific base that allowed the researcher to determine the attitudes of church leaders towards congregants taking ART in the Vhembe District of Limpopo, South Africa.

1.10 Defining Key Concepts

Key concepts are distinguishable by their thematic and logical connection to various aspects or tenets of the study as entailed in the research topic (Creswell, 2020:68).

Exploring: This refers to the investigation or search for answers that enable a better understanding of issues or questions. Whenever an individual researches or investigates something, the person is exploring (Merriam-Webster Dictionary, 2020:411). The researcher will explore the attitudes of church leaders towards congregants who are taking ART in the Vhembe District.

Attitude: This a persistent and all-encompassing view about a concept, an object, an issue or a person, which can be positive or negative. Attitudes are the foundation of definitive perspectives and often emanate from particular emotions, beliefs and previous conduct linked to those objects (Vanden Bos, 2017:17). In this study, attitude

refers to the beliefs and emotions of church leaders towards congregants who are taking ART in the Vhembe District.

Church leaders: These are also referred to as a pastor, an ordained elder, or an associate member approved by a vote of the clergy session and may be appointed by the bishop to oversee a circuit (Merriam Webster Dictionary, 2020:298). In this study, church leaders are pastors who are leaders of their congregants.

Congregants: This refers to an assembly of people who meet for the purpose of worship or instruction in religion (Merriam Webster Dictionary, 2020:300). In this study, congregants are the church members attending various churches for religious purposes.

ART: This is an acronym for antiretroviral treatment and refers to all drugs intended for preventing HIV prevalence (Thompson, Aberg & Hoy, 2012:387). These drugs do not completely cure HIV. Anti-retroviral therapy also refers to the medication used to suppress viral load in the blood system of people living with HIV as intensely as possible for as long as possible by using a tolerable and sustainable treatment for an indefinite period (Van Dyk, 2017:4). In this study, ART refers to drugs taken by HIV positive congregants to suppress the viral load in their blood system.

1.11 Dissertation Outline

The exploration of the study is presented in five chapters:

Outline of the Dissertation

The intended study is structured into 5 (five) chapters as indicated below:

Chapter 1: Overview of the study

This chapter presents the background and rationale of the study, the research problem, the significance of the study, the research purpose, objectives, and research questions.

Chapter 2: Literature review

This chapter provides the theoretical framework guiding the study and relevant literature exploring church leaders' attitudes toward congregants taking antiretroviral therapy.

Chapter 3: Research methodology and design

This chapter provided the research methodology, a detailed research approach, research design, data collection, data analysis, ethical considerations, and measures to ensure trustworthiness.

Chapter 4: Findings and discussion

This chapter presented interpreted data as research findings from the interviews conducted as the framework against which the evidence of the study is established.

Chapter 5: Conclusion, recommendations, study limitations and strengths

This chapter presented the study's conclusion in relation to the study findings and objectives. This chapter also provided the study's strengths, weaknesses, limitations, and recommendations, with the conclusion inclusive.

1.12 Summary

This chapter introduced the study by outlining the role that religion has in the prevention and management of HIV in South Africa. The chapter also described the context of HIV management within religious communities where beliefs of faith-based healing affect adherence to ART. The chapter also outlined that the problem of non-ART adherence has increased due to religious beliefs. Moreover, Chapter 1 outlined the purpose and objectives of the study, which included describing the attitudes of church leaders towards congregants taking ART. The chapter further described the qualitative approach used to conduct the study. In addition, Chapter 1 also defined key terms used in the study, including attitudes and HIV. The last section of Chapter 1 outlined the contents of the study's five chapters. The next chapter is Chapter 2, the literature review.

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

In this chapter, literature related to the study is reviewed. A literature review highlights the important findings of previous studies conducted in relation to the study (Grove, Gray & Burns, 2020:107). Moreover, a literature review provides an understanding and the theoretical and procedural contributions to a study subject matter (Grove et al., 2020:107). The purpose of the literature review and this chapter is threefold. Firstly, by reviewing research studies closely related to the present study, the researcher gained new insights and learnt of new approaches that informed and supported the study and its research design. Secondly and most importantly, in this critical review of related studies, the researcher aimed to identify and indicate the gap that other researchers in the field have not focused on. Thirdly, the researcher used the review to help place the study in an appropriate theoretical context. The chapter begins with a description of the HBM.

2.2 The theoretical framework

For the exploration purpose of this study, the researcher utilised the Health Belief Model. The HBM is one of the first theories developed to explain the change process in relation to health behaviour. When used appropriately, it provides organised assessment data about client's abilities and motivation to change their health status. A model is often described as a symbolic depiction of reality. The model provides a schematic representation of some relationships among phenomena and uses symbols and diagrams to represent an idea. A model helps to organise the study, examine a problem, gather and analyse data.

2.2.1 Health Belief Model (HBM; Becker, 1976,1978)

The HBM has become a popular framework in nursing studies focused on patient compliance and preventive health care practices (Polit & Beck, 2020:232). The model postulates that health-seeking behaviour is influenced by a person's perception of a threat posed by a health problem and the value associated with actions aimed at reducing the threat. The major component of the HBM includes perceived

susceptibility, perceived severity, perceived benefits and costs, motivation and enabling or modifying factors. The researcher in this study explored the attitudes of church leaders towards congregants taking ART in Collins Chabane Municipality, aiming at giving more information related to HIV infection, ART, management of the infection and prevention of further infection, then control of the pandemic by the year 2030 (UNAIDS, 2019); (WHO, 2020).

As HIV transmission is propelled by behavioural factors, theories about how individuals change their behaviours have provided the foundation for most HIV prevention efforts worldwide.

Perceived Susceptibility is a person’s perception that a health problem is personally relevant or that a diagnosis is accurate. Church leaders can positively influence global health issues due to their ability to influence attitudes and behaviours and reach remote populations (Corzine, 2019:89). There are several reasons why church leaders are influential members of the community when it comes to health issues. Church leaders are trusted, respected and seen as role models regarding health (Duff & Buckingham, 2018:105). Church leaders can promote health through preaching, teaching, giving information on health issues, collaborating with local health officials of NGOs or influencing local or national politics and policies (Corzine, 2019:89).

Perceived benefits are the patient’s belief that a given treatment will cure or help prevent the illness. Several studies have shown that spirituality is important to patients and affects healthcare decision-making and outcomes, including the quality of life (Ayuk, Ndifreke & Gyuse, 2018:116). The intersection of religious beliefs and ART experiences has several implications on ART adherence (Vasquez, 2018:25). Some religious organisations encourage PLWHA to continue with their treatment, while other churches have counsellors who assist PLWHA to cope with their condition.

Perceived Barriers include the complete duration and accessibility of the treatment. Some religious communities foster moral judgement about PLWHA by promoting negative attitudes toward the disease and the communities most affected by HIV and AIDS. Stigma has been closely linked with the level of congregational engagement in HIV work. Religious beliefs may intersect with ART experiences in ways that may pose

challenges to ART adherence. PLWHA who believe that their current health predicament can be cured spiritually are less likely to adhere to ART, but instead spend much of their time praying, doing religious rituals and visiting prayer houses for cure often stop their ART (Igbende et al., 2018:30). A qualitative study in Limpopo, South Africa by Norder et al. (2018:1404) indicate that barriers preventing the involvement of churches in HIV health care are stigma resulting in non-disclosure, increased stigma because of the association between HIV and sexuality and certain religious practices that interfere with medication adherence.

Motivation is the desire to comply with a treatment. In South Africa, opportunities for health-religious collaboration have been identified, such as holistic HIV care to include spiritual aspects, utilising the church's social access to the community and the potential of churches for HIV dialogue because they are identified as safe and accepting places Norder et al. (2018:1504). Among the modifying factors identified are personality variables, patient satisfaction, and socio-demographic factors.

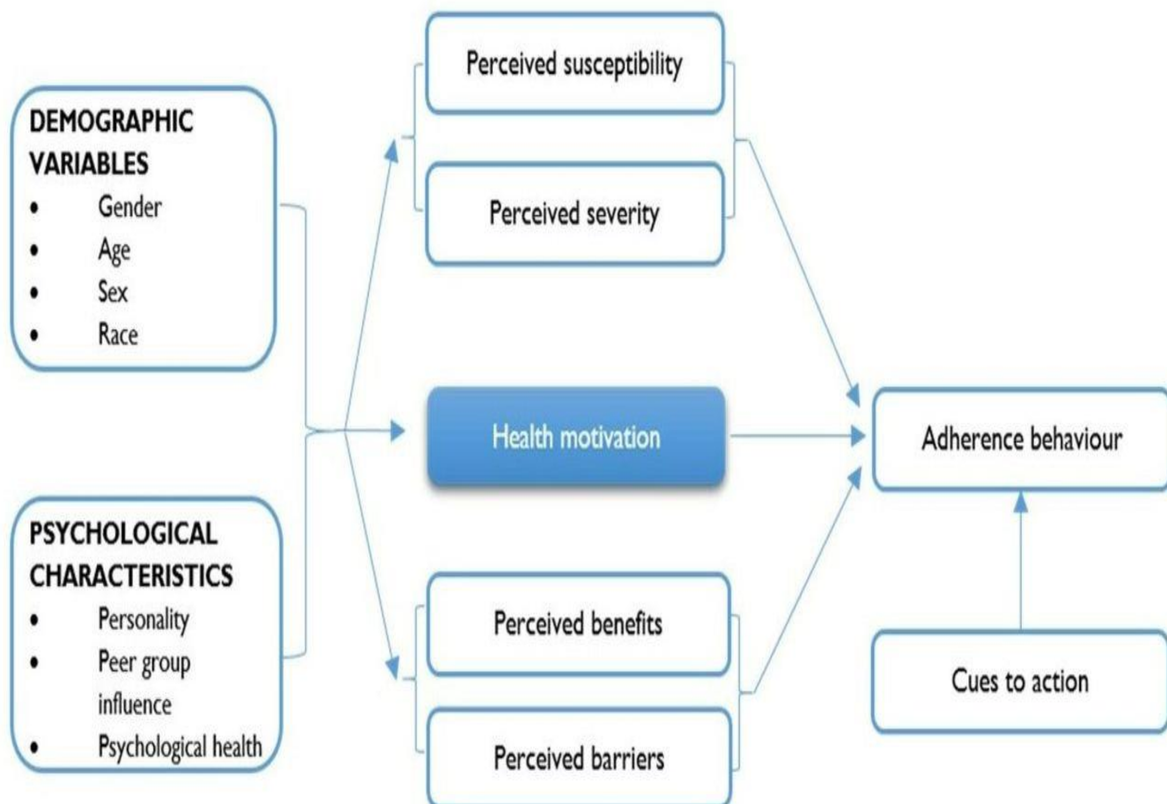

Figure 2.1: The HBM flow chart provides a possible explanation of why PLWHA take action to adhere to ART or not.

2.3 The impact of religion on people living with HIV and AIDS

Several studies by Ayuk et al. (2018) and Vasquez (2015) have shown that both the positive and negative quality of life affect healthcare decision-making. Patients view Health outcomes as important, and ART adherence is impacted by the intersection of religious beliefs and ARV experiences (Vasquez, 2015). Some religious organisations form groups to encourage PLWHA to continue with their treatment and other churches in addition, have counsellors that assist PLWHA in coping with and managing their condition (Vasquez, 2015). However, some religious communities promote a negative attitude toward HIV, while some communities foster moral judgement about PLWHA (Vasquez, 2015). The stigmatisation of HIV and AIDS has been linked to a level of congregational engagement in HIV projects that may ultimately pose challenges to ART adherence (Vasquez, 2015). People less likely to adhere to ART are those PLWHA who believe performing religious rituals, praying and embedding themselves in prayer sessions will cure their illnesses (Igbende et al., 2016).

2.3.2 The role of church leaders in encouraging adherence to ART

Church leaders' influence, combined with their ability to reach remote populations, can positively affect behaviours and global health issues of PLWHA (Corzine, 2019). Church leaders are seen as trusted, influential and respected members of the community, making them role models to many congregants concerning health-related affairs (Duff & Buckingham, 2015). Promoting good health practices can be achieved by church leaders through preaching, teaching the communities about better health routines, collaborating with local non-governmental organisations (NGOs), or influencing local or national politics (Corzine, 2019).

A sermon guide was developed in Kenya to empower church leaders with the tools and skills needed to impact congregational members with key measures on HIV-related issues, including treatment care for HIV and AIDS (Elizabeth Glaser Paediatric AIDS Foundation, 2020). In South Africa, health-religious collaborations and opportunities for comprehensive HIV care that include spiritual aspects have been identified with the utilization of the churches' social access and the presence of a safe and accepting environment to engage in HIV dialogue with the communities (Norder et al., 2015).

2.3.3 HIV and AIDS stigma and religion

Church groups in South Africa are diverse in their stance on PLWHA, which varies from implicitly dismissing the disease's existence (a more predominant response) to public condemnation of congregants engaging in "sexual immorality" and obligated to "repent" from their sins (Alio et al., 2019). Norder et al. (2015) conducted a qualitative study, which revealed that the sexuality and HIV nexus prevents church organisations from involvement in healthcare, which creates stigma-related barriers such as non-disclosure and inference with medication adherence.

Some studies have found that HIV-related attitudes vary between extreme judgementalism and exclusionary to accepting and inclusive among congregants, which indicates faith-based communities' mixed responses to HIV medicine. Based on the study conducted by Alio et al. (2019), 71% of South African church leaders admit that greater support and resources are required to address the inadequate skills to address HIV and AIDS-related stigma endured by PLWHA. This shows that moral judgement and negative attitudes are endorsed by religious communities (Reyes-Estrada et al., 2018). Several organisations are, however, involved in the war on HIV that is sometimes viewed as retribution from God for earthly sins and in communities that are less accessible to the government. In many instances, congregants are responsible for the condemnation of PLWHA as immoral persons (Kruger et al., 2018).

2.3.4 Spiritual or religious beliefs and adherence to ARV therapy

According to Dzansi et al. (2020), the substitution of ARV therapy with religious practices has caused the deaths of some PLWHA who discontinued their ART in pursuit of religious interests, including prayer camps and sessions of fasting for deliverance. Some religious leaders have been reported to be discouraging church congregants from taking ART rather than encouraging members with HIV to use alternative religion-based remedies such as water. Such a situation stigmatises and creates a discriminatory environment for PLWHA where they are categorised as immoral and atoning for their sins (Kruger et al., 2018). Regrettably, some patients become weaker and experience headaches, dizziness, and nausea during their dogmatic religious pursuits (Dzansi et al. (2020); (Krakauer & Newbery, 2007). Many religious organisations are mushrooming daily in the rural communities of Vhembe

District in Limpopo Province. This study will confine itself to churches in those Vhembe District communities.

2.4 Conclusion

Chapter 2 was the literature review and the theoretical framework. This chapter began with a description of the HBM and outlined the application of the model in compliance and preventive healthcare through perceived susceptibility, perceived benefits, perceived barriers, and motivation. The literature reviewed described how some religious groups encourage people to take ART. On the other hand, the stigma and discrimination faced by PLWHA in churches was described. From this discussion, it was noted that stigma and discrimination resulted in PLWHA not disclosing their HIV status and not adhering to ART. Chapter 2 also described how some religious beliefs resulted in PLWHA defaulting on ART due to the belief that HIV can be cured by faith. The next chapter is Chapter 3, which describes the study's methodology.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1. Introduction

The chapter outlines the methodology used to conduct the research. Grove et al. (2020: 304) define the research methodology as the procedures and techniques used to conduct a study. The research methodology is the logical plan used to systematically conduct the study (Nieswiadomy & Bailey, 2018:6). The methodology encompasses the study design and approach used to address the purpose of the study of attitudes of church leaders towards congregants taking ART in the Vhembe District. This chapter describes the specific strategies employed to select study participants and the population within which the sample was recruited. The chapter also describes how data was collected and analysed. The measures to ensure trustworthiness are also subsumed in the methodology. The specific steps in applying ethical principles are described and involve gaining ethical approval from the Ethics Committee (Higher Degrees Committee) of the College of Human Science at UNISA.

3.2 Study Approach and Design

3.2.1 Research approach

This study adopted a qualitative research approach, which has been mainly selected for its allowance of collection of data from participants in a narrative format (Nieswiadomy & Bailey, 2018:6). In addition, the qualitative approach was applied as data was collected in the participants' familiar ecological settings, which are the churches in the Vhembe District. A qualitative approach assists in explaining how congregants react differently to a similar problem.

3.2.2 Research design

Creswell and Creswell (2018:363) define a research design as "a set of formal procedures for collecting, analysing and interpreting data." A research design is also a guide for carrying out a study in a manner that enables the direct responses to research questions and the accomplishment of research objectives (Kumar, 2020:41). Kumar (2020:41) further comments that a research design should be guided by the research questions that the research intends to answer. The qualitative research approach espouses several research designs, namely, ethnography, grounded theory

and case studies (Creswell, 2020: 216). An explorative, descriptive design was used to explore the attitudes of church leaders towards congregants who are taking ART in the Vhembe District.

Explorative design further provided the researcher with flexibility and adaptations during data collection, which enabled possibilities to explore and explain the phenomenon of church leaders' attitudes towards PLWHA. Exploratory research designs are at most, inductive due to their attempt to build data collection instead of testing existing theories (Creswell, 2020:216). The descriptive research design on the other hand, was used to observe, describe, and record responses by the church congregants attending the identified churches, thus increasing the researcher's understanding of the church leaders' attitudes towards ART among congregants in the Vhembe District.

This study explored the attitudes of church leaders towards congregants who are taking ART, which renders exploratory and descriptive research design appropriate in the Vhembe District. Furthermore, church congregants could react and personally express practice-related scenarios that justify and further explain their reactions or responses concerning their attitudes and stigmatisation of PLWHA. This enabled the researcher to attain further knowledge about HIV and AIDS stigma and discrimination experienced by congregants undergoing antiretroviral therapy.

3.3 Research Methods

3.3.1 Study setting

The research was conducted at the Malamulele node of Vhembe District, Limpopo Province. The area is situated about 191km from the City of Polokwane. The Municipality consists of four nodes: Hlanganani, Malamulele, Saselamani and Vuwani. The focus of the study was on the Malamulele node. There are numerous church denominations within the Malamulele area, with 92 churches registered and recognised by the church forum.

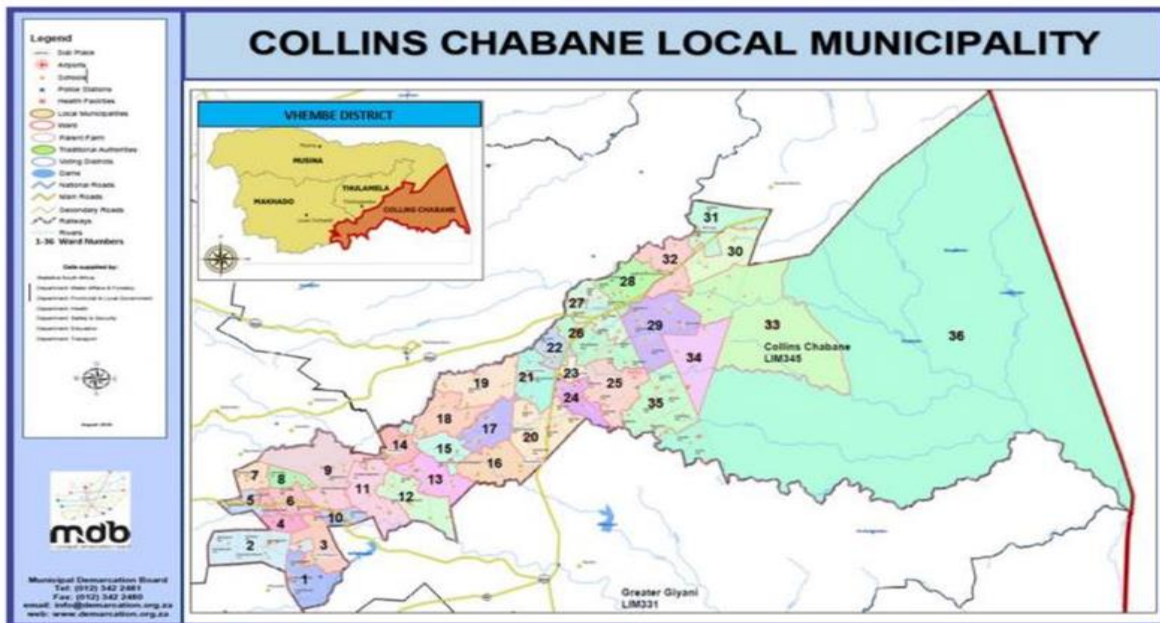

Figure 3.1: Map of the Malamulele node of Vhembe District

The map in Figure 3.1 above depicts the location and distribution of various religious denominations within Vhembe District.

3.3 Population and sampling

A population is the larger group of units, individuals, objects, systems or organisations from which a sample is drawn (Dahabreh, 2020:45). Pertaining to this study, and the population was church congregants and church leaders from the 92 churches registered under the Malamulele Church Forum. This population included only adults aged more than 18 years.

3.3.1 Sampling

Purposive sampling was used in this study to select the participating church congregants and leaders. Purposive sampling encourages the researcher to use their judgement for selecting participants deemed to be most informative on the questions or issues of interest to the researcher (Polit & Beck, 2020). The researcher purposely selected the available church congregants who registered under the Malamulele Pastors Forum and church congregants of the identified churches to participate in the study. The church congregants and leaders were interviewed until data saturation was achieved at the 30th participant, which determined the study's sample size. Participants were recruited using the database from 92 churches in Vhembe District.

Potential participants were recruited telephonically upon their acceptance to participate in the study; then, the researcher did door-to-door visits to provide the volunteering participants with relevant and correct information about the study.

3.3.1.1 Sample size

The sample comprised 30 congregants and leaders of the population of interest in the Vhembe District until data saturation was achieved.

3.3.1.2 Sampling of churches

Out of the 92 churches registered under Vhembe District, the researcher selected three (03) churches from which the participants will be selected. Convenience sampling was used to select the three churches out of the 92 churches in the Malamulele node. Polit and Beck (2020) explain that convenience sampling refers to the selection of the population most conveniently accessible to the researcher.

Table 2.1: Study sample size distribution according to the three churches selected for involvement in the study

Churches	**Number of Congregants**
Church 1	8
Church 2	8
Church 3	8
Church leaders	6
Total	**30**

3.3.1.3 Sampling/ Selection criteria

The sampling or selection criteria relate to the norm or standard the researcher determines or considers participants for their prospective involvement in the study (Flick, 2018). Accordingly, participants could be considered either eligible for inclusion or ineligible (excluded) in a study based on their possession or lack of those qualities considered relevant by the researcher (Grove et al., 2020).

3.3.1.4 Inclusion criteria

The criteria for inclusion of church congregants were the following:

- A church congregant who attends a church that is registered under the Malamulele Churches Forum is willing to take part in the study and

- Church congregants who are 18 years of age and above.

3.3.4.2 Exclusion criteria

The criteria for the exclusion of church congregants were:

- Church congregants whose churches are not registered under the Malamulele churches Forum.
- Church congregants not willing to take part in the study.
- Church congregants under the age of 18 years.

3.3.4.3 Inclusion criteria for the church leaders

The inclusion criteria for the church leaders were:

- A church leader within a church registered under the Malamulele Churches Forum willing to take part in the study
- Church leaders who are 18 years of age and above

3.3.4.4 Exclusion criteria for church leaders

The exclusion criteria for the church leaders were:

- Church leaders whose churches are not registered under the Malamulele Churches Forum.
- Church leaders not willing to take part in the study
- Church leaders under the age of 18 years.

3.4 Data Collection

Data collection is the process of obtaining information pertinent to resolving an identified research problem (Polit & Beck, 2020:4). The researcher must have authorisation before collecting data and is required to request authorisation from relevant authorities before collecting data. In this study, the relevant authorities who gave authorisation for the collection of data were the Collins Chabane Local Municipality municipal manager, secretary for the Malamulele Pastors Fraternal, secretary for the Madonsi Philadelphia Church, secretary for the Victory revival church and secretary for the Evangelical Presbyterian Church in South Africa.

The researcher used in-depth semi-structured interviews and an interview guide during the interview process with the participants. This study further used self-reports where study participants will respond to questions from the interviewer. The interviews

were conducted in a language suitable to the participants. The data collection method also determines the research instruments used (Polit & Beck, 2017:191). In self-report methods, research instruments include questionnaires and interviews. Polit and Beck (2017:191) further describe different types of interviews, including focus group interviews and semi-structured and in-depth interviews.

The in-depth semi-structured interviews allowed for the adaptability of the interview while maintaining the inquiry into the attitudes of church leaders towards members who use ART. The researcher began the interview by asking a central question and proceeded to probe by reflecting and summarising skills to encourage the participants to elaborate on their answers. Moreover, the researcher used field notes to capture non-verbal cues and a digital audio recorder to record all the interview sessions.

Interviews with the participants were conducted at the church in which the participants are members and were scheduled to suit the participants' availability. In addition, the participants met at a neutral venue within the community free to discuss their views. Informed consent was obtained from all participants before collecting data.

3.5 Data collection process

The researcher collected data from 30 participants using in-depth interviews. Semi-structured interviews further establish the thoughts and awareness of the individual participants through the utilization and aid of an in-depth semi-structured interview guide. An interview is a verbal conversation in which one person, the interviewer, tries to obtain information from and gain an understanding of another person (the interviewee). "An interview is an effective tool for gathering rich data on people's views, attitudes and the meanings that support their lives and behaviour" (Creswell, 2020:190). The researcher used qualitative in-depth interviews, described as taking field notes on the behaviour and non-verbal communication of the participants (Creswell, 2020:191). A notebook with descriptive notes was used to document participants' behaviour during the interviews. To conduct the interviews, two interview guides were used. The first interview guide was for church leaders and contained seven questions on the support provided to church congregants taking ART and recommendations for improving support to PWLHA. The second interview guide was for church congregants. The second interview guide for congregants had six questions

pertaining to church congregants' understanding of ART and church leaders’ attitudes towards congregants taking ART.

The two interview guides were prepared timeously to manage the interview sessions. The interviews were audio recorded and a note book was used to collect notes to ensure that the researcher does not miss valuable information acquired from the participants. Before the interview session, the participants voluntarily agreed to participate in the study. After that, the participants were provided with a consent form to sign following a full explanation of the study to each participant in a home language preferred and understood by these participants.

3.6 Data Analysis

Data was analysed using Tesch's eight steps in the coding process, as recommended by Creswell (2020:193). Thematic analysis was done. An independent coder was used to analyse the data. Tesch’s eight steps are discussed as follows:

Step 1: Organising and preparing the data analysis

Creswell (2020:193) recommends that all recorded or captured data be transcribed verbatim to enhance the analysis process. The researcher transcribed all the audio-recorded interviews verbatim on Microsoft Office to ensure safe storage and readability.

Step 2: Reading or looking at all the data

The researcher carefully read all the verbatim transcripts in an attempt to attain comprehension of data segments and their meaning. The meaning and understanding to emerge during the reading of the verbatim transcripts were written in the notebook along with the corresponding thoughts thereof. By carefully and repeatedly reading the participants' transcripts over an uninterrupted period, the researcher processed and understood the data in its totality to ensure quality data analysis and record all notes and thoughts in real-time as they come to mind.

Step 3: Coding all the data

Based on the existence or frequency of concepts in the verbatim transcripts, the researcher then scaled down data for coding while listing all topics that emerge in the process, grouping similar topics and separately clustering those that are dissimilar.

The researcher recorded notes and thoughts of the collected data in the margins of the paper where the verbatim transcripts appeared.

Step 4: Generating descriptions and themes

The researcher once again analysed the transcriptions with a concerted focus on the codes that existed from the concepts' frequency (Mental picture codes when reading through). Questions such as "Which words describe it"?" What is this all about?" and "What is the underlying meaning?" will guide the researcher in this step.

Step 5: Representing the description and themes

The researcher abbreviated the topics that emerged as codes, writing the abbreviation next to the appropriate transcription segments. After that, the researcher differentiated the codes by including meaningful instances of specific coded data analysis, writing the codes with a different colour pen than the pen colour in step 3, on the margins of the notebook.

Step 6: Develop the themes and sub-themes

Themes and sub-themes were developed from coded data and the associated texts, and the complete list was reduced by grouping related topics to create meaning for the themes and sub-themes.

Step 7: Comparing the codes, topics and themes for duplication

In this step, the researcher reviewed the work from the beginning, checking for duplication and refining codes, topics, and themes where necessary. The researcher grouped similar codes and recoded others to fit the description where necessary.

Step 8: Recoding the existing data, where necessary

The data associated with each theme was assembled in a single column to complete the preliminary analysis. Liaison between the researcher and an independent coder confirmed the themes and sub-themes of the researcher before the researcher produced the final research report.

3.7 Ethical Considerations

“Ethical guidelines refer to a set of moral principles or rules that give guidance to the researcher in researching to protect research participants” (Foundation for Professional Development, 2020:7). Researchers have a responsibility to ensure that the studies they conduct are ethically sound (Polit & Beck, 2020:100). The rights of the human beings participating in a study should be respected at all times as this remains the underpinning principle of ethics in research. Therefore, the proposed study considered the following:

3.7.1 Permission to conduct the study

To conform to ethical standards, the researcher attained permission to conduct the study from the Ethics Committee (Higher Degrees Committee) of the College of Human Science at UNISA. Thereafter, the researcher wrote formal letters of request to the Chairperson of Malamulele Churches Forum to obtain permission to collect data from their members.

Polit & Beck (2020:101) describe four main ethical principles governing ethical research conduct articulated in the Belmont Report: beneficence, respect for human dignity, justice and confidentiality, anonymity and privacy.

3.7.2 Beneficence

The researcher is obligated by the principle of beneficence to minimise injury and maximise the benefits. “This principle incorporates two rights: the right to freedom from harm and discomfort and the right to be protected from exploitation” (Polit & Beck, 2020:102).

The right to freedom from harm and discomfort - Researchers must minimise harm and maximise benefits (Polit & Beck, 2020:102). It should be the intention of human research to benefit the participants of the study or to create a more common situation for others. Additionally, the researcher must prevent, preclude, or minimise injurious effects in studies involving humans (Polit & Beck 2020:102). Moreover, participants should be protected from unnecessary harmful risks or discomfort, as their involvement ought to conform to essentially achieving salient social goals or gains that could otherwise not be attained. In human-related research, discomfort and harm could be social (e.g. loss of social support), physical (e.g. injury, fatigue), emotional (e.g. stress, fear), or financial (e.g. loss of wages).

The freedom from exploitation – it is a right that obligates the researcher to protect participants from any disadvantage through their participation in the study (Polit & Beck, 2020:102). To ensure participants are not exploited in any way, Polit and Beck (2020:103) recommend that the researcher should assure participants that they will not be disadvantaged by their decision to participate or not to participate in the study. Participants were assured that their involvement or withdrawal from the study would not in any way prejudice their treatment services at the church. Polit and Beck (2020:103) further note that the relationship built between the researcher and the participant should be used to do good to participants rather than cause harm. In this study, the participants will not be disadvantaged or exposed to damage by the researcher. The participants were assured that neither their participation nor their information would be used against them in any form.

3.7.3 Respect for human dignity

Respect for human dignity includes the self-determination right and the full disclosure right (Gray & Grove, 2020:100). The scholars note that the right to full disclosure and the right to self-determination form the foundation for informed consent. Gray and Grove (2020:100) further outline that the entitlement to freedom obliges the researcher to acknowledge that humans are autonomous and, as such, can determine their destiny without being controlled externally. Gray and Grove (2020:100) further state that the right to self-determination is ensured in a study by informing the participants of their entitlement to withdraw from the study at any time during the course, allowing participants to choose whether they want to participate or not in the study and informing them what the study is about. The study, in alignment with the recommendations of Gray and Grove (2020:100), informed participants, sought their consent and allowed the participants to withdraw without penalty.

In providing full disclosure, the study purpose and the participant's right to withdraw were divulged before the study (Polit & Beck, 2020:107). Gray and Grove (2020:100) "also note that the researcher must disclose the researcher's responsibilities during the study as well as the benefits and potential risks of participating in the study."

3.7.4 Justice

The right to fair treatment and the right to privacy are foundational to the principle of justice (Gray & Grove, 2020:101). *The right to fair treatment* obligates the researcher to equitably express the risks and benefits of the study. Polit and Beck (2020:108) posit that the issue of fair treatment is mainly observed in sample selection. The researcher equitably distributed the benefits of the research. As such, participant involvement was primarily informed by the study requirements rather than the vulnerabilities of each selected participant group. To assure participants that their interests were not exploited, obligations must be imposed to protect the principle of justice in this study (Gray & Grove, 2020:101). The researcher is obligated to treat individuals who refrain from participating (or withdraw from the study after initially agreeing) in an unprejudiced manner. The researcher is further bound to honour all agreements undertaken with participants (including remuneration for any stipends promised) while also demonstrating that respect for the participants' beliefs, habits, and lifestyles of people from different backgrounds and cultures is upheld. The researcher should also ensure that participants have access to research staff for their desired clarification and that researchers always afford them courteous and tactful treatment.

Gray and Grove (2020:102) *"define the right to privacy* as the liberty of people to control the time, extent and circumstances under which their personal information can be shared or not shared." The private information includes beliefs, practices, opinions and records. To uphold the right to privacy, Polit and Beck (2020:105) recommend the maintenance of strictest confidentiality in handling personal information, which includes ensuring anonymity. To uphold this right, participants were not asked to disclose their names. All interview recordings were kept confidential in password-secure files, whose passwords are known only to the researcher.

3.7.5 Informed consent

Gray and Grove (2020:103) outline that upholding the participants' rights is ensured with participants' full comprehension of the research and their willing participation. Furthermore, the informed consent includes a statement of the purpose of the research, a description of possible risks and benefits of participating, a description of how confidentiality will be applied, contact details of the researcher and a statement

explaining that the participant may withdraw at any time. Gray and Grove (2020: 103) further add that informed consent should provide information concerning the related research activities, including the researcher’s readiness or willingness to answer any of the participants’ questions during the investigation. Polit and Beck (2020:105) assert that participants’ informed consent should be proved through their signatures on the applicable consent form containing all the information about the participants' rights. Furthermore, the researcher ought to build a good and trustworthy relationship with the participants to ensure respect for participants and their right to self-determination and autonomy during the study. This implies that coercion by the researcher will not be accepted and that the participation or non-participation decision undertaken by the participants will be respected. In this regard, participation in the study will be voluntary.

3.7.6 Non-maleficence

Fitzpatrick and Wallace (2018:178) also describe the issue of non-maleficence to include scientific misconduct and describe scientific misconduct as intended acts of deception that include plagiarism, falsification of data, and irresponsible authorship. Fitzpatrick and Wallace (2018:178) “advise on the need to be aware of institutions' regulations regarding such acts and abide by such codes.” The researcher of this study is aware of the institution's regulations regarding scientific misconduct and has abided by these regulations. In addition, the researcher has read and understood the UNISA code of conduct in plagiarism and ethics.

3.7.7 Right to anonymity and confidentiality

Anonymity and confidentiality while collecting data are essential ethical practices designed to protect subjects' privacy during the study. The primary concern is the protection of the participant's interests and well-being identity. Anonymity can only be deemed true when the researcher cannot identify the respondent participant (Gray & Grove 2020:1109). Instilling confidence and anonymity of the participants was always maintained, and names and surnames were not requested from participants. Rather, a number code will be assigned to participants during their interviews and transcription sessions, which will assist in managing and identifying the different responses from participants, making it easier for the transcribers. The research participant was allocated a code, such as “Participant 1” to “Participant 30” to protect their identity. Additionally, all information about the address and contact details of the participants

was not recorded to protect their anonymity. However, all other data collected by the researcher was protected, and only the researcher and authorised members of the university had access. All raw data (interview transcripts, informed consent forms, field notes, and participants' identities) will be anonymised and subsequently kept safe. Due to their sensitivity, both electronic and hard copies will be kept in a different Dropbox of a password-protected computer, only accessible by the researcher, supervisor, and Human Sciences Research Ethics Committee working on this project. Furthermore, all data will be archived for 5 (five) years after the study's conclusion and permanently erased.

3.8 Ensuring Rigour/ Trustworthiness and Integrity of the Study

Ensuring rigour is also referred to as trustworthiness (Fitzpatrick & Wallace, 2018:1). The term, 'trustworthiness' refers to the believability of the research process and the accruing evidence-based data; that is, the confidence with which qualitative researchers generate their data as measured by the criteria of credibility, transferability, dependability, and confirmability (Polit & Beck 2020:107).

3.8.1 Credibility

Credibility refers to the researchers' interpretation of data and the confidence in the truth thereof (Polit & Beck, 2020:108). The researcher ensured credibility in the study by collecting data for approximately one month. During the data collection period, the researcher conducted persistent observation with the participants to ensure credibility. The researcher also pre-tested data collection tools to ensure they collected the right data that effectively met research objectives to enhance credibility (Flick, 2018: 59).

3.8.2 Transferability

According to Polit and Beck (2020:108), transferability is a reflection of the original findings applied to alternative settings with different participants. In qualitative studies, research output entails transferability as quality, according to which outcomes can be generalised to other contexts (Forero et al., 2018: 3). According to Forero et al. (2018:3), data saturation also enhances transferability by capturing as many angles as possible of the phenomenon of interest; thus, making it possible for the researcher's transference of findings to other environments (Forero et al., 2018:3). The researcher adequately described and detailed the sampling techniques applied in the selection of the study participants. The researcher further ensured transferability by allowing

readers to establish inferences regarding extrapolating the findings to other settings with the provision of detailed and contextualised descriptive information.

3.8.3 Confirmability

Confirmability relates to data's accuracy, relevance, or comparability by two or more independent sources. Confirmability further pertains to the establishment of data representation of information provided by participants and that the interpretations of the data are not fabricated by the inquirer (Polit & Beck 2020:109). If the data collected can confirm that the results and conclusions of a study are true, then confirmability in the research is attained. To guarantee confirmability in this study, the researcher engaged with experienced and professional research practitioners to check whether proper methodological processes were applied in the study and the extent to which the researcher coherently reached the findings and conclusions at the end of the study. This study examined notes from the in-depth interview, and voice recordings were listened to ensure that the data accurately reflects the participants' perspectives.

3.8.4 Dependability

Dependability refers to the consistency of findings relative to the context in which they were generated (Polit & Beck, 2020:109). Furthermore, according to Grove et al. (2020:392), dependability concerns the "*documentation of steps taken and decisions made during analysis". To ensure reliability, the researcher described all the processes and procedures applied in the research methodology.

3.9 Conclusion

The chapter outlined the methodology. Chapter 3 outlined the qualitative research approach used to conduct the study. The chapter further described the exploratory, descriptive study design that was used. In addition, the chapter described the rural township community of the Collins Chabane Municipality, where the study was conducted. Moreover, the chapter described how three churches were conveniently selected, and the 30 participants were purposively selected. Chapter three further described the in-depth interviews that were used to collect with the aid of a semi-structured interview guide. The data analysis method that utilised Tesch's eight steps is described in Chapter 3, and the ethical principles of beneficence, justice, respect for human dignity and the right to anonymity and confidentiality are outlined. Chapter 3

concludes with a discussion on measures to ensure trustworthiness. The study presents the findings in the next chapter.

CHAPTER 4

FINDINGS OF THE STUDY

4.1 Introduction

The previous chapter outlined the study's design and methodology. This current chapter presents the findings from the collected data, which is thematically analysed and interpreted for the study. The study aimed to explore the attitudes of church leaders towards congregants taking ART in Vhembe District of Limpopo, South Africa. The results of the interviews from the congregants in the three (3) different churches under Malamulele Pastors Forum in Collins Chabane Local Municipality were presented in the following sequence: The demographic information of the 30 participants is presented in tabular form inclusive of age, gender, place of residence (rural or urban area), their home language, marital status, level of education, employment status, and their source of income source.

4.2 Demographic Characteristics of the participants

Table 4.1 shows the age of the participants, which ranges from 32-78 years and most age groups are inclusive in the study findings with each percentage calculated.

Table 4.1: Participants' ages

AGE	FREQUENCY	PERCENTAGE
32 years	02	6.7%
33 years	01	3,3%
34 years	01	3.3%
37 years	01	3.3%
38 years	01	3.3%
39 years	02	6.7%
42 years	01	3.3%
43 years	02	6.7%
49 years	01	3.3%
50 years	02	6.7%
54 years	01	3.3%

56 years	02	6.7%
57 years	02	6.7%
58 years	01	3.3%
60 years	01	3.3%
63 years	02	6.7%
67 years	02	6.7%
70 years	02	6.7%
71 years	01	3.3%
75 years	01	3.3%
78 years	01	3.3%
Total	**30**	**100%**

Table 4.2 shows 100% (30) participants, of which 16 (53%) were females and 14 (47%) were males. The researcher did not influence the gender selection of the participants because they were presented by the authority of the particular church where data was collected.

Table 4.2: Participants' gender

Gender	Frequency	Percentage
Female	16	53%
Male	14	47%
Total	**30**	**100%**

Table 4.3 below shows that there were 12 participants (40%) from the rural areas and the rest being 18 participants (60%) were from around the township, which is urban-rural. The urban-rural townships are poorly developed and have few public facilities to cater to the surrounding villages.

Table 4.3: Participants' places of residence

Place of residence	Frequency	Percentage
Malamulele location	18	60%
Madonsi village	07	23%
Xitlhelani village	05	17%
Total	**30**	**100%**

Table 4.4 below illustrates that 20 (66%) participants are Xitsonga speaking, 05 (17%) spoke English, 03 (10%) and 02 (7%) were speaking the Sepedi language, and the researcher was able to allow them to use the language which they were comfortable with.

Table 4.4: Participants' home languages

Home language	Frequency	Percentage
Xitsonga	20	66%
Tshivenda	03	10%
English	05	17%
Sepedi	02	7%
Total	**30**	**100%**

Table 4.5 illustrates that 9 participants (30%) are single, 16 (53%) are married, two participants (7%) are divorced, and three participants (10%) are widowed. These demographic factors will assist the researcher in identifying the participants' concerns regarding their opinions while responding to the questions asked. However, that does not have any significance as to how they give answers to questions.

Table 4.5: Participants' marital status

Marital status	Frequency	Percentage

Single	09	30%
Married	16	53%
Divorced	02	7%
Widowed	03	10%
Total	**30**	**100%**

Table 4.6 demonstrated the level of education of the participants where one (3%) participant went up to grade 9, two (7%) grade 10, another one participant (3%) went up to grade 11, while 7 (23%) had grade 12 and lastly 19 (63%) had tertiary education. The researcher obtained these educational levels of the participants in their profiles to direct the questions relevant to their understanding and according to the level of HIV and AIDS education they have.

Table 4.6: Participants' level of education

Educational level	Frequency	Percentage
Grade 9	01	3.3%
Grade 10	02	6.7%
Grade 11	01	3.3%
Grade 12	07	23.3%
Tertiary level	19	63.3%
Total	**30**	**100%**

Table 4.7 illustrates the employment status of the participants. Maybe the participants need assistance when it comes to food and other basic needs for the sake of their health. According to the reflection of data in the table below, there are 11 (37%) participants employed, 10 (33%) unemployed, and 09 (30%) pensioners.

Table 4.7: Employment status

Employment status	Frequency	Percentage

Employed	11	37%
Unemployed	10	33%
Pensioners	09	30%
Total	**30**	**100%**

4.3 Results of the interviews

Data from the interviews was analysed using thematic analysis and supported with the exact responses of different participants and pseudonyms like Participant 1. The data analysis process generated themes with sub-themes that were aligned according to the study's objective and supported by the participants' actual responses. Data was collected from both the church congregants and the church leaders.

From the findings, four themes emerged. The first theme was positive attitudes. The theme of positive attitudes had one subtheme of encouragement. The second was negative attitudes towards congregants taking ART. The negative subthemes were judgemental attitudes, lack of acceptance and faith-based treatment versus adherence to ART. The third theme was stigma and discrimination. The theme of stigma and discrimination was supported by two subthemes: exclusion of congregants taking ART and labelling. The last theme was measures to address the attitudes of church congregants taking ART. The fourth theme was supported by two subthemes: information sharing and involvement of the Department of Health. These themes are illustrated in the table below.

Table 4.8: Main themes, themes and sub-themes

<table>
<tr><th>Main Themes</th><th>Themes</th><th>Subthemes</th></tr>
<tr><td rowspan="6">Attitudes of church leaders toward congregants taking ART</td><td>Positive attitude towards church congregants taking ART</td><td>Encouragement</td></tr>
<tr><td rowspan="3">Negative attitudes towards church congregants taking ART</td><td>Judgemental attitude</td></tr>
<tr><td>Lack of acceptance</td></tr>
<tr><td>Faith-based treatment versus adherence to ART</td></tr>
<tr><td rowspan="2">Stigma and discrimination</td><td>Exclusion of church congregants taking ART</td></tr>
<tr><td>Labelling</td></tr>
</table>

	Measures to address church leaders' attitudes towards congregants taking ART	Information sharing and training
		Involvement of the Department of health

These themes were described with narratives from the interview transcripts to answer the research questions and objectives of the study as intended.

4.4 Main theme: Attitudes of church leaders towards congregants taking antiretroviral therapy.

The congregants and the church leaders expressed positive and negative attitudes towards church congregants taking ART. The positive attitudes of church leaders towards congregants taking ART included an attitude of encouragement. On the other hand, the negative attitudes of congregants taking ART included judgemental attitudes, lack of acceptance, and faith-based treatment versus adherence to ART.

4.5 Theme 1: Positive attitude of encouragement

Some participants expressed that church leaders positively encouraged church congregants who took ART. Participant 2 shared their experience that the church leaders had a positive attitude toward people taking ART and would encourage them to continue taking ART. In addition, Participant 4 also noted that a church policy had been put in place which encouraged church congregants to take ART. Participant 26 described that some participants had a positive attitude towards church congregants taking ART, which would encourage church congregants to continue taking ART. Participant 13 also stated that her pastor is supportive and was her treatment buddy when she started taking ART. The following quotes support this.

> *"I think that one will depend on a particular denomination because these church leaders differ; there are church leaders who encourage people with HIV to take ART"* **Participant 2, church congregant.**

> *"The church leaders must support all people who collect treatment every month for the sake of their health. We have a church policy that includes a health desk in this structure. This structure comprises healthcare professionals such as doctors, nurses, social workers, and many more, making it easier for congregants to receive the necessary care they deserve as human beings entitled to being treated with dignity. Another thing this policy states is that these*

people must be treated in a manner that they are not criticized or embarrassed in front of other congregants. Actually, it promotes confidentiality in church." **Participant 4, church congregant**

"This type of leader they are motivational and preach life to their congregants, encouraging them to take good care of their health conditions to live longer even with any chronic condition. The church leaders in this second type show the public that they are called by God, and they try to talk sensitively when addressing issues of HIV and AIDS, the reason being not to offend other congregants who came to church for comfort only to find the opposite. They are welcoming and always ready to assist the needy." **Participant 26, church congregant**

The church leaders themselves described their understanding of church congregants taking ART by describing the measures they took to encourage the PLWH to continue taking ART. The following quotes from the church leaders supported this.

"*Another thing is we don't allow any stigmatization of some sort because if that happens, they might even stop coming to church, and that is not good at all because our main purpose is to make sure we help them save their souls. By so doing, we try by all means to give them the necessary support, we stand with them and also encourage them that they continue to take their treatment as instructed."* **Participant 6, church leader**

"I am a servant of God who was called to change people's lives. On the other hand, the PLWHA must take good care of their health as well as helping us to support them throughout the journey of life". ***Participant 25, church leader***

From the responses of the participants, both the church leaders and the church congregants, it was concluded that there were church leaders who had a positive attitude towards the congregants and they encouraged the church congregants to continue taking their ART. These findings of a positive attitude of encouragement are similar to the study conducted by Alio et al. (2019) in South Africa who found that religious leaders encourage ART adherence among PLWHA. Similarly, Norder et al. (2015) concluded that religious leaders are critical in ensuring PLWHA are supported in ART adherence.

4.6 Theme 2: Negative attitudes towards congregants taking ART

The second theme that emerged was negative attitudes towards congregants taking ART. This issue of negative attitudes included subthemes of judgemental attitudes and lack of acceptance of PLWH. The issue of negative attitudes was broadly described by the church congregants and supported by the church leaders, who acknowledged that among themselves. Some leaders had a negative attitude towards congregants taking ART. Participants 19 and 22 shared that the negative attitudes posed a severe risk to the lives of PLWHA because they were being labelled, forgetting that HIV can infect anyone. The responses below support an excerpt of a church congregant and a church leader highlighting the negative attitudes.

> *"The church leaders with negative attitudes segregate the PLWHA from other people, they show avoidance behaviour towards them and don't want even to shake hands with them for the reason that they will infect them. This is very bad because they make them feel isolated, feel unwanted in church and this negative attitude of our church leaders can contribute to them not taking treatment and affect their adherence to ART."* ***Participant 19, church congregant***

> *"I am a servant of God who was called to change people's lives. On the other hand, the PLWHA must take good care of their health as well as help us to support them throughout their journey of life. Another thing is to keep on reminding them that their life is in their own hands, therefore they must be careful when taking orders from the people around them including church leaders who have chosen to deviate from what they are told in meetings."* ***Participant 25, church leader***

From these quotes, it was concluded that church leaders had negative attitudes towards church congregants. These negative attitudes were described by the church congregants, including judgemental attitudes and a lack of acceptance of congregants taking ART. Several studies also confirm the issue of a negative attitude toward congregants taking ART (Norder et al., 2015; Palio et al., 2019; Reyes-Estrada et al., 2018). The Reyes-Estrada et al. (2018) study notes that such negative attitudes include stigma, discrimination, and judgemental attitudes.

4.6.1 Subtheme 2.1: Judgemental attitudes

The first subtheme aligned with the theme of negative attitudes of church leaders was the negative and judgemental attitudes directed towards church congregants who took ART. These judgemental attitudes were based on how PLWHA contracted HIV. Participants 4, 7 and 28 shared that church leaders had a negative attitude, which is why they are judgemental towards PLWHA, saying they were unfaithful to their partners. Participant 12 talked about knowing the modes of transmission of HIV to expose and stop church leaders who even give Bible quotes to support that sin is paid by punishment. The quotes from the church leaders below support the subtheme.

> *"Some church leaders are judgmental because one of the common ways of transmission is through sexual intercourse, therefore leaders will assume or conclude that you are having multiple partners, or that you were not faithful to your partner that is why you are infected with HIV"* ***Participant 4, church congregant***
>
> *"Church leaders don't take PLWH as people like them because their being leaders gives them the power to judge people and look down on them. They don't take other people like themselves in the actual sense. Participant 11 church congregant*
>
> *Most church leaders are judgmental towards the congregants taking ART because they say they committed adultery to end up with HIV."* ***Participant 26, church congregant***
>
> *"…main reason of negative attitudes towards other congregants than the others. They feel it is right to judge people because they are church leaders and don't even care about what that will cause to other people."* ***Participant 29, church congregant***

The quotes above show the church leaders' negative judgemental attitudes towards PLWH taking ART. These judgemental attitudes sometimes emanate from the perception that HIV transmission is associated with multiple partners. The findings of judgemental attitudes towards congregants taking ART are also confirmed in the study conducted by Reyes-Estrada et al. (2018) in the study conducted in Puerto Rico.

4.6.2 Subtheme 2.2: Lack of acceptance

The church leaders also showed an attitude of lack of acceptance towards congregants who were taking ART. From Participant 2 shared experiences, church leaders did not want any association with congregants taking ART. Similarly, Participant 22 shared that church leaders did not accept congregants taking ART. The participants also shared that this lack of acceptance resulted in the church congregants taking ART to leave the church. The excerpts supporting the subtheme are shown below:

> "*On the other hand, some church leaders don't want anything to do with PLWHA in their churches because they see them as cursed and dirty, so they think they will pass their predicament to their congregants if they keep them there. They only accept those who don't know their HIV status, not knowing that they also might be infected with the virus but did not tell them to try to protect their image at church.* ***Participant 2 church congregant***

> *"They show them negativity and are not willing to embrace or accept them unconditionally"* ***Participant 22, church congregant***

> *"Firstly, those with a negative attitude are not good to the congregants because they will scare them off the church due to their uncaring behaviour towards others. Another thing is they will cause harm than good to the PLWHA as they go to church expecting to be supported and not been rejected just because of their HIV status."* ***Participant 26, church congregant***

The church leaders also substantiated the issue pf lack of acceptance described by the church congregants by highlighting that there were church leaders who did not accept congregants taking ART. In the description of a lack of acceptance, Participant 25 explained that there were church leaders who did not like to handle difficult situations because they viewed HIV as a threat and, therefore, could not accept congregants taking ART. The excerpt from Participant 25, a church leader, is shown below:

> *"Like any other human being there are church leaders who don't like to interact with difficult situations, in my view they still see HIV and AIDS as a threat and want to see themselves far from such situations. HIV does not have a target audience because I might be negative today but become positive the next time*

I test again. So as church leaders, we need to be kind to everyone despite their HIV status because we might need them tomorrow.” ***Participant 25, church leader***

In summation, participants described the negative attitudes of church leaders who did not accept the congregants who were taking ART. This lack of acceptance resulted in church congregants taking ART to leave the church. However, these findings contrast with a study conducted in Soweto, South Africa, which found that most religious leaders accept PLWHA (Alia et al., 2018).

4.63. Subtheme 2.3 Faith-based treatment versus adherence to ART

Another negative attitude the church leaders took was faith-based healing versus ART, which emanated as a third subtheme. From the participants' descriptions, some church leaders believed fasting and prayer could provide PWLHA good health instead of ART. From the participants' description, this attitude contributed to PLWHA to stop taking ART. Participant 1, who was a church congregant, stated that there are church leaders who tell congregants that there is no HIV, but it is witch craft. Participant 2 also stated that church congregants taking ART would be told to drink holy water and holy tea and stop taking ART. The following narrative statements support this:

“There is wrong advice, such as to stop taking ART and rely on healing materials they receive from their respective churches like tea, holy water, and other things that are prayed for before given to them”, ***Participant 1, church congregant.***

“People who are taking ART are told to stop taking the treatment because they will pray for them, and they will be healed. Others tell them not to take any meals during fasting and prayer because it will make their prayers to be weak and they believe God answers only prayers when you have not eaten anything. This becomes a problem because most medications need to be taken after meals, so if they are stopped, they will eventually skip the treatment during that period of fasting and prayer which in turn is not good for ART as it must be taken daily and continuously for the rest of their lives.” ***Participant 2, church congregant***

“Some church leaders even discourage them from taking antiretroviral treatment because they want them to have faith in God to heal them after they

confess their sins, pray for, and believe they are delivered. This is the worst practice I don't like because servants of God must have information that will lead people to life rather than leading them to dig their graves. Our fear of such leaders who lack information is that they don't know how to advise congregants because the only way is to preach the gospel that will bring life and teach them about the Lord and saviour who will give them eternal life after death. Church leaders in the actual sense are the first to encourage PLWHA" ***Participant 7, church congregant***

The perceptions on the attitude of faith-based healing versus taking ART described by the participants were also described by church leaders who noted that they were aware that colleagues were aware of some church leaders who discouraged PLWHA from taking ART and instead implored them to have faith so that they can have good health or healing. The following quotes from the church leaders support this.

"Like HIV and AIDS is a sensitive topic to just go in front of people and tell them about healing when they know that it is incurable. Therefore, let all church leaders be willing to work with the department of health who know how to deal with such issues, by I mean that they need health talks before they go to their congregants with false information" ***Participant 24, church leader***

"That one is still a problem because as church leaders we are having regular Pastor's Forum meetings where we are taught about these chronic conditions and the danger of stopping people from taking treatment after being prayed for. This item is always on our agenda because we saw people die after they were told to stop taking treatment and believe that they are healed through prayer. It is so sad to realize that there are still church leaders who continue doing it because this organisation was initiated to do things in the same way… The substitution of ARV therapy with religious practices has caused the deaths of some PLWHA who discontinued their consumption of ARVs in pursuit of religious interests, including prayer camps and sessions of fasting for deliverance. Some religious leaders have been reported to be discouraging church congregants from consuming ARVs, rather encouraging members with HIV to use alternative religion-based remedies such as water." ***Participant 27, church leader***

From these quotes of the church congregants and the church leaders, it was concluded that there was an attitude where there was misinformation of faith healing versus the taking of ART, which disrupted adherence to ART of PLWH. Such faith-based treatment seems to be the main contributor to PLWHA's stopping of ART. The findings that some religious leaders encourage faith- based healing of HIV instead of ART confirm the findings of the study conducted by Kruger et al. (2018) in South Africa. Similarly, Dzansi et al. (2020) also concluded that there was a belief that faith-based healing could substitute ART, resulting in PLWHA not adhering to ART.

4.7 Theme 3: Stigma and discrimination

The participants described attitudes of stigma and discrimination shown by church leaders towards congregants taking ART. The stigma and discrimination were supported by two subthemes, which were exclusion and labelling of church congregants taking ART. The quotes from Participants 1, 19, 22 and 29 below broadly describe the stigma and discrimination of congregants taking ART:

> *"Challenges that PLWH face in the church, number one is discrimination in such a way that church leaders don't want to see themselves in any way interacting with them. They don't want to involve such congregants in church activities for fear that they will infect them or other congregants with HIV."* ***Participant 1, church congregant***

> "*Lack of confidence, low self-esteem and loss of social class because they might even neglect themselves physically as they will be affected psychologically because of the rejection from church congregants and their leaders"* ***Participant 19, church congregant***

> *"PLWHA are discriminated by church leaders and other congregants forgetting that they did not choose to be infected with HIV, some are born with the virus and others it is a result of rape"* ***Participant 22, church congregant***

> *They are discriminated against, stigmatised and separated from the rest of the congregants by their HIV status. They face a lot of challenges we can think of and are isolated from the other congregants using the name of their health condition to distinguish them. They suffer a lot under the conditions created by fellow Christians who were supposed to show them love like it is written in the bible.* ***Participant 29, church congregant***

From the quotes above it was concluded that church congregants taking ART experienced stigma and discrimination in the church community from the church leadership. The issue of stigma and discrimination in churches is confirmed by findings made by (Alio et al.,2019; Reyes-Estrada et al.,2018).

4.7.1 Subtheme 3.1. Exclusion of congregants taking ART.

The exclusion of congregants taking ART was experienced as coming from both church leaders and other congregants. Participants 7 and 13 explained that the discrimination was through exclusion from events in church. Participant 13 further explained that exclusion was also in ordinary Sunday church services. Participant 28, like Participants 7 and 13, described the exclusion from church events and further noted that they are excluded from leadership positions. The quotes below support the subtheme of exclusion:

> "…*being separated and sometimes not allowed to participate in any activity at church as if the virus is all over their bodies and belongings. They are not allowed to touch the instruments or microphones because the other congregants will not be able to use them again as if they are contaminated with the virus which is in the blood of these people". **Participant 7, church congregant***

> *"The challenges they face are those of being discriminated against throughout, whether there are events at church, or it is a normal Sunday service they are segregated from those whose status is unknown because there are congregants who never told anyone about their status of which the church leaders think they are okay and allocate them to participate in different sections in the church." **Participant 13, church congregant***

> *"The challenges they face are to be neglected or ignored by church leaders and other congregants who are still fortunate not to be having the virus, and they will be traumatised and be stressed most of the time which is not good for their health. They also face challenges when they will not be considered for any positions at church because of their HIV status. They also are not allowed to participate during conferences or when there are visitors in the church because they are not given time to do so. Sometimes they will miss job opportunities because their leaders will never recommend them due to their sickness. Others*

will not be allowed to find love and marriage in their respective churches because they know their HIV status, or if they meet someone from another church their church leaders might refuse to conduct their weddings." ***Participants 28, church congregant***

The stigma and discrimination were done by the fellow congregants towards fellow church congregants who were living with HIV. This is supported by the excerpt below.

"Mostly they find themselves without friends, they live a lonely life in the church where we find that if they use a chair the other congregants will never want to use it again. They don't have peace because if they try to get close to other people, they don't hide the fact that they see them as different and unworthy." ***Participant 14, church congregant***

From the quotes of the church congregants, it was concluded that church congregants taking ART were discriminated against through exclusion as candidates from the senior positions in the church sectors as well as discriminated when participating in events. Furthermore, discrimination was shown through the refusal to share equipment like microphones or chairs that PLWH had used. The exclusion of PLWHA in church activities was also confirmed in a study conducted by Alio et al. (2019), who found that exclusion was at the end of the continuum regarding stigma and discrimination in the church.

4.7.2 Subtheme 3.2: Labelling

The stigma and discrimination described by the participants also took the form of labelling of church congregants living with HIV. From the participants' descriptions, PLWHA were labelled according to their HIV status. Participants 19 and 22 shared that labelling was a severe risk to the lives of PLWHA. Participant 26 also described the issue of labelling and described how church leaders call PLWHA names during sermons. The quotes to support the subtheme are shown below:

"Church leaders must stop being judgmental because it will lead to congregants stopping to take their treatment with the fear of being labelled to be of little faith as they are told to believe in healing through prayer." ***Participant 2 church congregant***

"There is no need to label people by their illnesses, but to do regular visits at their homes and include those who are taking ART to the rest of the congregants." ***Participant 5, church congregant***

"Mostly church leaders don't understand the meaning of PLWHA, because they like to judge them immediately, they know their HIV status. By this, I mean that they label them as being unfaithful or have multiple sexual partners which suit them well to have been infected with this virus" ***Participant 7, church congregant***

"Another challenge they face is fear to disclose because that will let them be labelled, judged and called all sorts of names about their health status" ***Participant 11, church congregant***

"Another challenge is that one of embarrassment in front of other congregants through name calling or labelling them as the reckless that's why they have HIV infection." ***Participant 13, church congregant***

"Other church leaders even call them names while they are preaching they suffer emotional trauma inside the house of the Lord" ***Participant 26, church congregant***

The church leaders also acknowledged the labelling of PLWHA in the church community. From the descriptions, this labelling was also done by the church congregants and the church leadership would try and stop the labelling. The quote from Participant 6, a church leader, is shown below:

"As church leaders, we must make sure that these people are not labelled or distinguished by their HIV status, but be addressed by their names or titles because there are those PLWHA whom we don't know due to their fear to disclose their status. So, if we treat them equally, we will be giving them a chance to trust us in such a way that they will be able to talk to us about anything." ***Participant 6, church leader***

Many participants have to disclose their status because they have been labelled, judged, called all sorts of names about their health status and rejected. Similar findings are also confirmed in the study conducted by Kruger et al. (2018), who found that stigma and discrimination against PLWHA are characterised by condemnation of PLWHA as immoral.

4.8 Theme 4: Measures to address attitudes of church leaders towards congregants taking ART.

The participants also described various measures that could be implemented to address the attitudes of the church leaders towards congregants taking ART. Education and training were described as essential in empowering church leaders to understand the issues of HIV and AIDS and the use of ART. The Department of Health must play an active role in collaboration with the church leaders to address the challenges of HIV and AIDS and ART adherence. From this theme, two subthemes supported the theme: the first was information sharing and training and the second was the involvement of the Department of Health.

4.8.1 Subtheme 4.1: Information sharing

The participants described information sharing and training as critical to addressing the church leaders' attitudes towards congregants taking ART. Participant 1 described how church leaders ought to receive education on health matters, while Participants 10 and 23 indicated that information should be specifically for HIV and AIDS. The church leaders also supported the provision of information, as discussed by Participants 6 and 25, who were church leaders. This is supported by the quotes below:

> *"Education plays an important role, that's why I will recommend that church leaders need to have regular updates on health matters. Further training and materials such as posters to help church leaders have teaching aids while addressing their congregants on health issues."* ***Participant 1, church congregant***

> *"Church leaders must be given information to teach congregants about the importance of taking pills and to take full responsibility for their health because, at the end of the day, it will benefit them and their families, those who depend on them, the church and the community at large."* ***Participant 10, church congregant***

> *"I can recommend that the church leaders are given information about HIV and AIDS in general, secondly the mode of transmission and how to prevent it, and the importance of taking ART to help control the virus in their blood. This*

information might be of great help to our people who end up having complications because they followed the advice of their church leaders and stopped taking ART which is the only solution to their problems right now. If church leaders repeatedly get the information and also be updated when new info comes into being, the congregants will be safe in different churches." ***Participant 23, church congregant***

The church leaders also supported the issue of information sharing and training of church leadership on HIV and AIDS as a means of addressing church leaders' attitudes towards congregants taking ART. This is shown by the quotes below:

"I think we need to have regular meetings as church leaders to impart knowledge about HIV, share experiences and agree to do things that are uniform for the sake of our congregants who trust us with their lives as their spiritual leaders. It takes courage for a person to disclose their HIV status to us as church leaders so we need to acknowledge their confidence and help them accordingly." ***Participant 6, church leader***

If possible, all church leaders need to be thoroughly trained about HIV and AIDS issues including the reason for taking ART without stopping or interrupted because they will end up defaulting whilst trying to comply with church activities and put their life in danger" ***Participant 25, church leader***

The church congregants recommended education, training and health talks about HIV and AIDS be given to church leaders about ART. The other participants illustrated that awareness campaigns and training could strengthen acceptance of HIV and AIDS management. The recommendation for information sharing is also described in the study conducted by the Elizabeth Glasier Paediatric AIDS Foundation (2020).

4.8.2 Subtheme 4.2: Involvement of the Department of Health

The participants also noted that the involvement of the Department of Health was critical in addressing the attitudes of church leaders towards congregants taking ART. Participants 13, 18 and 26 shared that they would like the Department of Health to be involved in training church leaders on HIV and AIDS. Similarly, Participant 6, a church leader, expressed that the Department of Health must be involved in training the church leaders. The quotes to support the theme are shown below:

“This is what we need here from health professionals when they come to teach us, that sometimes the virus becomes resistant to certain medications and it will not be controlled again.” ***Participant 13, church congregant***

“The suggestion that I might give or propose is that the Department of Health itself, understanding that church leaders are the ones that are interacting with the congregants that are taking antiretroviral therapy in their churches, should take a lead to ensure that there is training for the church leaders on regular basis.” ***Participant 18, church congregant***

“I think the information on HIV and AIDS to the church leaders can do the trick. Regular HIV and AIDS awareness campaigns by the Department of Health might also be helpful. Strengthening HIV counselling and testing at churches by health professionals and regular giving of health talks once in a while as to how to take care of PLWHA can be of good help, and breaking down the mode of transmission of HIV so that people will understand that it does not fly in the air to pass to another person.” ***Participant 26, church congregant***

Church leaders explained that it was important for the Department of Health to provide information and engage the church leaders in addressing the attitudes of church leaders. This was supported by the quote below:

Another thing we need to have awareness campaigns at our churches where we invite health professionals to come and assist with the relevant and current information on issues of HIV and AIDS, including the rest of chronic conditions such as sugar diabetes and high blood which need to take treatment for life to be controlled. ***Participant 6, church leader***

From these quotations above, it was concluded that church leaders should have support from the Department of Health on HIV and AIDS training as a means to address attitudes towards congregants taking ART. Corzine (2019) also makes a similar recommendation to include political leadership in addressing the attitudes of church leaders toward PLWHA.

4.9 Discussion

The study aimed to explore the attitudes of church leaders toward congregants taking ART in the Vhembe District of Limpopo Province. From the participants' responses, it was concluded that some church leaders’ attitudes towards church congregants taking

ART were positive. This positive attitude was illustrated by the support provided to the church leaders. On the other hand, some church leaders showed a negative attitude towards church congregants who were taking ART. These negative attitudes included a judgemental attitude, lack of acceptance of PLWH and faith-based healing versus taking ART. The study also found that there was stigma and discrimination towards church congregants taking ART and it was in the form of labelling and exclusion. The last main theme was measures to address the attitudes of church leaders towards congregants taking ART. These measures discussed by the participants included information sharing and training as well as involvement of the Department of Health.

4.9.1 Positive and negative attitudes towards congregants taking ART

The church leaders' varying attitudes towards congregants taking ART is not unique to this study’s context. In another study conducted in South Africa, it was concluded that HIV-related attitudes of church leaders vary from extreme judgementalism and exclusionary to accepting and inclusive of congregants (Palio et al., 2019). A study conducted in Malawi used several different community-based leaders, such as traditional leaders, religious leaders and family initiation counsellors and found that the most diverse perceptions ranging from negative to positive regarding ART and HIV prevention strategies for adolescents were among religious leaders (Chimatiro et al., 2020). This variation in perceptions of religious leaders is concerning as it implies variations in the support or lack of support provided to PLWHA from one of the societal key pillars and may require training for religious leaders to provide uniform support.

4.9.1.1 Positive attitude towards congregants taking ART

From the study findings, the participants noted that church leaders had a positive attitude of encouragement towards congregants who were taking ART and encouraged them to take their ARVs. The church congregants such as Participant 4 stated that the church leaders supported PLWH taking ART and this support was in the form of encouragement and the church had formed a health desk of medical professions that encouraged PLWHA to take ART. This ideal situation of church leadership encouraging PLWHA to take ART is also described in the South African context by Norder et al. (2015), who note that religious leaders have the opportunities to provide a safe, accessible environment for PLWHA, to collaborate and provide comprehensive HIV care that intersects the health and religious beliefs. In addition, Alio et al. (2018), in a study with religious leaders in Soweto, South Africa, also noted

the positive attitudes of church leaders towards PLWHA by revealing that church leaders often played a mediating role between PLWHA and family members or community members where there is stigma and discrimination of PLWHA. The encouragement offered to PLWHA taking ART is also reiterated in another South African study by Kruger et al. (2018:10), who observed that religious leaders can significantly contribute to reaching and empowering communities in the avoidance of risk, exposure to HIV, offering physical and spiritual treatment to the infected and affected members, combating HIV and AIDS stigmatisation and discrimination, testing for HIV and encouraging those on treatment to continue administering their ART.

Although, Norder at el. (2015), Alio et al. (2019); Kruger et al. (2018:10) describe the ideal church leadership which encourages PLWHA to take ART by providing a safe environment and who play a mediating role in PLWHAs' lives, there is a paucity of literature that illustrates such encouragement and positive attitudes towards church congregants who take ART. In light of this, there is a need for additional studies that describe these positive attitudes of church leaders who encourage PLWHA on ART. Some studies have in contrast, illustrated a negative attitude by church leaders toward congregants on ART, such as a study conducted in Zimbabwe by Mutambara et al. (2021).

4.9.1.2 Negative attitudes of church leaders towards congregants taking ART

Concerning the negative attitudes of church leaders toward church congregants taking ART, many participants believed that church leaders' attitudes are negative and misleading towards PLWHA. The issue of predominantly negative attitudes towards PLWHA is not unique to the rural areas in Vhembe district in South Africa described in this study. Such negative attitudes towards PWLHA on ART were similarly described in a national population-based survey in Tajikistan, which found that rural residency was associated with negative attitudes of stigma and discrimination towards PLWHA (Zainiddinov., 2019). In this study, 40% of the participants were from rural areas and 60% were from rural townships. These negative attitudes discussed in the study included stigma and discrimination, judgemental attitudes and a lack of acceptance towards church congregants taking ART.

4.9.2 Judgemental attitudes

The study also found that church leaders showed a negative judgemental attitude towards church congregants who were taking ART. From the participants' shared experiences, it was concluded that church leaders judged church congregants based on their perceptions of how HIV was acquired among congregants. Participant 26 explained that church leaders perceived that church congregants acquired HIV from adultery as a result, judged them based on such perceptions. As a result, church leaders, from the congregants' perspective, were judgmental and showed condemnation to PLWHA as if they had been unfaithful to their partners or committed adultery. Hence, they have contracted the disease. This type of judgment led to congregants taking ART to feel unwanted, embarrassed and have low self-esteem due to being treated as unworthy by church leaders.

This issue of church congregants living with HIV being judged is also similar to findings by Reyes-Estrada et al. (2018) in their Puerto Rican study, who found that church leaders' attitudes were judgemental and this judgemental attitude could be extreme and was also founded on the moral judgement of previous sin committed by church congregants living with HIV.

4.9.3 Lack of acceptance towards PLWH taking ART

Another negative attitude towards PLWHA was the church leaders' lack of acceptance of PLWHA on ART. The participants noted that church leaders did not accept church congregants on ART. Such a lack of acceptance was demonstrated by Participant 22, who noted that church leaders exclude PLWHA and they would not accept them unconditionally. This finding on the lack of acceptance by church leaders contrasts with findings in the study conducted by Alia et al. (2018) in Soweto, South Africa, who found that all religious leaders reported that they accepted church congregants on ART. The above researchers note that several reasons can explain this difference. Firstly, participants in the study conducted by Alia et al. (2018) were all religious leaders, while this study participants who described the issue of a lack of acceptance were church congregants, albeit some church leaders like Participant 25 noting that there were church leaders *"deviated from the teachings"* and had a negative attitude towards congregants taking ART. Secondly, such a contrast in these two studies conducted in South Africa can be explained by the conclusion made by Chimatiro et

al. (2020) in Malawi, who noted that religious leaders held the most contrasting perceptions towards HIV and AIDS. Thirdly, this contrast in the findings can also be attributed to different contexts. This study was conducted in a rural setting, whereas the study by Alia et al. (2018) was in an urban setting, which also validates the conclusion by Zainiddinov (2019), who found that rurality was associated with negative attitudes towards PLWH. In light of these contrasting findings and possible explanations derived from other contexts, there is a need for further study to ascertain the acceptance of PLWHA among religious leaders.

4.9.4 Faith-based treatment versus adherence to ART

The study also highlighted the issue of faith-based treatment versus adherence to ART among church leaders. Participants indicated how church leaders encourage congregants taking antiretroviral therapy to take faith-based treatments so that they can be healed from their illnesses, including HIV. For example, Participant 1 talked about how some church leaders encourage PLWHA to stop taking ART because they must have faith that God can heal them through taking *"healing materials they receive from their respective churches like tea, holy water"*. In addition, participants shared their experiences that church leaders would say there is no HIV but witch craft which led to non-adherence to ART and consequential negative impact on viral load suppression.

According to Dzansi et al. (2020:13), the substitution of ART with religious practices has resulted in the deaths of some PLWHA, owing to their religious beliefs of discontinuing ART due to beliefs including attendance of prayer camps and sessions of fasting for deliverance. Various religious leaders have been reported to have discouraged members of their congregation from taking ART, encouraging them to use other religion-based remedies (Kruger et al., 2018:10). These acts resulted in poor health outcomes among some PLWHA (Dzansi et al., 2020:13).

4.9.5 Stigma and discrimination

One of the main themes described by the participants was the stigma and discrimination displayed by the church leaders towards congregants taking ART. The stigma and discrimination were shown through church congregants being isolated or differentiated from the rest of the congregants, as there was the belief that such

discrimination would prevent PLWHA from passing HIV to other congregants. Moreover, participants described how church leaders labelled church congregants taking ART, which stigmatised them. Discrimination was in the form of exclusion, with actions such as being denied sharing of instruments, being sidelined when senior appointments are made in church and exclusion from church events. The results of the negative attitude toward stigma and discrimination were not unique to this study and similar findings were also described in the study conducted in South Africa by Alio et al. (2019), who found that 71% of South African church leaders admit that greater support and resources are required to address their inadequate skills to address HIV and AIDS-related and stigma endured by PLWH.

One of the critical issues about stigma and discrimination described in the findings was the stigma and discrimination of PLWHA by other church congregants, as well as stigma and discrimination from church leaders. Noteworthy, Participant 14 described how fellow church congregants would not want to share a seat with PLWHA. The issue of stigma and discrimination from fellow congregants and leadership resonates with the study conducted by Reyes-Estrada. (2018) in Puerto Rico found that religious beliefs could influence stigma and discrimination towards PLWHA; as such, there could be stigma and discrimination from the whole religious community, including people in leadership positions. Moreover, Reyes-Estrada (2018) found that stigma and discrimination towards PLWHA could be from nurses providing care to PLWH due to the influence of religious beliefs. In light of the stigma and discrimination experienced by PLWHA from church leaders and congregants, church leaders are in a vantage position to mediate between other church congregants and congregants taking ART in such situations, as highlighted by Alio et al. (2019). However, this study's findings did not indicate any mediation role in addressing the stigma and discrimination of congregants taking ART. Such silence of the church leaders on stigmatisation and discrimination taking place among congregants is concerning.

4.9.6 Measures to address attitudes of church leaders toward Congregants taking ART

The study also found that information sharing and training and involvement of the Department of Health could be beneficial in addressing the attitudes of the church leaders toward congregants taking ART. These findings are similar to those discussed in the study conducted by Corzine (2019) who found that collaboration between

political leadership and NGOs was critical in ensuring that church leaders' good teaching practices and supportive preaching are done. Similarly, these findings confirm the findings of a study conducted in Kenya, which found that it was essential to empower church leaders with information on HIV and AIDS, which can be used during sermons (Elizabeth Glasier Paediatric AIDS Foundation, 2020). The Kenyan study further developed a tool guide for use during sermons that assisted church leadership in preaching on HIV and AIDS. Noteworthy, such a tool would benefit the local church leaders in the Collins Chabane local municipality whose sermons were inundated with labelling and name-calling of PLWHA from the descriptions of Participants 22 and 26.

4.9.7 The Health Belief Model: a framework for the discussion

The researcher used the HBM as a theoretical framework for the study. The HBM is premised on concepts including perceived susceptibility, perceived benefits, perceived barriers, cues to action and self-efficacy**.**

Perceived susceptibility: the study findings noted that church leaders encouraged church congregants to continue on ART. This encouragement aligns with the concept of perceived susceptibility, which acknowledges that the church leaders perceived the congregants to be at risk of developing AIDS should they not take ART; therefore, they encouraged PLWH to take ART. This was evidenced by Participant 4, who noted that churches have set up groups of health care workers who provide information on health issues in the church and draft policies mandating equal treatment of PLWHA in the church. Such initiatives were led by the church leaders who acknowledged the susceptibility of PLWH among congregants.

Perceived benefits: The HBM concept of perceived benefits asserts that people will perform a certain behaviour as they believe it will benefit their health. Studies have shown that spirituality is an important component of health decision-making (Ayuk et al., 2018:116). In this study, spirituality's influence on health decision-making was guided by the positive and negative attitudes of church leaders towards PLWHA taking ART, where church leaders would encourage members to take ART or have an attitude of faith-based healing, discouraging church congregants from taking ART.

Perceived barriers: The HBM describes how perceived barriers can influence people not to adopt positive health behaviours. From the study findings, these perceived barriers included negative attitudes from the church leaders. The negative attitudes from the church leaders included stigma and discrimination, such as judgemental attitudes, lack of acceptance and spiritual healing versus taking ART. These perceived barriers would lead to PLWH not taking ART or disclosing their HIV status.

4.10 Chapter Summary

A total of 30 church congregants and church leaders took part in the study from three churches. The ages of the participants ranged from 30 years to 78 years. The participants were mostly female(53%). Most participants had a tertiary qualification, with 3% having attained grade 9 as the highest education level. Most participants (53%) were married and the majority were employed (37%). In addition, the majority of the participants resided in the Malamulele location. 66% of the participants spoke Xitsonga.

Both church leaders and congregants shared their views that church leaders' attitudes towards PLWHA who take ART are negative. Such negative attitudes included judgemental attitudes and a lack of acceptance of PLWHA. Participants also described another negative attitude of how congregants taking ART would be discouraged from taking treatment because they believe in the "power of prayer". This faith-based treatment seems to be the main contributor to people living with HIV and AIDS stopping ART. However, some church leaders had a positive attitude towards church congregants who were taking ART and the positive attitude was that of encouragement. The chapter also revealed the stigma and discrimination towards congregants taking ART. This stigma and discrimination were in the form of labelling and exclusion of PLWHA. The findings also described measures to address the attitudes of church leaders taking ART. These measures included providing information and involving the Department of Health in information sharing.

The chapter also described the study findings in relation to previous studies conducted. From this discussion, it was noted that the church leaders had diverse attitudes towards PLWHA taking ART. These diverse attitudes included positive attitudes of encouragement described by the church congregants. This finding was congruent with other studies conducted in South Africa by Alio et al. (2019). In addition,

the study discussed the negative attitudes of church leaders, which could have been influenced by the rurality described by the study conducted by Zainiddinov. (2019). The chapter ended with a discussion of the key concepts in the HBM of perceived susceptibility equated to the positive attitudes of the church leaders, the perceived benefits which were aligned to the positive and the negative attitudes of church leaders and the perceived barriers which aligned to the study findings of church leaders' negative attitudes towards church congregants taking ART. The next chapter is Chapter 5, which summarises the study findings, provides recommendations and outlines the strengths and limitations of the study.

CHAPTER 5

RECOMMENDATIONS STRENGTHS AND WEAKNESSES, STUDY LIMITATIONS AND CONCLUSION OF THE FINDINGS

5.1 Introduction

Chapter four (4) presented the data and findings of the research study and discussed the findings in relation to previous studies conducted. The study followed the objectives outlined in Chapter 1 and in this Chapter, the summary of the results and conclusion are discussed. The chapter begins with an outline of the research findings according to the research objectives. The chapter also describes recommendations for church leaders, congregants, policy makers and the Department of Health. Moreover, the study's strengths and weaknesses are described in this chapter. The last section of Chapter 5 provides the concluding remarks.

5.2 Summary according to the research objectives

The outcome of the study can be applied by the management of the Limpopo Provincial Department of Health to make recommendations to the National Department of Health regarding the planning of overall strategies to prevent new HIV infections through 100% viral suppression in people living with HIV and AIDS who are taking antiretroviral therapy. Furthermore, the proposed study could assist in health promotion and prevention strategies as needed by church leaders in helping and supporting the parish in their quest to improve adherence to antiretroviral therapy.

The study outcomes could further assist in determining the health promotion and prevention needs of religious organisations regarding HIV and AIDS, and ART. Thus, aiding in developing support and collaborative strategies between the Provincial Department of Health and faith-based organisations. The research outcome will assist future researchers in furthering their investigation and development of additional ways and strategies to interrogate the problem at hand.

5.2.1 Objective one (1): attitudes of church leaders

The study concluded that the church leaders had both negative and positive attitudes towards congregants taking ART. The positive attitude of church leaders towards congregants taking ART was encouragement. Participants who included church

leaders and church congregants described how they encouraged congregants who were taking ART by setting up health desks, including health workers, preaching against stigma and discrimination and providing support to continue taking ART. There are churches with programs where church elders do home visits to check on their members on chronic treatment.

The participants also described the negative attitudes of church leaders towards congregants taking ART. The church leaders also acknowledged these negative attitudes, who shared that some church leaders showed a negative attitude towards congregants taking ART. The negative attitudes included judgemental attitudes, lack of acceptance and faith-based healing versus treatment. In describing the judgemental attitudes experienced by church congregants, participants explained that congregants taking ART were judged based on church leaders' perceptions of how PLWHA contracted HIV. Some church leaders are judgmental because one of the common ways of transmission is through sexual intercourse. Therefore, leaders will assume or conclude that one has multiple partners or that one was not faithful to their partner, hence the HIV infection.

The participants also described the lack of acceptance displayed by the church leaders. The lack of acceptance was displayed by church leaders, who did not want to be involved with congregants taking ART. Many participants are of the view that church leaders' attitudes are negative and misleading to people living with HIV and AIDS because they believe in what they are told when it comes to spirituality and healing from HIV and AIDS. Some church leaders' attitudes lead to congregants taking ART, stopping and taking faith-based advice.

5.2.2 Objective 2: stigma and discrimination

The majority of participants showed that PLWHA are discriminated against, isolated, stigmatised, neglected, rejected and feeling unwanted by church leaders and other congregants. The participants emphasised the fact that stigma, discrimination, isolation and feeling unwanted were a cause of stopping to take ART by the congregants who are HIV positive.

Most participants showed that there are still a lot of church leaders and congregants showing acts of discrimination towards congregants who are taking ART in churches

with a reason that they deserved it because they have sinned or committed adultery, and that is a punishment from God. Such stigma and discrimination usually pushed PLWHA to stop taking ART or move from one church to the other, trying to find the one where they had a feeling of belonging.

In describing the stigma and discrimination, participants illustrated that PLWHA is not allowed to participate in church activities such as leadership positions because of their HIV status. Such leadership positions included not being allowed to stand in for elections of Board members or any committee in church.

5.2.3 Objective 3: Measures to address attitudes of church leaders

The majority of the congregant's participants recommended education, training and health talks about HIV and AIDS be given to church leaders in relation to ART. The other participants illustrated that awareness campaigns and training could strengthen acceptance of HIV and AIDS management.

Most participants believe that education plays an important role, which is why they recommend that church leaders have regular updates on health matters. Further training and materials, such as posters to help church leaders have teaching aids while addressing their congregants on health issues. Church leaders need to know their congregants to identify if they have any problems and intervene before it is too late.

This also depends on the church leaders' willingness to learn new things and concern other peoples' wellbeing. If so, they need to involve other stakeholders, such as the department of health, to give information to the congregants occasionally. Health professionals know how to put their words so that they do not leave people offended. It will benefit both the leaders and congregants.

Information on HIV and AIDS to the church leaders can do the trick. Regular HIV and AIDS awareness campaigns by the health department might also be helpful. Strengthening HIV counselling and testing at churches by health professionals and regular giving of health talks once in a while as to how to take care of PLWHA can be of good help, and breaking down the mode of transmission of HIV so that people will understand that it does not fly in the air to pass to another person.

Provision of HIV and AIDS posters where everybody can go through them in their leisure time and get useful information for them and those close to them. However, we

need not forget to emphasize the prevention of HIV and AIDS taught to all congregants, including youth, to avoid new HIV infections and prevent further stigma and discrimination of those who tried to disclose, not knowing that they will be more stressed than when they kept quiet.

Church leaders and congregants need to be made aware of the risks they impose on PLWHA at their respective churches because, according to them, people are just reckless and in the end, they get HIV. They need training and to pass the information to their fellow religious leaders to do the same things when it comes to the treatment given to their congregants who are infected with HIV. When they have meetings, it would be good for them to include such health topics and discuss issues they do not understand well, which will broaden their knowledge about HIV and AIDS.

5.3 Recommendations

The study findings have made recommendations for additional research, church leaders, healthcare workers and church congregants.

5.3.1 Recommendations for additional research

This study was only conducted in the Malamulele node of Collins Chabane Local Municipality in Vhembe District. The researcher recommends that a similar study be conducted in three or more local Municipalities in Vhembe District to get more views about the attitudes of church leaders towards congregants taking ART.

5.3.2 Recommendations for church leaders

From the study findings, some negative attitudes portrayed by the church leaders could be mitigated by information provided on HIV and AIDS through training. With training on HIV and AIDS, it is expected that negative attitudes like stigma and discrimination could improve support for congregants taking ART.

Moreover, the study found that some church leaders have a positive attitude toward congregants taking ART, while some have a negative attitude towards congregants taking ART. From this, it is recommended that when they have meetings with the church leadership, it would be good for them to include health topics like HIV and AIDS and discuss issues supporting PLWHA.

5.3.3 Recommendations for church congregants

The study found that church congregants perpetrate some forms of stigma and discrimination. Such discriminatory actions included not sharing equipment like chairs and microphones. In light of this, it is recommended that church congregants learn how HIV is transmitted so that they can provide support to PLWHA and decrease the burden on church leadership to minimise HIV stigma and discrimination.

5.3.4 Recommendations for healthcare workers

The study also found that healthcare workers form part of the religious community in the Collins Chabane Municipality and some churches. They play a pivotal role by providing information through health desks. From the participants' descriptions, such initiatives have assisted in mitigating negative attitudes towards congregants taking ART. Therefore, it is recommended that such initiatives by health care workers extend to all churches.

Moreover, HIV and AIDS awareness sessions by healthcare workers in churches on HIV transmission and prevention should provide relevant information needed by the church leaders and congregants to know how to manage HIV and ART usage would be beneficial, especially on issues such as faith-based healing versus taking ART. Issues concerning the disease correctly. Such awareness sessions should be done regularly to keep them well informed and move with current information concerning HIV and AIDS and PLWHA, whilst bearing in mind that correct knowledge will lead to a change in behaviour and perceived benefits.

The study also recommends strengthening relations between the healthcare workers and the church leadership through training on ART adherence. With the church leadership's involvement in health issues, it is expected that stigma and discrimination against PLWHA will be minimised to improve disclosure and continuity of taking treatment correctly by PLWHA.

5.4 Strengths and weaknesses of the research study

There are strengths and weaknesses that the researcher has developed from the findings of the study.

5.4.1 Weaknesses of the research study

The outcomes of the study could not be conclusive of the attitudes of church leaders in general because a small sample was used; therefore, if a larger sample that covers a large geographical area were utilised, the study would have been more appropriate to conclude that it is the clear picture of what transpires in all churches. The use of one-on-one interviews in a qualitative study limits the researcher because the participant tries to give favourable answers to the questions to paint a beautiful picture of their respective churches.

5.4.2 Strengths of the research study

The previous chapter outlined the discussion of the study findings and all the objectives of the study were covered. The objectives were to explore the attitudes of church leaders towards congregants taking antiretroviral therapy in Vhembe District, to describe the stigma and discrimination of HIV and AIDS experienced by congregants taking antiretroviral therapy in Vhembe District, and to describe recommendation measures to address the attitudes of church leaders towards congregants taking antiretroviral therapy in relation to adherence and prevention of new HIV infections in pursuit of reducing the mortality rate and controlling the pandemic in the Vhembe District were represented and included in the study. There were no potential risks to the participants and the participants responded of free will and consented by signing consent forms and leaving the interview venue after all the questions were asked and responded to until the last one.

5.5 Study limitations

Limitations to the study are as follows:

- Participants in the research study are from the Malamulele node of Collins Chabane Local Municipality in Vhembe District of Limpopo.
- The research employed a qualitative research design; therefore, the findings cannot be generalised to all the church leaders in the Vhembe District.

5.6 Conclusion

The study aimed to explore the attitudes of church leaders towards congregants taking antiretroviral therapy in the Vhembe District of Limpopo, South Africa. PLWHA experienced stigma and discrimination against HIV and AIDS. It recommended

measures to address the attitudes of church leaders towards congregants taking antiretroviral therapy.

According to the findings of this study, it is anticipated that the information gained from different participants will help make recommendations that could assist Collins Chabane Local Municipality in Vhembe District of Limpopo and South Africa as a country. The findings of the study will enhance the identification of problems or gaps in relation to adherence to ART, high defaulter rate and HIV and AIDS-related mortalities. Therefore, the municipal authorities, the district and the provincial health department will determine the shortcomings, which will be helpful when updating their Policies and Guidelines concerning adherence to Art, viral load suppression and retention of PLWHA on ART.

The researcher felt the study findings would lead to PLWHA being free to disclose their status and see the condition as normal like the other chronic treatments that other people continue to take continuously and prolong their life expectancy. This will motivate them to continue taking ART without interruptions, prevent new infections and work towards combating the pandemic by the year 2030.

The exploration study showed that most of the participants interviewed know about the impact of the attitudes of church leaders towards congregants taking antiretroviral therapy, but ways to address those attitudes are still lacking. Therefore, there is a need for more educational programs in churches.

Reinforcement of awareness campaigns on HIV and AIDS, mode of transmission, preventative measures, antiretroviral therapy, and adherence to treatment as one of the preventive measures but not forgetting disclosure guidelines because that might assist in lessening the challenges that PLWHA face in churches with stigma and discrimination inclusive.

Therefore, the study concludes that the Department of Health should ensure that information starts from the ground to equip everybody with knowledge about this pandemic and strategies to deal with problems such as spirituality and adherence to ART. Regular HIV and AIDS awareness campaigns can serve this purpose.

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Appendix 1: Ethical clearance

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

22 February 2023

Dear Mrs Mkateko Maria Chauke

NHREC Registration # :
Rec-240816-052
CREC Reference # :
33927219_CREC_CHS_2023

Decision:
Ethics Approval from 22 February 2023 to 22 February 2024

Researcher(s): Name: Mrs. M. M. Chauke
Contact details: 33927219@mylife.unisa.ac.za
Supervisor(s): Name: Dr. T.R. Netangaheni
Contact details: netantr@unisa.ac.za

Title: ATTITUDES OF CHURCH LEADERS TOWARDS CONGREGANTS TAKING ANTIRETROVIRAL THERAPY IN VHEMBE DISTRICT, LIMPOPO, SOUTH AFRICA
Degree Purpose: Masters

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for one year.

The ***medium risk application*** *was reviewed by* College of Human Sciences Research Ethics Committee, in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

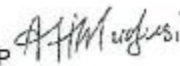
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.
5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No fieldwork activities may continue after the expiry date **(22 February 2024).** Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

*The reference number **33927219_CREC_CHS_2023** should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

Signature:

Signature: PP 

Prof. KB Khan
CHS Research Ethics Committee Chairperson
Email: khankb@unisa.ac.za
Tel: (012) 429 8210

Prof ZZ Nkosi
Acting-Executive Dean: CHS
E-mail: nkosizz@unisa.ac.za
Tel: 012 429 6758

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Appendix 2: Consent to participate in study

I, __________________ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the interview questions.

I have received a signed copy of the informed consent agreement.

Participant Signature…………………………………………………… Date…………………

Researcher's Name & Surname Mkateko Maria Chauke (please print)

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Researcher's signature…… Chauke …………………………

Date…………………

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

Appendix 3: Researcher acknowledgement

I, **Mkateko Maria Chauke**, hereby acknowledge that in my capacity as a researcher I am aware of, and familiar with stipulations and contents of the following: Unisa IP Policy

- Unisa Research Policy
- Unisa Ethics Policy

And that I shall conform to and abide by these policy requirements.

Chauke

____

Signature:

Date: 18/10/ 2022

Appendix 4: Participant Information Sheet

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PARTICIPANT INFORMATION SHEET

Ethics clearance reference number:

Research permission reference number:

Date :

TITLE: **Exploring attitudes of church leaders towards congregants taking antiretroviral therapy in Vhembe District, Limpopo, South Africa**

Dear Prospective Participant

My name is **Mkateko Maria Chauke,** a master's degree candidate in the Department of Health Studies at the University of South Africa. I am inviting you to participate in a study entitled **Exploring attitudes of church leaders towards congregants taking antiretroviral therapy in Vhembe District, Limpopo, South Africa**

WHAT IS THE PURPOSE OF THE STUDY?

The study aims at exploring the attitudes of church leaders towards congregants taking antiretroviral therapy in Vhembe District, Limpopo, South Africa

WHY AM I BEING INVITED TO PARTICIPATE?

You have been selected to participate to form part of a sample of 36 males and females from the ages of 18 and above in the Malamulele node of Vhembe District. You will be able to provide information which will be used to determine the factors contributing to non-adherence to ART within the Municipality and the country at large. Before you participate in the study you will be provided with a consent form where you will sign to confirm your willingness to participate in the study. It is also important to note that Covid-19 guidelines as stipulated by the University of South Africa and the South African Ministry of Health will be followed as a preventative measure against the virus.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

As a participant, you will be asked a series of questions by the researcher and you will be expected to provide answers. The study involves *audio taping of the interview questions and answers*. The primary reason for recording is so that the researchers would be able to transcribe and analyze the data in detail. The recording is also important so that there is no information that is not clearly recorded by the researcher. The interview questions will take about 45 to 60 minutes.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Participating in this study is voluntary and you are under no obligation to consent to participation. You are free to withdraw at any time and without giving a reason. If you participate in the study, you will be given a copy of this information sheet to sign and keep as evidence of your decision to participate in the study. You will also sign a written consent form. Withdrawing from the study will not deprive you of benefits in your community in any way.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

Participation in this study is entirely voluntary and there will not be rewards or reimbursements. However, taking part in this study will help to strengthen the community health system in Vhembe District and the country at large. The researcher will share the

finding of the study with you first, and the management of Vhembe District and the Ministry of Health. As a respondent you will have a chance to make a difference in your community and in the district where you work through your shared experiences in the study.

ARE THERE ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

The study may invoke sad emotions of past healthcare seeking experiences during the interview. If you feel any discomfort during the interview or data collection you are allowed to withdraw from the study. Even after withdrawing from the study, your identity will remain anonymous. If any harm attributed to the study occurs, you will be referred to professionals who may be of help to you.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

You have the right to insist that your name not be recorded anywhere and that no one, apart from the researcher and identified members of the research team, will know about your involvement in this research or your name will not be recorded anywhere and no one will be able to connect you to the answers you give. Your answers will be given a code number, or a pseudonym and you will be referred to, in this way in the data, any publications, or other research reporting methods such as conference proceedings.

The data *will also be taken to an external coder* and he/she will be subjected to *signing a confidentiality agreement. Thereafter, the confidentiality agreements will be submitted to the Research Ethics Review Committee for consideration.* The answers that you provided during the interview will only be available to and reviewed by people responsible for making sure that research is done properly, which will include the transcriber, external coder, and members of the Research Ethics Review Committee. Therefore, records of data that identify you will only be available to people working on the study, unless you give permission for other people to see the records.

Your anonymous data will be used for the research report. In addition, *the research report of the study may be submitted for publication, but individual participants will not be identifiable in it.*

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

Hard copies of your answers will be stored by the researchers for a period of five years in a locked cupboard/filing cabinet in the researcher's home for future research or academic purposes; electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. After the five-year period, hard copies of the data collected will be shredded. The electronic copies will be permanently deleted from the hard drive of the computer using a relevant software programme.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

There is no form of reward or compensation to participate in the study.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study has received written approval from the Research Ethics Review Committee, of the University of South Africa. A copy of the approval letter can be obtained from the researcher if you so wish.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact Mrs Mkateko Maria Chauke on +2782 694 5867 and email mkatekochauke27@gmail.com (Principal researcher), and Dr. T.R. Netangaheni (supervisor) on +27 76 189 5087 or +27 124296719 or email: robert.Netangahe@gmail.com.

The findings might be accessible by December 2024. Feel free to make follow up to the researcher on the provided communication tools.

Should you have concerns about the way in which the research has been conducted, you may contact Dr. T.R. Netangaheni (supervisor) on +27 76 189 5087 or +27 124296719 or email: robert.Netangahe@gmail.com. Contact the research ethics chairperson of the CAES General Ethics Review Committee, Prof K.B Khan on +27 11-471-2241 if you have any ethical concerns.

Thank you for taking time to read this information sheet and for participating in this study.

Thank you.

Chauke

____

Mrs Mkateko Maria Chauke

UNISA university of south africa

Appendix 5: Interview guide for church leaders

INTERVIEW GUIDE FOR CHURCH LEADERS

1. What are your roles as a church leader regarding PLWHA?
2. How do you as a church leader support PLWHA?
3. What is your attitude towards congregants taking ART?
4. What is your view on congregants taking antiretroviral therapy being stopped from visiting healthcare facilities?
5. What can be done to encourage PLWHA to continue with their treatment without defaulting again?

UNISA university of south africa

Appendix 6: Interview Guide for congregants

INTERVIEW GUIDE (CONGEGRANTS)

TITTLE: EXPLORING THE ATTITUDES OF CHURCH LEADERS TOWARDS CONGREGANTS TAKING ANTIRETROVIRAL THERAPY IN COLLINS CHABANE MUNICIPALITY

INSTRUCTIONS

There are no wrong or right answers. Once again, you are assured that your response will remain anonymous. Your cooperation is appreciated. The researcher will spend plus / minus 60 minutes with the participant during the interview.

QUESTIONS

ATTITUDES OF CHURCH LEADERS TOWARDS CONGREGANTS TAKING ANTIRETROVIRAL THERAPY

1. What is your understanding about ART?
2. What is your understanding regarding church leaders towards PLWH?
3. What is your view about attitudes of church leaders towards congregants taking antiretroviral therapy?

STIGMA AND DISCRIMINATION OF HIV AND AIDS EXPERIENCED BY CONGREGANTS TAKING ANTIRETROVIRAL THERAPY

1. What challenges do PLWHA face in the church?
2. What can be done to deal with these challenges?
3. What can the church do to ensure that congregants are supported to take their treatment correctly?

RECOMMENDATION MEASURES TO ADDRESS THE ATTITUDES OF CHURCH

LEADERS TOWARDS CONGREGANTS TAKING ANTIRETROVIRAL THERAPY

1. What information would you recommend that church leaders are given in relation to these attitudes towards congregants taking antiretroviral therapy?
2. In your view, how can church leaders ensure that PLWHA in churches continue taking their treatment without interruptions?

End of interview, thank you very much for your participation

Appendix 7: Request for permission to conduct study

REQUEST FOR PERMISSIOM TO CONDUCT THE STUDY

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN MALAMULELE NODE OF VHEMBE DISTRICT

TITTLE: Attitudes of church leaders towards congregants taking antiretroviral therapy in Vhembe District, Limpopo, South Africa

Date :

Contact person's name**: Mrs Mkateko Maria Chauke**

Contact person's Department: **Vhembe District Department of Health**

Contact person's building no. or room no: **Malamulele, Limpopo, South Africa.**

Contact person's telephone number: **+27 82 694 5867**

Email address: Email: mkatekochauke27@gmail.com

Dear Sir/ Madam

I, **Mkateko Maria Chauke,** am doing research with Dr Nentangaheni, in the Department of Health Studies towards a master's degree at the University of South Africa. I am requesting for permission to conduct a study **Tittle: Attitudes of church leaders towards congregants taking antiretroviral therapy in Vhembe District, Limpopo, South Africa.** The study aims at exploring attitudes of church leaders towards congregants taking antiretroviral therapy in Vhembe District. The proposed research will be conducted in Malamulele Node of Vhembe District. The sample will be a subgroup of 36 participants of the population of interest.

The findings from the study will add new insights to the existing literature and provide a base for conducting similar research studies in this context for the future. After the analysis of the challenges, the researcher will develop guidelines and make recommendations on how to improve policy, coordination, practice, and effectiveness of community health systems in the country.

Overall, the study's contribution will be viewed as a cornerstone for future programmes to be strengthened and intensified, regular monitoring and evaluation. These guidelines and recommendations will improve and strengthen the policy environment, coordination and practice of community health systems thus helping health care managers, other providers and ultimately the communities that will benefit from better quality health services. Potential risks will be some discomfort based on the uncertainty of responses to research questions and inconvenience based on the time/duration of the interviews.

Feedback procedure will entail follow up meeting via virtual and discuss or explain the findings of the results.

Yours sincerely

____

Mrs Mkateko Maria Chauke

Department of Health Studies

Appendix 7

REQUEST FOR PERMISSIOM TO CONDUCT THE STUDY

COLLINS CHABANE LOCAL MUNICIPALITY

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN MALAMULELE NODE OF VHEMBE DISTRICT

TITTLE: Attitudes of church leaders towards congregants taking antiretroviral therapy in Vhembe District, Limpopo, South Africa

Date : 20.02.2023

Contact person's name**: Mrs Mkateko Maria Chauke**

Contact person's Department: **Vhembe District Department of Health**

Contact person's building no. or room no: **Malamulele, Limpopo, South Africa.**

Contact person's telephone number: **+27 82 694 5867**

Email address: Email: mkatekochauke27@gmail.com

Dear Sir/ Madam

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Feedback procedure will entail follow up meeting via virtual and discuss or explain the findings of the results.

Yours sincerely

____

Mrs Mkateko Maria Chauke

Department of Health Studies

226 Collins Chabane Dr
Old DCO Building
Malamulele
0982

Private Bag X9271
Malamulele
0982
Tel (015) 851 0110
Fax (015) 851 0097

COLLINS CHABANE LOCAL MUNICIPALITY

Enq: Manganye N.P *Date: 28 February 2023*

House 309 A
Billy Maganu Street
Malamulele
0982
Email. Mkatekochauke27@gmail.com

Attention: Mrs Chauke M.M

SUBJECT: PERMISSION TO CONDUCT RESEARCH FOR MRS CHAUKE MKATEKO MARIA.

1. The above matter refers.

2. This serves to confirm that **Mrs Chauke M.M,** a student at University of South Africa, has been granted a permission to conduct research titled **(Exploring attitudes of church leaders towards congregants taking antiretroviral therapy in Collins Chabane Local Municipality)** with the sample of subgroup of 36 participants as part of her Masters in Health studies.

Wishing you a fruitful result on your research.

Regards

SHILENGE R.R.
MUNICIPAL MANAGER

Date

Vison: "A spatially integrated and sustainable local economy by 2030"

Mission: To ensure the provision of sustainable basic services and infrastructure to improve the quality of life of our people and to grow the local economy for benefit of all citizens

Appendix 7

REQUEST FOR PERMISSIOM TO CONDUCT THE STUDY

MALAMULELE PASTORS FORUM

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN MALAMULELE NODE OF VHEMBE DISTRICT

TITTLE: Attitudes of church leaders towards congregants taking antiretroviral therapy in Vhembe District, Limpopo, South Africa

Date : 20.02.2023

Contact person's name**: Mrs Mkateko Maria Chauke**

Contact person's Department: **Vhembe District Department of Health**

Contact person's building no. or room no: **Malamulele, Limpopo, South Africa.**

Contact person's telephone number: **+27 82 694 5867**

Email address: Email: mkatekochauke27@gmail.com

Dear Sir/ Madam

I, **Mkateko Maria Chauke,** am doing research with Dr Nentangaheni, in the Department of Health Studies towards a master's degree at the University of South Africa. I am requesting for permission to conduct a study **Tittle: Attitudes of church leaders towards congregants taking antiretroviral therapy in Vhembe District, Limpopo, South Africa.** The study aims at exploring attitudes of church leaders towards congregants taking antiretroviral therapy in Vhembe District. The proposed research will be conducted in Malamulele Node of Vhembe District. The sample will be a subgroup of 36 participants of the population of interest.

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Feedback procedure will entail follow up meeting via virtual and discuss or explain the findings of the results.

Yours sincerely

____

Mrs Mkateko Maria Chauke

Department of Health Studies

MALAMULELE PASTORS FRATERNAL

"united we stand, Ps 133:1"

Malamulele Pastors Fraternal
P.O Box 2997
Malamulele
0982

epublic Of South Africa,Limpopo Province,Malamulele,0982

DATE: 21/02/2023

Sir/Madam

ENDORSEMENT FOR MRS CHAUKE MKATEKO MARIA TO DO HER RESEARCH.

1. The above matters refers.
2. This is to confirm that Mrs Chauke Mkateko Maria who is working under the Department of Health, has been given permission to do her research at Malamulele areas her researcher will mainly be based on church leaders.
3. The leadership of Malamulele Central is hereby requesting for your full co-operation in this regard.

(Secretary)

Appendix 7

REQUEST FOR PERMISSIOM TO CONDUCT THE STUDY

MADONSI PHILADELPHIA CHURCH

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN MALAMULELE NODE OF VHEMBE DISTRICT

TITTLE: Attitudes of church leaders towards congregants taking antiretroviral therapy in Vhembe District, Limpopo, South Africa

Date : 20.02.2023

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Contact person's Department: **Vhembe District Department of Health**

Contact person's building no. or room no: **Malamulele, Limpopo, South Africa.**

Contact person's telephone number: **+27 82 694 5867**

Email address: Email: mkatekochauke27@gmail.com

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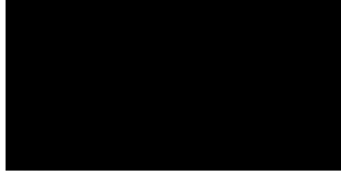
Feedback procedure will entail follow up meeting via virtual and discuss or explain the findings of the results.

Yours sincerely

____

Mrs Mkateko Maria Chauke

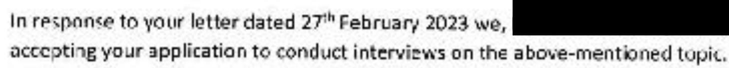
Department of Health Studies



28 February 2023

Dear Mrs Chauke M.M.

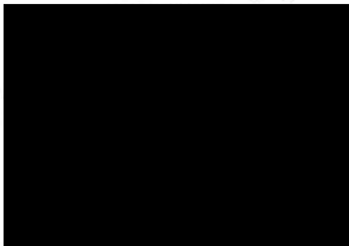
ACCEPTANCE TO CONDUCT INTERVIEWS ON EXPLORING THE ATTITUDES OF CHURCH LEADERS TOWARDS CONGREGANTS TAKING ANTIRETROVIRAL THERAPY IN COLLINS CHABANE MUNICIPALITY

In response to your letter dated 27th February 2023 we,  accepting your application to conduct interviews on the above-mentioned topic.

The church will provide you with participants who are willing to take part. The church position is to allow researchers to address topic that are critical in the church as well as the community.

We hope that you will enjoy doing your research.

Secretary



Appendix 7

REQUEST FOR PERMISSIOM TO CONDUCT THE STUDY

MALAMULELE EPCSA

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN MALAMULELE NODE OF VHEMBE DISTRICT

TITTLE: Attitudes of church leaders towards congregants taking antiretroviral therapy in Vhembe District, Limpopo, South Africa

Date : 20.02.2023

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Contact person's Department: **Vhembe District Department of Health**

Contact person's building no. or room no: **Malamulele, Limpopo, South Africa.**

Contact person's telephone number: **+27 82 694 5867**

Email address: Email: mkatekochauke27@gmail.com

Dear Sir/ Madam

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Yours sincerely

____

Mrs Mkateko Maria Chauke

Department of Health Studies

(Swiss Mission in S.A Founded in 1875)

MALAMULELE PARISH

....

Enq: 0608945273

02 March 2023

Dear Mrs Chauke Mkateko Maria

REQUEST TO CONDUCT RESEARCH AT OUR CHURCH: MALAMULELE EVANGELICAL PRESBYTERIAN: YOURSELF

1. The above institution hereby grant you permission to conduct research based on the title as indicated in your request letter dated 27 February 2023.
2. The Church and its leaders are more than ready to assist you in whatever information you might aspire to be assisted with as long as the information is in line with the Church's doctrine.
3. Hoping for a positive outcome after the research project
4. I thank you.

Yours in Christ,

....

Parish Secretary
As duly signed

Appendix 7

REQUEST FOR PERMISSIOM TO CONDUCT THE STUDY

VICTORY REVIVAL CHURCH

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN MALAMULELE NODE OF VHEMBE DISTRICT

TITTLE: Attitudes of church leaders towards congregants taking antiretroviral therapy in Vhembe District, Limpopo, South Africa

Date : 20.02.2023

Contact person's name**: Mrs Mkateko Maria Chauke**

Contact person's Department: **Vhembe District Department of Health**

Contact person's building no. or room no: **Malamulele, Limpopo, South Africa.**

Contact person's telephone number: **+27 82 694 5867**

Email address: Email: mkatekochauke27@gmail.com

Dear Sir/ Madam

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Feedback procedure will entail follow up meeting via virtual and discuss or explain the findings of the results.

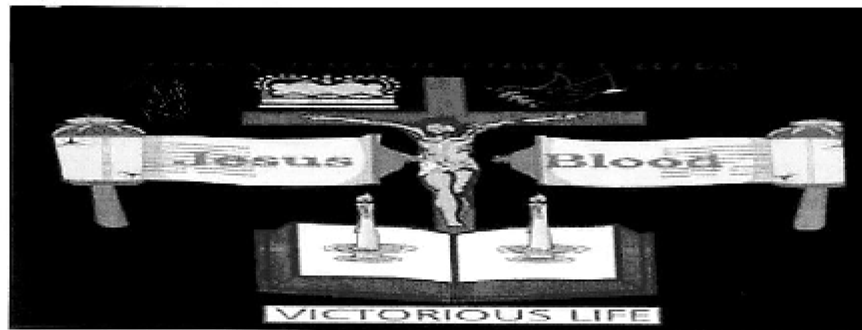
Yours sincerely

____

Mrs Mkateko Maria Chauke

Department of Health Studies

Appendix 8: Permission letter



Dear Mrs Mkateko Maria Chauke

GIVING A PERMISSION TO CONDUCT A RESEARCH ON OUR CHURCH

I am pleased to inform you that we have accepted you to come and do your research, We know that by conducting this research we will be benefiting, when it comes to the knowledge and understanding of the use of antiretroviral therapy in our churches and information that we are going to share it will be useful and helpful to all people of COLLINS CHAVANI MUNICIPALITY.

Looking forward on working with you.

(Secretary)

Appendix 8: Editor's certificate

Ground Floor, Lakeview Building 2004 Gordon Hood Ave, Centurion 0157
+27815909555
Email: info@editlink.co.za
Website: www.editlink.co.za

afregarde editlink
academic editing & data analysis

Editor's Certificate

This certificate is to certify that **ABISHA KAMPIRA** has provided professional editing services for the thesis titled

ATTITUDES OF CHURCH LEADERS TOWARDS CONGREGANTS TAKING ANTIRETROVIRAL THERAPY IN VHEMBE DISTRICT, LIMPOPO, SOUTH AFRICA

By

MKATEKO MARIA CHAUKE

The editor has carefully reviewed the thesis for grammar, punctuation, syntax, and overall clarity. They have also worked on improving the thesis structure and flow.

The editor's work did not include checking/verifying information that formed the manuscript.

Date: 26 October, 2023

Signature:

Professional Editors' Guild No: KAM002

Professional EDITORS' Guild
30 1993–2023
Promoting excellence in editing

Abisha Kampira
Associate member

Membership number: KAM002
Membership year: 2023

info@editlink.co.za
+27815909555

www.editlink.co.za