Perceptions of church members regarding congregants on antiretroviral therapy in Limpopo Province, South Africa

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ABSTRACT

The purpose of the study was to explore the perceptions of church members regarding congregants who are on antiretroviral therapy in Limpopo Province, South Africa. The study was conducted in churches of Vhembe District, Limpopo Province, South Africa. The study utilised an exploratory, descriptive, qualitative research design. The study focused on church members in Vhembe District of Limpopo Province. A non-probability purposive sampling method was used to select church members for participation. The sample size was 30 church members, determined by saturation of data. Semi-structured interviews were utilised to collect data, and data was analysed using Tech's eight steps of the coding process, through the content analysis method. The study yielded four themes, namely, church members’ understanding of antiretroviral therapy, attitudes of church leaders towards congregants on antiretroviral therapy, the roles, and responsibilities of church leaders towards congregants on antiretroviral therapy and, psychosocial challenges faced by congregants on antiretroviral therapy. Church members understood what antiretroviral therapy is used for, and some were specific about its functions. This study concludes that campaigns could be delivered through workshops targeting church members, including both church leaders and congregants.

Introduction

The World Health Organization (WHO) posits that 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) (WHO 2020). It is reported that there is still inadequate conformity to ART despite its increased access for the reduction rate of HIV-related mortalities globally (UNAIDS 2019). South Africa has the largest ART programme of all the developing countries in the world, with an estimated 7.7 million people living with HIV/AIDS (PLWHA) (WHO 2020). Although South Africa is progressing positively in the trial and viral suppression quest towards the achievement of the UNAIDS 90-90-90 targets, the country continues to struggle to control the spread of the epidemic (WHO, 2020; Day, 2020). Various studies conducted in South Africa identified some contributory factors of non-adherence to ART among PLWHA (Kheswa, 2017). These factors include, amongst others, fear of disclosure, educational level, religion, inadequate social support, underdeveloped health provider-patient relationships and residing outside of the home (Adeniyi, Ajayi, Ter Goon, Owolabi, Eboh and Lambert, 2017).
Various interventions such as forging collaboration between the healthcare services and facilities with religious institutions and Faith Based Organisations (FBOs) were implemented to accelerate awareness on subjects of prevention and treatment of HIV and AIDS in communities (Jobson, Khoza, Mbeng, Befula, Struthers, Kerongo and Peters, 2019). Religious institutions are important in assisting congregant members to manage and maintain their overall well-being when confronted with HIV and AIDS. Kruger, Greeff and Letsosa (2018) observed that religious leaders can significantly contribute to reaching and empowering communities to avoid risks and exposure to HIV and offering physical and spiritual treatment to affected members of the church. Furthermore, religious leaders can assist in combating stigmatisation and discrimination, testing for HIV and promoting adherence amongst those on treatment. Religious and spiritual leaders experience relationship challenges with caregivers and religious organisations when treating PLWHA (Arrey, Bilsen, Lacor and Deschepper, 2016). Conversely, religious practices have themselves contributed to poor ART adherence in certain communities in South Africa (Kheswa, 2017). For instance, some of the PLWHA may stop taking their ARTs due to religious beliefs.

The cessation of ART consumption by PLWHA through religious beliefs and practices impacts their health and well-being (Kheswa, 2017). Furthermore, some of these beliefs contradict strategies implemented by the South African government to improve the quality of life for all PLWHA (South African National AIDS Council, 2018). The substitution of ART with religious practices has resulted in the deaths of some PLWHA, owing to their religious beliefs of discontinuing the ingestion of ART in exchange for beliefs (Dzansi, Tomu and Chippes, 2020). Various religious leaders have been reported to discourage members of their congregation from using ART, encouraging them to use other religion-based remedies such as holy water (Kruger, Greeff and Letsosa, 2018). These religious acts and practices are common amongst all members of the church, including both church leaders and members of the congregation.

The perceptions of church members regarding congregants on ART in churches of Vhembe district, Limpopo province is unknown. For this reason, the authors explored the perceptions of church members regarding congregants who are on antiretroviral therapy in Limpopo Province, South Africa.

**Literature Review**

The purpose of the literature review it provide a background of the theoretical foundation used to conduct this research. It is also to extend the conversation to provide an overview of the research problem. For the exploration purpose of this study, the researcher utilised the Health Belief Model (Becker, 1974; Wethington, Glanz and Schwartz, 2015). The HBM was one of the first hypotheses created to describe how health behaviour changes. When applied correctly, it gives structured assessment data about the client's abilities and motivation to improve their health status. A model is commonly defined as a symbolic representation of reality. The model represents certain correlations between phenomena through symbols and diagrams. A model aids in the organization of research, the investigation of an issue, and the collection and analysis of data.

**Theoretical background**

The research used the Health Belief Model (HBM) to guide this study (Becker, 1974; Wethington, Glanz and Schwartz, 2015). The HBM has become a common framework in health studies focused on patient compliance and preventative care measures (Polit and Beck, 2020). According to the model, a person's perception of a threat posed by a health problem, as well as the value associated with acts aimed at minimizing the threat, influences their health-seeking behaviour. The HBM is made up of several important components, including perceived vulnerability, perceived severity, perceived rewards and costs, motivation, and enabling or modifying factors. The researchers in this study explored the perceptions of church members regarding congregants who are on antiretroviral therapy in Limpopo Province, South Africa. This study is in line to provide 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). Since HIV transmission is driven by behavioural variables, theories about how people modify their behaviour have served as the foundation for the majority of HIV prevention programs around the world.

**Perceived Susceptibility:** This refers to an individual's belief that a health problem is personally important or that a diagnosis is correct (Becker, 1974). Church members can positively influence global health issues due to their ability to influence each other’s attitudes and behaviours (Corzine, 2019). There are several reasons why church leaders are influential members of the community regarding health issues. Church leaders are trusted, respected and seen as role models in health (Duff and Buckingham, 2018). Church members can promote health through preaching, teaching, giving information on health issues, collaborating with local health officials or NGOs, or influencing local or national politics and policies (Corzine, 2019).

**Perceived benefits:** These are the patient's beliefs that a specific treatment will cure or help avoid their sickness (Becker, 1974). Several studies have demonstrated that spirituality is crucial for patients and influences healthcare decision-making and outcomes, including quality of life (Ayuk, Ndifreke & Gyuse, 2018). The intersection of religious beliefs and ART experiences has several implications for ART adherence (Vasquez, 2018). Some religious organisations encourage PLWHA to continue with their treatment, while other churches have counsellors who assist PLWHA in coping with their condition. Conversely, church members have the potential to provide support to congregants who are on antiretroviral therapy.

**Perceived Barriers:** This includes 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 situation can be spiritually cured is less likely to adhere to ART, instead spending much of their time praying, doing religious rituals, and visiting prayer houses for cure frequently discontinuing their ART (Igben et al., 2018). Norder et al. (2018) emphasized that challenges to churches’ involvement in HIV health care include stigma, which leads to non-disclosure, heightened stigma due to the relationship between HIV and sexuality, and specific religious practices that interfere with medication adherence.

**Motivation:** This is the desire to go through with a treatment. In South Africa, opportunities for health-religious partnership have emerged. This includes holistic HIV care that incorporates spiritual dimensions, leveraging the church’s social access to the community, and recognizing churches’ potential for HIV discussion since they are identified as safe and accepting places (Norder et al., 2018). Personality traits, patient satisfaction, and socio-demographic characteristics have all been found as modifying factors.

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

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 ART (Igben et al., 2018). However, there are still people who are less likely to adhere to ART, this includes those PLWHA who believe performing religious rituals, praying, and embedding themselves in prayer sessions will cure their illnesses (Igben et al., 2016).

**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).

**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).

**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).

**Research and Methodology**

**Research design, population and sampling**

This study adopted an exploratory, descriptive qualitative research design. This design was selected because it allowed the collection of data from participants in a narrative format to explore their perceptions (Nieswiadomy & Bailey, 2018). An explorative design...
was used to explore the perceptions of church members regarding congregants who are taking ART in the Vhembe District. A descriptive design was used to observe, describe, and record responses by the church members, thus increasing the researcher's understanding of the church members' perceptions. The study was conducted at a municipality in Vhembe district in Limpopo Province. The municipality is situated about 191km from the City of Polokwane. The municipality consists of four nodes, namely, Hlanganani, Malamulele, Saselamani and Vuwani. The study was conducted in one of the nodes which has numerous church denominations, estimated to be 92 registered and recognised by the church forum. The population were church members attending any of the churches within the church forum, this included both church leaders and congregants. Non-probability, purposive sampling was used to select participating church members. The researcher purposely selected available church members of the identified churches to participate in the study (Polit and Beck, 2020). The researcher purposely selected the available church members who registered under the Malamulele Pastors Forum and church congregants of the identified churches to participate in the study. Church members above the age of 18 years, who attended a church that is registered under the Malamulele Churches Forum willing to take part in the study. The sample was 30 participants, six were church leaders and 24 were congregants. Participants were interviewed until saturation was achieved to determine the sample size. Both male and female church leaders and congregants over the age of 18 years were included in the study. Church members under the age of 18 years were excluded.

Data collection and analysis

Data were collected through semi-structured interviews and an interview guide was used to guide the interview process (Polit and Beck, 2020). The interviews were conducted in a language suitable to the participants and translated into English. The interviews were recorded using a tape recorder after verbal consent was obtained from the participants. The researcher began the interview by asking a central question and proceeded to probe to encourage participants to elaborate more. Moreover, the researcher used field notes to capture non-verbal cues and a digital audio recorder to record all the interview sessions. Interviews were conducted in churches in which the participants were members and were scheduled to suit the participants’ availability. Informed consent was obtained from all participants before data collection. Data were analysed using Tech's eight steps of content analysis recommended by Creswell (2020). All recorded interviews were transcribed verbatim to enhance the analysis process. The researcher attentively reviewed all of the transcripts to gain an understanding of the data segments and their significance. The meaning and comprehension that developed from reading the transcripts were recorded in the notebook, along with the associated thoughts. The researcher carefully and again reviewed the transcripts of the participants and then scaled down the data for coding while identifying all subjects that emerged during the procedure, grouping similar topics and clustering those that are dissimilar. The researcher jotted down comments and ideas about the acquired data in the margins of the paper, where the verbatim transcripts appeared.

Trustworthiness

Trustworthiness was ensured by the confidence that the researcher generated their data as measured by the criteria of credibility, transferability, dependability, and confirmability (Polit and Beck, 2020). Credibility in the study was ensured by collecting data for approximately one month. The researcher pre-tested the data collection tools to ensure they collect the right data that can effectively meet research objectives (Plick, 2018). Data saturation enhanced 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). The researcher adequately described the sampling methods applied in the selection of the study participants. To guarantee confirmability, the researcher engaged with experienced and professional research practitioners to check whether proper methodological processes were applied in the study, as well as the extent to which the findings and conclusions were coherently reached by the researcher at the end of the study. Notes from the interviews were examined, and voice recordings were listened to, to ensure that the data accurately reflects the participants' perspectives. Dependability was ensured by keeping an audit trail of all field notes, transcripts, and audiotapes for five years to ensure auditing.

Ethical consideration

The researcher obtained permission to conduct the study from the Ethics Committee of the College of Human Science at the University of South Africa (Ref: Rec-240816-052). Permission to conduct the study was obtained from the chairperson of Malamulele Churches Forum. Participants were protected from potential harmful risks, discomfort, or emotional harm to uphold the principle of non-maleficence (Polit and Beck, 2020). Participants were assured that their involvement or withdrawal from the study would not in any way prejudice their treatment services at the church, and they were informed about what participation entailed. Participants' names and personal details were not disclosed, and all interview recordings were kept confidential in a password-secured file. The anonymity of the participants was ensured by assigning a number code during their interviews and transcription sessions, which assisted the researcher in managing and identifying the different responses from participants. Participants were given and signed informed consent forms that included a statement of the study's purpose, a description of the potential risks and benefits of participation, a description of how confidentiality will be maintained, the researcher's contact information, and a statement explaining that the participant could withdraw at any time. Once the participants were aware of what participation entailed, they were given the consent form to sign.
Findings
The study included 30 participants, six were church leaders and 24 were church congregants, namely, church members’ understanding of ART, attitudes of church leaders towards congregants on ART, the roles, and responsibilities of church leaders towards congregants on ART and, psychosocial challenges faced by congregants on ART in churches. From the 30 church members, participants three, six, 20, 21, 25 and 27 were church leaders and the rest were congregants. Vignettes will be used to reflect the participants’ actual responses.

Theme 1: Church members’ understanding of ART
The participants had different understandings of ART and its use. Most participants understood ART as a strategy used to control the virus, some further say that the pills are used to keep HIV-positive people healthy and live longer. The participants stated the following:

“I think it is a strategy to control HIV infection, this is using stopping the virus from replication in the human body through pills that are taken daily for the rest of that person’s life.” (Participant 2, Congregant)

“ART is a therapy that has been developed to control the spread of HIV in infected persons, and once it is started, they must take it for life. So, this therapy helps to weaken the virus in the blood of these people and let it sleep for as long as they don’t stop taking ART.” (Participant 29, congregant)

“ART stands for antiretroviral treatment. It is the treatment used to suppress the viral load of HIV, but it does not cure it” (Participant 3, church leader)

Some participants understood the role of ART in improving the CD4 count, suppressing the viral load and controlling HIV. They emphasised that ART was developed to make the virus sleep, prevent its multiplication, and revive the CD4 count while suppressing the viral load of the people living with HIV. The following are some of their voices:

“It is something that people with HIV take to strengthen their body’s immune system. It is a type of pill given to people who tested HIV positive to take for the rest of their lives to make the virus sleep and lengthen their life, those people who tested HIV positive their soldier in the body become weak and they are more likely to get sick now and then.” (Participant 7, congregant)

“It is a treatment taken by a person who is HIV positive, and the pills control the CD4 count that was reduced by the virus, so the treatment helps to increase it again and lower the viral load in the blood.” (Participant 15, congregant)

Theme 2: Attitudes of church leaders towards congregants on ART
Participants reflected different opinions regarding church leaders’ attitudes towards congregants on ART. Some indicated that church leaders were judgmental, while other church leaders were supportive. However, their attitudes depended on their knowledge of ART. Participants revealed that there are church leaders who tell congregants that there is no HIV, while other church leaders were judgemental and isolated PLWHA saying they were unfaithful to their partners. Furthermore, it was revealed that some church leaders were there to earn a living and did not show any concern about the congregants on ART. Lastly, some church leaders reflect attitudes that show passivity, judgment, and condemnation. The following are some of the comments:

“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 which is why you are infected with HIV. Whereas other church leaders will take it as a punishment from God because he punishes sin with incurable illnesses” (Participant 4, congregant).

“Mostly church leaders don’t understand, they like to judge them immediately. I mean that they label them as being unfaithful or have multiple sexual partners which suits them well to have been infected with this virus. Some church leaders even separate them from the rest of the congregants.” (Participant 7, Congregant).

“They undermine congregants who live with HIV because they think they are better than them and judge them for being infected as if they are careless. Most church leaders have a negative attitude towards congregants taking ART because they feel like they caused this to themselves, they were irresponsible and their actions are paying them off through being HIV positive, they even mention bible verses that the payment of sin is death. (Participant 10, congregant)

Participants also indicated that some church leaders reflect positive attitudes through encouragement and support. One participant revealed that her Pastor is supportive and was her treatment buddy when she started taking ART. She regarded herself as an ambassador in her church who is free to talk about being HIV positive and is taking ART without defaulting. The following are some of the participants’ voices:

“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, and some of the church leaders encourage people to believe in prayer. (Participant 2, congregant)
Participant 8: “There are those who support PLWHA, who are well informed about HIV and AIDS including how to take care of PLWHA. This type of church leader knows how to address their congregants sensitively... is approachable, accessible, and available which makes it easier for all congregants to trust them and feel free to talk about anything with them including disclosing their HIV status.” (Participant 8, congregant)

“I have been living with the virus for many years now and I am free to talk about it as I was accepted by my Pastor who gave me moral support when I needed it most. He also accompanied me to the hospital when they wanted me to have a treatment buddy, and that helped me so much that I even went to different places as an ambassador at HIV-related events.” (Participant 13, congregant)

Participants reflected that church leaders must treat congregants on ART the same way as the other church members, not to differentiate them because of their state of health. They must love them equally despite their sickness and not make them feel different from the rest of the congregants.

Theme 3: The roles and responsibilities of church leaders towards PLWHA

Participants shared their opinions on the roles and responsibilities of church leaders towards congregants on ART. The participants revealed that their role is to provide safety and ensure that congregants on ART are supported and not stigmatized within the church environment. Furthermore, they indicated that church leaders must take care of all congregants as it is the will of God. Church leaders acknowledged their role in using the word of God to assist congregants in dealing with their challenges. The following are some of the comments:

“My role as a church leader is to teach and preach the Word of God and allow the Holy Spirit to direct me as to how can I help the congregants living with HIV and AIDS in our church.” (Participant 27, church leader)

“My role is to see that PLWHA are accepted and supported throughout their stay at church. And when they are at church, they must not be separated but treated in the same way as the rest of the congregants. As church leaders, we must make sure that these people are not labelled or distinguished by their HIV status.” (Participant 6, church leader)

“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 which makes it easier for congregants to receive the necessary care.” (Participant 5, congregant)

Participants further suggested that it is the role and responsibility of church leaders to ensure that PLWHA is treated fairly and not subjected to stigmatization while in the church environment. The aim of supporting PLWHA is to ensure that they continue attending church and receiving the word of God despite their HIV status. The following reflects some of the voices:

“Another thing 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.” (Participant 6, Church leader)

Theme 4: Psycho-social challenges faced by church congregants of ART in churches

The study revealed that PLWIHA faces different adversities in the church environment. The participants suggested that there are psycho-social challenges in churches, which include discrimination, rejection, fear, embarrassment, and shame. These challenges are perpetuated by both congregants and church leaders towards PLWHA in church. Participants suggested that during some church activities, you will find church members being segregated based on their HIV status. They revealed the following about some of the social challenges PLWHA face in church:

“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, 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.” (Participant 13, 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.” (Participant 28, congregant)

Participants also reflected on the psychological challenges faced by PLWHA in church. They suggested that PLWHA often feel rejected, and isolated, with low self-esteem because of how they are treated in churches. The following are some of their voices:

“First challenge is that PLWH develop fear of rejection and they will feel isolated by both the church leaders and other congregants.” (Participant 9, congregant)

“Challenge number one is low self-esteem because PLWH will lose their confidence due to how they are treated in churches. They will feel useless and not worthy to live again.” (Participant 12, congregant)

“PLWHA face challenges such as shame, they are embarrassed in front of other congregants and suffer humiliation.” (Participant 17, congregant)
Discussion

The purpose of the study was to explore the perceptions of church members regarding congregants who are on antiretroviral therapy in Limpopo Province, South Africa. The findings indicated that church members understood what ART is used for, and some were specific about its impact in suppressing the viral load and improving the CD4 count. However, some church leaders were reported to be negative towards congregants on ART, while others were supportive. Those who were negative sometimes advised congregants on ART to stop taking medication and pray to be healed. Dzanssi, Tornu and Chippis (2020), found that 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. Non-adherence to ART exposes PLWHA to less effective viral suppression, exposing them to immediate health 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 importance of religious institutions and their leaders is in their assistance of congregant members to manage and maintain their overall well-being when confronted with HIV and AIDS. Arrey et al. (2016) highlighted the importance of religious and spiritual institutions in ensuring that PLWHA continues with their HIV/AIDS treatment despite their care by religious and spiritual leaders. Kruger, Greeff and Letsosa (2018) reiterated that religious leaders can significantly contribute to reaching and empowering communities in the avoidance of risk, and 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.

PLWHA believe that taking ART will assist them in managing the virus and will also prolong their lives. Several studies have shown that spirituality and religion are important to many people and that they affect healthcare decision-making and healthcare outcomes, including the quality of life, either positively or negatively (Ayuk, Ndifreke & Gyuse, 2018). The intersection of religious beliefs and ART experiences has several implications on ART adherence (Azia, Mukumbang, Shernaaz and Nyembezi, 2022). Some religious organisations form groups to encourage PLWHA to continue with their treatment, some churches have counsellors that assist PLWHA to cope with their condition. This study revealed that PLWHAs develop a fear of rejection and they often feel isolated by both the church leaders and other congregants. Furthermore, some congregants often feel unwanted, and they decide to move from one church to another trying to get acceptance, love and care as expected in a church.

ART adherence is impacted by the connection between religious beliefs and ARV experiences (Azia et al. 2022). Some religious organisations form groups to encourage PLWHA to continue with their treatment and others have counsellors that assist PLWHA to cope with and manage their condition. However, this is not the case with all religious organizations because some promote negative attitudes towards HIV and AIDS. Misinformation about HIV and AIDS is linked to some congregational engagements which promote poor adherence, because People are less likely to adhere to ART while they perform religious rituals, and prayer, to cure the disease (Igbende, Aumbur, Dooior, Mkpelanga, Ogwuche, Chindo, Terzungwe and Aiingona, 2016). Some religious communities promote a negative attitude toward HIV, while some communities foster moral judgment about PLWHA (Vasquez, 2015). Dzansi et al. (2020), highlighted that 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. Similarly, 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). These acts resulted in poor health outcomes among some PLWHA (Dzansi et al., 2020). 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). One of the critical issues highlighted in the current study was the stigma and discrimination of PLWHA by other church congregants and church leaders. The issue of stigma and discrimination from fellow church members resonates with a study conducted in Puerto Rico by Reyes-Estrada (2018), the study found that religious beliefs could influence stigma and discrimination towards PLWHA. There could be stigma and discrimination from the whole religious community, including people in leadership positions. 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. The recommendations for addressing the stigma and discrimination are made in the conclusion below.

Conclusion

The purpose of the study was achieved by exploring the perceptions of church members regarding congregants on ART in Limpopo province. The findings of this study revealed that as much as church members know about ART and its use PLWHA are subjected to rejection, discrimination, stigmatization, and lack of general support. Therefore, regular updates and awareness campaigns about HIV and AIDS are necessary in churches. Such campaigns will improve the consistency in practising the correct approach of encouraging PLWHA to continue to adhere to their medication so that their health can improve. This study recommends improved efforts to provide information to church members regarding adherence to ART, prevention of HIV reinfection, stigmatization and support measures religious groups can offer PLWHA. Furthermore, primary healthcare settings such as clinics and community
healthcare centers should provide training and educational programs to church leaders so that they can be able to promote ART adherence and reduce stigma within the church environment. The training and educational programs could offer practical steps towards reducing stigma and improving ART adherence. This may contribute to the reduction of HIV-related mortalities among PLWHA, and further improve their experiences in the church environment. This study considerably contributes to the literature, particularly the involvement with faith-based groups for successful HIV and AIDS preventive interventions in Sub-Saharan Africa, which is a gap in the research. Finally, it helps to explain the impact of current initiatives and addresses the main hurdles to HIV prevention in churches (Vigliotti, Taggart, Walker, Kusmasti, and Ransome, 2020). For further research, this study recommends the investigation of the effectiveness of specific interventions aimed at reducing HIV/AIDS stigma within churches. Comparative studies involving different religious denominations or regions within South Africa could provide broader insights into the cultural and doctrinal influences on ART adherence. Lastly, research could also explore longitudinal changes in perceptions, especially in response to targeted interventions within church settings.

Limitations

The following are the limitations of the study: i) Participants in the research study were from the Malamulele node of Collins Chabane Local Municipality in Vhembe District of Limpopo. The findings of the study cannot apply to other locations; ii) The research employed a qualitative research design; therefore, the findings cannot be generalized to all the church leaders in the Vhembe District; iii) The self-reported data collection methods used in the study, which included interviews, may have contributed to recall bias.

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References


