MIDLANDS STATE UNIVERSITY

FACULTY OF SOCIAL SCIENCES

DEPARTMENT OF PSYCHOLOGY

AN ASSESSMENT OF THE INFLUENCE OF CHRISTIAN FAITH ON ART ADHERENCE FOR CHRISTIANS LIVING WITH HIV AT ZNNP+ GWERU URBAN

BY

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DEDICATION

To Mduduzi Sidambe. Team Sid, with love.

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ABSTRACT

The study aim was to assess the influence of Christian faith on ART adherence by persons living with HIV subscribing to Christianity as their religion and enrolled in the Zimbabwe National Network of People living with HIV Gweru. The research was necessitated by the observation of the rise in Christian denominations that were found to be preaching the gospel of healing from HIV, alongside the presented statistics on the AIDS-related deaths and HIV prevalence rates within the district. The approach employed in the research was qualitative, taking on an exploratory nature, seeing that the area of assessing the respective impact of Christian faith on ART within the district, had been under-studied. Participants for the research were identified in a single-stage sampling procedure, through selecting them from an existent organizational database of the support groups in which the participants were enrolled. Data was analysed thematically, with demographics being interpreted and presented in a tabulated manner. The main findings of the research were that within the first year of being initiated on the ART program, participants tended to lean towards Christian faith as a source of consolation, in disbelief of their sero-status. As such, the church teachings and attitudes of persons surrounding them from the church system often discouraged them from taking ART. However, with time, following acceptance of their sero-status, Christians living with HIV were able to adhere better to their medication basing on the belief that God cared for them and wanted them to live long. As such, the conclusions drawn from the research were that Christian faith positively impacts adherence for persons living with HIV, only after the people in question would have managed to get through the factors that affect adherence for every other person on the ART program, such as disclosure, status acceptance and knowledge of ART.

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1. CHAPTER ONE: INTRODUCTION

1.1 Introduction

This chapter focuses on the preliminary aspects of the research. It presents the research giving background of the study, statement of the problem, purpose of the study, research questions, significance of the study, assumptions, delimitations of the study, limitations of the study, and definition of terms.

1.2 Background of the study

HIV continues to be a global public health issue, which has nations striving towards its elimination by the year 2030. In current statistics as given by UNAIDS (2017), a total of 36.7 million people are living with HIV (PLWHIV) in the globe. From this group a total of 19.5 million are reported to have access to anti-retroviral therapy (ART). This leaves 17.2 million PLWHIV unaccounted for, with regards to optimal maintenance of their well-being. Whilst the numbers may be indicative of progress in comparison to the 78 million PLWHIV recorded by UNAIDS factsheet (2017) since the start of the epidemic, the difference between persons on ART and those who are not is still high. This difference between the two, raises concerns as to whether the global 2030 year goal of attaining zero new infections, zero AIDS-related deaths and zero stigma, may be achieved. Hence, the need to continuously research and curb factors that may hinder its attainment.

The present day global community is characterized by Mambo (2016) as one that has been swept away by the advent of the radical Christian Pentecostalism. This advent focuses on the supernatural and instantaneous healing power of God. The Zimbabwe Library Association (2018) refers to the churches falling within this category of churches as African Initiated Churches. This is taken from the concept of how these churches are established by Africans, without the significant contribution of missionaries. Under this dispensation, prophets have emerged claiming to be the agents through which the healing may come. In these churches, healing services are prescribed for delivering people from all manner of illness, such as, but not limited to Cancer, Heart Disease and HIV (Mhlanga, 2014). People affected and those living with these ailments tend to be motivated by the preached hope of freedom from disease to an

extent that they would rather stand in the prayer line than dedicate their lives to medication, prescribed by certified medical practitioners.

In previous research conducted by Szaflarski, Ritchey, Leonard, Mrus, Peterman, Ellison, McCollough and Tsevat (2006) ART adherence and HIV related coping was concluded to be relatively higher amongst religious individuals than with unreligious individuals living with the virus. This was attributed to the sense of hope brought about in religious people's lives, through prayer as a coping mechanism. In essence, religion- a branch within which Christianity lies- had a positive impact on ART adherence. It is only concerning whether that may still be the case in the contemporary context.

WHO (2010) communicates that the global vision for treatment is primarily for the extension of human life, followed by an establishment of a standard measure for the treatment of the virus across the continents. This is very important in low income settings like Zimbabwe where treatment consists of one first line and one second line of ART regimens. The Ministry of Health and Child Care (MoHCC, 2002) identifies how important it is to follow-up patients and track how well they are coping with treatment, following its commencement. Treatment failure relates to drug resistance, whose causes are transmitted or acquired. Transmitted resistance takes place when an affected person is exposed to a resistant strain to treatment within their system. Acquired resistance occurs when a person, formerly adhering well to ART is no longer responding to treatment. In light of the statistics, UNAIDS (2017) posits that there were at least 420 000 AIDS-related deaths in the previous year, which can be attributed to drug resistance.

In a UNAIDS (2016) factsheet, Sub-Saharan Africa (SSA), which consists of Lesotho, Malawi, Mauritius, Mozambique, Namibia, Swaziland, South Africa, Tanzania, Zambia and Zimbabwe, bears a vast majority of PLWHIV in the globe estimated to be at least 25.5 million. Mapanda (2010) characterizes SSA as a region dominated by low and middle-income countries, facing many development, social and health challenges. As such, government-incentivised policies in catering for all PLWHIV fall into the many challenges faced, subsequently justifying why not all infected persons may not be on ART. However, in Zimbabwe, where Manayiti and Ncube (2017) cite the continual rise of Pentecostal churches, PLWHIV are reported to have been influenced to either discontinue or underestimate ART as a means of "taking ahold" of God's promise for supernatural healing.

These Pentecostal church ministrations have also led the Minister of Health and Child Care's to warn "false prophets" against their preaching of this gospel of healing from HIV related illnesses (stating how it could prove dangerous to PLWHIV) mentioned by the RadioVOP (2014). With this overt castigation, significant interest towards the relationship between Christianity and ART adherence was drawn.

Chatumba (2016) also quotes the National AIDS Council (NAC) Provincial Coordinator, who highlighted how Gweru has a high HIV prevalence rate of 19.9 percent amongst persons aged 15 to 39. Prevalence was also described as higher in the urban community than in the rural areas surrounding the city. Whereas applaud is duly directed to the significant reduction of HIV related deaths and prevalence rates since the year 2000 around the country, it still is concerning why the prevalence remains high within the city of Gweru. NAC, (amongst other organisations within the city working on HIV and AIDS-related issues) has also not formerly released statistics on religion-related barriers to reducing this prevalence rate within the city. Alongside the rising numbers of alternative means of dealing with ailments-offered by modern day prophets, one wonders whether the delay in eliminating the virus within the district, may be facing a go-slow due to people choosing the religious alternatives over scientific medicinal methods.

1.3 Statement of the problem

According to Mhlanga (2014), the present-day Christian society is overtly resorting to Faith in God as the only healing source to various diseases, including HIV. Whilst doing so may be a source of solace to PLWHIV, this drift opens up challenges to the elimination of the virus and its devastating effects on communities. This is because in place of its containment through ART, PLWHIV may neglect prescribed therapy, and consequently, the neglect will contribute to the significant numbers recorded in undesired AIDS-related deaths. region. HIV prevention has also become central to religious multiple studies confirming the active role of religious leaders in AIDS-related behavior

More so, in Zimbabwe, the relationship between poor ART adherence and Christianity has been underexplored. Formal documentation has little to no evidence in form of a research done to substantiate the relationship, hence the justification for the conduction of this research.

1.4 Significance of the study

The research intended to primarily benefit the researcher in helping to acquire research skills and attainment of the Bachelor of Sciences Honours Degree in Psychology. The research evidence was helpful in the development of theories which facilitated an optimal balance between scientific medicine and religion, particularly Christianity.

This study also intended to be beneficial to policy makers, such as the Ministry of Home Affairs within the district, which would find it handy to develop legislative measures to curb misinformation and the brainwashing of people to believing in the instantaneous elimination of HIV through prayer. Furthermore, the study sought to guide development workers, particularly the National AIDS Council, Ministry of Health and Child Care, Population Services International as well as the respective City Health Department thriving towards the elimination of the HIV and AIDS epidemic in mapping a way forward with regards to advocacy for a healthy nation, which is appreciative of both medical and spiritual approaches to well-being.

In addition, the research served to be beneficial to PLWHIV, serving as a tool through which they would gather knowledge on balancing between Christianity and ART.

1.5 Research objectives

The purpose of the research was to assess the adherence of Christian adults living with HIV in Gweru urban. Details relating to the strategies employed by CLWHIV in balancing between Christian doctrine and ART adherence were exposed in the research. Another aim of the research was to find out what percentage of the Christian adult population living with HIV in Gweru had regressed from ART due to exposure to the doctrine of faith. The research also purported to identify means through which ART and Christian faith may be integrated to enhance drug adherence amongst Christians living with HIV enrolled in the Zimbabwe National Network of PLWHIV

1.6 Research questions

1.6.1. How do Christians living with HIV (CLWHIV) balance between faith-in-God and ART adherence?

1.6.2. Do the factors that affect Christian adherence to ART vary from those that affect non-Christians?

1.6.3. Are there gender disparities to spirituality and ART adherence amongst CLWHIV?

1.6.4. How can Christian principles be effectively integrated with medical means of managing HIV, such as ART?

1.7 Assumptions of the study

In this study, it was assumed that CLWHIV sometimes fail to optimally cope with adhering to ART due to the doctrine they are exposed to which practices the concept of Faith. It was also assumed that the sample, with which the research was conducted, was reflective of the total population. The treatment guidelines provided by the World Health Organisation were also assumed to be highly operational if applied in their correct manner. The possibility of ART being integrated with Christian doctrine was also assumed within the study.

1.8 Delimitations of the study

The study was conducted in Gweru CBD where adult PLWHIV enrolled under ZNNP+ Gweru district convene for their monthly meetings. The group consisted of heterosexual adults (male and female) living with HIV, with a majority who subscribed to Christianity as their religion. Persons living with the virus with undefined religious affiliations were included for comparative assessment of whether Christianity as a stand-alone religion significantly impacted ART adherence. The participants considered for the research included all persons initiated on ART within the past 2 years who gave consent to taking part in the research. The study also focused on PLWHIV accessing ART from Gweru City, within the programming range of ZNNP+.

1.9 Limitations of the study

The researcher envisaged confidentiality as an issue limiting the research. As much as it was assured given the operations of the network within which they were drawn, HIV and AIDS related issues are personal and sensitive to an extent that PLWHIV generally perceive they are being taken advantage of by programmers, for personal gain. To curb the insecurities of participants, the researcher engaged assistance with breaking the ice with participants from the Programs Officer prior to the process of data collection, seeing that they were already comfortable with communicating with them.

1.10 Definition of key terms

Christianity and Faith

According to Aten, Boyer, Tucker and Brent (2007) this is a person who adheres to the teachings of Jesus Christ and believes in only one God. For the purpose of this research, a Christian was taken to be not only a person who adheres to the teachings of Jesus Christ in general, but rather one who attends to these teachings consistently and regularly. The frequency in reading the bible was also considered as a basis for defining Christianity. The definition was also accommodative of Christians attending their services within traditional African churches, that is churches established by African leaders.

Christian faith in this research's context predominantly focused on the ideologies surrounding instantaneous healing and miracle-working power of God and relating it to how this power cures all manner of ailments affecting people.

Anti-Retroviral Therapy

WHO (2018) mention how standard antiretroviral therapy (ART) consists of the combination of antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of HIV disease. ART also prevents onward transmission of HIV. Huge reductions have been seen in rates of death and infections when use is made of a potent ARV regimen, particularly in early stages of the disease. WHO (2018) recommends ART for all people with HIV as soon as possible after diagnosis without any restrictions of CD4 counts. It also recommends offer of pre-exposure prophylaxis to people at substantial risk of HIV infection as an additional prevention choice as part of comprehensive prevention. Countries are now following to adapt and implement these recommendations within own epidemiological settings. For the purpose of this research, ART was considered as the effectual drugs prescribed and administered to PLWHIV for the suppression of the human immune deficiency virus.

Adherence

The term adherence means taking drugs in the exact, prescribed manner. This involves taking drugs at the right time as well. WHO (2010) identify a 90 to 95 percent range of ART doses which need to be taken for optimal viral load suppression within an infected person's system.

The required levels for Anti-retroviral drugs to be highly effective and to have them prevent the emergence of resistant viral strains are those from 95% and above. Proper adherence was taken to mean having an infected person take their medication every day without missing not more than three doses a month, per twice regimen, as well as maintaining the consistency in adherence year after year.

<u>HIV treatment lines</u>

These relate to a combination of ant-retroviral drugs taken by persons living with HIV. It consists of two treatment lines. The first line is composed of ARVs to be taken first primarily for the suppression of the virus. The second line regimen is prescribed for individuals on the first line regimen who experience treatment failure or are severely affected by the side effects of the first line regimen.

<u>ART Resistance</u>

ART resistance involves HIV's ability to change its structure such that the drugs are unable to optimally supress it. In this way, the drugs are made less effective. WHO (2018) state that resistance tends to occur when prescribed drugs are not taken in the way they should. For example, if one overdoses, or forgets to take their medication, they expose their system to resistance. The WHO definition of resistance was used as an operational definition within the research.

1.11 Chapter Summary

This chapter focused on the preliminary aspects of the research. It presented the research giving background of the study, statement of the problem, purpose of the study, research questions, significance of the study, assumptions, delimitations of the study, limitations of the study, and definition of key terms.

2. CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

The chapter reviews given literature in form of a conceptual framework of the Church's view on HIV and AIDS, A theological view of Faith-in-God and HIV disclosure within the church. The manner in which Christians living with HIV balance their faith in God and ART will be presented in two standpoints of viewing God, which are cited as believing God as a loving Father who encourages preservation of human life through ART and believing in God as a miracle-worker who cures HIV. Gender disparities in ART adherence are also explored, with citations of how women have predisposing factors to HIV contraction and are more prone to spirituality than men, hence their assumed likelihood of better adhering to ART based on these. The researcher also presents literature on the integration of Christian principles with medical methods of managing HIV. The theoretical framework and knowledge gap have also been respectively highlighted.

2.2. Conceptualising the issues surrounding HIV and AIDS within the church

2.2.1. The Church's view on HIV and AIDS

From its onset, the issue of HIV and AIDS in the communities has always been significantly rooted in a community's culture. People have always looked beyond the biomedical components of the virus and focused on the aspect of sex and how it relates to morality. As such, as Kelly (2009) posits, when one presents that they have been infected with the virus, it's a matter of people inferring with whom unprotected sex has been engaged in, where the sex took place, how it was done as well as the moral implications such as how much of a sin against God that was. Kopelman (2002) presented a study on how the church has always been fundamentalist in interpreting sexual behaviours and these tend to extend into the interpretation of HIV and AIDS related issues.

In the study a review of the church's response to HIV and AIDS related issues was assessed and the summarised result was how HIV was viewed as sinful or acquired through sinful means. The fundamentalist view presents that HIV is a punishment from God inflicted those in violation of the moral code which forbids promiscuity and sex before marriage.

Kopelman (2002) makes an interesting enquiry, which is, "If HIV/AIDS is punishment, then who is bad?" challenging the stigma of the church in embracing issues surrounding HIV and AIDS. Whilst the study paved way for the understanding of the varying views the church presents when understanding HIV issues, the study lacked an appreciation of how in other churches HIV and AIDS issues are much more accommodated, which is what the research also sought to unravel, in assessment of how these perceptions impact ART adherence on the overall.

Luker (2004) conducted a study where he posited that for some people, the responses presented by churches to HIV and AIDS remained ambivalent. This was stated to be because churches were not presenting a uniform response to HIV, seeing that they conceptualized Christianity in differing mannerisms. The study basically crystallized the need to delve deeper into the doctrines of faith presented in churches, so as to be able to easily assess the impact they had on people's health beliefs and health seeking behaviours and with reference to the particular study, it would be easier to assess the impact these had on ART adherence by members subscribing to the respective teachings.

Members of the Seventh Day Adventist Church on one hand are understood:

> "To proclaim care and compassion through their public policy statements on HIV… [while] others proclaim another kind of Christian message. Instead of providing care, prevention and education, some churches (in particular the evangelical and charismatic) moralise, try to rid and cleanse infected people of their sins and wrong doings" (Tevi, 2005:xx)

To this end, the theological position that HIV is a punishment from God has encouraged a doctrine of condemnation in place of compassion and impartiality to assisting persons living with the virus, who subscribe to Christianity as their religion. Whilst religion can be notably be appreciated for its life affirming role to people living with HIV, the research redirects focus to how the fundamentalist teachings impact ART adherence by Christians living with HIV within the Gweru Urban district, enrolled under the Zimbabwe National Network of PLWHIV.

More so, Shuman (1999) posited that the issues of faith within a respective denomination ultimately inspire the response of the church to HIV and AIDS related issues, which in turn influences how a person living with the virus responds to the church system and overall ART

adherence. The conceptualisation of HIV in the Christian community is suggestively supposed to be fundamentally grounded on the teaching that all those who have "come to Christ", that is have chosen to become Christians, are members of one body. As such, if one person is found to be living with HIV, the whole body has the virus. This therefore determines the level of care and support which a Christian denomination will render to persons living with HIV. Basing on the church's teachings, the CLWHIV's adherence to ART is assumed to be enhanced by the founding beliefs of the church.

Below is a figure presented by Kelly (2009), which represents the Seventh Day Adventist church view on HIV and AIDS in Papua New Guinea, in support of how church beliefs can positively influence adherence behaviours of CLWHIV:

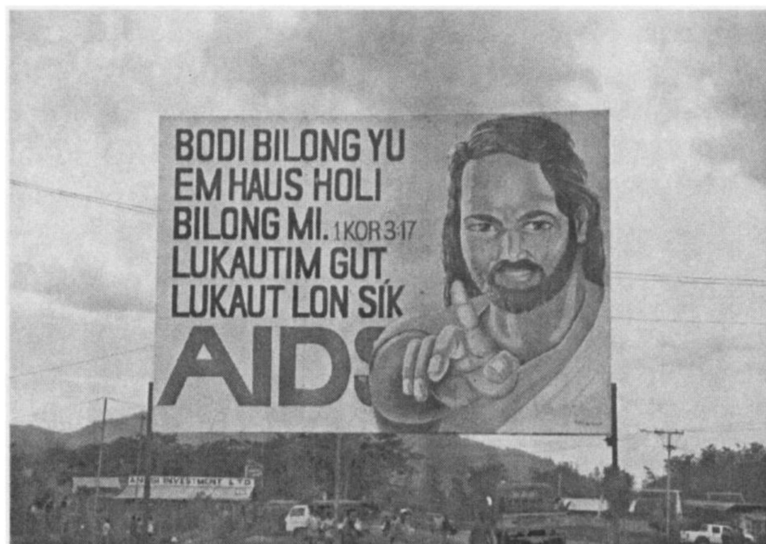

Figure 1: SDA Church conceptualisation of HIV and AIDS

The image reveals the relationship there is between the whole Christian body and an individual's life. Inscribed is a bible verse which reads, "God's temple is sacred and you are that temple, (1 Corinthians 3 verse 17), a translation of "*Bodi bilong yu em haus holi bilong mi*". The rest of the inscription of the billboard, "*Lukautim gut lukaut lon sik AIDS*" translates to "Look after yourself well, look out for AIDS"

In as much as Kelly may be considered to have presented the stance taken by some Christians in responding to the HIV epidemic and encouraging adherence within their sector, the study scope

was only confined to one church in particular, which raises questions on the generalization of the information gathered on other Christian denominations as is within the Gweru urban area. This therefore became an area the research sought to patch up, as the researcher engaged Christian participants cutting across various Christian denominations.

2.2.2. The theological view on Faith in God

Modern day faith is referred to by varying names for example “the gospel of prosperity”, Word of Faith movement or Faith-Formula movement, amongst others. Defining the movement as a denomination or categorising it as either charismatic or non-charismatic is considered to be an injustice by Sarles (1986). The biblical concept has, however been “reduced to a formula, a set of principles which, when applied, guarantees specific remuneration”. (Morris 2012:91). Such remuneration tends to cater for the exerciser of faith’s greatest desire. For example, if one’s greatest desire was healing, in exercising their faith; the form of beneficial remuneration would be the healing they expected.

Morris (2012) conducted a study where he presented how biblical faith has mostly been soteriological in its nature. This means from its inception, faith has always been directly linked to the concept of salvation. Faith was conclusively understood to be the binding agent that links mankind to God’s need to draw back man to himself and save them from the snares of his rivalry, the devil.

Higgins, Dusing and Tallman (1994:110-111) conducted an assessment where their view that:

> “faith is defined most succinctly as belief…and not merely a passive mental assent to factual data; rather it is the active, positive response of one’s total being to follow Christ”

, was presented. Faith was rendered a requirement for Christian living at all levels, be it physical, spiritual, psychological or social. If a Christian is able to be applying their faith in all these aspects, considering how faith itself is given by God, the covenant between them and God, as well as their communion is enhanced.

Packer (1989:400) makes several observations which are important to defining faith in the biblical manner. Firstly, faith involves developing the “right” belief about God. Throughout the

bible, the issue of trust in God rests on what he has revealed about his purposes and character, which, when understood well, effects the beneficial results to the ones believing in Him. Secondly, a divine testimony is the basis of faith. This testimony is directly linked to the conviction that God is superior than man and he cannot lie. The last observation is that faith is not only a supernatural but also a divine gift. It being supernatural and a gift is what makes God the founder of all forms of faith, including faith required for the salvation of man. According to Williams (1988), the last observation substantiates how, to Christians, faith is not "merely wishful thinking" but the result of God's response to the heart that searches and yearns out for Him sincerely. Faith is believed to go beyond the things that can be seen and reaches right into the convictions that what is not seen exists and is provided by God, only. Some religious organizations in Africa in their HIV/AIDS intervention efforts supplement treatment of the disease with prayer and religious exercises in pragmatic outreach programs.

In all these studies of what faith is, researchers failed to present what the level of faith required to influence behaviour were to be at. Discussions on how huge or small the faith needed to be in enabling humans to make decisions such as adherence or non-adherence to ART were minimally discussed, hence the purpose of the research-which is to assess how Christian faith, at whatever level, influences ART adherence.

2.2.3. HIV disclosure within the church

HIV status disclosure relates to how a CLWHIV attempts to make their condition known within their respective environment. Jourard (1958), a humanistic psychologist presented that at the core of an individual's being was the intent to be known and being known encompassed a great level of disclosure about oneself. Together with his colleagues, Jourard devised a sixty-item self-disclosure questionnaire which enquired upon experiences of past self-disclosure directed to four targets which are one's mother, father, male and female friend, respectively. The ability to disclose information about oneself to others was attributed to good mental health and well-being. This means, without the element of disclosure regarding phenomena that describes someone, well-being is affected. In this regard, non-disclosure was concluded that it can lead to physical, psychological, emotional and social harm. As such, the researcher aimed at understanding to what extent this was true in the case of CLWHIV enrolled in ZNNP+ Gweru urban.

Given the stigma that one can attract, with disclosing everything about themselves to others, it is also important to note that disclosure has to be exercised in an environment which is permissible of such. For example. With HIV and AIDS related issues, it would not be advisable for a person living with the virus to disclose their status to individuals who think negatively of the virus, as they would only fall prey to their ignorance and stigmatisation. In a suitable environment, where one's church-mates are non-judgemental, disclosure would help provide a social support basis, within which the person living with HIV may find solace and be encouraged-even in adhering to their medication.

The World Health Organisation in their extensive review conducted by Medley, Garcia-Moreno, McGill and Maman (2004), found out that PLWHIV who had disclosed their status were in a better position to receive tangible social support in managing to live well despite their condition. Whilst the review makes it possible to understand why HIV disclosure is important in ART adherence, the review was not accommodative of factors such as religious doctrine that may affect one's perceptions of who to disclose to. Secondly, the review was specifically generalized without delving into the specific issues that may affect Christians in disclosing their status within the church. In light of these gaps, the researcher thus sought to fill them in by focusing on the Christian community living with HIV in Gweru urban enrolled at ZNNP+, for clarification on how disclosure within the particular group influenced ART adherence.

This encompassed not only the general provision of care by those offering the support, but also an increased attendance to the person's drug use and adherence to prescribed medications. According to Valle and Levy (2009), disclosure also impacted the manner in which a person living with HIV evaluated thoughts and handled situations of hopelessness on drug use (which are factors to non-adherence), based on the consideration of their social support sphere.

2.3. Faith in God and ART adherence

Spirituality and religion has been cited as having several benefits on Christian lives, especially when it comes to encouraging ART adherence. Bauer (2010) cites a supplement published which was concerned about HIV and AIDS issues, the impact of religion and the way of life of persons living with HIV. In it, 550 participants were asked in one study, to describe spirituality as a determinant of a quality life. A significant number of the respondents were reported to believe

that having God as their source of strength enabled them to cope better with living with HIV. Unfortunately, the study incorporated the concept of spirituality in a general manner, without discrepancies created between particular sects of spiritual groups such as Christian spirituality. For this reason, this research narrowed down to focusing on human spirituality basing on the Christian front.

These respondents were identifiably affiliated with a religious organization for a relatively long time.Another study presented by Bauer (2010) exposes how Christianity as a specific religion, improved the quality of life for catholic PLWHIV through prayer, church attendance, reading of both scripture and other religious literature. Whilst the research was able to bring out vital aspects that help in Christian coping strategies that enhance ART adherence, its scope was confined to not only the Catholic sect of the Christian community, but it also bore contextual differences from those presented in Africa, seeing that the study was conducted in America.

2.3.1. The God who encourages preservation of life

Kananda (2014), a popular South African development worker also shared her views on ART adherence in conference, citing how they are largely determined by a person's thoughts of how God considers their condition. This thought is concluded to be the guiding belief towards how whether one will adhere to ART or not. In her background story, Chriselda Kananda, a mother of two, who was diagnosed with HIV, 14 years into her marriage highlights how her thoughts of an Almighty and loving God, who protects his own at all costs guided her into accepting her condition. Following the acceptance, she related with HIV as an insignificant virus, with no particular capacity to kill her, seeing that she ultimately believed in God as her source of strength.

She testifies to derogating the impact of HIV to destroy her life in comparison to the power of God who she believed to be the keeper of her life. With confidence she states:

> "HIV to me is insignificant compared to the power of my God, to the extent that it has to take on the face of any disease on the planet…For me, taking my ARVs involves me saying to myself, 'I'm treating my body from the flue I can probably contract later on'-*angithi labantwana siyabahlabisa ama polio vaccination bangaz'ukuwuthola umkhuhlane?* [Is it not the case

> with your children when you send them (to the doctor's) for polio vaccination to prevent them from contracting polio in future?]…that's my relationship to ART in my case of HIV" (Kananda, 2014: xx)

In a testimony presented to her church in Cape Town, Chriselda mentions how, for her, living with HIV as a Christian, ART adherence was a consequential means of protecting the life of the body which God had given her. God, according to Kananda (2014) is a supernatural being, who in his capacity to heal, requires his followers to believe that whatever situation that may befall them, they are never to worry about not living through it well, but should rather focus on engaging the methods at their disposal in enhancing the quality of their lives in the physical world.

An example given of practicing not to worry about being diagnosed with HIV and living with the virus as a Christian, involves the taking of medications prescribed, and eating the right foods as well as surrounding oneself with the best understanding company, so as not to default. Chriselda mentions how faith in God was key in enhancing ART adherence. This testimony presents how respective attitudes within the dynamics of Christian faith can positively influence positive adherence of ART by CLWHIV.

However, the side presented by Kananda was contextually relevant to her personal convictions of how she related with God. The researcher appreciates that human perceptions differ and as such, a more holistic approach in understanding experiences of Christians living with HIV was explored to assess whether the view of Kananda could be generalized for all Christians living with HIV within the Gweru Urban area.

2.3.2 The miracle-working God who cures HIV

The gospel of faith healing is described by Kelly (2009) as a teaching by some Christian churches as a means of restoring hope to CLWHIV. The gospel is mostly preached by the African Indigenous Church leaders. In this gospel, HIV is believed to be a manifestation of prevailing evil of the supernatural world, into the natural world, through the infected person's life. Mhlanga (2014) exposes in their research article how God in certain denominations, is believed to be a miracle worker, whose healing power operates instantaneously. The healing power tends to also considered to be highly effectual, (Mambo, 2016). HIV is rendered an

insignificant virus, which God can cast out of any church member's body, basing on their level of faith. Christians living with the virus are often encouraged to believe in the miracle working power of God in totality, as doubt resulted in incomplete or no healing at all. In the radical Pentecostal denominations, being diagnosed with HIV or living with the virus depicts a weak Christian life, filled with little faith in God.

Seeing that within the Zimbabwean context, there is little evidence on how negatively this affects ART adherence, the castigation of such ministrations by the Minister of Health and Child Care in Radio VOP (2014) is suggestive of how CLWHIV may be prone to non-adherence due to teachings of Faith in God within the church.

Figure 2: ***The depiction of the church as a hub where HIV may be cured***

The above picture is a poster advertised on a sidewalk between Eighth and Ninth Street in Gweru City, along Leopold Takawira Avenue. On the far top left, is the inscription "HIV/AIDS Healed", which goes to show how rampant the Gospel of a miracle working God is in the city.

Chivugare (2016) published an article of a testimony by Margaret Mazwi, who confesses to low ART adherence due to pursuing healing from God through Faith. Margaret Mazwi is a mother of

four children who lives in Harare, Zimbabwe. She encountered health problems as from the year 1998, following the birth of a child, who passed on in 5 years. Prior to the child's death, Margaret had been in attendance of a church service where a prophet had predicted the death of the child. Margaret's health continued to deteriorate even after her child's death and was later diagnosed with HIV in 2006.

Despite having been immediately enrolled into ART, Margaret confesses to being in denial of her status and attempted to balance her faith in God as a miracle worker and God as one who had preserved her life through having her introduced to ART. During one of the church services, Margaret disclosed of her status to the congregation and the church pastor convinced her that she had the spirit of a goblin within her, causing her to have the virus. Basing on the former predictions regarding her child's death, Margaret did not second guess the thought. The prophet also informed Margaret of how her faith was the one keeping her alive and healthy, and not the antiretroviral drugs. As such, with enough faith, she could be cleansed of this goblin and be rendered HIV-free.

With these teachings, Margaret lapsed in taking ART, convinced that the concoction presented by the prophet, would heal her. It is thus understood that whilst other CLWHIV may choose to believe God is the giver of ART as HIV suppressing treatment, others may believe in Him as a miracle-working being, who cures them from HIV and either attitudes, affect how CLWHIV adhere to ART.

2.4. Universal factors that affect ART adherence for people living with HIV

With regard to the area enquired upon in this research, Chesney (2000) is cited as a relevant author. She conducted a research in the United States on the factors that affect adherence to ART by persons living with HIV using clinical trials and clinical practice. Principal factors that were identified, included patient factors such as drug and alcohol abuse, dietary restrictions, distance from health-care facilities as well as a patient's belief system. The research clearly generalized that factors that affected any person living with HIV. However, by highlighting the contribution of religious factors-under which Christian faith is incorporated, the researcher found it worth delving deeper into finding out if these factors would remain constant in assessing how adherence was affected by what, for Christians living with the virus.

Weaver, Pane, Wandra, Windiyaningsih, Herlina and Samaan (2014) also conducted a study on factors that influence adherence to ART in the Indonesian Jakarta Urban area. The study was focused on 261 outpatients on the ART program at the hospitals within the area. Logistics regression analyses were made of use within the research, with the results being weighed on the chi square for comparative reasons to responses.

It was concluded that for the Indonesian Jakarta urban population, persons living with HIV relied heavily on social support as a factor that affected how they adhered to their medication. As such, room for further research regarding the extent to which social support and from where social support primarily emerged, was left. The research is operational in understanding how social support is vital in ART adherence, however, it did not clarify whether if the sources of this support differed for people living with HIV, the result of ART being negatively affected by the social sphere PLWHIV surrounded themselves with, would still be concluded on. It is therefore the purpose of this research to find out if factors that affect ART adherence, are universal for both Christians and non-Christians.

2.5. Gender disparities in Spirituality and ART adherence

According to Marshall and Taylor (2006), the issues surrounding HIV and AIDS have always been gendered. In terms of exposure, women are more at risk to contract the virus, than is the case with men. Gender issues are understood to be one of the key factors that drive the response to AIDS in Africa. This is because many a time, there is a power imbalance between men and women and this imbalance is what drives the spread of the virus in heterosexual relationships between the two sexes. The attitudes of the society and the behaviours of both sexes towards each other, help expose these disparities.

2.5.1. Predisposing factors that make women vulnerable to contracting HIV

A key issue faced by the African society in general, the church included in it, is the nature of the relationship of marriage between men and women. Generally, studies have shown that African women aspire to get married and yet, in a paradoxical manner, the marriage setup is the primary reason the women are at risk of contracting the virus. The reasons why this is so is because their husbands may already have been infected with the virus prior to them getting married, or the husbands may infect their wives having contracted the virus from extra-marital sexual

intercourse. Another reason is that men in Africa have a tendency of not practicing safe sex, as is required in these extra-marital affairs. As such, condoms are rarely used for safe sex.

Marshall and Taylor (2006) also cite the gendered nature of HIV and AIDS issues as directly related to the harmful sexual practices that women and girls succumb to within the continent, that predispose them to contracting the virus. Through analysis of data, they concluded on how women in Africa were frequently exposed to practices such as marriage by abduction and widow inheritance, which in their harmfulness bore, not only public health concerns, but also psychological effects on the women experiencing them.

Women's beliefs about their sexual roles were found to contribute to their vulnerability, despite having most practices that increase their risk of infection being spiraled by beliefs about men's sex roles. Girls are brought up to believe that they should seek to satisfy the sexual needs of their husband rather than expect mutual sexual satisfaction. This may result in support for practices such as 'dry sex', and female circumcision. Young women have sexual relationships with older men - 'Sugar Daddies' - who give them presents, while they also have a partner of their own age.

In addition, poverty often forces women into risky sexual relations. The underlying cause of this situation is the way in which women and girls in parts of Africa are socially subordinate to, and economically dependent upon, men. Contemporary non-church culture can endorse the view that men are dominant and are expected to have several partners. Women are expected to be submissive and passive. They are often economically dependent on men and are therefore in a weak position to negotiate about sexual matters, or to challenge extra-marital relationships. Women have little control over whether, where, and how sexual relations take place.

Dube and Kanyoro (2004) hint on anecdotal evidence from South Africa, which suggested that social change and ongoing high levels of poverty and unemployment appear to have a particular effect on the male psyche, which in turn impacts on women's vulnerability to HIV. With a man unable to articulate his masculinity by providing for his family, or having status from a job, he may look even more to demonstrate it through his sexual prowess with multiple, concurrent partners.

The given research areas on the gendered nature of contracting HIV are suggestive of how the attendance of participants in the research is most likely to be gender biased. Also, the responses

of participants are to be gender biased-with females being more outspoken in comparison to the males. In essence, the researcher sought to find out if this was the case in Gweru urban with regards to CLWHIV adherence to ART.

2.5.2. The gendered nature of Spirituality

The relationship between gender and spirituality is one of great interest. Many scholars grasp to understand this interaction. Most agree that women tend to be more religious than men (Hammermeister, Flint, El-Alayli, Ridnour, and Peterson, 2005). However, this could be because of the way religion is defined on typical scales. Bryant (2007:835) defined spirituality as:

> "the process of seeking personal authenticity, genuineness, and wholeness; transcending one's current locus of centricity (i.e., recognizing concerns beyond oneself); developing a greater connectedness to self and others through relationships and community; deriving meaning, purpose, and direction in life; and openness to exploring a relationship with a higher power or powers that transcend human existence and human knowing."

Rich (2012) presents how traditionally, spirituality has been male-focused and involved maturation and a "coming into oneself." However, recent spiritual emphasis has involved coming into relationship, both with God and with the religious community. This emphasis coincides with the female tendency to focus on emotional and relational connectedness, while men may focus more on God's might and judgment when they consider religion.

In his study, Bryant (2007) administered a Cooperative Institutional Research Program (CIRP) Freshman Survey to representative samples of incoming first year college students at 434 colleges and universities. This survey covered multiple topics, including the students' values, activities, attitudes, and self-assessments. Three years later, a subset of the original sample completed a survey, which dealt with spirituality and the effect of college on students' spirituality. The results of this study indicated that women scored higher than men in religiosity (Bryant, 2007).

The gap between women and men on the construct of religious practice was smaller than it was on the construct of religious belief. Thirty five percent of women were committed to religious

belief compared to twenty-seven percent of men. Twenty-two percent of women were committed to religious practice compared to eighteen percent of men. Women were found to have higher spirituality scores.

In line with the HIV epidemic and ART adherence, it can only be assumed that women's ART adherence may be highly influenced by their level of religiosity than is the case with men who have lower spirituality levels. The assumption is made, following the realization that there is little documented evidence of this theory within the field, hence the need of the research to uncover the truth within the theory.

More so, the study generally portrayed how religiosity was higher for females in comparison to males, with no accompanying assessment on the impact the religiosity levels had on human behaviours such as ART adherence. It is a matter of interest to find out in this particular research, the extent in which women's religiosity levels hinted on from Bryant's research, influence behaviours such as ART adherence with respect to the CLWHIV enrolled at ZNNP+ Gweru urban.

2.6. The integration of Christian principles and medical means of managing HIV

Awoyemi (2008) proposes that from a significant part in history, Christianity has remained the one religion that encourages people to preserve their lives in all ways possible. Within the teachings of Jesus inscribed in the bible flows basic scientific concepts which aid in the preservation of human lives. In combating the HIV epidemic, Garner (2000) considers the church as a primary institution for the instilling of a mindset which is appreciative of medical means of treatment, which is ART, amongst members of the congregation. Nussbaum (2005) proposed that churches have been under the misconception that it is the role of scientists to diagnose diseases and the role of the church to help people cope within the adversity of such. Through this ideology, Nussbaum (2005) pushes for the re-allocation of roles between the scientific field and theological field, for optimal preservation of human life.

Ram (1988) pointed out that science has concentrated on healing the bodies of men and with the development of modern psychology, doctors have come to recognize that sickness of the mind can also be treated, amongst other diseases. The spiritual dimension of man is considered difficult for medicine to deal with, since precise measurement of the invisible aspects of spiritual

sickness or health is impossible. However, spiritual illness, preached in churches may be expressed in feelings of emptiness, loneliness, violence, greed, or general meaninglessness of life. These may be indicators of broken relationships with man and with God which cannot be detected in modern medicine. In this regard, the concept of HIV as a spiritual factor is justified. However, with respect to the treatment administered, there is need for both spiritual leaders and scientists to appreciate the dynamics of HIV originality, so as to effectively treat it.

Furthermore, Ram (1988) goes on to mention that:

> “Primary health care is a people's movement. The leaders are ordinary people with human and spiritual values, who can move their communities towards the goal of health and a full life”

The quote exposes how it is necessary to have church leaders engage in public health issues, so as to ensure public health safety for every member of the society. In essence, this approach encourages advocacy within the churches, where religious leaders empower their congregants on the methods in which they may prevent the contraction and spread of the Human Immune Virus.

2.7. Theoretical Framework

The lenses from which the research will be seen are that of the Social Cognitive Theory (SCT). The theory is quoted by Bandura (2001) as one that deals with cognitive, emotional aspects and aspects of behavior for understanding behavioral change. The social cognitive theory explains how people acquire and maintain certain behavioral patterns, while also providing the basis for intervention strategies (Bandura, 1997). Within this framework, it is assumed that evaluating behavioral change depends on the factors environment, people and behavior. These three factors constantly influence each other.

The following diagram shows the interaction between these three factors:

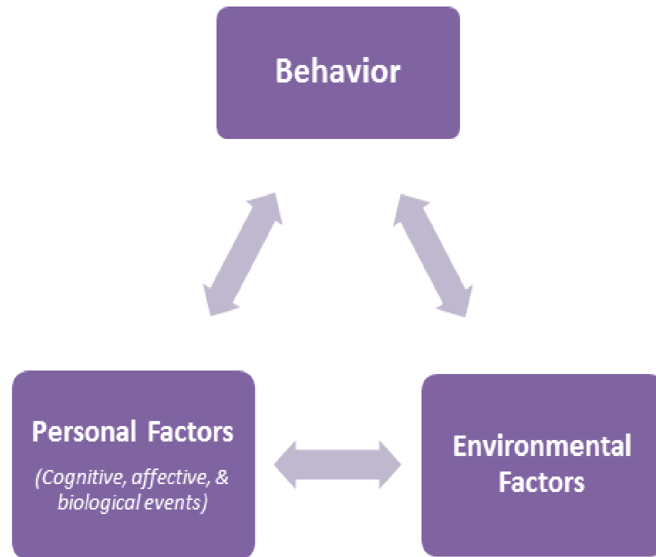

Figure 3: Information flow within the SCT

The environment refers to the factors that can affect a person's behavior within the surrounding context. This may be a social or physical environment. The social environment encompasses ones family members, colleagues and friends, whilst the physical is confined to factors such as the geographical location of one's setting. Bandura (1997) posited that the process of observational learning is governed by four key aspects, which are attention, retention, reproduction, and motivation. According to Wood and Bandura (1989), attention is a process in which people selectively observe and extract information from the ongoing modeled activities. Retention involves a process of transforming and restructuring information in the form of rules and conceptions and the storage of such information into memory. Reproduction is the act of performing the actual behavior that was observed. The fourth aspect concerns motivation which propels the learner to attend to, practice and retain information.

This model helps one understand the reasons why people are motivated to attend religious meetings where Christian faith ministrations are made and why behaviors such as low ART adherence may be consequential. As such, it is operational within the research.

2.8.Knowledge Gap

HIV and AIDS related issues continue to be a public health concern around the globe. Whilst various organizations work tirelessly, thriving towards the elimination of the epidemic, there still

exists barriers to effectively achieving this goal. Notably amongst these, is the impact of Christian religion on ART adherence.

In previous research conducted by Imran, Syed, Mohammad, Kaeshalya and Christopher (2014) on HIV/AIDS patient's perspectives on disease and disclosure in Malaysia, it was found out that religion contributed significantly towards people's management of the virus. Out of an interviewed total of 13 participants, 31 percent communicated how they thought of both virus and syndrome as incurable, though they had hope for healing in the future. The research introduces the need to singularly consider religion as a factor that influences ART adherence by PLWHIV. However, considering the wide scope of religion, the researcher noticed a gap in focusing specifically on Christianity as a religion, seeing that the belief system teachings differs from other forms of religion

With the advent of Christian Pentecostalism dominating the sphere of Christian faith, the impact teachings from this domain on PLWHIV and their adherence to ART remains under-researched in Zimbabwe. Little data regarding the area of research has been presented, hence the gap this study seeks to fill in.

2.9.Chapter Summary

The chapter reviewed given literature in form of a conceptual framework of the Church's view on HIV and AIDS, A theological view of Faith-in-God and HIV disclosure within the church. The manner in which Christians living with HIV balance their faith in God and ART was presented in two standpoints of viewing god, which were cited as believing God as a loving Father who encourages preservation of human life through ART and believing in God as a miracle-worker who cures HIV. Gender disparities in ART adherence were also explored, with citations of how women had predisposing factors to HIV contraction and were more prone to spirituality than men, hence their assumed likelihood of better adhering to ART based on these. The researcher also presented literature on the integration of Christian principles with medical methods of managing HIV. The theoretical framework and knowledge gap were also respectively highlighted.

3. CHAPTER THREE: RESEARCH METHODOLOGY

3.1. Introduction

The current chapter contains the methodology of the study. This includes the research design, sampling method used and also methods of collecting data. Methods of analyzing and presentation of data are also going to be discussed in this chapter. Ethical considerations employed in this study are also going to be discussed as they are significant in the solicitation of data in order for a research to be successful

3.2. Research Paradigm

The research took on a qualitative approach. According to Mertler (2006), a research approach constitutes of a formal plan to conduct an action research study. Creswell (2009) identifies three methods through which a research may be conducted. These being a qualitative, quantitative or mixed methods approach. According to Creswell (2007), a qualitative research allows exploration and understanding the meaning individuals or groups ascribe to a human or social problem. Qualitative research also encompasses the documentation of data from a natural setting, from which it would have been collected (Bogdan and Biklen, 1992). This would mean having gathered data be analysed inductively by the researcher and them making interpretations of the meaning of the data.

With regards to the issue of measuring the extent in which Christian faith impacts ART adherence among PLWHIV, the qualitative paradigm worked best in helping document the testimonials of the infected persons enrolled in the Gweru urban ZNNP+ chapter, following an attendance to focus group discussions held monthly by the organisation. More so, qualitative research was relevant in helping the researcher explore the fairly new phenomena of Christianity impacting ART adherence in Gweru urban, as is characterised in the research paradigm.

3.3. Research Design

The research design applied in the research was exploratory in nature. In carrying out a research, Mertler (2006) points out how a research design helps specify the exact way the research is going to take. In essence, it is the “blueprint” which details how the research is going to be carried out. Wyk (n.d) is of the view that an exploratory design is made of use in research which addresses

high levels of uncertainty regarding prevailing phenomena within a respective environment. At times there may exist a level of ignorance to delve into the respective area. As is in the case of Christianity influencing ART adherence, where little research within Zimbabwe has been presented, the design was found to be handy in contextualising the subject matter.

An advantage of using the exploratory design was that it helped the researcher identify the boundaries in which Christian faith affected ART adherence, as an area which is not usually focused on in research.

3.4. Target Population

A population, in Tuckman (1998)'s viewpoint involves the establishment of boundary conditions that specify who or not is to be included in a respective study. In this case, PLWHIV both on ART and those who have regressed, enrolled in ZNNP+ Gweru aged 18 and above, with a majority subscribing to Christianity as their religion were targeted by the study. The study was accommodative of non-Christians for comparative purposes, so as to measure the extent in which Christian faith would affect adherence. ZNNP+ Gweru Urban has an estimated total of 66 PLWHIV (both male and female) enlisted in their programming area within the 18+years cohort. These therefore formed the basis of the targeted population, from which the sample would be drawn.

3.5. Population Sample

In the study, a single-stage sampling design, defined by Babbie (2007) as one in which the researcher has access to names in the population, was made of use. This was convenient, as there already was a dataset of the 66 target population members enrolled in ZNNP+ Gweru urban. Mertler (2006) poses that a sample is a subset of a population. A sampling procedure will therefore involve the selection of the specific number of participants from the total population, from within which the data gathered may be generalized to represent the whole population. Chiromo (2006) hints on how at times it may be difficult to reach out to the whole population, hence the need for a sample group, whose size is much more manageable and representative enough of the larger group's concerns being researched on.

In selecting the sample participants, the study employed the stratified random sampling technique which is categorised under probability sampling. This helped ensure an equal chance of selection for all participants in the given study (Brian and Makherji, 2005). Stratified random sampling was necessary for the classification of gender, and ensuring that there was a balanced ratio between males and females in the sample, in line with the standard population ratio of 48% males: 52% females stated in the Demographic Health Survey (2015). As such, 20% of the total population (which is an estimated 66 members), were engaged in the research, that is 13 members of the network.

3.6 Research Instrument

A semi-structured interview guide was the data collection tool made of use in this research. Flick (2007) characterises a research instrument as a tool or measuring device that will be used in collection of research data. Cohen and Manion (2007) describe an interview as a two-person enquiry which is used to obtain research related information, following its initiation by an interviewer. Data analysis using this instrument is believed to be simple by Best and Khan (1983), who further stipulate how responses gathered can be easily compared to each other.

The interviews were audio-recorded by the researcher for each participant, with non-verbal cues being observed and noted in the researcher's notebook. During the interview, the researcher probed, in seeking clarification on the impact of Christian faith on ART adherence from respondents. Open ended questions were employed, allowing participants to describe both their perceptions on the influence of their faith on ART adherence, as well as describe their experiences of ART adherence as CLWHIV. The audios were later deleted following the researcher's transcription of the information gathered from the participants.

3.7. Data Collection Procedures

The data collection process was carried out by the researcher, physically. This was convenient in allowing the researcher to interact with respondents directly and more intimately. Data collection coincided with the selected participants' monthly support group meetings, which made them easily accessible at a venue they were already comfortable in. data was collected on two consecutive days with the interviews starting off at mid-morning 10am and stretching into mid-afternoon, that is at 3pm. Data was collected at Mkoba 4, 5 and 9, at two support group leader's

houses where the participants often meet for their meetings. Communication with the support group leaders had been previously done, with the researcher being allowed to come during and conduct the interviews between 10am and 3pm, leaving an hour before the convening of the support group's monthly meetings at 4pm on both days.

Prior to the collection of data, clearance was sought from ZNNP+ Gweru, to allow use of the information for the purposes of this research and as a pre-test study of the effectiveness of the interview guide, 4 participants (2 males and 2 females) who were not a part of the final group of participants were engaged. The original guide consisted of 14 questions, with some later removed as they were found to be repetitive in enquiry and responses given.

Interviews were conducted in Ndebele and Shona and were later transcribed into English for presentation. The calculation and measurement of self-reported adherence for participants followed the guideline on ART, presented in the following table:

MISSED DOSES	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	<15
ADHERENCE %	100	98	97	95	93	92	90	88	87	85	83	82	80	78	77	75	>75

Figure 4: Adherence Measurement Scale

As such, the formula for calculating adherence entailed equating a 30 day supply of ARVs multiplied by the two lines totalling 60 doses, multiplied by 100. The taking of all 60 doses correctly, consistently this resulted in 100% ART adherence. Self-reports on adherence persons living with HIV in participation were taken into account in rating the adherence levels.

3.8. Ethical Considerations

Sternberg (2004) defines ethical considerations as a set of moral principles which are proposed by an individual or groups and are consequently widely accepted, and suggest behavioral expectations and rules about the most correct conduct towards respondents and tentative subjects The Zimbabwe National Network of PLWHIV (ZNNP+) were approached for approval to conduct the research. Participants' consent with room to withdraw from the research at any given time, should they feel like, was enforced. Shared confidentiality with participants was

maintained and no names were openly disclosed in the interviews. Participants were encouraged to formulate pseudo names which would be referred to during the interview.

All completed demographic information was destroyed after the analysis and data presentation to ensure maintenance of confidentiality. Participants were informed of the process of the research and information made available to those immediately involved in the research.

3.9. Data Presentation and Analysis Procedures

According to Sternberg (2004), data analysis is a method of transforming, inspecting, cleaning and modeling data with the objective of discerning useful information, proposing conclusions, and supporting decision-making. Tesch (1990) is of the view that data analysis is significant as it discovers patterns and relationships in the data collected. Consequently, data analysis was a significant part of the research because it constituted the basis of the information from which conclusions were drawn.

In the study, the researcher used content as well as thematic analysis in the relevant parts directed towards answering the research questions presented in the interviews. According to Creswell (2007), content analysis is a standard technique for the analysis of data that comes from several sources oscillating from textual material, interviews, pictures and video materials and questionnaires. Demographic data collected on respondents was transcribed and presented in a tabulated manner.

The translation of interviews was facilitated and the data presented in continuous prose. Thematic Analysis was engaged in reporting on the information gathered ranging from CLWHIV's beliefs on ART adherence, Motivators and De-motivators in Christian teachings to ART adherence as well the views on developmental worker's strategy for integration of Christian faith in biomedical HIV treatments. Thematic Analysis involves the analysis of data in qualitative research, which bases on recording themes within given sets of data following probing and identification of these, Tashakkori and Teddlie (2003).

Saunders, Lewis and Thornhill (2007) stated that themes are patterns across data sets that are imperative to the description of phenomenon and are supplementary to a specific research question. Patterns are identified through a process of data familiarization, theme development

and revision. In the study, the researcher implied thematic analysis of data by examining themes that emerged during the conduct of the study. Thematic analysis is a reliable data analysis method as it ensembles questions interrelated to peoples' experiences, perceptions and views and it can be used in diverse theoretical frameworks.

3.10. Chapter Summary

The current chapter contained the methodology of the study. This included the research design, sampling method used and also methods of collecting data. Methods of analyzing and presentation of data were also discussed in this chapter. Ethical considerations employed in this study were discussed as they are significant in the solicitation of data in order for a research to be successful.

4. CHAPTER FOUR: DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1. Introduction

This chapter focuses on the presentation, analysis and interpretation of data. The purpose of this study was to assess the influence of Christian faith on ART adherence by persons living with HIV in Gweru urban, enrolled in the Zimbabwe National Network of People living with HIV. Data was collected through a semi structured interview guide, which was conducted to both Christians and non-Christians. Responses are summarized on given tables. For questions on the influence of Christian faith on adherence to ART, data is presented under themes, which are answers to the research questions. The emerging sub-themes which emanated from interview questions are presented as direct quotes.

4.2. Section A: Participant demographics

4.2.1. Religious Affiliation

Of the 13 participants, who were interviewed in the research, 38%, that is 5 participants, were non- Christians and did not indicate affiliation with any other religion. 62% of the participants were Christians affiliated to various religious organizations within Gweru. This data goes to show how the research was more inclined to understanding the Christian perspective of ART adherence, than generally understanding how adherence was for persons living with HIV.

The churches listed in which the Christian participants attended services are as follows:

Table 4.2.1, showing participants by church affiliation

Church name	**Number**
Seventh Day Adventist	1
Apostolic Faith Mission	1
Zimbabwe Assemblies Of God Association	1
Prophetic Healing and Deliverance Ministries	1
United Family In Christ	1
Masowe	2
New Apostolic	1
Total	**8**

It is made notable how the majority of respondents were affiliated with the African Religious Churches, with only 13% of the Christian population attending services at a mainline church (the SDA church). This implies the likelihood of responses being aligned to the churches' predominant message of God being a healer of HIV, hence negative ART adherence.

4.2.2. Gender

The research was composed of the following information:

Table 4.2.2 showing participants by gender classification

SEX	**RESPONDENTS**	%
FEMALES	9	**69**
MALES	4	**31**
TOTAL	13	100

The majority of the respondents were female. Males constituted of a lesser percentage, which implies how the research bears an imbalanced presentation of the responses between the two on perceptions regarding the impact of Christian faith on ART adherence.

4.2.3. Age

Table 4.2.3a, revealing the various age classification for Christian participants

age	**No**
18-25	1
26-35	3
36-45	3
46-55	0
56-65	1
Total	**8**

The above table shows the total number of Christians living with HIV, with respect to their various age-groups. The age range of 26 years to 35 and 36 years to 45 years have a similar total of 38%, which implies the dominant ages in which compliance to Christian teaching is most dominant.

Table 4.2.3b, revealing the age classification for non-Christian participants

age	**No**
18-25	1
26-35	2
36-45	1
46-55	1
56-65	
Total	**5**

Table 4.2.3b shows the age range for the non-Christian population. The 26-35 age range bore a total of 40% representation. This was helpful in the comparison for ART adherence differences between the respective group of participants and that of Christian participants.

4.2.4. Level of Education

The level of education section results comprised of 9 participants who had completed their Ordinary level cycle of education, 2 participants who had reached Advanced level education and 2 participants who had managed to reach tertiary level. This is as presented in the table below:

Table 4.2.4 showing Participant's level of education

Level of Education	**No**	**%**
O'Level	9	69
A'Level	2	15.5
Higher Education	2	15.5
TOTAL	**13**	**100**

This information is an indication of the literacy levels of the participants in the study and also implied how capable the participants were of identifying the instances of non-adherence, or enhanced adherence as influenced by their belief system, without much probing for clarity.

4.2.5. When ART was started

YEAR	No	%
2009	5	38
2011	2	15.5
2013	2	15.5
2015	2	15.5
2016	2	15.5
TOTAL	**13**	**100**

Table 4.2.5 showing participants by their dates of commencing ART

The date of commencing ART was enquired upon to understand how an individual's maturation in terms of years influenced their adherence to ART. As such, it was implied that the longer the years of taking ART, the better the adherence to ART, despite exposure to Christian faith doctrine.

4.2.6. Employment status

Of the total participants (13), 7, that is 54% indicated that they were self-employed. 4, (31%) indicated that they were not employed at all and 2, that is 15% communicated that they were formerly employed on a contract basis with one as a shop assistant and another as a till operator. This revealed the vulnerability of the population of persons living with HIV, which bore the likelihood of them being receptive of Christian faith teachings that were most likely to give them pseudo hope of having the virus eliminated from their bodies.

THEMATIC PRESENTATION OF FINDINGS

4.3. Section B: Participant Knowledge on ART

This section of the interview guide was structured to give a basis for comparing the responses of both Christian and non-Christian participants, in assessment of the significance of Christian faith

on ART adherence. The section also helped the researcher majorly respond to the research question: Do the factors that affect Christian adherence to ART vary from those that affect non-Christians? The following themes were derived from participants' responses to the questions in this section:

4.3.1. Knowledge of ART influences adherence

When asked what they knew about ART, the participants demonstrated how it encompassed eating the right foods, being around a supportive social structure as well as taking medication at the right time all the time. 2 participants commented on how following this structure of ART was important in adherence, so as to avoid defaulting. One further went to explain the disadvantages of not having enough knowledge by reflecting on her own experiences saying,

> *"When I started ART, I knew I would have to take the medication every day, but it had not been emphasized how important it was to take the medication at the same time. So for the first 8 months having been initiated on ART I took my medication at any time I remembered to do so, and justified it by saying I still was able to adhere to ART. Little did I know I was on the verge of defaulting. By the time I went into the ninth month, the HIV was now resistant to my medication and had to be initiated on the second line of treatment."*

Both Christians and non-Christians concurred that without the right knowledge on how to adhere to ART, and the general knowledge on what ART is, it was difficult to adhere to the therapy.

4.3.2. Drug side-effects influence non-adherence

All participants, after being asked about the disadvantages of being on ART and how the drugs made them feel, cited how the side effects of the drugs they were taking were unpleasant, which sometimes demotivated them from taking the medication right. When asked what these side effects were, participants highlighted drowsiness, terrifying hallucinations, swelling of feet or sharp pains under the feet which often disabled their upper motor capabilities.

9 participants (69%) who had commenced ART between the years 2009 and 2013, further commented on the side effects of the medication they were enrolled into when they first got diagnosed of HIV, stating how it had distorted their body shapes by adding extra weight in

places such as their neck backs and leg-calfs. A participant, who had been moved by the side effects, shared their story:

> *"After I started noticing how my body was changing-developing this thick neck and thick legs, thinning skin, I stopped taking the medication for a while, because I did not my body to show that I was on ART…Back then if your body changed, people judged you intensely and the stigma never ended and I just did not want that to happen to me."*

Another participant added to the theme by sharing:

> *"The pills often make me drowsy and whenever I take them, I have to ensure that I am in an environment conducive enough for me to sleep immediately. It is only fortunate that nowadays we only get to take the pill once a day. When it was two pills a day, I used to avoid taking one in the early morning because it would be difficult for me to engage in my day-to-day activities with the drowsiness-I am a married man, and am self-employed. If I do not work for the family, no one will and I cannot allow my status to affect how I do so."*

As a follow-up question, the participants were asked how many times they had missed taking ART because of being demotivated by the side-effects and the following results were drawn:

Table 4.3.2 exposing participants response to question 4

Question 4 probe	Once	Twice	Thrice	4 times	Over 5 times
How many times did you miss taking your medication because of the side effects?	1	1	3	1	7

54% of the participants indicated having missed taking ART within the same month over 5 times, which according to the adherence measurement scale in page 27 relates to a total of 92% adherence and below. Recommended adherence at any given point is 100% and anything below

that is a cause for concern, as such, adherence is considered low for persons living with HIV due to drug side effects.

4.3.3 Sero-status acceptance helps determines ART adherence

Both Christian and non-Christian participants were asked to describe how they found out about their HIV status and how difficult their knowledge of their status influenced how they took their medication. 92 % (12) of the participants related their diagnosis to a series of illnesses that had them hospitalized on several occasions at the hospital. Upon hospitalization, that is when tests were done and they were notified of their status. Of the 12 participants, 11, that are 92%, stated that it was hard to appreciate their status, as they thought they would die soon. The disbelief made it difficult for them to take their medication within the first year of ART initiation. The remaining participant who had also discovered their status after being hospitalized hinted the following:

> *"My husband and I were a sero-discordant couple from the onset. I was HIV negative and he was positive. On several occasions we had tried for a baby without going to the clinic for a check on viral load and that is how I contracted the virus from him. When I became ill and was told I had HIV, I was not bitter, because I already knew there was likelihood I could contract the virus from him at some point. I gladly accepted my status and it was easy for me to take my medication because I knew I had a partner who was comfortable with my status and would encourage me to do so as well."*

As such, adhering to ART was less straining for this participant as compared to the others who had difficulties in accepting their status.

The participant who was never hospitalized discovered they were HIV positive after being sent on a mandatory HIV test by a healthcare worker, prior to the birth of their child. She confesses to being suicidal after the diagnosis, seeing that she had contracted both pregnancy and the virus from an uncle who had continuously raped her. She states,

> *"I did not care about the pills that were being administered to me then. All I wanted to do was die. Here I was, raped and HIV positive. How better could my*

life ever get? I stayed without taking them, till I got very ill and almost got the death I wanted."

Failure to accept their status led to non-adherence for both Christians and non-Christians as was gathered in the research.

4.3.4. Service provision by care facilitators motivates or demotivates ART adherence

In question 1 and 11, the participants were asked to describe how they found the providers of the Network, how strict they were on adherence and what measures they had in place in ensuring optimal adherence amongst all members. All participants communicated that the network was strict to a point that they regularly followed up on member medication schedules within the clinics where they collected their medication and also held monthly workshops with the members to encourage adherence. All the participants concurred to the idea raised by one member that if it was not for the organization that encouraged adherence in its strictness, they would have probably defaulted from taking their medication a long time ago. This was seconded by participants, basing on a highlight given on how at times daily hassles where stigma is revealed by members of society easily discourages people to take their medication. As such, the care of service providers determined whether they would adhere to ART or not.

4.4 Section C: Living with HIV as a Christian

In this section, the researcher sought to understand the specific details that motivated or demotivated Christians from adhering to ART as persons living with HIV. The following themes were derived from this section:

4.4.1. Church doctrine influences ART adherence

Regarding the enquiry made into how the message in the participant's respective churches influenced how they take ART, 8 (100%) of the Christians demonstrated that in some way the message had impacted how they later took their medication. This influence was either negative or positive as illustrated by one participant attending services at PHD ministries who said:

"At times in church, the preacher teaches about how sickness was never a part of God's plan and I go back home with the intent to exercise my faith hoping for healing and neglect to take my medication"

Another participant attending services at the Seventh Day Adventist church stated how at their church, their message was usually filled with encouragement for life and due to the belief that God cared for them despite their sickness, they looked to ART as God's way of healing them and preserving their life, hence their adherence to the medication. This could imply that the church's message influences ART adherence.

4.4.2. Church doctrine influences disclosure

Concerning the question on whether or not Christian participants had disclosed their status to other church members, 7 (87.5%) indicated that they had and 1 (12.5%) said they had not. When asked what motivated them to either disclose or non-disclosure, participants cited how they had made an assessment of the church's response based on the message they teach. The participant who had not disclosed in their church said:

"I chose not to disclose to other church members because of the way they would judge me. You know at times from the message and teachings given, you just know where the church stands on certain issues."

This could imply how church doctrine also influence disclosure, which in turn impacts ART adherence.

4.4.3 Personal convictions of faith influence ART adherence.

Having been asked to describe how their relationship with God was before and after diagnosis with the virus all Christian participants (8 that is 100%) indicated that they felt closer to him than before. One further illustrates this by stating:

"Now I understand and appreciate him in my life better than before. I believe he is the preserver of life and he has been doing that for me. A lot of people died because of the virus and till today I live and every day I am grateful to

God for giving scientists the thought to make ARVs…My faith is renewed because of this."

This could imply how a personal conviction of who God is, influences motivations that guide ART adherence for Christians living with HIV.

4.4.4. Gender differences to spiritual coping impact ART adherence

Regarding the question on whether the message of the church influenced how participants take their medication, all (100%) 6 female Christian participants indicated that spiritual coping had contributed to them taking their medication. One particular respondent said:

> *"Having my faith as a shield helped me to cope better with life and accepting my status and because of this; I am always reminded to adhere to my medication, seeing that it is my only hope for life at the moment."*

The 2 male participants indicated that for them, ART adherence could not be necessarily attributed to their faith or the message being taught in the church. They cited how for them it was mainly influenced by intrinsic hope for a better tomorrow, which did not necessarily emerge from their belief system. This therefore implies that women are most likely to attribute their ability to cope with HIV and adherence to ART to the faith that empowers them, unlike the males.

4.4.5. Integration of scientific healing methods in the church is dependent on a church's mindset

Regarding the question on how medical means of healing could be embraced in the church, 100% of the participants concurred that the church needed to be willing to embrace these scientific methods as functional within the body of Christ and necessary for people in the greater society, all which they were a part. This is illustrated by one of the participants who said:

> *"It is necessary that people believe in modern medicine everywhere-even in the church, such as the drugs we are taking to suppress viral load. Without the mindset that appreciates God's effort to heal people through scientific means,*

churches will always be the place where people get conflicting thoughts for healing."

From this response, it is implied how the church's perceptions of scientific healing methods form the basis of the doctrine that is going to be later taught to members, as well the attitudes churches are going to have on persons living with HIV, which may later affect how they adhere to their medication.

4.5. Conclusion

This chapter focused on the presentation, analysis and interpretation of data. The purpose of this study was to assess the influence of Christian faith on ART adherence by persons living with HIV in Gweru urban, enrolled in the Zimbabwe National Network of People living with HIV. Data was collected through a semi structured interview guide, which was conducted to both Christians and non-Christians. Responses were summarized on given tables. For questions on the influence of Christian faith on adherence to ART, data was presented under themes, which were answers to the research questions. The emerging sub-themes which emanated from interview questions were presented as direct quotes.

5. CHAPTER FIVE: DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

The chapter comprises of the conclusions the researcher made regarding the influence of Christian faith on ART adherence for Christians living with HIV in Gweru urban enrolled in the Zimbabwe National Network for Persons Living with HIV, within the district. The chapter proffers recommendations to policy makers on how to curb the negative impact Christian faith has on ART adherence in Gweru urban. Room for further research is cited following a summary of a discussion of the research findings.

5.2. Discussion of findings

This section discusses the finding presented in the previous chapter and how they relate to the previous research presented as relevant literature as well as the given research questions. The discussion incorporates how Christians living with HIV balance their faith in God and ART adherence, gender disparities to spirituality and ART adherence, as well as the ways of integrating Christian doctrine with medical means of managing HIV.

5.2.1. How Christians living with HIV balance their faith in God and ART adherence

From the research it was found out that Christians living with HIV tend to experience difficulties in balancing their faith with ART adherence during the first two years of ART initiation. With time, however the difficulties subside and focus is redirected to being able to live to see the next day. This is mostly influenced by factors such as disclosure to other church members and one's acceptance of their status as the years accumulate.

The belief in Christian doctrine often encouraged Christians living with HIV to comply to taking their medication at the prescribed times well. These findings concur with the topical presentation given by Kananda (2014) regarding how the convictions held by people about the existence of a loving God who wants life to be preserved by all means, motivates people living with HIV to live right. As part of living right, CLWHIV thus incorporate ART adherence as part of their strategies of ensuring that their lives are preserved for longer. It is to be noted, however, that Kananda in her observations had left out an analysis of how the message of healing taught in some Christian denominations posed as a motivational factor for non-adherence. This is what

was uncovered in this research and the particular persons living with HIV, whose adherence was found to be intensely affected included those recently initiated on the ART program, who have not fully accepted their sero-status and have not enough information about the benefits of taking their medication right, at the prescribed times.

More so, the research findings showed that whilst the message in the church may impact the motivations to adhere to ART, a larger population of people who were well empowered on what ART is, adhered better to their medication than those who lacked sufficient information on ART. The lack of information was also attributed to the number of years of having taking ART, seeing that all participants who had matured in taking ART reported better adherence in the present than those who had been initiated on the program in slightly over two years. The participants who had been initiated on ART in slightly over two years reported how they were still moved by the church doctrine and this had sometimes influenced them to consider not taking their medication.

These findings justify why there was need to the Minister of Health and Child care in RadioVOP (2014) to castigate the teachings of certain religious leaders, citing how they bore a likelihood of influencing non-adherence amongst people living with the virus. It is made clear from the research that the castigation was not to be generalized for all persons living with HIV as formerly implied, but rather the persons recently diagnosed with the virus, who may be encountering challenges in accepting their status and the new way of life.

Issues of HIV disclosure within one's church posed as factors that threatened proper adherence to treatment for people living with HIV. The participants raised how the church's response to their status served as either a motivational or de-motivational factor for them to adhere to ART. Generally, all participants communicated the need of disclosing their HIV status to the church, for reasons that ranged from creating a trail for them to be exempted from other church activities that had the likelihood of harming their adherence cycle.

5.2.2. The Universality of Factors that affect Art adherence for Christians and Non-Christians

Amongst the findings in the research, was how there existed general factors that affected ART adherence for both Christians and non-Christians in a similar manner. One such factor that was given participants was that of non-adherence spiraled by the side effects of the drugs being taken.

This finding was found to be related to the study Chesney (2000) made on the factors that affected adherence to ART in the United States of America. In the study, Chesney concluded that inconvenient dosing frequency, dietary restrictions, pill burden, and side effects, were patient factors that affect adherence to ART. This was confirmed in the research, upon comparing the extent to which factors that affected ART adherence were universal for both Christians and non-Christians.

5.2.3. Gender disparities to Spirituality and ART adherence

From the research, gender dynamics to ART adherence and Christianity were observed. Women, who took to Christian principles as their major source of hope, adhered better to ART in comparison to the males who were non-Christian. In comparison to the Christian males, women who were more spiritually inclined presented more intense motivations to taking ART and adhering to their medication. The Christian males whose focus was less redirected to their basis of faith were found to have had more encounters of non-adherence than the females.

The findings were similar to the study presented by Marshall and Taylor (2006) which concluded on how the issues of HIV and AIDS were gendered within the church, with reference to the nature of marriage. On the other hand, where Marshall and Taylor (2006) focused on the general aspect of pointing out the gender imbalance that was existent in the society, the research clarified on how this gendered nature to spirituality impacted ART adherence for both sexes.

5.2.4 Ways of integrating Christian principles with medical means of managing HIV

The research sought to find out the various ways in which ART adherence could be encouraged within the church, with preachers positively influencing ART adherence through the message and doctrine taught within the church. From the findings, it was presented by all participants that the drive for the integrative strategy was the mindset church leaders had towards HIV and AIDS issues. According to the participants, if church leaders led the way in being accommodative of scientific methods of healing without necessarily nullifying their relevance in comparison to God’s healing power, not only would it be easy to ensure an integrated function of both Spiritual and scientific methods of healing within the church, but also, would there be a reduction in HIV related stigma within the church (a factor which negatively affects the adherence of Christians living with HIV in various church denominations).

These findings were in agreement with the study presented by Trinitapoli (2006) which explored the role religion played in HIV transmission, by focusing on the place of religious organizations in shaping the HIV risk behavior of individual congregants. Through analysis of data regarding the church's response presented in rural Malawi, she concluded that that congregations in rural Malawi were responding to AIDS-related issues by participating in activities like caring for the sick, sponsoring AIDS education programs for youth, and emphasizing the care of orphans as a religious responsibility. Where Trinitapoli focused on the church's action-response, the researcher exposed how these actions could only come to existence, if the church had a mindset that was willing to embrace people living with HIV and help care for them.

Looking back at the Social Cognitive theory-the lens from which this research was seen, Bandura (1997) makes it understandable how with a mindset that is willing to embrace change, church leaders will frame an operational system of environmental factors for persons living with HIV, that enable them to look to personal factors which may positively influence ART adherence as a key result behaviour.

5.3. Conclusions

The research was an assessment of how Christian faith influences ART adherence for Christians living with HIV enrolled in ZNNP+ Gweru urban chapter. It primarily focused on adult persons living with HIV residing in Gweru urban in attendance of church services in various denominations within the city. The study involved non-Christian participants who provided a comparative analysis on whether Christian faith actually impacted ART adherence. It was found that generally, both sets of participants concurred to certain factors that affected their adherence, such as the side effects of the drugs. However, the Christian participants further enunciated the influence of the messages of faith being taught in their respective churches, stating how the teachings had either motivated their adherence to ART.

ART adherence by Christians living with HIV in Gweru urban enrolled in the Zimbabwe National Network of People Living with HIV is positively impacted by Christian faith. This is seen in how Christian doctrine largely frames the scope in which people are able to cope with living with the virus, disclose of the status to other people and be intrinsically motivated to take

their medication as prescribed, all which are factors that are required for proper adherence to occur.

It is to be noted that the positive influence Christian faith has on ART adherence for people living with HIV follows a course that encompasses a victim's knowledge of ART, and an unwavering belief in God as the protector of life, who encourages ART adherence, through gifting scientists with knowledge on how to develop HIV medication packaged as anti-retroviral therapy.

There are differences to ART adherence between males and females, basing on their level of Christianity and attendance to Christian faith doctrine. More so, to effectively shape the course of how churches may embrace medicinal methods of managing ART, there is need for religious leaders to change their negative thoughts on how HIV comes into existence within the church, so as to give teachings that are accommodative of people living with the virus within the church.

5.4. Recommendations

The Ministry of Health and Child Care Gweru, is recommended to intensify its methods of delivering sufficient information to persons newly initiated on ART, followed by regular follow-ups on defaulting persons within their databases. This will serve to tighten the gap on adherence for persons living with HIV, seeing that a significant number of the population are led to non-adherence based on their lack of sufficient knowledge on ART.

Behaviour Change programs relating to HIV and AIDS issues and stigma within the communities should be held by development workers and are to incorporate church leaders form various denominations. This is to be done to enlighten church leaders on the negative impact their message has on persons newly initiated on the ART program, and to encourage them to be more mindful of the negative impact their messages have on ART adherence of the respective populations.

Christians already living with the virus are recommended to be forthcoming about their experiences in living with the virus, in the church, so as to encourage persons newly diagnosed with HIV within the churches not to default. In continuing the cycle of awareness, the stigma and

the negativity in church doctrine may be overlooked, with focus being redirected to ensuring the livelihood of all humanity within the church, primarily and the society at large.

5.5. Recommendations for Further Research

This research was primarily inclined towards the qualitative approach in assessing the influence of Christian faith on ART adherence. As further research, it is encouraged that the quantitative approach be incorporated in measuring the same phenomena.

The research also focused only on Gweru urban residents enrolled in the ART program. It would be necessary that the study be extended at national level, in assessment of ART adherence and how it is influenced by Christian faith

In addition, further research could be implemented in assessing the extent in which other religions other than Christianity solely influence ART adherence for persons living with HIV. Studies have primarily focused on how the broad concept of religion shapes people's behaviours, which include ART adherence. It is encouraged that the subsets that consist of religion be singlehandedly assessed on their respective impact on such behaviours.

Adherence to ART by participants was also measured through participant's self-reports which were subject to bias. As such, further research could be engaged in measuring adherence using other clinical means such as pill count and patient medical record review.

Interventions to address non-adherence also could focus on other factors that affect adherence, other than the influence of Christian faith.

5.6. Summary of Chapters

In this chapter, the researcher discussed the findings in reference to given literature and the given theoretical framework, made conclusions and gave recommendations that would guide the Ministry of Health and Child Care, development workers as well as persons living with HIV in attendance of religious ceremonies in their varying denominations.

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APPENDICES

APPENDIX A:RESEARCH INSTRUMENT

INTERVIEW GUIDE FOR PLWHIV ON ART

Section A: Personal information

Age :

Sex:

Church Affiliation :

When did you start ART? :

Level of Education:

Employment status:

Section B: Participant Knowledge of ART

1.. **How did you hear about ZNNP+?**

(Probes: What encouraged you to register with the network?)

2. **What do you know about ART?**

(Probes: Why is it important to take the antiretroviral drugs at the same time every day? What happens to the HIV-virus when you start taking ART?)

3. **What are some of the advantages of being on ART?**

(Probes: Has your health improved? If yes, what impact has that had on your life?)

4. **What are some of the disadvantages of being on ART?**

(Probes: What side effects have you experienced? How severe has these side effects been? How many times did you miss taking your medication in avoidance of these side effects?)

5. **What type of drugs are you currently taking and how often do you take them?**

(Probes: When do you usually take them? How do you remember to take them? Have you ever change the drugs you are taking? If yes, why?

6. **How sick were you before you started ART?**

(How long have you have been sick before you started ART? What was your CD4 count when you started ART? What is it now?

7. **How did you find out about your HIV- status?**

(Probe: Was your partner sick? Did you suspect you had HIV before you went to the doctor?)

Section C: Living with HIV as a Christian

8. **Have you ever disclosed your status to other church members?**

(What was their response? Have they been supportive?)

9. **How has your relationship with God been like, since you got diagnosed with the virus?**

(Describe how you relate with Him now and how you related with Him before the diagnosis)

10. **How does the message being taught in your church influence how you take ART?**

(How encouraging are they when it comes to teaching on scientific means of managing the virus? How possible is it to take ART and also believe in God?)

11. **How do you find providers at ZNNP+?**

(How strict are they with adherence? What happens to you if you do not adhere to your drugs? How is the provider's attitude to people with HIV and AIDS? How do the providers help you with your adherence to ART?)

12. **How do you think medical methods of healing can be embraced in the church?**

(Probes: How best can preachers in churches embrace the reality of HIV? How would you encourage someone in the church who has been recently diagnosed with the virus and is finding it hard to balance between taking their medication and believing in God for a healing miracle?)

APPENDIX B: PARTICIPANT CONSENT FORM

RESEARCH CONSENT FORM

ASSESSMENT OF THE INFLUENCE OF CHRISTIAN FAITH ON ART ADHERENCE

Dear Mr, Mrs, Ms, Miss

I am Sibongile Moyo, student at the Midlands State University. I am currently conducting research on HIV and AIDS:

Assessing the influence of Christian faith on ART adherence. This study is in partial fulfillment of my Bachelor of Science Degree in Psychology. You have been selected as a respondent in this study. The information collected from you will be kept confidential.

Participation is voluntary. Kindly tick with a cross(**X**) if you are willing to participate. Would you like to participate?

YES

NO

SIGN…………………………….

DATE……………………………

SIBONGILE MOYO

APPENDIX C: LETTER FROM ORGANISATION

APPENDIX C : LETTER FROM ORGANISATION

ZNNP+ Midlands Province

9051 Gym Kanna Grounds

Gweru

tel:(054) 220 543

11 April 2018

The Chairperson, MSU Psychology Department

RE: CONFIRMATION OF RESEARCH DATA COLLECTION APPROVAL FOR SIBONGILE MOYO

This letter serves to inform you that Sibongile Moyo was allowed to conduct her research in assessing the influence of Christian faith on ART adherence by members enrolled in the Network.

She was assisted with the respective information and resources required upon request throughout her data collection period.

Yours faithfully,

F. Mukuze (Programs Coordinator)

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APPENDIX D: DATA COLLECTION LETTER

Midlands State University

Established 2000

P BAG 9055
GWERU

Telephone: (263) 54 260404 ext 2156
Fax: (263) 54 260233/260311

FACULTY OF SOCIAL SCIENCES
DEPARTMENT OF PSYCHOLOGY

Date: 05 03 2018

To whom it may concern

Dear Sir/Madam

RE: REQUEST FOR ASSISTANCE WITH DISSERTATION INFORMATION
FOR: Sibongile Moyo (R14635??)
BACHELOR OF PSYCHOLOGY HONOURS DEGREE

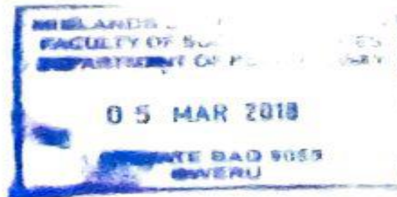
This letter serves to introduce to you the above-named student, who is studying for a Psychology Honours Degree and is in his/her 4th year. All Midlands State University students are required to do research in their 4th year of study. We therefore, kindly request your organisation to assist him/her with any information that she/he requires.

Topic: An assessment of the influence of Christian faith on ART adherence of Christians living with HIV enrolled at ZNNP+ Gweru [illegible]

For more information regarding the above, feel free to contact the undersigned.

Yours faithfully

N. Ncube
Chairperson



APPENDIX E: AUDIT SHEET

MIDLANDS STATE UNIVERSITY

SUPERVISOR- STUDENT AUDIT SHEET

DATE	TOPIC DISCUSSED	COMMENT	STUDENT'S SIGNATURE	SUPERVISOR'S SIGNATURE

STUDENT'S SIGNATURE ……………………………………………………………..

SUPERVISOR'S SIGNATURE …………………………………………………………

APPENDIX F: TURNITIN REPORT

MSU E-learning | Turnitin | Feedback Stud

https://ev.turnitin.com/app/carta/

Sibongile Moyo | dissertation draft

Match Overview

8%

#	Source	Type	%
1	digitalcommons.liberty...	Internet Source	2%
2	scholar.sun.ac.za	Internet Source	2%
3	www.e-alliance.ch	Internet Source	2%
4	Submitted to Midlands ...	Student Paper	1%
5	www.who.int	Internet Source	1%
6	Angela Kelly. "The Body...	Publication	1%
7	apps.who.int	Internet Source	1%