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Perceptions of HIV-Positive Patients Towards Faith-Based Community Support in a Rural Setting

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Abstract

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Studies have demonstrated different perspectives on faith-based organizations (FBOs). Various quantitative studies have been performed for many years; however, there is minimal qualitative research literature investigating the phenomenon of attitudes of HIV-positive patients in a faith-based structure. The purpose of this study was to examine the lived experiences of a sample of 7 participants aged 18-65 from rural areas of a southern U.S. state who have lived with HIV and have sought community support. The focus was on various interventions by rural religious community support programs. Patients' perceptions and experiences regarding the possible improvement of their quality of life were also studied and investigated. Social cognitive theory served as the theoretical framework. The overarching research question involved understanding how participants make meaning of their experiences with HIV and community support in the context of their faith in God. Data were collected using in-depth, structured face-to-face interviews. This data and themes were coded and developed utilizing the NVivo software. Results indicated that FBOs are reliable for social and healthcare services among HIV-positive African Americans. However, several loopholes stopped many from using the services: stigma, racial discrimination, and sexual discrimination towards LGBTQ patients. Implications for positive social change include recommendations for increased funding to FBOs, promotion of awareness by employing champions of HIV/AIDS who are health workers, further health worker education, and increased awareness that can help lead to the eradication of racial inequality.

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Dedication

I dedicate my dissertation to my entire family and many friends. A special feeling of gratitude to my loving mother, Teela Rollins; special brothers, Dakota Walker and Ruperto Estrada; sisters Shenita Colson, Belinda Vaughters, Vincia B. Miller, Bobby Smith, Ruby Pearson, Gervonne Carter, Jennifer Harmon, Jana Nance, and Rev. Michael D. McClellan, whose words of encouragement and push for tenacity ring in ears. The Estrada and the Jackson families have always inquired about my very special progressions. This dissertation's dedication is also to my deceased family members: Dorris P. Rollins, Rev. John H Partee, John B Long, Saundra M. Rollins, Jean Kpan, Sandra Lowery-Rucker, and Marcy Hester-Wiggins, and teacher Jan Gore. I thank my church families: Rock Hill A. M. E. Zion Church of Concord, NC, Sandy Ridge A. M. E. Zion Church of Landis, NC, and Victory Tabernacle Interdenominational Ministries of Harrisburg, NC, who have supported me throughout the process. I will always appreciate all they have done. Special thanks to Anna Douglas, Isaac Kamami, Barbara Williams, and Sylvia Muckelvaney, and Dr. Nicole-Sherrill Corry for assisting me in developing my technology skills, for the many hours of proofreading, and Rev. Samuel C. Blanks for helping me to master the value of leadership. I dedicate this work and give special thanks to my Lord and Savior, Jesus Christ.

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Chapter 1: Introduction

Introduction

Human Immunodeficiency Virus (HIV) is a major epidemic, not just in the United States but also across the globe. The first case of HIV in the United States was first recorded in the mid to late 1970s; and became more widespread in the 1980s and 1990s (Centers for Disease Control and Prevention [CDC], 2019a). Left untreated, HIV can develop into acquired immune deficiency syndrome (AIDS), which destroys the body's ability to stave off further disease and infection (CDC, 2019a). Although there is no cure for the virus, the global public health community and the federal government have set ambitious treatment targets to end the HIV/AIDS pandemic (Drain et al., 2019). This is despite the inadequate supply of anti-retroviral drugs and services across the globe for HIV-positive patients.

HIV disproportionately affects African Americans and other minority populations (Knighton et al., 2016). In 2016, 1.1 million Americans aged 13 or older were HIV-positive (CDC, 2019c). Of those tested, 476,100 were Black or African American (CDC, 2019c), representing 43.3% of the HIV-positive population. African Americans who were HIV-positive in 2016 were 7.3 times the rate of Whites (CDC, 2019c). The disproportionate rate of infection by ethnicity indicates the need to create and implement community programs for prevention and education (Abara et al., 2015). Currently, programs implemented to manage HIV are frequently inadequate. The inadequacy is instigated by various factors ranging from stigma to an individual's fear of disclosing HIV-positive status (Bussone, 2017; Ojikutu et al., 2016). Education, awareness, and cultural appropriateness are required to reduce stigma (Ojikutu et al., 2016). Thus, effective community management initiatives are needed to support HIV-positive individuals, which may subsequently reduce the spread of the disease. This study provided a better understanding of the perceptions of HIV-positive individuals regarding faith-based community support to find strategies to reenergize their involvement in Faith-based organizations (FBOs).

In the remainder of this chapter, I summarized relevant literature related to this topic, concerns based on existing evidence, the focus of the study, research questions, purpose statement, and social cognitive theory (SCT). The social cognitive theory is also defined, and its constructs are thoroughly analyzed. Particular emphasis is given to the application of the theory as a guide to the study and analysis of the factors affecting the perceptions of HIV-positive patients towards faith-based organizations. The nature of the study was next, along with a discussion of the qualitative research design, a brief description of study participants, concepts under examination, and techniques for analyzing collected data. The chapter includes an analysis of the definitions, assumptions, scope and delimitations, biases, and principles guiding the findings' transferability.

Background

Human Immunodeficiency Virus is one of the world's premier infectious diseases (Folasire et al., 2014). The condition causes severe suffering to patients in various ways. Accompanying HIV is an increased vulnerability to opportunistic infection and mental anguish, among other intense challenges (Ojikutu et al., 2016). People living with HIV suffer from shame, leading them to live in denial or not disclose the condition (Ojikutu et al., 2016). Individuals living with the disease may be more concerned about their health conditions and their exposure to imminent death, intensifying the risk of depression and other mental conditions that adversely affect their quality of life. People living with an HIV-positive patient may hold various negative views of the infected individual, which affects their interpersonal relationships with others in the community (Wu & Li, 2013). Due to the stigmatization and psychological disturbance of people living with HIV, community support perceptions vary significantly from one locality to another (Pindani et al., 2013). Faith-based interventions that tailor intervention components to the determinants of HIV-related stigma can effectively address HIV-related stigma in African American communities in the United States (Jason et al., 2016). The interventions are vital in health and illness; however, more work is needed to determine the link between the quality of life in patients with HIV and their perceptions of these community support programs.

The number of HIV-positive patients actively participating in community programs that somewhat or specifically address HIV-related concerns has drastically reduced over the past few years. Various studies have related this undesirable decline to changes in different social contracts, such as better hospital-based and home-based care and improved society's perception of the disease (Bauermeister et al., 2017; Eaton et al., 2019; Pingel & Bauermeister, 2017; Valaitis et al., 2017). This trend is especially true for African-Americans living with HIV. It explains the drop in community involvement levels through such programs, especially in states dominated by African-Americans (Coleman et al., 2016). In rural areas, HIV-positive individuals often have few to no resources for psychological or community support (Valaitis et al., 2017). Compounding this problem is that the majority (80.1%) of adults living in rural areas are African American (Weisman et al., 2015). Among the barriers that rural patients disproportionately faced was a lack of community-based HIV information and fear of social prejudice, especially in the workplace and social gatherings (Bradley, 2018). Another study of belonging to the African

Diaspora, which includes all people of color, is a case study of community reactions in rural areas. This study confirmed the difficulty of disseminating knowledge, opening dialogue, creating formal and informal networks, and building partnerships, preventing what the authors deemed a “health-enabling social environment” (Mampane, 2018, p. 25).

African Americans are strongly religious and heavily involved in their churches and other faith-based endeavors (Francis & Liverpool, 2009). Accordingly, the high rates of HIV among this population, coupled with deep faith, indicate the need to provide community support to HIV-positive African Americans. In addition to the traditional role of offering spiritual guidance and comfort, Faith-Based Organizations (FBOs) have had an extended reach in rural communities to provide psychological and counseling services (Ochillo, van Teijlingen, & Hind, 2017). The social prejudice and discrimination associated with HIV and the stigma directed at those who acquired it have made community organizations sluggish to coordinate assistance to needy members of their communities. This trend is even worse by the lack of knowledge of alternative avenues to addressing such disparities (Francis & Liverpool, 2009). In recent years, however, FBOs have assumed a more prominent role in HIV education and care in rural communities.

Faith-Based Organizations play a significant role in HIV education efforts, particularly in rural areas, with trained leaders serving as agents of change in guiding the organizations’ direction (Coleman et al., 2016). These organizations are also beneficial in providing socialization and development; they may even offer comprehensive sexual education to all community members. Increasing community support based on a spiritual foundation benefits individuals and society, especially concerning HIV awareness and emotional support in rural, primarily African American communities (Coleman et al., 2016).

People’s perceptions of HIV-positive individuals may have personal and socio-economic costs on individuals, family networks, and communities (Maskay et al., 2018). Individuals and cultures have overemphasized the need to protect themselves rather than provide support and reassurance to those affected by the disease resulting in feelings of isolation and discrimination (Grossman & Stangl, 2013). HIV-related social pressure is a significant challenge in deterring and controlling the spread of the virus. FBOs have the ability and resources to provide supportive care to address the community resources that are lacking among HIV-positive individuals.

In rural communities, HIV-related humiliation accompanies individuals’ prejudicial beliefs about the victim’s dangerous acts. Such prejudicial attitudes may put individuals living with HIV in unnecessarily hostile and uncomfortable situations as they face many forms of discrimination and neglect. In confronting the misconceptions and resolving the epidemic, efforts are needed to allow open discussion of HIV within faith communities. Faith-based intervention efforts must include religious leaders, community-based organizations, local and state officials, people living with HIV, community leaders, and families. A set of systemic and cultural factors lead to a lack of HIV education, evaluations, or sexual risk reduction measures while maintaining the social pressures attached to HIV infection (Abara et al., 2015). African Americans in the southern United States appear to bear this disease’s burden and the associated social side effects.

Some scholars have focused on HIV-positive individuals' perceptions of faith-based community support in rural areas (Khamarko et al., 2013; Kontomanolisetal, 2017). Faith-based support can have tremendous positive effects on HIV-positive patients in low-and middle-income countries (Khamarko et al., 2013). The researchers found that community support for HIV-positive patients influenced adherence to medication, healthcare access, and quality of life.

Alternatively, Kontomanolis et al. (2017) showed that communities lack the resources required to seamlessly incorporate HIV-positive individuals, resulting in those people becoming marginalized and isolated. Dixit et al. (2009) noted that people who have HIV need proper education, access to medication, and equal employment opportunities readily met through community support. A faith-based intervention could encourage more members of society to provide help to HIV-positive individuals (Vitillo, 2009). Despite these known benefits, there is insufficient literature on how to get HIV-positive patients more involved in FBOs to boost their living standards. Understanding their perceptions of FBOs establishes a foundation for improving their participation. Accordingly, more scholarly inquiry into HIV-positive individuals' perceptions and experiences with FBOs is necessary to uncover ways to enhance the anticipated level of participation.

Problem Statement

Incidences of HIV among African Americans are higher than among other races in the United States. According to the CDC (2020), there are about 38,700 new HIV infections in the US annually. Approximately 42% of the new infections occur among African Americans. The southern part of the United States, mainly dominated by blacks, makes up about 52% of the new cases, followed by the west at 19% (CDC, 2020). Although African Americans are often deeply religious, there is a lack of adequate support from FBOs (Hall et al., 2017). Nonetheless, attitudes regarding care for HIV-positive persons have not received sufficient analysis and need further research. The gap suggests a need to explore the perceptions of individuals with HIV on FBO support. This aims to identify the beliefs and convictions which inform their involvement in the organizations and establish how to boost their participation. Thus, this study sought to establish why many African Americans living with the virus take little interest in involving in FBOs. It also assessed what the patients know about these organizations and how their perceptions inform their decisions on FBOs' involvement.

FBOs are a significant asset because they appeal to broad audiences and affect many people (Francis & Liverpool, 2009). Faith leaders and their respective institutions play a crucial role in providing service to the community, with links to the reduction of HIV-related health factors (Sutton & Parks, 2013). Faith-based social workers from the Christian church are also often involved in their health ministry activities. Repositioning faith-based organizations at the heart of HIV response intervention is critical in facilitating health outcomes, reducing new cases, and ensuring that the patients attain social wellness.

Purpose of the Study

The study would facilitate understanding the perceptions of people living with HIV/AIDS on assistance accorded by faith-based community support in rural areas. The research focused on the African American populations in all Piedmont area clinics located in the rural area of North Carolina to identify the different interventions by Faith-Based support programs developed in their communities. The study assessed the target group's perceptions and experiences and how responses would be enhanced to improve their quality of life. With great significance, the study would contribute to adherence to how religious-based organizations and cultural precursors influence the sensitiveness of patients.

Research Questions

RQ1. How do African-American HIV+ patients perceive faith-based community support, as defined by their role in the societal interventions of African-American faith-based organizations?

RQ2. How do perceptions of HIV+ patients towards faith-based and community support influence quality of life?

RQ3. How do perceptions of HIV+ patients towards faith-based community support influence the decision to reveal HIV status?

Theoretical Framework

One of the theories that can be used to explain the perceptions HIV-positive patients have on faith-based community support in a rural setting, especially concerning their betterment, is the social cognitive theory (SCT). The theory posits that various personal factors interactively influence each other through a framework based on personal interactions and observations (Bandura, 1999). In other terms, Albert Bandura was convinced that social interactions, environment, and behaviors greatly inform the perceptions and behaviors of individuals that live and work within those social contexts. SCT incorporates affective, behavioral, cognitive, biological, and environmental elements (Bandura, 1999). By applying Bandura’s (1999) argument and assumptions, it is fair to suppose that HIV-positive patients living within communities where faith-based support is strong and praised by the members generally have a positive perception of FBOs. They are also more motivated to get involved in the programs they offer. The reciprocal is expected with patients living in communities where faith-based community programs are weakly rooted. This theory can be used to explain why the involvement of HIV-positive patients in FBOs is reducing. Le et al. (2017) found that African Americans with greater involvement in faith communities greatly support religious and social activities. However, the number of African-Americans actively involved in faith communities is reduced (Le et al., 2017). When this theory is used, it can be supposed that the negative perception of HIV-positive patients on FBOs is directly linked to the overall reduced involvement of African Americans in faith communities.

Social cognitive theory is built on six constructs, which can explain the correlation between HIV-positive patients' perceptions and faith-based community support. The constructs, including reciprocal determinism, behavioral capacity, observational learning, reinforcements, expectations, and self-efficacy, when looked at from the society level, can explain how people learn and regulate behavior or perceptions (Bandura, 1999). For instance, the reciprocal determinism construct holds that people tend to adopt thoughts and behaviors based on dynamic and reciprocal interaction among them. As such, the perceptions held by people around an HIV-positive patient on faith-based community support might act as a stimulus toward the patient's perception of the support provided by FBOs. In line with SCT's tenets, it is possible to explore the perceptions and experiences of HIV-positive individuals regarding faith-based interventions.

Due to its frequent application in behavior observation and subsequent modifications, the SCT framework is a handy tool to delineate the impact and ramifications associated with HIV infection while, at the same time, establishing the basis for low enrollment of HIV-positive patients to community organizations aimed at managing the spread of the epidemic. According to Bandura (1999), self-efficacy is a significant component of the SCT framework as it relates to individual behavior. By incorporating the concept of self-efficacy, I would acknowledge individuals’ control over their behavior, hence developing outreach techniques based on individuals’ autonomy.

Nature of the Study

The study employed qualitative research, specifically content analysis research design. Of the three types of research—qualitative, quantitative, and mixed methods—qualitative is the best suited to uncover participants’ perceptions and lived experiences. Various reasons informed the decision to select a content analysis design for this study. First, it is highly flexible and is helpful in carrying out an extensive exploration of respondents’ attitudes, perceptions, intentions, and experiences. Secondly, the design focuses on generating a wide range of ideas, perceptions, and opinions that a person might have on a specific issue, making it useful in exploring patients’ perceptions of community-based support (Zournazis et al., 2018). Thus, the qualitative design is fit for this study.

Content analysis was used to explore HIV patients’ perceptions of faith-based community organizations (FBOs) concerning their services. Realistic phenomenology is a phenomenological study that allows researchers to explore meaning through a sample of participants who share experiences and understanding of a particular phenomenon (Creswell, 2015). This approach incorporates ontological essence in everything, including sentient and collective social action (Vacchelli, 2018). A realistic phenomenological approach is appropriate for capturing the experiences and perceptions of HIV-positive individuals concerning FBOs’ support. As used in this research, FBOs are not-for-profit organizations interested in promoting social wellness through religious inspiration (Zournazis et al., 2018). Phenomenology enabled the researcher to focus on participants' experiences related to their perceptions of faith-based community support and the quality of life. Phenomenology is the appropriate design for this inquiry.

The research was conducted using semi-structured audio-recorded interviews using open-ended questions to allow for detailed responses, with queries specific to how faith-based community support has affected participants' lives. Research questions were based on a social cognitive perspective, with data collection from interviews relating to the experiences and perceptions of the HIV-infected participants. After transcribing all recordings, I used Nvivo software to review each participant's responses to identify common elements, points of view, and characteristics. An extensive analysis of the elements was then conducted to determine specific factors that inform the patients' perception of FBOs.

Definitions

Community support: Community support is an organized system of care to assist adults with long-term disabilities to meet their needs and develop their potential without unnecessary isolation or exclusion from the community. In this study, community support applies to HIV-positive individuals (Zournazis et al., 2018).

Faith-based interventions: are volunteers or dedicated individuals' responses to social work based on their religion (Payne-Foster et al., 2016).

Faith-based organization (FBO): An FBO is developed on a selected religious ideology. It has a clear mission statement and often draws its activists (leaders, staff, and volunteers) from a religious group (Anugwom & Anugwon, 2018).

HIV prevention: For this study, HIV prevention may consist of activities, programs, and services developed to prevent or reduce HIV transmission for individuals who are non-infected with HIV, as well as individuals who were HIV-positive (National HIV Prevention Inventor, 2009).

Assumptions

This inquiry bases its arguments, data collection process, analysis, and conclusions on various tangible assumptions. It is assumed that personal perceptions of FBOs are intrinsic and voluntary. Based on this assumption, there is no intention to compel or coerce respondents to provide a specific response. Additionally, the respondents provided responses based on their judgments and convictions. This assumption is critical in overcoming bias. Secondly, it is assumed that there was no researcher bias. There was no chance for the researcher to consciously or unconsciously focus on questions and data that supports his beliefs and expectations, which might lead to skewed results.

Scope and Delimitations

To qualify, participants must reside in Piedmont - North Carolina and have had experiences with and perceptions of FBO resources. Individuals who were not HIV-positive, do not reside in the rural area of study or had no related experiences were ineligible for inclusion in the research inquiry. Therefore, I adopted a conservative approach in the interest of participants' mental health, community support, and ethical considerations. Interviews were limited to HIV-positive patients over control programs to discuss community resources' perceptions in rural areas.

Limitations

Limitations are restrictions or issues in a study outside of the researcher's control that may decrease the transferability of findings. Like any other research, this study exhibited numerous potential limitations. The greatest limitation was its small sample size. Although it targets a population of HIV-positive patients living in rural areas, it only had a sample size of seven people. The small sample might not accurately represent the targeted population. As such, the results might be less reliable even though it is efficient to analyze and see the trend for the population.

Another significant limitation was the use of purposive sampling in selecting participants. The nonprobability sampling method could increase biases as participants were selected based on convenience and self-selection. In this case, every potential qualifying individual was not given an equal opportunity to participate, leading to potential bias. My connection with various FBOs might have also led to researcher bias, posing a greater threat to reliability.

To address the threat of researcher bias, I carefully examined my beliefs and expectations, documenting them with bracketing and setting them aside so as not to influence data collection or findings. Other means of addressing limitations included applying qualifying criteria to participants, executing a qualitative phenomenological study according to Creswell (2013) guidelines, and involving participants in confirming data. I strived to promote the participants' confidence, trust, and openness by developing early familiarity with the participant's culture before collecting information.

Open-ended questions were posted during the interview, allowing the participants to articulate their experiences dealing with HIV. I utilized sessions with the dissertation chair to discuss the study approach, identify flaws, develop ideas, and recognize bias well as peer scrutiny of the research by peers and colleagues. Due to my connection to FBOs, researcher bias might have posed a threat to reliability. To address the threat of researcher bias, I took time to carefully examine my beliefs and expectations, documenting them with the practice of bracketing and setting them aside not to influence data collection or findings. Other means of addressing limitations included applying qualifying criteria to participants, executing a qualitative phenomenological study according to guidelines, and involving participants in confirming data.

Significance

This study uniquely explored the perceptions and experiences of individuals with HIV regarding the support and resources provided by FBOs. Without research such as this, their views of community behaviors and approaches could have remained undisclosed. Achieving a better understanding of HIV-positive patients' opinions could inspire several strategies and plans to provide community support in rural areas, particularly among FBOs. For instance, creating health awareness among people living with HIV can only be successful if the targeted people are responsive and self-motivated to take part in such activities. While previous studies have explored the aspect of community involvement and initiatives in HIV control and patient care, little has been done to address the influence of belief and religious systems-based efforts on HIV control.

Summary

Negative attitudes towards HIV-positive patients pose chronic social problems, particularly in rural areas where such incidences are higher. Due to various sociocultural and economic risk factors, FBOs are private, conservative, and at times hesitant to provide community support. In addition to facing several adverse physical and mental health effects, HIV-positive people in rural areas find fewer resources available for effective treatment and support. Due to its applicability to spirituality and empowerment, SCT was an appropriate conceptual framework for investigating the lived experiences and perceptions of HIV-positive individuals regarding community support from FBOs in rural settings. This study was a means of addressing the lack of qualitative research regarding this phenomenon. Chapter 2 will incorporate a review of published literature that documents findings from quantitative, qualitative, and mixed methods studies relative to perceptions of HIV-positive patients toward faith-based community support in a rural setting.

Chapter 2: Literature Review

Introduction

The purpose of this is to explore the perceptions of Human immunodeficiency virus (HIV) -positive patients on faith-based community support in rural settings. The focus of the literature review section will be looking into how HIV-positive patients perceive the support rendered to them by faith-based organizations (FBOs). Additionally, this study sought to reveal whether such support has been beneficial to HIV/AIDS patients or whether it has been ineffective. The main topics that are explored in the current chapter include theoretical framework, social aspects of HIV-related stigma, roles of faith-based organizations in HIV-positive patient care, the prevalence of HIV in rural areas, perception of HIV-positive patients regarding quality of life, challenges of faith-based aids care, and, behavioral changes among HIV positive after diagnosis and therapy.

Literature Search Strategy

Based on the established criteria, I started the literature review by searching the Walden University online library databases, including EBSCO, PubMed, Medline, CINAHL, Science Direct, ProQuest digital dissertations, PsycINFO, PsycARTICLES, PsycINFO, Google Scholar, and SocINDEX with Full Text. For example, the initial searches conducted involved terms like *Faith-Based Community Support for HIV Patients*. This search produced 0 articles from the EBSCO database within the Walden University online library. However, when Google Scholar was used to search the same term, it yielded over 27,600 results within a fraction of a second. By modifying the search term to *recent peer-reviewed articles on Faith-Based Community Support for HIV Patients*, the result was reduced to 17,200, where 10,400 articles were rejected since they were irrelevant to the literature required. The search was further narrowed down by concentrating on articles based on research conducted and published within the previous five years. This led to the selection of 50 articles, which comprised of peer-reviewed journals that met the criteria of this literature.

Moreover, the search term' Social Cognitive Theory' was initially used to locate materials on the theoretical framework applied to determine the perceptions (about the topic) in the study. This yielded over 7,190 results through Google Scholar. The number of articles reviewed was again narrowed down by changing the search term to *peer-reviewed articles on social cognitive theory relating to Faith-Based Community Support for HIV Patients* and selecting more of those published within the previous five years. The same search strategies were applied to other terms used for obtaining relevant articles on the different factors considered to be associated with Faith-Based Community Support for HIV Patients, especially in rural areas, as reviewed in this chapter.

Theoretical Foundation

The theoretical framework applied for the current research is the social cognitive theory (SCT). Social cognitive theory (SCT) began as social learning theory (SLT) in the 1960s (Bandura, 1977) (Bandura, 1986). It gained its name from Sociologist Albert Bandura, who developed it in 1986 based on the social learning theory that had earlier been developed in 1977 (Boslaugh, 2008). Bandura conducted a social experiment to show that learning occurs through three main concepts: observation, imitation, and modeling the actions of other people (Cooper & Lu, 2016). Specifically, the researcher carried out a series of studies called the ‘Bobo Doll Experiments’ in which preschool children were exposed to two conditions. In the first condition, the children could see an adult model hitting a Bobo doll while depicting verbal and physical aggression in the process (Cooper & Lu, 2016). The second group of children was exposed to a non-aggressive adult model hitting a Bobo doll. The two groups of children were taken to a third room filled with toys, including a Bobo doll; the children were interrupted during their playtime. The researcher found that children who were exposed to aggressive adults showed similar behavior by being physically and verbally aggressive toward the Bobo doll when frustrated (Cooper & Lu, 2016). While the social learning theory focuses on how individuals learn through observation, SCT focuses on the cognitive aspect of the observational learning process.

SCT asserts that individuals are agents whose behavior influences and is influenced by their surroundings (Bandura, 2001) (Bandura, 1976). The implication is that individuals are bound to learn both desirable and undesirable traits from their environment. Additionally, the theory also explains that not all observed behavior from the environment is reproduced as one only exhibits those that he or she finds rewarding; hence, punishable behavior is less likely to be reproduced (Beauchamp, Crawford, & Jackson, 2018). According to SCT, personal change that is useful in regulating behavior involves people believing in the cognitive ability to control their thoughts, motivation, and other related behavioral aspects (Bandura, 1994). The cognitive aspects of thought and feelings were found to influence the determinants of behavior.

SCT is regarded as one of the fundamental theories related to HIV infection control exercise (Enwereji & Eke, 2016). The theory relates to perceived self-control that is grounded in human behavior. Although the theory does not significantly explain why individuals should choose to change their behaviors, it proposes that they should adopt effective practices such as preventive actions. Notably, the word “environment” mentioned in Bandura’s SCT may comprise of social beliefs and norms. Bandura (1994) emphasizes that HIV infection prevention entails people adopting significant influence over their social environment and behavior. Allan (2017) noted that social beliefs and norms guide individuals to develop the confidence to exercise substantial control of their behavior.

Essentially, the theory explains that human behavior is influenced by the actions of others, individual experiences, or environmental factors (Rana & Dwivedi, 2015). Usually, SCT is applied when behavior change is required to promote the well-being of a population (Rana & Dwivedi, 2015). At its core, SCT provides a framework for social support to vulnerable members of a community. In the current study, the use of SCT was important because it helped understand how social factors affect the perception of HIV-positive patients. Also, exploring SCT helped me understand how behavior change can be promoted among HIV-positive individuals, including the appropriate use of rewards and incentives. Most importantly, the SCT provided a guideline on how individuals can interact in their environment to ensure better treatment outcomes.

According to SCT, personal factors that influence knowledge based on observations and interactions include behavior, affection, biological and environmental events (Bandura, 1999). The theory is extensively applied in HIV/AIDS-related cases due to the social nature of the disease (Derose et al., 2016). Several studies have indicated that unlike other illnesses, which draw compassion and emotional support from society, HIV is mostly associated with discrimination, prejudice, and discretization (Coleman et al., 2016; Derose et al., 2016). Evidence indicates that about a third of countries globally deny HIV-positive patients to enter their borders (Pryor & Bos, 2016). In 2010, the Chinese government ruled against an HIV-positive teacher resuming his job after being diagnosed with the disease (Pryor & Bos, 2016). Such incidences reveal that HIV illness is accompanied by social stigma (Pryor & Bos, 2016).

The SCT has been widely utilized in focusing on interceptive practices for HIV infection and transmission behaviors. The practices include the development of guided practice, knowledge, awareness of health risks, and effective preventive practices, among others (Bandura, 1994). According to the theory, these practices are regarded as self-efficacy, a word derived from an individual's behavioral capacity. To achieve self-efficacy, individuals should change their behavior and develop a substantial reason for their motive to change. The theory postulates that perceived self-efficacy is focused on individuals' belief that they can employ control over their behavioral motivation. Notably, individuals' beliefs critically impact what they choose to do. Bandura (1994) emphasizes that a lack of self-efficacy among individuals inhibits them from effectively managing their conditions despite knowing what to do to possess the required knowledge.

Several studies linking Bandura's SCT to promote interceptive HIV practices have been conducted. Yang et al. (2017) explored SCT regarding condom use in commercial sex; and noted that SCT was significantly influential. Self-efficacy was among the key factors of risk and significant protective measures. Similarly, Espada et al. (2016) applied SCT in advocating for the use of condoms in adolescents. The authors presented that cognitive knowledge of condom use in preventing HIV infection and self-efficacy were among the significant concepts of SCT. Hence, it is crucial to conclude that the application of SCT in sexual behavior has significantly yielded several benefits. SCT was chosen for the proposed study based on the findings from Espada et al. (2016) and Yang et al. (2017).

SCT suggests that self-efficacy is developed through mastery of experiences, vicarious or observational adherence, and social persuasion (Simoni, Franks, Lehavot, & Yard, 2011). Rana and Dwivedi (2015) used SCT to examine citizens' general perceptions regarding adopting electronic government (e-government) systems in terms of outcome expectations, social influence, self-efficacy, affect, and anxiety. The study included 419 participants drawn from eight cities in India. The study revealed the core of SCT by indicating that citizens' perceptions influenced the government's action, and the government's proposed action shapes society's thinking (Rana and Dwiveidi, 2015). Additionally, the study presented that self-efficacy is a crucial factor that positively impacts e-government users' outcome expectations (Rana and Dwiveidi, 2015). The impact is improving the user's poverty by providing justice and solving their issues.

SCT is also interlinked with career, performance, choice, and academic interest models. Lent et al. (2016) applied SCT to investigate career self-management examining which factors influenced college students to make specific career decisions. Additionally, the researchers sought to understand how self-efficacy was influenced by social support, outcome expectations, and level of career decidedness. A study by Lent et al. (2016) developed a self-management model that was utilized to predict career decidedness, decisional anxiety, and exploration goals. The authors revealed that potentially focusing on decisional and conscientiousness career choice can be achieved through setting time for career exploration. Carillo (2010) employed SCT to understand technology adoption and use trends. A key point highlighted by the author was that self-efficacy in SCT is not an isolated concept but rather influenced by environmental, emotional, and cognitive factors. Overall, SCT is a crucial aspect of society that was used in the current research to explain the behavior and perception of HIV-positive individuals.

Key Concepts

Social Aspects of HIV-Related Stigma

Several existing studies have shown that HIV-positive patients are stigmatized by their condition (Otey & Miller, 2016; Coleman et al., 2016); stigma comes in various forms. Therefore, apart from creating management measures for HIV, it is crucial to understand the social aspects of AIDS-related stigma and reduce stress among patients. Coleman et al. (2016) examined the relationship between social factors such as religiosity, gender, education, and stigmatization related to HIV. To achieve their goal, the researchers included 1,747 participants drawn from 34 African American Faith-Based Organizations (FBOs) in South Carolina from the years 2008 and 2009. The study participants were evaluated on the extent to which they associated with HIV/AIDS patients and the HIV-related stigma level. The responses were then summed on the AIDS Attitude scale (AAS-G) to establish the stigma scores. The findings revealed that knowing an HIV patient reduced the degree of stigmatization response.

Nevertheless, knowing a gay person was noted to correlate with a less stigmatization response. An unlikely result obtained in the study is that religiosity did not significantly correlate with a high HIV stigma level. Moreover, higher levels of education and the female gender were realized to associate with lower stigmatization levels.

HIV/AIDS-related stigma continues to be a significant inconsistent burden for most patients worldwide. Coleman et al. (2016) revealed that age, gender, and educational levels are some of the factors associated with the HIV/AIDS-related stigma. These factors are significant in understanding how stigma can be addressed. Specifically, the revelation that patients with higher education experience less stigma suggest that they may be better exposed to disease management than those with less education. It is crucial to present through the revelations that the stigma can be intercepted through informative interventions by the FBOs. Interventions such as educational seminars can effectively address HIV/AIDS-related stigma, especially in a community setting.

Most importantly, this study's findings can reduce the abstract view of the disease that often promotes stigmatization. However, a fundamental limitation of the by Coleman et al. (2016) is that it only drew its participants from a sample of the congregation rather than the general population. Such a strategy may have led to bias in the respondents' perception regarding HIV/AIDs. Meanwhile, Derose et al. (2016) conducted a related study in which they examined the predictors of HIV-related stigmas with Latino and African American cohorts. It is crucial to investigate predictors and dimensions of the church-affiliated perspective to develop substantial reduction actions on HIV-related stigma. By investigating 1,235 participants from three Latino churches and two African American churches in the Western US, Derose et al. (2016) found that the main HIV-stigma dimensions included feelings of blame, feelings of shame, fear of rejection, and discomfort. Additionally, the investigation revealed that homosexuality and drug addiction are strongly associated with HIV stigma.

These findings show that church congregants have diverse perceptions regarding HIV/AIDS-related stigma. These perceptions vary between racial and ethical aspects. From an ethical perspective, homosexuality is associated with negative attitudes among church-affiliated populations. However, these negative attitudes seem incapacitated by knowing someone is HIV positive (Derose et al., 2016). In particular, the results deconstruct the idea of HIV-related stigma and show the specific problems the patients face. A critical gap noted in the study is that they did not gather participants' knowledge regarding HIV, homosexuality, or drug addiction (Derose et al., 2016). The proposed study attempted to fill the gap by offering a clear direction of church-affiliated perspective stigma reduction interventions.

Roles of Faith-Based Organizations in HIV-Positive Patient Care

HIV-positive patients now have greater opportunities of living longer, thanks to substantial roles played by FBOs. Spiritual organizations are uniquely positioned to offer vital services beneficial to HIV-positive patients, especially in community settings (Stephens, 2018). However, a lack of research has been conducted on FBOs’ specific roles and responsibilities. Anugwom and Anugwom (2018) assessed the intervention adopted by FBOs in supporting and caring for patients living with HIV in Enugu State, Nigeria. The results showed that their primary role is organizing educational programs such as seminars. These sentiments are noted to resonate with Schoenberg (2017), who revealed that training and promoting protection protocols are among the roles of faith-based organizations in supporting HIV-positive patients.

FBOs have much more to offer other than spiritual assistance to HIV-positive patients. Anugwom and Anugwom (2018) are keen on providing significant roles for FBOs. Among their roles, educational programs positively impact HIV-positive patients and other people involved in offering care, especially family members. These programs can be achieved through organizing seminars that inform HIV-positive patients on acceptance of their condition. The success of the educational programs shows a clear justification that the FBOs have made great progress in addressing HIV-related stigma and other problems. Despite providing information on the roles of HBOs, Anugwom and Anugwom (2018) have a critical literature gap in that they generalized their findings with the entire of Nigeria. Besides, the study did not inform whether the interventions were conducted in rural or urban areas. Hence, it is relatively impossible to form a solid conclusion from the survey regarding the roles of FBOs.

HIV/AIDS-related stigma may differ in patients from different geographical settings. Hernandez et al. (2018) purport that most HIV-positive patients in rural areas are affected by stigma and depression. These challenges are noted to affect the patients' well-being negatively. HIV-positive patients in rural areas may have difficulty accessing essential education materials and health providers with HIV expertise. Patients in rural areas may be unable to access long-distance care due to a lack of resources and limited transportation. As such, rural-based training programs offered by FBOs are crucial interventions aimed at enhancing effective support and care for people living with HIV. The rural-based HIV/AIDS issue continues to escalate due to limited or inexistence health care and support. Despite that, FBOs play a critical role in providing effective care in disadvantaged geographical areas; crucial intervention is required to better understand the epidemic in rural areas. Schafer et al. (2017) stated that teaching awareness to people living with HIV positively impacts reducing fear and stigma.

HIV/AIDS is among the world's most serious public health-related epidemics. However, Olowu (2015) realized that the interventions to intercept the infection had been focused on third-world countries, especially in Africa. The author investigated the roles of FBO in supporting HIV patients in Lesotho. The survey revealed that education, voluntary counseling, and medical and treatment are among the roles of FBOs. These findings are confirmed by the United States Agency for International Development (USAID) report, which lamented that FBOs have a history of providing education to HIV-positive patients in African countries.

In contrast, Woods-Jaeger (2015) presented that the role of FBOs is to focus on infected patients and the affected community and family. These roles entail advocating for required policies such as access to treatment and cancellation of debts. Notably, the study contains a flaw in its methodology criteria. Oluwu (2015) classifies the literature search as a primary source of data. Regarding the weakness, it is questionable to insist that the data used is valid, making the study findings incredible and unreliable.

Perceptions of HIV-Positive Patients Regarding Quality of Life

Although providing medication to HIV/AIDs patients is critical in managing their physical health, it is also essential to explore their personal opinions to understand which area of life they may need assistance with. Womack, Novick, and Fried (2018) examined the problem of falls among HIV-positive individuals. The researchers wanted to know the cause of falls among HIV patients and any effect it had on their lives. The study methodology employed purposive sampling, which included 21 HIV-positive participants aged 47 – 71 years who had received primary care from a clinic after experiencing fall (s). Among the 21 respondents, five were recruited through posted fliers, while sixteen were recruited during clinic screening.

Falls and faints are among the issues associated with HIV-positive patients. Womack, Novick, and Fried (2018) showed that the falls of six participants were due to extrinsic causes, while the rest had intrinsic causes. In contrast, Erlandson et al. (2016) reported that most falls in HIV-positive patients result from internal causes such as dizziness. Additionally, falls can be caused by an impaired balance among patients with HIV. A significant point to note is that HIV-positive patients have a higher vestibular dysfunction rate, which influences infrequent imbalances (Erlandson et al., 2016). Moreover, conditions such as peripheral neuropathy, arthritis, dehydration, and hepatic encephalopathy may affect the high frequency of falls in HIV-positive patients (Erlandson et al., 2016). In most cases, such falls result in fractures and other body injuries in infected patients (Erlandson et al., 2016). The proposed study attempted to explore some fall reduction interventions.

Despite the development of strategic measures to support and prevent HIV infection, understanding of the epidemic remains a significant problem. Blake et al. (2017) explored the perception and experiences of HIV-positive patients regarding the knowledge of managing chronic disease. The researchers investigated the patients' knowledge regarding various topics such as family support, stigma, self-care, coping with the disease, and access to resources (Blake et al., 2017). The study methodology entailed purposive sampling of 35 HIV-positive male participants of African American ethnicity living in the rural part of Southern US, specifically in the Piedmont area. The findings showed that most respondents identified the family as their primary source of emotional and physical support (Blake et al., 2017). However, a significant number explained that since being diagnosed, they had experienced unfair treatment from some family members (Blake et al., 2017). The participants also explained that coping with the HIV condition was challenging since it was accompanied by other illnesses such as cardiovascular diseases, hypertension, and diabetes (Blake et al., 2017). Moreover, most participants experienced stigma in which their HIV-positive condition was associated with being gay (Blake, Taylor, and Sowell, 2017).

People living with HIV/AIDS have different challenges depending on their geographical settings. Blake et al. (2017) are significant to the proposed study regarding the challenges experienced by HIV-positive patients living in rural settings. The perception of the participants shown in the analysis is also crucial in providing insight into what should be assessed in the present study and what should be expected in the findings. However, a fundamental limitation of the study is that it only considered male participants. This limitation was addressed in the current research by considering participants from both genders. Also, a crucial gap identified in both studies is that they did not consider the other parameters, such as faith-based support or the patients' location, which may significantly affect their views. The literature gap was addressed in the current research.

Perception of HIV-Positive Patients Regarding Decision to Reveal HIV Status

The decision of HIV-positive patients to disclose their health status to those around them is often difficult due to the respondents' reaction uncertainty. It is crucial to analyze why some patients disclose or refuse to disclose their status to family or friends to understand how the disease affects the patients involved. Lee et al. (2015) examined the reasons that motivated HIV patients to disclose their status and the impact of such disclosure. The study was conducted in fifteen clinics across Puerto Rico and the US. The findings indicated 82.7% of the participants had at least informed one person about their HIV-positive status. The main reasons for non-disclosure provided by the other respondents included fear of withdrawal of social support by family and friends leading to HIV-related stigma.

Additionally, such respondents explained that they did not want to be upset or worry about their disclosure target. However, the researchers realized that there was no significant difference in social support between respondents who had disclosed their HIV status and those who did not. The study was important to the current research since it deconstructed the idea that disclosure of HIV status always leads to discrimination and withdrawal of social support.

Moreover, by revealing what motivates HIV patients to share or refrain from informing others about their condition, the study indicates how fear of HIV can be reduced. A key limitation of the study is that the researchers did not examine how the participants acquired their HIV status, significantly influencing whether they shared information about their condition. Evangeli and Wroe (2017) highlight that HIV-positive individuals who acquire the virus at birth tend to share their status in the community and encourage a responsible lifestyle compared to individuals who got it through other means.

HIV-positive patients have the challenge of living with a chronic disease and disclosing their conditions to others. Farooq and Mughal (2016) examined the challenges experienced by HIV-positive patients regarding disclosing their health condition. The researchers considered the impact of cultural beliefs in influencing the patients' decision to share vital information. The study utilized purposive sampling to select 13 participants who were all HIV-inflected and were visiting an HIV clinic in Islamabad, Pakistan. A key finding of the study is that religious beliefs in Pakistan hindered the patients from disclosing their HIV-positive status since it prohibits discussions on sex and safe sex. Other than the presented findings, it is crucial to reveal that older members of society are less likely to disclose their HIV status than younger ones due to the perceived emotional burden they may impose on the other family members who look up to them.

Additionally, women are less likely to disclose their HIV status than men since such revelations would be considered an act of hindering the family's prestige. These assumptions are critical in showing how various factors influence the ability of an individual to disclose their status. The key concepts identified in the presented evidence was considered in making the interview questions for the current study. A key gap in the studies regarding disclosing HIV status is that they did not examine how the disclosure of HIV status affected the sociability of the individuals.

Challenges of Faith-Based AIDS Care

Faith-based AIDS organizations are run by religious bodies and focus on providing care and support to HIV-positive patients. Abara et al. (2015) studied the challenges associated with FBO. The study revealed that the primary problem associated with faith-based AIDS care is stigma directed toward patients. The researcher noted that most religious teachings view HIV-positive patients as those with sinful behavior and moral failings. This stigma can be attributed to the initial media attention that links HIV to “risk groups” such as prostitutes. Thus, religious outfits view HIV as a disease for the immoral members of society. Such stigmatization is more likely to arise in faith-based AIDS care and reduce the effectiveness of patient care for HIV patients.

Additionally, the stigma may also reduce the possibility of HIV-positive individuals seeking support from such institutions due to fear of being discriminated against. Olowu (2015) found that funding is another critical challenge of FBO; organizations barely have funds for activities beyond the training of volunteer workers. I noted that the lack of funding means such organizations cannot provide the extensive patient support needed to improve outcomes. Stewart et al. (2016) found that FBOs’ roles in providing support to HIV-positive patients are limited in what they can do. Limitations are mostly due to the financial strain that such organizations contend with due to a shortage of donor funding that is sometimes faced (Stewart et al., 2016).

The findings are crucial because they show that curbing stigma can significantly help enable HIV-positive patients to seek FBO services. Patient care efficiency is also likely to reduce because of such shame (Stewart et al., 2016). The issue of limited finances also helps to explain why support services that such organizations can offer become limited, thus exposing patients to low-quality care, especially in poor communities (Stewart et al., 2016). The low-quality services may stem from the fact that some faith-based AIDS care institutions only have funds to train volunteers. Trained care personnel like nurses and counselors may be lacking from the care centers meaning that close and specialized patient care may not be provided (Stewart et al., 2016). Religious discrimination in other communities may also make some patients shy away from FBOs that are not run by the religions they belong to. Differences in faith and beliefs are the leading causes of such challenges (Abara et al., 2015). The studies' main limitation is the lack of investigation of the effects of the challenges investigated on patients' long-term health outcomes and the available alternative programs. The research results were vital in understanding the main difficulties associated with faith-based AIDS care.

Behavioral Changes among HIV Positive after Diagnosis and Therapy

Several types of research have investigated the behavior changes observed among HIV-positive patients (Rutstein et al., 2017; Hoenigl et al., 2015). Rutstein et al. (2017) found that a considerable reduction in risky behavior was observed among HIV-positive patients after diagnosis. The researcher noted that after HIV diagnosis, most people who turn out HIV-positive show more responsible sexual behavior. The researcher linked such a change in risky behavior to counseling advice after diagnosis. The researcher concluded that testing could be used as one of the ways of reducing the spread of HIV. Contradictory, Hoenigl et al. (2015) found an increase in behavioral risk after HIV diagnosis among MSM who turn out HIV positive. The researcher noted that such behavioral change happens because of mental stress during the early post-diagnosis period. Similarly, Hall et al. (2017) added that the prevalence of increased risky behavior after diagnosis is higher among poor communities. The researcher noted that in such places, high-quality AIDS care might be lacking, thus reducing the effectiveness of counseling services.

The finding that the availability of adequate patient care, including counseling services, reduces risky behavior among HIV-positive patients is crucial in guiding the current study on what to ask the sampled participants. It shows that health service providers and AIDS care centers should make counseling a propriety service when dealing with HIV-positive patients. Counseling and close care can be applied to increase acceptance rates and reduce the prevalence of HIV. Cultural and social influences that do not promote HIV/AIDS awareness may also make patients lose their social life, further exposing them to risky behavior. Additionally, a lack of family support also leads to a considerable negative change in behavior. Increasing awareness about HIV/AIDS, especially among the youth, has been observed to reduce stigma, promote acceptance and, as such, reduce risky behavior after diagnosis and early therapy (Hall et al., 2017). Overall, increased HIV awareness, testing, and counseling reduce risky behavior among HIV-positive patients. The limitations of the research are the omission of the effect of post-diagnosis behavior change on the treatment outcomes of HIV-positive patients. The researchers also failed to link post-diagnosis risky behavior to new infection rates. The results of the studies were useful in observing the effect of HIV diagnosis and therapy on behavior. The results assisted in identifying the relevance of counseling services to HIV-positive patients.

Summary and Conclusions

The current chapter provided a critical review of the literature that aligns with the current study subject. The review presented that the social stigma theory best explains the experiences of HIV-positive patients since it reveals why some individuals are stigmatized in society and their response to such stigmatization. A key trend noticed after the literature review is that eliminating the stigma associated with HIV is critical in improving the mental health and physical well-being of patients involved. The analysis also indicated that the main dimensions of the stigma that negatively influences HIV-positive patients include feelings of blame, shame, fear of rejection, and discomfort. An unexpected finding from the review is that there is a high prevalence of HIV in rural settings compared to urban areas, mainly due to inadequate awareness and higher poverty levels. The key challenges facing FBOs were limited funding and strict religious principles that provoked the stigma of HIV-positive patients. A major literature gap noticed in the studies is that most of them did not analyze how the location of HIV-positive patients in rural settings affected their perception. The other limitation observed in most reviews is the bias in participant selection, such as choosing only male respondents. The proposed study addressed some of the literature gaps identified in the reviewed research articles. Chapter 3 will present the methodology for the proposed study.

Chapter 3: Research Methodology

Introduction

This study aimed to explore HIV-positive patients' perceptions of faith-based community support in a rural setting. As a result, it facilitated understanding the perceptions of HIV-positive patients on assistance accorded by faith-based community support in rural areas. The research focused on the African American populations in a rural area in North Carolina, specifically in Piedmont area clinics, to identify the different interventions by Faith-Based support programs developed in their communities. The study assessed the target group's perceptions and experiences and how responses would be enhanced to improve their quality of life. Historically, churches and other faith-based organizations have formed the foundation for establishing and developing social cohesion and organization in rural areas. The church is equal to a center for disease prevention and health promotion and creates a focal point for health equity (Coleman D. et al., 2010). It is important to note that faith-based organizations in rural areas form the center for belief reinforcement, hence playing a vital role in reducing HIV-related stigma about transmitting the disease. Besides, people living with HIV have different perceptions of the health promotions and disease prevention programs the faith-based community organizations offer. This study used non-probability sampling techniques, convenience, and purposive sampling to get a sample from the population. Interview protocols were used to collect data. This chapter discusses the research design and rationale, the researcher's role, the methodology, issues of trustworthiness, and a summary. I also gave an in-depth analysis of the descriptive phenomenological research tradition used in this study.

Role of the Researcher

The researcher in the study played the role of an observer as a participant. According to Galvin and Holloway (2015), this is a fundamental requirement in the descriptive phenomenological methodology, where the researcher observes the phenomenon in its natural setting. According to Sauro (2015), the observer as participant role ensures that the participants know the observer’s research goals. The researcher had limited interaction with the participants and played a neutral role while listening to them and recording events as they unfolded from the patient's responses. Sauro (2015) asserts that an observer as a participant researcher would quantify the participants’ behavior and statements occurrences and get an idea about the frequency of the perception.

The Research Design and Rationale

Research Questions

This study sought to answer the following questions:

RQ1. How do African-American HIV-positive patients perceive faith-based community support, as defined by their role in African-American faith-based organizations’ societal interventions?

RQ2. How do perceptions of HIV-positive patients towards faith-based community support influence quality of life?

RQ3. How do perceptions of HIV-positive patients towards faith-based community support influence the decision to reveal HIV status?

Central Research Concepts

The central concepts in the study included the perceptions of African-American HIV-positive patients on faith-based community support, the influence of the perceptions on the quality of life of the patients, and the effect of the perception by African-American HIV positive patients on faith-based community support to the revealing of one’s HIV status. The descriptive phenomenological approach is a methodological concept to studying human experiences; it is subjective and based on individuals’ living standards. The researcher focused on how the physical environment influences participant behavior (Van Manen, 2016; Galvin & Holloway (2015).

Descriptive Phenomenology Research Tradition

This research adopted a descriptive phenomenology research tradition. Descriptive phenomenology is a discovery-oriented method that describes the psychological phenomenon’s structure for a more in-depth, holistic, and comprehensive understanding (Broome, 2011; as cited in Giorgi, 2009). Therefore, the approach was critical for this research because it aims to determine the lived experiences of HIV-positive patients and the perception of HIV-positive towards the faith-based community. This approach helped the researcher better understand how HIV-positive patients’ experiences are shaped by their interaction with faith-based organizations in their communities. It enabled the researcher to do proper content analysis and examine experience. It is subjectively lived to develop new meanings and appreciations to inform, re-orient and reform. Moreover, it generalized the understanding and delivery of faith-based community support to HIV-positive patients in rural areas.

Researcher-Participants Relationships

The study established a personal relationship with the respondents by introducing and establishing a rapport and providing instructions to the participants about the research and how it would be conducted. That would help conduct interviews and ensure that the responses given are concurrent with the research questions (Galvin & Holloway, 2015). A personal relationship enabled smooth data collection. According to Prior (2017), a personal relationship would not make the participants shy when providing information. It would also develop a professional relationship to ensure seriousness and professionalism in data collection (Galvin & Holloway, 2015). That entailed controlling the interviews while doing a cross-check of observations on the respondents' attitudes to ensure that they do not go out of the topic since an interview on healthy status can arouse emotions. Establishing a professional relationship would enable the researcher to collect reliable results.

Research Bias

There are potential research biases that were anticipated. The bias included the possible influence of the researcher on the possible outcomes of the responses. To overcome this bias, the researcher remained consistent and resisted any temptation intended to reach positive responses, the measure of the problem at hand, and adhered to the ethical considerations to remain reflexive and transparent about his preconceptions (Polit & Beck, 2014; as cited in Galdas, 2017). According to Pannucci and Wilkins (2017), one way of dealing with biases is identifying them in advance and informing the participants about the possibility of such bigotry and the significance of being honest in their responses to avoid such biases. Researcher bias may also occur from the power relationship between the participants and the researcher. This was overcome through the establishment of a personal relationship with the respondents.

Ethical issues

There were various ethical issues associated with the study. According to the Council for International Organizations of Medical Sciences (2017), the stigma associated with HIV/AIDS can make the participants' confidentiality and privacy an issue. To address this, the participants were assured of biographical confidentiality to protect their privacy. The study utilized the principle of informed consent, a requirement of research ethics (American Sociological Association, 1999). It informed the participants of their rights and roles in the study before it commenced. Participation in the study was voluntary and based on the participant's convenience.

The participants were guaranteed data safety and welfare based on the Health insurance portal accountability act (HIPAA). The data would be kept in utmost secrecy, and the participants were asked to consent whether they accepted their responses to be shared with the relevant academic body. I also collected the data on firsthand without relying on third parties like hospital records which can breach data privacy.

Additionally, participants might demand incentives in the form of facilitation to provide information, which would be done precisely in the form of meal and transport compensation not to affect the interview outcomes. Doing a study within one's work environment may bring about some ethical issues due to prior knowledge of the phenomena. To address that, I examined my beliefs and expectations, documenting them with bracketing and setting them aside not to influence data collection and results.

Methodology

Participant Selection Logic

The target population referred to the entire group of individuals who met the requirements of being the respondents in the study. According to a report by AIDSVu.org (2018), a total of 19,532 African Americans in North Carolina were HIV positive. The qualitative phenomenological research approach required the study of a reasonable portion of the population from which generalization can be made; however, the exact number of people with HIV-positive status in rural areas of North Carolina had not been well unearthed by previous studies. Therefore, this research targeted the population in the Piedmont area as a representative of the population of HIV-positive patients in North Carolina rural. The study used a combination of nonprobability sampling techniques called convenience sampling and purposive sampling to select a group of 7 participants. The study participants were selected using the above two sampling procedures based on their HIV status, previous experience with a faith-based community organization, and the participants' accessibility given the time and resource constraints (Alkassim R. et al. 2016). The participants had to be residents of rural areas of North Carolina and adults between 18 years and above of both genders.

Sampling Method and Sample Size

A sample is a portion of a population taken for a study. It is a crucial aspect of qualitative research. Barratt et al. (2015) assert that a sample helps examine a study's feasibility. This study used non-probability sampling procedures called purposive and convenience sampling to select participants. The two non-probability sampling procedures were vital for this study because they guided the researcher in choosing participants based on knowledge and experience about the phenomenon of the study (Alkassim R. et al. 2016). The researcher built a rapport with nurses in Piedmont area rural clinics to reach the target population and obtain the sample. The nurses who are in close contact with HIV patients are the appropriate health personnel who knows their clients, including their personal history.

The rationale behind such a small sample size is that saturation tends to occur with small samples in phenomenological studies; thus, a sample of 5 to 25 participants would represent the population (StatisticsSolutions, 2020). In this study, the sample size of 7 participants consisted of male and female HIV-positive African American patients aged 18-65 years who had experience with a faith-based community organization. This is because the target population was considered homogeneous (Alkassim R. et al., 2016). In a qualitative study of this nature, there are no specific formulae for calculating the sample size. Accordingly, the researcher may make use of the proposed sample size or even engage fewer or more participants (O'Reilly & Parker, 2013)

This research's saturation point was expected to be attained at seven individuals due to homogeneity. Thus, increasing the sample size would not add any new information to the research. Therefore saturation guided the researcher to the point where sampling should be stopped for adequate data collection. I utilized the homogenous sampling method of purposive sampling technique to select the sample since it is anticipated that many contacted individuals would want to be participants (Barratt et al., 2015). In this case, purposive sampling was used to select the participants that the researcher regards to have vital information that would enrich this study. Barratt et al. (2015) noted that exclusion and inclusion criteria are very significant in qualitative research; one has to be an HIV-positive patient in rural North Carolina.

Furthermore, the patient should have contacted a faith-based organization in the recent past about the past two years up to the study's time to make them appropriate for the research. The participants must agree to be available and easily reachable for interviews. This formed a base for selection into the sample according to the convenience sampling method procedure. Any participant who would not meet the above-highlighted criteria would not be included in the sample since they would not help attain this study's primary objective.

Instrumentation

Data for this research came from secondary sources and primary sources. The researcher used secondary data from the rural clinic to get potential participants who got ARTs assistance from the clinic. That was vital since descriptive phenomenology required the researcher to mask their prior knowledge to avoid bias; hence, public volunteerism would lead to stigmatization or prejudice. Primary data was collected during interviews using a Sony UX560 tape recorder. The tape recorder was preferred because of its valuable collection of features: it can be recharged via USB, has an easy-to-navigate menu, and has a legible backlit screen. This tape recorder was essential for this study since it ensured data safety and security for the transcription process during analysis. The interview protocol developed by the researcher ensured that the researcher collected the data that the study intended to collect (Cope, 2014). Additionally, it ensured the uniformity of questions asked to enhance the reliability of the study. Moreover, the interview protocol provided procedural data collection and discussion of all the study questions. However, tape recording would only be done upon the participant's consent. If the participants did not accept the use of tape recorders, the researcher would take notes of the responses as the participants responded to the questions asked.

In addition to the researcher-developed interview protocol, this study used a Carolyn Perry-*published research protocol* used to conduct a survey of HIV-positive black women in 2012. The protocol was used in America on black-American women who were HIV positive. The protocol was relevant to the current study because it was previously used on African Americans, who were also the target population of this study. However, due to the study's diversity, some modifications were made to the protocol. The questions were tailored to reflect the current situation in the rural areas of North Carolina.

Additionally, questions on Faith-based Organizations were added to capture the theme of the current study. The Questions asked were also modified to cater for both men and women, as provided in the researcher-modified research protocol. While developing the protocol, religion was highly considered because the current study focuses on Faith-based organizations. Therefore, the questions were religiously sensitive to avoid offending the participants.

Validity is an indication of the research instrument's soundness. It ensured that the findings truly reflected the phenomena that were to be measured (Cope, 2014). The modified protocol was sent to the responsive department to ascertain the protocol items' correctness for validity. The researcher first tried out the method during a pilot study to ensure the validity of tape recording as a tool for collecting data. The researcher also personally visited the clinics in North Carolina to cross-check the accuracy of the available data on HIV-positive patients who seek ARTs services in the facility. Additionally, the researcher consulted senior scholars in the field, such as the study supervisor, to examine if the instrument items would match the content they were supposed to gather.

Pilot Study

A pilot study refers to a small-scale pre-study in the study area. It is done to evaluate the feasibility, time, cost, and adverse events of the research to improve the study design before the main research (Manen, 2016). A pilot study is significant to this study because the researcher established the tools' validity through the pilot study and made necessary adjustments before embarking on the main data collection. Additionally, the pilot study enabled me to identify the challenges I would likely face in the actual data collection process and prepare adequately to handle them. Moreover, it familiarized me with the study and the study area. In a particular way, a pilot study enriches the main research (Kim, 2010).

A pilot study was carried out in the northern region of North Carolina. However, the sample results from the pilot study patients were not part of the main study. As the researcher, through the help of the rural clinic and an FBO, I identified the participants and informed them about the research purpose, their rights, and their roles. The pilot study results were analyzed differently and did not form part of the actual study results.

Data Collection Procedure

The researcher used secondary data from the rural clinic records for patients seeking Anti-Retroviral Theorem drugs (ARTs) to locate possible participants. The researcher booked an appointment with the participants at the local clinic in the Piedmont area of rural North Carolina and collected primary data in an interview using the interview protocol. During the research, the participants were assigned name codes to conceal their identity and ensure confidentiality as required in the research ethics (American Sociological Association, 1982). The research tools used in the pilot were the ones used in the main study.

The researcher collected the data using the tape recorder to record the interview conversations as the participants answered the questions. The data would then be transcribed for analysis. After the research, the researcher thanked the participants and gave room for questions and concerns. Afterward, the participants were requested to provide their contact information for easy location whenever a need for the same research emerged. The researcher would maintain contact with the clinic in case of any need for follow-ups to repeat any section of the data collection process. As they left the interview room, the participants were facilitated for lunch and transport.

Data Analysis Plan

Data analysis is a pivotal section of any given research. Drew et al. (2008) wrote that data analysis perhaps has more undesirable undertones in qualitative research than any other single part of the research process. The negative connotation could be ascribed to the fact that data is usually recorded in qualitative studies in words, descriptions, opinions, and feelings rather than numbers. In this study, the tape-recorded data was decoded, cleaned, and arranged thematically according to the study questions.

The perception of HIV-positive patients about Faith-based organizations was be analyzed in terms of their attitude towards the FBO role, their interaction with the FBO workers, and whether the FBO has helped them. Data were analyzed on the quality of life according to medical accessibility to HIV Positive patients, living conditions, economic integration, and interaction with others in society. Revealing the HIV status was analyzed on the willingness to test for HIV, enroll for ART services, and come out to tell others about one's health status without fear of victimization.

The decoding was done manually. Variations in the response were determined by examining the responses from the male and female participants. The researcher would explain the variations. A reasonable number of participants are crucial in making such comparisons (Legard et al., 2003). That would ensure that the study's information is not misleading (Legard et al., 2003). The analyzed data was presented using pie charts and bar graphs using NVivo software, from where conclusions were drawn based on the findings. The discrepant cases were treated as control experiments and were not part of the analysis. However, the research protocol ensured no discrepant cases since the sample size was small.

Issues of Trustworthiness

Credibility of Results

I employed various techniques to ensure credibility. I adopted purposive and convenience sampling methods to ensure the participants met the set criteria for qualification. Prior familiarization with the study area was also done to assess the potential cultural limitations. The researcher conducted a proper consultation on secondary sources to better understand the target study participants. Jonsen et al. (2015) suggest that credibility occurs when complexities are visualized through an analytic process, articulated with tentativeness and openness about the final research outcomes to avoid premature conclusions being made. This ensured the responses from an individual's experiences, and viewpoints were verified against the others’ responses. Thus, a comprehensive perspective of the participants' attitudes, behavior, or needs was developed by the contributions of a wide range of respondents.

Transferability

Transferability refers to the external validity of the research. It is primarily linked with the applicability of the study findings. Qualitative research results are often particular to the environment and individuals (Miller et al., 2014). However, cases of transferability cannot be assumed. Denscombe (2014) agrees that practitioners can infer the findings to their positions if, to their satisfaction, the situations at hand seem like the ones described in a study. In this study, the researcher provided sufficient information about the study area to enable the users to make transfers. An audit trail was used to ensure transferability.

Dependability of Research Findings

The researcher addressed reliability issues to ensure the dependability of the findings. Reliability refers to the ability to get consistent and similar results using the same techniques in a similar study area with equal participants and time (Cope, 2014). The researcher would report the findings in detail to enable future researchers to apply the same techniques and get similar results. The comprehensive coverage would go a long way in allowing the reader to assess the depth to which proper research practices are adhered to. The readers would be able to develop an understanding of the techniques and their effectiveness. With this regard, the study incorporates the research design and its implementation to describe the plan and the execution on a strategic level. Moreover, a reflective appraisal of the project would evaluate the effectiveness of the undertaken inquiry process.

The concept of conformability relates to the qualitative investigator's comparable concern to objectivity in research (Cope, 2014). The triangulation method was used to ensure conformability. The method was used to reduce the researcher's bias. The major conformability indicator was the level to which the researcher accepted his biases. Reliability plays a significant role in any given study. Intercoder reliability refers to the level to which more than one coder agrees to code the data gathered with an application of the same coding mechanism (Cope, 2014). To achieve reliability, the researcher got another coder with prior knowledge of the study objectives to code the data independently. Different coders helped examine the coding's accuracy, thus producing more accurate and reliable results than one coder.

Ethical Procedures

The researcher ensured that participant selection and data collection protect the respondents (Council for International Organizations of Medical Sciences, 2017). The researcher ensured the study participants' confidentiality and privacy by giving them anonymous name codes to conceal their identities. The research subject and the researcher's role were revealed to the participants before the commencement to conform to the ethical requirements of informed consent (American Sociological Association, 1982). Accordingly, any data provided was protected from unwanted access. The researcher handled the collected data with much confidentiality and was only used for this study. Any participants who decided to withdraw from the study were at liberty to do so at any time.

Throughout this research project, trustworthiness was maintained to forestall any unfortunate behavior, as proposed by specialists. Arrangements were made for divulgence to guarantee members' classification by sticking to the Walden University Institutional Review Board (IRB) rules for educated assent and secrecy. The IRB's reason was to corporate ethical research, including human subjects—this exploration ought to be directed with deference for singular decision; instituted with the best level of helpfulness/non-perniciousness conceivable, including the security of members, especially those of weak populaces, and with proper oversight. Even though formal IRB thought of a doctoral understudy's investigation wasn’t directed until one's proposition guard was effectively finished, understudies should be well-acquainted with the IRB's necessities and proposals as they start even the initial steps of conceptualizing their work.

Summary

This chapter provided the methodology to guide this study and the adopted descriptive phenomenological tradition. The research was done in the piedmont clinics in the rural North Carolina area. Convenience and purposive non-probability sampling procedures were used to select the study participants. The target population consisted of both men and women aged 18-65 HIV-positive patients living within the Piedmont areas of North Carolina. Participation in the study was voluntary, and seven people were selected to constitute the study sample. The researcher built both professional and personal relationships with the participants. Data was obtained using interview protocols, while credibility and transferability were achieved through an audit trail. The researcher adhered to various ethical aspects, such as ensuring the participants' confidentiality and tape-recording upon participant consent. Data were analyzed thematically as per the research questions using NVivo software. The next chapter presents the study's findings with detailed data analysis, presentation, and interpretation.

Chapter 4: Results

Introduction

This study aimed to establish and understand the perceptions of African American HIV-positive individuals toward faith-based health organizations in rural areas. In the 2016 CDC HIV report, 476,100 positive cases were African Americans, representing 43.3% (CDC, 2019c). In the same report, the number of Africa American positive cases was 7.3 times that of white people (CDC, 2019c). This issue has been more pronounced due to the increasing LQBTQ community population consisting of 7.1% of the US population (Jones, 2022). In this group, 10% are African American gay people. Most of the participants in this study identified as homosexuals, which made the study establish societal stigma as more pronounced towards them.

Studies have been done on African American HIV/AIDS patients' utilization of healthcare services in the US, as the literature review identified; however, there is limited literature on the same topic relating to FBO facilities. The qualitative study using a phenomenological approach utilized remote audio-recorded interviews where African American HIV-positive participants were engaged in 35-40 minutes interviews. The data analysis worked on three main research questions to find their answers. These included:

RQ1. How do African-American HIV+ patients perceive faith-based community support, as defined by their role in the societal interventions of African-American faith-based organizations?

RQ2. How do HIV+ patients' perceptions of faith-based and community support influence quality of life?

RQ3. How do HIV+ patients' perceptions of faith-based community support influence the decision to reveal their HIV status?

This research study section also elaborated on data collection, i.e., qualification of participants, audio recordings, transcription of the audios, transfer of data into NVIVO 11 software, coding, and phenomenological analysis.

Pilot study

I decided to conduct a pilot study to assess the research tools' credibility and ensure data would be collected effectively. I designed a separate consent form for this purpose that I administered together with the research questions. In the process, I identified some errors in the interview questions that I corrected before conducting the final data collection. The pilot study was conducted partially at the FBO facilities in Piedmont, rural North Carolina, while the other participants were solicited via a flyer via social media. Those willing to participate remotely received a soft copy of the consent form via email that they read, signed, and sent back. Microsoft teams and Zoom platforms were used for the interviews, while physical interviews were recorded with audio recorders. Six participants were interviewed, whose responses identified a few technical errors in the tool, such as some questions being more quantitative than qualitative. After the brief analysis of the instrument and rectification, the interview questions guide was ready to be used for the main research study.

Setting

There was no organizational or personal influence on the participants or the outcome of this study. The participants were recruited following the research ethics as prescribed and scrutinized by the IRB. The study subjects received approved tools approved by the IRB, which included social media flyers and interview questions. Additionally, the approved data collection methods included physical audio-recorded interviews at the FBO facilities and audio-recorded online interviews. The research offered an outlet for the willing participants to proudly share their experiences, opinions, and recommendations regarding the study.

Demographics

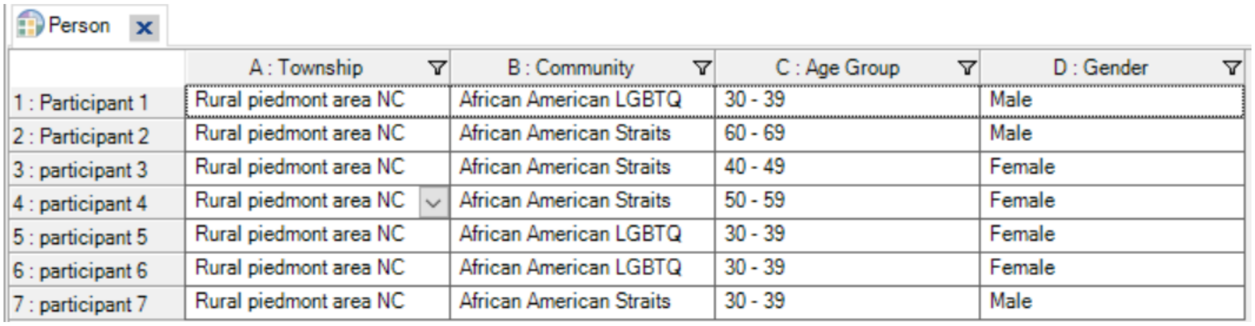
The key demographics considered by this study were race, age, economic level, and gender. To ensure a homogenous model in the designated IPA, I limited the age for inclusion criteria to 18-65. At first, I had considered including a minimum of 24 years in the criteria. However, my committee chair found it unreasonable to omit the 18-23 age group since they can still provide meaningful responses.

Moreover, African American was the participant race in this study since it is one of the minority races in the US and comprises a significant group living with HIV/AIDS, as described in the literature review. The race suffers a lot of racial discrimination and historical injustices, predisposing them to low socio-economic status, thus being exposed to drugs, unsafe sex practices, and many homosexual affairs. This accounts for the high rate of new HIV infections and justification for the race inclusion in the study. Nonetheless, there was no gender discrimination as willing participants meeting inclusion criteria were selected without regarding their gender; hence there were females and males in matching numbers.

Before data analysis, demographics were the first to be screened in the NVIVO software. Even though a few demographic parameters differed, they were essential to identify any unique trend in the responses influenced by such demographics. I created a 'person' as a single case classification. I added gender, age group, community, and Township in this category. Then, I created case nodes from the uploaded transcriptions named participants 1-7. At this point, I could assign each participant a unique attribute, i.e., age group, gender, etc. Finally, I created a case classification sheet to illustrate the demographics, as shown in figure 1.

Figure 1

Participant demographics



	A : Township	B : Community	C : Age Group	D : Gender
1 : Participant 1	Rural piedmont area NC	African American LGBTQ	30 - 39	Male
2 : Participant 2	Rural piedmont area NC	African American Straits	60 - 69	Male
3 : participant 3	Rural piedmont area NC	African American Straits	40 - 49	Female
4 : participant 4	Rural piedmont area NC	African American Straits	50 - 59	Female
5 : participant 5	Rural piedmont area NC	African American LGBTQ	30 - 39	Female
6 : participant 6	Rural piedmont area NC	African American LGBTQ	30 - 39	Female
7 : participant 7	Rural piedmont area NC	African American Straits	30 - 39	Male

Data collection

The first interview was held on August 9, 2022, while the last one was held on September 22, 2022, where seven interviews were conducted. The interview process proved to be time-consuming, as anticipated by the limitations of this study. Even though the investigator got willing participants, they took a long time to create an appointment since most were busy working citizens above 40. The first respondent was solicited via the distribution of flyers; he then assisted me in getting two of his colleagues who met the inclusion criteria. After a week, I got another interested participant through Facebook after posting the flyer on North Carolina groups. I acquired the other three participants via the distribution of flyers at a waiting area in Piedmont rural areas FBO clinics.

Each participant was taken through the consent information process, where they were explained the study, risks, and benefits. They were also given a physical consent form for those who availed themselves physically and via email for those interviewed remotely. Fifteen responders were interested in participating in the study, but eight did not meet the inclusion criteria. Mostly it was because they did not reside in rural North Carolina and had never utilized the services of FBOs. These were thanked and appreciated for their interest in being part of the study and discharged.

At the start of the interviews, the participants were reminded that they had a right to ignore the question they had no idea about. They were also notified that the interview was being recorded, and thus, they should avoid sensitive identifiers like names and ID numbers. The interviews lasted between 9 and 17 minutes. This variation was influenced by the participant's level of knowledge and willingness to provide detailed responses.

Data analysis

Before the start of the analysis on NVIVO software, I had an opportunity to read through each transcript I made, to obtain key questions and thoughts that inspired the analysis process and generate critical findings. As Willig (2008, P.58) described, the investigator applied the IPA protocol (Interpretive phenomenological analysis), effectively identifying themes after re-reading the transcripts, structuring the analysis, producing summaries of themes in table forms, and constructing a cohesive narrative.

Nonetheless, I performed a descriptive analysis noting keywords, data sets, emotions, and phrases used by participants to explain their experiences and opinions towards their past utilization of FBO services. For instance, participant 1 saying, "I was disappointed with myself, I was angry," is a highlighted code that elicits relevant emotions that can facilitate exploring if FBO services helped the individual come to acceptance and live with the condition.

The last strategy in gathering analysis data was using a conceptual approach. Even though this method was time-consuming due to brainstorming demands, it helped generate more meaningful information, creating major themes at the end. After analyzing the participant's storytelling and emotions, I formulated several concepts; stigma, quality of life, acceptance, insight, and feedback. This was done with the help of a pen and a piece of paper while making the drafts to come up with meaningful themes and categories. I moved the highlighted codes into relevant categories such as motivation to treatment and coping, image and rating, awareness, health information and recommendation, and positive, negative, and neutral emotions. I finally deduced four key themes from these categories: attitude, Experiences, knowledge, and perceptions. When carefully examined, these themes can closely answer the research questions and relate to the research topic. Below in table 1 is an illustration of the same.

Table 1

Themes, Categories, Codes

Themes	**Subthemes**	**Codes**
Perceptions	Image	Uninterested, stigma in FBO, Ritualistic ways, untrustworthy, non-sensitive, hypocrisy, mean, disappoints, hope, renews faith, helpful, listening, racism, judgmental, more effective.
	Rating	1, 3, 5, 7, 10
Attitude	Positive	Take it positive

		Absolutely positive Nicer
	Negative	Negative person Negative attitude
	Neutral	Different Depends
Knowledge	Awareness	Well-being, abscondance, unaware, marketing, fears, education, regular checkup, raising voice.
	Health information	Side effects, counseling, information, Viral load, T-cells, medication, specific diet, self-esteem, training population, Misconceptions.
	Recommendation	Ensure equality, overcome fear, save more people, be empathetic, compassionate, regular testing and more funding.
Experiences	Coping	Stigma, disappointment, denial, acceptance, despair, suicidal, peace, decision, closer to God.
	Motivation to treatment	Vaccination, Church screening event, Faith, Good treatment at FBO, Quality of care at

		FBO, Purpose, Hospitable, Ambassador, adherence, positivity.

Evidence of trustworthiness

Credibility

As highlighted in chapter 3 of this research, I applied three fundamental principles to describe credibility: transparency, rigor, and sensitivity to context. Data Sensitivity in research can be established by considering the participants' voices by recording their experiences and then converting them from audio to text verbatim (Smith et al., 2009). The participants were comfortable sharing their stories which necessitated I avoid bias. I did this by keeping a record in the form of a reflective journal throughout the data collection process until I began the data analysis. This ensured I avoided preconceptions and personal conclusions that could cause before data analysis.

I adhered to rigor through an intensive interviewing process where I could clarify interview questions for better understanding and appropriate responses. Unlike the documented interview time frame of 35-40 minutes, it took a maximum of 60 minutes for some respondents who occasionally provided irrelevant responses prompting the interviewer to clarify and throw a question again. The interview questions provided a rigor that kept the subjects on track in answering pertinent questions. One participant withdrew after getting an emergency matter to attend to, leaving behind seven participants who provided detailed responses. While applying the three analysis approaches for IPA (linguistic, conceptual, and descriptive), data was adequately analyzed.

According to Moustakas (1994), getting participants' feedback from their analyzed data is crucial to ensure rigor and hence trustworthiness of a study. I did this by sending soft copies of the initial analysis after transcription to the participants through email. They provided feedback on the context of their perceptions towards FBOs as initially analyzed. On average, I received a rating of 8/10, where the majority agreed the analysis was perfect, while only one participant provided more insights and rated 4/10. Nonetheless, I was confident that this feedback, alongside other study methods, established rigor in the research.

The last effort put into rigor was looking for peer reviews, which ensured the study had no self-biases or other errors (Johnson et al., 2020). I consulted independent research experts who had no affiliation with my school to get honest and unbiased feedback. I sent a copy of the initial data analysis, transcripts, and codebook. My analysis report was identified as satisfactory, while the codebook had some redundancy, where I was advised to compress some codes into clear and meaningful categories, e.g., have 'awareness' and 'experiences' as subthemes of 'knowledge.'

Transferability

Transferability becomes visible in a study when behavior and experiences description provides sufficient meaning to the document reader. The content can make sense and be meaningful to the 'outsiders' (Korstjens & Moser, 2018). The information in this research is first written in the participant's language before an interpretation is provided, making it universally understandable and letting readers compare it with what they have experienced. This study is thus transferrable to other settings, such as other races living with HIV.

Dependability

Dependability refers to having a reliable study, a qualitative study in this context. Even though research results are never duplicated, a study's research methods follow a particular formula to ensure the dependability of the research (Smith et al.,2009). Therefore, research should use a detailed narration of the results, which allows another investigator to follow the same process but obtain different results since study settings and other conditions vary. This study provided detailed documentation, including recruitment flyers, an open-ended interview guide, a pilot test, consent forms, and a code book in the appendix section. The move creates a guide that can help other researchers conduct studies of similar nature with ease.

Confirmability

Confirmability focuses on the researcher's objectivity, allowing other readers and researchers to confirm the study findings. It helps to establish that the findings are not derived from researchers' opinions but from the collected data (Shenton, 2004). It is the last step in the establishment of a study's trustworthiness. In this study, I stepped away from the data for several days after each step, from transcription to the end of the analysis. I also kept an audit trail and a reflective journal in the data collection to prevent personal biases. Additionally, I provided direct quotes as spoken by the participants and transcribed (Smith et al., 2020). This helped to unravel the participant's thought process, which implies that the results are not my ideas.

Results

Since this research had to answer three questions, the analysis led to results related to Perceptions of HIV-positive African Americans towards FBO facilities where the parent objective was conveniently established. According to Given (2008), qualitative researchers are interested in participants' perceptions to understand what they have experienced in social, cultural, and individual interactions. They do this by carefully analyzing participants' emotions, storytelling, narratives, and reactions to concepts or individuals. Likewise, this study's first research question was answered by directly assessing the participants' attitudes and perceptions as stand-alone themes.

RQ1. How do African-American HIV+ patients perceive faith-based community support, as defined by their role in the societal interventions of African-American faith-based organizations?

Perceptions

The seven Participants received the same set of interview questions, but some had comprehensive details while others were quite brief. From this interaction, I could establish two sub-themes that worked under Theme perceptions: Image and Rating. The participant's positive or negative description of how they perceived GBO facilities in NC rural was categorized as the image they had. On the other hand, they were asked to rate the facilities based on their experience directly. This rating stood out as a sub-theme that would help the facilities know how the community in question ranks them.

Image

Even though several participants expressed a dissatisfying image of FBO services, the majority described a positive image of the same. Those who praised the FBO'S efforts in caring for HIV/AIDS patients had this to say.

> Participant 2 agreed with this statement: 'faith-based organization would represent the image of their faith and how their health workers could handle HIV-positive clients.'

Participant 3: '… I'm only familiar with a few, and everyone that I have been to is, is basically uplifting and, and inspiring….'

Participant 5:' Um, I guess it doesn't make you feel like straight medical; I guess it's just the quality of care. Like you have someone who will pray with you and talk to you and actually listen to you'.

Participant 4: '…And I think that a faith-based organization could probably help those individuals just to be on a path of some sort, …that a faith-based would, um, give them a path and a, and a more of a purpose….'

For the participants who had unsatisfactory remarks had this to say:

Participant 1: …' Uh, I think that the stigma that's in the faith-based arena keeps a lot of people away from it... That's the last place that I would go to; it's just no trust; there's no trust...'

Participant 1 also responded negatively to this question: 'Do you think that faith-based organizations represent the image of their faith and how their health, um, workers handle HIV-positive clients?'

Participant 6: '…I feel that, um, that you would need intense training about the sensitivity of our population due to how some people contracted the disease'.

Participant 7: 'Um, but for the most part, I, I'm usually comfortable that I experienced people being, uh, very rude to me as, as nurses and, you know, I have experienced it, but for the most part they're, you know, no, like, I feel like they are, um, they, I don't know. I feel like that's everywhere every, you know, everybody can be rude'.

After exploring the word frequency for the image sub-theme, it was established that most of the conspicuous words portrayed a positive image, as shown below.

Figure 2

Word frequency for image

Rating

When asked to rate the FBO out of 10, the participants had an opportunity to evaluate the performance and quality of care at those facilities. This rating directly demonstrated their perceptions. Three people rated less than five out of ten, while four rated five or more. Therefore, this confirmed the accuracy of the described image the participants had given.

Attitude

To reinforce the theme of perception, attitude as another theme was used to assess the relationship between participants' emotions and their decisions to choose FBO facilities. The findings established that participants with negative attitudes towards FBOs were likely or had already stopped using their services. For example, participant 1 had this to say: '…That's just my last place to go to in my head only because of what I've been through with church. And it hasn't been a physical, um, you know, condition. It's just been just, um, emotional….' The same participant responded to the attitude question as follows: '…I don't like to be a negative person. Um, but I think the faith-based community can do way better'. Secondly, when participant 6 was asked if FBO had helped them with any information to improve their lifestyles, they responded: '…professional organizations may offer the great deal system...'.Moreover, the same participant had a negative attitude toward FBOs. She said, 'I have a negative attitude because I feel due to being almost nonexistent and few far in between they not addressing the needs' (min 07:30).

RQ2. How do perceptions of HIV+ patients towards faith-based and community support influence quality of life?

Experience

The client's experiences as a theme were part of an expression of how their interaction with the FBO facilities imparted information and inspired them to adhere to treatment, accept their condition, cope with the virus, and educate others. This was examined by one subtheme: Motivation to treatment. It was noted that some participants had mixed experiences feelings about their experiences, especially regarding their motivation for treatment.

Motivation to treatment

A participant was demotivated by the absence of HIV screening events like they do for other diseases, which could portray a stigma against the virus or perceive it as a product of sin. This can be pretty demotivating to seek healthcare services at such facilities. The consequence of demotivation is a poor quality of life since the patients feel stigmatized, neglected of little worth hence their quality of life becomes poor. Their viral load will go high while their CD4 cell count will drop. For instance, participant 1 had this to say:

> '…The church will hold a vaccine, um, drive-through for COVID-19; they'll hold a vaccine drive-through for monkey pox. They'll hold, they'll hold a drive-through for, uh, flu shot. Um, the whole of the, but you rarely see a church saying, Hey, we have HIV testing today….'

Participant 3 expressed her motivation to seek treatment in FBO as her down spirit becomes elevated when she receives care full of encouragement at the facility.

> '…Once I go seek treatment or whatever, and I, I, I mention that when I leave, everything that I took in is left there….'

Moreover, other participants said that the therapeutic treatment they received from the health workers motivated them. This positivity is the beginning of embracing a high-quality life among HIV/AIDS patients (Mbilinyi et al., 2011). For instance, participant 7 said:

> '…They have offered me, um, you know, the therapy they've offered me, um, a great deal of, you know, positive advice and to, you know, just stay positive regardless….'

Other participants agreed that they had been motivated by the quality of care available at FBO facilities which could encourage them to stay loyal to the facilities.

Participant 2: 'Just the quality of care that I receive.'

Participant 5 agreed to the question about becoming an HIV/AIDS ambassador based on the motivation to live a quality life thanks to the FBO facilities:

Participant 5: 'Yeah, a hundred percent.'

Knowledge

Participants were assessed on their level of knowledge about health information, which directly influences their quality of life. Knowing basic information about HIV, body immunity, and treatment is the first step towards actively participating in one's healthcare process. The sub-theme of health information was then explored, as the results show below.

Health information

All participants in the study were knowledgeable about drug side effects, and none of them had experienced any side effects from the antiretroviral drugs:

> Participant 1: '…um, no, I've been on my medication for four years now, and I don't, I haven't experienced any side effects...'
>
> Participant 2: 'I haven't had any side effects.'
>
> Participant 6: '…side effects to that of using the antiretrovirals? No'

Some participants expressed a rich knowledge of health information due to their health-seeking at FBO facilities. For instance, Participant 3 had gained knowledge about diet and mental health, and she was living the example. The participant also boosted her self-esteem through the invaluable health information she had acquired from FBOs. Likewise, participant 4 had a related response.

> Participant 3: '…give you a specific diet and talk about the importance of a positive mind… And they encourage you to, like, if you are, if your mindset does start to, you know, if you get depressed or sitting around feeling hopeless or whatever, they encourage you to reach out to someone that will listen and, um, you know, give you positive advice to keep you encouraged'.

> Participant 3:'… yes, it has. Um, you know, it has; they encourage me to, you know, share my experience with others, you know, without the shame….'

Participant 4: '…I guess it could improve your self-esteem if you're there again in that type, that frame of mind and that mental state….'

Participant 2 seemed well informed since, when asked about his expectation of support from FBOs, he listed key scientific concepts that are essential to HIV-positive individuals:

> Participant 2:' To make sure that viral load is suppressed, and these T cells were increased… Regular testing? '

Participant 7 expressed her interest in educating others about the virus and fighting misinformation, myths misconceptions, thanks to the knowledge imparted by FBOs:

> Participant 7:'… I've decided to use my voice to, you know, educate, even if I go to schools and high schools and talk or, you know, even if I'm at the hospital and, you know, I could be given getting a regular checkup, and I see, you know, young girls or young boys, I would use my voice to, you know, speak on things and children to be, you know, careful and to protect their self and, you know, just to educate them more about it. And it doesn't mean just because somebody has this disease that is contagious or you can't touch this person, or you can't sit beside this person because you feel like you would contract that disease...'

RQ3. How do perceptions of HIV+ patients towards faith-based community support influence the decision to reveal HIV status?

The participant's coping level was assessed as a subtheme under experiences which highlighted their acceptance after the process of grief due to the shocking diagnosis. In the coping process, different participants expressed different periods it took them to accept their condition. Moreover, awareness and recommendation were other categories explored under the themes; of experiences and knowledge. The influence of FBO facilities in helping the patient reveal their HIV status proudly was thus assessed by digging into how the facilities helped them to cope and spread awareness. The recommendation was open feedback that participants got as an opportunity to express their confidence and control over their health by suggesting what the FBO facilities and government can do to improve the health care services for HIV/AIDS patients. It was noted that all participants had recommendations to make after accepting to live with their condition.

Experiences

Coping

Since their first day of diagnosis, it took the participants different durations to get used to living with HIV. Some reported seeking FBO services for counseling and drug therapy; others used other professional facilities, while some battled it on their own until they came to terms with it.

Participant 1: '…' first is hard to accept… I was disappointed with myself, I was angry….' Moreover, participant 1 reported that he accepted the positive status on his own without seeking any psychotherapy, and it has been six years of coping.

Participant 1 (02:50): '... I accepted it on my own….'

Participant 1 (03:49): '…it would've been six years so far….'

Participant 1 (09:38): '…From plenty of times I felt like giving up, um, with this journey'…

Participant 2 responded that it was so easy for him to cope and accepted the diagnosis immediately, on his own and has lived with the condition for eight years and has never felt like giving up.

Participant 2: 'immediately'…' on my own'…' 8 years'.

Speaker 1: Look, all right, is it a time you felt like giving up on your journey of living with?

Participant 2: 'No'

Participant 3 took a few months to come to terms with the diagnosis. She had suicidal thoughts, which necessitated seeking therapeutic help from FBO facilities for psychiatric counseling and spiritual guidance.

Participant 3: '…about nine months to really accept it.'

Participant 3: '…I did see counseling because I was in a dark space in my life, so I was somewhat suicidal….'

Participant 3: 'I was diagnosed in 1987.'

Participant 4 did not take long to accept the situation, nor was she depressed to seek therapy.

Participant 4: 'Um, honestly, it didn't take that long….'

Participant 4: 'Um, I just accepted on my own, and just, you know, I just stepped forward.'

Participant 5 said that it took her a week to accept and had to do a second test to believe.

> Participant 5 (00:45): 'um, it took about a week for it to hit. Um, and I did ask for a second test to be done. (01:12): I sat it on my own; I didn't own anyone to know. (01:27): 'Two years.'

Participant 6 said she had difficulty making peace with living with the virus after diagnosis. She repeated a series of tests unbelievably. However, due to the incompatibilities in the church organization near her, she did not seek therapy in the FBO facility. It took her four months of denial, but she has coped with the condition for four years.

> Participant 6 :(00:28):' I was diagnosed almost four months, four years ago, and it was very difficult. I went and got two tests, and it was also positive. (00:55): I would've preferred a church-based organization to help me, but it was a mixture of French health and moving on. (01:11): 'Four years.'

Participant 7 said that it took her a long time to accept living with the virus, especially in the first year. She agreed that FBO facilities had a partial influence alongside other professional centers that helped her to cope. She finally accepted the status, and she is making better choices.

> Participant 7 (00:26): '… it actually took me a very, very long time to, like, come to grasp…I have accepted to say I've been dealing with this for like four years now. The first year was, was the most difficult one…I'm living my life healthier now, and I'm making better choices and decisions now'. (01:26): 'Um, I would say a little bit of both. I did receive some professional, you know, help about the situation'.

Participant 7 (11:21): '…I will be living with this disease, but now it's, it has been peaceful, very, very positive'. (13:35): '…it has really drawn me closer to, you know, God….'

Knowledge

Awareness

Not all participants had received actualized the awareness spread by FBO, but some had a positive message to share with others, educate them, and proudly disclose their HIV-positive status. Participant 2 seemed to be less aware or could have overlooked HIV/AIDS care services available at FBO facilities.

Participant 2: 'I haven't been to any faith-based close.'

Participant 2:' I think they are there.'

Participant 2 (07:08): '…I would not decide to be some ambassador. Um, and yeah, no….'

Participant 2 (09:30): '…I don't think that a lot of people are aware … So I think that maybe better marketing at this point….'

Participant 5 was aware and knowledgeable about the multidisciplinary health teams available at FBO facilities and their duties but was not very conversant with the locations of FBO facilities in rural areas.

Participant 5: (04:23):' I mean, yeah, I guess they could, some churches have like health ministries that are nurses and doctors that are placed here to help, I guess, any type of disease, kind of like if you had diabetes or, you know, hypertension, they would be there to help.' (06:15): 'I don't know. I've never really looked'.

Participant 6 awareness of FBOs and HIV/AIDS was highly informed by the stigma and fears she had experienced.

> Participant 6: 'Yes. This has opened my eyes and shows that there are more needed ambassadors for HIV and aids support services. FBOs are quick to do other services but do not want to address HIV aids because of the stigma and fears'.

Participant 7 seemed to believe in raising her voice after being motivated by FBOs to cope with the situation. She was focused on educating other groups about how to live with the condition.

> Participant 7 (01:26): '…getting healthier and find ways to, you know, educate the community more about it…' (06:51): I'm educating others in the community, and I'm using my, my situation to be a voice….'

Knowledge

Recommendation

The participants were given an opportunity to give their recommendations for improvement based on how FBO facilities have treated them, weaknesses, and gaps available. This was only possible by people who had accepted their positive results and proudly lived with their condition.

> Participant 1:'… look at people as wholesome and everybody as equal…' (06:19): '…I'm hoping that the church could be able to provide the same care that they give to certain entities…' (13:17): …' I think if the church hits if they overcome that fear, I think a lot more people, we could save a lot more lives...' (15:03): 'They need to have more empathy. They need to be more compassionate…' (16:45): '…I just want the church to do

better. That's all…' (17:08): I just wanted the church to practice what it preaches. That's all.

Participant 2: 'Regular testing?'

Participant 2: 'The resources that we need continued, manage life with what we have….'

Participant 3: 'I think that they should be more supportive that, you know, it's like, you know, more funding, more knowledge, just more support.'

Participant 5 (09:34): '…listening, given that extra, uh, support that we need…' (10:12): '…have people that, that work there that have tested positive for, um, HIV and they've lived past the quote-unquote expectation, um, survival rate. That, that means a world. Like if you can see someone that's just like you...' (11:37): 'job funding… but they don't have money unless someone gives it…' (11:47): they're hardly compensated….'

Participant 6: (06:57): '…more servicing in the state, North Carolina to assist people…' (07:16):' Um, I say communication.' (07:56):' For, um, more funding and training sessions to address the epidemic.'

Participant 7: (14:25):'… it's just proper education… to keep God first...' (15:06): to come up with meetings and community meetings…' (16:53): 'Uh, to put more funds… bring awareness to this topic'… proper medication'.

Summary

This chapter gathered four key themes to answer the three research questions: attitude, perceptions, knowledge, and experiences. The themes of experiences and knowledge came out more visible as the main influence of perceptions that African American HIV-positive community have towards FBOs. The third theme which was quite useful in the study was the perceptions. Moreover, two subthemes strongly demonstrated the achievement of the main objective of this study: coping and image.

Research question 1

The first research question about how HIV+ African Americans perceive FBOs based on the facilities' social interventions was entirely answered by the themes of perceptions (subtheme: rating and image) and attitude (subtheme: positive, negative, and neutral).

Most participants positively described FBO facilities when assessing the 'image' subtheme. They attributed the facilities to a good representation of their faith by having health workers who offer HIV-positive clients a caring hand. They agreed to have been inspired and uplifted besides being attended therapeutically. Some participants also stated how they were spiritually lifted by having someone pray with them and listen to them at the facilities. Nonetheless, FBOs were mentioned as path and purpose-providing institutions to their clients.

On the negative side, some participants attributed the FBO facilities with a stigma, leading to a loss of trust and keeping patients away. Moreover, some participants mentioned a lack of sensitivity to HIV among the health workers and recommended more training for those who diagnose and care for HIV/AIDS population. Lastly, a participant said that rude nurses and other workers at FBO facilities kept him away.

Nevertheless, participants were asked to rate the FBO services based on the quality of care offered. The majority provided a rating ranging from average to ten out of ten. The majority of those who gave a high rating were females. The tone of the majority of men demonstrated a poorly rated facility.

Research question 2

The second research question was about HIV-positive patients' perceptions of FBOs and how it influences their quality of life. The theme of experience was explored through the subtheme 'motivation to treatment' while the theme of knowledge was explored through the subtheme of 'health information. It was established that some participants were demotivated by how FBO facilities overlooked the HIV topic and preferred to hold campaigns and screening events for other diseases. They stigmatize the virus and never want to associate the church with it. This demotivates the patients against seeking care at the facilities.

The participants who expressed motivation for treatment at these facilities attributed it to a more positive and gentle therapy. Others described the services as of high quality. Nonetheless, one participant agreed to be highly interested in becoming an ambassador and spreading the motivation to others diagnosed with HIV in their community.

On the level of knowledge towards health care as a theme, the participants expressed a significant possession of health information, especially fundamental scientific concepts revolving around HIV. They all knew the drug side effects and had never experienced them despite being on ARVs for a long time. A cross-section of participants demonstrated a rich knowledge of immunity-boosting diets and sound mental health especially avoiding depression and embracing high self-esteem. Nevertheless, other participants could mention the importance of regular CD4 cell and viral load count in the disease monitoring process. The last participant vowed to educate young people in schools about the disease.

Research question 3

Research question 3 was about revealing HIV status as influenced by the participant's perceptions towards FBOs. First, all participants were to have accepted their positive status to qualify for the study. However, those who participated had a story to tell on their journey towards coping since day one of diagnosis. The study focused on how FBOs helped them cope and proudly reveal their HIV status.

Most participants reported having gone through the denial phase of depression before accepting the results. Some even admitted to having taken a series of tests in disbelief. The majority coped without needing therapy, while a few sought spiritual help and counseling at FBOs. During the interviews, most participants had managed HIV for more than five years. Indeed one lady (participant 3) had coped with it for 35 years since 1987. Generally, even though the majority coped without FBO's help, they appreciated its presence which gave them a reason to live after they got their diagnosis from there.

On the subtheme of 'awareness' under the theme of 'knowledge, a section of participants embraced awareness by spreading a positive HIV/AIDS message they had obtained from FBOs. They were also asked about the services offered by FBOs. Only one participant could hardly tell about HIV/AIDS care at FBOs, while the rest were aware. Another participant recommended marketing as a strategy to make the public aware of FBO'S HIV/AIDS support programs. Nonetheless, a cross-section of participants was aware of the stigma, fears, myths, and misconceptions associated with HIV. They vowed to raise their voice to educate other groups.

Lastly, participants were allowed to give recommendations to accomplish the ultimate process of opening up and revealing their HIV status. The most visible recommendations were government funding to FBOs, ensuring equality in healthcare, being more compassionate and empathetic, regular testing, and offering more community education.

The next chapter (5) discusses the results obtained from this study. This will link them to the theoretical framework and available literature and help to elaborate on how the research would have answered the research questions. Looking at the demographics, gender played an influential role in the responses.

Chapter 5: Discussion, recommendation, and conclusion

Introduction

This study was conducted to establish the perceptions of African American HIV-positive towards FBO's social and health support in rural areas. According to the CDC infectious diseases data on HIV for 2019, 14300 new infections belonged to African Americans, representing 40% of the new infections (CDC, 2020). Even though HIV.gov (2022) is determined to reduce these figures by 25% in 2025 and 90% by 2030, this number is expected to rise proportionately as the population grows. Another issue is the growing population of the LGBTQ community, which requires more attention and prevention measures since the risk of infection is higher among them (Hallett et al., 2011). This study considered both straight and LGBTQ communities to participate to ensure fairness and a more effective solution for black communities. Nonetheless, due to the high cost of medical and psychosocial support in many private facilities, alongside racial discrimination, the African American communities prefer non-profit organizations such as faith-based ones used by this study as one of the variables (McDonnell & Idler, 2020). Therefore, this study was based on strong grounds of visible challenges and issues facing African American HIV/patients and thus can help uplift their lives.

Numerous studies have been previously done on African American community and HIV/AIDS. However, studies providing the association with faith-based facilities are limited. As described in the literature review section of this study, Anugwom (2018) is the one who did the closest research title to this study, but the study was done in the Enugu state, Nigeria. However, a lot remained unexplored since the African healthcare system differs by a big gap from that of the United States. The existing research gap established by the literature review led to this study's success in obtaining key findings, as interpreted by this research chapter.

Interpretation of findings

This study's interpretations were interconnected to the previously reviewed and existing literature. This was done to validate the results and fill the existing literature gap at the end of the study. The four themes were compressed into three areas based on the previously described existing literature: Quality of care Perceptions, Perceptions of spirituality, and Perceptions of equality.

Perceptions on quality of care

According to a study by Ochillo (2017) on FBO influence on HIV prevention in Africa, it was established that religion and social support offered by FBOs had improved the quality of life. This finding goes in parallel with that of this study. As reported by the majority of the participants, they had improved their quality of life due to coping, medication adherence, regular checkups, and embracing life positivity thanks to the FBOs' concoction of health and spiritual interventions. All participants expressed being shocked after receiving the news of the diagnosis. However, Chippindale and French (2001) argued that pre-test counseling promotes quality of life by preparing the client psychologically to receive the bad news. This reduces suicidal cases and depression.

In this study, the majority described the FBOs they had visited with a positive reputation. Their attitude was majorly positive except for a few who had been disappointed with the services. The majority also rated the facilities at five or more. This implied that they had been impressed by the services offered. According to Somi et al. (2021), HIV patient satisfaction with care promotes adherence to antiretrovirals, leading to reduced viral load and the suppression of CD4 T cells. In turn, this is an indicator of improved quality of life among HIV/AIDS patients.

Nonetheless, the study established that FBO facilities had established strategies that motivated the participants to seek HIV care. For instance, some FBO facilities have established programs to use HIV/AIDS patients as champions and ambassadors to spread awareness. This was mentioned by one of the participants, who was proud to have taken up such a position. Another participant proposed putting up some HIV-positive health workers to motivate patients, especially recently diagnosed ones. CDC (2018) has supported and implemented a community ambassadors program where survivors of different diseases and those suffering from chronic illnesses are installed as ambassadors. This motivates the depressed and demotivated ones to adhere to medication, lifestyle, and dietary recommendations.

Additionally, some participants expressed demotivation with FBOs services and programs. They said that churches had stigmatized HIV and preferred to hold screening and primary prevention events for other diseases. Another participant reported rudeness among healthcare workers, which kept them away. According to Shrestha et al. (2021), 40% of the 121 HIV-positive participants had a suboptimal level of medication adherence, resulting from a lack of motivation for treatment at the healthcare facilities. This greatly affects patients' quality of life and reduces their life span.

Perceptions on spirituality

Spirituality is an important aspect of human life where they seek connection with a supreme being to find life's purpose, peace, and hope (Scott, 2022). The primary goal of faith-Based hospitals is to support people's spirituality hence bestowing hope, faith, and good morals. In this study, I established that half of the participants were spiritual, inspired by the FBOs. Some responded that FBOs had helped their faith more than physical health. This was attributed to prayer sessions with patients, preaching to them, and installing a chaplain who talks to the patients on spiritual matters. The other half of the participants were less interested in being neither spiritual nor religious. Indeed, despite growing up in a religious family where the father is a bishop, one participant said he dislikes the church for its hypocrisy. According to Unantenne et al. (2013), long-term chronic illness management requires mental fortitude, adherence to medical advice, and being committed to adjusting socially. To achieve this transformation, many patients embrace spirituality or strengthen their faith in their religion. This is the typical process that half of the participants had undergone. Being at peace with their God made it more therapeutic than just taking medications.

Nonetheless, according to Tebei et al. (2016), spirituality was described as a natural capacity that provides positive health effects. Spiritual powers were found to reduce anxiety and help patients, and their families accept and cope with the diagnosis. This kept most of the participants soldiering on with life every day.

Moreover, Swihart et al. (2021) describe religious-cultural competence as providing healthcare services that consider and meet the patient's social, cultural, and religious needs. This ultimately improves patients' quality of care and health outcome. This study focused on African American communities where the majority are Christians and have unique life practices. The participants reported having spiritual welfare considered even when some were not interested in that. When cultural competence is considered, therapeutic communication promotes drug adherence and motivates patients to develop an interest in regular checkups (Swihart et al., 2021). This is what happened with the majority of the participants who had coped and embraced health-seeking behavior.

Perception on equality

The participants were examined on their perceptions of whether there is equal treatment at FBOs based on race, culture, and economic capabilities. In this study, spiritual equality had been established all participants were okay with their Christian religion being the dominant one in these FBO facilities. However, it would be hard to tell if other religions were discriminated against since all participants treated were Christians. However, inequality dominated on the race question. All participants had experienced or believed that African Americans were discriminated against based on their skin color while seeking healthcare or social support at these facilities. According to Rutledge (2021), healthcare providers at individual or institutional levels should strive to ensure that patients receive competent, equal, and sincere treatment options. However, this does not usually happen due to a lack of culturally competent and racially unbiased treatment options. The study recommended that institutions develop programs and policies that provide sound care that considers diversity and equality. They should also hire healthcare workers who can provide equal care across ethnicities and races. This was reflected in the participants' recommendations, where they raised racial discrimination issues.

Theoretical framework

As stated earlier in the literature review, Social Cognitive theory was the closely identified theory that guided this research topic. SCT describes how different experiences, environmental factors, or people's actions influence how individuals' health behaviors (RhiHub, 2018). Moreover, Bandura (1999) posited that SCT incorporates environmental, cognitive, behavioral, and biological elements. In this research, SCT was reasonably practical in guiding its process. Like this study, several others have successfully applied this theory and obtained relevant results. For instance, Li et al. (2011b) conducted a study on HIV education programs in high schools by applying the effects of SCT. The study found that SCT had effectively contributed to the efficacy and feasibility of cultural adaptation to the administered FOK programs for HIV prevention in high schools.

Likewise, in this study, participants were treated differently in FBO facilities. Some had gone to better FBOs than others. These had a better image and story to describe those facilities. They could praise those dissatisfied who could rate the facilities poorly and give a bad image description. Therefore, this theory enabled this study to obtain real experiences and data about FBOs' services since patients could cognitively think and offer sound judgment and reasoning regarding their perceptions.

Limitations in the study

This study considered common limitations that affect qualitative studies, especially biases. As discussed earlier on the trustworthiness issue, bias can threaten the same, leading to skewed results. Strategies were laid out as advised by the IRB to avoid bias. This included avoiding the involvement of workmates as participants, which may lead to biased responses.

Secondly, since I am an African American, it could lead to bias since the subjects were also of the same race. In response, I formulated an interview guide with a series of questions that were strictly followed to avoid biases but stick to the interests of this research.

As a norm of phenomenological study design, a small sample size is picked to obtain rich data and establish patterns. The limitation can occur where emerging patterns may not be found with a small sample size. To counter this, the initially proposed sample size was 5 participants; however, during data collection, the size was increased to 7 until the process became saturated.

Nonetheless, it was time-consuming to carry on the process in qualitative research since one participant could take even one hour and have to record the audio multiple times, which makes the data cleanup quite challenging. To manage this challenge, I created appointments with willing participants where we met at our convenience or held a meeting remotely. This ensured no one was bothered by their schedules. Moreover, I analyzed the data on a fast computer that conveniently helped to discard non-useful pieces of audio and transcribed the rest.

Recommendations

Most of this research's literature is centered on the perceptions of African American HIV/AIDS patients on FBOs (Ochillo et al., 2017). The study was done to establish the perceptions of African American PLWHA towards FBOs, where they seek health services in rural North Carolina. HIV/AIDS is a broad topic that requires dynamic research as there are gaps when the world advances in various aspects. Since the emergence of the Covid-19 pandemic until its control through vaccination, HIV/AIDs had been overlooked yet had no cure, unlike Covid-19 that, which could heal spontaneously.

The researcher recommends continuous HIV/AIDS studies, which are not interfered with by seasons. In this study, I had my findings; however, there is still a big gap, especially in different demographics and geographical coverage. Future studies can probably be conducted on Hispanic-American or Asian American communities. It can also be conducted purely on queer society. This helps the specific community by addressing its needs.

Nonetheless, this was a phenomenological study that examined participants' real experiences with healthcare at FBOs. However, future studies can be conducted using longitudinal studies, which can control key demographics and test others. Moreover, more studies can be conducted in this field. This can identify severe suffering, people in denial, and unique cases requiring more attention.

Furthermore, the participants were an eye opener by providing key proposals to help the FBO facilities improve their services. They recommended more funding from the federal government to the FBO facilities to increase primary prevention services and HIV/AIDS care capacity. They also recommended recruiting healthcare workers belonging to PLWHA to set a good example of coping with the disease to other patients. Nevertheless, they opined eradication of racial inequality and why the black community is a major victim. Lastly, the participants proposed intensive education and training of healthcare workers to keep them updated about caring for HIV/AIDS patients. These recommendations go a long way to re-establish trust and reliability in these FBOs that were once a hope to society.

Implications

Faith-based organizations provide a central point for societies of different socio-economic statuses to benefit from spiritual and healthcare impact. Moreover, they are reputably known to be a key social capital that impacts communities positively (Idler et al.2019). Most clients of HIV/AIDS care at FBO health facilities are African Americans belonging to middle and low socio-economic status, as mentioned in the literature review. Few studies have been published about the perceptions of African Americans towards these FBOs' services, especially those in rural settings. This study focused help improve HIV/AIDS care services at these facilities for the benefit of minority races, particularly African Americans.

The findings of this study demonstrated several loopholes, such as racial discrimination, poor health worker communication, HIV stigma, sexuality stigma, and poor social support. When this feedback is disseminated through proper channels at the facilities, it can be taken positively and used for organizational changes and service delivery improvement. Consequently, this helps to create a sense of purpose and hope for the HIV champions who need continuous support to have a prolonged and better quality of life. Nonetheless, various agencies that fund these FBOs can use the study to explore what their clients say and thus mobilize appropriate resources toward service delivery improvement.

Methodological, theoretical, and/or empirical implications

The research questions were answered through qualitative methods via the IPA application, which helped link the data to the questions. IPA is an effective approach that provokes thoughts when approaching data through multiple stages, reflecting and perceiving from different angles.

By exploring various experiences that HIV/AIDS patients go through, I understood and appreciated the importance of these FBOs in helping individuals cope with the disease from the day they are diagnosed. Nonetheless, the qualitative method proved to be a promising approach in future studies that can uncover more issues about African Americans living with HIV.

Moreover, this study's results backed up the social cognitive theory related to perceived human behavior on self-control and the risk of HIV infection. For the already HIV-positive individuals, the theory describes how they interact with their environment to realize the best treatment outcomes. This was established by how participants treated and diagnosed at different FBO facilities portrayed different narrations of their HIV experiences. Some individuals demonstrated early coping, while others had longer denial phases and depression. This would be important to recommend standardizing care to a certain bare minimum quality to ensure effective treatment of the less fortunate and minority races.

Recommendation for practice

This study was conducted to provide scholarly contribution as well as improve health practice in the FBO facilities since it is hard to find perfection in the field. Even though the study established an overall satisfaction and a positive attitude of HIV-positive patients towards FBOs, they made several recommendations for improving healthcare delivery. Some participants recommended a more therapeutic environment comprising of gentle tone that provides hope since they said some health practitioners were rude. Secondly, participants had identified scarce resources at these facilities, such as staff shortages and slow services. They recommended more funding from stakeholders such as the State government and non-profit organizations.

Nonetheless, racial discrimination and stigma were mentioned multiple times as what kept the participants away from seeking services at these facilities. Standing on neutral ground, I would support the participant's sentiments since they concur with the silent cry of the minority race that has been going on for a long time. Therefore, the study would be pretty remarkable if, through its effort, African American HIV patients receive better healthcare services at these facilities.

Conclusion

To summarize the findings and their interpretation, the study found good reliability in the FBO services. However, a significant number had stopped using the services due to the stigma and insensitivity to HIV status. The majority of the participant had a positive attitude and rated fairly well. However, the minority who had issues could not be overlooked. The issues included racial discrimination against the black community who sought HIV/AIDS care at FBOs. There was also a reported stigma against HIV and homosexuality that kept the LGBTQ community away hence poor adherence to treatment.

Nevertheless, the quality of care was not flawless either. Even though the majority reported being well counseled and offered health information, some groups were not fully informed about proper diet, HIV screening, and viral load detection. Therefore, participants recommended improving HIV awareness and education at FBOs, providing more funding, recruiting more empathetic healthcare teams, and establishing regular testing.

This research made a significant contribution towards HIV/AIDS care, especially among the minority races, i.e., African Americans. The recommendations made therein by participants can be used to improve healthcare practice by promoting quality of care at FBOs. I hope this research initiative will be furthered on the critical issue and extend to other minority races at a high risk of HIV/AIDS.

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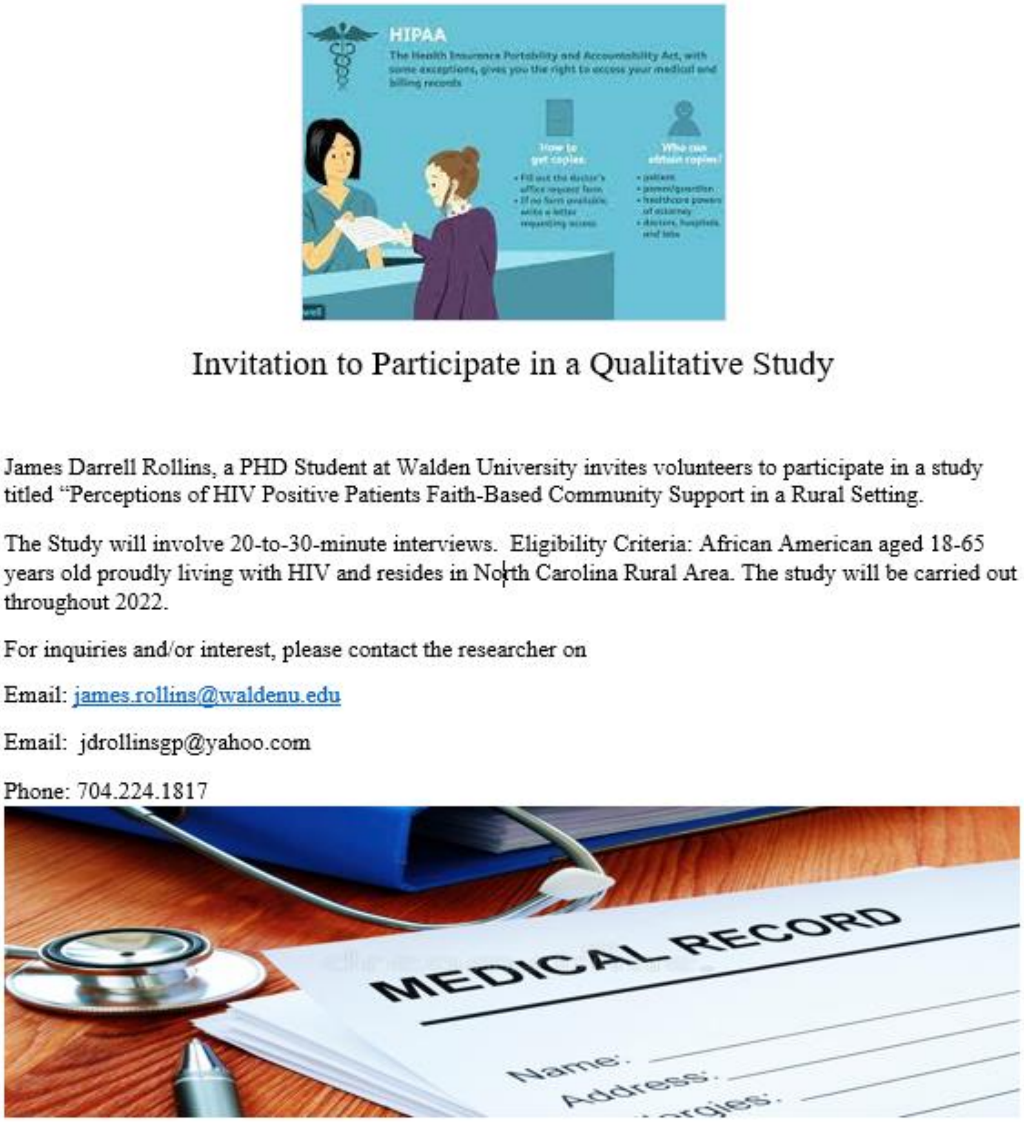
Appendix A: Recruitment flyer



Invitation to Participate in a Qualitative Study

James Darrell Rollins, a PHD Student at Walden University invites volunteers to participate in a study titled “Perceptions of HIV Positive Patients Faith-Based Community Support in a Rural Setting.

The Study will involve 20-to-30-minute interviews. Eligibility Criteria: African American aged 18-65 years old proudly living with HIV and resides in North Carolina Rural Area. The study will be carried out throughout 2022.

For inquiries and/or interest, please contact the researcher on

Email: james.rollins@waldenu.edu

Email: jdrollinsgp@yahoo.com

Phone: 704.224.1817

Appendix B: Pilot study consent form

You are invited to take part in a pilot study for a research study about Perceptions of HIV Positive Patients Towards Faith-Based Community Support in rural areas of North Carolina. This form is part of a process called "informed consent" to allow you to understand this pilot study before deciding whether to take part.

This pilot study seeks 7 volunteers who are:

- Aged 18-65 years, both genders, and proudly living with HIV.
- They must reside in rural areas of North Carolina
- They must be African Americans

This pilot study is being conducted by a researcher named James D. Rollins, who is a doctoral student at Walden University.

Pilot Study Purpose:

The purpose of this pilot study is to establish the feasibility of the main study, assess whether questions will make sense to the participants, or establish if the researcher will need extra resources.

Procedures:

This pilot study will involve you completing the following steps:

- Participating in a 20-30 minute private interview that will be audio-recorded

Here are some sample questions:

1. Is there a time you felt like giving up on your journey of living with HIV, then FBOs restored your esteem?
2. Do you think that Faith-based health facilities have more quality of care than other types of health facilities? If so, what are the advantages that make you prefer them?

Voluntary Nature of the pilot Study:

Research should only be done with those who freely volunteer. So everyone involved will respect your decision to join or not.

If you decide to join the pilot study now, you can still change your mind later. You may stop at any time. Your decision to decline to participate in the study will not impact your ability to receive services at the clinic. Moreover, you can decline to answer any question.

Risks and Benefits of Being in the pilot Study:

Being in this pilot study could involve some risk of minor discomforts that can be encountered in daily life, such as sharing sensitive information. With the protections in place, this study would pose minimal risk to your well-being. Your personal information will not be collected, and your identity will remain confidential.

This study offers no direct benefits to individual volunteers. The indirect benefit of this pilot study is to ensure the validity and efficiency of the main study leading to its success; hence the findings will help to recommend necessary improvements in the FBO facility.

Payment:

There is no payment for participating in this study.

Privacy:

The researcher is required to protect your privacy. Your identity will be kept confidential within the limits of the law. The researcher may ask for your first name for the purpose of frequent address, which ought to be respectful during interviews. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. If the researcher were to share this dataset with another researcher in the future, the dataset would contain no identifiers, so this would not involve another round of obtaining informed consent. The data obtained will be stored using codes instead of codes and until the end of the main study, where it will be discarded since it will no longer be important. The paper copies will be put in paper shredders, while computer files will be permanently deleted.

Contacts and Questions:

You can ask questions of the researcher by **emailing the researcher at** james.rollins@waldenu.edu. If you want to talk privately about your rights as a participant or any negative parts of the study, you can call Walden University’s Research Participant Advocate at 612-312-1210. Walden University’s approval number for this study is **IRB will enter approval number here**. It expires on **IRB will enter expiration date.**

You might wish to retain this consent form for your records.

Obtaining Your Consent

If you feel you understand the pilot study and wish to volunteer, please indicate your consent by _filling in the information below. **Alternatively, if you received this consent via email, you can reply to the email with the word “I consent.”**

Printed Name of Participant ____________________

Date of consent ____________________

Participant’s Signature ____________________

Researcher’s Signature ____________________

Appendix C: Study consent form

You are invited to take part in a research study about Perceptions of HIV Positive Patients Towards Faith-Based Community Support in rural areas of North Carolina. This form is part of a process called “informed consent” to allow you to understand this study before deciding whether to take part.

This study seeks 7 volunteers who are:

- Aged 18-65 years and proudly living with HIV.
- They must reside in rural areas of North Carolina
- They must be African Americans

This study is being conducted by a researcher named James D. Rollins, who is a doctoral student at Walden University.

Study Purpose:
The purpose of this study is to establish the perceptions of people living with HIV/AIDS on assistance accorded by faith-based community support in rural areas.

Procedures:
This study will involve you completing the following steps:

- Participating in a 20-30 minute private interview that will be audio-recorded

Here are some sample questions:

3. Is there a time you felt like giving up on your journey of living with HIV, then FBOs restored your esteem?
4. Do you think that Faith-based health facilities have more quality of care than other types of health facilities? If so, what are the advantages that make you prefer them?

Voluntary Nature of the Study:
Research should only be done with those who freely volunteer. So everyone involved will respect your decision to join or not.

If you decide to join the study now, you can still change your mind later. You may stop at any time. Your decision to decline to participate in the study will not impact your ability to receive services at the clinic. Moreover, you can decline to answer any question.

Risks and Benefits of Being in the Study:
Being in this study could involve some risk of minor discomforts that can be encountered in daily life, such as sharing sensitive information. With the protections in place, this study would pose minimal risk to your well-being. Your personal information will not be collected, and your identity will remain confidential.

This study offers no direct benefits to individual volunteers. The study has indirect benefits to the HIV patients where the awareness about HIV will increase, and the group feels important as any other member of society. Additionally, there will be a continuation to offer high-quality care in the faith-based facilities by providing recommendations based on research findings. Once the analysis is complete, the researcher will share the overall results by sharing the summary on the Scholarworks journal at Walden University research.

Payment:

There is no payment for participating in this study.

Privacy:

The researcher is required to protect your privacy. Your identity will be kept confidential within the limits of the law. The researcher may ask for your first name for the purpose of frequent address, which ought to be respectful during interviews. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. If the researcher were to share this dataset with another researcher in the future, the dataset would contain no identifiers, so this would not involve another round of obtaining informed consent. Data will be kept secure by using codes instead of names. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:

You can ask questions of the researcher by **emailing the researcher on** james.rollins@waldenu.edu. If you want to talk privately about your rights as a participant or any negative parts of the study, you can call Walden University's Research Participant Advocate at 612-312-1210. Walden University's approval number for this study is **IRB will enter approval number here**. It expires on **IRB will enter expiration date.**

You might wish to retain this consent form for your records. You may ask the researcher or Walden University for a copy at any time using the contact info above.

Obtaining Your Consent

If you feel you understand the study and wish to volunteer, please indicate your consent by _filling in the information below**. Alternatively, if you received this consent via email, you can reply to the email with the word "I consent."**

Printed Name of Participant	____________________
Date of consent	____________________
Participant's Signature	____________________
Researcher's Signature	____________________

Appendix D: Interview Questions

Interview Questions

5. When you got diagnosed with HIV, how long did it take you to accept the positive results? Did you try a second test? Explain that instance.
6. Did you get any member of an FBO to counsel you, or you went to a professional counselor or did you just accept on your own and move on.
7. How many years have you lived as an HIV champion since diagnosis?
8. Do you believe that faith-based health facilities can offer more passionate care than other private and public health facilities? What are your thoughts?
9. Do you think that Faith-based health facilities have more quality of care than other types of health facilities? If so, what are the advantages that make you prefer them?
10. On a scale of 1-10 (1-being extremely dissatisfied and 10 being extremely satisfied), how would you rank FBOs in satisfying your healthcare needs?
11. Do you think faith-based hospitals have contributed to any of these; adherence to antiretroviral drugs, high viral load, and generally good health? Elaborate.
12. Have you ever had a bad experience in any faith-based hospital caused by nurses' rudeness, negligence, long queues, payments, etc.? elaborate
13. Is there a time you felt like giving up on your journey of living with HIV, then FBOs restored your esteem?
14. Do you believe that there are better faith-based hospitals than others in handling HIV/AIDS here in North Carolina?
15. Do you think there could be any unfair treatment based on a racial or social-economic basis in Faith-based hospitals?
16. Do you think that the FBOs represent the image of their faith in how their health workers handle HIV-positive clients?
17. Based on what you have learned from your provider and nurses at your preferred FBO, are there any long-term side effects of using the ARVs?
18. What information has the FBOs offered to improve your lifestyles and your general body health, if any?
19. Based on the information offering in your FBO of choice, have you been able to improve your self-esteem and probably decided to be an ambassador of HIV in the future? Elaborate on your fears or any stigma.
20. Have the FBOs influenced you spiritually to strengthen your relationship with a supreme being, e.g., made you get more connected to Jesus Christ for eternal life?
21. What inspires you to stay loyal to health services from FBOs and not any other facility type?
22. What are your future expectations about your health and support from FBOs?

23. What do you think the FBO/ hospitals need to do to improve the quality of care for the HIV-positive population?
24. Do you have an overall positive or negative attitude towards FBOs in how they handle HIV-positive champions?
25. What do you think the US federal/state should do to empower the FBOs' healthcare systems that improve health-seeking behavior among HIV-positive people?
26. Do you have any additional views to add to our discussion topic that maybe we have not touched on?

THEMES	SUBTHEMES	KEY QUESTIONS
1) ATTITUDE	Loyalty	"Do you have an overall positive or negative attitude towards FBOs in how they handle HIV-positive champions?"
2) KNOWLEDGE	Health information	"What information have the FBOs offered for you to improve your lifestyles and your general body health, if any?"
3) PERCEPTION	Rating	"On a scale of 1-10 (1-being extremely dissatisfied and 10-being extremely satisfied), how will you rank FBOs in satisfying your healthcare needs?"
4) EXPERIENCES	Motivation to treatment	"Have you ever had a bad experience in any faith-based hospital caused by nurses' rudeness, negligence, long queues, payments, etc.? elaborate"

Appendix E: Sampled transcripts

Participant 4:

Speaker 1 (00:01):

Okay, this is James raw with participant number five on September the 15th, 2022. Um, the first question is, when you got diagnosed with HIV, how long did it take you to accept the positive results? And did you try a second test?

Speaker 2 (00:26):

Um, honestly, it didn't take that long. Um, I'm more of a realist and, um, just accept it. I mean, it is what it is. Um, and no, I did not go, um, for a second one.

Speaker 1 (00:40):

Okay. And did you get any member of a faith-based organization, like a church, to counsel you, or did you go and get professional counseling, or did you just accept it on your own and move on?

Speaker 2 (00:54):

Um, I just accepted on my own, and just, you know, I just stepped forward.

Speaker 1 (01:00):

Okay. How many years have you lived as an HIV champion? Since the diagnosis? Basically, what that's. Okay. And do you believe that faith-based organization facilities can offer more passionate care than other private and public health facilities? What are your thoughts?

Speaker 2 (01:23):

Um, I, I would imagine that they could, if it is, um, the same type of beliefs that an individual would have that was going there. Um, I certainly think that some people base a lot of their well-being on their faith, so, uh, and a lot of cases, then yes, I think it would.

Speaker 1 (01:43):

Okay. And do you think that faith, uh, based organizations, facilities have more quality of care than other types of facilities is? So what are the advantages that make you prefer then?

Speaker 2 (01:58):

Um, as far as the better quality of care? I, I can't really answer that just, um, because I don't have experience in to be able, you know, to say yes or no on that.

Speaker 1 (02:08):

Okay. And on a scale of one to 10, one being extremely dissatisfied and 10 being extremely satisfied, how would you rank a faith-based organization and satisfying your healthcare needs?

Speaker 2 (02:25):

Um, again, if not being there, I don't really, you know, I haven't had that experience to, to rank it in my mind, I would think and hope that everybody would be on the same page, regardless of whether it's a faith-based facilitator or not. But I know that's probably not realistic, but, you know, in, in a purpose world, that's how it would be.

Speaker 1 (02:43):

Okay. And, uh, do you think that like a faith-based organization can contribute to any of these adherence to intra retroviral drugs, high, viral lows, and generally, good health basically, is what it's asking. Do you think that a faith-based organization can help, you know, like with the education and management and

Speaker 2 (03:07):

Stuff like that? I think so. Yes. I would think so. Like I said, I haven't had manage, but I would absolutely think so when I hear that, I would think that they have, um, you know, more of a caring type side to the end that would be more open to hearing, um, you know, and treating people that have certain, um, issues that other hospitals may look down on. So I would think that they would be better.

Speaker 1 (03:29):

Okay. And I know you said that you haven't really had the experience with a faith-based organization, but, um, in general, have you had a bad experience caused by nurses, rudeness, negligence, long queues, payments or et cetera?

Speaker 2 (03:49):

Um, I mean, yes. I think everybody probably has had a bad experience just with other people. Maybe having a bad day of being rude would just be the extent of it. I'm pretty much speak my mind, so I would probably speak it back. So, okay. Not, not, not bad, bad, but a little.

Speaker 1 (04:05):

Okay. Is there a time you felt like giving up in your journey of living with HIV and then like a faith-based organization can restore your, um, esteem?

Speaker 2 (04:18):

Um, not so far goes pretty much what, when I give up, it's a wrap, so I better just keep on moving forward from my from my perspective.

Speaker 1 (04:26):

Okay. And do you believe that there are, uh, better faith-based organizations than others in handling HIV AIDS here in North Carolina?

Speaker 2 (04:38):

Uh, I don't know to answer that, really I'm. Um, okay. I don't know things to that.

Speaker 1 (04:44):

Okay. Let's see here. Okay. Do you think that there could be any unfair treatment based on a racial or social economic basis in a faith-based organization?

Speaker 2 (05:01):

Um, and a perfect world to answer that question would be, um, no, there wouldn't be, but being that we're in the real world, of course, there is whether it's, you know, set out loud or not, but if you're in America today, you know, that all those issues are happening anyway, so.

Speaker 1 (05:17):

Okay. And do you think that a faith-based organization represents their image of faith in how their health workers handle HIV, positive clients? Again, I know you're not. Okay. And based on what you have learned from your provider and nurses, um, are there any long-term effects of you using your antiretroviral medications

Speaker 2 (05:48):

There? Again, I can't, you know, really answer that, being that I don't do a faith-based.

Speaker 1 (05:53):

Okay. So, and what, what information, well, you said, um, well, what information do you think a faith-based organization can offer to improve your lifestyle and health and your general body health? If any?

Speaker 2 (06:11):

Um, I think that there are some individuals that are swayed by the mental state that they're in. And I think that a faith-based organization could probably help those individuals just to be on a path of some sort, um, especially those that are not strong-willed, um, and kind of succumb to the the doom and gloom that I would hope that a faith-based would, um, give them a path and a, and a more of a purpose and, um, a more positive outlook just on like in general.

Speaker 1 (06:44):

Okay. Okay. Based on the information that will be offered in a faith-based organization, will you be able, um, do you think you will be able to improve your self-esteem and probably decide to be an ambassador of HIV in the future? Elaborate on your fears or stigma, any stigma?

Speaker 2 (07:08):

Um, I, I don't know. I don't know that, um, I mean, I guess it could improve your self-esteem if you're there again in that type, that frame of mind and that mental state, um, I would not decide to be some ambassador. Um, and yeah, no, <laugh>

Speaker 1 (07:30):

Okay. Okay. So have a faith-based organization influenced you spiritually to strengthen your relationship with the Supreme being like it made you get more connected to Christ for eternal life?

Speaker 2 (07:44):

Um, again, I, you know, I have my own, you know, personal, um, religious beliefs that have a decent organization to influence that at all.

Speaker 1 (07:53):

Okay. Me just one minute here. Okay. What inspires you, uh, what will inspire you to stay loyal to health, to, um, health service from a faith-based organization and not any other type facility that's if you was wi connected with the faith-based organization?

Speaker 2 (08:23):

Um, I guess if I would give it a try, I would just want some type of wow factor to be there to, to make me feel like it's different than anywhere else. I would want the quality of care to be at least the same if not above. Um, I think it's amazing that they're offered, you know if it falls in line with somebody's beliefs.

Speaker 1 (08:43):

Okay. And what are your future expectations about your health and support from faith-based organizations?

Speaker 2 (08:51):

Well, just based on conversations with you and like actually doing this and opening my eyes a little bit to the fact that there really are faith-based like facilities, um, medical facilities, I just wasn't aware of that. Um, but the medical field was that diversified. So, um, I, I may give it a try at some point.

Speaker 1 (09:10):

Okay. Which brings to, um, the next question, and that would tie into, um, what faith-based organization will need to do to improve the quality of care for the HIV-positive population. Do you have any additional comments for that?

Speaker 2 (09:30):

Um, maybe, um, just more of getting information, you know, out to the public and if proper channels and where it needs to go. I don't think that a lot of people are aware, um, of the differences, to be honest, and the fact that they really, that they can go somewhere that's totally tied into the, um, their religious beliefs. So I think that maybe better marketing at this point, so that people will know.

Speaker 1 (09:53):

Okay. And do you have an overall positive or negative attitude? Um, if towards faith-based organizations in how they would handle HIV positive champ champions, that's just saying, do you think if, um, if you were connected with a faith-based organization, do you think that they would have a positive?

Speaker 2 (10:15):

I would definitely take it as a positive. I'll be positive for sure.

Speaker 1 (10:19):

Okay. And what do you think the US federal state should do to improve, to empower the faith-based organization's healthcare systems to improve health-seeking behavior among HIV-positive people?

Speaker 2 (10:35):

Oh, I'm not gonna be touching anything at the government at any state or federal level needs to do and not do <laugh>.

Speaker 1 (10:43):

Okay. So, and do you have any additional views to add to our discussion topic that maybe we have not touched on?

Speaker 2 (10:53):

Um, just to say that the whole little, um, questionnaire and, um, little interview processes and like me, and I appreciate that. I think I'm always open to learning new things and has, has possibly, um, will make me go and try a different, um, facility at some point just based on this.

Speaker 1 (11:11):

Okay. All right. Thank you so much.

Appendix F: Codebook

30/10/2022 04:30

James Rollins Codebook

Name	Description	Number Of Sources	Number Of Coding
Attitude	African American HIV/AIDS patients' positive or negative attitude towards FBO	7	7
awareness		5	17
coping		7	31
Experiences	Motivation to treatment	7	49
health information		6	17
Image		7	45
Knowledge	What the participant know about their health through	7	67
motivation to treatment		6	18
negative		2	2
neutral		1	1
Perceptions		7	52
Positive		4	4
Rating		6	7
recommendation		6	33