Life After Being Diagnosed With HIV/AIDS: Exploring the Experiences of Young Women Aged 18-35 Diagnosed With HIV/AIDS in Mtubatuba Municipality, KwaZulu-Natal Province

By

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ABSTRACT

In rural South Africa, young women face multiple challenges after being diagnosed with HIV/AIDS. This study explored the lived experiences of young women aged 18 to 35 who had been diagnosed with HIV/AIDS in the Mtubatuba Local Municipality, KwaZulu-Natal province, using the health belief model (HBM) and Goffman's stigma theory to frame their psychosocial journeys. The study was guided by the interpretivist paradigm, where a qualitative research design was employed, using purposive sampling to access 15 participants. Semi-structured interviews were conducted, and thematic analysis was utilised for data analysis. The findings indicate that initial reactions to the diagnosis are marked by profound shock, fear of death, anger, and self-blame, which highlight the enduring perception of HIV as a fatal and morally stigmatised condition in rural communities. However, there was a gradual move towards acceptance, which is largely facilitated by counselling, health education, and supportive family networks. Health workers are pivotal in reframing HIV as a manageable condition, although inconsistencies in counselling quality highlight structural gaps in care. While family and peer support provide emotional stability, disclosure is fraught with fear of rejection, gossip, and community judgement. The absence of formalised external support groups and economic empowerment initiatives further exacerbated the participants' psychosocial vulnerabilities. Coping strategies included strict adherence to antiretroviral treatment through alarms, calendars, and reminders; reliance on prayer and spirituality for resilience; lifestyle modifications such as reduced alcohol intake; and cautious navigation of romantic and sexual relationships. The study concludes that while biomedical interventions have transformed HIV into a manageable chronic condition, psychosocial and structural challenges remain significant barriers to holistic well-being. The study recommends strengthening community-based counselling, stigma reduction campaigns, and socio-economic support structures, alongside integrating spiritual care and safe disclosure protocols.

Keywords: HIV/AIDS, young women, diagnosis, stigma, psychosocial support, resilience, KwaZulu-Natal

DECLARATION

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Life After Being Diagnosed With HIV/AIDS: Exploring the Experiences of Young Women Aged 18-35 Diagnosed With HIV/AIDS in Mtubatuba Municipality, KwaZulu-Natal Province.

I declare that the above dissertation is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of a complete reference list.

I further declare that I submitted the dissertation to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at UNISA for another qualification or at any other higher education institution.

31 January 2026

SIGNATURE DATE

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TABLE OF CONTENTS

ABSTRACT i

DECLARATION ii

ACKNOWLEDGEMENTS iii

LIST OF TABLES viii

LIST OF FIGURES viii

LIST OF ABBREVIATIONS ix

CHAPTER 1: INTRODUCTION TO EXAMINING YOUNG WOMEN'S LIFE AFTER BEING DIAGNOSED WITH HIV/AIDS

1.1 Introduction 1

1.2 Problem statement 2

1.3 Research aim, questions, and objectives 3

1.3.1 Research aim 3

1.3.2 Research questions 3

1.3.3 Research objectives 3

1.4 Significance of the study 4

1.5 Key concepts of the study 4

1.6 Methodology of the study 6

1.7 Theoretical frameworks 6

1.8 Dissertation chapter layout 7

CHAPTER 2: LITERATURE REVIEW AND THEORETICAL FRAMEWORKS

2.1 Introduction 9

2.2 Contextualising HIV/AIDS 9

2.3 Factors that lead to susceptibility to HIV/AIDS 12

2.4 Post-HIV/AIDS diagnosis: Changes and challenges of people living with HIV/AIDS (PLWHA) 14

2.5 Coping strategies used by PLWHA ... 17
2.5.1 HIV treatment ... 17
2.5.2 Religion ... 18
2.5.3 Alcohol ... 19
2.6 Theoretical framework: The health belief model (HBM) and Goffman's stigma theory ... 20
2.6.1 The HBM ... 20
2.6.2 Goffman's stigma theory ... 22
2.6.3 Relevance of the HBM and Goffman's stigma theory ... 23
2.7 Research gap ... 26
2.8 Conclusion ... 27

CHAPTER 3: METHODOLOGICAL REFLECTIONS OF CONDUCTING RESEARCH WITH YOUNG WOMEN DIAGNOSED WITH HIV/AIDS IN MTUBATUBA

3.1 Introduction ... 29
3.2 Research paradigm: Interpretivism ... 29
3.3 Qualitative research design ... 30
3.4 Study area ... 30
3.5 Sampling and selection of participants ... 32
3.6 Profile of the participants ... 34
3.7 Data-collection method ... 36
3.8 Data-analysis method ... 38
3.9 Trustworthiness of the study ... 41
3.10 Ethical considerations ... 42
3.11 Being reflexive during the study ... 44
3.12 Conclusion ... 45

CHAPTER 4: NAVIGATING LIFE AFTER DIAGNOSIS: PSYCHOSOCIAL EXPERIENCES AND COPING STRATEGIES OF YOUNG WLWHA IN RURAL KWAZULU-NATAL

4.1 Introduction 46
4.2 Themes 46
4.2.1 Theme 1: Emotional and psychological responses to an HIV/AIDS diagnosis: Shock, fear of death, self-blame, and acceptance with family support 47
4.2.2 Theme 2: Role of support systems in disclosure, healing, and adherence: Family members, healthcare workers, formal external support groups, and community perceptions 50
4.2.3 Theme 3: Coping strategies adopted by young WLWHA: Antiretroviral therapy (ART), religion, living healthier, partner support, and the future 56
4.3 Conclusion 62

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction 64
5.2 Summary of chapters 65
5.3 Summary of key findings 67
5.3.1 Emotional and psychological reactions to HIV/AIDS diagnosis 67
5.3.2 Secrecy and fear of stigma 68
5.3.3 Acceptance and healing through counselling and education 68
5.3.4 Role of family and peer support in emotional recovery 69
5.3.5 Coping strategies: Spirituality and personal resilience 70
5.3.6 Structural gaps and unmet needs 70
5.4 Limitations of the study 71
5.5 Recommendations for policy development, government intervention, and future research 72
5.6 Conclusion 74

REFERENCE LIST 112

APPENDICES

Appendix A: Information Letter 93

Appendix B: Informed Consent Form 96

Appendix C: Consent Form: Audio-Recording 97

Appendix D: Permission Letter to the Department of Health 98

Appendix E: Permission Letter to Mpukunyoni Clinic 100

Appendix F: Letter to the Counsellor 102

Appendix G: Copy of Ethics Certificate 104

Appendix H: Permission Letter From the Department of Health 105

Appendix I: Letter From the Councilor 106

Appendix J: Interview Guide (English) 107

Appendix K: Interview Guide (IsiZulu) 110

LIST OF TABLES

Table 3.1: Inclusion and exclusion criteria 33

Table 3.2: Demographics of the participants 35

LIST OF FIGURES

Figure 2.1: The HBM and stigma theory on HIV/AIDS 24

Figure 3.1: Location of the Mpukunyoni Clinic in the Enqopheni area 31

Figure 3.2: Summary of themes and subthemes 40

LIST OF ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
GBV	Gender-based violence
HAART	Highly active antiretroviral therapy
HBM	Health belief model
HIV	Human immunodeficiency virus
PLWH	People living with HIV
PLWHA	People living with HIV/AIDS
PrEP	Pre-exposure prophylaxis
SDG	Sustainable Development Goal
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization
WLWH	Women living with HIV

CHAPTER 1:
INTRODUCTION TO EXAMINING YOUNG WOMEN'S LIFE AFTER BEING DIAGNOSED WITH HIV/AIDS

1.1 Introduction

HIV infects approximately seven million people in South Africa, with prevalence varying by province (Ramjee, Sartorius, Morris, Wand, Reddy, Yssel & Tanser, 2019). KwaZulu-Natal has the highest percentage of HIV/AIDS-infected individuals, estimated to be over two million (Khumalo, Ntuli, Lutge & Mashamba-Thompson, 2022). Unemployment and a lack of primary education are among the issues that contribute towards the spread of HIV/AIDS, especially among young women and particularly in rural areas (Linganiso & Gwegweni, 2016; Mampane, 2018). Young women tend to be more susceptible to HIV/AIDS infection than men because they engage in sexual encounters with older males or multiple partners for survival (Linganiso & Gwegweni, 2016). Women's vulnerability and risk of HIV/AIDS are also linked to cultural practices and the subordination of women in society, especially in rural regions (Mampane, 2018). Women in rural areas are often forced into submissive roles, where men have full control and rights over them, which results in power inequalities in relationships (Madiba & Ngwenya, 2017; Mhungu, Sixsmith & Bunett, 2023). Forced sex and sexual coercion frequently manifest as violent acts in married and cohabiting relationships, where these are key drivers of the spread of HIV/AIDS (Madiba & Ngwenya, 2017).

Although efforts have been made to support individuals who are diagnosed with HIV/AIDS, to be diagnosed with HIV/AIDS usually occur in different stages. These stages include the time of diagnosis, when the person is often in disbelief, and the phase of accepting the situation (positive adaptation) or being in denial or rejection (negative adaptation) (Arias-Colmenero et al., 2020). This study therefore investigated the experiences of young women aged 18 to 35 who has been diagnosed with HIV/AIDS in the rural areas of Mtubatuba in the uMkhanyakude District. The focus was on gaining insight into how these young women cope with the changes in their lives that occur after being diagnosed with HIV/AIDS. Limited studies have focused on how young women in rural areas specifically in Mtubatuba deal with their diagnosis, the

support available to manage it, and the individual strategies they use to live after diagnosis.

1.2 Problem statement

South Africa has the highest rate of HIV infection globally (Johnson & Dorrington, 2021). However, KwaZulu-Natal continues to be the South African province with the most cases of HIV infection (Johnson & Dorrington, 2021). Despite significant success in addressing the HIV outbreak in the KwaZulu-Natal province, the rate of infection remains elevated, particularly among teenage girls and young women (Khumalo et al., 2022). According to Hlongwa, Peltzer and Hlongwana (2020), several intervention programmes aimed at reducing the spread of sexual transmitted diseases (STIs), such as HIV, have not sufficiently addressed the issue, as unsafe sexual behaviour among women of reproductive age remains a public health priority in South Africa. Hlongwa et al. (2020) explain that unsafe sexual behaviours are associated with adverse health outcomes, such as STIs, HIV/AIDS, and unwanted pregnancies in women. These behaviours include engaging in sexual intercourse with several partners, having sex without protection, and having sex while intoxicated or under the influence of drugs (Hlongwa et al., 2020). Duko, Ayalew and Ayano (2019) argue that people living with HIV/AIDS (PLWHA) commonly suffer from untreated alcohol use disorders, which can lead to high-risk behaviours such as unsafe sexual practices, which can potentially increase the transmission of HIV/AIDS and interfere with the response to antiretroviral therapy (ART).

Limited research has explored life after an HIV diagnosis, particularly for young women in rural areas, specifically in Mtubatuba. This study is significant because existing literature indicates that PLWHA experience stressors such as stigma, discrimination, despair, and various psychological effects following their diagnosis (Amal & Pandin, 2021; Fauk, Mwanri, Hawke, Mohammadi, Ward, 2022). For PLWHA, the moment of diagnosis is critical, as it often leads to feelings of frustration, hopelessness, anxiety, lack of understanding, and sadness (Arias-Colmenero et al., 2020; Masevhege & Skhosana, 2026). This study therefore aimed to look into the experiences of young women aged 18 to 35 after being diagnosed with HIV/AIDS.

1.3 Research aim, questions, and objectives

1.3.1 Research aim

The aim of the study was to understand the experiences of young women aged 18-35 who are living with HIV/AIDS in the rural areas of Mtubatuba. This research intended to determine how these women deal with the changes in their lives after being diagnosed with HIV/AIDS, the support offered, and strategies used to live after their diagnosis.

1.3.2 Research questions

The following primary research question was formulated for this study: **What are the experiences of young women aged 18 to 35 after being diagnosed with HIV/AIDS in the rural areas of Mtubatuba in the uMkhanyakude District?**

The following secondary research questions were formulated to assist in addressing the primary research question:

- How do young women aged 18 to 35 feel after being diagnosed with HIV/AIDS in the rural areas of Mtubatuba in the uMkhanyakude District?
- What support is available for young women aged 18 to 35 to deal with being diagnosed with HIV/AIDS in the rural areas of Mtubatuba in the uMkhanyakude District?
- What are the coping strategies used by young women aged 18 to 35 to deal with being diagnosed and living with HIV/AIDS in the rural areas of Mtubatuba in the uMkhanyakude District?

1.3.3 Research objectives

The research objectives of the study were as follows:

- To understand how young women aged 18 to 35 feel after being diagnosed with HIV/AIDS in the rural areas of Mtubatuba in the uMkhanyakude District.
- To explore the support available for young women aged 18 to 35 to deal with being diagnosed with HIV/AIDS in the rural areas of Mtubatuba in the uMkhanyakude District.

- To explore the strategies used by young women aged 18 to 35 to deal with being diagnosed and living with HIV/AIDS in the rural areas of Mtubatuba in the uMkhanyakude District.

1.4 Significance of the study

Building on the problem statement, minimal research specifically in rural areas such as Mtubatuba has focused on life after the HIV/AIDS diagnosis, particularly regarding the experiences of young women living with HIV (WLWH). The findings from the consulted research were largely gathered numerically (quantitatively) and based on Western models, which do not aid African communities in understanding the feelings and attitudes of women following an HIV/AIDS diagnosis (Muula, 2008). It is essential to learn about the support available to PLWHA, as studies show that they often suffer from stigma and other stressors (Kimera et al., 2020; Mpofu & Ganga-Limando, 2024). Amal and Pandin (2021) highlight that the difficulties faced by PLWHA influence their daily lives, overall welfare, and medication management, which in turn affects their quality of life. This study suggests that the knowledge-based results of this study may assist in improving decision making regarding HIV-related policies (Arias-Colmenero et al., 2020). Additionally, it may help medical researchers to identify better treatment and coping strategies for patients with HIV/AIDS. Building on the problem statement, minimal research has focused on life after the HIV/AIDS diagnosis, particularly regarding the experiences of young women living with HIV (WLWH) in rural areas.

1.5 Key concepts of the study

Acquired immunodeficiency syndrome (AIDS): Kapadiya (2022) defines AIDS as a chronic, possibly life- threatening condition caused by HIV. HIV reduces the body’s ability to resist infection and disease by weakening the immune system.

Adolescent age: Adolescence is the period of life between growing up and becoming an adult, which lasts from the ages of 10 to 19. It is a distinct stage of growth for humans and a critical period for creating the conditions for healthy living (World Health Organization [WHO], 2017).

Antiretroviral therapy (ART): ART is the use of anti-HIV medications to treat patients who are infected with HIV. The conventional treatment consists of a combination of

medications that suppress HIV replication (commonly referred to as highly active antiretroviral therapy or HAART). The combination of medications is used to boost potency while decreasing the possibility of the virus developing resistance. ART lowers mortality and morbidity rates for HIV-infected people while improving their quality of life (WHO, 2015).

Diagnose: To diagnose is to determine the identity of a disease, illness, etc. by a medical examination (Greg Stanley and Associates, 2013). This study refers to young women who were diagnosed with HIV.

Experience: Webster (2017) defines experience as “the events that create a community’s, nation’s, or humankind’s conscious past”.

Human immunodeficiency virus (HIV) is transmitted through direct needle injections into the bloodstream or through contact between infected bodily fluids and damaged tissues or mucous membranes (Vitale & Ryde, 2018). It is also transmitted through unprotected sexual intercourse (Shaw & Hunter, 2012). HIV targets and integrates into CD4 cells, a subset of immune system white blood cells, once it enters the body. As these cells grow in number to combat infections, they create additional copies of HIV, which eventually prevent the body from responding to illnesses and opportunistic infections (Vitale & Ryde, 2018).

Stigma: Goffman (1997) state that stigma is a collection of unfavourable and unfair judgements that a society have about something.

Rural area: Rural areas are generally excluded from the definition of urban regions and are typically large, open areas with few dwellings and few inhabitants, in contrast to urban areas, which have a larger population (Dasgupta et al., 2014).

Young women: A young woman is a female in her early adulthood, usually in her late adolescence or early 20s, although the age range varies depending on cultural and societal context. She has completed adolescence and is distinguished by her youth, vitality, and potential for physical growth and maturity (Vocabulary.com, 2025). In this study, young women are defined as women of the ages 18 to 35 years.

1.6 Methodology of the study

This study used a qualitative research design to explore the experiences young women aged 18 to 35 who were diagnosed with HIV/AIDS who live in the rural areas of Mtubatuba. Qualitative research is instrumental in understanding people's experiences in specific situations (Mohajan, 2018). This design provides an in-depth description of individual experiences, including feelings, views, and knowledge (Mohajan, 2018). In this study, this methodology allowed the participants, as self-aware individuals, to speak authoritatively about their situations. Furthermore, the qualitative method enabled me to acquire comprehensive insight into the experiences of young women aged 18 to 35 who were diagnosed with HIV/AIDS, including how they cope with the changes in their lives following their diagnosis, the support available to them, and the strategies they employ to live after their diagnosis. The participants for this study were recruited using purposive sampling, and 15 young women aged 18 to 35 took part in the study. The researcher selected these 15 participants from Mpukunyoni Clinic, specifically those who visited the clinic monthly for medication refills and viral load testing. Semi-structured interviews were conducted to collect data for this study, and thematic content analysis was employed as the method of data analysis.

1.7 Theoretical frameworks

The health belief model (HBM) and Goffman's stigma theory were employed in this study. These two frameworks complement each other and are suitable for developing HIV-specific health initiatives and strategies that target both individuals and wider societal settings. HBM was coined by social psychologists from the United States Public Health Service in the 1950s, based on the idea that beliefs about disease and risk reduction actions strongly influence health behaviour. The HBM was chosen because it predicts health behaviours by focusing on individual beliefs about health conditions (Tarkang & Zotor, 2015). It explains how individuals' perceptions of risk, the benefits associated with action, the difficulties in taking action, and their confidence in taking action, along with cues to action, determine their choices (Tarkang & Zotor, 2015). In this study, the term "individuals" refers to young women who live with HIV/AIDS, and the research focused on their experiences after diagnosis. The HBM helped me to examine young women's desire to get well (value) and their belief that a

specific health intervention available to them can minimise sickness (expectation). The expectation was further understood in terms of the individual's assessment of personal vulnerability to and the severity of an illness, as well as the likelihood of being able to lower the risk through one's own behaviour (Green, Murphy & Gryboski, 2020). In this study, lowering risks in young women's behaviour means improving their health. For example, HIV-positive young women may adhere to ART, eat well, avoid alcohol and drugs, and reduce the number of sexual partners, all of which assist in managing HIV/AIDS and improving quality of life (Ashraf & Virk, 2021). The HBM is also based on the idea that individual perceptions of diseases (HIV/AIDS) and strategies for reducing their prevalence determine health behaviour (Green, Murphy & Gryboski, 2020).

Goffman's theory of stigma is essential to this study as it provides insight into the social obstacles experienced by PLWHA. It highlights how community labelling and unfavourable attitudes result in rejection and impair a person's ability to obtain care, comply with medication, and engage in life freely (Peltzer & Pengpid, 2019). In this study, Goffman's theory of stigma contributed to examining the substantial transformation in young women's self-perception and self-worth that occurs following diagnosis, which leads to feelings of shame and the perception of being "damaged". Being diagnosed with HIV/AIDS is frequently met with community rejection because the diagnosis contradicts the stereotype of how individuals should behave in that society (Madiba & Diko, 2021). Many South Africans believe that HIV is caused by sexual acts and is a form of punishment for immorality (Madiba & Diko, 2021). HIV-positive women, in particular, are perceived as prostitutes, which stigmatises those who have contracted HIV in the eyes of the community (Madiba & Diko, 2021).

1.8 Dissertation chapter layout

This dissertation contains the following chapters:

Chapter 1 introduces the study. It outlines the study's problem statement, research aim, research objectives, and research questions. The chapter further outlines the significance of the study and the key concepts. The chapter concludes with a brief summary of the methodology used, the theoretical frameworks employed, as well as an outline of the chapters of the dissertation.

Chapter 2 examines existing literature on the studied phenomenon and identifies the knowledge gaps and theories that guided this research. It reviews the literature on HIV/AIDS as the study explored the experiences of young women that are diagnosed with HIV/AIDS. The chapter begins by contextualising HIV/AIDS, followed by a discussion of factors that lead to susceptibility to HIV/AIDS, post-HIV/AIDS diagnosis and changes and challenges of PLWHA, and the coping strategies used by PLWHA. The chapter outlines the study's theoretical frameworks, namely the HBM and Goffman's stigma theory. Lastly, it focuses on clarifying the research gap in understanding the lived experiences of young women after diagnosis, particularly in rural areas such as the Mtubatuba Local Municipality.

Chapter 3 outlines the research methodology and methods employed in this study. This chapter discusses the data-collection tools and data-analysis methods used to collect, examine, and utilise data. It also discusses the selection of the research site. The reliability and honesty of the information collected and the findings are discussed, as well as the ethical guidelines that were followed to ensure that the study was conducted ethically. The chapter concludes with an explanation of how reflexivity was maintained throughout this study.

Chapter 4 thematically presents the findings on the lives of young women between the ages of 18 to 35 who are diagnoses with HIV/AIDS, focusing on life after diagnosis, support, and coping techniques. It analyses the collected data and presents the study's findings by focusing on three main key themes: emotional and psychological experiences post-diagnosis, the availability and influence of support systems, and HIV/AIDS coping techniques.

Chapter 5 is concluding this study by providing a short discussion regarding the findings, as well as answers to the primary research questions. The chapter contains an overview of the key findings, concluding remarks, as well as the suggestions for future studies.

CHAPTER 2:
LITERATURE REVIEW AND THEORETICAL FRAMEWORKS

2.1 Introduction

In 2021, the estimated prevalence of HIV/AIDS incidence among South Africans of all ages was 13.7%, equating to 8.2 million people living with HIV (PLWH). This represents an increase from an estimated 3.8 million in 2002 (Imenda, 2022). Statistics South Africa (2021) reports that between 2002 and 2020, the country's mortality rates due to AIDS decreased from 181 497 to 85 159, mostly because of the use of ART. However, HIV/AIDS remains an epidemic in the country, and it is critical to examine the quality of life of PLWHA as they continue to live with the virus and achieve viral suppression (Ghiasvand, Waye, Noroozi, Harouni, Armoon & Bayani, 2019). HIV patients face not only physical challenges but also social stigma and misjudgement, which can severely impact individuals' lives (Ghiasvand et al., 2019). Non-adherence, substance misuse, and refusal to practise safe sex are among the most significant factors that undermine the success of ART in PWLH. Social and behavioural interventions must be properly integrated to effectively minimise risk in order to reduce disease transmission (Ghiasvand et al., 2019).

This chapter provides an overview of the literature relevant to the HIV/AIDS pandemic, as the study focused on exploring the experiences of young women diagnosed with HIV/AIDS in rural areas. In this regard, the chapter begins by contextualising HIV/AIDS. The following section delves into the factors that lead to susceptibility to HIV/AIDS and thereafter examines the challenges and changes faced by PLWHA following a diagnosis. Furthermore, the coping strategies used by PLWHA are highlighted, with a focus on HIV treatment (ART), religion, and alcohol usage. This chapter further discusses the theoretical frameworks used in this study, namely the HBM and Goffman's theory of stigma. The final part of this chapter aims to clarify the research gap in understanding the lived experiences of young women after HIV/AIDS diagnosis, particularly in the rural areas such as Mtubatuba Municipality.

2.2 Contextualising HIV/AIDS

HIV/AIDS continues to be a global health concern, particularly in developing regions, with sub-Saharan Africa being the most affected by the epidemic, accounting for nearly

70% of global infections (Arias-Colmenero et al., 2020). South Africa has approximately 7.8 million PLWH, which is considered the highest national prevalence worldwide (Duby et al., 2022). Young women and adolescent girls are disproportionately affected, representing around 25% of new infections annually, which is twice the rate observed among their male counterparts (Duby et al., 2022). This gender disparity is driven by structural and environmental factors, including socio-economic inequality, limited access to healthcare, and prevailing gender-norms (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2019).

Despite global medical advancements and the availability of ART, over 38 million people continue to live with HIV worldwide (Teshale et al., 2022). While high-income countries have seen a decline in new infections, the epidemic remains entrenched in low- and middle-income regions. Women of reproductive age are particularly vulnerable due to biological factors, social inequalities, and restricted access to health services (Dellar, Dlamini & Karim, 2015). Globally, HIV/AIDS is not only a health issue but also a socio-economic challenge; it exacerbates poverty, disrupts family structures, and undermines productivity. The WHO (2015) and UNAIDS (2019) have emphasised the epidemic's intersection with broader development goals, notably Sustainable Development Goal (SDG) 3, which promotes health and well-being. However, progress is hindered by persistent stigma, uneven healthcare infrastructure, and funding limitations.

South Africa's HIV landscape reflects global patterns but also presents unique challenges. The epidemic is gendered, with adolescent girls and young women facing heightened risk due to unequal power dynamics, cultural expectations, and widespread gender-based violence (GBV) (Ngwenya, Nkosi, Mchunu, Ferguson, Seeley & Doyle, 2020). Provincial disparities further complicate this issue, with KwaZulu-Natal consistently recording the highest prevalence rates. These variations highlight the importance of understanding HIV/AIDS within specific socio-cultural and economic contexts. KwaZulu-Natal stands out as the province most affected by HIV in South Africa, which is linked to a combination of socio-economic challenges, cultural practices, as well as systemic vulnerabilities that increase susceptibility to infection (Ngwenya et al., 2020).

The continued high infection rates highlight the multifaceted nature of epidemic management. Barriers such as stigma, inefficiencies in the health system, and social exclusion impede both prevention and treatment efforts (Ahmed et al., 2018). National strategies, including South Africa's National Strategic Plan on HIV, TB and STIs, advocate for integrated approaches that combine biomedical interventions with efforts to address social determinants such as poverty and education (Elliott & Escott, 2014). However, implementation remains uneven, especially in rural and peri-urban areas where healthcare infrastructure is the weakest. KwaZulu-Natal, particularly the uMkhanyakude District, exemplifies how global health crises manifest in localised settings. The district has historically recorded some of the country's highest HIV prevalence rates (Elliott & Escott, 2014). Factors such as poverty, unemployment, and limited access to reproductive health services contribute to the epidemic's persistence. These conditions typically push young women into transactional or age-disparate relationships, where power imbalances limit their ability to negotiate safe sex (Casavant, 2020).

Cultural and gender dynamics further complicate the epidemic. Patriarchal norms, restrictive gender roles, and GBV significantly increase women's vulnerability to HIV/AIDS (Ngwenya et al., 2020). In rural areas, women frequently face economic dependence, social expectations of submissiveness, and limited reproductive agency. These conditions reflect global findings on the socially constructed nature of HIV risk (Carlsson-Lalloo, Rusner, Mellgren & Berg, 2016). Stigma also remains a barrier, particularly in rural communities, where silence around sexual health discourages service uptake and status disclosure (Anima-Korang, Gere & Salimi, 2018). Moreover, the healthcare infrastructure in rural areas mirrors broader challenges. Clinics often face staff shortages, long wait times, and inconsistent ART supply chains, all of which undermine the quality of care (Moyo, Chasela, Brennan, Ebrahim, Sanne,Long & Evans, 2016). Although ART is widely available, adherence is hindered by factors such as transport costs, stigma, and competing responsibilities, especially among young women (Adeniyi, Ajayi, Ter, Goon, Owolabi, Eboh & Lambert, 2018). These intersecting challenges highlight the need to view HIV/AIDS not merely as a medical issue but as a complex social and developmental concern.

Mtubatuba thus provides a critical case for understanding how the epidemic manifests in local contexts. The lived experiences of young women diagnosed with HIV/AIDS in

this municipality cannot be separated from the intersecting realities of poverty, cultural expectations, and structural barriers that shape their daily lives. By situating the study within this provincial and municipal context, the research emphasises the necessity of context-specific interventions that move beyond biomedical solutions to address the socio-cultural and structural determinants of health.

2.3 Factors that lead to susceptibility to HIV/AIDS

Women's heightened susceptibility to HIV/AIDS in South Africa is shaped by a complex interplay of socio-cultural and structural factors. Age-disparate relationships, particularly with older men, significantly increase the risk due to power imbalances that limit young women's ability to negotiate condom use, which amplifies their vulnerability to HIV infection (Dellar et al., 2015). Economic hardship often drives young women into transactional and concurrent sexual partnerships, which create overlapping sexual networks and accelerate HIV transmission (Casavant, 2020). Limited access to education and economic opportunities further restricts women's autonomy, which reduces their engagement with prevention strategies and increases their exposure to high-risk behaviours (Mthembu, Maharaj & Rademeyer, 2019). Cultural norms, GBV, and stigma also undermine women's reproductive agency, which reinforces unsafe sexual practices and obstructs access to healthcare (Ngwenya et al., 2020; UNAIDS, 2019; Carlsson-Lalloo et al., 2016). Together, these factors reveal the multidimensional nature of HIV vulnerability among women, especially in rural areas such as Mtubatuba Municipality.

Socio-economic deprivation is a key factor that exacerbates women's susceptibility to HIV/AIDS, particularly in rural and peri-urban areas. Poverty, unemployment, and food insecurity create conditions where young women may be compelled to enter transactional relationships to secure basic needs such as shelter, clothing, or school fees (Casavant, 2020). These transactional sexual encounters often involve limited negotiation power, which renders condom use inconsistent and increases the likelihood of HIV transmission (Casavant, 2020). Research from sub-Saharan Africa indicates that economic hardship heightens vulnerability by restricting women's autonomy and perpetuating dependence on older male partners who may already be HIV positive (Dellar et al., 2015). The structural reality of poverty thus translates into

elevated biological and social risks for young women, which highlights the interconnectedness of economic deprivation and health outcomes (Dellar et al., 2015).

Educational disadvantage further compounds vulnerability. Women with limited access to secondary or tertiary education are less likely to obtain comprehensive sexual and reproductive health information and are less able to critically evaluate risk behaviours (Mthembu et al., 2019). Low levels of education have been linked to reduced condom use, weaker negotiating capacity, and limited engagement with HIV prevention campaigns. For example, women without formal education were found to be twice as likely to engage in high-risk sexual behaviours compared to their more educated counterparts (Teshale et al., 2022). Education therefore plays a protective role, not only by providing information but also by fostering agency, independence, and alternative livelihoods that reduce economic reliance on risky sexual partnerships.

Gender inequality is a pervasive socio-structural driver of HIV vulnerability. Patriarchal norms in South Africa, particularly in KwaZulu-Natal, reinforce the subordination of women in intimate relationships, which limits their agency in sexual decision making (Ngwenya et al., 2020). Young women often face coercion in relationships, where the refusal of unprotected sex is equated with mistrust or disobedience (Ngwenya et al., 2020). GBV, which remains widespread in rural KwaZulu-Natal, intensifies this vulnerability by normalising male dominance and undermining women's reproductive autonomy (UNAIDS, 2019). Studies have shown that women who are exposed to GBV are significantly more likely to contract HIV, as coercive sex increases the likelihood of unprotected sexual intercourse and biological susceptibility through physical trauma (Carlsson-Lalloo et al., 2016).

Cultural norms and social attitudes also play a central role in increasing women's vulnerability to HIV/AIDS. In many South African communities, discussions about sexuality and reproductive health remain taboo, which limits young women's access to accurate information about prevention and treatment (Duby et al., 2022). Traditional gender expectations often prioritise male sexual autonomy over women's reproductive rights, which makes it difficult for women to assert safer sex practices, such as condom use. Furthermore, the cultural endorsement of age-disparate and polygynous relationships exposes women to overlapping sexual networks, where the risks of HIV transmission are magnified (Dellar et al., 2015). These cultural dynamics illustrate how

social norms create an environment that severely restricts women's ability to protect themselves (Dellar et al., 2015).

Religion and spirituality further complicate the intersection between culture and health behaviour. While faith can serve as a source of resilience and coping (Santos et al., 2019), certain religious teachings continue to discourage condom use or frame HIV as divine punishment, which deepens stigma and obstructs prevention efforts (Bukhori, Hidayanti & Situmorang, 2022). Religious beliefs, such as seeking healing through fasting and prayer, having faith in the healing powers of pastors and prophets, or believing that HIV is spiritual and that the demons causing it may be cast out through rituals associated with religion, have also been described as challenges to adherence to ART (Azia, Nyembezi, Carelse & Mukumbang, 2023). This dual role of religion highlights the need for culturally sensitive interventions that work with, rather than against, community belief systems.

The interaction of poverty, limited education, and gender norms highlights the multidimensional nature of susceptibility. Structural barriers constrain women's ability to exercise control over their health, while socio-economic dependence pushes them into high-risk situations. While programmes such as conditional cash transfers and educational bursaries have demonstrated some success in reducing vulnerability, gaps remain in addressing the deeper cultural and structural inequalities that perpetuate the epidemic (Ngwenya et al., 2020). A comprehensive response to HIV susceptibility among young women must therefore not only provide biomedical solutions but also tackle the structural inequalities that continue to shape their lived realities. In evaluating these dynamics, it becomes clear that cultural norms, stigma, and health system barriers are interconnected factors that sustain women's vulnerability to HIV. Without addressing these deeply rooted barriers, biomedical interventions alone will remain insufficient in curbing the epidemic among young women in Mtubatuba Municipality.

2.4 Post-HIV/AIDS diagnosis: Changes and challenges of people living with HIV/AIDS (PLWHA)

People undergo significant and varied changes following an HIV/AIDS diagnosis that impact their physical health, psychological well-being, and social interactions.

HIV/AIDS can lead to stress, as well as physical and mental harm (Kontomanolis, Michalopoulos, Gkasdaris, & Fasoulakis, 2017). Jones, Byun, Billings, Shorten, Kempf, Vance and Puga (2023) found that HIV-positive women experience more anxiety than men. PLWHA are also concerned about suicide (Govender & Schlebusch, 2012) and frequently face stigma, which persists to this day. This stigma can lead to feelings of guilt and shame, which will likely affect their ability to maintain a positive self-image and sound mental health (Kontomanolis et al., 2017). PLWHA experience devastation, grief, despair, lack of awareness, and emotional anguish following their diagnosis (De la Cruz, Caine & Mill, 2016). These feelings can result in depression and frustration that stem from unmet life goals (De la Cruz et al., 2016).

WLWH experience increased psychological stress (Ashaba et al., 2017) and may face HIV-specific stressors related to their diagnosis and treatment, as well as non-HIV stressors such as poverty, stigma, discrimination, violence, and unemployment (Adamu, Mchunu & Naidoo, 2019). Psychological stress in WLWH is associated with poor physical and psychosocial health, as well as psychiatric problems. Factors such as personality, social support, and coping methods influence the stress responses of WLWH (Adamu et al., 2019).

HIV/AIDS patients also worry about suicide (Govender & Schlebusch, 2012). Chronic illnesses, including HIV, are associated with psychiatric disorders, according to Dabaghzadeh, Jabbari, Khalili and Abbasian (2015). More than one-third of HIV-positive women in the United States of America report suicidal thoughts within a month of diagnosis, and motherhood is a predictor thereof (Govender & Schlebusch, 2012). Treatment can lessen suicide risk; however, PLWHA have a much higher rate of suicidal thoughts than the general population (Govender & Schlebusch, 2012). Suicidal thoughts can be caused by anxiety, depression, hopelessness, illness severity, antiretroviral side effects, low CD4 count, and adverse medication reactions. Stigma, prejudice, unemployment, low income, isolation, and lack of social support also contribute to this issue. Factors such as age, female gender, and substance use further increase the risk (Dabaghzadeh et al., 2015; Pei et al., 2021). Strong social connections and community support can help to reduce suicidal ideation.

Prevention requires identifying risk and protective factors (Dabaghzadeh et al., 2015). HIV stigma continues to affect HIV-positive individuals, as they face prejudice,

discrimination, and social isolation (Wardell, Shuper, Rourke & Hendershot, 2018). According to Paudel and Baral (2015), HIV-related stigma encompasses rejection and discrimination, as well as self-stigma, fear of judgement, and negative repercussions if individuals disclose their status. Stigma associated with the inadequate compliance to HIV medication, reluctance to seek healthcare due to discrimination, and worse mental health outcomes, including depression.

Stigma is particularly pronounced in rural areas. Anima-Korang et al. (2018) discovered prejudice, violence, and exclusion affecting rural PLWHA families, businesses, communities, and healthcare facilities. These experiences can lower self-esteem, internalise stigma, inhibit disclosure, and hinder access to care. Such issues degrade health outcomes in rural areas and weaken preventative and treatment programmes, which increase HIV transmission and mortality. Reducing stigma is therefore essential to improve disclosure rates, service use, and the quality of life for PLWHA in rural regions (Anima-Korang et al., 2018).

Hedge, Devan, Catalan, Cheshire and Ridge (2021) report that effective combination ART in the late 1990s helped PLWHA to attain undetectable viral loads, which resulted in near-normal life expectancy and no transmission risk. Scientific evidence has reduced stigma in several cases. Despite these achievements, Hedge et al. (2021) and Fauk, Hawke, Mwanri and Ward (2021) warn that discrimination persists in hospitals, workplaces, and communities. Stigma prevents people from HIV testing and starting treatment, which indicates that medical progress has not eliminated the social stigma of HIV. Pre-existing inequities exacerbate stigma. According to Lovato (2016), HIV stigma compounds discrimination based on gender and sexual orientation. HIV-positive women face multiple stigmas, which limit their access to care and increase their risk of violence. Hedge et al. (2021) also note that family members and carers of PLWHA may encounter “courtesy stigma”, a phrase developed by Gofman (1963) in order to describe stigmatisation of those closest to affected individuals. This phenomenon amplifies the detrimental effects of HIV stigma beyond the individuals who are directly affected, which emphasises the need for structural and societal remedies.

2.5 Coping strategies used by PLWHA

Being HIV positive means that individuals must take better care of themselves, engage in a strong fight for their lives, and show greater love to others in order to receive the support they need (Arias-Colmenero et al., 2020). Those who are HIV positive should modify their behaviours with the belief that these adjustments are necessary to live a normal life, overcome the diagnosis, and increase the desire to live. Focusing on positive behaviours such as maintaining a cheerful attitude, engaging in moderate physical activity, eating a balanced diet, and striving for an active social life will help individuals leave undesirable habits behind. This approach can help to prevent feelings of sadness, hopelessness, and isolation (Amal & Pandin, 2021).

According to Arebo, Ewach, Omara, Oyella, Aciro Lucky and Kabunga (2022), PLWHA may be categorised into two groups based on the goals of their behaviours: approach coping and avoidant coping. Approach coping involves behaviours such as providing emotional support, addressing problems, and reorganising one's thoughts to actively deal with stressors. For example, PLWH require emotional support, especially upon receiving their diagnosis (Arebo et al., 2022). Avoidant coping, on the other hand, refers to behaviours that attempt to evade unpleasant situations, such as blaming, social isolation, denial, and disengagement. For instance, a person with HIV may ignore stress and anxiety, engage in substance abuse, and avoid taking their medication (Du, Crook, Whitener, Albright, Greenawalt & Zurlo, 2015).

2.5.1 HIV treatment

When people are diagnosed with HIV, they are required to undergo HIV treatment known as ART, which involves the use of anti-HIV medications to treat HIV-infected individuals. HAART employs anti-HIV drugs to reduce viral replication (WHO, 2015). While HIV patients live longer with ART, it must be properly monitored (Arias-Colmenero et al., 2020). ART is widely available in South Africa and it has resulted in a decrease in HIV/AIDS related mortality as well as new infections, although non-adherence remains a significant issue. Many patients skip their prescriptions due to factors such as transportation, meal availability, and long wait times at public clinics (Ahmed et al., 2018). Depression and stigma can also impact adherence, as individuals may internalise shame and discontinue therapy, along with other available

treatments (Nurfalah, Yona & Waluyo, 2019). Pharmacological side effects and treatment fatigue further discourage utilisation, particularly among young women who manage childcare and household responsibilities (Moyo et al., 2016). These challenges highlight that the availability of ART does not guarantee its efficacy.

Therapy and three specific antiretroviral drugs are standard treatments for newly diagnosed patients to manage or eliminate viral load (Davenport, Khoury, Cromer, Lewin, Kelleher & Kent, 2019). Early treatment promotes immunological recovery and lowers the risk of HIV-related cardiovascular disease and cancer (Garrett et al., 2018). Menéndez-Arias and Delgado (2022) argue that modern regimens are less toxic and better tolerated, which makes adherence simpler for many patients. Early ART reduces community-level transmission rates, which demonstrates its benefits for both treatment and prevention (Adamu et al., 2019). ART is also essential for preventing mother-to-child transmission (Moodley, Moodley, Sebitloane, Maharaj & Sartorius, 2016). Pregnant women who utilise ART experience reduced perinatal HIV transmission and improved maternal outcomes (Moodley et al., 2016). The WHO also recommends long-term multi-drug combinations during pregnancy, which have increased child HIV-free survival (Adeniyi et al., 2018). Bailey, Zash, Rasi and Thorne (2018) further emphasise that women of reproductive age need ART to reduce HIV-related child mortality.

2.5.2 Religion

Many HIV-positive individuals use faith to cope with their diagnoses. Religion provides meaning to life, redefines relationships, and aids in accepting death (Oliveira, Vieira, Mistura & Jacobi, 2015). It can help people to reframe their lives, lessen fear, and find solace and strength to embrace their illness (Santos et al., 2019). Spirituality fosters faith in a higher power for healing and recovery, distinct from familial and social attachments (Santos et al., 2019). Many HIV-positive individuals discover hope, meaning, and strength in spirituality. Spiritual vitality reduces anxiety and enhances psychosocial management of HIV (Pinho et al., 2017; Zainal-Abidin, Ariffin, Badlishah-Sham & Razali, 2022).

Religious coping involves faith-based cognitive, emotional, and behavioural responses. Healthcare experts also recommend it in patient support programmes to

improve individuals' quality of life. It helps patients to reinterpret pain, strengthen acceptance, and enhance quality of life; however, it can have negative effects when HIV is perceived as divine punishment, which could undermine adherence and psychosocial well-being (Osamika, 2019). Studies show that spiritual-religious coping enhances well-being and reduces distress by providing meaning to suffering and building resilience (Osamika, 2019; Zainal-Abidin et al., 2022). Spiritually oriented coping helps people to regulate emotions, take responsibility for their behaviours, and maintain self-control under stress (Amal & Pandin, 2021). These strategies promote empowerment and support the idea that religious and spiritual practices can help HIV patients to manage their condition.

2.5.3 Alcohol

HIV-positive patients often drink excessively, which has been researched for its effects on health and adherence (Hahn & Samet, 2010). Alcohol is a common emotional coping method, particularly in response to stress and stigma, although it has been linked to poor clinical and psychosocial outcomes (Wardell et al., 2018). Alcohol consumption is closely associated with poor ART adherence, which reduces treatment efficacy (Madhombiro, Musekiwa, January, Chingono, Abas & Seedat, 2019). Research in South Africa indicates that traumatised individuals use alcohol to cope with the emotional toll of HIV. Social stigma, gender inequities, and limited supportive environments hinder young women's ability to adapt positively after diagnosis (Myers, Sorsdahl, Morojele, Kekwaletswe, Shuper & Parry, 2017). A lack of coping tools and social support leads many individuals to turn to alcohol to manage stress, despite its long-term consequences (Vazquez-Colón, 2016). Trauma, marginalisation, and maladaptive coping mechanisms are interconnected among WLWH (Myers, Carney, Browne & Wechsberg, 2018).

Alcoholism is one of the most common behavioural issues among PLWH worldwide, with estimates suggesting that between 30% and 50% of PLWH have alcohol-related problems, which significantly impair treatment outcomes (Pokhrel, Pokhrel, Neupane & Sharma, 2018). Heavy drinking accelerates HIV disease progression, reduces quality of life, and increases the risk of opportunistic infections (Shuper, Joharchi, Monti, Loutfy & Rehm, 2017). The use of alcohol also undermines social and spousal

support structures, which leads to lower adherence to ART and adversely affects both physical and mental health (Madhombiro et al., 2019).

Researchers emphasise that alcohol-related coping is often part of a broader pattern of avoidant coping strategies, including disengagement, denial, and substance use (Merrill, Wardell & Read, 2014). These maladaptive practices perpetuate poor adherence, deteriorate health, and contribute to disengagement from HIV care (Wardell et al., 2018). Thus, while alcohol may provide temporary stress relief, its long-term effects increase health risks, diminish coping capacity, and negatively impact the well-being of PLWH.

2.6 Theoretical Framework: The health belief model (HBM) and the Goffman's stigma theory

The HBM and the Goffman's (1963) stigma theory were employed in this study to offer a detailed understanding of the experiences of young women who were diagnosed with HIV and how they cope with the changes in their lives following their diagnosis in rural areas. These theories are suitable and complement each other because they both offer a framework for developing HIV-specific health initiatives and strategies that target both individual and wider societal settings. The HBM is important in recognising and encouraging HIV prevention behaviour, as it explains how individuals' perceptions of risk, the benefits associated with action, the difficulties in taking action, and their confidence in taking action, along with cues to action, determine their choices (Tarkang & Zotor, 2015). Goffman's (1963) theory of stigma is crucial as it provides insight into the social obstacles faced by PLWH. It highlights how community labelling and unfavourable attitudes can lead to rejection and hinder a person's ability to obtain care, adhere to medication, and engage in life freely (Peltzer & Pengpid, 2019).

2.6.1 The HBM

In the 1950s, social psychologists from the United States Public Health Service developed the HBM based on the idea that beliefs about disease and risk reduction actions strongly influence health behaviour. Key concepts used to explain the HBM include perceived susceptibility, severity, benefits, barriers, cues to action, and self-efficacy (Green, Murphy & Gryboski, 2020). Perceived susceptibility refers to an individual's perception of their risk of illness. People are more likely to take precautions

when they recognise their risk. Young women who believe that delaying or skipping ART could lead to opportunistic infections or AIDS-related consequences are more likely to seek treatment (Green, Murphy & Gryboski, 2020). Tarkang and Zotor (2015) argue that awareness of susceptibility increases motivation to use condoms, which reduces the risks of transmission and reinfection.

Perceived benefits describe how much individuals believe certain health habits will prevent or treat illness. To improve their health, HIV-positive young women may adhere to ART, eat well, avoid alcohol and drugs, reduce the number of sexual partners, and use ART, which assists in managing HIV/AIDS and improving quality of life (Ashraf & Virk, 2021). As Tarkang and Zotor (2015) note, behaviour change is likely when individuals believe certain actions will provide meaningful protection. Perceived barriers reflect the challenges of changing habits. Stigma, poverty, lack of healthcare, GBV, and unsupportive work or home environments hinder young HIV-positive women from accessing the care they need and from living healthy, empowered lives (Washburn, 2020). Such barriers sometimes outweigh the apparent advantages, which makes desirable behaviours difficult to maintain (Washburn, 2020). Loutfy et al. (2016) discovered that individuals fear stigma, discrimination, and violence when disclosing their HIV status, which affects their likelihood of seeking treatment. Structural, psychosocial interventions, and community sensitisation are needed to overcome these hurdles.

Perceived severity involves assessing the seriousness of an illness and its potential impact on daily life. Despite being aware of the medical threats, some young women underestimate the risks of opportunistic infections or the consequences of non-adherence to ART, which can lead to delays in taking action (Washburn, 2020). However, recognising the severe implications of untreated HIV/AIDS, such as long-term disability and premature death, increases compliance with prevention and treatment measures (Tarkang & Zotor, 2015). Cues to action serve as motivators for health behaviour and may include media campaigns, symptoms of illness, encouragement from healthcare practitioners, or observing the experiences of others (Washburn, 2020). Young women benefit from external reminders and community-based interventions that enhance treatment adherence and safety (Tarkang & Zotor, 2015).

Lastly, self-efficacy relates to self-confidence in health habits. Even those who feel high vulnerability or severity may not act without self-efficacy. A woman may assume that condom use or ART adherence will safeguard her health, but she may not act if she questions her capacity to maintain these practices (Tarkang & Zotor, 2015). Self-efficacy must be built through health education, counselling, and peer support. In the findings and conclusion chapters, this study uses perceived susceptibility, severity, benefits, barriers, cues to action, and self-efficacy to understand how young women in Mtubatuba cope with HIV after being diagnosed. The study identifies behavioural motivators and impediments to health outcomes by relating their experiences to the HBM.

2.6.2 The Goffma's stigma theory

The stigma theory was introduced by Goffman in 1963. Goffman (1963) describes stigma as a "gravely discrediting attribute which lowers the person who bears it from being an ordinary individual to a discredited, tainted human being". Nevertheless the attribute itself may not naturally discrediting, alternatively, it becomes discrediting due to the way individuals are categorised in the community as well as the societal standards associated with specific groups. Certain qualities are deliberately framed as undesirable because of their negative connotations and the prejudices attached to them (Goffman, 1963). Goffman (1963) identifies three interconnected forms of stigma. Enacted stigma refers to mistreatment or discrimination, while perceived stigma is the belief that a condition will attract negative attention. Internalised stigma results in feelings of shame, worthlessness, and guilt when individuals adopt society's negative perceptions of themselves (Hedge et al., 2021). Stigma impacts both social relationships and self-perceptions.

Goffman's stigma helps in explaining PLWH's experiences. Strong words, social rejection, and discrimination from communities and healthcare workers are examples of HIV stigma. Gender inequality, low education, and intimate partner abuse further stigmatise WLWH, which prevents them from seeking treatment (Peltzer & Pengpid, 2019). Due to this stigma, many HIV-positive individuals fear job loss, family rejection, and social isolation (Akatukwasa et al., 2021). Stigma can lead to secrecy, delayed healthcare, and social withdrawal. Internalised stigma illustrates how much women

feel “contaminated” or morally despised by society. This internal struggle is strongly linked to depression, low self-esteem, and poor adherence to ART (Turan et al., 2017).

Research also shows that stigma affects the marriage, fertility, disclosure, and treatment adherence of women in sub-Saharan Africa. To avoid stigma, women may forgo marriage or childbirth, or conceal their HIV status from family and partners (Akatukwasa et al., 2021). Healthcare stigma prevents Ethiopian and South African women from accessing maternal or sexual healthcare, which increases health risks (Zarei, Joulaei & Fararouei, 2017; Chekole & Tarekegn, 2021). Goffman’s (1963) stigma theory provides insight into the complex relationship between HIV/AIDS and social identity. Although the theory does not directly address health issues, its focus on how stigma affects social standing and personal well-being makes it relevant for studying young HIV-positive women in Mtubatuba Municipality. This study explored how gender, poverty, and healthcare access influence women’s coping strategies and quality of life.

2.6.3 Relevance of the HBM and Goffman’s stigma theory

Figure 2.1 illustrates the interconnectedness of diagnosis, perceptions, stigma, coping, and outcomes. It emphasises that women’s life trajectories post-diagnosis are not determined solely by medical availability but by the interaction of beliefs, stigma, and coping choices within socio-structural contexts.

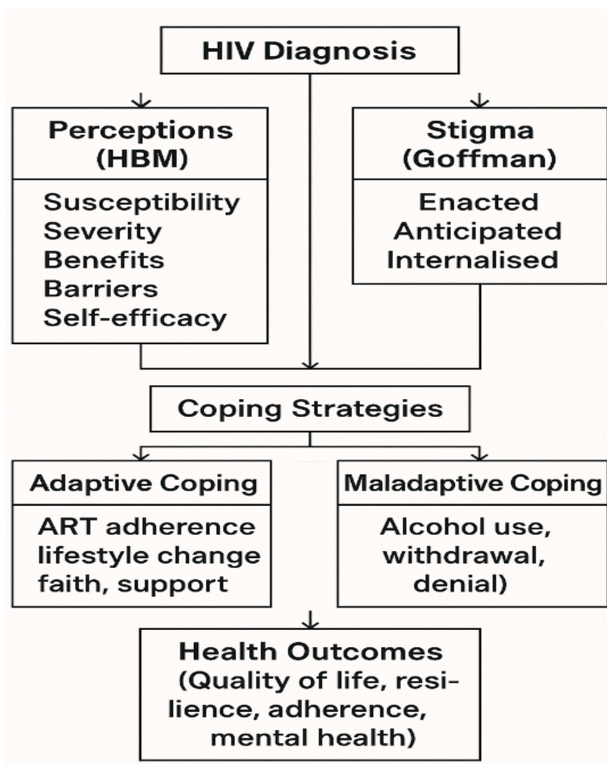

Figure 2.1: The HBM and stigma theory on HIV/AIDS

Source: Adapted from Green, Murphy and Gryboski (2020)

The use of the HBM is particularly relevant because it accounts for the cognitive and motivational processes that determine whether young women adopt preventative or treatment behaviours (Green, Murphy & Gryboski, 2020). As previously indicated, this model emphasises perceived susceptibility, severity, benefits, barriers, cues to action, and self-efficacy as important factors that explain why individuals engage or fail to engage in health-protective behaviours. For this study, perceived susceptibility and severity were central determinants of women's health behaviours. Women who recognise themselves as highly vulnerable to opportunistic infections are more likely to adhere to ART and adopt preventative behaviours such as condom use (Tarkang & Zotor, 2015). Conversely, those with low perceptions of risk may underestimate the consequences of non-adherence. The construct of perceived benefits is also crucial, as it shapes motivation to remain in care, while perceived barriers such as stigma, poverty, and treatment fatigue often outweigh potential health gains (Washburn, 2020).

Diagnosis represents a critical turning point, often accompanied by shock, denial, and heightened psychological stress (Ashaba et al., 2017). These emotional responses

shape initial perceptions of susceptibility and severity, which in turn influence treatment-seeking behaviours. For instance, women who view HIV as a manageable chronic condition may accept ART more readily, while those who associate diagnosis with imminent death may disengage from care. Applying this concept in this study was essential, given that the region experiences a combination of high HIV infection rates, persistent stigma, and structural deprivation. Women in rural KwaZulu-Natal face higher risks due to socio-economic inequalities, intergenerational relationships, and frequent GBV (Dellar et al., 2015). The HBM highlights why, despite awareness of prevention measures, women may not consistently adopt protective behaviours.

Goffman's (1963) stigma theory expands the framework by examining the external and internalised social pressures that discourage disclosure, reduce treatment adherence, and intensify psychosocial distress (Hedge et al., 2021). Stigma and socio-economic barriers significantly decrease adherence rates among women in low-resource settings, even when ART is widely available (Ahmed et al., 2018). This indicates that cognitive assessments cannot be separated from social and structural contexts.

Coping strategies are conceptualised along two dimensions: adaptive strategies (e.g., ART adherence, positive lifestyle changes, and faith-based resilience) and maladaptive strategies (e.g., avoidance, alcohol use, and withdrawal). Individuals who engage in adaptive strategies report better mental health and quality of life, whereas maladaptive strategies exacerbate disease progression and psychosocial distress (Amal & Pandin, 2021; Madhombiro et al., 2019). Following diagnosis, stigma plays a mediating role. Women who anticipate social rejection may conceal their status, adopt maladaptive coping strategies such as alcohol use, or disengage from healthcare (Wardell et al., 2018). Conversely, supportive social networks and religious coping can reduce stigma, enhance self-efficacy, and promote resilience (Pinho et al., 2017; Zainal-Abidin et al., 2022). The framework thus positions stigma as both a barrier and a determinant of the coping process.

Women in rural KwaZulu-Natal face higher risks due to socio-economic inequalities, intergenerational relationships, and frequent GBV (Dellar et al., 2015). The HBM highlights why, despite awareness of prevention measures, women may not consistently adopt protective behaviours. At the same time, Goffman's (1963) stigma theory illustrates how social penalties discourage engagement with healthcare and

limit disclosure. Together, these theories ensure that the study interrogated not only individual choices but also the structural and cultural forces that constrain those choices.

2.7 Research gap

Despite extensive scholarship on HIV/AIDS, substantial gaps remain in understanding the lived experiences of young women after diagnosis, particularly in rural areas such as the Mtubatuba Local Municipality. Existing literature has primarily prioritised biomedical interventions, while psychosocial realities, cultural dynamics, and the everyday struggles of young women have not been adequately examined. For instance, research has frequently focused on the clinical outcomes of ART (Menéndez-Arias & Delgado, 2022; Garrett et al., 2018); however, few studies have critically interrogated how treatment adherence interacts with stigma, socio-economic inequalities, and mental health challenges. This indicates a gap in integrating medical and social perspectives, which is necessary to provide a holistic understanding of life after diagnosis.

The literature also highlights stigma as a central barrier for PLWH, but this phenomenon has not been fully contextualised among young women aged 18 to 35. Studies in South Africa and across sub-Saharan Africa identify enacted, anticipated, and internalised stigma as key determinants of health-seeking behaviours (Turan et al., 2017; Peltzer & Pengpid, 2019). However, much of this research does not sufficiently unpack the intersection of stigma with gendered power relations, cultural expectations, and socio-economic constraints. Akatukwasa et al. (2021) demonstrate that stigma in rural communities significantly shapes disclosure and access to care, yet there remains limited inquiry into how such dynamics evolve after diagnosis, particularly among young women who navigate familial, marital, and social pressures.

Mental health challenges represent another underexplored dimension. While several studies have established links between HIV and psychological distress, including depression and anxiety (Adamu et al., 2019; Ashaba et al., 2017), most of these works focus on broad populations rather than specific age groups or gender categories. Research indicates that young women may experience more exposure to mental health challenges due to societal expectations, reproductive responsibilities, and GBV

(Jones et al., 2023). Yet, there is a scarcity of research on how these intersecting pressures shape the post-diagnosis mental health trajectories of women in rural KwaZulu-Natal.

Another research gap lies in understanding coping strategies beyond the dichotomy of adaptive and maladaptive mechanisms. Research has documented religion and spirituality as important resources for resilience (Santos et al., 2019; Zainal-Abidin et al., 2022), while other studies point to harmful behaviours such as alcohol use as avoidance strategies (Wardell et al., 2018, Madhombiro et al., 2019). However, few research studies have examined the dynamic interplay between these coping approaches or considered how community and cultural settings influence the adoption of particular strategies. Moreover, interventions have often treated coping strategies as static and overlooked how they evolve in response to treatment experiences, stigma, and social support structures.

The literature also reveals a limited empirical focus on rural South African settings, with much of the research derived from urban populations or generalised national surveys (Ngwenya et al., 2020). Ngwenya et al. (2020) emphasise that rural young people face distinct barriers in accessing health services, including distance to clinics, a shortage of youth-friendly facilities, and cultural taboos surrounding sexuality. How these barriers specifically affect young women post-diagnosis remains underexplored. Most rural-based studies concentrate on prevention or mother-to-child transmission (Moodley et al., 2016; Adeniyi et al., 2018), while broader psychosocial experiences, such as navigating relationships, employment, and disclosure, are under-researched. This study addresses these gaps by focusing specifically on the lived experiences of young women in the Mtubatuba Local Municipality by situating their narratives in both the HBM and stigma theory to generate contextually grounded insights.

2.8 Conclusion

The literature review in this chapter highlighted the multifaceted challenges experienced by PLWHA. After diagnosis, people face heightened psychosocial burdens that include depression, anxiety as well as suicidal ideation, which highlight the complex interplay between mental health and chronic illness. These experiences are intensified by stigma, which manifests in enacted, perceived, and internalised

forms that directly shape disclosure decisions, treatment adherence, and overall quality of life. The chapter demonstrated that the coping strategies adopted by PLWHA are diverse and shaped by individual, social, and structural factors. Some individuals rely on adaptive mechanisms such as religious and spiritual practices, which provide hope, resilience, and meaning in the face of illness. Others, however, resort to maladaptive behaviours such as alcohol consumption, which further undermine ART adherence and exacerbate vulnerability. Central to individuals' capacity to cope effectively is access to ART, which remains the cornerstone of biomedical management and prevention of HIV transmission. Studies demonstrate that while ART has extended life expectancy, adherence is still undermined by poverty, stigma, and systemic challenges in healthcare delivery. Religious and community institutions are similarly double-edged, which either strengthen coping capacity or perpetuate stigma, depending on their orientation. The chapter further addressed the study's theoretical frameworks, namely the HBM and Goffman's stigma theory, which have been shown to offer useful lenses for interpreting these dynamics and helping to situate women's lived realities within broader behavioural and sociological contexts. Lastly, the research gaps that this study aimed to fill were addressed in this chapter.

The next chapter reflects on the methodology and methods used to conduct this study with young women aged 18 to 35 on their experiences of HIV/AIDS post-diagnosis, the support offered, and coping strategies used in the rural areas of Mtubatuba.

CHAPTER 3:
METHODOLOGICAL REFLECTIONS OF CONDUCTING RESEARCH WITH YOUNG WOMEN DIAGNOSED WITH HIV/AIDS IN MTUBATUBA

3.1 Introduction

This chapter discusses the research design and procedures used to meet the objectives of the study. The aim of the study was to understand the experiences of young women aged 18 to 35 who were diagnosed with HIV/AIDS in the rural areas of Mtubatuba. This study aimed to discover how these women cope with the changes in their lives after being diagnosed with HIV/AIDS, the support available to them, and the strategies they employ to live after their diagnosis. The study was informed by the interpretivist research paradigm to examine the experiences of young women living with HIV/AIDS (WLWHA) in rural areas, as well as the context and meaning the participants attributed to their circumstances and their management of HIV/AIDS. The qualitative research design also allowed me to interact with the participants to gain insight into their experiences of the phenomenon studied. Firstly, this chapter begins by explaining the interpretivist paradigm utilised in the research and how it influenced the methodological design, methods, and approaches. Secondly, it reflects on the study's research techniques and methodologies, including aspects such as research sampling, data collection, and data analysis. Thirdly, the chapter describes the steps taken to secure the study's credibility and to address ethical issues. Lastly, this chapter reflects on the reflexive process I employed throughout the investigation.

3.2 Research paradigm: Interpretivism

This study was guided by the interpretivist research paradigm. The purpose of interpretivism is to explain individuals' lived experiences of a phenomenon as described by the research participants (Mohajan, 2018). The interpretivist paradigm enables investigators to interpret the surroundings from the participants' perceptions and experiences (Thanh & Thanh, 2015). An interpretive technique offers a framework for assessing what participants in studies need to share concerning their encounters and allows them to explore their views (Thanh & Thanh, 2015). The interpretivist research paradigm was also beneficial to this study as it examined the experiences of young WLWHA in rural areas, as well as the context and meaning that the participants

attributed to their circumstances and their dealings with HIV/AIDS. This paradigm allowed the study to fully understand the participants' reality through their experiences and recognise that such experiences may differ from one person to another due to the influence of societal or past experiences. The chosen research paradigm also enabled me to comprehend the participants' behaviour and the psychological effects of their HIV diagnosis.

3.3 Qualitative research design

A qualitative research design was followed to achieve the purpose of this study. According to Yin (2015), qualitative research is a method that is used to examine and comprehend the significance of both individuals and groups that contribute to a human or social issue. This design assists in understanding people's experiences in specific situations (Mohajan, 2018). Additionally, qualitative research provides an in-depth description of individual experiences, including feelings, views, and perspectives (Mohajan, 2018). This methodology allowed the participants, as self-aware individuals, to speak authoritatively about the situation being studied. It also enabled me to employ probing skills to gain a deeper understanding of their responses. Qualitative research facilitated the collection of detailed data and a representation of the lived circumstances of young women who are diagnosed with HIV/AIDS in rural areas.

3.4 Study area

Figure 3.1 shows a map of the study area, namely the Mpukunyoni Clinic in the Enqopheni area.

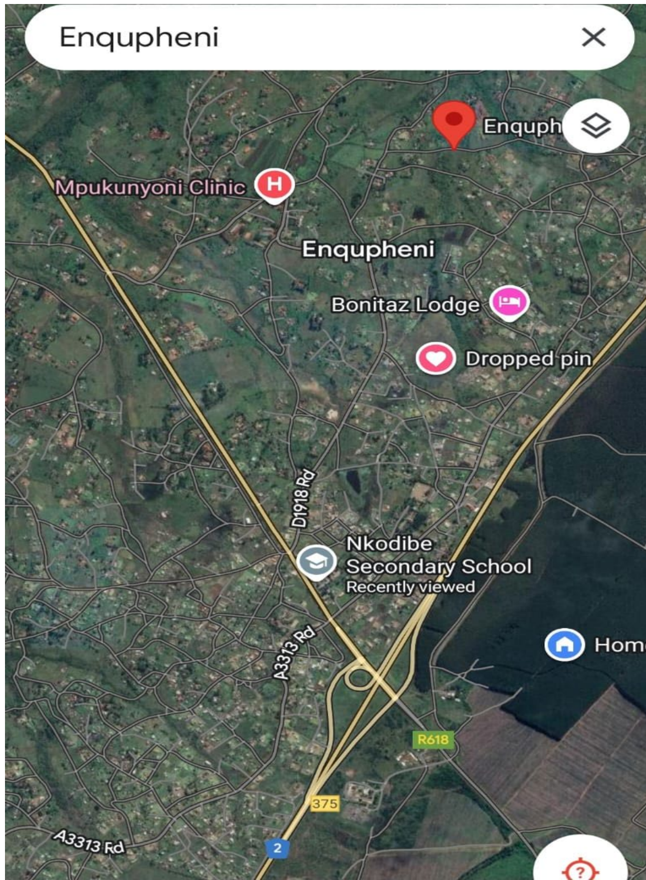

Figure 3.1: Location of the Mpukunyoni Clinic in the Enqopheni area
Source: Google Maps (2025)

The selected area for the study was the Mtubatuba rural area, which is located in the uMkhanyakude District. The Mtubatuba Local Municipality is one of the five Category B municipalities in the uMkhanyakude District, which is situated in the north-eastern part of the KwaZulu-Natal province. Mtubatuba is located at the southern end of the uMkhanyakude District, with the N2 separating the municipality into Mtubatuba East and Mtubatuba West (Mtubatuba Local Municipality, 2013). Accordingly, the uMkhanyakude District is among the poorest in the country, as the majority of residents in Mtubatuba are impoverished, particularly PLWH. The population predominantly relies on government social subsidies and pensions (Elliott & Escott, 2014). uMkhanyakude is one of South Africa’s poorest districts and is characterised by high rates of HIV and unemployment (Ngwenya et al., 2020). The study’s population consisted of young women aged 18 to 35 who had been diagnosed with HIV and received monthly antiretroviral (ARV) refills from the Mpukunyoni Clinic.

Mtubatuba was a suitable research site due to its high percentage of PLWHA, particularly young women who are also unemployed (Ngwenya et al., 2020). Mpukunyoni Clinic was specifically chosen for the study because of the large number of patients who visit the clinic regularly. Located in the Enqupheni area in the Mtubatuba Local Municipality, Mpukunyoni Clinic was conveniently accessible to both myself as the researcher and the participants.

3.5 Sampling and selection of participants

According to Moser and Korstjens (2018), a sample is a collection of people selected for a particular study. The process of selecting a small portion of a population to present the whole population is known as sampling (Moser & Korstjens, 2018). Participants of the study were selected using purposive sampling, which is non-probability sampling technique. In this method, participants are selected by the investigator based on their preferences, which are influenced by the study, and their willingness to share information (Rahman, 2023). Rai and Thapa (2015) state that purposive sampling allows researchers to use their judgement to hand-select research participants from a target group according to specific requirements. Consequently, the purposive sampling technique was employed to select young women aged 18 to 35 who were diagnosed with HIV/AIDS from the local clinic in the rural areas of Mtubatuba.

One benefit of purposive sampling is that it allows researchers to choose a sample based on their understanding of a phenomenon (Rai & Thapa, 2015). This study involved 15 young women aged 18 to 35 as participants and data saturation was reached with 15 participants. Data saturation refers to the moment at which no information, themes or insight emerge, rendering additional data collecting irrelevant (Braun & Clarke, 2021). It guarantees the validity and reliability of the study and shows that the phenomenon has been thoroughly investigated. However, it is often associated with small sample size (less than 20), depending on the topic’s complexity and homogeneity (Hennik & Kaiser, 2022). The researcher selected these participants from Mpukunyoni Clinic, specifically targeting those who visited the clinic once a month for medication refills and viral load testing. After obtaining ethical clearance from the University of South Africa’s College of Human Sciences Research Ethics Committee (see Appendix G), I sought permission from the Department of Health (Hlabisa

Hospital) and then approached the clinic manager to gain access to the participants. To obtain this approval, I wrote a letter requesting permission to conduct research from Hlabisa Hospital (see Appendix D). Once approval was granted (see Appendix H), I wrote to the manager of Mpukunyoni Clinic to request access to potential participants (see Appendix E). I worked closely with the clinic manager, to whom I submitted the study's inclusion criteria and an information letter aimed at potential participants. I discussed the study with the clinic manager and provided her with all relevant documents, including the information letter (see Appendix A), consent form (see Appendix B and C), the approval from the Department of Health (see Appendix H), the interview guide (see Appendices J and K), and the ethical clearance certificate (see Appendix G).

Upon gaining access to the clinic, the clinic manager appointed the nurse in charge to assist with accessing and selecting participants that matched the study's criteria. The nurse in charge had a close relationship with the participants, which was beneficial, as HIV/AIDS is a sensitive matter. Additionally, complying with the Protection of Personal Information Act was important, as participants might not easily share their status with a researcher but would feel more comfortable doing so with the nurse in charge. To provide a description of what was required to participate in the study, the charge nurse reviewed the information letter and the interview guide with the participants.

The participants were chosen based on the inclusion and exclusion criteria listed in Table 3.1.

Table 3.1: Inclusion and exclusion criteria

Inclusion	Exclusion
A woman.	A man.
A woman who resides in Mtubatuba rural area in the uMkhanyakude District.	A woman who does not reside in the Mtubatuba rural area in the uMkhanyakude District.
A woman who is between the ages of 18 to 35.	A woman who is not between the ages of 18 to 35.
A woman was recently (in the last year) diagnosed with HIV and who resides in the Mtubatuba rural area in the uMkhanyakude District.	A woman who was not recently diagnosed with HIV and not residing in the Mtubatuba rural area in the uMkhanyakude District.
A woman who visits the clinic once a month for medication refills, viral load testing, and psychosocial follow-up.	A woman who does not visit the clinic once a month for medication refills, viral load testing, and psychosocial follow-up.

3.6 Profile of the participants

Table 3.2 describes the participants in this study, specifically focusing on how age, level of education, job, marital status, and residence affected their lives after being diagnosed. Fifteen young women aged 18 to 35, who had been diagnosed with HIV/AIDS and who were from the Mtubatuba Local Municipality in KwaZulu-Natal participated in the study. The participants ranged in age from 21 to 35. Individuals aged 18 to 35 are more likely to contract HIV due to their social, economic, and cultural circumstances (UNAIDS, 2021; Kimera et al., 2020). Age influences reactions to diagnosis, coping strategies, and engagement in treatment. According to Jones et al. (2023), younger women demonstrate resilience but are also more psychologically distressed by life challenges. The demographic distribution of the participants aligns with national HIV incidence data, which highlights the need for tailored interventions for young South African women.

In terms of education, some participants dropped out of school before completing Grade 12, although most had completed secondary schooling. Five of the 15 participants had achieved Grade 12, while the others had Grade 1 to 11 schooling. Studies demonstrate that HIV vulnerability increases with lower educational attainment due to limited health awareness and prevention resources (Akatukwasa et al., 2021; Duby, 2022). Education helps individuals to overcome stigma and improve adherence, according to Fauk et al. (2021). Low education levels underscore the need for educationally tailored interventions to enhance health literacy among HIV-positive young women. Kholiwe and Masisi, who completed Grade 10 and Grade 9 respectively, reinforced the association between limited education and knowledge gaps, such as Kholiwe’s unfamiliarity with pre-exposure prophylaxis (PrEP). This highlights the relevance of the HBM in understanding perceived susceptibility and limited cues to action due to insufficient health information.

The participants were primarily unemployed. Only three of the 15 interviewees worked casually, while the other 12 were jobless. Unemployment restricts healthcare access and increases psychosocial stress, which heightens HIV-related risks (Casavant, 2020). Anuar, Shah, Gafor, Mahmood and Ghazi (2020) also found that HIV-positive young women who are unemployed have lower treatment adherence and mental well-being. Employment, or lack thereof, considerably affects individuals’ experiences with

HIV as it influences both treatment and psychosocial wellness. Olga, who was employed, appeared to have better access to care and greater autonomy in disclosure, which highlights how economic security facilitates personal agency, which is a key construct in the HBM's notion of perceived control. Several participants reported cohabiting or long-distance romantic relationships. Arebo et al. (2022) found that married or cohabiting women negotiate HIV disclosure and treatment adherence with their partners. Single women may face less partner-related stigma but greater familial and societal censure (Chekole & Tarekegn, 2021). This study corroborated these perspectives as the participants managed disclosure, stigma, and support in various relationships. For example, Masisi's delayed disclosure and subsequent rejection reflect the social consequences of stigma, as theorised by Goffman (1963), whereby the visibility or perceived "spoiled identity" of HIV status creates a risk for relational exclusion.

In terms of living arrangements, most participants lived with their parents or siblings, while some lived with their partners. According to Bukhori et al. (2022), support from family helps HIV patients to cope emotionally; nevertheless, Fauk et al. (2021) warn that family help may jeopardise confidentiality and stigmatise HIV patients. Partnered and single participants exhibited varied HIV disclosure and treatment autonomy. Pamukhti, Erawati, Muniroh and Dewi (2021) stress the delicate balance between family support and personal agency in HIV-positive women. Masisi, who lived with her mother, exemplified the protective role of familial support, while Kholiwe's emotional support from her late partner and mother reflected a resilience dynamic shaped by collective care.

Table 3.2: Demographics of the participants

No.	Participant	Age	Marital status	Highest educational level	Employment	No. of children
1.	Anele	21	Single	Grade 10	Unemployed (still in school)	1
2.	Buhle	30	Single	Grade 11	Unemployed	2
3.	Carol	35	Single	Grade 10	Unemployed	2
4.	Dudu	24	Single	Grade 1	Unemployed	2
5.	Esther	32	Single	Grade 12	Unemployed	4
6.	Fikile	34	Single	Grade 12	Employed	4
7.	Gloria	29	Single	Grade 12	Unemployed	3
8.	Hlengiwe	25	Single	Grade 11	Unemployed	1
9.	Irene	29	Single	Grade 6	Unemployed	1
10.	Jabu	29	Single	Grade 10	Unemployed	1

11.	Kholiwe	33	Single	Grade 10	Unemployed	3
12.	Lungile	24	Single	Grade 12	Unemployed	2
13.	Masisi	27	Single	Grade 9	Unemployed	3
14.	Nonhle	32	Single	Grade 12	Employed	1
15.	Olga	28	Single	Grade 12	Employed	2

3.7 Data-collection method

Semi-structured interviews were used collect data for this study. Osborne and Grant-Smith (2021) suggest that semi-structured interviews, which follow a list of questions, enable a degree of freedom regarding how questions are addressed and allow for follow-up questions. Wholey, Hatry and Newcomer (2018) state that researchers should consider using semi-structured interviews if they wish to probe or ask open-ended questions to elicit each person’s reflections and experiences. In this study, semi-structured interviews were facilitated by open- ended questions from an interview guide to gain an understanding of the experiences of young women who were diagnosed with HIV/AIDS.

The interview guide (see Appendices J and K) used in this study consisted of demographic questions about gender, race, age, occupation, and level of education, which were included in Section A. The second section of the interview guide focused on questions about the experiences of young WLWHA, how they cope with the changes in their lives that accompany receiving an HIV/AIDS diagnosis, the support offered, as well as the coping mechanisms they used. I conducted face-to-face interviews with the participants at Mpukunyoni Clinic. Semi-structured interviews have the advantage of allowing the researcher to observe the participants’ body language when they respond to questions, which provides an additional source of data for analysis and interpretation (Osborne & Grant-Smith, 2021). I was able to utilise non-verbal cues such as facial expressions and tone of voice, which facilitated the collection of supplementary data to enhance the responses provided by the participants.

As highlighted in Section 3.5, I requested authorisation from the clinic manager to select and access participants after receiving approval from the Department of Health. Potential participants were approached during their monthly clinic appointments, and interviews took place following their consultations. The interviews were conducted in the presence of the counsellor, who was a social worker from the Department of Social

Development. I sought the social worker's assistance due to the sensitive and personal nature of the study, as the participants' emotions could flare during the interviews. Prior to the commencement of each interview, the participants were informed of the objectives and intent of the research, as outlined in the information sheet (see Appendix A). The participants were asked for their consent to use an audio recorder during the interviews. To express their willingness to engage in the study, the participants were provided with written consent forms (see Appendices B and C).

I prepared the consent forms before the study began, and read the information together with the participants prior to the interviews. Given that their participation was voluntary, the participants were advised that they could discontinue participating from the study any time without facing any consequences.

Due to the sensitive nature of the study, I conducted the interviews in a private consultation room at Mpukunyoni Clinic, which is typically used by the doctor to see patients. The clinic manager suggested that I come on Mondays and Wednesdays to use the room when the doctor is unavailable. Each interview session lasted between 30 and 45 minutes. The interviews were conducted in isiZulu, as the participants were comfortable with and preferred this language. The majority of patients who visit Mpukunyoni Clinic speak isiZulu as their first language. The participants were able to express themselves in their preferred language, which allowed them to feel at ease and communicate freely. Consequently, the interview guide was also translated from English to isiZulu (see Appendix K). The interviews were recorded using a mobile phone audio recorder and saved, with access restricted to me and my supervisor. Notes were taken throughout the interviews. All the interview recordings were transcribed verbatim from isiZulu to English, and it is important to note that I am fluent in isiZulu. Data were collected over two months (November to December 2024).

Lastly, it is important to note that during the interviews, the consultation room I used stored large boxes of condoms and other clinic supplies, which meant that the nurses occasionally entered the room to collect condoms or other equipment. Since some participants had left their parents to care for their young children at home, they requested that their cell phones not be put on mute, as they needed to hear their phones ring. Others mentioned that they were expecting calls from their partners, which affected the recordings and disrupted the sessions. Nonetheless, these

distractions and disturbances did not impact the accuracy of the interviews, as I paused the recordings and checked to ensure that the participants were able to keep up with the conversation.

3.8 Data-analysis method

For this study, thematic content analysis was used as a method of data analysis. According to Sundler, Lindberg and Palmer (2019), thematic analysis is suitable for a study that aims to better understand a certain phenomenon through a thorough interpretation of data. Thematic analysis is a qualitative data-analysis method that presents data in broad categories and themes. Notably, it enables researchers to identify themes and relate them to the entire collection of information (Terry, Hayfield, Clarke & Braun, 2017). Data-analysis procedures are clear and consistent methods that qualitative investigators employ to reach their conclusions. These approaches must be believable, trustworthy, and repeatable in the context of qualitative research (Kalpokaite & Radivojevic, 2019). Ngulube (2015) argues that, although the process itself takes time, providing meaning and order to vast amounts of data requires that the analysis be thorough, rigorous, ordered, and methodologically documented.

Thematic analysis in this study was carried out in three stages to identify themes (Terry et al., 2017). This study's data was collected in isiZulu, the preferred language of the participants. I transcribed and interpreted the data from the audio recordings and notes made during the interviews into English. Nascimento and Steinbruch (2019) state that transcribing is more than just a simple technical process. This is because it entails the selection, reduction, and interpretation of audio information into written documents. Each of the interviews was transcribed verbatim to ensure that the participants' viewpoints and lived experiences were documented. Following transcription, I reviewed all of the transcripts prior to analysing them. Given that I am fluent in isiZulu, transcribing and translating the interviews from isiZulu to English was not challenging.

After the transcription process, I read through the transcripts of the interviews to become familiar with the information and to identify common themes and trends in order to address the issues being investigated. The initial phase of conducting qualitative analysis involves becoming acquainted with the data collected by reviewing the recordings and notes repeatedly until all of the data are understood (Maguire &

Delahunt, 2017). This further ensures that the researcher has obtained the relevant data and is familiar with it before analysis (Terry et al., 2017).

In data analysis, coding is used to break down large amounts of information into smaller, significant bits (Maguire & Delahunt, 2017). Coding involves the researcher rereading each transcript to detect common themes (Williams & Moser, 2019). Williams and Moser (2019) explain that the open coding process entails breaking down the data into discrete parts and thoroughly analysing and contrasting them to find patterns and discrepancies. Considering this, I employed open coding to find similar themes in the participants' responses to the questions asked. The following themes were developed to represent young women's lived experiences after being diagnosed with HIV: emotional and psychological experiences after HIV/AIDS diagnosis, availability and influence of support systems, and coping strategies adopted to manage living with HIV/AIDS. The process of developing themes was guided by the research objectives, as captured in Figure 3.2. Upon reading the transcripts, I found similarities in experiences after being diagnosed with HIV/AIDS, available support, and coping strategies, which are presented as the major themes. Subsequently, subthemes were developed, organised, and presented to reflect the participants' experiences of life after being diagnosed with HIV/AIDS (see Figure 3.2). For example, for Research Objective 1, which focused on understanding how young women aged 18 to 35 felt after being diagnosed with HIV/AIDS, I noted a major theme that related to emotional and psychological experiences after HIV/AIDS diagnosis. From there, I further examined the transcript and identified subthemes that corresponded to the major theme. The subthemes found refer to the issues around shock, sadness, and devastation upon diagnosis; fear of death and assumptions about limited lifespan; self-blame, guilt, and emotional struggles; acceptance and emotional healing through counselling and education; and the influence of family support and peer support on emotional recovery.

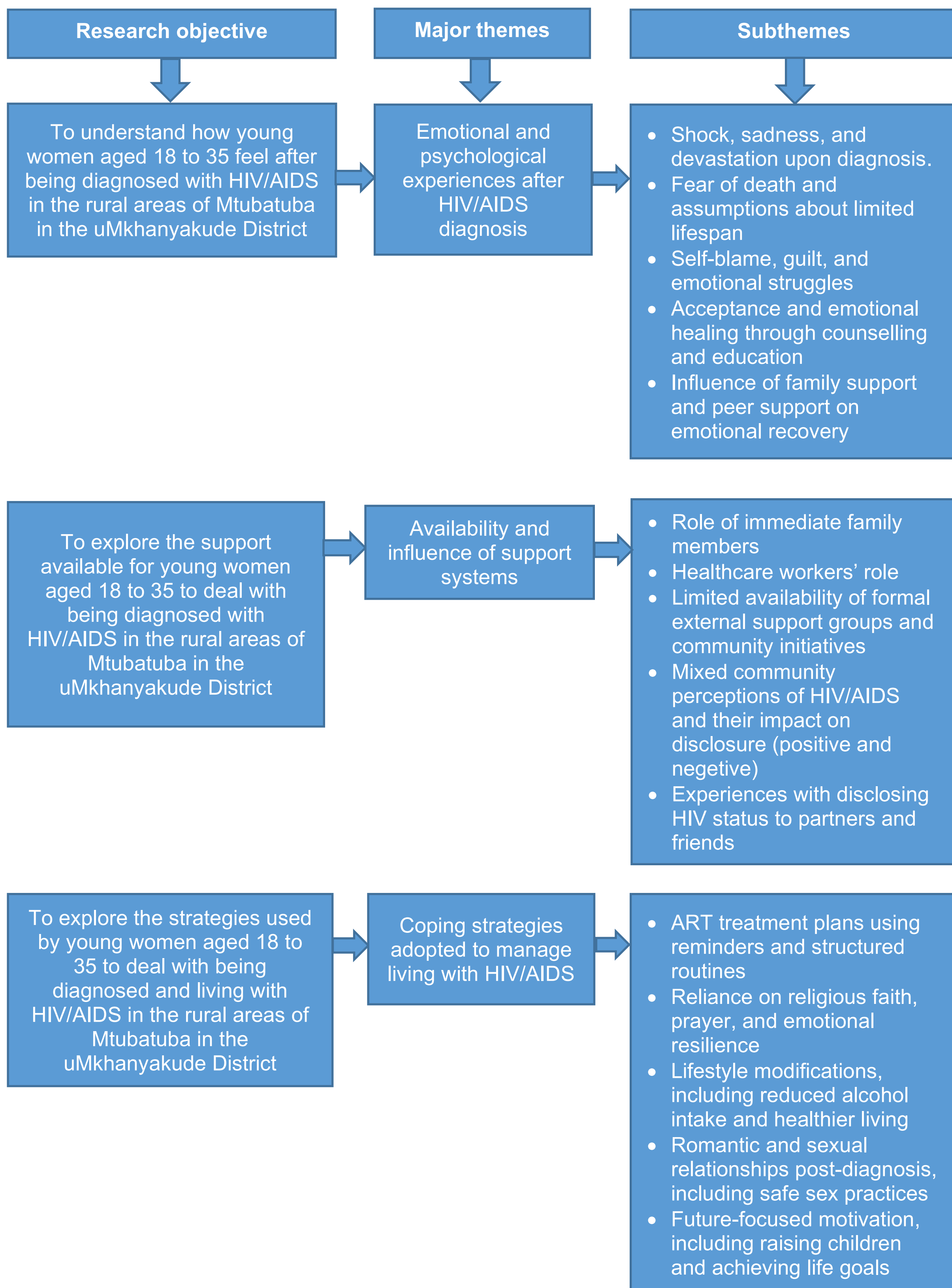

Figure 3.2: Summary of themes and subthemes

3.9 Trustworthiness of the study

The most suitable criteria for assessing trustworthiness are often a subject of debate among qualitative researchers. Nonetheless, it is currently agreed that the most important criteria for assessing the trustworthiness of qualitative research are credibility, transferability, confirmability, and dependability (Kyngäs, Kääriäinen & Elo, 2019).

Credibility measures how authentic the results of qualitative research are, based on the perspectives provided by the study (Stahl & King, 2020). I thoroughly examined young women's experiences following an HIV/AIDS diagnosis to ensure credibility. Purposive sampling was employed to select participants in order to gather extensive data on the experiences of young women after being diagnosed with HIV/AIDS. During the initial recruitment meeting with the participants, I discussed the goal of the study with them, which helped to establish and build trust. Stahl and King (2020) argue that the degree of consistency between the findings from different research participants is used to assess the credibility of qualitative research findings. In this study, 15 participants were invited to share their experiences by answering a set of identical questions.

Transferability rests on the belief that results can be generalised or extended to different populations or circumstances (Stahl & King, 2020). To enhance the transferability of the results, I thoroughly explained the aims, intent, and data-collection methods to the participants and requested them to ask any questions they had for further insight or elaboration. Consequently, the methodology chapter details how data were collected and analysed, which can assist readers in generalising the results to other contexts.

According to Polit and Beck (2012), the degree to which findings may be verified or confirmed by other researchers is known as confirmability in qualitative research. Polit and Beck (2012) further state the data must appropriately reflect the information provided by the participants, and the researcher must refrain from interpreting the data in a manner that differs from the meanings intended by the data source. I reviewed the transcripts multiple times to ensure that the information was documented correctly. Throughout the research study, the recordings were examined by my supervisor, who also reviewed the transcripts to verify the study's accuracy. Furthermore, I described

and clarified every stage of the data collection and processes used. This approach is expected to enable other scholars to accurately assess the trustworthiness and integrity of the entire procedure (Stahl & King, 2020).

Dependability refers to the consistency of data over time and across multiple circumstances (Stahl & King, 2020). The study's dependability was ensured by recording the interviews and taking notes. The participants shared their experiences, and the data were collected with their permission. It was assessed by confirming that the conclusions, interpretations, and suggestions were relevant to the information gathered from the participating individuals.

3.10 Ethical considerations

According to Laryeafio and Ogbewe (2023), ethics is an umbrella term for moral principles that addresses how well researchers uphold their obligations to participants on social, legal, and professional levels. Moriña (2021) states that the goal of social research ethics is to safeguard participants from harm and rights violations. Additionally, ethics helps researchers to conduct their work properly. For this study, I obtained ethical approval from the College of Human Sciences Research Ethics Committee of the University of South Africa (see Appendix G). Authorisation to conduct this research at Mpukunyoni Clinic was sought from and approved by the Department of Health at KwaHlabisa Hospital (see Appendices D and H). Thereafter, I sought permission from the clinic manager to access potential participants (see Appendix E). The study's morality was ensured by following ethical guidelines, which included autonomy, confidentiality, privacy, non-maleficence, and beneficence.

To maintain the participants' autonomy, I provided an information sheet (see Appendix A) and consent forms (see Appendix B and C) before they took part in the study. The participants were informed that their participation was voluntary and that they could withdraw at any point during the study. The primary principle of autonomy in research is to make sure that participants are fully informed of their involvement (Laryeafio & Ogbewe, 2023). It was therefore made clear to the young women who participated in the research that their involvement was entirely voluntary. It was further emphasised that the participants would not receive any rewards for taking part in the study. All the

participants were informed of this aspect, and they freely agreed to take part by signing the informed consent forms.

Protecting each participant by not disclosing their information to the public without their consent is known as confidentiality. Confidentiality is a critical aspect of research; consequently, acquired data must be kept private (Moriña, 2021). To uphold the participants' dignity, I ensured that any information shared during the interviews was neither disclosed to anyone nor shared anywhere. The participants' privacy was maintained, given the sensitivity of the study, the interviews were conducted in a confidential consultation room at Mpukunyoni Clinic, which the participants visit monthly to collect their medication. Furthermore, I safeguarded the participants from stigma by not disclosing their real names in the research report; pseudonyms were used, and I omitted any information that could be used to identify them. The information provided by the participants was treated as strictly confidential at all times. The raw data, which included transcriptions, written informed consents, and the audio recordings of interviews, were stored on OneDrive, accessible only to myself and my supervisor.

Non-maleficence is the practice of preventing participants from suffering any harm that might arise from participating in a research project (Laryeafio & Ogbewe, 2023). As the researcher, I acknowledge that most of the participants were uneducated and unemployed; they also depended on the healthcare system at Mpukunyoni Clinic, which raised concerns regarding manipulation and vulnerability. The participants may have felt scared and coerced because they were approached by the clinic manager and the nurse in charge. I understood the potential power dynamics that arose when the clinic manager visited the patients. Therefore, to avoid maleficence, I ensured that these power dynamics did not affect the study by requesting that the clinic manager allow me and a counsellor to approach the participants, thus ensuring that their participation was voluntary.

I also ensured ethical integrity and protected the participants during the interviews by making certain they were not harmed in any manner, either physically or psychologically. When emotions flared during the interviews, given the study's sensitive and personal nature, I utilised the services of the Ward 13 social worker to provide counselling. To obtain the social worker's services, I wrote a letter to the

Department of Social Development requesting counselling support (see Appendix F). I received a letter of acceptance from the Department of Social Development, confirming that the social worker would assist (see Appendix H). I chose to work with the Ward 13 social worker because she consistently provides services and conducts various support groups in the community. It is also important to note that none of the participants required psychological support at any point.

3.11 Being reflexive during the study

Olmos-Vega, Stalmeijer, Varpio and Kahlke (2023) define reflexivity as a collection of ongoing, interconnected, challenging methods that help researchers to self-consciously assess, consider, and determine how their personal viewpoints and settings affect the research processes. When conducting interviews, researchers need to be reflective, as this can impact the way participants express their experiences (Muthanna & Alduais, 2023; Bayane, 2025). Ali (2015) specifies that researchers must be reflexive to prevent projecting their personal biases onto the stories of the research participants. The interpretivist research paradigm was employed in this study to ensure representation of the participants' views and experiences of the studied phenomenon. It was important to allow the participants to discuss their experiences without making them feel criticised. I therefore behaved and spoke in a non-judgemental manner, with empathetic and attentive listening, which assisted in making the participants feel comfortable. To avoid giving the impression that I was passing judgement, I made sure to closely monitor my facial expressions and non-verbal cues.

The goal of reflexivity is to neutralise the impact of subjectivity by recognising and addressing it. Neutralising, also referred to as bracketing, is a technique by which researchers strive to set aside aspects of their own knowledge, such as pre-existing theories and personal beliefs that may influence their research (Olmos-Vega et al., 2023). I currently work as a social worker for the HIV/AIDS Directorate in a non-profit organisation. My responsibilities include facilitating HIV/AIDS prevention programmes and offering clients psychosocial services such as counselling. Consequently, I began this study with beliefs and opinions about the lived experiences of young WLWH, based on extensive literature review and professional experience, which I had to consider throughout the entire process. For instance, one participant stated that none of her sexual partners were aware of her HIV status and that she had not disclosed

her diagnosis of HIV/AIDS to them. She added that she had no plans to inform them anytime soon. As a facilitator of HIV/AIDS prevention programmes, I felt frustrated and wanted to encourage her to inform her romantic partners. However, I had to bear in mind that my suggestions could affect the interview, which might result in answers that reflected my opinions rather than the participant's perspective. I employed a reflexive approach to analyse the participants' experiences, setting aside any prior beliefs and personal opinions in order to consider their perspectives and acknowledge that I had not been in their position. Throughout the study process, I reflected on their positional validity and practised reflexivity to minimise the potential for bias during the data-gathering and -interpretation stages.

3.12 Conclusion

The qualitative research design was considered the most suitable option for this study, as it enabled me to gather information on the experiences of young women who received an HIV/AIDS diagnosis. I collected data using semi-structured interviews, which provided a more thorough and detailed perspective on how young women cope with the changes in their lives after being diagnosed with HIV/AIDS, the support offered, and the strategies they employ to live after their diagnosis. Verbatim transcriptions of the interviews, along with additional notes, were used to ensure fair representation of the participants' experiences and perceptions. The shared experiences and perceptions related to the studied phenomenon contributed to addressing the objectives of the study and primary research question. The thematic analysis method further facilitated the development and presentation of the participants' voices and experiences. I established trustworthiness in the study by adhering to ethical procedures and criteria. Lastly, I provided a reflexive account of how the study was conducted.

The next chapter discusses the findings of this study, which focus on young women's life experiences after being diagnosed with HIV/AIDS.

CHAPTER 4:
NAVIGATING LIFE AFTER DIAGNOSIS: PSYCHOSOCIAL EXPERIENCES AND COPING STRATEGIES OF YOUNG WLWHA IN RURAL KWAZULU-NATAL

4.1 Introduction

The chapter presents the findings and analysis of the lived experiences of young women aged 18 to 35 who had been diagnosed with HIV/AIDS in the Mtubatuba Local Municipality, KwaZulu-Natal. It examines the psychological, social, and behavioural challenges of chronic illness in a resource-constrained rural area using in-depth interview data from 15 participants. The findings reflect the complexities of the participants' journeys, which reveal both similar trends and unique distinctions. Thematic analysis was employed to present the findings in three main themes focused on the emotional and psychological experiences post-diagnosis, the availability and influence of support systems, and HIV/AIDS coping techniques. The first theme addresses the participants' emotional and psychological experiences post-diagnosis, which are characterised by shock, dread of mortality, and self-blame. The second theme centres on emotional healing through education and family support after diagnosis. It highlights how family, healthcare workers, and the community influence disclosure, treatment, and resilience. Finally, the last theme examines adaptive coping methods, including ART adherence, spirituality, lifestyle adjustments, and future-oriented motivation, particularly in relation to parenthood and life goals. These approaches draw attention to a resilience framework grounded in personal experiences rather than general health models. Despite the importance of clinical interventions, this chapter demonstrates that culturally appropriate psychosocial support, reducing stigma, and enhancing rural community support and healthcare systems are the primary factors that contribute to emotional recovery and long-term health.

4.2 Themes

This section discusses the themes and subthemes that emerged from the interviews.

4.2.1 Theme 1: Emotional and psychological responses to an HIV/AIDS diagnosis: Shock, fear of death, self-blame, and acceptance with family support

Being diagnosed with HIV is characterised by emotional turmoil, marked by an intense psychological response that includes shock, sadness, fear, guilt, and eventual adaptation. For most of the young women in this study, the initial reaction to the HIV diagnosis was overwhelmingly devastating. Many participants described it as the most emotionally challenging moment of their lives. These responses were shaped by internalised societal fears and perceptions of HIV as a fatal condition. For instance, Esther reflected on the confusion and despair she felt at the time of her diagnosis:

> *"When I learned that I have HIV, I was devastated. Since I was so young when I received my HIV diagnosis, I was unsure of what to do."*

Similarly, Gloria expressed how the diagnosis shattered her sense of hope:

> *"It was really hard for me to accept, and I believed it to be the end of my life."*

These narratives illustrate how the shock of an HIV diagnosis is often linked to widespread beliefs about the illness, such as the perception of HIV as a fatal condition, which makes it difficult for diagnosed individuals to accept their diagnosis. Moreover, the participants' emotional turmoil was intensified by feelings of betrayal and relational conflict, particularly in cases where the infection was perceived as resulting from a partner's deception or neglect. Kholiwe articulated her anger and sense of injustice as follows:

> *"I do not want to lie; I was quite angry with my partner since I knew he had infected me … I informed him that if I became infected with HIV, it would be his fault."*

This narrative aligns with Asrat, Schneider, Ambaw and Lund's (2020) assertion that HIV diagnoses can severely disrupt one's psychological well-being, particularly in contexts where emotional and social support systems are inadequate. Hayes (2020) states that socio-economic pressures make young individuals, particularly women in low-resource households, more prone to psychiatric breakdowns following the diagnosis. The participants' experiences in this study highlight the need for early

psychosocial interventions and support structures to help individuals navigate the emotional impact of an HIV diagnosis.

Fear of death also emerged as a contributing factor to the participants' reactions to their diagnosis of HIV. Despite their knowledge of ART, many participants struggled to reconcile their diagnosis with the possibility of a long and healthy life. For example, Gugu said: *"It was really hard for me to accept, and I believed it to be the end of my life."* This statement indicates that while Gugu understood the situation, she had not yet fully accepted it emotionally. Similarly, Carol shared: *"Thanks to the clinic's educational support, I came to terms with the situation."* Carol's statement shows that structured support and accurate health information play a crucial role in reframing beliefs about survival and treatment. Kimera et al. (2020) highlight that youth, even in ART-accessible areas, may retain fatalistic attitudes due to a lack of psychosocial guidance.

In addition to shock and fear, several participants described feelings of self-blame and guilt, especially in the context of sexual behaviour and motherhood. For instance, Buhle admitted:

> *"I sometimes feel guilty since we do not use condoms on a regular basis, and I have not informed him about my HIV status."*

This response shows that Buhle went through a lot of pain because she felt ashamed about having risky sex and could not tell her partner. For others, reflections on past decisions or relationships triggered remorse. Fikile, for instance, questioned her sexual history: *"Because I have different baby daddies, I continued to wonder how I became infected."* These expressions of guilt were intensified by cultural narratives that stigmatise women for their sexual choices (Ndayishimiye et al., 2020; Fauk et al., 2021). Such internalised stigma often hinders emotional healing and highlights the need for gender-sensitive counselling.

Despite these emotional challenges, many participants described a gradual process of acceptance, which was facilitated by counselling and health education support. Participants who received consistent and compassionate care from healthcare providers reported feeling more confident in managing their condition. Buhle noted: *"The way nurses explained the necessity of treatment has made me more focused on*

my own treatment." This increased her focus on adherence. Similarly, Dudu shared: *"Every time they take out my file at the clinic, they always compliment me for taking my treatment accordingly."* This reinforced her emotional recovery but only through the support received from healthcare service providers. According to Nshimyumuremyi et al. (2022), trust in healthcare systems and continuous psychosocial education are essential for fostering resilience among HIV-positive youths.

Family and peer support also emerged as enablers of emotional recovery. Mothers, in particular, were mentioned as sources of strength and non-judgemental support. Buhle reflected:

> *"Without my mother, I do not think I would be able to manage this situation with such confidence."*

Buhle's narrative illustrates that family and peer support provided emotional solidarity and reduced isolation. Irene also noted: *"My friend is easy to talk to, which is why I told her ... We truly support one another."* These relationships align with findings by Kimera et al. (2020) and Barnhart, Asiimwe-Kateera, Nyombayire, Kirwa, Adedimeji and Rusine (2022), who emphasise the significance of intimate social networks in mitigating the emotional impact of HIV diagnoses.

The findings reveal that the psychological journey following an HIV diagnosis involved an initial period of emotional collapse, which was characterised by shock, fear, and guilt, followed by a trajectory towards acceptance and resilience. The combination of therapeutic counselling, informative healthcare interventions, and strong family or peer support played a crucial role in this transformation. However, persistent internalised stigma, particularly related to gender norms, continued to hinder complete emotional recovery for some participants (Goffman, 1963). As Hayes (2020) and Pamukhti et al. (2021) argue, sustained mental health support tailored to the socio-cultural realities of young women in rural settings is vital for promoting holistic well-being in HIV care.

4.2.2 Theme 2: Role of support systems in disclosure, healing, and adherence: Family members, healthcare workers, formal external support groups, and community perceptions

Close family members provided emotional and practical support to young WLWHA in Mtubatuba. For the majority of the participants in this study, their greatest source of support was family, particularly their mothers and siblings. Emotional support was derived from non-judgemental conversations and verbal encouragement. For example, Anele reflected on how supportive her mother was when she disclosed her diagnosis:

> *“My mother told me to calm down ... she has been helping me cope with the stress.”*

Assistance with daily routines, clinic accompaniment, and medication reminders were offered by family members. For instance, Fikile said:

> *“My family is very supportive ... they also remind me when it is time for treatment or taking pills.”*

The participants’ emotional stability and acceptance were enhanced by disclosing their HIV diagnosis to their family members. Moreover, the family responses in this study also impacted the participants’ attitudes towards their diagnosis, adherence to therapy, and psychological adjustment. This supportive environment improved resilience, increased treatment participation, and decreased internalised stigma (Goffman, 1963). These narratives also suggest that mothers and female relatives are the primary carers and supporters following a diagnosis. Pamukhti et al. (2021) argue that family support systems help PLWH cope with the psychological impacts of their diagnosis. Asrat et al. (2020) add that HIV-positive individuals with supportive families tend to cope better with despair and stigma.

Those who had not disclosed to their family members were concerned about using their medication secretly, which led to inconsistent adherence and psychological distress. For example, Lungile shared:

> *“I did not tell my family and friends about my HIV status ... I prefer to keep it to myself and my partner.”*

Participants like Lungile concealed their status from their families due to fear of criticism and concerns about privacy. Hayes (2020) notes that non-disclosure can lead to emotional and logistical challenges, such as managing treatment in secrecy and skipping doses. Limalvin, Putri and Sari (2020) also found that hiding one's HIV status from family out of fear of rejection or gossip adversely affects mental health and treatment adherence. Empathy, respect, and understanding in the family appear to foster acceptance and resilience, regardless of the circumstances. Family-focused interventions and counselling are vital components of HIV/AIDS care, particularly in rural Mtubatuba.

It is significant to note that the participants in this study had both positive and negative experiences when disclosing their HIV status to partners and friends. The findings indicate that HIV-positive young women receive a variety of reactions from friends and lovers. For instance, Esther reported that disclosure led to improved understanding, support, and relationships:

> *"The first person I informed about my HIV status was my partner, who was shocked to hear the news. He supported me throughout the process."*

However, Buhle expressed reluctance, guilt about past experiences, and disclosure anxiety:

> *"I have not told my partner yet; I'm currently looking for a way to tell him."*

The process of disclosure was influenced by pre-existing connections, trust, and the personalities of the information recipients. Generally, women who confided in understanding spouses or supportive family members felt better and adhered more rigorously to treatment. However, fear of rejection, judgement, or betrayal prevented many participants from disclosing, particularly to their partners, which highlights anticipated stigma and significant psychological difficulties. These findings suggest that the decision of young women who are living with HIV/AIDS to disclose affected their emotional health and social integration.

Support from clinic staff also emerged as an effective support system for young women following their HIV/AIDS diagnosis. Most participants reported that clinic staff were discreet, pleasant, and helpful when providing HIV information, which positively impacted their emotional coping and medical adherence. Health personnel conducted

consultations with each patient individually in a private setting. For example, Dudu said:

> *"The staff at the clinic treats me extremely nicely, and it sometimes feels like you are talking to friends. They ensure privacy because you enter the room alone with the nurse; no one will know what is going on inside or why you came to the clinic."*

Confidentiality must be maintained to promote open communication and trust. The participants reported that the support of the nurses alleviated their concerns about early diagnosis and treatment. Structured health talks and educational seminars, either prior to or during consultations, were also beneficial. Several participants noted their awareness of ART side effects, adherence, and psychological coping strategies. For instance, Carol emphasised this by saying:

> *"At the clinic, they educate you about all things HIV-related before giving you ARVs, so they do more than just give you treatment; they give you hope."*

Clinic-based education and support can help PLWHA manage their illness, enhance their quality of life, and lower their risk of spreading the virus. They may feel inspired and encouraged by the certainty and direction they receive.

Nevertheless, a few participants reported fluctuations in the nurses' behaviour, with some personnel being less approachable. Some participants in this study were hesitant to acknowledge the emotional pain caused by this difference. For example, Buhle explained:

> *"Yes, I receive good treatment from the clinic staff; however, they are not all the same. While some nurses are open to conversation, others are not. Because of the way the person assisting treats you, you may wonder if she has family problems. You see that the person you are supposed to report your problem to is not in a good mood, so you return home with your problems unresolved. Some are very easy to talk to; you do not hesitate to share anything with them. They give you time to open up about whatever problem you have."*

In this study, most young HIV-positive women valued healthcare workers for their role in providing awareness, acceptance, and continuity of care. The importance of trust between healthcare providers and patients was emphasised, which demonstrates that

the relational quality of clinical encounters significantly affects patients. Nursing confidentiality and a non-judgemental approach reduce fear and stigma. Asrat et al. (2020) also observe that psychological counselling and supportive clinical environments help to reduce depression and enhance engagement in HIV/AIDS care. Additionally, Barnhart et al. (2022) highlight that peer and health worker support increased ART retention among Rwandan youths, which suggests that these dynamics extend across sub-Saharan Africa.

Regular pre- and post-counselling sessions also help patients to understand ART and make informed disclosure and adherence decisions (UNAIDS, 2021; Hayes, 2020). In this study, the young women were inspired by health education programmes provided by nurses at the clinic. For example, Gloria mentioned:

> *"It was really hard for me to accept, and I believed it to be the end of my life. However, thanks to talking to the nurses in this clinic, they provided me with the information and support I needed. I even met some of the people I know coming to the clinic, and I also accepted the situation and the fact that you can live with HIV."*

Treatment literacy reinforcement is needed for young women diagnosed with HIV, who often face gendered stigma and misinformation (Ndayishimiye et al., 2020). Although nurse attitudes varied, the general trend supported a healthcare setting that promotes psychological resilience and treatment adherence. The communication, confidentiality, and compassion of nursing and caregiving positively impact health behaviours. Patient experience may be limited by inconsistent staff training and counselling quality, particularly for those who experience emotional distress or ambiguity at the time of early diagnosis. Many young HIV-positive individuals worry about emotional instability and stigma; staff training to maintain empathy and anonymity is therefore vital (Kimera et al., 2020; Pamukhti et al., 2021). Healthcare practitioners should provide social and emotional support to young women after diagnosis. They influence HIV disclosure, beliefs, and long-term health beyond clinical settings, as the findings highlight that patients are more likely to follow treatment recommendations when healthcare workers are viewed as partners rather than authorities. HIV intersects with social vulnerability and insufficient psychological

resources in rural areas like Mtubatuba; healthcare personnel should therefore receive focused capacity-building training to enhance relational competency.

To incorporate the role of family members and healthcare workers, formal external support groups are essential for young women who are coping with an HIV/AIDS diagnosis. Mtubatuba, as reported by the participants in this study, has limited institutional support organisations and community activities for young WLWHA. Most participants had never heard of or attended organised support programmes outside of clinic visits. For instance:

> Researcher: *"Are there any other support services or programmes available for people with HIV in Mtubatuba that you attend?"*
>
> Buhle: *"No, I never heard of such services. I don't know if they exist."*

Healthcare institutions and informal family or peer networks provide the most assistance. The lack of community-level psychosocial therapy and peer support models affects treatment adherence and emotional well-being among young women who are diagnosed with HIV. Clinics that offer medical care and minimal psychological support demonstrate a scarcity of holistic HIV/AIDS care in rural areas. Consequently, coping relies on resilience and close social networks rather than institutionalised community services. Most participants exhibited this trend, which demonstrates that Mtubatuba's healthcare and community support structures are inadequate for those diagnosed with HIV/AIDS.

Clinics are the sole HIV resource besides family, which is concerning because peer groups, economic empowerment initiatives, and focused psychological interventions promote the mental health and medication adherence of HIV-positive youths (Nshimyumuremyi et al., 2022; Barnhart et al., 2022). The absence of such programmes reveals a significant service delivery gap that leaves affected young women without psychosocial support. This aligns with the HBM, which states that issuing cues to action is important, such as developing campaigns and other strategies to help PLWH remember the importance of maintaining a healthy lifestyle.

Organised peer support and economic incentive programmes increased ART adherence and mental health among HIV-positive youths in Rwanda (Barnhart et al., 2022). Kimera et al. (2020) argue that peer support groups reduce stigma and

encourage HIV-positive youths to seek care. The findings of this study demonstrate a lack of holistic approaches, which indicates a missed opportunity to integrate social interventions into healthcare. This study's findings therefore contradict global best practices and growing empirical evidence that HIV care models should include community-based assistance. This absence indicates a service delivery gap and a systematic failure to view HIV/AIDS as a multifaceted issue that requires psychosocial, economic, and therapeutic solutions. Rural areas such as Mtubatuba therefore need external support networks to treat young HIV-positive women holistically.

While young women diagnosed with HIV cited forms of support, there were mixed views regarding community perceptions of HIV/AIDS. The attitudes of Mtubatuba community members towards HIV/AIDS affected the participants' disclosure post-diagnosis. Participants such as Fikile observed less overt stigma and a more normalised view of HIV/AIDS, as she alluded:

> *"My community does not make negative remarks about HIV/AIDS. They appear to be very knowledgeable about HIV. They used to create HIV jokes, such as 'It's now 8:00, so it's time for fork and knife', which meant it was time to take ARVs. So you feel comfortable discussing HIV since the people around you are also open and accepting of HIV."*

Dudu also shared a joke that is made by her community around HIV/AIDS:

> *"I believe that things have changed, and that HIV is now regarded as a normal illness. HIV is now referred to as 'SONKE' [which means "we all have it"], and people no longer judge people living with HIV/AIDS."*

However, participants such as Esther continued to face indirect discrimination and judgement. For example, she said:

> *"Others in my community make negative comments about people with HIV ... it proved to me that people are not properly educated about HIV."*

This dualism confused disclosure possibilities with social rejection fears. Participants who perceived their community members as acceptable told a few family members and trusted friends, while others feared gossip and condemnation. Buhle also mentioned her fear of disclosing to people in the community and preferred to disclose to people she trusted: *"Depending on the type of people you are currently interacting*

with, I become afraid to disclose my HIV status at times." Many participants in this study disclosed their HIV statuses while balancing self-protection and emotional and social assistance due to community perceptions.

The findings of this study show that support systems are essential for young WLWH as they navigate disclosure, recovery, and treatment compliance. These systems, which include support from family and partners, healthcare practitioners, official external support groups, and community perceptions, offer practical, emotional, and informational help. Families may provide comfort, protection, and a sense of belonging, which are crucial for dealing with the challenges of disclosure and therapy. Women who confided in their spouses or family members generally felt better and adhered to treatment. However, many were afraid of being rejected, judged, or betrayed, especially by partners, which highlighted the anticipated stigma and significant psychological challenges. Healthcare providers use motivational interviewing and counselling strategies to improve adherence and address treatment difficulties. Positive interactions between healthcare personnel and patients contribute to a welcoming atmosphere that promotes transparency and adherence. Support groups, especially those including individuals who have had similar experiences, provide a secure environment in which to share challenges, receive emotional support, and learn coping skills from others. Participation in support groups may help individuals feel less isolated and stigmatised, which will foster a sense of belonging and resilience. Positive community views towards PLWH may encourage disclosure and minimise stigma, which will allow for increased social support. However, negative community views may hinder disclosure, limit access to treatment, and adversely affect compliance with treatment.

4.2.3 Theme 3: Coping strategies adopted by young WLWHA: Antiretroviral therapy (ART), religion, living healthier, partner support, and the future

In this study, young women diagnosed with HIV employed various coping strategies, with setting reminders for ART use being particularly common. The participants emphasised the importance of adhering to treatment as a means of managing the disease. Clinic appointment cards, mobile phone alerts, and family support networks assisted many participants in taking their medication on time. For instance, Anele set midnight alarms to remind her to take her medication:

> *“I set the alarm to ensure that I do not forget because sometimes I simply forget, and it never takes days, just minutes or hours.”*

While Carol also used calendar reminders, her mother’s or siblings’ encouragement further assisted in taking the medication on time. She mentioned, *“I set the alarm, but my mother is very helpful as she also constantly reminds me to take medication.”* Although some people skipped ART due to school or daily life, most continued. Setting alarms or reminders for the timely taking of medication helped others with minor concerns, such as skipping dosages while watching television.

Existing research on ART adherence among HIV-positive youths also highlights a strong association with medication scheduling (Ashraf & Virk, 2021). Ashraf and Virk (2021) suggest that family support networks and mobile phone reminders can help HIV-positive individuals remember to take their medication. The necessity of social and technical reminders, such as setting mobile phone alerts, indicates functional adaptation in coping with circumstances. Although most participants had a good adherence mindset, Buhle reported minor forgetfulness: *“I sometimes forget, hence I set the alarm to remind myself to take the treatment.”* This resonates with Arebo et al.’s (2022) assertion that psychological distractions such as stress and everyday social activities continue to be major obstacles even for motivated people.

Mpukunyoni Clinic’s educational reinforcement and community-level stigma reduction may have boosted the participants’ adherence. Duby et al. (2022) found a similar trend in rural South African clinics that offer integrated counselling and education. According to Green, Greer and Simon (2020), family interventions and reminders, regardless of their effectiveness, may reflect a lack of motivation in individuals. Green, Greer and Simon (2020) believe that internalised attitudes about health and independence lead to long-term adherence. External stimuli can initiate positive behaviour. Comparisons with this study show that health interventions should empower individuals and provide psychological stability.

Spiritual practices have become important for many PLWHA as a way to deal with stress, rebuild hope, and build inner power. This study also showed that most of the participants depended on prayer and religious faith to cope with the psychological effects of their diagnosis. Participants such as Fikile said that they prayed more after being diagnosed, which helped them to find peace and a sense of purpose. Fikile said:

"As someone who grew up going to church and praying, I use prayer to cope. My partner and a family member are both helpful."

Dudu also said that prayer not only helped her feel better emotionally, but it also made her stick with her treatment. This suggests that spirituality and health habits are closely linked. For some participants, such as Gloria, church-based socialisation and spiritual continuity from childhood reinforced their emotional resilience. Gloria stated:

"It is motivating to see other people living freely with their HIV status. My family's support has been quite helpful. We've been going to church since we were kids, so the prayer is very helpful."

Religious engagement, along with self-acceptance and family support, psychologically helped the participants to maintain a stable identity despite living with a chronic illness. The narratives of the participants align with global scholarship on the psychological and spiritual resilience of HIV-positive individuals. Bukhori et al. (2022) argue that spiritual coping mechanisms, including prayer, religious music, and meditation, help to reduce existential anxiety and enhance treatment commitment, particularly among Muslim communities. Arebo et al. (2022), focusing on the Ugandan context, noted that strong religious faith helped patients to transform trauma into resilience. Notably, in this study, the participants also demonstrated that religious involvement often reinforced adherence to ART (Ashraf & Virk, 2021).

Moreover, the findings reflect the role of non-institutional emotional resilience. While formal psychological counselling was largely absent, the participants independently constructed coping systems through faith, familial bonds, and personal acceptance. This aligns with Arias-Colmenero et al. (2020), who observe that informal social networks often substitute for mental health infrastructure in rural settings and become vital support structures. Nevertheless, Fauk et al. (2021) emphasise that supplementing spiritual reliance with structured psychosocial support groups, especially those inclusive of spiritual discourse, could enhance long-term mental health outcomes and reduce the risk of isolation. Therefore, while prayer and faith significantly empowered the young women of Mtubatuba, integrating these practices into formalised community wellness programmes may further promote emotional well-being and sustainable HIV care.

Lifestyle modifications, including reduced alcohol intake and healthier living, emerged as a coping mechanism in this study. Many participants adjusted their lifestyles, particularly their alcohol consumption and health practices. For instance, Carol reduced her alcohol use to prioritise her health and adhere to treatment regimens. Before her diagnosis, she used to drink alcohol on weekends, but she cut down after recognising the detrimental effects on her health and her ability to follow her treatment plan. Carol said:

> *"I used to drink a lot, but I have cut down lately. I now only go on Saturdays and come back on Sundays."*

This was echoed by other participants, such as Irene, who said:

> *"I do drink on weekends with my friends. We occasionally use snuff. We strive to avoid using it every day."*

Participants like Jabu also gave up drinking and linked sobriety to better treatment and family commitments:

> *"No, I no longer drink alcohol. I used to drink, but I've stopped. I believe I simply got tired of drinking and also wanted to fix my life as I used to consume alcohol a lot."*

Regular clinic visits, a healthier diet, and medicine reminder alarms were among the lifestyle adjustments made by the young women, beyond reducing their alcohol consumption. This indicates a significant change in self-care habits and an increase in health awareness due to the diagnosis. It also supports the HBM, which posits that individuals are more likely to adopt healthy behaviours if they believe these actions can lower their risk of illness (Carpenter, 2010). The findings of this study corroborate existing literature on HIV management that promotes lifestyle changes. Amal and Pandin (2021) argue that reducing alcohol intake, eating healthy, and attending medical appointments enhance ART adherence and improve the quality of life for HIV-positive individuals. Menéndez-Arias and Delgado (2022) indicate that lifestyle factors can alter the pharmacokinetics of ARV medication, noting that alcohol consumption may reduce treatment efficacy and accelerate disease progression. Casavant (2020) similarly found that young women in Mozambique increasingly embraced healthier habits, initially with ambivalence but ultimately for their survival. In this study, some

participants appeared to recognise the need for rapid change in their lives, which was likely influenced by the training programmes offered by their healthcare facilities.

Navigating romantic and sexual relationships post-diagnosis, including safe sex practices, was also a part of the coping strategies adopted to manage living with HIV/AIDS in this study. The HIV-positive young women in this study revealed complex and passionate love and sexual interactions. Participants like Anele promoted PrEP to protect their relationships. Anele said:

> *“I advised him to take PrEP, and I make sure he takes his medication, especially when I visit him.”*

Others, like Kholiwe, used condoms without disclosing their status out of fear of rejection or emotional loss. She shared the following:

> Researcher: *“I would like to find out if you are in a romantic relationship. If yes, how has your sex life been affected after being diagnosed with HIV?”*
>
> Kholiwe: *“Yes, I’m in a relationship. We are not having any sexual issues. We always wear condoms because I have not told him about my HIV status, and I want to ensure that we have safe sex.”*
>
> Researcher: *“Are you having any plans of telling your partner about your HIV status?”*
>
> Kholiwe: *“Not yet, but I will tell him when I’m ready.”*

This narrative echoes Chekole and Tarekegn’s (2021) argument that stigma-induced silence often leads partners to withhold information and not use condoms consistently, which puts both individuals at risk and increases mental stress. Hedge et al. (2021) argue that shame and fear of judgement remain significant barriers to open communication in sexual relationships. Despite the promotion of HIV education and PrEP services across the country, shame and false information continue to persist, which undermines women’s confidence, as seen in Kholiwe’s decision to delay disclosing her status even though she consistently used condoms with her partner. Carol’s response further highlights a common fear, namely abandonment, particularly for women who rely on their partners emotionally or financially. She mentioned:

> *“I’m frightened they will leave me, something I cannot afford right now.”*

Gloria expressed moderate acceptance and resumed sexual activity with variable condom use. For example, Gloria said, *"We wear condoms more often but not always."* These stories show how internal conflict, trust dynamics, and social stigma impact coping mechanisms from proactive disclosure to silent self-protection.

In this study, there was a mix of quiet caution and direct conflict. For example, Olga informed her partner of her HIV status. Initially, her partner tried to avoid discussing it, but later changed his stance and had himself tested. Olga narrated:

> *"Yes, I was able to inform my partner about my HIV status; however, it was tough for him to accept. A few days after I told him the news, he simply ignored me. I believe he was shocked to hear the news, but he soon recovered. The situation is now back to normal. He too went to the clinic and was diagnosed with HIV, so we are able to take our medications freely."*

This case illustrates how open conversation can be beneficial, particularly regarding sharing responsibility for treatment and safe sex. Conversely, the caution exhibited by others highlights deeply rooted emotional, social, and economic structural weaknesses that hinder disclosure. Jones et al. (2023) argue that the mental toll of living with HIV is exacerbated when individuals depend on others and fear being hurt. Those who use condoms and who learn more about PrEP demonstrate their commitment to health, yet they also reveal existing policy gaps. Emotional acceptance, as seen with Anele, may stem from effective counselling; however, others' reluctance to be open indicates a need for psychosocial support that enhances their negotiation skills, provides greater financial freedom, and creates a safer environment for communication. Programmes that address gender power imbalances, financial vulnerability, and social stigma are crucial to ensure that safe sex practices are not only adopted but also maintained in a respectful and secure setting.

Lastly, future-focused motivation, including raising children and achieving life goals, was highlighted as one of the coping strategies adopted to manage living with HIV/AIDS. HIV was framed as a story of survival, family duty, and the desire to live to motivate participants. Individuals like Carol and Gloria expressed a desire to live longer to raise their children, thereby displaying goal-oriented health management. For example, Gloria shared:

"I made the decision to look after myself because I have kids to look after."

Similarly, Carol said:

"I wish to have a long life. I also want to raise my children because children prefer to be near their mothers."

Fikile also found strength and optimism in education, work, and parenthood:

"I am motivated by the fact that I have children to raise; if I die, who will care for them?"

Focusing on future goals enhanced treatment adherence and emotional resilience. The pursuit of secure families, personal growth, and life goals drove proactive and hopeful diagnosis management.

Future orientation is also highlighted as key to HIV resilience. Nshimyumuremyi et al. (2022) found that goal-setting and ambitions among Rwandan HIV-positive teens improved ART adherence and mental well-being. Kimera et al. (2020) also observed that young HIV-positive individuals with educational and professional objectives were more likely to adhere to treatment and maintain mental health. In this study, the participants' experiences reflect an even greater emphasis on familial responsibilities, notably the desire to raise children. Barnhart et al. (2022) argue that HIV-positive youths adhered better to ART when programmes focused on child-rearing and future planning. According to Duby et al. (2022), future orientation is protective; however, unmet goals in the absence of psychosocial support can lead to depression and treatment fatigue. Mtubatuba healthcare providers should therefore promote future-focused motivation and support patients' educational, financial, and familial goals to ensure sustainability. The participants' focus on future life goals serves as an adaptive coping technique, but healthcare and social systems must provide the necessary support.

4.3 Conclusion

This chapter reflected on the lives of young women in Mtubatuba, KwaZulu-Natal, who are HIV-positive and must navigate the social, psychological, and medical effects of having HIV/AIDS. The study indicates that following a diagnosis, individuals' transition

from being emotionally devastated by shock, fear, self-blame, and hopelessness to gradually accepting their situation, adapting to it, and becoming stronger. This process is primarily facilitated by therapy, education, and social support. It is therefore evident that engaging with the health system, particularly with caring and knowledgeable healthcare workers, is crucial for increasing ART adherence and reducing internalised shame. Support from family members, especially mothers, also emerged as a significant protective factor that positively impacts both mental healing and practical health management. However, the absence of formalised community-based support systems and the persistent fear of social judgement hinder many people from achieving happiness and health. While the stigma surrounding HIV/AIDS is evolving, it continues to influence individuals' decisions to seek help and hinder their ability to integrate with their peers. This highlights the need for widespread community education and anti-stigma efforts. The coping mechanisms of young women demonstrate their independence and ability to change, whether through organised treatment, religious practices, lifestyle changes, or future goals related to motherhood and self-improvement. These methods illustrate a framework of resilience rooted in real-life experiences rather than general health models. This chapter emphasises that, while clinical interventions are important, emotional recovery and long-term health primarily depend on culturally sensitive psychosocial support, reducing stigma, and improving rural communities and healthcare systems.

The next chapter concludes the study by presenting a summary of the findings and a conclusion, as well as the recommendations of the study.

CHAPTER 5:
CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This study explored the experiences of young women aged 18 to 35 who were diagnosed with HIV/AIDS in the rural areas of Mtubatuba. The focus of the study was to understand how these women cope with the changes in their lives following their diagnosis, the support available to them, and the strategies they employ to live after their diagnosis. The primary research question addressed by the study was: “What are the experiences of young women aged 18 to 35 after being diagnosed with HIV/AIDS in the rural areas of Mtubatuba in uMkhanyakude District?” Although significant progress has been made in public health outreach and the accessibility of ART, this study demonstrated that biomedical success alone is insufficient to ensure the overall health of HIV-positive women. Upon diagnosis, young women in rural South Africa often endure considerable emotional pain, which is exacerbated by gendered social norms, unstable finances, and inconsistent community support systems. It was found that family networks and counselling are crucial for helping individuals adhere to their treatment and accept their emotions. However, the lack of robust external support systems continues to create psychosocial vulnerabilities. The study showed that HIV/AIDS is a problem in many ways, especially in rural areas with few resources. Based on these results, future interventions should adopt a multifaceted approach. They should include not only improved healthcare but also targeted psychosocial programmes, community re-education, and poverty reduction. It is also important to equip young women with the tools they need to heal emotionally and stay alive in the long run through health education and social and economic support. Ultimately, this chapter summarises the study’s contribution to the larger conversation about HIV/AIDS by focusing on how health and social care are provided in KwaZulu-Natal in a manner that is tailored to the local context and that takes gender into account.

This chapter concludes the study by addressing a summary of the chapters, providing a summary of the key findings, discussing the limitation of the study as well as making recommendation for future research.

5.2 Summary of chapters

This study comprises of five chapters, with the first chapter providing essential background on the prevalence of HIV/AIDS in KwaZulu-Natal, especially among young women in rural areas. The chapter emphasised the lack of research on life after diagnosis for this demographic and highlighted the psychological and emotional challenges faced by individuals diagnosed with HIV/AIDS, including stigma, fear, and hopelessness. Most existing studies focus on urban settings, leaving rural experiences underexplored; this study thus aimed to understand how young women in rural areas cope with their diagnosis and the support systems available to them. By focusing on women aged 18 to 35 in Mtubatuba, the study sought to fill a critical gap in the literature and contribute to a more inclusive understanding of post-diagnosis experiences.

Chapter 2 focused on the prevalence of HIV/AIDS and on understanding the experiences of young women in rural areas following diagnosis. The chapter transitioned from a global overview to a localised analysis to offer a deeper understanding of the HIV/AIDS pandemic in South Africa. It outlined the wide-ranging effects of the virus, particularly the psychological and emotional toll it takes on those who are diagnosed. Individuals often face intense psychosocial challenges such as anxiety, depression, and suicidal thoughts, which are closely linked to the chronic nature of the illness. These mental health struggles are further complicated by stigma, which appears in various forms (enacted, perceived, and internalised) and significantly influences decisions around disclosure, treatment adherence, and overall well-being. The chapter emphasised that stigma not only isolates individuals but also affects their ability to seek care and maintain a healthy lifestyle.

The chapter also explored the diverse coping strategies employed by PLWHA, which are shaped by personal, social, and structural factors. Adaptive strategies, such as religious and spiritual practices, were shown to foster resilience, hope, and a sense of meaning, while maladaptive behaviours, like alcohol use, were found to hinder treatment adherence and increase vulnerability. Access to ART was identified as a crucial factor in effective coping and serves as the foundation of biomedical management and prevention. The role of religious and community institutions was discussed as complex; these entities can either support individuals or reinforce stigma, depending on their orientation. The chapter incorporated theoretical frameworks to

interpret these dynamics, notably the HBM and Goffman's (1963) stigma theory. The HBM was chosen for its relevance in explaining how perceptions of risk, benefits, and barriers influence health-related behaviours, while Goffman's (1963) stigma theory provided insight into the social obstacles and identity shifts experienced after diagnosis. These frameworks helped to contextualise the transformation in self-worth and self-perception among young women, which revealed how stigma leads to feelings of shame and being perceived as "damaged" and highlighted the need to address research gaps in rural HIV/AIDS studies.

Chapter 3 detailed the research design and methodology used in this study, which adopted a qualitative approach grounded in interpretivism to explore the experiences of young women aged 18 to 35 to 35 who were diagnosed with HIV/AIDS in the rural areas of Mtubatuba. This design enabled the participants to share their lived realities as self-aware individuals while allowing me to use probing techniques to gain deeper insights. The qualitative method facilitated the collection of rich, detailed data that reflected the complex circumstances surrounding HIV diagnosis in rural settings. The study was conducted at Mpukunyoni Clinic in the Enqupheni area of the Mtubatuba Local Municipality, where purposive sampling was used to select 15 participants who visited the clinic monthly for medication refills and viral load monitoring. Semi-structured interviews were employed to gather data, and thematic content analysis was used to interpret the findings. The chapter also addressed the trustworthiness of the study and outlined ethical considerations, including autonomy, confidentiality and privacy, and beneficence and non-maleficence. Reflexivity was a key component, where I consciously set aside personal biases to authentically engage with the participants' perspectives. Throughout the research process, I maintained positional awareness and practised reflexivity to minimise prejudice during data collection and analysis.

Chapter 4 presented the findings and analysis of the lived experiences of young women aged 18 to 35 who had been diagnosed with HIV/AIDS in the Mtubatuba Local Municipality, KwaZulu-Natal. Drawing from in-depth interviews with 15 participants, this chapter explored the psychological, social, and behavioural challenges of living with a chronic illness in a resource-constrained rural setting. The thematic analysis revealed three key themes: emotional and psychological responses post-diagnosis, the role of support systems, and coping strategies. The participants described a

journey marked by emotional turmoil, including shock, fear, self-blame, and hopelessness, followed by gradual acceptance and adaptation. This emotional transition was supported by therapy, education, and social support, which helped to build resilience. The involvement of compassionate healthcare workers was shown to improve ART adherence and reduce internalised stigma. Family support, particularly from mothers, played a crucial role in emotional recovery and practical health management. However, the absence of formal community-based support and the persistent fear of social judgement continued to hinder overall well-being.

Despite some progress in reducing stigma, many participants still faced challenges in disclosing their status and integrating socially. This highlights the need for broader community education and anti-stigma initiatives. The coping strategies employed by these young women demonstrated resilience and adaptability, which ranged from structured treatment adherence to spiritual practices and future-oriented goals. These strategies reflect a lived framework of strength that goes beyond conventional health models. The chapter emphasised that while clinical interventions are vital, long-term emotional recovery depends heavily on culturally sensitive psychosocial support. It also highlighted the importance of improving rural healthcare systems and community structures to better support PLWHA. Religious and community institutions were found to play a dual role, which either empowered individuals or reinforced stigma. The findings illustrated the complex interplay between personal agency, social context, and systemic support in shaping the experiences of young WLWHA in rural South Africa.

5.3 Summary of key findings

This section discusses the study’s key findings.

5.3.1 Emotional and psychological reactions to HIV/AIDS diagnosis

Young women diagnosed with HIV/AIDS in the Mtubatuba Local Municipality revealed a significant psychological impact following their diagnosis. Shock, sadness, and numbness indicated a collapse in identities and life goals for many. These experiences echo those observed by Asrat et al. (2020), who note that early responses to HIV diagnosis are often influenced by social links to mortality, humiliation, and social exclusion. According to Akatukwasa et al. (2021), rural sub-Saharan African women often experience worry and panic after diagnosis due to cultural stigma and a lack of

mental support. Self-blame and shame, which typically manifest as guilt or a sense of moral failing, increase emotional instability (Fauk et al., 2021). Internalising social stigma impairs emotional healing and may induce long-term psychological distress, especially in communities where HIV is heavily moralised (Amal & Pandin, 2021). This study highlighted the reality that young women, particularly those from low-income families, must contend with both disease and societal stigma. This highlights the need for ongoing, trauma-informed mental health interventions to address the emotional impact of diagnosis and the psychological adjustments required for long-term adaptation.

5.3.2 Secrecy and fear of stigma

Young HIV-positive women in Mtubatuba fear social stigma, which encourages hiding or not disclosing their status. Many participants were concerned about revealing their status outside of therapeutic settings, primarily due to fears of losing friends, romantic relationships, and community standing. Chekole and Tarekegn (2021) found that anticipating stigma, such as gossip, avoidance, or overt discrimination, drives individuals to conceal their illness from friends, family, and the community, which results in isolation. Hiding an HIV status may exacerbate psychological suffering and hinder access to crucial informal support networks, even as it protects against immediate social harm. Fauk et al. (2021) argue that non-disclosure creates an environment where women are morally assessed, particularly regarding sexuality and reproductive health issues. Diress, Seyoum and Alemu (2020) note that stigma, whether anticipated or experienced, can reduce adherence to ART and participation in community or religious activities. The risk of social rejection in Mtubatuba makes it difficult to build supportive relationships and seek psychological rehabilitation for long-term well-being. This contribute to Goffman's theory of stigma to highlight that stigma can lead to secrecy, delayed healthcare, and social withdrawal. Interventions must aim to reduce community stigma and provide safer spaces for disclosure, as secrecy reinforces silence and vulnerability in affected populations.

5.3.3 Acceptance and healing through counselling and education

HIV acceptance and mental health improve with structured therapy and focused health education. After diagnosis, comprehensive HIV counselling enhances emotional

resilience and shifts attitudes towards HIV from viewing it as a death sentence to recognising it as a manageable chronic disease. According to Anuar et al. (2020), regular, client-centred counselling increases HIV patients' health knowledge, ART adherence, and coping strategies. HBM instruction enhances self-efficacy and the acceptability of medical regimens (Green et al., 2020). This contribute to HBM to highlight behavioural motivator and impediments to health outcomes. It explain why individuals engage or fail to engage in health-protective behaviours. Therefore Self-efficacy is built through health education, counselling and peer support. The findings of this study also revealed significant differences in the quality and accessibility of psychosocial support in Mtubatuba's healthcare system. Some individuals experienced positive interactions with compassionate healthcare workers, while others had brief conversations that lacked HIV advice or emotional support. Ndayishimiye et al. (2020) attribute such disparities to staff shortages, excessive patient loads, and inadequate training in psychosocial care. Inconsistent therapy may delay acceptance, induce emotional distress, and alienate patients (Amal & Pandin, 2021). These findings emphasise the need for structured, high-quality counselling programmes that address the psychological needs of young rural women, as well as the medical and social realities of living with HIV.

5.3.4 Role of family and peer support in emotional recovery

Young HIV-positive women in Mtubatuba needed family and peer support to cope and adhere to ART. When they confided in supportive family members, especially mothers or siblings, they felt more stable and motivated to continue their treatment. Barnhart et al. (2022) found that family-based empathy and practical care can minimise diagnosis-related psychological strain and help individuals accept their condition. Nshimyumuremyi et al. (2022) discovered that peer-led psychosocial models reduced stigma, promoted positive identity, and sustained mental health among Rwandan HIV-positive youths. The findings of this study revealed that family network disclosure is ambiguous and risky. Some participants felt connected and supported, while others experienced rejection, blame, or ostracism, which increased their vulnerability and isolation. Fauk et al. (2021) and Akatukwasa et al. (2021) state that family support depends on education, HIV culture, and family dynamics. While clinic-based or informal peer support was welcomed for sharing experiences, encouragement, and

hope, it was underused. Given the complexity and fragility of informal support systems in rural settings, multi-level interventions are needed to strengthen family capacity for empathetic assistance and to improve access to organised peer support programmes.

5.3.5 Coping strategies: Spirituality and personal resilience

Young HIV-positive women coped with faith and resilience. Most of them sought solace and support through prayer and from churches and spiritual leaders. Religious beliefs provide existential meaning and social connection, which help to avoid chronic illness-related unhappiness and hopelessness (Bukhori et al., 2022). Arebo et al. (2022) state that spiritual coping fosters agency, acceptance, and optimism. Spiritual responses vary, with some perceiving their diagnosis as a test of faith and others as divine vengeance, which may inhibit acceptance and healing. Amal and Pandin (2021) warn that fatalistic interpretations of illness can reduce participation in biomedical therapies and negatively impact self-efficacy. Personal resilience, including re-engagement with work, education, and income-generating activities, restores self-worth and mental health beyond spirituality. Casavant (2020) emphasises that poverty, gender, and health influence these pathways to empowerment and notes that economic marginalisation may impair resilience, while targeted skills building and economic empowerment can facilitate long-term adaptation. Mtubatuba faces high transportation expenses, poverty, and limited career opportunities, which underlines the need to address structural determinants of health and implement psychosocial interventions to foster resilience and agency in young HIV-positive women.

5.3.6 Structural gaps and unmet needs

Although some young HIV-positive women in Mtubatuba demonstrated resilience and adaptability, the findings of this study revealed structural gaps and unmet needs in psychosocial assistance. Many participants expressed concerns about the lack of youth-focused programmes, economic empowerment initiatives, and gender-sensitive group therapy. Kimera et al. (2020) argue that holistic and community-based HIV interventions are essential to address the psychosocial and economic vulnerabilities of rural African youth. UNAIDS (2021) notes that clinical care is often prioritised over emotional and social well-being for young HIV-positive individuals, as institutional support mechanisms are scarce. Green et al. (2020) contend that vocational training

and education can empower HIV-positive young women both economically and psychologically; yet rural programmes are limited. Ndayishimiye et al. (2020) highlight the disparities in post-diagnosis counselling and the need for integrated medical and socio-economic support. Despite the availability of ART, emotional and psychosocial treatment remains inconsistent and often inadequate, which leaves affected individuals vulnerable and with a lower quality of life. The findings call for the urgent expansion of inclusive, community-driven programmes that address biological needs, broader health factors, and psychosocial well-being. Cross-sectoral collaboration, community stakeholder participation, and a commitment to gender-sensitive, culturally responsive care are essential to building such systems.

5.4 Limitations of the study

This study was conducted in the Mtubatuba Local Municipality in the uMkhanyakude District of KwaZulu-Natal, a rural setting that provided rich, context-specific insights into the experiences of young WLWHA. While the findings offer valuable depth and insights, they may not be directly transferable to urban contexts or regions with different healthcare infrastructures and social dynamics. Moreover, the use of purposive sampling and a sample size of 15 participants was appropriate for achieving thematic saturation in qualitative research. However, the study may not have fully captured the diversity of experiences across different educational, religious, or socio-economic backgrounds. One of the limitations that the study had was that I could only refer to small sample size and also from single clinic not considering other clinics. The focus on young women provided a necessary lens for understanding gendered experiences, but it excluded perspectives from male counterparts and healthcare providers, which could have added further depth and institutional context. The study's design intentionally centred on the voices of young women to explore their lived realities in detail. Nonetheless, future research could benefit from a broader participant base to explore intersecting viewpoints. The findings should therefore be interpreted within the socio-geographic and demographic scope of the study.

5.5 Recommendations for policy development, government intervention, and future research

The KwaZulu-Natal Department of Health should consider establishing community-based counselling for rural young women to reduce HIV-related psychological trauma. The lack of accessible and consistent psychological support increased feelings of shock, dread of death, and guilt, according to the study. Training community health workers to lead peer-led support groups can enhance emotional resilience and provide a confidential space for coping, sharing experiences, and fostering hope. Additionally, distributing mental health services at primary clinics would reduce logistical barriers, promote continuity of care, and encourage adherence to ART. Given that psychosocial care must accompany medical interventions, national HIV programmes should formalise these services.

The study's findings suggest that both anticipated and actual stigma continue to make it difficult for people to come forward and improve their emotional well-being. To combat negative beliefs about HIV and help individuals understand that it is a manageable long-term condition, a province-wide multimedia campaign targeting rural communities is recommended. To make the experience more relatable and to encourage empathy, these advertisements should include testimonies from local women who are living healthily with HIV. Incorporating HIV education into school lessons and community workshops will help to raise awareness of the issue from an early age, particularly among young men. This approach will help to shift gender roles and encourage everyone to participate in HIV prevention efforts.

The participants' psychological and emotional suffering was commonly linked to socio-economic marginalisation, which increases dependency and limits future opportunities. The Department of Social Development in KwaZulu-Natal should collaborate with NGOs to create income-generating programmes for HIV-positive young women. Skills training in sewing, agriculture, or digital services could support the local economy. These socio-economic interventions would boost self-esteem, future orientation, and health-seeking behaviour.

Since faith is an important part of how people cope with stress, it is essential that spiritual counselling be included in HIV support services. Clinics, NGOs, and businesses in Mtubatuba should work together with religious groups to educate

spiritual leaders about HIV, ART, and how to provide non-discriminatory advice and support. These leaders can offer faith-based motivational counselling that upholds women's worth and dispels fatalistic beliefs that HIV is a punishment. Incorporating faith into messages about treatment adherence may also encourage healthy behaviour while reducing depression and feelings of isolation.

Disclosure was particularly delicate and psychologically exhausting. Standardised safe disclosure guidelines should assist young women in navigating this complex process at health facilities. The protocols should include pre-disclosure counselling, post-disclosure assistance, and partner mediation when necessary. Structured disclosure support can enhance treatment adherence, reduce anxiety, and encourage early social support. Health practitioners should receive disclosure training as part of their ongoing development to promote empathy and professionalism.

To help individuals consistently adhere to their ART, healthcare workers should provide young women with easy-to-use adherence tools. For example, Jones et al. (2023) suggest that these could include ART calendars in multiple languages, phone alerts, pillboxes with daily checklists, or digital apps that track adherence. Adherence tools should be introduced during counselling after a diagnosis, and individuals should also be able to use them during training sessions. Clinics should establish a peer-led adherence coaching programme so that women who have been on a regimen for at least two years can assist new patients in maintaining it. This model encourages responsibility and fosters an environment where everyone feels empowered (Pamukhti et al., 2021).

Comparative studies between HIV-positive individuals living in cities and those in rural areas would enhance our understanding of how infrastructure, healthcare access, stigma, and social and cultural norms influence coping mechanisms. The rural setting of Mtubatuba presents unique psychological, social, and structural challenges that may differ significantly from those in eThekwini or Johannesburg, which are urban environments. Such comparative studies could provide valuable insights into these differences.

Furthermore, researchers should investigate the effectiveness of programmes that offer psychosocial support, financial assistance, and peer-led initiatives in improving mental health and adherence to ART among HIV-positive youths. Many participants

in this study reported a lack of formal external support. Frameworks for monitoring and evaluation should therefore be integrated into the design of future studies.

5.6 Conclusion

This study explored the lived experiences of young women aged 18 to 35 who had been diagnosed with HIV/AIDS in the rural Mtubatuba Local Municipality, KwaZulu-Natal. Using a qualitative research design and thematic analysis, it illuminated the emotional, psychological, and social challenges these women face post-diagnosis.

By centring voices often excluded from health policy discourse, the study provided valuable insights into how stigma, support systems, cultural norms, and personal agency shape the journey of living with HIV. The findings highlight the persistent impact of HIV/AIDS on young women in rural South Africa, which extends beyond clinical settings. A particularly striking theme was the prevalence of initial emotional distress, shock, fear, self-blame, and hopelessness, followed by gradual acceptance and resilience, especially among those who accessed counselling, health education, or family support. Institutional, familial, and peer-based support systems emerged as critical in mitigating negative mental health outcomes and promoting adherence to ART.

Stigma, both anticipated and experienced, was a recurring theme, with many participants expressing fear of judgement, rejection, and diminished social roles. These findings highlight the need for public health interventions that address stigma through education, community engagement, and media representation. The study also revealed instances of institutional stigma, which suggest a need for improved training among healthcare providers to ensure compassionate, non-discriminatory care. Peer-led initiatives were identified as promising avenues for empowerment, as they would offer both psychosocial support and opportunities for leadership and skill development. The study's implications extend to policy and service delivery, which emphasise the importance of youth-friendly, inclusive, and decentralised healthcare models. Interventions must be tailored to the developmental realities of young women, who often navigate HIV alongside motherhood, relationships, and economic independence. This study calls for a holistic, context-sensitive, and person-centred response to HIV/AIDS in rural South Africa. The voices of young women in Mtubatuba

not only reveal the complexities of living with HIV but also serve as a compelling call to action for policymakers, practitioners, and researchers.

REFERENCE LIST

Adamu, A., Mchunu, G. & Naidoo, J.R. 2019. Stress and resilience among women living with HIV in Nigeria. *African Journal of Primary Health Care & Family Medicine*, 11(1), pp. 1-6.

Adeniyi, O.V., Ajayi, A.I., Ter Goon, D., Owolabi, E.O., Eboh, A. & Lambert, J. 2018. Factors affecting adherence to antiretroviral therapy among pregnant women in the Eastern Cape, South Africa. *BMC Infectious Diseases*, 18, pp. 1-11.

Agbiji, E. & Agbiji, O.M. 2016. Pastoral care as a resource for development in the global healthcare context: Implications for Africa's healthcare delivery system. *HTS Theological Studies*, 72(4), pp. 1-12.

Ahmadi, F., Khodayarifard, M., Zandi, S., Khorrami-Markani, A., Ghobari-Bonab, B., Sabzevari, M. & Ahmadi, N. 2018. Religion, culture and illness: A sociological study on religious coping in Iran. *Mental Health, Religion & Culture*, 21(7), pp. 721-736.

Ahmed, S., Autrey, J., Katz, I.T., Fox, M.P., Rosen, S., Onoya, D., Bärnighausen, T., Mayer, K.H. & Bor, J. 2018. Why do people living with HIV not initiate treatment? A systematic review of qualitative evidence from low-and middle-income countries. *Social Science & Medicine*, 213, pp. 72-84.

Akatukwasa, C., Getahun, M., El Ayadi, A.M., Namanya, J., Maeri, I., Itiakorit, H., Owino, L., Sanyu, N., Kabami, J., Ssemmondo, E. & Sang, N. 2021. Dimensions of HIV-related stigma in rural communities in Kenya and Uganda at the start of a large HIV 'test and treat' trial. *PLoS ONE*, 16(5), e0249462.

Ali, R. 2015. Rethinking representation: Negotiating positionality, power and space in the field. *Gender, Place and Culture*, 22(6), pp. 783-800.

Amal, A.I. & Pandin, M.G.R. 2021. Stressor and coping strategies of people living with HIV/AIDS (PlWHA): A literature review. *Preprints*, 05 April 2001. Available at: https://www.preprints.org/frontend/manuscript/6a7666525a9ce50664f26bde91f520fd/download_pub

Anima-Korang, A., Gere, B.O. & Salimi, N. 2018. Stigma and discrimination: Coping strategies for persons living with HIV/AIDS in rural America. *IAFOR Journal of Psychology & the Behavioral Sciences*, 4(1), pp. 33-44.

Anuar, H., Shah, S.A., Gafor, H., Mahmood, M.I. & Ghazi, H.F. 2020. Usage of health belief model (HBM) in health behavior: A systematic review. *Malaysian Journal of Medicine and Health Sciences*, 16(11), pp. 2636-9346.

Arebo, B., Ewach, G.F., Omara, J., Oyella, P., Aciro Lucky, R. & Kabunga, A. 2022. Post-traumatic stress disorder and coping strategies among people with HIV in lira district, Uganda: A cross-sectional study. *HIV/AIDS Research and Palliative Care*, 14, pp. 255-264.

Arias-Colmenero, T., Pérez-Morente, M.Á., Ramos-Morcillo, A.J., Capilla-Díaz, C., Ruzafa-Martínez, M. & Hueso-Montoro, C. 2020. Experiences and attitudes of people with HIV/AIDS: A systematic review of qualitative studies. *International Journal of Environmental Research and Public Health*, 17(2), 639.

Ashaba, S., Kaida, A., Coleman, J.N., Burns, B.F., Dunkley, E., O'Neil, K., Kastner, J., Sanyu, N., Akatukwasa, C., Bangsberg, D.R. & Matthews, L.T. 2017. Psychosocial challenges facing women living with HIV during the perinatal period in rural Uganda. *PLoS ONE*, 12(5), e0176256.

Ashraf, M. & Virk, R.N. 2021. Determinants of medication adherence in patients with HIV: Application of the health belief model. *JPMA*, 71(5), pp. 1409-1412.

Asrat, B., Schneider, M., Ambaw, F. & Lund, C. 2020. Effectiveness of psychological treatments for depressive symptoms among people living with HIV/AIDS in low- and middle-income countries: A systematic review and meta-analysis. *Journal of Affective Disorders*, 270(1), pp. 174-187.

Azia, I.N., Nyembezi, A., Carelse, S. & Mukumbang, F.C. 2023. Understanding the role of religious beliefs in adherence to antiretroviral therapy among Pentecostal Christians living with HIV in sub-Saharan Africa: A scoping review. *BMC Public Health*, 23(1), 1768.

Bayane, P. 2025. My Research Journey into Family Domestic Work: Methodological Reflections of Conducting Research with Sister-Maids and Sister-Madams in Limpopo. *The Qualitative Report*, 30(12), 4750-4763.

Bailey, H., Zash, R., Rasi, V. & Thorne, C. 2018. HIV treatment in pregnancy. *The Lancet HIV*, 5(8), pp. e457-e467.

Barnhart, D., Asiimwe-Kateera, B., Nyombayire, J., Kirwa, K., Adedimeji, A. & Rusine, J. 2022. Perspectives on a peer support and group-based economic incentives program for Rwandan youth living with HIV. *PLoS Global Public Health*, 2(3), e0000492.

Beaudry, J.S. & Miller, L. 2016. *Research Literacy: A Primer for Understanding and Using Research*. New York: Guilford Publications.

Braun, V. and Clarke, V. 2021. To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative research in sport, exercise and health*, *13*(2), pp.201-216.

Bukhori, B., Hidayanti, E. & Situmorang, D.D.B. 2022. Religious coping strategies for people with HIV/AIDS (PLWHA) Muslims in Indonesia: A qualitative study with a telling-the-stories. *Heliyon*, 8(12), e12208.

Carlsson-Lalloo, E., Rusner, M., Mellgren, Å. & Berg, M. 2016. Sexuality and reproduction in HIV-positive women: A meta-synthesis. *AIDS Patient Care and STDs*, 30(2), pp. 56-69.

Carpenter, C.J. 2010. A meta-analysis of the effectiveness of health belief model variables in predicting behavior. *Health Communication*, 25(8), pp. 661-669.

Casavant, I. 2020. Risks for HIV Infection Among Adolescent Girls and Young Women in Mozambique. Doctoral Dissertation. Minneapolis: Walden University.

Chekole, Y.A. & Tarekegn, D. 2021. HIV-related perceived stigma and associated factors among patients with HIV, Dilla, Ethiopia: A cross-sectional study. *Annals of Medicine and Surgery*, 71, 102921.

Chowdhury, I.A. 2015. Issue of quality in a qualitative research: An overview. *Innovative Issues and Approaches in Social Sciences*, 8(1), pp. 142-162.

Cloete, A., Mafoko, G., Blose, S., Mashologu, Y., Zuma, K., Maduna, V., Mthembu, J., Mabaso, M., Simbayi, L., Jooste, S. & Matseke, G. 2015. *The People: Living with HIV Stigma Index: South Africa 2014: Summary Report*. Pretoria: HSRC Press.

Colbert, A.M., Kim, K.H., Sereika, S.M. & Erlen, J.A. 2010. An examination of the relationships among gender, health status, social support, and HIV-related stigma. *Journal of the Association of Nurses in AIDS Care*, 21(4), pp. 302-313.

Colombini, M., Mutemwa, R., Kivunaga, J., Stackpool Moore, L. & Mayhew, S.H. 2014. Experiences of stigma among women living with HIV attending sexual and reproductive health services in Kenya: A qualitative study. *BMC Health Services Research*, 14, pp. 1-9.

Dabaghzadeh, F., Jabbari, F., Khalili, H. & Abbasian, L. 2015. Associated factors of suicidal thoughts in HIV-positive individuals. *Iranian Journal of Psychiatry*, 10(3), 185.

Dasgupta, P., Morton, J., Dodman, D., Karapinar, B., Meza, F., Rivera-Ferre, M.G., Toure Sarr, A. & Vincent, K.E. 2014. Rural areas. In: Field, C. & Barros, V. (Eds.). *Climate Change 2014: Impacts, Adaptation, and Vulnerability*. Cambridge: Cambridge University Press. pp. 613-657.

Davenport, M.P., Khoury, D.S., Cromer, D., Lewin, S.R., Kelleher, A.D. & Kent, S.J. 2019. Functional cure of HIV: The scale of the challenge. *Nature Reviews Immunology*, 19(1), pp. 45-54.

Deekshitulu, B. 2015. Stress aspects in HIV/AIDS disease. *International Journal of Indian Psychology*, 3(1), pp. 75-80.

De la Cruz, A., Caine, V. & Mill, J. 2016. Sub-Saharan African immigrants living with HIV in Canada: A narrative inquiry. *International Journal of Migration, Health and Social Care*, 12(3), pp. 194-210.

Dellar, R.C., Dlamini, S. & Karim, Q.A. 2015. Adolescent girls and young women: Key populations for HIV epidemic control. *Journal of the International AIDS Society*, 18, 19408.

Diress, G., Seyoum, Y. & Alemu, A. 2020. Disclosure and its factors among women living with HIV in Northwest Ethiopia. *HIV/AIDS – Research and Palliative Care,* 12, pp. 869-877.

Du, P., Crook, T., Whitener, C., Albright, P., Greenawalt, D. & Zurlo, J. 2015. HIV transmission risk behaviors among people living with HIV/AIDS: The need to integrate HIV prevention interventions and public health strategies into HIV care. *Journal of Public Health Management and Practice: JPHMP*, 21(2), pp. E1-E10.

Duby, Z., Verwoerd, W., Isaksen, K., Jonas, K., Maruping, K., Dietrich, J., Lovette, A., Kuo, C. & Mathews, C. 2022. 'I can't go to her when I have a problem': Sexuality communication between South African adolescent girls and young women and their mothers. *SAHARA-J: Journal of Social Aspects of HIV/AIDS*, 19(1), pp. 8-21.

Duko, B., Ayalew, M. & Ayano, G. 2019. The prevalence of alcohol use disorders among people living with HIV/AIDS: A systematic review and meta-analysis. *Substance Abuse Treatment, Prevention, and Policy*, 14, pp. 1-9.

Elliott, F. & Escott, B. 2014. *Biodiversity Sector Plan: uMkhanyakude District Municipality*. Cascades: Ezemvelo KZN Wildlife.

Emard, N. 2017. HIV community stigma and risks for HIV/STI syndemics. In: Lerman, S., Ostrach, B. & Singer, M. (Eds.). *Foundations of Biosocial Health: Stigma and Illness Interactions*. Lanham: Lexington Books. p. 157.

Fauk, N.K., Hawke, K., Mwanri, L. & Ward, P.R. 2021. Stigma and discrimination towards people living with HIV in the context of families, communities, and healthcare settings: A qualitative study in Indonesia. *International Journal of Environmental Research and Public Health*, 18(10), 5424.

Fauk, N.K., Mwanri, L., Hawke, K., Mohammadi, L. and Ward, P.R. 2022. Psychological and social impact of HIV on women living with HIV and their families in low-and middle-income Asian countries: A systematic search and critical review. *International Journal of Environmental Research and Public Health*, *19*(11), p.6668. https://doi.org/10.3390/ijerph19116668

Garrett, N., Norman, E., Leask, K., Naicker, N., Asari, V., Majola, N., Karim, Q.A. & Karim, S.S.A. 2018. Acceptability of early antiretroviral therapy among South African women. *AIDS and Behavior*, 22, pp. 1018-1024.

Ghiasvand, H., Waye, K.M., Noroozi, M., Harouni, G.G., Armoon, B. & Bayani, A. 2019. Clinical determinants associated with quality of life for people who live with HIV/AIDS: A meta-analysis. *BMC Health Services Research*, 19(1), 768.

Goffman, E. 1963. *Stigma: Notes on the Management of Spoiled Identity*. London: Penguin.

Goffman, E. 1997. Selections from *Stigma*. In: Davis, L.J. (Ed.). *The Disability Studies Reader*. New York: Routledge. pp. 203-215.

Google Maps. 2025. *Map of Enqopheni Area*. Available at: https://maps.app.goo.gl/dAdfinUeRNHSi1fTA

Govender, R. & Schlebusch, L. 2012. Suicidal ideation in seropositive patients seen at a South African HIV voluntary counselling and testing clinic. *African Journal of Psychiatry*, 15, pp. 94-98.

Ghafouri, R. & Ofoghi, S. 2016. Trustworth and rigor in qualitative research. *International Journal of Advanced Biotechnology and Research*, 7(4), pp.1914-1922.

Graziano, A.M. & Raulin, M.L. 2000. *Research Methods: A Process of Inquiry*. 4th ed. Boston: Allyn & Bacon.

Green, E.C., Murphy, E.M. & Gryboski, K. 2020. The health belief model. In: Sweeny, K., Robbins, M.L. & Cohen, L.M. (Eds.). *The Wiley Encyclopedia of Health Psychology*. Chichester: John Wiley & Sons. pp. 211-214.

Green, K., Greer, J. & Simon, M. 2020. Empowerment through economic independence: The impact of vocational training for HIV-positive young women. *Development in Practice*, 30(6), pp. 807-818. https://doi.org/10.1080/09614524.2020.1780029

Greg Stanley and Associates. 2013. *A Guide to Fault Detection and Diagnosis*. Available at: https://gregstanleyandassociates.com/whitepapers/FaultDiagnosis/faultdiagnosis.htm

Hahn, J.A. & Samet, J.H. 2010. Alcohol and HIV disease progression: Weighing the evidence. *Current HIV/AIDS Reports*, 7, pp. 226-233.

Hakiba, S. 2022. Navigating the disclosure dilemma: Perspectives of young women living with HIV in low-resource communities. *Journal of HIV/AIDS & Social Services*, 21(2), pp. 129-146. https://doi.org/10.1080/15381501.2022.2042411

Hayes, E.V. 2020. Human immunodeficiency virus and acquired immunodeficiency syndrome. In: Kliegman, R.M. & St. Geme, J.W. (Eds.). *Nelson Textbook of Pediatrics.* 21st ed. Philadelphia: Elsevier. pp. 2087-2117.

Hayfron-Benjamin, A., Obiri-Yeboah, D., Ayisi-Addo, S., Siakwa, P.M. & Mupepi, S. 2018. HIV diagnosis disclosure to infected children and adolescents; challenges of family caregivers in the Central Region of Ghana. *BMC Pediatrics*, 18, pp. 1-11.

Hedge, B., Devan, K., Catalan, J., Cheshire, A. & Ridge, D. 2021. HIV-related stigma in the UK then and now: To what extent are we on track to eliminate stigma? A qualitative investigation. *BMC Public Health*, 21, pp. 1-10.

Hennink, M. and Kaiser, B.N. 2022. Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social science & medicine*, *292*, p.114523.

Hlongwa, M., Peltzer, K. & Hlongwana, K. 2020. Risky sexual behaviours among women of reproductive age in a high HIV burdened township in KwaZulu-Natal, South Africa. *BMC Infectious Diseases*, 20(1), pp. 1-9.

Imenda, M.S. 2022. *Investigating How Stigma AIDS the Spread of HIV Infections Among Young Women in Johannesburg and Possible Interventions to Ameliorate the Problem* (Master's thesis, University of South Africa (South Africa)).

Irungu, E., Chersich, M.F., Sanon, C., Chege, R., Gaillard, P., Temmerman, M., Read, J.S., Luchters, S. & Kesho Bora Study Group. 2012. Changes in sexual behaviour among HIV-infected women in west and east Africa in the first 24 months after delivery. *Aids*, 26(8), pp. 997-1007.

Johnson, L.F. & Dorrington, R.E. 2021. *Modelling the Impact of HIV in South Africa’s Provinces: 2020 Update*. Cape Town: Centre for Infectious Disease Epidemiology and Research, University of Cape Town.

Johnson, M., Samarina, A., Xi, H., Valdez Ramalho Madruga, J., Hocqueloux, L., Loutfy, M., Fournelle, M.J., Norton, M., Van Wyk, J., Zachry, W. & Martinez, M. 2015. Barriers to access to care reported by women living with HIV across 27 countries. *AIDS Care*, 27(10), pp. 1220-1230.

Joint United Nations Programme on HIV/AIDS (UNAIDS). 2019. *AIDS Statistics 2019 Fact Sheet: HIV Epidemic Update*. Available at: https://www.unaids.org/en/resources/fact-sheet

Joint United Nations Programme on HIV/AIDS (UNAIDS). 2021. *Young People and HIV*. Available at: https://www.unaids.org/en/resources/documents/2021/young-people-and-hiv

Jones, M.C., Byun, J.Y., Billings, R., Shorten, A., Kempf, M.C., Vance, D.E. & Puga, F. 2023. Tools for screening and measuring anxiety among women living with HIV of reproductive age: A scoping review. *AIDS and Behavior,* 27(8), pp. 2649-2668.

Kalpokaite, N. & Radivojevic, I. 2019. Demystifying qualitative data analysis for novice qualitative researchers. *The Qualitative Report*, 24(13), pp. 44-57.

Kapadiya, M.N. 2022. AIDS case study. *International Journal of Nursing Education and Research*. 10(1), pp. 21-22.

Kaur, M.D. 2020. Challenges in the lives of HIV-positive women. *EPRA International Journal of Multidisciplinary Research*, 6, pp. 103-109.

Khumalo, G.E., Ntuli, S., Lutge, E. & Mashamba-Thompson, T.P. 2022. Geo-analysis: The distribution of community health workers in relation to the HIV prevalence in KwaZulu-Natal province, South Africa. *BMC Health Services Research*, 22(1), pp. 1-14.

Kim, D.J., Mirmina, J., Narine, S., Wachtel, J., Carbajal, J.M., Fox, H. & Cáceda, R. 2022. Altered physical pain processing in different psychiatric conditions. *Neuroscience & Biobehavioral Reviews*, 133, 104510.

Kimera, E., Vindevogel, S., Kintu, M.J., Rubaihayo, J., De Maeyer, J., Reynaert, D., Engelen, A.M., Nuwaha, F. & Bilsen, J. 2020. Experiences and perceptions of youth

living with HIV in Western Uganda on school attendance: Barriers and facilitators. *BMC Public Health*, 20, pp. 1-12.

Kontomanolis, E.N., Michalopoulos, S., Gkasdaris, G. & Fasoulakis, Z. 2017. The social stigma of HIV–AIDS: Society's role. *HIV/AIDS-Research and Palliative Care*, 9, pp. 111-118.

Kyngäs, H., Kääriäinen, M. & Elo, S. 2019. The trustworthiness of content analysis. In: Kyngäs, H., Mikkonen, K. & Kääriäinen, M. (Eds.). *The Application of Content Analysis in Nursing Science Research*. Cham: Springer International Publishing. pp. 41-48.

Laryeafio, M.N. & Ogbewe, O.C. 2023. Ethical consideration dilemma: Systematic review of ethics in qualitative data collection through interviews. *Journal of Ethics in Entrepreneurship and Technology*, 3(2), pp. 94-110.

Limalvin, N.P., Putri, W.C.W.S. & Sari, K.A.K. 2020. Overview of the psychological, social and economic impact on PLWHA at the Spirit Paramacitta Foundation, Denpasar. *Directory of Open Access Journals*, 11(1), pp. 81-91.

Linganiso, W.S. & Gwegweni, J.M.T. 2016. What perpetuates the spread of HIV/AIDS in rural South African communities? A closer look at social factors. *Austin Journal of Public Health and Epidemiology*, 3(1), 1031.

Loutfy, M., Johnson, M., Walmsley, S., Samarina, A., Vasquez, P., Hao-Lan, H., Madihlaba, T., Martinez-Tristani, M. & Van Wyk, J. 2016. The association between HIV disclosure status and perceived barriers to care faced by women living with HIV in Latin America, China, Central/Eastern Europe, and Western Europe/Canada. *AIDS Patient Care and STDs*, 30(9), pp. 435-444.

Lovato, L.V. 2016. Intersectionality of Identity and HIV-Related Stigma. Doctoral Dissertation. Charlotte: The University of North Carolina at Charlotte.

Madhombiro, M., Musekiwa, A., January, J., Chingono, A., Abas, M. & Seedat, S. 2019. Psychological interventions for alcohol use disorders in people living with HIV/AIDS: A systematic review. *Systematic Reviews*, 8, pp. 1-16.

Madiba, S. & Diko, C. 2021. Telling children with perinatal HIV about their HIV serostatus: Healthcare workers' practices and barriers to disclosing in a South African

rural health district. *Journal of Primary Care & Community Health*, 12, 2150132720984757.

Madiba, S. & Ngwenya, N. 2017. Cultural practices, gender inequality and inconsistent condom use increase vulnerability to HIV infection: Narratives from married and cohabiting women in rural communities in Mpumalanga province, South Africa. *Global Health Action*, 10(S2), 1341597.

Maguire, M. & Delahunt, B. 2017. Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars. *All Ireland Journal of Higher Education*, 9(3), 3352.

Mampane, J.N. 2018. Exploring the “blesser and blessee” phenomenon: Young women, transactional sex, and HIV in rural South Africa. *Sage Open*, 8(4). https://doi.org/10.1177/2158244018806343

Masevhege, T. and Skhosana, R. 2026. The unheard lived experiences of women living with HIV in Gauteng province, South Africa. *Discover Social Science and Health 6,36*. https://doi.org/10.1007/s44155-026-00371-0

Menéndez-Arias, L. & Delgado, R. 2022. Update and latest advances in antiretroviral therapy. *Trends in Pharmacological Sciences*, 43(1), pp. 16-29.

Merrill, J.E., Wardell, J.D. & Read, J.P. 2014. Drinking motives in the prospective prediction of unique alcohol-related consequences in college students. *Journal of Studies on Alcohol and Drugs*, 75(1), pp. 93-102.

Mhungu, A., Sixsmith, J. and Burnett, E. 2023. Adolescent girls and young women’s experiences of living with HIV in the context of patriarchal culture in sub-Saharan Africa: a scoping review. *AIDS and Behavior*, *27*(5), pp.1365-1379. doi: 10.1007/s10461-022-03872-6. Epub 2022 Nov 1. PMID: 36318422; PMCID: PMC10129999.

Misir, P. 2015. Structuration theory: A conceptual framework for HIV/AIDS stigma. *Journal of the International Association of Providers of AIDS Care (JIAPAC)*, 14(4), pp. 328-334.

Mncadi, M.E. 2017. Experiences of Nursing Students in the Management of HIV/AIDS Patients in a Selected Public Hospital in KwaZulu-Natal, South Africa. Doctoral Dissertation. Kwadlangezwa: University of Zululand.

Mohajan, H.K. 2018. Qualitative research methodology in social sciences and related subjects. *Journal of Economic Development, Environment and People*, 7(1), pp. 23-48.

Moodley, T., Moodley, D., Sebitloane, M., Maharaj, N. & Sartorius, B. 2016. Improved pregnancy outcomes with increasing antiretroviral coverage in South Africa. *BMC Pregnancy and Childbirth*, 16, pp. 1-10.

Moriña, A. 2021. When people matter: The ethics of qualitative research in the health and social sciences. *Health & Social Care in the Community*, 29(5), pp. 1559-1565.

Moser, A. & Korstjens, I. 2018. Series: Practical guidance to qualitative research. Part 3: Sampling, data collection and analysis. *European Journal of General Practice*, 24(1), pp. 9-18.

Moyo, F., Chasela, C., Brennan, A.T., Ebrahim, O., Sanne, I.M., Long, L. & Evans, D. 2016. Treatment outcomes of HIV-positive patients on first-line antiretroviral therapy in private versus public HIV clinics in Johannesburg, South Africa. *Clinical Epidemiology*, 8, pp. 37-47.

Mpofu, L. and Ganga-Limando, M. 2024. The lived experiences of HIV-positive women in rural Zimbabwe: A qualitative focus group study. *South African Family Practice*, *66*(1), p.5823. https://doi.org/10.4102/safp.v66i1.5823

Mthembu, Z., Maharaj, P. & Rademeyer, S. 2019. "I am aware of the risks, I am not changing my behaviour": Risky sexual behaviour of university students in a high-HIV context. *African Journal of AIDS Research*, 18(3), pp. 244-253

Mtubatuba Local Municipality. 2013. *Integrated Development Plan for 2013-2014*. Mtubatuba: Mtubatuba Local Municipality.

Muthanna, A. & Alduais, A. 2023. The interrelationship of reflexivity, sensitivity and integrity in conducting interviews. *Behavioral Sciences*, 13(3), 218.

Muula, A.S. 2008. HIV infection and AIDS among young women in South Africa. *Croatian Medical Journal*, 49(3), pp. 423-435.

Myers, B., Carney, T., Browne, F.A. & Wechsberg, W.M. 2018. Development of a trauma-informed substance use and sexual risk reduction intervention for young South African women. *Patient Preference and Adherence*, 12, pp. 1997-2006.

Myers, B., Sorsdahl, K., Morojele, N.K., Kekwaletswe, C., Shuper, P.A. & Parry, C.D. 2017. "In this thing I have everything I need": Perceived acceptability of a brief alcohol-focused intervention for people living with HIV. *AIDS Care*, 29(2), pp. 209-213.

Nascimento, L.D.S. & Steinbruch, F.K. 2019. "The interviews were transcribed", but how? Reflections on management research. *RAUSP Management Journal*, 54(4), pp. 413-429.

Ndayishimiye, P., Uwase, R., Kubwimana, I., Niyonzima, J.D.I.C., Dine, R.D. & Nyandwi, J.B. 2020. Availability, accessibility, and quality of adolescent sexual and reproductive health services in urban health facilities of Rwanda: A survey among social and healthcare providers. *BMC Health Services Research*, 20(1), 697.

Neuman, W.L. 2006. *Social Research Methods: Qualitative and Quantitative Approaches*. 6th ed. Boston: Pearson.

Ngulube, P. 2015. Qualitative data analysis and interpretation: Systematic search for meaning. In: Mathipa, E.R. & Gumbo, M.T. (Eds.). *Addressing Research Challenges: Making Headway for Developing Researchers*. Midrand: Mosala-MASEDI Publishers & Booksellers. pp. 131-156.

Ngwenya, N., Nkosi, B., Mchunu, L.S., Ferguson, J., Seeley, J. & Doyle, A.M. 2020. Behavioural and socio-ecological factors that influence access and utilisation of health services by young people living in rural KwaZulu-Natal, South Africa: Implications for intervention. *PLoS ONE*, 15(4), e0231080. https://doi.org/10.1371/journal.pone.0231080

Nshimyumuremyi, J.N., Mukesharurema, G., Uwamariya, J., Mutunge, E., Goodman, A.S. & Ndahimana, J. 2022. Implementation and adaptation of a combined economic empowerment and peer support program among youth living with HIV in rural Rwanda.

Journal of the International Association of Providers of AIDS Care, 21, 23259582211064038.

Nurfalah, F., Yona, S. & Waluyo, A. 2019. The relationship between HIV stigma and adherence to antiretroviral (ARV) drug therapy among women with HIV in Lampung, Indonesia. *Enfermeria Clinica*, 29, pp. 234-237.

Oliveira, A.D.D.F., Vieira, M.C.A., Mistura, C. & Jacobi, C.D.S. 2015. Effects of HIV in daily life of women living with AIDS. *Revista de Pesquisa: Cuidado é Fundamental Online*, 7(1), pp. 1975-1986.

Olmos-Vega, F.M., Stalmeijer, R.E., Varpio, L. & Kahlke, R. 2023. A practical guide to reflexivity in qualitative research: AMEE Guide no. 149. *Medical Teacher*, 45(3), pp. 241-251.

Osamika, B.E. 2019. Coping strategies predicting quality of life among people living with HIV/AIDS. *PEOPLE: International Journal of Social Sciences*, 4, pp. 1689-1711.

Osborne, N. & Grant-Smith, D. 2021. In-depth interviewing. In: Baum, S. (Ed.). *Methods in Urban Analysis*. Singapore: Springer. pp. 105-125.

Pamukhti, B.B.D., Erawati, M., Muniroh, M. & Dewi, N.S. 2021. Experiences of people living with HIV/AIDS in surviving life. *Nurse and Health: Jurnal Keperawatan*, 10(2), pp. 292-303.

Paudel, V. & Baral, K.P. 2015. Women living with HIV/AIDS (WLHA), battling stigma, discrimination and denial and the role of support groups as a coping strategy: A review of literature. *Reproductive Health*, 12, pp. 1-9.

Pei, J.H., Pei, Y.X., Ma, T., Du, Y.H., Wang, X.L., Zhong, J.P., Xie, Q., Zhang, L.H., Yan, L.X. & Dou, X.M. 2021. Prevalence of suicidal ideation, suicide attempt, and suicide plan among HIV/AIDS: A systematic review and meta-analysis. *Journal of Affective Disorders*, 292, pp. 295-304.

Peltzer, K. & Pengpid, S. 2019. Prevalence and associated factors of enacted, internalized and anticipated stigma among people living with HIV in South Africa: Results of the first national survey. *HIV/AIDS – Research and Palliative Care*, 11, pp. 275-285.

Petersen Williams, P., Brooke-Sumner, C., Joska, J., Kruger, J., Vanleeuw, L., Dada, S., Sorsdahl, K. & Myers, B. 2020. Young South African women on antiretroviral therapy perceptions of a psychological counselling program to reduce heavy drinking and depression. *International Journal of Environmental Research and Public Health*, 17(7), 2249.

Pinho, C.M., Dâmaso, B.F.R., Gomes, E.T., Trajano, M.D.F.C., Andrade, M.S. & Valença, M.P. 2017. Religious and spiritual coping in people living with HIV/Aids. *Revista Brasileira de Enfermagem*, 70, pp. 392-399.

Pokhrel, K.N., Pokhrel, K.G., Neupane, S.R. & Sharma, V.D. 2018. Harmful alcohol drinking among HIV-positive people in Nepal: An overlooked threat to anti-retroviral therapy adherence and health-related quality of life. *Global Health Action*, 11(1), 1441783.

Polit, D.F. & Beck, C.T. 2012. Nursing research: Generating and assessing for nursing practice. *Research in Nursing & Health*, 29(5), pp. 489-497.

Polit, D.F. & Beck, C.T. 2017. *Essentials of Nursing Research: Appraising Evidence for Nursing Practice.* 8th ed. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins. pp. 29-32.

Rahman, M.M. 2023. Sample size determination for survey research and non-probability sampling techniques: A review and set of recommendations. *Journal of Entrepreneurship, Business and Economics*, 11(1), pp. 42-62.

Ramjee, G., Sartorius, B., Morris, N., Wand, H., Reddy, T., Yssel, J.D. & Tanser, F. 2019. A decade of sustained geographic spread of HIV infections among women in Durban, South Africa. *BMC Infectious Diseases*, 19(1), pp. 1-9.

Remien, R.H., Stirratt, M.J., Nguyen, N., Robbins, R.N., Pala, A.N. & Mellins, C.A. 2019. Mental health and HIV/AIDS: The need for an integrated response. *Aids*, 33(9), pp. 1411-1420.

Rai, N. and Thapa, B. 2015. A study on purposive sampling method in research. *Kathmandu School of Law*, 5(1), pp. 8-15.

Santos, F.D.R.P., Amaral, L.R.O.G.D., Santos, M.A.D., Ferreira, A.G.N., Moura, J.F.D. & Brito, L.B. 2019. Repercussions of spirituality in the lives of women living with HIV. *Revista Cuidarte*, 10(3), e711.

Shaw, G.M. & Hunter, E. 2012. HIV transmission. *Cold Spring Harbor Perspectives in Medicine*, 2(11), a006965.

Short, W.E. & Vissandjée, B. 2017. Women living with HIV in India: Looking up from a place of stigma, identifying nexus sites for change. *Diversity and Equality in Health Care*, 14(3), pp. 159-166.

Shuper, P.A., Joharchi, N., Monti, P.M., Loutfy, M. & Rehm, J. 2017. Acute alcohol consumption directly increases HIV transmission risk: A randomized controlled experiment. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 76(5), pp. 493-500.

Stahl, N.A. & King, J.R. 2020. Expanding approaches for research: Understanding and using trustworthiness in qualitative research. *Journal of Developmental Education*, 44(1), pp. 26-28.

Statistics South Africa. 2021. *Statistical Release P0302: Mid-Year Population Estimates 2020*. Available at: http://www.statssa.gov.za/publications/P0302/P0302 2021.pdf

Struwig, F.W. & Stead, G.B. 2001. *Planning, Designing and Reporting Research*. Cape Town: Juta.

Strydom, P. 2011. *Contemporary Critical Theory and Methodology*. New York: Routledge.

Sundler, A.J., Lindberg, E., Nilsson, C. & Palmér, L. 2019. Qualitative thematic analysis based on descriptive phenomenology. *Nursing Open*, 6(3), pp. 733-739.

Tarkang, E.E. & Zotor, F.B. 2015. Application of the health belief model (HBM) in HIV prevention: A literature review. *Central African Journal of Public Health*, 1(1), pp. 1-8.

Terry, G., Hayfield, N., Clarke, V. & Braun, V. 2017. Thematic analysis. In: Willig, C. & Rogers, W.S. (Eds.). *The SAGE Handbook of Qualitative Research in Psychology*. Thousand Oaks: Sage Publications. pp. 17-37.

Teshale, A.B., Yeshaw, Y., Alem, A.Z., Ayalew, H.G., Liyew, A.M., Tessema, Z.T., Tesema, G.A., Worku, M.G. & Alamneh, T.S. 2022. Comprehensive knowledge about HIV/AIDS and associated factors among women of reproductive age in sub-Saharan Africa: A multilevel analysis using the most recent demographic and health survey of each country. *BMC Infectious Diseases*, 22(1), 130.

Thanh, N.C. & Thanh, T.T. 2015. The interconnection between interpretivist paradigm and qualitative methods in education. *American Journal of Educational Science*, 1(2), pp. 24-27.

Tiwari, G.K. 2015. Chronic physical illness affects emotion regulation process: A case of HIV/AIDS. *The International Journal of Indian Psychology*, 3(1), pp. 158-166.

Turan, B., Budhwani, H., Fazeli, P.L., Browning, W.R., Raper, J.L., Mugavero, M.J. & Turan, J.M. 2017. How does stigma affect people living with HIV? The mediating roles of internalized and anticipated HIV stigma in the effects of perceived community stigma on health and psychosocial outcomes. *AIDS and Behavior*, 21, pp. 283-291.

Vazquez-Colón, C.A. 2016. Coping Skills, Social Support, and Quality of Life Among Puerto Rican Women Undergoing Drug and/or Alcohol Treatment. Master’s Thesis. Bellingham: Western Washington University. Available at: https://cedar.wwu.edu/wwuet/533/

Vitale, A. & Ryde, J. 2018. Exploring risk factors affecting the mental health of refugee women living with HIV. *International Journal of Environmental Research and Public Health*, 15(10), 2326.

Vocabulary.com. 2025. *‘Young Woman’*. Available at: https://www.vocabulary.com/dictionary/young woman

Wanjala, S.W., Nyongesa, M.K., Mapenzi, R., Luchters, S. & Abubakar, A. 2023. A qualitative inquiry of experiences of HIV-related stigma and its effects among people living with HIV on treatment in rural Kilifi, Kenya. *Frontiers in Public Health*, 11, 1188446.

Wardell, J.D., Shuper, P.A., Rourke, S.B. & Hendershot, C.S. 2018. Stigma, coping, and alcohol use severity among people living with HIV: A prospective analysis of

bidirectional and mediated associations. *Annals of Behavioral Medicine*, 52(9), pp. 762-772.

Washburn, L. 2020. *Understanding the Health Belief Model*. Knoxville: University of Tennessee.

Webster, M. 2017. *Data Protection in the Financial Services Industry*. London: Routledge.

Wholey, J.S., Hatry, H.P. & Newcomer, K.E. (Eds.). 2018. *Handbook of Practical Program Evaluation*. 4th ed. San Francisco: Jossey-Bass.

Williams, M. & Moser, T. 2019. The art of coding and thematic exploration in qualitative research. *International Management Review*, 15(1), pp. 45-55.

World Health Organization (WHO). 2015. *Guideline on When to Start Antiretroviral Therapy and on Pre-Exposure Prophylaxis for HIV*. Available at: https://www.who.int/publications/i/item/9789241509565

World Health Organization (WHO). 2017. *Transformative Accountability for Adolescents: Accountability for the Health and Human Rights of Women, Children and Adolescents in the 2030 Agenda*. Available at: https://content.sph.harvard.edu/wwwhsph/sites/2413/2017/09/IAP-Annual-Report-2017-online-final-web_with-endnotes.pdf

Yin, R.K. 2015. *Qualitative Research from Start to Finish*. New York: Guilford Publications.

Zainal-Abidin, A.N.I., Ariffin, F., Badlishah-Sham, S.F. & Razali, S. 2022. Exploring spiritual and religious coping among PLHIV in a Malaysian Muslim community: A qualitative study. *HIV/AIDS (Auckland, NZ)*, 14, 409.

Zarei, N., Joulaei, H. & Fararouei, M. 2017. Perceived stigma and quality of life among women living with HIV/AIDS. *Women's Health Bulletin*, 4(1), pp. 1-6.

APPENDICES

Appendix A: Information Letter

Project Title: Life After Being Diagnosed With HIV: Exploring the Attitudes and Experiences of Young Women Aged 18-35 Diagnosed With HIV in Mtubatuba Municipality in uMkhanyakude District, KwaZulu-Natal Province

Researcher: Miss Nothando Sosibo

This information letter and the informed consent form may include words that are not familiar to you. Please feel free to ask questions about anything you do not understand or is unclear for you to understand. You can also ask questions about anything you want to learn more about in this study.

You may take home an unsigned copy of the consent form for you to think about or discuss any of the contents with family or your friends before deciding to take part in this study.

If you agree to take part in this study, you will be required to sign your name or make a mark on the informed consent form. You will also be offered a copy to keep.

Introduction

Hello, my name is Nothando Sosibo. I am a student at the University of South Africa (UNISA). I am conducting this research as part of master's degree under the supervision of Dr Percyval Bayane (my supervisor) and would like to invite you to take part in this study. You have been selected to participate in this study because you are matching the characteristics of this study, which are experiences and attitude of young women with HIV in rural areas of Mtubatuba Municipality.

Voluntary participation

For you to participate in this study and to make an informed decision, I would like to explain the purpose, risks, and benefits, what is expected of you as well as what you can expect from me. It is up to you to decide if you would like to participate in this study and you may choose to leave this study at any time without providing a reason. Your participation in this study is voluntary.

Aim of the study

The aim of the study is to understand the attitudes and experiences young women aged 18 to 35 diagnosed with HIV in rural areas of Mtubatuba. The study seeks to gain insights of how these women deal with the changes after being diagnosed with HIV, support offered, and strategies used to live thereafter.

Research

I will be conducting semi-structured interviews and I will be using an interview guide that consists of open-ended questions about your experiences, and challenges that you have been facing after being diagnosed with HIV. The interview will be approximately 45 minutes long and will be conducted face to face. During the interviews, I will write down what you are saying and record you using a voice recorder. The voice recorder will be used to ensure that your words are exactly as you are saying them. The notes and the recordings will not contain your name or any other identifying information. The information and the recordings will be stored my computer, which will be password-protected, and the recordings will be destroyed after a period of five years.

What are my rights as a participant?

You are free to decide if you want to take part in this study and your participation is voluntary. You can refuse to participate, or you can choose to stop participating at any time without providing reasons.

Are there any risks or discomforts involved in the interview process?

If you decide to choose to participate in this study, you will be required to share your experiences and attitude after being diagnosed with HIV. The information you share may be sensitive and this may cause health issues such as trauma and therefore the researcher will use the services of the social worker from the Department of Social Development. The social worker will be on standby during the interview and available on the research site.

Are there any benefits to this study?

Participating in this study will not benefit you materially as there are no rewards offered for your participation. Your participation will contribute by adding to the literature in the higher education sector as there is little research that explores the attitudes and experiences young women aged 18 to 35 diagnosed with HIV in rural areas of

Mtubatuba. The study seeks to gain insights of how these women deal with the changes after being diagnosed with HIV, support offered, and strategies used to live thereafter.

Are there any costs to taking part in the interviews?

There will be no costs associated with face-to-face interviews as I will meet you at the clinic during your monthly clinic appointments.

Will I be paid?

You will not be paid for your participation in this study.

Will what I tell you remain confidential?

Confidentiality will be maintained in this study as information shared during the interview process will not be shared with anyone and will only be accessible to myself as well as my supervisor, Dr Percyval Bayane. You have a right to privacy and therefore your anonymity will also be maintained by using a pseudonym to protect your identity in this dissertation or any other academic publication.

Ethical approval

This study proposal has been submitted to the University of South Africa (UNISA) College of Human Sciences Research Ethics Committee.

Problems or questions

If you have any questions about this study, you can contact:

Researcher's contact details: Miss Nothando Sosibo
Email address: 46334122@mylife.unisa.ac.za
Telephone: 074 405 2628

Supervisor contact details: Dr Percyval Bayane
Email address: bayanp@unisa.ac.za
Telephone: 012 429 6577

College Research Ethics Committee (CHS) Integrity Officer: Prof. Janice Moodley
Email address: moodljk@unisa.ac.za

Appendix B: Informed Consent Form

I hereby confirm that I have been informed about my involvement in this research and further consent to the following:

- I have received, read, and understood the contents of the information sheet regarding this study.
- I am aware and understand that what I say will be written down and/or recorded for the purposes of this research.
- I consent that data collected during this study will be processed in a protected manner.
- I am aware that I may at any stage, without prejudice, rightfully withdraw my consent and participation without providing a reason.
- Sufficient opportunity has been provided to me to ask questions and I, of my own free will, declare that I am ready to participate in this study.

Signatures:

I have read this consent form, and all my questions and concerns have been answered to my satisfaction. My signature below confirms that:

□ I agree to participate in this study.

Signature of participant:

Signature: ____________________ Date: _______________

□ I do consent and give the research staff permission to sign on my behalf of my voluntary participation in this study.

Researcher signature: ________________ Date: _______________

Appendix C: Consent Form: Audio-Recording

I hereby confirm that I have been informed about my involvement in this research and further consent to the following:

Permission to audio-record:

My signature below confirms the following:

□ I do not give the research staff permission to audio-record my interview.
□ I give the research staff permission to audio-record my interview.

Participant signature:

Signature: ______________________ Date: ______________

Appendix D: Permission Letter to the Department of Health

KwaZulu-Natal Department of Health (KZN)
Hlabisa Hospital
P/Bag X5001,
Hlabisa
3937

Dear Sir/Madam

Re: Request permission to conduct research: Student number: 46334122

I Ms. Nothando Sosibo, hereby ask for a permission to conduct a research study in Mpukunyoni Clinic. I am currently working for the Department of Social Development –UMkhanyakude District stationed at Mzondeni Community Care Organisation as a Social Worker. I'm studying towards a Master's degree in Social Behavioural Studies in HIV and Aids with Unisa under the supervision of Dr. Percyval Bayane, Lecturer Department of Sociology, UNISA.

My study is entitled "Life after being Diagnosed With HIV/AIDS: Exploring the Experiences Young Women Aged 18-35 Diagnosed With HIV/AIDS in Mtubatuba Municipality in uMkhanyakude District, KwaZulu-Natal Province"

I will be interviewing 15 women living with HIV who are on ARV treatment at Mpukunyoni Clinic. I am enclosing my copy of the research proposal. I will appreciate your timeous responses as your permission is one of the requirements for ethical approval of my proposal.

It is hoped that the information to be gained from this research will help to understand the experiences young women aged 18-35 diagnosed with HIV/AIDS in rural areas of Mtubatuba. The study seeks to gain insights of how these women deal with the changes after being diagnosed with HIV, support offered, and strategies used to live thereafter. There is no anticipated risk to the study and participants can withdraw any time if they wish to do so without any obligation.

Should you require any further information about any aspects of this request or the study, please contact me on 0744052628 or 46334122@mylife.unisa.ac.za.

My supervisor, Dr. Percyval Bayane may be contacted on 012 429 6577 or email address: bayanp@unisa.ac.za

Kind Regards,
Ms. Nothando Sosibo

Appendix E: Permission Letter to Mpukunyoni Clinic

Request permission to conduct research in Mpukunyoni Clinic

Department of Health
The Clinic Manager
Mpukunyoni Clinic
Mtubatuba
3935

Dear Madam

Re: Request permission to conduct research: Student number: 46334122

I, Ms. Nothando Sosibo, hereby ask for a permission to conduct a research study in Mpukunyoni Clinic. I am currently working for the Department of Social Development –Umkhanyakude District stationed at Mzondeni Community Care Organisation as a Social Worker. I'm studying towards a Master's degree in Social Behavioural Studies in HIV and Aids with UNISA under the supervision of Dr. Percyval Bayane.

My study is entitled "Life After Being Diagnosed With HIV: Exploring the Attitudes and Experiences of Young Women Aged 18-35 Diagnosed With HIV in Mtubatuba Municipality in uMkhanyakude District, KwaZulu-Natal Province".

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It is hoped that the information to be gained from this research will help to understand the attitudes and experiences of young women aged 18-35 diagnosed with HIV in rural areas of Mtubatuba. The study seeks to gain insights of how these women deal with the changes after being diagnosed with HIV, support offered, and strategies used to live thereafter. There is no anticipated risk to the study and participants can withdraw any time if they wish to do so without any obligation.

Should you require any further information about any aspects of this request or the study, please contact me on 0744052628 or 46334122@mylife.unisa.ac.za.

My supervisor, Dr. Percyval Bayane may be contacted on 012 429 6577 or email address: bayanp@unisa.ac.za

Kind Regards,
Ms. Nothando Sosibo

Appendix F: Letter to the Counsellor

Department of Social Development
The Social Worker
KwaMsane Service Office
Mtubatuba
3935

Dear Madam

Re: Requesting the services of the Social Worker: Student number: 46334122

I Ms. Nothando Sosibo, hereby ask for the services of the Social Worker as I will be conducting a research study in Mpukunyoni Clinic situated in Nkodibe area (ward 13). I would like you to be on standby during the interviews and available on the research site. I will be in need of your services because the information the participants might share may be sensitive and this may cause health issues such as trauma. You will provide counselling should the need arises.

I am currently working for the Department of Social Development –Umkhanyakude District stationed at Mzondeni Community Care Organisation as a Social Worker. I'm studying towards a Master's degree in Social Behavioural Studies in HIV and Aids with UNISA under the supervision of Dr. Percyval Bayane.

My study is entitled "Life After Being Diagnosed With HIV: Exploring the Attitudes and Experiences Young Women Aged 18-35 Diagnosed With HIV in Mtubatuba Municipality in uMkhanyakude District, KwaZulu-Natal Province"

I will be interviewing 15 women living with HIV who are on ARV treatment at Mpukunyoni Clinic. I am enclosing my copy of the research proposal. I will appreciate your timeous responses as it is one of the requirements for ethical approval of my proposal.

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changes after being diagnosed with HIV, support offered, and strategies used to live thereafter. There is no anticipated risk to the study and participants can withdraw any time if they wish to do so without any obligation.

Should you require any further information about any aspects of this request or the study, please contact me on 0744052628 or 46334122@mylife.unisa.ac.za.

My supervisor, Dr. Percyval Bayane, may be contacted on 012 429 6577 or email address: bayanp@unisa.ac.za

Kind Regards,
Ms. Nothando Sosibo

Appendix G: Copy of Ethics Certificate

College of Human Sciences_CREC

Date: 06/08/2024

Dear: Ms Nothando Sosibo

Decision: Ethics Approval from 06 August 2024 to 05 August 2025

NHREC Registration # : (Rec-240816-052)
Ref #: 3816
Name: Ms Nothando Sosibo
Student #: 46334122
Staff #:

Researcher: Ms Nothando Sosibo

Ngqopheni area, next to Mpukunyoni Clinic, Mtubatuba, 3935

Mtubatuba

46334122@mylife.unisa.ac.za 0744052628

Supervisor: Mr PERCYVAL BAYANE bayanp@unisa.ac.za

"Life after Being Diagnosed with HIV/AIDS": Exploring the Experiences of Young Women Aged 18-35 Diagnosed with HIV/AIDS in Mtubatuba Municipality, KwaZulu Natal.

Qualification: Master of Art in Social and Behavioural Studies (HIV/AIDS)

Thank you for the application for research ethics clearance by the College of Human Sciences_CREC for the above-mentioned research study Ethics approval is granted for one year.

The **high-risk application** was **reviewed** by the College of Human Sciences_CREC on **06 August 2024** in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College of Human Sciences_CREC.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.

5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act

Page 1 of 2

Appendix H: Permission Letter From the Department of Health

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Physical Address: 60, [illegible] street, Hlabisa
Postal Address: Private Bag X5001, Hlabisa 3937
Tel: (035) 838 0321 Email: martin.tshipuk@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:
MEDICAL

Date: 18 September 2024

Ms. Nothando Sosibo (46334122)
Ngqopheni Area
Mtubatuba
3935

Dear Ms. **Nothando Sosibo**

PERMISSION TO CONDUCT RESEARCH STUDY IN HLABISA HOSPITAL DISTRICT – MPUKUNYONI CLINIC

I have pleasure in informing you that permission has been granted to you by Hlabisa Hospital to conduct your research study titled "**LIFE AFTER BEING DIAGNOSED WITH HIV/AIDS: EXPLORING THE EXPERIENCES YOUNG WOMEN AGED 18 – 35 DIAGNOSED WITH HIV/AIDS IN MTUBATUBA MUNICIPALITY IN UMKHANYAKUDE DISTRICT, KWAZULU-NATAL PROVINCE**".

Please note the following:

1. Please ensure that you adhere to all the policies, procedure, protocols and guidelines of the Department of Health with regards to this research.
2. Please ensure this office is informed before you commence your research.
3. Hlabisa Hospital will not provide any resources for this research.
4. You will be expected to provide feedback on your findings to Hlabisa Hospital.
5. You are required to contact this office regarding dates for providing feedback when the research has been completed.

Thanking you.

Sincerely

Dr Martin Tshipuk
Medical Manager – Hlabisa Hospital

Date

GROWING KWAZULU-NATAL TOGETHER

Appendix I: Letter From the Councilor

KWAZULU-NATAL PROVINCE
SOCIAL DEVELOPMENT
REPUBLIC OF SOUTH AFRICA

DIRECTORATE: SOCIAL SERVICES

UBOMBO SERVICE OFFICE
Private Bag X834
Ubombo
3970

AGREEING TO ASSIST WITH COUNSELLING PROCESS DURING DATA COLLECTION

I Bonisiwe Pretty Gumede with Registration Number: 10-34224, as a Registered Social Worker I agree to assist with Counselling process during Data Collection. I will be assisting Ms Nothando Sosibo (Student Number: 46334122) who is pursuing her Masters Degree at UNISA.

The title of her Research Study is "Life after being diagnosed with HIV/AIDS": Experiences of Young Women Aged 18-35 diagnosed with HIV/ AIDS in Mtubatuba Municipality, Kwa-Zulu Natal Province.

Date:
24/05/2024

Signature: ________

Appendix J: Interview Guide (English)

Section A

1. Demographic questions

1.1 How old are you?

1.2 Where do you currently live?

1.3 What is your marital status?

- If you are married, do you live with your spouse?

1.4 What is your highest educational level?

1.5 Are you currently employed?

Section B

2. Interview lead questions

2.1 When and how did you find out that you are HIV positive?

2.2 Tell me what it meant to you when you discovered you had HIV.

- How did you react to finding out you were HIV positive and what emotions came up to you?

2.3 Did you tell any other people about the results you learned? If so what, what were the reaction of the people you told?

- Were you able to disclose your HIV status to your partner? If yes, how did your partner handle the news you shared?
- Have you told your family and how did they perceive it?

2.4 After being diagnosed with HIV, did you feel free to talk about your HIV status around people or in the community?

- If yes, please explain what motivated you.
- If no, please explain why you were not free to talk about your HIV status.

2.5 How are HIV and AIDS seen in your community?

- Do people make remarks in your presence that indicate that they are aware of your HIV status? If so, what kind of remarks?
- How do these remarks make you feel?

2.6 Tell me about the problems you encounter since you have been diagnosed with HIV. How you handle them?

2.7 I would like to find out if you are in a romantic relationship. If yes, how has your sex life been affected after being diagnosed with HIV?

2.8 Have you ever engaged in alcohol or drugs since you learned about your HIV status? If yes, please explain why.

2.9 Have you experienced any fear of going to the clinic to collect your medication because of what people might say?

- If yes, how did you overcome that experience?

2.10 Overall, how does your condition impact your family?

- How does it impact your partner and friendships?

2.11 Please tell me about your relationship with your clinic or healthcare provider. How do they handle the issue of confidentiality or privacy?

- How do the clinic staff treat you? Do you feel free to share your problems with them? If no, please explain.

2.12 Do you adhere to your treatment as recommended by your healthcare provider? If no, please explain.

- If yes, please explain what motivates you to adhere to your treatment.

2.13 What are some of the things that help you remember to keep your HIV-related appointments?

2.14 What are some of the difficulties that you encounter in keeping your appointments?

2.15 What are some of the coping strategies you use in order to deal with your HIV diagnosis?

- How do those strategies help you deal with your HIV status?

2.16 Are there any other support services or programmes available for people with HIV in Mtubatuba that you attend?

- If yes, what have you experienced in using them?
- Is there any improvement in terms of changing your lifestyle?

2.17 Would you like to add anything else?

Appendix K: Interview Guide (IsiZulu)

<u>Isahluko A</u>

1. Demographic questions

1.1 Mingaki iminyaka yakho yokuzalwa?

1.2 Uhlala kuphi njengamanje?

1.3 Ngabe ushadile yini?

- Uma ushadile ngabe uhlala naye yini umyeni wakho?

1.4 Ugcine kuliphi ibanga esikoleni?

1.5 Uyasebenza yini?

<u>Isahluko B</u>

2. Interview lead questions

2.1 Kwakunini futhi wathola kanjani ukuthi unesandulela ngculazi?

2.2 Awungitshele, kwasho ukuthini kuwe mhla uthola ukuthi unesandulela ngculazi?

- Wazizwa kanjani futhi imuphi umuzwa owakufikela ngenkathi uthola ukuthi unesandulela ngculazi?

2.3 Kukhona yini abantu owabatshela ngemiphumela yakho yokuba nesandulela ngculazi? Uma bekhona owabatshela ngabe bona bazizwa kanjani ngalokho?

- Ngabe wakwazi ukutshela umlingani wakho ngemiphumela yakho yokuthi unesandulela ngculazi? Uma kunjalo umlingani wakho usamukele kanjani isimo sakho?
- Umndeni wakho wona ngabe wawazisa ukuthi unesandulela ngculazi? Uma kunjalo basamukele kanjani isimo sakho sokuba nesandulela ngculazi?

2.4 Ngemuva kokuthola ukuthi unesandulela ngculazi ngabe wakwazi yini ukukhuluma ngokukhululeka ngesimo sakho sokuba nesandulela ngculazi phakathi kwabantu noma emphakathini?

- Uma uthi yebo, ngabe yini eyayikugqugquzela?
- Uma uthi cha, ngabe yini eyayikwenza noma ekwenza ungakhululeki ukukhuluma ngesimo sakho emphakathini?

2.5 Ngabe umphakathi ophila kuwo uzizwa kanjani noma usibheka kanjani isifo sesandulela ngculazi kanye nengculazi uqobo?

- Ngabe abantu emphakathini bakhuluma izinkulumo ezingezinhle, ezikugconayo ezikhombisa ukuthi bayazi ukuthi unesandulela ngculazi? Uma kunjalo, zithini lezo zinkulumo?
- Zikuphatha kanjani lezozinkulumo?

2.6 Awungitshele ngezinkinga obhekana nazo njengoba uphila nesifo sesandulela ngculazi? Ubhekana kanjani nazo lezo zinkinga?

2.7 Bengifisa ukwazi ukuthi ngabe bukhona yini ubudlelwano bezothando okubo. Uma bukhona ngabe ukuthola kwakho ukuthi unesandulela ngculazi kwayiphazamisa kanjani impilo yakho yezocansi?

2.8 Uke wazibandakanya yini ophuzweni oludakayo noma ezidakamizweni selokhu wathola ukuthi unesandulela ngculazi? Uma uthi yebo ngabe yini imbangela?

2.9 Uke waba sesimeni lapho ufikelwa ukwesaba kokuya emtholampilo uyolanda imishanguzo yakho ngenxa yokusaba ukuthi abantu bazothini?

- Uma uthi yebo, ngabe wamelana kanjani naleso simo?

2.10 Kukho konke ngabe isimo sakho sokuba nesandulela ngculazi siwuphazamisa kanjani umndeni wakho?

- Umlingani wakho nobungani khona kuphazamisa kankakanani?

2.11 Ngicela ungazise ngobudlelwane bakho nomtholampilo wakho ukuthi ngabe bazisingatha kanjani izimfihlo?

- Ngabe abasebenzi basemtholampilo bakuphatha kanjani? Ngabe uzizwa ukhululekile ukukhuluma ngezinkinga zakho nabo? Uma kungenjalo ngicela uchaze?

2.12 Ngabe imishanguzo yakho uyithatha ngendlela oyalelwe ngayo emtholampilo na?

- Uma kunjalo ngicela ungazise ukuthi yini ekugqugquzelayo?

2.13 Ngabe yiziphi ezinye zezinto ezenza ukhumbule ukuthi kufanele uye emtholampilo?

2.14 Ngabe yiziphi izingqinamba obhekana nazo ukuze ugcine izikhathi zokuya emtholampilo?

2.15 Ngabe imaphi amasu owasebenzisayo akusiza ekutheni umelane nesifo sesandulela ngculazi?

- Ngabe lawomasu akusiza kanjani ukumelana nesandulela ngculazi?

2.16 Ngabe zikhona yini izinhlelo ezenzelwe ukusiza abantu abanesandulela ngculazi ozivakashelayo eMtubatuba?

- Uma zikhona ngabe zikukhaliphise kanjani ukuthi umelane nesifo sesandulela ngculazi?
- Ngabe ukhona yini umehluko eziwenzile empilweni yakho?

2.17 Ngabe kukhona okunye obungafisa sikhulume ngakho?