Exploring the experiences of men living with the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome at Okhahlamba Local Municipality

by

Vuyisiwe Nxumalo

217066864

Supervisor

Prof. N. M Mazibuko

Submitted in fulfilment of the requirements for the degree of Master of Social Sciences in Social Work in the School of Applied Human Sciences in the College of Humanities University of KwaZulu-Natal, Howard College, Durban.

October 2023

DECLARATION

I, Vuyisiwe Nxumalo, declare that this research dissertation is my own original work.

I have acknowledged in this dissertation all citations and references of other persons' writings and data.

Verbatim comments found in other people's work were put into quotation marks; and in some cases they were rewritten and referenced.

This work has not previously been submitted to any university or institution of higher learning for any qualification or certificate.

[redacted]

Vuyisiwe Nxumalo

217066864

____

Prof. N. M Mazibuko

[redacted]

DATE 11 March 2024

DEDICATION

This dissertation is dedicated to the participants in this study and to all men across South Africa living with HIV/AIDS who have continued to live their lives with their heads held high despite the stigmatisation that still comes with an HIV positive status − to all men who continue to take the ARV treatment and who care for their health and that of their intimate partners. This dissertation is also dedicated to everyone who has either been infected or affected by HIV/AIDS.

Lastly, this dissertation is dedicated to every individual who has shown me support in the process of my studies. Thank you for your support, for believing in me, and for your words of encouragement.

ACKNOWLEDGMENTS

Firstly, I thank God Almighty for keeping me thus far; for the wisdom, bravery and strength to begin this journey, and to see it through: despite all the challenges and hardships, He has kept me moving forward with my head held high.

My profound gratitude goes to my grandparents, Mr. Siphiwe Mazibuko and Mrs. Sithembile Mazibuko, my father, Mr. Samuel Nxumalo, his fiancée, Miss Gcinile Dlamini, and to the family at large, Ngiyabonga boMgabhi noZwide!

My love and appreciation goes to my daughter, Simnikiwe Kamvalethu Zesuliwe Nxumalo. You give me drive and a purpose to be the best version of myself.

Thank you to my participants, for allowing me into their personal spaces; and for giving me their time and a part of themselves. Your dedication and willingness to be a part of my study have played a vital role in my academic journey.

My sincerest appreciation goes to my supervisor, Prof. N. M. Mazibuko. Thank you for being my guide and support. For your time dedicated to helping me in this journey and wisdom imparted. May you continue to make a remarkable impact and contribution to the department, the field of academia, and to society at large. God bless you, Phuthini!

Much appreciation goes to Mr. Michael Nthlokwa, Miss Senamile Zungu, Mr. Bukhosi Ngwenya and Mr. Sicelo Mlambo, who have shown me enormous support and have never grown weary.

Finally, I would like to express my appreciation to my friends I will eternally be grateful to everyone. May God bless you all.

ABSTRACT

Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) has been a part of the world since 1981 when first its discovery was made. It can be argued that the virus has become a normal part of human life; however, is this argument valid in this day and age? This research study explored the experiences of men living with HIV/AIDS, paying particular attention to reasons that led to their HIV testing, disclosure of HIV status, the possible stigmatisation and marginalisation or positive response encountered; the social, emotional, or economic challenges met, and the coping mechanisms adopted post HIV-positive diagnosis.

This study aimed to explore the experiences of men in Okhahlamba Local Municipality living with HIV/AIDS. Social constructionism and the ecosystems theory were adopted as theoretical frameworks to help understand and to reach the intended aim of the study. A non-probability sample of fifteen men living with HIV/AIDS was selected by using purposive sampling for data collection. This study was a qualitative study − it employed the interpretive paradigm and an exploratory design. The data was collected using semi-structured interviews. The most apposite themes were identified and analysed using thematic analysis.

The study revealed that the reaction of males to their seropositive status is similar to that of females; furthermore, the study noted that rejection and fear of stigmatisation results in delayed disclosure of HIV-positive status. Additionally, the study supported studies that alluded to a relationship between trust and disclosure. Conclusions and recommendations were drawn based on data collected from the study which show that there is still a need for increased HIV/AIDS education, consistent development of the skills of counsellors, and implementation of a multisectoral response to the HIV/AIDS pandemic.

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

TABLE OF CONTENTS

Chapter One

1. Contextual and Theoretical Framework of the Study

Chapter Two

2. Literature Review………………………………………………………..

Chapter Three

3. Methodology

Chapter Four

4. Data analysis and Findings

Chapter Five

5. Conclusions

ABBREVIATIONS

HIV - Human Immunodeficiency Virus

AIDS - Acquired Immunodeficiency Syndrome

DESA- Department of Economic and Social Affairs

PLWHA- People living with HIV/AIDS

TB- Tuberculosis

OLM- Okhahlamba Local Municipality

KZN- KwaZulu-Natal

SA- South Africa

UN- United Nations

DEFINITION OF TERMS

Human Immunodeficiency Virus- a retrovirus which causes AIDS:

Acquired Immunodeficiency Syndrome - the late stage of HIV infection that occurs when the body's immune system is badly damaged because of the virus.

Department of Economic and Social Affairs - is part of the United Nations Secretariat and is responsible for the follow-up to major United Nations Summits and Conferences

People Living With HIV/AIDS- individuals or groups of people who are infected with HIV/AIDS

Okhahlamba Local Municipality- a local municipality, under uThukela, in KwaZulu-Natal

KwaZulu-Natal- a province within South Africa

South Africa- a country located in the southern part of the African continent

United Nations- an international organization whose stated purposes are to maintain international peace and security, develop friendly relations among nations

CHAPTER ONE

1.1 INTRODUCTION

For years society has played and continues to this day to play a vital role in the construction of gender roles. Most importantly, one is aware that society constructs certain behaviours and norms. Masculinity may be associated with risky sexual behaviour; as a result, spreading the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS). At the heart of masculinity construction among men in African communities, is that one should have multiple sexual partners in order to prove the ability of optimum sexual performance (stamina); and to provide as a man (financial strength). These norms, such as engaging with a number of sexual partners, may have over the years put men at higher risk of contracting HIV; and possibly unintentionally, spreading the virus through the pressure received from peers and in their surroundings to have unprotected sex with multiple sexual partners. This may have been the cause of the rise of other social problems such as unwanted pregnancies and the number of children who grow up with absent fathers. According to Statistics SA (2017), a shocking 61.8% of children under the age of 18 live without their fathers. Reasons for this rate differ, with 10.1% of these fathers reported as deceased; while 51.7% are reported to be alive, however, not actively participating in their children's lives.

The researcher will, in this chapter, comprehensively present the following: background of the current study, problem statement, rationale of the study, and the aim and objectives of the study. The above will then be followed by the research questions that steered the study, the theoretical framework employed in this study, the definition of terms used in the study, and the structure of the dissertation.

1.2 BACKGROUND OF THE STUDY

Men are groomed from a relatively young age to be providers for their families and in their societal role to possess traits such as independence, bravery, and strength. In a United Nations (UN) report (2011) by the Department of Economic and Social Affairs (DESA), gender roles as per the study were verified; and it is noted that men are generally expected to be providers and breadwinners, while women and girls are generally expected to nurture, provide care, and be responsible for reproductive aspects of family life.

At the beginning of 2020, South Africa (SA) was hit by the COVID-19 pandemic simultaneously with other parts of the world. The pandemic resulted in the disruption of the lives of individuals of all ages. There were negative effects on business leading to the closure, fear, and chaos within government sectors such as the health department which was at the forefront of the pandemic. Findings by Finfind (2020) showed that of the 15 000 small, medium, and micro enterprises sampled, a high 42.7% of businesses closed due to the Covid-19 pandemic. Through the closure of businesses heads of households lost their jobs, leading to loss of income and ability to provide for their families.

Statistics SA (2020) reported that during the Covid-19 period the unemployment rate stood at a high of 32.5% in the October – December quarter. Such meant that approximately 7.2 million people were unemployed, a rise from the 30.8% rate reported in the previous quarter. This was also within the Covid-19 era of June-September. Okhahlamba Local Municipality (OLM) alone recorded an appalling 52.3% unemployment rate in the year 2011 (Okhahlamba IDP, 2021). A UN report

(2011) by the DESA illustrates that the unemployment of a man leads to a sense of failure in their role as providers, although powerless in preventing their unemployment.

According to Ab Aziz, Tengu Ismail, Ibrahim, Yaacon and Mohd Said (2022), men are less likely to seek assistance with health-related issues; which authors further add translates to inadequate health services. Researchers state that men delay preventive health services use due to traditional masculinity social constructs. Such include extreme self-reliance and stoicism in relation to healthcare services Ad Aziz et al. (2022). Furthermore, these researchers suggest that the low level of men's engagement in health-services seeking is influenced by many factors including the health-service system not being tailored for men. This raises concern on the level to which men are careful about their health.

Culturally, men are not only groomed to be providers but are also encouraged to explore and engage in sexual activities with multiple sexual partners to prove manhood. Cosma and Gurevich (2020) revealed that for men in their study, sex with women was described as a rite of passage; and a required hurdle to overcome in maintaining masculinity. When men do not engage in sex or have fewer sexual experiences, they are at risk of being marginalised and labelled disapprovingly (Mfecane, 2008). This trend may have evolved over the years in other parts of South Africa and the world; however, this was the noted attitude of men in general who reside within the Okhahlamba Local Municipality. The researcher was prompted to conduct research on the perspective of a sample of men within this municipality.

In light of the two noted 'vital' aspects in the construction of 'real' masculinity, the ability to provide and the ability to engage sexually with several women, what happens when there is a distraction and a man is unable to fulfil these set standards of masculinity, for instance when he is ill? Do men, therefore, become less masculine? What challenges do men encounter who are unable to fulfil their role as men? It is questions such as these that prompted the researcher to propose a study into the experiences of men living with HIV/AIDS within Okhahlamba local municipality. The OLM has a population of 135 123 people, females accounting for 71 403, and males for 63 729 (uThukela IDP, 2021/22). Through engaging with literature and by observation, the researcher noted the high stigmatisation by men nationally, and in this small town, associated with HIV/AIDS and any other illness, especially when experienced by men.

1.3 PROBLEM STATEMENT

The proposed study seeks to explore the experiences of men living with HIV/AIDS, the possible stigmatisation experienced, individuals' reasons for their HIV testing, how they may have had to de-construct society's construction, if any, of what masculinity is; and how living with chronic illness may or may not have constrained them from performing certain duties that are understood to be duties of men. Senyurek, Kavas, and Ulman (2021) note that people living with HIV/AIDS experience stigma from various sources, such as friends, family, co-workers, sexual partners, healthcare professionals, and institutions. People living with HIV/AIDS (PLWHA) are most likely compared with people with other chronic illnesses such as diabetes and high blood pressure. This is a much-needed study. Since the discovery of HIV in 1983, according to UNAIDS (2019), in 2018 South Africa alone recorded and reported about 240 000 new HIV infections; and about 71 000 South Africans died due to AIDS-related illnesses.

Furthermore, Avert (2019) records that South Africa is the largest and the most high-profile country in Africa and subsequently in the world, within the HIV epidemic. In 2018 the country had an estimated 7.7 million people living with HIV. Fear of an HIV-positive status disclosure occurrence continues to exist among people living with HIV/AIDS. People infected with the Human Immunodeficiency Virus experience fear the disclosure of their HIV status for divergent reasons, even 30 years post the first reported case of HIV/AIDS. Senyurek et al. (2021) comment in their study that PLWHA experience the fear of not being welcomed in healthcare facilities, of confronting the disease, and of being taken care of post-disclosure of diagnosis.

The infection rates at the municipality under study have been reported to be steady. According to the uThukela IDP (2021), in 2009, 46.6% of the population was living with HIV/AIDS in the uThukela district. This district includes the Okhahlamba Local Municipality. In 2013, the number of victims decreased to 40.0%; and remained steady yet high until 2020. Although the infection rate has remained steady, there is still a need for prevention programmes to be scrutinised for gaps in service. New programmes must be established to mitigate the spread and lead to a lower infection rate.

While there is vast literature on people living with HIV in South Africa, and on homosexual men living HIV internationally, there is limited literature on men living with HIV in South Africa and particularly in OLM. This study aims to fill this gap in literature by exploring the experiences of men living with HIV in Okhahlamba Local Municipality. Furthermore, this is intended to provoke an interest among researchers to explore this area of study. An exploration of this phenomenon might expose solutions to fill the gap that might exist in health care and support services for men living with HIV.

1.4 RESEARCH AIMS AND OBJECTIVES

1.4.1 Aim

This study aims to explore the experiences of men living with HIV/AIDS in Okhahlamba Local Municipality.

1.4.2 Objectives

- To establish the experiences of men living with HIV/AIDS in Okhahlamba Local municipality
- To find out the psycho-socio-economic experiences of men living with HIV/AIDS in Okhahlamba Local Municipality.
- To find out the adjustment and adaptation HIV-positive men have managed post-diagnosis.

1.5 RESEARCH QUESTIONS

- What have participants experienced (positive or negative) due to their HIV-positive status?
- What social, emotional, or economic challenges have participants experienced post-diagnosis?
- How have participants been coping with an HIV-positive status? What, if any adjustments have been made by participants?

1.6 RESEARCH METHODOLOGY

Chapter Three of this dissertation will deliver the comprehensive research methodology utilised in this study. The research approach, sampling method, data-collection and analysis tool utilised will be summarised.

1.6.1 Research approach

Gounder (2012), in his study, states that research methodology is a systematic way of solving a problem. The researcher notes that research methodology is defined as the study of methods by which knowledge is gained; and its aim is to make available a work plan for optimal research. This research study was of a qualitative nature, which employed the interpretive and exploratory design.

1.6.2 Sampling

The study utilised non-probability, purposive sampling. The study used a sample of fifteen (15) men living with HIV/AIDS. The table below illustrates a summary of the sample for this study.

Table 1.1 Summary of the Sample

SAMPLE	**SAMPLE AGE GROUP**	**METHOD OF SAMPLING**	**TOTAL**
Sample 1	**18- 25 years**	**Purposive sampling**	**07**
Sample 2	**26- 34 years**	**Purposive sampling**	**04**
Sample 3	**35- 40 years**	**Purposive sampling**	**04**
Total			**15**

This study made use of purposive sampling. Some 15 men were sampled from the population of men accessing healthcare services from Bergville Clinic in Okhahlamba Local Municipality. Participants in this study lived in different wards. Participants were selected based on their availability and willingness to participate in the study.

1.6.3 Data-collection and analysis

The researcher employed semi-structured interviews to collect data for the study. Myers (2009), as cited in Gounder (2012), notes that qualitative research is an in-depth study of social and cultural phenomena which focuses on text. The use of semi-structured interviews in particular for this study aided the researcher by guiding the interviews. Interviews also opened paths and allowed opportunities for new themes to emerge apart from the themes that were guided by the interview structure and research objectives.

Thirteen (13) interviews were contact interviews (face-to-face), and two (2) interviews were conducted telephonically at the participants' request. All interviews were administered individually for each of the 15 participants. The same interview structure was used for all participants.

Contact interviews were recorded using a voice-recording cellphone app which reduced the cost of conducting this study while also capturing the participants' responses in their original tone; such aided the researcher during the data-analysis phase. Telephonic interviews were transcribed during the interview because the interviews could not be recorded. The data collection in this study was analysed using the thematic data analysis.

1.7 THEORETICAL FRAMEWORK

The researcher found it fitting that the study employ two theories: the social constructionist and the ecosystems theories. These theories were most relevant in attempting to understand and reach the intended aim of the study. The ecosystems theory asserts that subsystems are interdependent and are interconnected in nature; while the social constructionism theory alludes to individuals' views being shaped by society and their environment. These two theories are most appropriate for this study in that they help to view someone in the context of their environment; therefore a change in one system causes or influences changes in the next system. The two selected theories proved therefore to be the most suitable and useful for this study as they allowed for the understanding of HIV/AIDS in relation to men by looking at social constructions and experiences of men living with HIV. Furthermore, this allowed for an understanding of these social constructs and the holistic effects of the HIV/AIDS pandemic using the ecosystems theory.

1.7.1 Social Constructionism Theory

As cited in Andrews (2012), Burr (1995) acknowledges the major influence of Berger and Luckmann in the development of the social constructionism theory. Berger and Luckmann (1966) argue that people are born into a sociocultural context with pre-existing norms. People therefore assume that everyone perceives their world in the same way. So it is for everybody within their sociocultural context. Berger and Luckmann (1991) view society as existing both as objective and subjective reality. The former stems from the interaction of people with their social world; equally, the social world influences the people. Andrews (2012) notes that Schwandt (2003) asserts that constructionists believe that knowledge and truth are created and not discovered by the mind. In short, the social constructionism theory holds that individuals' personal views and meanings are socially determined. This is to say that all individuals view the world and concepts such as HIV/AIDS as constructed by their social world.

Socialization occurs through engagement with significant others who facilitate the objective reality of society, rendering it meaningful; in this way, it is therefore internalised by individuals (Berger & Luckmann, 1991). Socialization is achieved through the medium of language. The use of language has helped men living with HIV to share their thoughts, experiences, and expectations, possibly leading to new constructions of ideas of masculinity. The use of the language of their choice, which was isiZulu, helped research participants articulate their narratives well and confidently. Participants assumed full ownership of their own stories, which they shared in their own tone and language. Ngcobo (2011) posits that it is through the use of language in social interaction, negotiations, and meaning regeneration that people living with HIV/AIDS (PLWHA) learn to accept and manage their illness.

It is also through the interaction of the members of a particular society that discrimination and stigmatisation of people living with HIV/AIDS is either constructed or destroyed. Thoughts and understanding that HIV/AIDS is attained only through promiscuous sexual behaviour; or that only a certain group of people such as gay men contract the virus, are constructed by social beings through interaction with one another. It is furthermore through social construction that ideas arise that HIV/AIDS is not a death sentence. Such will lead to PLWHA experiencing less stigmatisation and more support and encouragement by their society to lead healthier lives.

1.7.2 Ecosystems Theory

This study was constructed upon the ecosystems theory which asserts that subsystems are interdependent. The ecosystems theory was developed by Bronfenbrenner (1977:1979) who drew upon the prior work of Lewin. Lewin's theory proposed that human behaviour was a function of dynamic interaction between the social atmosphere and an individual's psychological encounter. Connolly & Harms (2011) maintain that this theory helps us to think about the interaction between people and their social and physical environments; furthermore, helping us to understand through the use of ecosystems theory how changes occurs.

The ecosystems theory emphasizes that human beings and their environment are interdependent and interconnected in all spheres. Therefore, should a disturbance occur in one system all other systems will subsequently be disturbed. Ecosystems are likened to a spider web − if one section of the web is interrupted that whole web shakes. For example, should a family's breadwinner fall ill and therefore be unable to work due to HIV/AIDS, the family will lose income. Subsequently, the company at which the person is employed will have lower production; as a result of the sick employee they will be short of an employee. Finally, the economy at large will suffer: the gross domestic product (GDP) will drop when production has been disrupted and the unemployment rate will rise. This theory, therefore, proves to be most suitable for a study of this nature as it assesses the problem at all levels of engagement − micro, mezzo and macro. Berk (2001:25) asserts that the ecosystems theory "views the person as developing within a complex system of relationships affected by multiple levels of the surrounding environment."

At the micro level, the study viewed men with a HIV-positive status, together with their families, while also including their surrounding primary societies. Ngcobo (2011) notes that a micro-systemic change takes place as soon as the individuals receive their HIV-positive diagnosis. Issues of disclosure of an HIV-positive status, and the overall change in the person's lifestyle are likely to have an impact on all other subsystems.

At this level, HIV-positive persons are likely to experience stigmatisation and discrimination by their communities due to the disclosure of their status or visible physical changes caused by the virus. This discrimination and stigma may have negative effects on the psychological health of not only the HIV-positive men, but also on that of their families and intimate partners. Ngcobo (2011) asserts that the open narration of experiences of being HIV-positive is still a taboo issue in many communities of South Africa.

On another aspect, the macro-system level refers to the policy formulations and changes implemented by the government, which in return impact the micro and mezzo systems. Ngcobo (2011) makes use of the KZN Local Economic Department HIV/AIDS Final Report to explain the impact of the HIV pandemic on the macro system, as conducted by Colvin, Du Toit, and Hadingham (2005:35):

"The vulnerability of women and the youth to poverty and their reliance on state-provided welfare will increase, whether through infection of themselves or that of family members. The Department of Social Development (DSD) predicts that the increasing number of people affected by HIV/AIDS will lead to continued growth in demand for state support." Ngcobo (2011) supports the aforementioned by asserting that the bidirectional link between HIV/AIDS and poverty implies that, although poverty causes an increase in the spread of HIV/AIDS, the disease itself also impoverishes affected households. This therefore leads to continuous need for state support for people living with chronic illnesses, including HIV/AIDS.

1.8 SIGNIFICANCE OF THE STUDY

The study is significant in addressing the gap in literature on the experiences of men living with HIV; the study will therefore add value to the social-work body of knowledge. It will enlighten the social workers on the psycho-social needs of HIV-positive men based on the narratives of the experiences of men living with HIV. The study will further highlight the strengths and coping mechanisms of men living with HIV, which will potentially serve as a guide when using the strengths perspective in responding to the needs of men living with HIV. The study will inform both knowledge of and the body of practice of future interventions when working with such a population. The study seeks to influence HIV/AIDS policies to cater particularly to the needs of men living with HIV/AIDS.

1.9 STRUCTURE OF THE DISSERTATION

The rest of the research report is structured in the following manner:

Chapter Two

This chapter delivers an in-depth review of literature on HIV/AIDS from both global and national perspectives. Special attention is given to literature on the impact and effect of the virus in relation to masculinity, HIV/AIDS testing, status disclosure, socio-economic factors, and policies and legislations relevant to this study.

Chapter Three

This chapter discusses the research design and the research methodology utilised to collect data for the purposes of answering the research questions and reaching the intended objectives of the study. The research methodology focuses on the sampling method, sampling size, sampling strategy, tools/techniques of the data-collection plan and model of enquiry − a thematic analysis. This chapter also comprehends the ethical considerations before and during the study; and furthermore, the limitations of the study are discussed.

Chapter Four

This chapter presents the findings of the study. Themes and sub-themes that emerged are discussed in relation to adopted theoretical frameworks and literature review.

Chapter Five

This chapter provides a summary of the entire study, with the conclusions, recommendations, and questions for future research.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter entails a review of literature that is supported by principles of the social construction theory and those of the ecosystems theory. This chapter will provide theoretical contributions to support the HIV/AIDS phenomenon in relation to men.

This chapter will follow this order of sequence and present findings and discussions with regard to HIV/AIDS both globally and nationally, HIV/AIDS and masculinity, men and HIV testing, men and HIV-status disclosure, HIV/AIDS and finances, and arguments about HIV/AIDS policies.

2.2 HIV/AIDS GLOBALLY AND NATIONALLY

The existence of the HIV/AIDS pandemic has caused panic, fear, and disruption in the lives of many people, both those infected by the virus and those close to the infected (the affected). HIV/AIDS holds the record for the longest-surviving virus, dating back to the first case of the HI virus in 1981 (Avert, 2010). While this virus is the longest-surviving virus, it has also cost many people their lives, with the first recorded HIV/AIDS-related deaths in South Africa occurring in late December 1981 and January 1982 (Simelela & Venter, 2014).

HIV, according to the World Health Organization (WHO) is an infection that attacks the body's immune system, particularly the white blood cells called CD4 cells. Health practitioners further emphasize that with CD4 cells destroyed, persons living with HIV become susceptible to opportunistic infections such as Tuberculosis. Later in the study, evidence will be presented that supports how HIV infected individuals susceptible to opportunistic infection.

The global summary of the AIDS epidemic report of 2009 confirmed that by the end of 2008, 33.3 million people were living with HIV. The report furthermore asserts that South Africa accounts for at least 5.6 million of the reported HIV/AIDS infections (UNAIDS, 2010). The number of people infected with HIV/AIDS in South Africa raises reasonable questions relating to its HIV/AIDS education and prevention strategies, with South Africa being ranked third-highest in HIV/AIDS in Africa (Elflein, 2023). Avert (2019) reports that South Africa has at least 7.5 million people living with the HIV/AIDS virus, which is a slight decline from 7.7 million people the previous year (2018).

In a survey conducted by the Human Sciences Research Council (2017), the province of KwaZulu-Natal held the highest percentage of HIV infections; with Black African females accounting for 20.6% of the infections and Black African males at 12.5%.

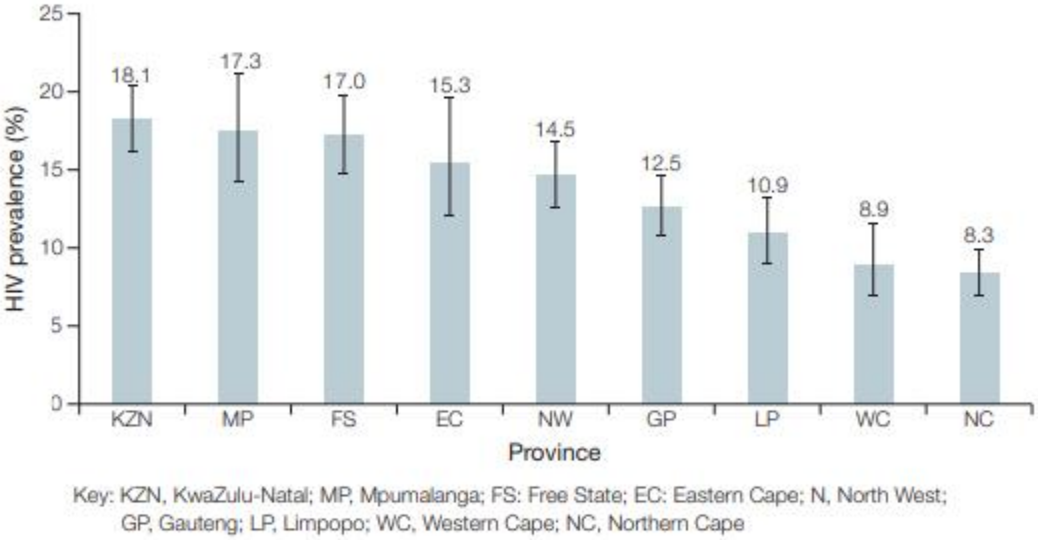


Figure 1. The prevalence of HIV across provinces in South Africa, 2017.

As South Africa holds the record for the biggest and most high-profile of HIV epidemics in the world, it furthermore accounts for a third of all new HIV infections in Southern Africa. (Avert 2019). This clearly illustrates a need for more rigid methods to curb the infection rate within the borders of South Africa. In sub-Saharan Africa, nearly 60% of people living with HIV are women (UNAIDS, 2008).

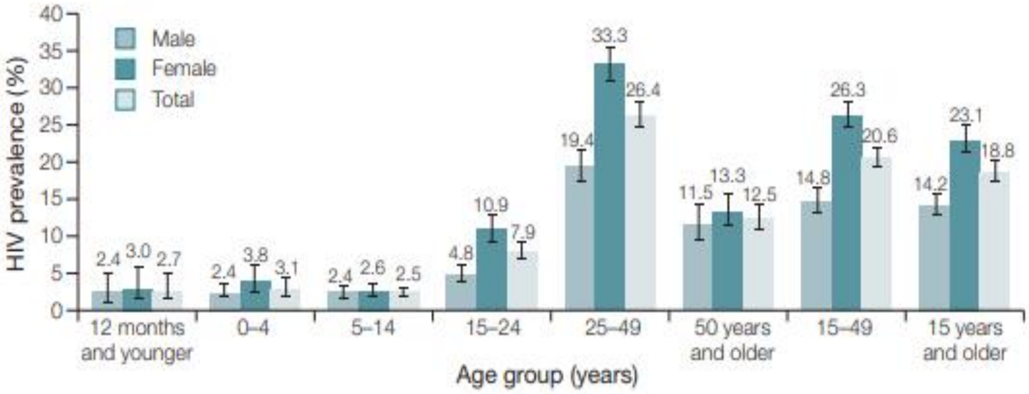


Figure 2. HIV prevalence by selected by age and sex, South Africa, 2017.

Relating to the above information, Lynch, Brouvard and Visser (2010) add that this has resulted in many debates around HIV and gender being focused on women. The researchers assert that women are vulnerable to infection not only due to physiological differences but also due to power imbalances in society. The high rate of female HIV/AIDS infection may be influenced by a number of factors including dependence on male counterparts/partners, therefore resulting in the inability to initiate safe-sex practices; and low rate of males utilizing HIV-testing services.

2.3 HIV/AIDS IN RELATION TO MASCULINITY

Lynch et al. (2010) note that theories of masculinity provide a framework to understand the responses and depictions of men in the HIV epidemic. Furthermore, Lindsay and Miescher (2003) propose that African masculinities in particular are heavily contested due to the varying influences of race, economic status, class, political history, and religion. Masculinity, particularly negative notions of masculinity such as portraying a “strong” and self-sustaining character that says “men who utilised health facilities are weak” or that “health care facilities are for women” perpetuate the spread of HIV/AIDS to their “weaker” counterparts (females). In contrast, Lynch et al. (2010) acknowledge the plurality of masculinities. However, these researchers argue that certain common practices contribute to the way in which men construct and reconstruct their masculinity in the sub-Saharan region; and South Africa in particular, can be identified.

Skovdal, Campbell, Madanhire, Mupambireyi, Nyamukapa & Gregson (2011) state that South African studies have focused on certain traits that men are expected to possess in certain cultural contexts, such as being tough, aggressive, physically strong, sexually unstoppable, and in competition with other men. Men often delay healthcare visits as this act may risk their loss of place as men who possess one of the ideal masculinity notions of being physically strong.

Research studies on masculinity in South Africa show that sex with women constitutes a significant portion of men’s masculine identities. (Leclerc-Madlala 2001: Hunter 2004; Mfecane 2008). Men, prior to an HIV/AIDS diagnosis, hold the dangerous view that their manhood is measured through the number of women they attain and engage with, sexually. This, in turn, increases men's chances of both infection or reinfection of other persons. Skovdal et al. (2011) maintain that health-risk behaviours, such as having unprotected sex and multiple sexual partners, may be directly associated with the notion of virility and assertion of masculinity.

"It has also been noted that by focusing on the position of women in the epidemic, the needs of men who are living with HIV are often overlooked." Lynch et al. (2010: 17). From literature it is evident that the manner in which healthcare facilities are modelled or positioned poses a challenge to men in accessing the services. In addition to social constructions of healthcare facilities being for females, facilities also are said to create an atmosphere that does not accommodate men, supporting these social constructs on healthcare facilities. Furthermore, Armstrong et al. (1999) as cited in Lynch (2010) add that men often find support structures such as clinics inaccessible. Clinics are mostly modelled on women's needs, which may be the reason men are less likely to seek health care. The literature apropos of HIV/AIDS and masculinity has painted a generally negative picture of masculinity and the impact of such an outlook on the lives of men (Shefer, Ratele, and Strebel, 2005).

In a previous study, men have expressed that their fear of using healthcare services stems from the idea of being less masculine in showing weakness and the stigma associated with living with HIV/AIDS (Mfecane 2008). Colmenro, Perez-Morente, Ramos-Morcillo, Callipa-Diaz, Ruzafa-Martinez & Hueso-Montoro (2019) assert that stigma is a negative element that limits individuals' adaptation to the disease; and creates difficulties in relationships with the population in general.

2.4 MEN AND HIV POSITIVE STATUS DISCLOSURE

Villar-Loubet, Bruscantini, Shikwane, Weiss, Peltzer & Jones (2013) note that, although disclosure potentially serves as an element in treatment engagement, such disclosure may be marred by stigma and rejection. While it is undeniable that disclosure serves as a pathway to healing and acceptance, the response of society may either encourage or discourage HIV-positive persons to disclose their status, through either meeting disclosure with support and empathy or by rejection and stigmatisation. Findings of a study conducted by Ngcobo (2011) revealed that HIV-infected women found it difficult to disclose their status to their intimate partners; and one of the reasons for this was their fear of being rejected by their partners.

Subsequently, a study conducted by Mfecane (2012) indicated that men's fear of losing their status as men was part of the reason for disclosure of status being delayed. Furthermore, Mfecane (2012:8) noted that the delay in disclosing HIV status was also "tied to the immediate fear of losing material and emotional support from an intimate partner and close relatives." The response of both men and women in relation to status disclosure appears to be parallel. In both of the above-mentioned studies conducted on two different groups similar results of people living with HIV were yielded, people not disclosing or delaying disclosure of HIV-positive status for fear of rejection by their intimate partners on whom they depend. "The positive effects of disclosure, such as facilitating entry into care, may also be overshadowed by Intimate Partner Violence (IPV), abandonment, rejection by loved ones and social discrimination." Peltzer and Mlambo (2013).

Ngcobo (2011), in her study found that for fear of stigma some chose to conceal their status for as long as possible. They feared being labelled undesirable; while some chose to lie and render a false diagnosis (such as cancer) in order to be accepted as 'normal' by their peers. Viller-Loubet et al. (2013) found in their study that men were apprehensive to disclose for the fear of their partners' reaction (i.e., being hurt, holding a grudge, confiding in other women). To an extent, HIV disclosure was perceived as emotionally cleansing, healing, and somewhat liberating. PLWHA who chose not to disclose their HIV-positive status have included fear of rejection, stigmatisation, marginalisation or loss of partner among other reasons for non-disclosure.

On the contrary, a study by Villar-Loubet et al. (2013) revealed that women asserted that if a partner did not disclose his status, they would leave the relationship for fear that he tested positive. This reiterates that there is indeed a kinship between trust and disclosure. Failure to disclose a seropositive status indirectly meant a lack of trust, and in other ways, a lack of love. Peltzer and Mlambo (2013) note that there is a relationship between disclosure and trust. Partners who trust each other are more likely to disclose their HIV-positive status as opposed to those who do not trust their partners.

Mindry, Maman, Chirowodza, Muravha, Van Rooyen & Coates (2011) state that self-disclosure of HIV-serostatus may be stressful and risky due to potential ramifications such as loss of financial and emotional support. While the fear of potential negative consequences of disclosure by HIV-positive persons is understandable, this does not remove the importance of status disclosure, especially to sexual partners. Such disclosure may propel partners to adopt safer sex practices to avoid reinfection or to facilitate treatment initiation if already infected. Peltzer & Mlambo (2013) assert in support of the aforementioned statement that disclosure could result in the adoption of preventative behaviours by partners. Disclosure by an HIV-positive partner also encouraged the other partner to seek HIV testing services.

2.5 HIV/AIDS IN RELATION TO SOCIO-ECONOMIC FACTORS

According to the White Paper on Social Welfare (1997: 88), HIV/AIDS leads to the financial vulnerability of individuals and families, who often lose their formal sector employment. Such can affect entire households if the person is the key breadwinner with dependants in rural areas and neighbouring countries. Financial vulnerability at the loss of employment may pose threats and disruption to ecosystems; and to other aspects of an individual and family lifestyle, including their social status and physical wellness due to possible change in diet and nutrition in attempting to adjust to unemployment.

UNAIDS (2014) reports that the people living with an HIV Stigma Index noted that PLWHA experience a three times higher rate of unemployment than the national unemployment rate. HIV-positive men who have families to provide for tend to struggle with acceptance of their health and financial status. Men who as a result of HIV have become ill, are disadvantaged, being unable to work, therefore unable to fulfil the financial and basic needs of their families. In the Free State province, Bachmann and Booysen (2003) found that the average income and expenditure of AIDS-affected households was 9% lower than those not affected by the pandemic.

The HIV/AIDS pandemic therefore exposes individuals and families infected and affected to greater chances of vulnerability than their unaffected peers. Ngcobo (2011) asserts that the bidirectional link between HIV/AIDS and poverty implies that, although poverty aggravates the spread of HIV/AIDS, the disease itself also impoverishes affected households. This therefore leads to a continuous need for state support for people living with chronic illnesses, including HIV/AIDS.

Men, due to the expectations of men being key providers for their families may in addition to the physical illness experience psychological distress. The inability to provide may potentially result in men suffering from mental-health issues not directly arising from the HIV/AIDS, but from the results of AIDS-related illnesses, leading to job loss.

2.6 RELATED POLICY ON HIV/AIDS

While Richardson et al. (2014) aver that globally, both gender and racial inequities play a significant role in perpetuating the HIV/AIDS pandemic, there are policies and legislation in place to help curb the spread of HIV/AIDS while protecting the rights and dignity of those living with HIV/AIDS.

2.6.1.1 National strategic plan for HIV/AIDS, TB and STI (2023-2028)

The above-mentioned policy aims at reducing the transmission of HIV/AIDS, while reducing barriers to and increasing access to treatment. The policy also aims at reducing inequities, stigmatisation, and discrimination against PLWHA. The policy recognises a need for mental health and social services; there is a strong link between biological illness, social ills and mental health. Furthermore, the policy aims to improve the quality of life of PLWHA beyond the suppression of HIV viral load, through the multi-sectoral partnerships in the implementation of the national strategic plan (NSP).

The goals of the NSP include the strengthening of community-led responses to HIV/AIDS, STIs and TB. This is achieved through community education and equipping communities with relevant information to place them at the forefront of the advocacy for preventive measures against HIV/AIDS, STIs and TB. The policy further aims to increase knowledge and behaviour that promote HIV prevention; and subsequently, to reduce the rate of new infections through implementing high HIV prevention programmes.

This policy is in place to ensure that there is equitable access to HIV/AIDS, TB and STI services for all who reside in South Africa and are infected by the above-mentioned diseases. Through the expansion of research into HIV/AIDS, TB and STIs, the NSP intends to strengthen the national response to these diseases. The full and proper implementation of this strategic plan will reduce stigmatisation experienced by PLWHA which includes men living with HIV, and it will encourage men to actively utilize social services including social work services. The increase in HIV/AIDS knowledge through this strategy will encourage men living with HIV to adhere to their treatment plan and encourage other men living with HIV to make use HIV testing services and stick to their prescribed treatment plan. With increased knowledge of HIV within communities will give rise to the advocacy of HIV and prevention of the spread of HIV.

2.6.2.1 National Health Act 61 of 2003

This Act serves to protect PLWHA from discrimination based on their seropositive status. Under this Act the health records of PLWHA are protected. This Act therefore aims to maintain the confidentiality of PLWHA in order to protect them from discrimination. This Act further aims to ensure that healthcare services are accessible to all, irrespective of race, gender, sexuality, or HIV-status. The National Health Act aims to provide quality and equal distribution of health services through various initiatives such as mobile clinics, and even school and home visits in exceptional cases. This Act therefore ensures that all persons, including those living with HIV/AIDS and other chronic and communicable diseases, have access to equal and quality healthcare services by professionally trained personnel. Receiving quality healthcare services will encourage more men living with to seek health care services, because they are confident that their health records will be protected therefore their HIV status will be kept confidential unless they decide to disclose their HIV status voluntarily. Men living with HIV will have better access to health care services through this policy as it intends to distribute health services through initiatives such as mobile clinics. The distribution of health care services will help alleviate the financial burden associated travel costs to the clinic monthly or bi-monthly.

2.6.2.2 Occupational Health and Safety Act 85 of 1993

This Act sets out to protect those with chronic illness such as HIV/AIDS and TB from discrimination and unfair treatment, while also protecting those who are not infected through placing safety measures to minimize occupational exposure. This Act serves as a means of creating workplaces that are non-discriminatory against PLWHA or other chronic illnesses including communicable diseases. The Act serves as a guide on how employers and employees should deal with matters of HIV testing, confidentiality, and disclosure of seropositive results. Creating a safe and supportive working environment for PLWHA to ensure that they are able to work under normal conditions post diagnosis is an essential principle of this Act.

This policy protects PLWHA in the workplace from marginalisation and unfair treatment based on their HIV status. Furthermore, it ensures that HIV positive persons including men receive support in the workplace to aid in decrease stress related to HIV and increase productivity in the workplace. The full and consistent implementation of this legislation in various workplaces will help to decrease social isolation of PLWHA, protecting them from unfair treatment. The Act will thus help create a safe environment that will promote healthy lifestyle choices even in the workplace; and raise awareness and education on HIV/AIDS within employment areas.

2.7 CONCLUSION

Literature reviewed illustrates a need for more rigorous methods of lowering the infection rate in SA. The literature revealed that there is a link between negative masculinities such as having multiple sexual partners and self-sustaining characters that portray men who utilize healthcare facilities as weak, and the widespread nature of HIV/AIDS. Skovdat et al. (2011), in support of the above, state that health-risk behaviours may be directly associated with virility and the manner of affirming masculinity among men.

The chapter revealed that disclosure serves as a pathway for healing, acceptance, and treatment; however, disclosure may be met with stigma, discrimination, and rejection. Studies further revealed that fear of rejection and loss of financial and emotional support upon disclosure were causes of non-disclosure. In addition to this, literature revealed that there is a relationship between trust and status disclosure (Peltzer and Mlambo, 2013). The literature also revealed that disclosure of a seropositive status to an intimate partner encourages the partner to seek HIV-testing services.

HIV/AIDS, according to literature reviewed, exposes individuals and families infected and affected to greater chances of poverty and vulnerability than their uninfected counterparts. Ngcobo (2011) noted that there is a bidirectional link between HIV/AIDS and poverty; therefore, this leads to increased dependence on government.

The literature review unpacked the national strategic plan 2023- 2028 which is in place to reduce HIV/AIDS transmission and to reduce barriers to treatment access. The National Health Act 61 of 2003, in addition to the NSP, protects the rights of PLWHA and promotes maintaining of patients' records confidentially to protect them from any discrimination or stigmatisation. Furthermore, the Act seeks to ensure that PLWHA have access to quality healthcare services. The reviewed occupational Health and Safety Act seeks to protect PLWHA and those with TB and STIs from discrimination and isolation in the workplace. Furthermore, the Act serves to create a safe and supportive working environment for PLWHA and for those with other chronic and communicable diseases.

This chapter covered the literature on HIV/AIDS, disclosure of seropositive status and the socio-economic implications thereof. The chapter further addressed relevant policies and legislations put in place by the government as measures to combat HIV/AIDS and to curb its spread, while providing PLWHA with protection against unfair treatment, ameliorating inaccessible healthcare services and stigmatisation.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

This chapter is dedicated to providing a detailed discussion on the methodology used in this study. The research paradigm, design, and research approach of this study are discussed in this chapter. Furthermore, this chapter will discuss population and sampling methods, data-collection methods utilised, and data-management and analysis. Trustworthiness of the study, ethical clearance and limitations thereof will be discussed.

3.2 RESEARCH PARADIGM

This study adopted an interpretive paradigm. Orman (2016) argues that the research paradigm means more than a philosophical way of thinking. Kivunja & Kuyini (2017) note that this paradigm attempts to "get into the mind of the subjects being studied" and to understand and interpret what the subject is thinking or making of the context. The interpretive paradigm allowed the researcher to focus on understanding the experiences of men living with HIV from the subjective experiences of the participants of this study. "The main ideas on which this paradigm (interpretive) rests on are that people are fundamentally different from objects." (Du Plooy-Cilliers, 2014: 27). We cannot study human beings in the same way that we study objects in the natural sciences, because, unlike objects, human beings change all the time; and the environment in which they find themselves constantly influences them (Du Plooy-Cilliers, 2014). This paradigm allowed the researcher to explore how HIV has affected and changed the lives of the participants who live with HIV. The interpretive paradigm was the most suitable for the current study as it sought to acquire society's understanding of the explored phenomenon, with the assumption that the natural version of reality would be the one determined by society. The paradigm has allowed the researcher to insert herself into the minds of the participants, exploring with empathy their experiences of living with HIV/AIDS, therefore proving to be useful to the researcher.

3.3 RESEARCH DESIGN

Akhtar (2016) defined a research design as a structure of the research that is the “glue” holding together all the elements of a research project. The study has subscribed to the exploratory research design. The study being of a qualitative nature required an accurate and vivid depiction of the participants’ responses. The explorative research design helped the researcher to organize her research and ideas in such a way as to look for blunders and deficiencies (Akhtar, 2016). Furthermore, Akhtar (2016) mentions that research design helps the researcher to organize his or her ideas so as to increase the possibility of seeking for errors and shortages. This research design was suitable for the current study as it helped the researcher to provide an in-depth account of the experiences of men living with HIV in Okhahlamba Local Municipality.

3.4 RESEARCH APPROACH

Crossman (2018) states that a qualitative research approach allows for people to be studied in their natural settings; helping to interpret a phenomenon in terms of the connotation people ascribe to them. This study utilised the qualitative approach as the selected study method. Greeff (2002), as cited in Ngcobo (2011), states that the qualitative approach allows for the participant to share stories about both their past and present experiences. This research approach was most suitable as it allowed the participants to provide a well-articulated account of their experiences in their own words. The approach allowed the researcher to capture these experiences in their most natural form and tone for interpretation.

Rubin and Babbie (2013) expressed that the qualitative approach deals with the subjective data as perceived by the participant. Labane (2009), as cited in Maxhakana (2021), states that the qualitative research approach seeks to probe an individual’s emotional state and exposure to behaviours, their attitude included. This approach therefore allowed for flexible interaction between participants and the researcher.

3.5 POPULATION AND SAMPLING

The study has employed the non-probability sampling method. According to Engel and Schutt (2013), sampling refers to the process of selecting a sample to participate in the study; and a sample is defined as the subset of the population under study. Non-probability sampling denotes the cognizant selection of a specific group of the population that should have expertise or knowledge about a certain topic. Purposive sampling was employed by the researcher for the present study.

Robinson (2014) suggests that purposive sampling is generally understood as a judgement technique − an intentional selection of participants based on their ability to engage a specific theme, concept, or subject. This method is the most suitable: participants will be sampled as per their experiences of living with the HI virus. The participants were approached for the study from a database on PLWHA by Love Life and Bergville Clinic.

From a Database of 250 men living with HIV provided by the Bergville clinic, the database was of men who have been accessing their ARV treatment from Bergville Clinic for the past 10 years from the time this database was requested in September 2022. The researcher selected the men using a 1 out of every 15 men. The 15 selected men were contacted by researcher telephonic-ally to invite them to participate in the study. Of the 15 contacted, 5 men declined the invite request to participate in the study. The researcher started counting again from the last group in the previous selection, using the same system of 1 of 15 men.

Once a participant agreed to participate in the study, he would be given an opportunity to choose which method is more suitable for him between a contact and a telephonic interview, provide a date and time most convenient for him. Before interviews began each of the participants was given the informed consent form, together with the researcher the participant read through the informed consent form and participants were granted an opportunity to ask for clarification in the event that they did not understand some part(s) of the form. Once participants understood the contents of the informed consent form and signed it, interviews would proceed.

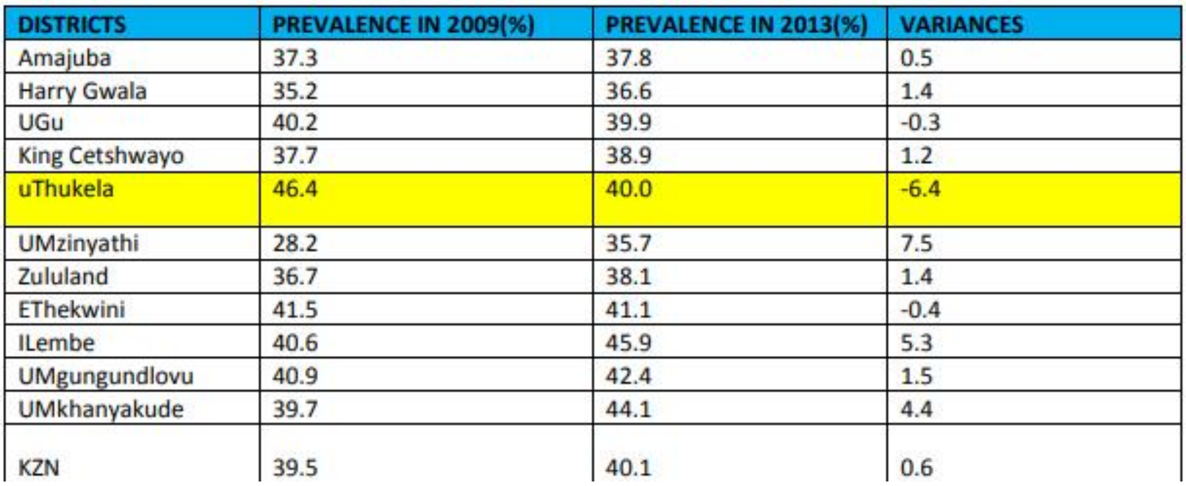
Contact (face-face) interviews were held at different locations as per request by participants request, venues were within participant's residential areas. For the safety of the researcher, she was accompanied by someone who remained in the car while the researcher conducted her interviews with participants. The interviews average duration was 40 minutes for all 15 interviews conducted.

Prior to the interviews, the researcher allowed the participants to take charge of the interview processes pre- interviews, by granting participants the freedom to give the researcher a suitable venue that will make them comfortable and safe, and a time that will be convenient for them so they are given time to prepare themselves for the interviews. These two methods helped minimize trauma as participants were emotionally and mentally prepared to touch on parts of their lives that are not easy to reflect upon and talk about. Furthermore, during the interviews the researcher would reaffirm participants to validate their experiences and feelings without making participant feel like victims or villains in their stories, however as the main characters of their lives so they can be comfortable with their current life as men living with HIV.

The study engaged a sample of 15 adult participants. The sample consisted of the following:

- 15 men living with HIV

The population for this study is men between the ages of 18 and 40 living with HIV/AIDS. The population selected was found at the Okhahlamba Local Municipality. The population was selected on the basis that they are residents of the Okhahlamba Local Municipality. The population under study takes in the number of people within the municipality who are living with HIV/AIDS. The population size of OLM in 2011 was 132 068 of which 11% (about 14 527 individuals) were PLWHA (Okhahlamba IDP, 2021).



DISTRICTS	PREVALENCE IN 2009(%)	PREVALENCE IN 2013(%)	VARIANCES
Amajuba	37.3	37.8	0.5
Harry Gwala	35.2	36.6	1.4
UGu	40.2	39.9	-0.3
King Cetshwayo	37.7	38.9	1.2
uThukela	46.4	40.0	-6.4
UMzinyathi	28.2	35.7	7.5
Zululand	36.7	38.1	1.4
EThekwini	41.5	41.1	-0.4
ILembe	40.6	45.9	5.3
UMgungundlovu	40.9	42.4	1.5
UMkhanyakude	39.7	44.1	4.4
KZN	39.5	40.1	0.6

Table 3.1. Source: uThukela Integrated Development Plan 2020/21

Okhahlamba Local Municipality, together with the Department of Health, both serve as the gatekeepers to this population. The researcher gained access to the population following obtaining permission from the gatekeepers of OLM, in the office of the mayor and the Department of Health, the department of health research and knowledge management to conduct research on this population. Participants were selected from the Bergville Clinic data base of males accessing their anti-retroviral treatment from the clinic. This was following delays in the launch of a support group by Love Life in conjunction with Bergville Clinic's HIV/AIDS support unit; which was the researcher's initial pool of potential participants.

The selection criteria for the male participants were men living within the Okhahlamba municipality, who have been given after diagnosis an HIV-positive status; and who were between the ages of 18 and 40 years at the period of this study. Males who were below 18 and showed an interest in the study at the start of the data-collection phase were unfortunately excluded from the sampling plan of this study.

3.6 DATA COLLECTION APPROACH

The researcher made use of the semi-structured interview method to collect data from the participants.

Semi-structured interviews

According to Cousin (2009:71), a semi-structured interview is a tool that "allows a researcher to develop an in-depth account of experience and perception with individuals." This data-collection technique was suitable for the conducted research in that it allowed for flexibility, probing for relevant responses, gaining insight, and in-depth exploration of this particular topic; and the technique allowed the researcher to gain a deeper understanding of the subject at hand. Kasa (2017) notes that in-depth interviews are more appropriate for situations in which open-ended questions are to be asked that elicit a depth of information from relatively few people; however, this method can be time-consuming.

The researcher kept a journal where she documented the events that occurred during the research process. The researcher did this in order to have a clear record of her research journey. The journal includes dates of her initial engagements with all persons who participated in making this study a success, including letter to the Department of Health, Ma'at Institute, and Okhahlamba Local Municipality. The dates of interviews conducted and the original transcripts of interviews before they were translated into English.

3.7 DATA MANAGEMENT AND ANALYSIS

Blandford (2009) notes that there are three important factors that researchers analysing qualitative data obtained through semi-structured interviews should consider. The factors centre on whether or not the thematic data analysis is useful, what counts as a theme, and how the identified themes should be presented. The researcher has identified the themes as per the responses of the participants. The data was analysed using the thematic analysis.

In analysing the data collected in the present study the six phases or steps of thematic data-analysis were used. According to Braun & Clarke (2012), as cited in Cooper, the 6 steps are as below.

Step 1. Familiarize

In this phase, the researcher familiarised herself with the data collected. The researcher transcribed all audio recordings of the interviews; this helped the researcher to become familiar with the data collected; and allowed the researcher to work effectively with her data, being well acquainted with it. This proved to be a stepping phase that assisted the researcher in coding the data collected. The researcher read through transcriptions and listened repeatedly to the audio recordings to complete this step successfully.

Step 2. Generate initial codes

The researcher began to assign codes to the data collected. A code in this respect is understood as a brief description, highlighting points or statements of interest made to the researcher by the participants. This is the first step and a necessary step in organizing data. Coding is dependent on the type of analysis the researcher will be performing. In the current research, the researcher made use of the exploratory thematic analysis. There was another option of a coding software; however, the researcher chose to code by taking notes on printed transcription.

Step 3. Search for themes

Themes served as an active interpretation of codes and the data. Themes helped the researcher combine codes to form a single theme for codes that are associated. During this phase, the researcher relied on analytic examinations of narrations.

Step 4. Review themes

In this step, the researcher ensured that the themes were useful, and were a precise representation of the data collected. The researcher at this step combined or removed some themes, and created new themes in ensuring the correct representation of the data. The researcher continued to do the above until the set of themes was logical, distinctive, and denoted the data accurately.

Step 5. Define and name themes

In this step, the researcher began to name and describe the themes identified in the previous step. Themes are descriptive, defined themes involved articulating exactly what is meant by each theme. At this point of the analysis, the researcher was able to tell a logical story about the particular theme.

Step 6. Produce report

The researcher ensured that there was enough information about the project in order to enable the reader to evaluate the quality of the research. Themes were used to present the research findings; quotes from what participants said were used to demonstrate research findings; however, information participants outlined as confidential was not used as quotes in the research findings.

3.8 TRUSTWORTHINESS OF THE STUDY

It is essential that any research conducted be trustworthy. The researcher utilised the Lincoln and Guba's framework (2013) to assess the trustworthiness of this study. The framework outlined that there are four methods of ensuring a study's trustworthiness, which are outlined below.

3.8.1 Transferability

Elo et al. (2014) state that transferability occurs when the findings of a study can be generalised and transferred to other settings or fields of research. The researcher's inclusion of participants' coherent biographical descriptions, and thorough explanation of the outlined findings of the study, increase the possibility of other researchers being able to assess the applicability of this study in other settings. The findings of the study will be made available to the Okhahlamba Local Municipality and local health departments, so that the municipality and health departments may grasp the level of satisfaction of their population with HIV-support programmes, in achieving transferability.

3.8.2 Credibility

The researcher ensured that all recorded data collected from interviews with the current study's participants were transcribed in order to ensure that an accurate representation of the experiences of men living with HIV was depicted. In addition, the researcher ensured that all participants who formed part of the study were relevant and appropriate for the study, thus ensuring credibility. Mzinyane (2017:64) notes that "the goal of assessing credibility is to demonstrate the inquiry was conducted in a manner that identifies and describes findings accurately." The researcher maintained credibility of the study through sending all interview transcripts to her supervisor for reviewing purposes. Furthermore, all audio recordings and transcripts will be stored safely for a period of five years; thereafter, data will be destroyed.

3.8.3 Confirmability

Maxhakana (2021: 59) states that "the term 'confirmability' refers to the notion that the facts must not be influenced by the investigator's prejudice along with intrusion." The researcher ensured this by being neutral throughout the study. This avoided bias in the study findings in supporting her paradigm of the study. Additionally, to maintain confirmability, the researcher compiled a descriptive report that clearly depicts the findings, to allow for other researchers to confirm the findings. Mzinyane (2017) states that a research report should be well detailed in order for the other person to confirm findings.

3.8.4 Dependability

Ntshangase (2016: 60) remarks that "research needs to have concrete data sources which will yield information that is truthful, thus valuable to readers." As cited in Cebekhulu (2015), according to Ulin et al. (2002), consistency of the research process determines the study's dependability. The researcher ensured dependability by selecting participants relevant to the current study. In addition, the researcher outlined all research methods, and consistently maintained them throughout the study.

3.9 ETHICAL CONSIDERATIONS

3.9.1 Informed consent

Informed consent is an ethical and legal requirement for research involving human participants; furthermore, it is a process in which participants are informed about all aspects of the trial (Nijawan, Janodia & Musmade, 2013). The researcher ascertained that informed consent was granted by first engaging verbally with the participants to explain the nature of the study and the reasons for study. Thereafter, once participants agreed to participate in the study, they were requested to complete and sign the informed consent form (Annexure A). The informed consent outlined the details of the researcher: name, surname, student number, institution, contact details, including details of the supervisor. The informed consent forms are kept together with the recordings and transcribed data obtained from the semi-structured interviews.

3.9.2 Voluntary participation

Participants were made aware that their participation in the current study was voluntary and that they would not receive any monetary reward for participating in the study. Kumar (2014) asserts that participation in a study should be voluntary, not coerced. Participants were made aware of their rights as participants in the study, which included withdrawing from the study at any point should they so desire, choosing not to answer questions which they are uncomfortable responding to; and choosing not to be audio-recorded. All this was verbally expressed to each participant and was also outlined in detail in the informed consent form.

3.9.2 No harm to participants/non-maleficence

As per this principle, it is the researcher's duty to ensure that no harm occurs to the research participants either as a direct or indirect result of the study. Participation in social research may cause a participant to reflect on personal issues, bringing about emotional distress. The researcher should not finish an interview until some resolution of emotional distress has been found (Vanclay, Baines & Taylor, 2013). The researcher ensured that the place of the interviews would be safe and comfortable for participants; and that questions were asked in such a manner as not to cause any harm to the participants. The researcher furthermore requested that counselling sessions by the Ma'at Institute worker(s) take place for participants who experience post-traumatic stress disorder as a result of the data-collection process. These sessions will take place telephonically through what is called tele-therapy.

3.9.3 Confidentiality

Kasa (2017) directs that the respondents be made aware that the information they provide to the researcher is strictly confidential. Bless, Higson-Smith & Sithole (2013) state that information given by the participants must not be made available to anyone except the researcher(s). Confidentiality will be achieved through the control of all recordings and notes taken during semi-structured interviews; they will not be accessible to any other individuals except the researcher and the supervisor. The data will be stored both on hard copy and electronically. The participants will be identified using pseudonyms in place of their real names, to maintain confidentiality. The participants were to be interviewed in public spaces selected by participants, as these premises would be secure and comfortable for participants.

3.9.4 Anonymity

Allen (2017) asserts that anonymity is an ethical practice designed to protect the privacy of human subjects when collecting, analysing, and reporting data. The names of the participants will not be used in the publication; the researcher will make use of pseudonyms instead. Anonymity is a procedure of obtaining data without any personal identification of the participant being given (Allen, 2017).

3.9.5 Consent from gatekeepers

The researcher obtained all documentation and permission necessary to conduct research using their resources. Permission and documentation obtained include research approval from the KwaZulu-Natal Department of Health (DoH) health-research and knowledge management, a letter of support and granting of access from the DoH, Emmaus Hospital, a letter of support from Ma'at Institute to provide psycho-social support services to participants should they require such; and a gatekeeper's letter from Okhahlamba Local Municipality granting access to support staff and facilities. Consent letters are attached.

3.9.6 Ethical clearance

The research furthermore obtained full ethical clearance (certificate of ethical clearance) from the University of KwaZulu-Natal Humanities and Social Sciences Ethics Committee. The certificate attached permits the researcher to conduct her research, being an ethically sound and acceptable study.

3.10 LIMITATIONS OF THE STUDY

3.10.1 Fear of public humiliation

Participants assumed that their selection to participate in the study was aimed at humiliating them; therefore, they were initially reluctant to participate. The participants found it difficult to discuss matters pertaining to their health with a young female researcher. The researcher reassured participants of anonymity and confidentiality. Furthermore, the researcher established rapport with the participants and offered a safe space for them to talk freely about their experiences as men living with HIV.

3.10.2 Fear of experiencing post-traumatic stress disorder (PTSD)

The participants feared experiencing post-traumatic stress disorder due to the sensitivity of the subject. Although provision had been made to ensure that persons who suffer from PTSD receive professional social-work services, participants were still sceptical about participating due to the sensitivity of the study.

3.11 CONCLUSION

In this chapter, the research methodology of this study was discussed. The study was a qualitative interpretive study. A sample of 15 men living with HIV/AIDS, residing at an area under Okhahlamba Local Municipality and between the ages of 18 to 40 years was selected. Participants were selected purposefully; the adopted data-collection instrument was semi-structured interviews. The data analysis utilised for this study was the thematic analysis; and the reasons for the selection of this method were discussed. Lastly, this chapter included the discussion of trustworthiness, ethical considerations, and limitations of the study.

The research findings will be discussed in Chapter Four of this dissertation.

CHAPTER 4

DATA ANALYSIS AND FINDINGS

4.1 INTRODUCTION

This chapter renders an outline of the results of the data collected from study participants, which was collected through semi-structured interviews. A sample of 15 male participants living with HIV/AIDS were interviewed individually in the quest to fulfil the objective and to answer the study questions. Participants' responses are presented according to key questions which correspond with each objective. The data was analysed using the thematic data-analysis method, which aided the researcher in thoroughly and closely examining participants' responses; and in noting emerging themes from the data gathered.

This chapter will be divided into three sections, namely, presentation of participants' demographics, themes that emerged from the study, and the conclusion. Themes that emerged from the semi-structured individual interviews are as follows: initial reaction upon diagnosis discovery; sharing or disclosure of HIV-positive status; challenges post HIV-positive diagnosis; and availability of support systems.

4.2 PRESENTATION OF PARTICIPANTS' DEMOGRAPHICS

Table 4.1 Biographic profile of each participant

Name	Age	Ethnic group	Marital status	Employment status	Sexual orientation
Participant A	30 years	Zulu	Single	Unemployed	Heterosexual
Participant B	36 years	Zulu	Married	Employed	Heterosexual
Participant C	39 years	Zulu	Married	Rather not answer	Heterosexual
Participant D	28 years	Sotho	Married	Employed	Heterosexual
Participant E	20 years	Zulu	Single	Unemployed	Heterosexual
Participant F	26 years	Zulu	Single	Employed	Heterosexual
Participant G	20 years	Zulu	Single	Learner	Heterosexual
Participant H	22 years	Zulu	Single	Student	Heterosexual
Participant I	39 years	Sotho	Widowed	Employed	Heterosexual
Participant J	33 years	Zulu	Single	Unemployed	Heterosexual

Participant K	20 years	Zulu	Single	Unemployed	Heterosexual
Participant L	22 years	Zulu	Single	Employed	Heterosexual
Participant M	20 years	Zulu	Single	Student	Heterosexual
Participant N	23 years	Zulu	Single	Student	Homosexual
Participant O	36 years	Zulu	Single	Employed	Heterosexual

Table 4.1 is a representation of the demographic details of 15 male participants in the current study across the following five (5) categories:

Age

Participants in this study were all of consenting age, between 20 and 39 years of age during the data-collection phase. A notable gap of 19 years was seen between the youngest and oldest participants in the current study. This gap in age meant that the study was at an advantage in that the researcher gathered the experiences of men living with HIV/AIDS across two (2) decades. It is interesting to note that of the fifteen (15) male participants, two (2) were born HIV-positive. which therefore allowed the researcher to gain insight into the experiences of younger males (below the age of 18) living with HIV/AIDS, who were not included in the sample of participants for this study.

Ethnic group

Table 1 presents that 2 of the 15 male participants of the study are from a different ethnic group, which is Sotho, in an area that is predominantly Zulu and is regarded as a rural area with fewer opportunities for employment. This representation of a different ethnic group provided the researcher with insight into individuals that was least expected. This diversity in culture opened the researcher to a different perspective of men living with HIV who are not from the common ethnic group. Thirteen (13) participants were Zulu who formed part of the majority of the study participant, this is due to the geographic area. The diversity in ethnicity indicates that experiences and challenges (if any) cannot be limited to one ethnic group.

Employment status

The demographic information delivered in Table 1, shows that six of the sample of men who participated in the study were employed; while four were unemployed at the time the data was collected. One participant chose not to reveal his employment status; and four were either students or learners. This awarded this study the opportunity to absorb different narratives. The experiences of an HIV-positive employed man differ from the experiences of an unemployed HIV-positive man. While the aforementioned have varied experiences, the perspective and reasoning of a learner and students at institutions of higher education and training may differ widely due to their environment. The study presents a view of various economic statuses which allows for wider exploration of the experiences of men in differing financial positions.

Sexual orientation

The study presents a different view of sexual orientation; the researcher did not limit recruitment only to men who identify as heterosexual men. Views of a homosexual man are explored in the study; although 14 of the study participants were heterosexual men, the experience of a homosexual man added to the richness and significance of the study. The in-depth experiences of a man who identifies himself as having a different sexual orientation provided the researcher with a wider view than only a one-sided (heterosexual) perspective. The study opened the opportunity to explore not only gendered (male/females based on visible genital differences) experiences; but also experiences of differently sexually oriented people (hetero/homosexual, based on one's identification with genders attracted to).

4.3 FINDINGS

Research findings were guided by the objectives of the study; and are presented according to the themes identified.

Table 4.2 Table Presenting Themes and Sub-themes

No.	Themes	Sub-themes
4.3.1	Reaction upon diagnosis discovery	Shock, fear, anger and difficulties accepting diagnosis Disbelief and confusion Regret and hurt
4.3.2	Disclosure of status	Delayed disclosure Voluntary disclosure
4.3.3	Challenges post-diagnosis	Adapting to a new life
4.3.4	Availability of support systems	Family and friends as support structures Healthcare professionals as support structures

4.3.1 Reaction upon diagnosis discovery

Receiving or learning of one's HIV diagnosis can be life-changing. Diagnosed persons may be filled with varying emotions ranging from shock, fear, sadness, regret, anger, denial to hopelessness. Being diagnosed with HIV may lead to any of the aforementioned emotions even if only suspected of having HIV (Senyurek et al. 2021; Hult et al. 2009). This study explored the experiences of men living with HIV through understanding their feelings and emotions upon receiving their HIV-positive diagnosis. Below are sub-themes of participants' reactions upon receiving news of their HI-Virus diagnosis.

4.3.1 Shock, fear, anger, and difficulties initially accepting diagnosis

Five (5) of the study participants reported having being shocked by their HIV-positive diagnosis. Some later on expressed that it had been difficult to accept their diagnosis. Participants' responses suggested that for various reasons they had never expected to find themselves with an HIV-positive status. The following extracts support this:

Participant A: "I was really shocked, I even asked the sister to test me again using the other hand this time (laughs), because I didn't believe that I of all people was sick. Even the reason I tested was being forward, I saw a tent and I was like let me go and check, little did I know that what I am getting myself into"

Participant D: "Eyy sister, I was shocked, I was scared and didn't believe it… what will I tell my wife? I know a lot of people who died because of AIDS back home, so I was scared that I will also die."

Participant E: "I don't know how I can say I felt, it was hard to accept what happened, I was very angry at my mom."

Participant G: "I was really shocked because there is no one that I know at home who was taking any pills."

Participant L: "I was shocked like everyone or as everyone."

Although participants expressed having experienced shock and fear, it is evident that not all feared potential stigmatisation or discrimination. One participant's fear stemmed from past experience of witnessing people die of HIV/AIDS and therefore feared that he too would die.

Participant D: "I know a lot of people who died from AIDS back home, so I was scared that I will also die.

4.3.2 Disbelief and confusion

Five (5) of the 15 participants alluded to having experienced disbelief and confusion at the discovery of their positive HIV diagnosis. Two (2) participants further referred to themselves and their new lifestyle as "umuntu wePhilisi" (a pill person) and "Impilo yami yonke sekuzoba eye Philisi" (my whole life will now be a pill life). The extracts below clearly show accounts of participants' reactions:

Participant F: "I felt like I was losing my mind because I thought to myself I will now be a person who depends on pills, my whole life will now be a pill life, I will now be a pill person."

Participant I: I felt as if the world turned on me, my mind was messed up. My goodness how? I didn't believe it at all."

Participant J: "Yoh! I didn't believe, I felt like I was dreaming and asleep, I was shocked because this meant that my whole life will now depend on pills."

Participant O: "I didn't believe , I asked a number of times whether the sister was sure and she told me it is as I see."

Participants' disbelief is largely seen in their language and expressions on receiving news of their HIV-positive diagnosis. Participants used words such as *'Ngathi ngiyadunyelwa/Ka otloa ke firikane monahano'* (I felt like I was losing my mind) and *'kwakungathi ngiyaphupha'* (it felt like a dream) to describe their disbelief and confusion over their HIV-positive diagnosis. One participant's confusion was additionally caused by misconceptions of how people contract HIV/AIDS. In his account he stated:

Participant K: "I was confused, I thought they were talking to someone else not me because how would such be because I have never been with any woman, I was really confused."

This response showed that there is a need for more intensive and rigid HIV/AIDS transmission campaigns. The misconception that HIV/AIDS can only be contracted through unprotected sexual intercourse with an HIV-positive person may otherwise be widely believed and accepted.

4.3.3 Regret and hurt

Three of the 15 participants expressed that they felt a sense of regret and hurt on hearing the diagnosis. While of the three participants one expressed that he was hurt by the reality of knowing; however, he was not shocked as he was born HIV-positive. The participants expressed their reaction in this manner:

Participant B: "It was 2019, when I found out that I'm HIV positive. I don't know what I can say I felt when I saw the test came back. That moment I tested at my new workplace, I don't know whether I must say I starting working there at the wrong time or what. When I started at work they were doing a health and wellness program, I got myself into trouble eishh. When I thought of what happened, I felt a sense of regret."

Participant M: "I was born positive…so I wasn't shocked it's just the reality of knowing that hurt me the most."

Participant N: "Shame I was really shocked, I don't want to lie. I was hurt but at the same time I asked myself what did you expect? Because I was risky shame."

It is undeniable that authors, academics, and individuals infected and affected by HIV can agree to one known fact about receiving a HIV positive or any chronic illness diagnosis: that it showers individuals with mixed emotions irrespective of race, gender, sexuality, religious views or socio-economic status. Two of the fifteen participants revealed that their HIV testing was voluntary and was not due to any pre-existing or underlying illness. Two participants were born HIV-positive, while others did not give details during the semi-structured interviews of reasons for their testing. One participant, when asked, did not present a clear image of his reaction upon receiving an HIV-positive diagnosis. However, his response does show that his testing was not a voluntary action but was as a result of ill health (tuberculosis).

Participant C: "I had no choice but to accept. I found out I was sick because it was found that I have TB when I returned from Maputo on work purpose. I wasted no time, I started my treatment, I didn't want to be anyone's burden."

The responses provided by participants and the low number of participants who openly admitted to voluntary testing for HIV, supports studies that revealed that men are less likely to seek healthcare structures such as clinics. This is because these institutions are seen as sculpted for women's needs, with the needs of men often overlooked (Armstrong et al. 1999; Lynch 2010). Participants not being vocal on whether their testing was voluntary reinforces findings from various studies that men behave as they see expected of a male 'macho' culture. Expectations in some cultural contexts are of men being strong and tough in all aspects − physically, mentally and emotionally (Cloete et al. 2010; Skovdal et al. 2011).

Accepting diagnosis and adjusting to an HIV-positive life may be challenging and can negatively affect persons living with HIV. Therefore, persons diagnosed HIV-positive should be given all necessary support according to their needs, helping them on their journey of accepting and adjusting to an HIV-positive life. A study by Senyurek et al. (2021) elicited that PLWHA may be under tremendous pressure due to struggling with lifestyle changes caused by the HI virus. Such can include ceasing all sexual activities, avoiding close contact with people to avoid involuntary disclosure of the HIV status; and not being able to talk about their HIV status with family and friends. This therefore leads us to the next theme which sought to explore participants' disclosure of their HIV-positive diagnosis.

4.4 DISCLOSURE OF STATUS

Various studies have revealed that disclosure may be met by stigma and rejection. Delayed disclosure by men was prompted by fear of losing their status as men; similarly, women delayed disclosure for identical reasons (Villar-Loubet 2013; Ngcobo 2011; Mfecane 2012). Participants in this study revealed that they disclosed their HIV-positive status to someone whom they trusted, which reinforces the findings of a study revealing a relationship between disclosure and trust (Pelzter and Mlambo 2013). The researcher noted that there was, however, a delay in disclosure among some participants due to fear, while other participants did not delay disclosure.

4.4.1 Delayed disclosure

Three (3) of the 15 reported not disclosing their status soon after receiving their diagnosis for various reasons, ranging from fear to internalised stigma. A study by Muralidharan et al. (2017) states that other reasons for PLWHA concealing their status was internalised stigma and fear of rejection. This finding is parallel with the responses provided by study participants who delayed status disclosure.

Participant A: "No one sisi, I didn't tell anyone because I was scared, and they didn't find out because I said I want no one near my room because I didn't want any mistake of anyone seeing my pills. Eventually, I told my mom."

Participant D: "Not immediately, I was scared to tell anyone, I stopped sleeping with my wife because I didn't want to kill her also. I told her after some time when I had accepted that this is not going change because I don't like it, she decided to test also and she was also positive" Participant E: "I told my cousin but I didn't tell him immediately after I knew my status, but again I'm sure my gogo already knew because she raised me and she always told me to take my pills."

Participants' responses showed that three of the participants delayed disclosing their status to their partners or close family. Anxiety and reluctance to disclose an HIV-positive diagnosis, fears of being rejected and discriminated against, are evidence of the persistent nature of AIDS-related stigma in communities and households (Cloete et al. 2010). A response by one participant revealed that there is a gap to be filled in the knowledge of people in relation to HIV/AIDS. There is evidence of internalised stigmatisation seen in the reported action of the participant who isolated himself in order to limit risk of others finding out that he is on HIV treatment.

Participant A: "...and they didn't find out because I said I want no one near my room because I didn't want any mistake of anyone seeing my pills. Eventually, I told my mom."

4.4.2 Voluntary disclosure

Some 12 of the 15 men participating in the study reported disclosing their HIV-positive diagnosis to their close family, intimate partners, and in some cases, their close friends. This high record of participants disclosing their status earlier than other participants supports other studies which state that PLWHA are most willing to share their status with their partners. This is to gain emotional support from their families as well as to take precautions against transmission. Disclosure also has positive effects such as facilitation of entry into care (Senyurek 2021; Peltzar and Mlambo 2013).

Participant G: "I was young when I found out that I'm HIV, I was 16, I told my uncle and he was shocked. He then told me that they didn't think I got infected, I was confused as to what was he talking about. He explained to me that when I was growing up, there was an incident in the soccer field and there was an injury that I sustained and they didn't pay much attention to it."

Participants' responses reveal that participants who were born HIV-positive were more open or found it to be less of a burden to disclose their status to close friends and family compared with others. Extracts below show participants' responses:

Participant H: "They already knew at home, so I just told my closest friend and my girlfriend."

Participant M: "They already knew, even my friends knew that there were pills that I was taking, although they didn't know what those pills were for because I also didn't know but as I grew up I understood and we're good, everyone at home is supportive."

Participant I reported that the told a friend that he had "AIDS"; which, however, was not the case as he had HIV. Another participant reported that he shared his diagnosis with his mother who he had then tasked to inform his father. Below are extracts from participants' responses:

Participant I: "I called a friend of mine and I told him of these unbelievable, I have HIV, I didn't believe it for real. Nntate (referring to friend) told me that life is like that, there are a lot of people who live with it (referring to HIV), you can never see it with your eyes."

Participant J: "I didn't have much of a choice, I told my friend whom we went testing with. I also told my mother and I asked her to tell my father."

While other participants' disclosure was received with support and understanding, one participant's disclosure to an intimate partner was met with rejection: his partner left him post-disclosure of a positive HIV status.

Participant F: "I told my girlfriend (referring to then girlfriend) what dis she do? She left me, I told my aunt also because I lived with her."

Disclosure of an HIV-positive status is essential; it is an individual's personal choice which is highly recommended. However, the reactions of the next person to the news are beyond the control of the HIV-positive individual. Participants reported having an "obligation" to disclose their status to their family: in return, their disclosure was met with support and understanding. Below are participants' responses:

Participant L: "I disclosed to them at home because then nurse told me it will help me to have support from home."

Participant C: "It is not possible for you to know you are sick and not tell your wife, I told my wife and my cousin brother."

Participant O: "I told my brother and my current partner."

Participant N: "I told my sister since she's the one that I live with, our parents have long passed on. I also told my social worker who was my foster care social worker. They were very supportive, they didn't judge me instead, they advised me to fix my ways and be a child that listens."

Participants' disclosure and response therefore of support show findings that support the study: disclosure is perceived as emotionally healing, cleansing, and liberating (Viller-Loubet 2013). Findings furthermore reveal that men participating in this study, irrespective of employment status, received open support post-disclosure of HIV-positive status. One participant reported that he was initially held responsible for his partner's HIV-positive status. The participant took full responsibility for the positive status of his partner: he stated that he hated himself for what had transpired.

Participant B: "well, I was in a tight position, so I had to tell them at home, I told my wife, we both went to the doctor to test and indeed I had infected her. We told my mother about what happened and she went crazy, she threw insults telling me of how I told someone's child from her home only for me to kill her. I hated myself"

Participants disclosed to their families, intimate partners, and close friends. The study revealed that delayed testing or avoidance of regular testing by participants led to the unintentional spread of HIV. Two participants openly reported that their partners also tested positive for HIV. Status disclosure by a HIV-positive partner encourages the other partner to seek HIV testing services (Peltzer and Mlambo 2013).

This study reveals that many people are diagnosed HIV-positive in many countries, South Africa included. HIV-positive people are still subjected to stigma, discrimination, and marginalisation from family and communities (Senyurek et al. 2021; Muralidharan et al. 2017; Cloete et al. 2010). However, there is an improvement in attitudes found within the study location. This may be associated with the knowledge and understanding of HIV/AIDS by individuals.

Various studies reveal that PLWHA experienced extreme discrimination due to their positive status, such as dismissal from work, marginalization, verbal abuse, and social exclusion (Muralidharan et al. 2021; Cloete et al. 2013; Mfecane 2010). Participants from this current study did not report experiencing any of the aforementioned; rather, their disclosure was met with understanding, care, and support. Participants reported having being accepted with their positive status; and attitudes towards them remained unchanged.

4.5 CHALLENGES POST-DIAGNOSIS

Participants' experiences differed slightly as some participants reported challenges which they faced and still face; while others reported to be coping well with minimal to no challenges. Of the 15 participants in the study, 8 participants reported facing or having faced challenges post-diagnosis of an HIV-positive status.

4.5.1 Adapting to a new life

As with most people living with HIV/AIDS, participants faced challenges post their HIV/AIDS diagnosis and status disclosure. Some challenges stemmed from internalised stigma; while others came from their environment. Below are extracts from participants' responses pertaining to challenges experienced post-diagnosis:

> *Participant A: "The first is that your whole life is now dependent on pills. Now everything that I do, I must make sure that when the time for me to take my pills comes I'm home… another one is the one that I had already told you about… relationships, ever since I learnt how I am I have never had a stable relationship, maybe I'll have one when I find someone like me(referring to an HIV positive status). I have never had a long-lasting relationship with any woman because this will need me to eventually tell her of my situation because after some time of being in a relationship you stop using condoms so when that time comes, I find ways to break up with the woman."*

One of the participants reported having a challenge maintaining romantic relationships as this will require him to reveal his reasons for wanting consistent condom use. In his words: "*after some time of being in a relationship you stop using condoms."* Additionally, he reported that his then-partner left him post-diagnosis. This may contribute to participants avoiding reaching stages of disclosure in romantic relationships.

A participant shared experiencing financial challenges. In addition to his HIV-positive status he had ill-health, visual and auditory problems, which require check-ups which he cannot afford as he is unemployed.

Participant E: “There’s nothing new besides what was already there, my eyesight and hearing problem, constantly being sick and not being able to life a life like others. My hearing aid are there but they are at Estcourt hospital, my problem is I don’t have the money to go fetch the, outside that there’s nothing.”

Another participant shared that he avoided playing sports for fear of infecting the next person − he was infected through sport. See extract below:

Participant G: “There were challenges, I started avoiding sports, because that where I got infected.. through soccer. So I was scared that I might reinfect others so I stopped playing soccer, so life is tricky because I am fearful most of the time.”

Contrary to the other research studies conducted (Cloete et al. 2010; Mfecane 2010) men participating in this study in their responses reported not experiencing stigma from their community due to their HIV status. However, one participant faced anger from his mother for infecting his wife; and one participant was rejected by his then-lover due to his HIV status. This account is shown in the extract below:

Participant B: “The hardest was being hated by my mother because I infected my wife with the virus, it took her a long time to be at peace and forgive me even when my wife begged her to forgive me… Another one was adjusting to a life of pills, it was hard to take pills everyday, have you seen them? They’re big! The greatest challenge was knowing that as this is difficult for me to take these pills, someone else is taking them when they did nothing, they are taking them only because they loved and trusted me. As time went by with the support of my wife, I overcame these challenges.”

Other participants reported facing a challenge with adjusting to the new life of depending on medication or anti-retroviral treatment/therapy so as to lead a normal life. Furthermore, participants shared that some days are better than others. These extracts show participants’ accounts as follows:

Participant I: “Ahh there are those things here and there… taking your pills on time, eating healthy, especially since my wife passed on, it is really hard.”

Participant L: "I could say there are but there aren't… because not all days are the same. Sometimes its hard especially when you remember that you're slightly different from your peers. This situation forced me to grow up and be responsible."

A participant shared experiencing difficulties accepting his HIV-positive diagnosis as follows:

Participant D: "It was really hard to accept but I didn't have a choice so I accepted and acknowledged that this is my new life."

One participant reported experiencing challenges with lifestyle changes and living in regret. The extract below provides evidence of this:

Participant N: "Changing my lifestyle because now I must consider the partner of the person I would sleep with because they don't want to use protection because we're drunk in most cases. As you can see I'm gay so I would sometimes be an experiment to straight (referring to heterosexual) men. Another one is the pills, taking those pills is hard oe (friend) , taking them everyday is hard its worse when you know that you got yourself into that situation."

Participant N showed that part of his reasons for lifestyle changes was in consideration of the partners of the men he engaged with sexually; who in most cases are heterosexual men who refused to use protection.

Participant C reported that one ought to accept when they have received an HIV-positive diagnosis as follows:

Participant C: "When you've heard the news, you've heard them so you must accept. There's nothing that has changed they are still how they (family and friends) were before."

Participant F who had been rejected by his lover upon diagnosis reported that he did not have any challenges. Instead, he had found an understanding "iMama" (partner). Below is an extract of his experience:

Participant F: "Outside being rejected by my then girlfriend that I loved, there's nothing else. We're still pushing at work, same goes for my home and family, I found an understanding girlfriend... she's educated that's why (laughs)."

Other participants reported not experiencing any challenges, other than ensuring that they take their treatment as prescribed. The extracts below show participants' responses:

Participant J: "No, there aren't sisi. Life is still the same, the other thing that changed is I now take pills."

Participant O: "No, I did not have any. Life went on as usual the difference is it (life) now had treatment but its more or less still the same."

Participants showed that they received support from family and from healthcare professionals. See extracts below:

Participant H: "Well, life is still worth living, I'm coping well, all thanks to the nurse and my family for that."

Participant M: "No I didn't have any (challenges). I think maybe if I didn't have a support system that's strong maybe I would have challenges but I have all that I need."

Interestingly, the study showed narratives of participants receiving acceptance and support from their families and friends. The responses of participants which revealed minimal challenges showed that there is development in relation to HIV/AIDS education and understanding.

4.6 AVAILABILITY OF SUPPORT SYSTEMS

HIV/AIDS care and support services refer to non-anti-retroviral treatment. These include professional, social, emotional, and family support. Participants reported having good and stable support systems which proved to be very helpful in their lives.

4.6.1 Family and friends

The availability of family support assists a person living with HIV/AIDS in adjusting and coping with their positive status. Support received by PLWHA furthermore helps encourage treatment adherence to attain viral load suppression. Participants' responses reveal the impact the support received from their family and friends has in their lives as PLWHA. Below are extracts of their narratives:

> *Participant B: "My wife is the one person who supports me more than anyone else, my mom also made peace and forgave me, she also supports, but my wife has been my greatest support system."*

Participant O shows how support from those around PLWHA may help refocus and set new goals that promote stability and life-long commitment. He states that he is considering marrying his partner due to the love and support she shows him irrespective of his HIV-positive status, while she is HIV negative:

> *Participant O: "I am coping because i have people who support me, my brother and partner, I'm even considering marrying her because of the love that she shows me when I'm the one that is suck and not her."*

The responses of Participants J and G correlate with narratives that allude to social support systems helping PLWHA to accept their HIV-positive status:

Participant J: "Yes, my family supports me a lot, they make it much easier to face the situation."

Participant G: "Yeah, my uncle and aunt. They help me a lot and they also encourage me a lot."

While emotional support was available for Participant E, he still encountered a challenge of financial constraints. He is unemployed and is dependent on his cousin for financial assistance to attend to his medical needs:

Participant E:"Yes my cousin is there, she's the one who takes care of me, but the problem is she is also unemployed, so we don't have money to cover all travel expenses (for check ups)."

Participants L and M reported that they have a strong support system and this allows them to offload and talk about their feelings. Such is essential in the care and support of persons living with HIV/AIDS. The extracts below express participants' experiences:

Participant L: "Yeah I have i-support system and its very strong, I can talk to them about anything that is related to my illness. If I feel down, I know I can talk to them."

Participant M: "They are all supportive at home… my family is there, my friends are there… I have all I need, I am coping very well."

4.6.2 Healthcare professionals

A study by Adrewin and Chien (2008) showed that healthcare professionals labelled HIV-infected patients as infectious beings. Contrary to this study, participants in my study found consolation and support from their healthcare professionals in addition to the support from their families. The extracts below support this:

Participant C: "They are there, and they are all qualified. There are nurses also and they are helpful, my wife is there and she's also helpful."

Participant H: "Yeah well one lives okay, I am coping well, thanks to the nurses and my family for that."

Participants showed that the support of healthcare professionals was of great help. These professionals helped sufferers to offload; and gave them the courage to soldier on. Below are extracts that show participants' accounts of healthcare professional support:

Participant A: "Pertaining my condition, my mom is my support system and the nurse at the clinic, when I go collect my treatment we talk and the burden is lifted from my shoulders."

Participant D: "She did help me (nurse), every time when I feel like it's a lot, I think of the words the sister (nurse) told me that life goes on and I remember that really life does go on."

A different experience was noted: in addition to all support systems, two participants received support from psycho-social experts in the field, the social workers. This shows the multidisciplinary support available for PLWHA within Okhahlamba Local Municipality. The extracts below support this statement:

Participant F: "Knowing learned people helps, I have a friend who's a social worker, he advised and guided me also after I found out and was rejected by then lover. He helped me accept my situation as it is. I have the power to choose which direction I take from that point going forward."

Participant N: "My sister and my social worker are very supportive and they don't judge me instead they guide me and tell me to straighten my ways and be a child that listens."

One participant made mention that the social worker from whom he received support had worked on his foster-care case previously. This shows how social workers impact and form a relationship with their clients; such may serve the client even post-termination.

Chapter 5

RECOMMENDATIONS AND CONCLUSIONS

5.1 INTRODUCTION

This chapter will present a summary of the findings of the study. The chapter will provide recommendations and conclusions based on the empirical evidence derived from the findings of the study that were presented in the previous chapter. Themes that emerged in the previous chapter will be revisited to incorporate findings with the research aims, objectives, and relevant theoretical frameworks adopted for this study.

The study aimed at exploring the experiences of men living with the Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome within Okhahlamba Local Municipality. The objectives of the study included establishing the experiences of men in Okhahlamba Local Municipality who are living with HIV/AIDS, to uncover their psycho-socio-economic experiences. The study also explored the adjustments and adaptations HIV-positive men have made post-seropositive status diagnosis.

This was a qualitative study, which applied the interpretative and exploratory design. Non-probability purposive sampling was utilised to select study participants. Theoretical frameworks adopted for this study were the ecosystems theory and social construction. The qualitative data was collected from a sample of 15 men (as outlined in Chapter 3) living with HIV/AIDS. Through semi-structured individual interviews the researcher conducted in-depth insight into participants to gain insightful accounts of the experiences of participants living with HIV/AIDS. Interviews were conducted at a safe and mutual venue that was most convenient and comfortable for participants, while some interviews were conducted telephonic-ally. The data collected was analysed using the thematic data analysis.

Men participating in the study were between the ages of 19-39 years at the time of the study; 4 of the 15 men were unemployed, 6 men were employed, 4 men were either students or learners, while 1 man preferred not to provide an answer. The study had a diversity in ethnicity as it included 2 Sesotho-speaking men and 13 isiZulu-speaking men; 1 man identifies as a homosexual, while 14 identify as heterosexuals. Men from this study cut across all marital statuses − 11 were single, 3 were married and 1 man was widowed.

5.2 SUMMARY OF THEMES IDENTIFIED

The themes and sub-themes to be discussed are categorised as follows:

-Reaction upon diagnosis discovery

-Disclosure of status

-Challenges post-diagnosis

-Availability of support systems.

5.2.1 Reaction upon diagnosis discovery

Findings of this study showed that there is no linear way of reacting to an HIV-positive (seropositive) status. Participants' reactions ranged from shock to fear, to hurt and regret. While not all participants revealed the reasons that led to their HIV testing, at least three participants revealed that they had tested voluntarily; some revealed that they were born HIV-positive. None of the participants reported that their testing was influenced by any health issues or illness; however, none of the participants expected to find themselves living with HIV.

The study reflected that participants' feelings of shock and fear were not necessarily because they feared stigma and discrimination; instead they feared the reaction of their intimate partners and potential chances of infection of their intimate partners. In addition to this fear, another participant expressed that his fear stemmed from his "fast approaching death" as per the social constructionism theory which states that individuals' views and meanings are socially determined. Therefore, although the participant reveals that he had seen people dying from HIV/AIDS, there are also certain influencing social constructs that paint a picture of HIV/AIDS being an untreatable and deadly disease.

The discovery of a seropositive status was met with confusion and disbelief. Some went to the extent of self-stigmatizing and labelling by referring to themselves as "umuntu wephilisi" meaning "the one who is on medication", specifically, anti-retroviral (ARV) treatment. This particular use of language demonstrates that people living with HIV/AIDS tend to self-marginalize and internalise negative meanings and views of their illness. The study furthermore revealed that there are still misconceptions that exist regarding the transmission of HIV/AIDS. Transmission is seen as only through unsafe sex practices; some believe that PLWHA cannot live normal lives due to their seropositive status. This finding shows the need to create educational programmes aimed at sharing factual information about HIV/AIDS, including its symptoms, transmission, and treatment plans.

Individuals from the study who were born HIV-positive assert that the discovery or understanding of their condition brought more hurt than shock which is contrary to emotions experienced by those who were not born positive. Feelings of regret that stemmed from actions that led to a seropositive status are evident from the findings. These findings suggest that one can never prepare oneself for a chronic illness such as HIV/AIDS. Findings reveal that, although a participant has been on ARV treatment for all their lives, discovering what the treatment was for created rage and anger towards their infector. Findings of the study are parallel to the findings of Senyurek et al. 2021; Hult et al. 2009) which assert that feelings of hurt, shame, regret, shock, and anger, inter alia, are inevitable regardless of individuals having suspected that they may be HIV-positive.

Findings of the study did not vividly reveal participants' reasons that led to seeking HIV testing services, whether this was a voluntary action or otherwise. Of the 15 male participants in this study, less than 30% indicated voluntarily seeking HIV testing services; and this was not due to any visible symptoms or suspicions of having HIV/AIDS. This finding supports findings from other studies that suggest that men are less likely to utilize healthcare structures, these seemingly modelled for women (Armstrong et al. 1999; Lynch 2010). The low rate of men from this study initiating first-time HIV testing services shows that social constructs of health facilities being services created for women continue to exist. Therefore, this reveals a need for male-focused services that will encourage men to utilize healthcare services.

5.2.2 Disclosure of status

Findings revealed that, while the majority of male participants in this study had disclosed their seropositive status early on, there was a minority group that chose to conceal their status for some time before disclosing it to those they trusted.

Findings also support other findings that there is a relationship between disclosure and trust (Peltzer and Mlambo 2013). All participants in this study disclosed their seropositive status either to their intimate partners, family members, or close friends.

Findings show that those who concealed their status and delayed disclosure did so due to fear of rejection by the intimate partner or family; and due to fear of infection, especially of intimate partners. This finding supports other findings suggesting that PLWHA conceal their status due to self stigmatisation and fear of rejection (Muralidharan 2017). A need for increased counselling services for PLWHA to liberate PLWHA from self-stigmatisation, self-isolation, and any negative behaviours arose from this study.

Furthermore, findings of the study revealed a high volume of study participants heeding the counsel of their healthcare practitioners and disclosing their HIV-positive status as early as possible. Moreover, the study revealed that the disclosure by these HIV-positive men was met with support, although this was not an immediate response to all the men. This shows that progress that has been made since the first reported case of HIV in the 1980s. Some people have come to understand that HIV/AIDS is not a death sentence; rather, it is a manageable chronic illness. This does not mean that there is no need for more rigid HIV education campaigns and programmes. In some communities PLWHA are still subjected to negative responses such as dismissal from work, verbal abuse, and social exclusion.

The findings from this study furthermore support the findings that reveal that PLWHA are most willing to share their seropositive status with their families and intimate partners in order to gain emotional support (Senyurek 2021; Peltzer and Mlambo 2013).

However, the study also reveals that not all men's disclosure was met with the understanding and support that men may have anticipated. One participant faced rejection by his then-intimate partner upon disclosure of a seropositive status. Another participant faced the wrath of his mother as he had infected his wife. However, after the shock and anger of his mother, his disclosure was eventually received with support which brought relief to the participant. This current study therefore supports the findings of a study that asserts that disclosure is seen as emotionally healing, cleansing, and liberating (Viller-Loubet 2013). Furthermore, the findings show that participants received similar support from those to whom they disclosed their status, irrespective of their employment status.

Findings of the current study support findings that assert that disclosure by an HIV-positive partner encourages the other partner to seek HIV testing services (Peltzer and Mlambo 2013). This is evident as two participants reported their partners seeking HIV testing services post the disclosure of a seropositive status by their intimate partners.

Contrary to studies conducted that reveal that PLWHA is still subjected to marginalization, stigma and discrimination from their communities and families (Senyurek et al. 2021; Muralidharan et al. 2017; Cloete et al. 2010), this study reveals a more progressive view in attitudes by communities and families that PLWHA are subjected to. The study reveals a more supportive and understanding view by those living in the environment of PLWHA who participated in the current study.

The ecosystems theory emphasises an increase in such views and attitudes of understanding that HIV/AIDS is not a death threat, but rather, a manageable chronic illness. Support for PLWHA will lead to a balance in ecosystems from the micro level, in that family units will be preserved and remain balanced. A balance will be evident at the mezzo level, as fewer PLWHA will experience mental-health issues that will cause disruption to their productivity due to stigmatisation. At the macro level, the economy will grow because more individuals will fully and actively participate in economic activities due to non-isolation and non-marginalisation resulting from their HIV-positive status. Furthermore, a smooth implementation programme of policies pertaining to HIV/AIDS will be created. Such will not focus mainly on HIV education and protection of PLWHA, but will focus on promoting the lives of persons living with HIV/AIDS so as to create a deeper and more intimate sense of belonging within communities.

5.2.3 Challenges post diagnosis

While some infected male participants faced challenges post diagnosis and disclosure, findings show that these challenges were either perpetuated by internalised negative thoughts and stigma or by the surrounding environment. Findings also reveal that some HIV-positive men face minimal to no challenges.

Challenges that arose from this study range from challenges in adapting to a positive status to avoiding stable romantic relationships to financial problems that stem from a seropositive status. Challenges revealed by this study include difficulties adapting to a new life as a HIV-positive man. An infected male participant narrated that he avoids remaining in a romantic relationship for too long as this will require him to reveal his seropositive status in building trust between himself and his partner. This shows that a seropositive status has the potential to destabilize a romantic and committed relationship. Furthermore, this finding reveals how consistent use of protection is not only for the intention of curbing the spread of HIV but as a way of concealing one's seropositive status.

This study revealed an incident of rejection due to a seropositive status. A participant living with HIV revealed that his then-partner rejected him and left him post his disclosure of his seropositive status. This re-emphasizes the need for continued rigorous HIV education in communities. Additionally, financial challenges as a result of HIV/AIDS were revealed in this study. An infected male expressed that there are negative financial implications perpetuated by living with HIV. One is required to collect one's ARV treatment on stipulated dates; and this incurs travelling costs for PLWHA. While the participants of this study did not reveal any information of financial challenges prior to HIV diagnosis, it was revealed that there were financial challenges experienced post diagnosis. This presents as a problem despite the government attempting to lessen the burden on communities through making healthcare services accessible for all through mobile clinics.

The findings from this study revealed the extent to which self-stigmatisation results in disruption to an individual's life; commonly, this includes the avoidance of activities which were once enjoyable due to fear of infecting the next person. This may give rise to mental-health issues. This stigmatisation creates additional challenges and difficulties as alluded to in a study conducted in which the findings were that (stigma) negatively impacts individuals' ability to adapt to a chronic disease (in this case HIV/AIDS); and creates difficulties in relationships (Colmenro et al. 2019). While the findings show self-stigmatisation, self-destructive behaviours and choices by PLWHA, some infected men experience external challenges. An infected man from this study in addition to already existing emotions of hurt and regret was showered with anger and insults from his mother due to infecting his wife with HIV/AIDS.

The findings show that men living with HIV/AIDS experienced challenges with adapting to the new lifestyle that came with living with HIV/AIDS. Having to depend on medication or ARV treatment to lead a healthy and normal life proved to be a challenge for men living with HIV/AIDS. One man with a seropositive status further added "Especially when you have brought it onto yourself." While all men with a seropositive status were aware of the benefits of taking their medication as prescribed, taking treatment is still seen as a difficulty. Findings showed that problems stemmed from having to consume the medication at a stipulated time daily, and the number of the tablets to consume .

The study showed that some lifestyle changes that were seen as problematic were influenced by concern for the next person. A homosexual man asserted that he must consider his sexual partner. This finding shows how UBUNTU, being considerate of the health of persons one share life with, can serve as an encouragement to curb the spread of HIV/AIDS. The White Paper on Social welfare (1997) defines Ubuntu as "people are people through other people." This supports the saying that says "No man is an island", which implies that no human is self-sufficient, but humans are interconnected and are dependent on one another. The support that was experienced by men living with HIV who participated in this study reiterated that Ubuntu fosters care and support which in turn gives participants a sense of belonging and acceptance. Through caring and considering the next person one can avoid intentional spread of the virus.

Additionally, with all the hurdles experienced by men living with HIV/AIDS within the Okhahlamba Local Municipality, the findings of the study reveal that none regretted disclosing their seropositive status. The low rate of, stigmatisation discrimination, and marginalisation of PLWHA shows the progress that has been made in relation to HIV/AIDS awareness.

5.2.4 Availability of support systems

Findings of the current study disclose that the availability of support systems plays an enormous role in the lives of PLWHA. HIV/AIDS care and support services refers to professional social and emotional support and support by family. Studies assert that families are seen as the primary source of physical and socio-economic support (Mturi et al. 2006).

Stable support from family, friends and intimate partners, as per findings of the study, assisted men living with HIV/AIDS in adjusting and coping with their seropositive status. Support from intimate partners promoted healing and acceptance. Findings show that the support received from one's community promoted acceptance of one's status. Men who participated in the study asserted that through the support of their families and loved ones, they were able to accept their situation. This emphasises the need to increase and strengthen family HIV/AIDS management programmes to sustain and encourage family support for PLWHA.

Findings provide evidence that strong and consistent support for PLWHA helps in refocusing and setting of new goals, promoting stability. An infected man from this study stated how support from his community encouraged stability, in that he has taken the decision to marry his partner. This action will create a stable environment for healing and growth; and will furthermore help curb the spread of HIV/AIDS. Monogamy promotes faithfulness between couples: monogamy is the practice of having one partner with whom to share a sexual relationship (Schacht and Kramer 2019).

Contrary to findings from other studies showing that healthcare professionals labelled HIV/AIDS-infected patients as infectious beings (Adrewin and Chien 2008), the current study revealed that HIV-infected men from this sample found consolation, non-judgement and support from healthcare practitioners. Findings furthermore show that men living with a seropositive status were fully satisfied with the support services of healthcare practitioners. These patients were confident of receiving support from qualified personnel. The study shows the importance of the support received by men living with HIV/AIDS.

Findings reflected a viable collaboration of a multidisciplinary support system and family support system in helping PLWHA to adapt and adjust to life as PLWHA. Other studies outlined (Peterson et al. 2010; Kasiram 2006) that spiritual support for PLWHA facilitated coping with the life-long illness. Such spiritual support provided hope, strength and peace. Based on their studies this was a relative truth. The current study did not show spirituality as a coping mechanism for men living with HIV/AIDS.

Given the above narratives, it is evident that participants in this study enjoyed solid and effective support from their families and friends; while for some clients this support was not immediately received, as in the case of Participant B. however, participants received support beyond their families and friends. This study shows evidence of support from healthcare (nurses) personnel, and psycho-social support by social workers.

The support participants received helped them in their journey of acceptance, healing, and adjustment to their new life. Participants were shown to be accepting of and satisfied with the support offered and received; and the support has proved to be helpful.

5.3 RECOMMENDATIONS

From the gathered data of this study, the following recommendations are provided in line with social construction and the ecosystems theory.

5.3.1 Recommendations in relations to micro-level systems

5.3.1.1 Family counselling

While the study highlighted the benefits of family support, it also showed a need for strengthened family therapy. Without a doubt, HIV/AIDS does not only affect the infected person but also affects those around them family, friends, and intimate partners. The provision of family therapy for PLWHA and their families will provide all parties with emotional and psychological support needed to commence their journey towards healing and acceptance. Family therapy will also assist HIV/AIDS-infected persons through the facilitation of a disclosure process for PLWHA. Individualised family interventions will be designed by counsellors so as to ensure that maximum benefits of family therapy are attained.

5.3.1.2 Individual therapy

Findings revealed that nurses played a vital role in the journeys of men living with HIV/AIDS through accepting their seropositive status. Services by nurses gave PLWHA a sense of identity beyond their seropositive status. Through individual pre- and post-counselling services, PLWHA were able to improve their self-esteem and gain hope for the future. Therefore, there is a need for increased training of nurses and counsellors in order to provide effective services to patients. A study by Inungu and Karl (2006) proposes that training could include an assertiveness and life-skills programme.

Counsellors could be encouraged and rewarded for their great services to PLWHA. Such would increase their dedication to their work and motivate them to continue to develop within their field of practice; this would increase the quality of services rendered to PLWHA. An augmentation in the quality of services will furthermore help address and de-construct social constructs and myths of PLWHA. Such myths reinforce perceptions of PLWHA as people who are carriers of a deadly contagious disease; and of HIV/AIDS being an untreatable illness.

The utilization of multidisciplinary counselling services has proved successful and beneficial to PLWHA. The implementation of collaborative services between HIV/AIDS counsellors, social services and healthcare practitioners would provide holistic and effective services to PLWHA; and ensure the smooth transition of infected persons to new lifestyles by preparing them emotionally and psychologically for this lifestyle change.

5.3.2 Recommendations in relation to mezzo-level systems

5.3.2.1 Group therapy/support group

This study recommends that support groups be promoted in all spheres. The promotion of group therapy or support groups and encouragement of involvement thereof of men living with HIV/AIDS will help strengthen a sense of belonging among PLWHA. Group therapy will create an additional support system for PLWHA, particularly for men living with a seropositive status. Furthermore, group therapy will create a safe place for HIV-positive men to share their experiences, shortcomings and victories in a space where there is no judgement, discrimination, or stigmatisation.

The promotion of support groups for men living with HIV/AIDS, through channels such as social media and other channels, could raise awareness around HIV/AIDS and promote HIV testing, acceptance, and adherence to treatment by men living with HIV/AIDS. By making the seeking of HIV testing services normal, there could be a greater chance of curbing the spread of HIV/AIDS − the sooner one knows their HIV status, the earlier one's lifestyle changes.

5.3.2.2 Community education

The study found that there is a need for increased strategic community education about HIV/AIDS, its symptoms, testing services availability, treatment options, and ways of reducing chances of reinfection. The implementation of these strategic educational programmes could help de-construct negativity associated with HIV/AIDS. It could also help facilitate non-judgemental acceptance of people living with a seropositive status. A solid support system/structure could be created to help those living with HIV/AIDS face challenges that arise from living with HIV/AIDS. This recommended strategy could help enlighten communities in making them HIV/AIDS-wise or 'woke' (a state of being actively attentive to important societal facts and issues) in order to do away with myths that have lasted for generations around HIV/AIDS; thus, creating and promoting unity and empathy within communities.

5.3.3 Recommendations in relation to macro-level systems

Initiation and funding must be provided to non-governmental organizations/non-profit organizations that will focus on the mental health and wellness of men, especially those in rural areas. This could help and encourage men to take care of both their physical health by correct eating habits and by taking their medication as prescribed. Mental health of men can be supported by breaking free or liberating themselves from self-stigmatisation and self-discrimination.

A multisectoral approach could be employed in developing plans, programmes, policies, and interventions for PLWHA. The implementation of this approach could ensure that a variety of stakeholders/service providers as needed by HIV-positive persons would provide valuable input and would be readily available and accessible.

Comprehensive HIV/AIDS counselling education could be incorporated into the curriculum of social-work students. This would equip them with the necessary skills to ensure the effectiveness of the multisectoral approach. Furthermore, regular development of service providers could be beneficial to services relating to HIV/AIDS. Treatment is ever advancing and therefore requires that persons/professionals working with PLWHA are also constantly making efforts to advance and develop their knowledge of HIV/AIDS.

The government could make it compulsory that local and district municipalities initiate programmes in partnership with NGOs and NPOs that would focus on men living with a seropositive status, including assisting PLWHA. For example, a men's lounge movement could be formed, which will serve as a networking opportunity for men living with HIV/AIDS. Here men can share opportunities, coping strategies, and create awareness around HIV/AIDS, and present benefits of HIV testing and adherence to treatment prescribed.

Findings of this study will be disseminated to the Department of Health , the Department of Social Development , NGOs, NPOs and other relevant stakeholders including academics.

5.4 IDENTIFIED AREAS FOR FURTHER RESEARCH

This study explored the experiences of men living with HIV/AIDS, by way of a small sample of 15 men with a seropositive status within the OLM. The findings of this study therefore cannot be generalised to the whole population of men living with HIV/AIDS; therefore, it is recommended that further research be conducted on a larger scale.

Further research could be conducted on the experiences of caregivers and families of men living with HIV/AIDS. This could be so as to understand their experiences and challenges if any, as persons affected by HIV/AIDS through the infection of their loved ones.

Further research may be conducted on the adaptation and coping strategies employed by men living with HIV/AIDS post-diagnosis. Findings from such a study could be useful and effective when presented to other men living with HIV/AIDS.

5.5 CONCLUSION

The aim of the study was to explore the experiences of men living with HIV/AIDS: such was achieved. However, there was a limitation to the study − not all set objectives were highlighted and met, particularly not the objective of gathering available coping mechanisms and strategies of men living with HIV/AIDS.

Infected men, as with other recipients of a HIV-positive diagnosis, experienced a number of varying emotions, including fear, shock, regret, and anger. These men living with HIV/AIDS experienced difficulties accepting their diagnosis and making lifestyle changes. The study revealed and supported findings that assert that men are unlikely to utilize healthcare facilities/services or HIV testing. The study revealed a relatively low number of infected men indicating voluntary testing for HIV/AIDS. All participants disclosed their seropositive status to those whom they trusted; this was despite having doubts and fears around disclosure.

Furthermore, revealed in the study was the progress that has been made in relation to understanding HIV/AIDS. Infected men received support and sympathy from those with whom they shared their seropositive status, including those whom they had infected with the virus. Non-stigmatisation and non-discrimination were seen in the findings. Some men with a seropositive status had been subjected to isolation, stigmatisation, or discrimination due to their HIV positive status. Increased programmes aimed at addressing HIV/AIDS education are, however, still necessary; findings cannot be generalised to the entire population of men living with HIV/AIDS.

Infected men who required further support were referred to relevant institutions for further counselling services, as mentioned in Chapter 3 of this study. The low number of male participants requiring further support indicated the effectiveness of their available systems of support (family, friends and professionals). Such also showed that these HIV-positive men understood that HIV/AIDS is not a death sentence; rather, this is a manageable chronic illness.

References

Akhtar, I. (2016). *Research Design: Semi-Structured Qualitative Studies*. London: Sage Publishing.

Allen, M. (2017). *Confidentiality and anonymity of participants*. The SAGE Encyclopaedia of communication research methods.

Andrews, T. (2012). *The Grounded Theory Review: What is social constructionism?* University College Cork. Vol. 11(1), 39-46.

Arias-Colmenero, T., Perez-Morente, M., A., Ramos-Marcillo, A., J., Capilla-Diaz, C., Ruzafa-Martinez, M., & Hueso-Montro, C. (2020). *Experiences and attitudes of people with HIV/AIDS: A systematic review of qualitative studies*. International journal of environmental research and public health.

AVERT (2010). *Women and HIV/AIDS Statistics*. Retrieved July 3, 2011, from: http://www.avert.org.

AVERT 2019). *HIV and AIDS in South Africa*. Retrieved August 18, 2021, from: https://www.avert.org

Bachmann, M., & Booysen, F. (2003). *Health and economic impact of HIV/AIDS on South African households: A cohort study. BMC Public Health*, 3(1). Doi:10.1186/1471-2458-3-14.

Berger, P. L., & Luckmann, T. (1966). *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. New York: Anchor Books.

Berger, P. L., & Luckmann, T. (1991). *The social construction of reality*. London: Penguin Books.

Bless, C., Higson-Smith, C., & Sithole, S. L. (2013). *Fundamentals of Social Research Methods - An African Perspective*. Retrieved August 17, 2021, from: http://books.google.com/books/about/Fundamentals_of_Social_Reasearch_Methods.html?id=gDdOmQEACAAJ

Bronfenbrenner, U. (1977) *The experimental ecology of human development*. Cambridge, Mass.: Harvard University Press.

Byaruhanga, R., Andersson, L., & Govender, K (2021). *Hegemonic masculinity and risky sexual behaviours in KwaZulu-Natal, South Africa*. African Journal of Social Sciences and Humanities Research. Vol 4(1), 1-17. Doi:2689-5129

Cloete, A., Strebel, A., Simbayi, L., van Wyk B., Henda, N., Nqeteko, A. (2010) Challenges faced by people living with HIV/AIDS in Cape town, South Africa: Issues of group risk reduction interventions. Hindawi publishing corporation.

Colvin, M., Du Toit, D. & Hadingham, T. (2005) *KwaZulu-Natal Led HIV/AIDS Final Report: Local Economic Development Support Programme KwaZulu-Natal*. Component Final Report (1). http://www.cadre.org.za/files/kzn-led-report.pdf.

Cousin, J. (2009) *Researching Learning in Higher Education*: *An Introduction to Contemporary Methods and Approaches.*

Cosma, S., & Gurevich, M. (2020) *Securing sex: embattled masculinity and the pressure pursuit of women's bodies in men's online sex advice*. Ryerson University. Canada

Connolly, M., & Harms, L. (2011) *Ecosystem's theories*. Cambridge University Press

Creswell, J. W., & Poth, C. N. (2017) *Qualitative inquiry and research design: Choosing among five approaches.* Sage publications.

Du Plooy-Cilliers, F., Davis, C., & Bezuidenhout, R. M. (2014) *Research Matters. Claremont*: Juta.

Engel, R. J., & Schutt, R. K. (2013). *The practice of research in social work* (3rd ed.). Sage Publications, Inc.

Human Sciences Research Council (2017), *The fifth South African national HIV prevalence, incidence, behaviour, and communication survey. HIV impact assessment summary*. Retrieved July 2008

Itulua-Abumere, F. (2013) *Understanding men and masculinity in modern society.* The University of Roehampton. Daytona Global Enterprise Limited. Nigeria

Kasa, L. (2017) *A comprehensive study on the impact of inequality towards rural development: The study of Mthatha Sub-region with King Sabatha Dalindyebo municipality*. Unpublished master's in social work dissertation: Walter Sisulu University

Kivunja, C. & Kuyini, A. B. (2017) *Understanding and applying research paradigms in Educational Contexts.* University of New England Vol 6, No. 5.

Leclerc-Madlala, S. (2001). *Virginity testing: managing sexuality in a maturing HIV/AIDS epidemic.* Medical anthropology quarterly, 15(4), 533–552. https://doi.org/10.1525/maq.2001.15.4.533

Lynch, I., Brouvard, P., W., & Visser, M., J. (2010) *Constructions of masculinity among a group of South African men living with HIV/AIDS: Reflections on resistance and change, culture, health & sexuality*, 12:1, 15-27, DOI: 10.1080/13691050903082461

Moon, K. T. D., & Brewer, S. R. (2016) *A Guideline to Improve Qualitative Social Science Publishing in Ecology and Conservation Journals*. Ecology and Society 21(3):17.

Mturi, A., Nzimande, N., Dungumaro, E., & Sekokotla, D. (2006) *Household structures in contemporary South Africa.* Loyola Journal of Social Sciences, 20(1), 19-45

Ngcobo, N. P. (2011*) Exploring the narratives of women living with HIV/AIDS in a designated health setting*. Unpublished Master of Social Work Dissertation. Durban.: University of KwaZulu-Natal.

Nijhawan, L. P., Janodia, M. D., & Musmade, P. B. (12013) *Informed consent: Issues and challenges. Journal of advanced pharmaceutical technology and research*. Medknow Publications

Okhahlamba Local municipality. (2020/2021) Integrated Development plan draft.

Orman, T. F. (2016). *"Paradigm" as a Central Concept in Thomas Kuhn's Thought*. International Journal of Humanities and Social Science, Vol. 6(10), 47-52.

Peltzer, K., & Mlambo, G. (2013) HIV disclosure among HIV positive new mothers in South Africa. Journal of psychology in Africa.

Ratele, K. (2013) *"Masculinities without Tradition."* Politikon 40 (1): 133–156.

Robinson, R. S. (2014) *Purposive Sampling.* In: Michalos A.C. (eds) *Encyclopaedia of Quality of Life and Well-Being Research.*

Schlichthorst, M., Sanci, L. A., Pirkis, J., Spittal, M. J., & Hocking, J. S. (2016) *Why do men go to the doctor? Socio-demographic and lifestyle factors associated with* *healthcare utilisation among a cohort of Australian men.* The author(s) BMC Public heath 2016, 16(suppl 3):1028 Dol 10.1186/s12889-016-3706-5

Senyurek, G., Kavas, M. V., & Ilman, Y. I. (2021) *Lived experiences of people living with HIV: a descriptive qualitative analysis of their perceptions of themselves, their social spheres, healthcare professionals, and challenges they face daily.* BMC Public health

Simelela, N. P., & Venter, W. D. F. (2014) *A brief history of South Africa's response to AIDS*

Skovdal, M., Campbell, C., Madanhire, C., Mupambireyi, Z., Nyamukapa, C., & Gregson, S. (2011) *Masculinity as a barrier to men's use of HIV services in Zimbabwe.* Globalization and health.

Statistics SA (2017) General Household survey. 2017

Statistics SA. (2020) Annual report 2019/2020. 2020.

https://www.statssa.gov.za/publications/P0318/P03182017.pdf

UNAIDS. (2008) *UNAIDS global report.* UNAIDS. http://data.unaids.org/pub/GlobalReport/2008/jc1510_global_report_pp29_62_en.pdf

UNAIDS. (2010) *UNAIDS report on the global aids epidemic*. UNAIDS

https://www.unaids.org/globalreport/Global_report.htm

United Nations. (2011) *Men in Families and Family: Policy in a Changing World.* United Nation. New York. Department of Economic and Social Affairs.

https://www.un.org/esa/socdev/family/docs/men-in-families.pdf

uThukela District Municipality. (2020/2021) Integrated Development Plan Review.

Vanclay, F., Baines, J. T., & Taylor, C. N. (2013) *Principles for ethical research involving humans: ethical professional practice in impact assessment Part 1,* Vol. 31(04), 243-253.

White Paper for Social Welfare. (1997). *Principles, guidelines, recommendations, proposed policies, and programmes for developmental social welfare in South Africa.*

https://www.gov.za/sites/default/files/gcis_document/201409/whitepaperonsocialwelfare0.pdf

UNIVERSITY OF KWAZULU-NATAL™
INYUVESI YAKWAZULU-NATALI

Information Sheet and Consent to Participate in Research

Date:

Dear Sir.

My name is Vuyisiwe Nxumalo, Masters Candidate (Master of Social Sciences-Social work) from the University of KwaZulu-Natal-Howard College Campus in the School of Applied Human Sciences. I can be contacted on:

Cell: 071 138 1262
Email: 217066864@stu.ukzn.ac.za.

You are being invited to consider participating in a study that involves research on the experiences of men living with HIV/AIDS living under the Okhahlamba Local Municipality.

- The aim and purpose of this research is to explore the in-depth experiences of men living with HIV/AIDS within Okhahlamba Local Municipality.
- The study is expected to enrol 15 men of all races residing in Okhahlamba (Bergville) and are between the ages of 18 and 40 years.
- It will involve the following procedures: completion of Informed Consent and declaration and active participation in semi-structured in-depth interview with researcher, whereby the participants will be asked questions as guides to the interview.
- The duration of your participation if you choose to enrol and remain in the study is expected to be 45 minutes to one and a half hours per interview session. Each participant will be requested to participate in one interview session with the researcher.
- The study may involve the following risks and/or discomforts: Participants may experience trauma due to the sensitivity of the study which involves a chronic illness that may have possibly be acquired in traumatic manners.
- You have a choice to participate, not participate or stop participating in the

research. You will not be penalised for taking such an action.

- I hope that the study will be beneficial in the practice and body of knowledge to inform the social workers of the psychosocial needs based on the narratives of the experiences of men living with HIV/AIDS, and potentially influence the policies on HIV/AIDS to cater more for men living with HIV/AIDS in South Africa.
- **Participants will not receive any direct benefits from the study including monetary benefits.**
- The personal information of participants, including their name and surname and those of whom they may reveal in the process of data collection, will not be revealed in thesis which will complied by the researcher, your anonymity as a willing participant will be protected.
- Data will be stored in secure storage and destroyed after 5 years.
- Due to the sensitivity of the topic under research, participants who will require psychosocial support services will be referred to the Department of Social Development to receive necessary counselling from professional Social workers.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number: HSSREC/00004219/2022).

- If you are willing to be interviewed, please indicate (by ticking as applicable) whether or not you are willing to allow the interview to be recorded by the following equipment:

	Willing	Not willing
Audio equipment		

In the event of any problems or concerns/questions you may contact the researcher on Cell: 0711381262 or by email: 217066864@stu.UKZN.ac.za.

My supervisor is Prof. N M Mazibuko who is located at the School of Applied Human Sciences, University of KwaZulu-Natal/Howard College Campus, Durban and can be contacted by email; MazibukoN3@ukzn.ac.za.

Alternatively, you may contact UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Thank you for your contribution to this research.

DECLARATION

I…………………………………………………………………………… (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT DATE

……………………………………… …………………………………

UNIVERSITY OF
KWAZULU-NATAL
INYUVESI
YAKWAZULU-NATALI

Semi-Structured interview schedule

Participant’s details:

	Response
Race:	
Age:	
Marital Status:	
Occupation:	
Home Language:	
Highest Grade Passed:	
Residential Address:	
Number of Dependants:	
Total Household income per month:	

The following questions and themes will be explored in the interview and focus group:

1. Diagnosis of your status

- When was your first discovery of your HIV-positive status?

2. Receipt of this information

- How did you feel upon receipts of HIV-positive status?
- Pre- and post-test counselling? Explain.

3. Making your adjustment to HIV/AIDS (biopsychosocial, ecological challenges, and successes)

- What are the challenges encountered after receipt of HIV/AIDS diagnosis?
- How have the challenges generally affected your life?
- Did you encounter challenges of disclosing status?
- Do you have available sources of support (emotional, financial, etc)?

- Do you require further support?
- How have you been coping with an HIV positive status, explain

4. Municipal programmes

- Are there any municipal programmes for people living with HIV/AIDS? (if yes, how have they been beneficial to you)
- Are you satisfied with the services provided? explain

5. What is your message to other people living with HIV/AIDS?

Thank you