THE RESILIENCE OF WOMEN LIVING WITH HIV AT WINNIE MANDELA INFORMAL SETTLEMENT WITHIN EKURHULENI METROPOLITAN MUNICIPALITY.

by

MASEVHEGE MAMBO TREVOR

submitted in accordance with the requirements for the degree of

MASTER OF SOCIAL WORK

in the subject

SOCIAL WORK

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: DR RM SKHOSANA

APRIL 2024

DECLARATION

Name: Masevhege Mambo Trevor Masevhege

Student number: 60828188

Degree: Master of Social Work

THE RESILIENCE OF WOMEN LIVING WITH HIV AT WINNIE MANDELA INFORMAL SETTLEMENT WITHIN EKURHULENI METROPOLITAN MUNICIPALITY.

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

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

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

SIGNATURE

05 April 2024
DATE

ACKNOWLEDGEMENTS

I would like to express my gratitude to the following individuals who have played a pivotal role in the successful completion of my study:

- I express my sincerest gratitude to the Almighty for endowing me with the fortitude and sagacity to persevere through my academic pursuits.
- I express my sincere gratitude to Dr. Skhosana RM, my esteemed research study supervisor, for her unwavering commitment, invaluable guidance, and exceptional patience throughout the course of this study.
- To the University of South Africa and the Department of Social Work, I express my sincerest gratitude for providing me with the invaluable opportunity to pursue my academic endeavors within this esteemed institution.
- To the Department of Health of the Ekurhuleni Metropolitan Municipality for the gracious permission granted to conduct the study.
- To all Winnie Mandela Informal settlement women living with HIV who participated in the study
- Prof. Malesa K.J and Dr. Dipela M.P for the invaluable research mentorship and support provided.
- To my esteemed family and friends, who have unwaveringly maintained their belief in me and provided constant encouragement to diligently complete this research study, I express my sincere gratitude.

DEDICATION

This thesis is dedicated to my late father, Mr. Masevhege Muravha Peter. I wish you were here to witness my accomplishments. I would like to express my heartfelt gratitude to my mother, Mrs. Masevhege Monica. Your support and guidance have made all of this possible. Additionally, I would like to extend my appreciation to my siblings, family, and friends for your support. Lastly, I want to thank all healthcare professionals who are at the forefront of combating the burden of HIV/AIDS. Victory is certain.

ABSTRACT

Globally, it was estimated that over 37 million individuals were infected with the Human Immunodeficiency Virus (HIV), with women being more affected by the virus compared to men. This can be attributed to various factors, such as women's low economic status and the violation of their sexual rights. Despite the availability of Antiretrovirals (ARVs) to mitigate the effects of HIV, Women Living with HIV (WLWHIV) still need certain traits to cope with the challenges. The study aimed to explore and develop a thorough understanding of the resilience strategies used by WLWHIV to cope with their HIV diagnosis.

A qualitative, phenomenological design was utilized, and participants were purposefully selected. Data was collected using semi-structured interviews with fifteen WLWHIV who are part of the Central Chronic Medication Dispensing and Distribution Programme (CCMDD) at Winnie Mandela Clinic, Ekurhuleni, Gauteng Province in South Africa. Data was analysed using Tesch's approach and four themes and fifteen sub-themes emerged. Trustworthiness was applied as a means of verifying the accuracy and reliability of the data. Ethical considerations were strictly adhered to, including obtaining informed consent, maintaining confidentiality and anonymity, ensuring beneficence, debriefing participants, and avoiding harm.

Study findings have established that WLWHIV go through different experiences brought on by the virus. Some succumb to these negative experiences, while others are able to rise above them and become resilient to the virus. The study found several strategies are used for one to be resilient to HIV, such as disclosing their HIV status, attending HIV support groups and maintaining a healthy lifestyle. Additionally, social workers and family members were found to play a vital role in building resilience among WLWHIV. These findings will help social workers develop interventions to assist newly diagnosed women, will make significant contributions to the academic field and aid policymakers in crafting policies that foster resilience among WLWHIV.

Keywords: HIV, Informal Settlement, Living with HIV, Resilience, Women

TABLE OF CONTENTS

Contents

LIST OF FIGURES AND TABLES

LIST OF ABBREVIATIONS

AIDS - Acquired Immunodeficiency Syndrome

AGYW - Adolescent Girls and Young Women

ARV - Antiretroviral

CBOs -Community-Based Organizations

CCMDD - Central Chronic Medication Dispensing and Distribution Programme

CDC - Centers for Disease Control and Prevention

CD4 - Cluster Differentiation Group 4

DOH – Department of Health

GAD – Generalized Anxiety Disorder

GBV - Gender-Based Violence

HIV - Human Immunodeficiency Virus

ILWHIV - Individuals Living with Human Immunodeficiency Virus

MSPs - Multiple Sexual Partners

NGOs - Nonprofit Organizations

PLWHIV- People Living with Human Immunodeficiency Virus

PMTCT- Prevention of Mother to Child Transmission

POPI - Protection of Personal Information

PPD – Postpartum Depression

PTSD – Post-Traumatic Stress Disorder

PuPs – Pick-up Points

QOL – Quality of Life

SA – South Africa

SABSSM IV - Sixth South African National HIV Prevalence, Incidence, Behaviour, and Communication Survey

SES - Socio-Economic Status

SIV - Simian Immunodeficiency Virus

SRPS – Stress-Related Psychological Sequelae

SSA - Sub-Saharan Africa

STIs - Sexually Transmitted Infection

UNAIDS - Joint United Nations Programme on HIV/AIDS

USA – United State of America

VL – Viral Load

WHO - The World Health Organization

WLWHIV – Women Living with Human Immunodeficiency Virus

CHAPTER 1

1. GENERAL INTRODUCTION OF THE STUDY

1.1 INTRODUCTION

The purpose of this chapter is to provide an overall understanding of the background of the study, the problem statement, the rationale behind the study, the theoretical framework, and the research aim, question, and objectives. Additionally, this chapter will introduce the methodology applied in the study, ethical considerations, define key concepts, and provide an outline of the report's structure.

1.2 THE BACKGROUND OF THE STUDY

Human immunodeficiency virus (HIV) is one of the most serious public health threats of the 21st century, with over 40 million people having lost their lives and continuing to die due to HIV-related diseases (Fauci & Lane, 2020). In the mid-90s, 20 million people were estimated to be living with HIV globally (Hemelaar, Elangovan, Yun, Dickson-Tetteh, Kirtley, Gouws-Williams, & Zhang, 2020). Since then, the prevalence of People Living with HIV (PLWHIV) has grown to 39 million globally as of 2022, with women and girls accounting for 53% (HIV.ORG, 2022). HIV.ORG (2022), further indicate that of the 39 million PLWHIV globally, 37.5 million were adults (aged 15 years and above) and 1.5 million were children (aged 0-14 years). However, a recent report suggests that there has been a global reduction in new HIV infections. According to Joint United Nations Programme on HIV/AIDS [UNAIDS] (2022), the number of new HIV infections globally has decreased by 59% since reaching its peak in 1995.In 2022, 1.3 million people were newly infected with HIV, with women and girls accounting for 46%, compared to 3.2 million people in 1995 (HIV.ORG, 2022). It is also worth noting that some geographical areas have significantly higher HIV burdens than others (Sullivan, Johnson, Pembleton, Stephenson, Justice, Althoff, and Rosenberg, 2021).

Two-thirds of all People Living with HIV (PLWHIV) globally are African, with the Sub-Saharan region bearing a disproportionate burden of HIV infection (Tolmay, Knight, Muvhango, Polzer-Ngwato, Stöckl, & Ranganathan, 2022). According to Tolmay et al. (2022), this region accounts for 71% of the global population of PLWHIV. The countries most affected by the HIV epidemic in Sub-Saharan Africa (SSA) are South Africa, Eswatini, Lesotho, Mozambique,and Botswana (Kharsany & Karim, 2016). However, the majority of PLWHIV reside in South Africa (SA) (Kim, Tanser, Tomita, Vandormael, & Cuadros, 2021). The overall HIV prevalence rate among the South African population is estimated to be 13.9%, with 19.6% being adults between the ages of 15 and 49 years (Statistics South Africa, 2022). In 2022, 8.45 million people were reported to be living with HIV (Stats SA,2022). HIV prevalence was significantly higher among certain sub-groups (Palanee-Phillips, Rees, Heller, Ahmed, Batting, Beesham, Heffron, Justman, Makkan, Mastro, Morrison, Mugo, Nair, Kiarie, Philip, Pleaner, Reddy, Selepe, Steyn, & Baeten, 2022). It was estimated that 31% of women aged 25 to 49 in South Africa were living with HIV (Palanee-Phillips et al., 2022).

Poor areas in South Africa seem to have a greater HIV burden (Mabaso, Makola, Naidoo, Mlangeni, Jooste, & Simbayi, 2019). One such area is the Ekurhuleni Metropolitan Municipality, where the study was conducted. Ekurhuleni Metropolitan Municipality appears to be one of the hardest hit by HIV within the Gauteng province, with an HIV prevalence rate of 14.3% (Mshweshwe-Pakela, Hansoti, Mabuto, Kubeka, Hahn, & Hoffmann, 2020). The Department of Health (2018) also reported a high HIV prevalence rate among women, standing at 63% in the Ekurhuleni Metropolitan Municipality. According to the Department of Health Tier.net (2022), Winnie Mandela clinic, located in the Thembisa township within the Ekurhuleni Metropolitan Municipality, where the study participants were sampled, has a total of 7,467 PLWHIV ARV treatment. Among these people, 4,085 are actively enrolled in the Central Chronic Medication Dispensing and Distribution (CCMDD) program, which provides an alternative means of accessing medicine for stable patients. Of these enrolled patients, 1,475 are man and 2,610 are women (Department of Health Tier.net, 2022).

It is important to acknowledge that the discovery and implementation of ARV drugs have significantly slowed down the progression and deterioration of health in PLWHIV majority of them being women (Schatz, David, Angotti, Gómez-Olivé, & Mojola, 2022). ARV is a standard treatment for people diagnosed with HIV which has completely transformed the course of the disease from a life-threatening infection to a manageable chronic condition (Buh, Deonandan, Gomes, Krentel, Oladimeji, & Yaya, 2022). According to Buh et al. (2022), ARV works by preventing the virus from replicating or multiplying, reducing the patient's viral load, increasing their Cluster Differentiation Group 4 (CD4) count, lowering the risk of opportunistic infections and hospitalizations, improving their quality of life, and reducing mortality. In 2013, the World Health Organization (WHO) issued guidelines stating that ARV should be provided free of charge in all public health facilities worldwide for all PLWHIV, regardless of their clinical stage or CD4 cell count (WHO, 2018). It is recommended that individuals who are willing to start ARV treatment should be initiated on the same day or within seven days of their HIV diagnosis (WHO, 2018).

Although ARVs have significantly slowed down the progression of HIV and the decline in health PLWHIV, there are still several socio-economic factors that present a challenge to their well-being (Adeoye, 2018). These factors include, but are not limited to, poverty, unemployment, stigmatization, discrimination, mental health challenges due to increased stress, and additional financial burdens resulting from commitments that that would otherwise be non-existent in the absence of HIV (Chettimada, Lorenz, Misra, Dillon, Reeves, Manickam, & Gabuzda, 2018). It is therefore clear that PLWHIV, especially women are faced with a distinct or peculiar set of challenges they have to contend with daily (Weinstein, Lee, Mendez, Harkness, Safren, & El-Sadr, 2021).

Although the feminist movement has made significant strides in improving the status of women in society, especially in addressing socio-economic factors that disadvantage women, such as those living with HIV, remnants of this patriarchal system are still prevalent in many societies, particularly in Africa (Sen, 2019). In Africa, women are expected to submit to the authority of men, who are regarded as masters, which effectively disempowers women and hinders their ability to exercise their reproductive rights (Bhatia, Harrison, Kubeka, Milford, Kaida, Bajunirwe, Wilson, Psaros, Safren, &

Bangsberg, 2017). This leaves them vulnerable to sexual, emotional, and physical abuse from their spouses or partners (Bhatia et al., 2017). Furthermore, societal expectations that women must be obedient to men often prevent them from negotiating safe sex, resulting in a higher risk of Sexually Transmitted Infections (STIs), including HIV (Patrão, McIntyre, Costa, Matediane, & Azevedo, 2021). The lower economic status of women often leads them to enter relationships with the primary goal of financial gain, especially for younger women (Tolmay et al., 2022). Additionally, historically, women have had limited opportunities for education, which is crucial for a successful life (Sen, 2019). Overall, despite comprising a larger population, women are underrepresented compared to men in most occupations (International Labour Organization, 2017). This is evident that being a woman in a patriarchal society comes with numerous challenges, especially in impoverished African communities such as the Winnie Mandela Informal settlement in South Africa where the study was conducted.

The unemployment rate for women in South Africa stood at 36.8% in the second quarter of 2021, compared to 32.4% for men (Stats SA, 2021). According to Escalante, Maisonnave, and Chitiga (2021), this suggests that women have less economic empowerment and often rely on men for financial support, as some men believe that women should only have domestic roles. In addition, reports suggested that 39% of children in South Africa are raised solely by their mothers after separations with the fathers, placing a significant burden on these women (Profe & Wild, 2017). These multiple stressors make the lives of women more challenging, especially for those living with HIV (Ledesma, Ma, Vongpradith, Maddison, Novotney, Biehl, LeGrand, Ross, Jahagirdar, & Bryazka, 2022)

Due to the multitude of adversities that women encounter, as mentioned above, in conjunction with their HIV status, some women become overwhelmed and fail to function at an optimal level (Ross, Ingabire, Umwiza, Gasana, Munyaneza, Murenzi, & Anastos, 2021). Nevertheless, there are those who maintain a relatively stable level of health functioning and uphold positive adaptation, and these individuals are commonly referred to as resilient (Dale & Safren, 2018).

The concept of resilience is strongly correlated with the ability to manage stress or, in a more objective sense, the ability to recover to a certain level of normalcy following a major upheaval (Olsson, Jerneck, Thoren, Persson, & O'Byrne, 2015). Resilience can be applied to various domains, but in psychology, it is defined as an ongoing process of positive adaptation after experiencing significant setbacks or stress (Olsson et al., 2015). Some experts view resilience as a process rather than a state, as there is growing evidence that mental transformation and personal growth training can help develop resilience. (King, Newman, & Luthans, 2016). Dale, Cohen, Kelso, Cruise, Weber, Watson, Burke-Miller, and Brody (2014), indicates that resilience is linked to environmental and psychosocial factors, such as higher education, income, and employment, and women tend to have less access to these resources compared to men. Characteristics of resilience include accepting one's fate, striving to achieve goals, seeking support from peers and society, helping others in similar situations, being flexible, and taking responsibility (Woollett, Cluver, Hatcher, & Brahmbhatt, 2016). Resilience, in the context of HIV, refers to the ability to effectively adapt to difficult life events, including stigmatization, judgment, discrimination, and other experiences that come with an HIV diagnosis (Dale & Safren, 2018). Consequently, it can be deduced that resilience is crucial for WLWHIV to navigate the challenges of both their daily lives and their HIV status, ultimately leading to better health outcomes for populations at high risk.

Studies as gathered from the literature have shown that women face numerous hardships, particularly those living with HIV. It is also apparent that there are a number of characteristics one needs to possess if they are to be described as resilient to HIV. Some of the characteristics of resilient individuals include pride in past achievements, strong sense of purpose, but the highest effort regardless of the situation, the ability to find the humorous side of things, know where to turn for help, faith, and a belief that things happen for a reason (Connor & Davidson, 2003). These were some of the characteristics observed by researcher in some of the WLWHIV he interacted with as his clients at Thembisa Hospital in the Ekurhuleni Metropolitan Municipality where he used to work. The researcher concluded that these women were likely to be resilient in the face of challenges brought about by their HIV diagnosis.

As a social worker, the researcher was curious about the resilience strategies employed by WLWHIV who have been able to overcome the challenges presented by their condition and continue to live normal lives comparable to those who are HIV-negative. This curiosity prompted the researcher to conduct a study aimed at exploring and developing a thorough understanding of the resilience strategies used by WLWHIV to cope with their condition at the Winnie Mandela informal settlement. It is hoped that understanding the resilience strategies of these women will provide social workers with the necessary knowledge to develop strategies that can equip newly diagnosed HIV-positive women with coping strategies, empower other WLWHIV who are struggling to cope with their HIV diagnosis, and guide policymakers in developing policies that address barriers preventing other WLWHIV from being resilient to the challenges brought by their HIV status.

The following section will present the problem statement.

1.3 PROBLEM STATEMENT

According to John (2020), every research begins with the identification of a problem, and that problem should be clearly defined at the outset. The problem being researched, or the purpose of the research needs to be clearly defined if the research is to fulfill its purpose, which is to provide answers to questions and generate new knowledge (Nasution & Aulia, 2019). The researcher believe that the problem statement is at the heart of any research project and that it is critical to the success of the research effort.

Being diagnosed with HIV is a hardship because it is a lifelong chronic condition that requires lifestyle changes and constant monitoring to increase the chances of staying healthy (Bygrave, Golob, Wilkinson, Roberts, & Grimsrud, 2020). Living with HIV is associated with stigma at multiple levels of society, poor health, feelings of helplessness, hopelessness, and depression (Earnshaw, Kidman, & Violari, 2018). Additionally, HIV negatively affects the economic well-being of individuals. For example, individuals must allocate financial resources for treatment and adhere to a diet that is often more expensive and limited compared to someone who is HIV negative (Naidu, 2020). Therefore, it is evident that PLWHIV, especially women, experience a significant burden due to their status. This burden varies across society and is often greater for those who lack financial security (Bosire, 2021).

In South Africa, various socio-economic factors make women more vulnerable to the challenges posed by HIV (Wabiri & Taffa, 2013). For example, women have lower employment rates than men, experience higher rates of poverty, and are often victims of intimate partner violence (Izugbara, Obiyan, Degfie, & Bhatti, 2020). Given these negative factors, one might expect HIV-related mortality to be higher among women than men. However, the UNAIDS (2021) report suggests that although there are more WLWHIV in South Africa compared to men, it is men who experience higher mortality rates due to HIV-related causes. In 2021, approximately 27,500 men lost their lives as a result of HIV-related causes, while the number for women was 22,200 (UNAIDS, 2021). This suggests that women demonstrate greater resilience in the face of the challenges associated with an HIV diagnosis.

This phenomenon holds tremendous significance, as the absence of resilience and subsequent failure to cope with the challenges that arise due to an HIV diagnosis may result in several negative consequences for affected individuals. These challenges include, but are not limited to, the inability to concentrate on other crucial aspects of their life and even suicide (Douaihy, Grubisha, Lyon, & Ann, 2017). Additionally, the lack of resilience has been linked to the rapid progression of the disease, ultimately leading to a deterioration in the quality of life and hastened death (Emlet, Harris, Furlotte, Brennan, & Pierpaoli, 2017). Therefore, it is imperative to understand how other women cope with this condition.

Table 1.1: List of studies conducted that includes Resilience of women and HIV.

Author (s) & year	Title	Study site	Methodology
Dale et al. (2014)	Resilience among women with HIV: Impact of silencing the self and socioeconomic factors	United States of America (USA)	Quantitative – Questionaries
Koch et al. (2022)	Exploring Resilience Among Black Women Living with HIV in the Southern United States: Findings from a Qualitative Study	USA	Qualitative – Interview guide
Adamu et al. (2019)	Stress and resilience among women living with HIV in Nigeria	Nigeria	Quantitative – Questionnaires
LoVette et al. (2023)	Examining Associations Between Resilience and Sexual Health Among South African Girls and Young Women Living with and Without HIV	South Africa	Quantitative – Scoping Review

After reviewing the literature, the researcher discovered that there have been studies conducted on WLWHIV and resilience. Table 1.1 above reveals some of those studies. However, the researcher also noted that most studies conducted on WLWHIV have primarily focused on the challenges and vulnerabilities they encounter, neglecting to study positive outcomes and resilience. While some studies have been conducted on women's resilience in relation to HIV, there is no evidence of a qualitative study focusing on the resilience strategies of WLWHIV conducted in South Africa, specifically in the Gauteng province, including at Winnie Mandela informal settlement, where this study was conducted. This gap in research prompted the researcher to conduct a study aimed at exploring and understanding the resilience strategies that WLWHIV use to cope with their HIV diagnosis in the Winnie Mandela informal settlement in the Gauteng province. This prompted the researcher to conduct a study aimed at exploring and understanding the resilience strategies that WLWHIV use to cope with the HIV diagnosis at Winnie Mandela informal settlement in Gauteng province.

The need to conduct the study stemmed from a desire to educate WLWHIV who are struggling to cope with their condition. This study aims to provide them with strategies that other women use to be resilient to HIV, thereby minimizing the decline in their quality of life. WLWHIV already face disadvantages in society, so this study is crucial in offering support. Furthermore, this study will contribute value to the academic field, especially in South Africa, where there is limited published work on the resilience strategies employed by WLWHIV to cope with the virus. The recommendations from this study will assist policymakers in developing policies that promote resilience among women living with HIV, as well as those who have recently been diagnosed.

1.4 STUDY RATIONALE

Globally, research on HIV and women has primarily focused on the challenges and negative effects it brings, while positive outcomes and resilience have been under-studied (Wen, Yeh, Xie, Yu, Tang, & Chen, 2021). HIV has long been a dreaded disease without a cure, resulting in severe suffering and death for those affected. However, amidst this backdrop of hopelessness, uncertainty, and despair, the researcher during his support visits to Aurum Counsellors at Winnie Mandela clinic has encountered WLWHIV from the Winnie Mandela informal settlement. These women exude confidence, speak positively about themselves, and hold hope for the future. It can be assumed that these women have been able to overcome the challenges of being HIV-positive and live lives comparable to HIV-negative women. They diligently adhere to medication regimens and seek help from various HIV support structures within the Winnie Mandela clinic. In short, these women can be described as resilient in the face of challenges brought about by an HIV diagnosis.

There is no debate that resilience is critical in combating the impacts of HIV. It is essential for social workers to understand the strategies employed by resilient women to in achieving this state of mind following an HIV diagnosis. This motivation prompted the researcher to explore how and from where these WLWHIV draw their strength. The findings of this study aimed to address the challenges faced by WLWHIV who often suffer silently, as well as those who have recently received an HIV diagnosis and those who have been living with HIV but struggle to accept their status, which lead them to depression and, tragically, suicide (Fox, Jackson, Hansen, Gasa, Crewe, & Sikkema, 2007). This will enable women to become more resilient in the face of HIV and live more fulfilling and meaningful lives. In this context, a meaningful life is defined as one in which individuals can engage in things they care about (Dixon, 2021). Also, importantly, there is a strong correlation between meaningfulness and hope (Abdollahi et al., 2020) and hope is one of the key attributes needed for one to be resilient in life (Satici, Kayis, Satici, Griffiths, & Can, 2020).

It is hoped that by learning and understanding the coping mechanisms employed by women who live positively with HIV, social workers can develop more effective interventions to assist newly diagnosed women. Furthermore, those struggling to cope with the stressors of living with HIV can directly benefit from the findings of this research, as it details the strategies used by resilient individuals to navigate these stressors. Furthermore, this research will add significance to the realm of academia since there is presently no existing literature on the strategies employed by WLWHIV to manage their condition in South Africa. The findings made by this study will aid policymakers in crafting policies that foster resilience among WLWHIV and those who have recently received a diagnosis.

The following section will discuss the theoretical framework applied in this study.

1.5 THEORETICAL FRAMEWORK

Theoretical frameworks are crucial in research, whether it is quantitative, qualitative, or mixed methods research. All research should have a valid theoretical framework to justify the importance and significance of the work (Lederman & Lederman, 2015). A theoretical framework serves as the foundation of any study, providing a starting point for the study and guiding researchers in formulating research questions and investigating the problem

(Heale & Noble, 2019). For this study, the researcher considered feminist and resilient theory as suitable frameworks.

1.5.1 Feminist Theory

Feminist theory, also known as feminism, refers to a progressive movement that is predominantly led by women that advocates for the cessation of gender disparity (Ferguson, 2017). Mohajan (2022) further alludes that feminist theory encompasses a variety of ideas that stem from the belief that women are not inferior to men and should not be solely defined by their relationship to men, such as being servants, caregivers, mothers, or prostitutes. Furthermore, it posits that our existing disciplines, systems, and societal structures can be improved by adopting a feminist perspective (Mohajan, 2022).

In many societies, women have been treated as second-class citizens for centuries, with limited resources and opportunities for self-development (Bodalina & Mestry, 2020). Cultural beliefs and stereotypes have perpetuated patriarchy and male domination over women (Bodalina & Mestry, 2020). This has been reinforced by the concept of biological essentialism, which suggests that women are genetically predisposed to nurturing roles and are most suited to taking care of children and men in the home (Birke, 2017).

However, the rise of feminism and the feminist agenda challenged the demeaning of women as property and brought about significant changes. The initial wave of feminism, known as the First Wave, emerged in the USA and focused on women's suffrage and property rights (DuBois, 2019). The Second Wave of feminism, which occurred in the 1960s and 1970s, aimed to achieve economic and social equality for women and reevaluate gender relations. It originated in the USA but spread to Western civilizations and other parts of the world (O'Neill, 2017). It also brought attention to issues such as marital rape, reproductive rights, and domestic violence, which affected women as a group (O'Neill, 2017).

This study is relevant to feminist theory because it advocates for women's equality, self-determination, sexual health, reproductive rights, and freedom of speech. It aligns with the researcher's intention to allow WLWHIV to share their experiences and challenges. Weaver, Sharp, and Britton (2020) argue that feminist theory focuses on women's perspectives and experiences, aiming to address social inequalities, oppression, and injustice, and promote equality and social justice. It sheds light on social problems, trends, and issues that are often overlooked from a male perspective within social structures.

Feminism is highly relevant to this study because women's vulnerability to HIV is influenced by the patriarchal society that restricts their reproductive rights. This study, like feminist theory, seeks to improve the lives of all individuals, particularly women. Social work aims to understand the relationship between personal circumstances and institutional oppression and recognizes the interconnectedness of public and private life (Payne, 2020).

1.5.2 Resilience Theory

The resilience theory originates from the field of child psychology, with Norman Garmezy being credited as its developer (Liebenberg & Moore, 2018). Initially, the theory aimed to explain how children facing disadvantages and exposed to adverse environments could still succeed despite their level of risk (Garmezy, 1993). However, the resilience theory can be applied to various fields, including HIV management. In a broader sense, the theory seeks to elucidate how individuals can triumph over the detrimental effects of risk exposure, effectively cope with traumatic experiences, and avoid the negative outcomes associated with specific risks (Van Breda, 2018).

On the other hand, resilience theory is a conceptual framework for understanding how certain individuals can bounce back after experiencing adverse situations (Li, 2020). According to Ledesma (2014), it takes a strength-focused approach to resilience, in which a person is capable of surpassing their initial level of functioning and continuing to grow and function despite facing repeated exposure to stressful experiences, frustration, and misfortune.

The resilience theory played a fundamental role in this study as it explores the ability to adapt to adversity, such as the challenges faced by individuals with chronic illnesses and situations that can generate stress (Chenneville, Gabbidon, Lynn, & Rodriguez, 2018). Additionally, this theory recognizes that while all individuals, groups, and communities encounter difficulties or adversities, as is the case with WLWHIV in this study, researchers must remain attentive to their strengths, interests, abilities, and potential regardless of their problems, illnesses, or shortcomings. Therefore, the researcher's primary focus was on the strengths and resilience of WLWHIV, rather than on their problems (Stuart, 2019).

It is important to note that the resilience theory does not ignore the existence of challenges, but rather advocates for leveraging the strengths and adaptability of WLWHIV as a pathway to overcoming these challenges (Pulla, 2017). Furthermore, the core characteristics of this theory highlight the importance of understanding vulnerability (or risk or adversity) when conducting research on WLWHIV. This theory was significant in this study and aligned with the researcher's intentions because the researcher aimed to comprehend the challenges participants face, the history and context of those challenges, their coping mechanisms, and the available resources to support their resilience. This perspective is also supported by Krikorian (2022), who argues that clients/participants are more than just their challenges. Therefore, the researcher's questions not only focused on the diagnosis and HIV-positive status of the participants, but also delved into their coping resources, strengths, and efforts to manage their challenges, as these are crucial aspects of understanding them, their social environment, and their complete human experience, encompassing both negative and positive aspects, vulnerability, and strength.

The incorporation of feminist and resilience theory into this research aimed to explore how WLWHIV successfully cope with life after being diagnosed. The researcher focused on women in the Winnie Mandela informal settlement because they are part of marginalized populations. There is a growing interest in the potential impacts of resilience on health, and major organizations that study health-related challenges, such as the

Economic and Social Research Council in the UK, consider resilience to be an influential factor for lifelong health and well-being (King, Newman, & Luthans, 2016).

The following section will discuss the research aim, question and objectives.

1.6 RESEARCH PURPOSE/AIM, QUESTION AND OBJECTIVES

The creation of the research aim, question, and objectives is the initial step in every study. For a study to have an impact on society and the academic world, it must have clear, concise research aims, question and objectives (Harris, Holyfield, Jones, Ellis, & Nea, 2019). The impact of the study is enhanced by well-formulated research aim, questions and objectives that make it easy for potential users to grasp the purpose of the study (Farrugia, Petrisor, Farrokhyar, & Bhandari, 2010). The research aim, question and objectives will be presented in the following sections.

1.6.1 Purpose/Aim of The Study

A purpose or aim of a study simply refers to what a researcher hopes to have achieved at the end of the study (Green & Thorogood, 2018). It can be conceptualized as the utility a researcher thinks their study findings will provide to society (Swaraj, 2019).

In the context of this study, *the aim was to explore and develop a thorough understanding of the resilience strategies used by WLWHIV to cope with their HIV diagnosis.*

1.6.2 Research Question

Research questions can be developed from theoretical knowledge, previous research or experience, or a practical need at work (Doody & Bailey, 2016). A crucial step in research is defining the research question since it helps focus the study's aim and objectives on a few key topics (Creswell, 2014). The choice of methodology, methods, sample, sample size, data collection tool, and data analysis techniques are all guided by the research questions (Nardi,2018). According to the researcher, every question should be connected to the study's aim and objectives for it to accomplish its intended goals.

As this study followed a qualitative approach, the researcher opted for a research question because a research question is a highly focused question that addresses one specific concept. The main research question that guided this study was:

- What resilient strategies do WLWHIV use to cope with their HIV diagnosis at Winnie Mandela Informal settlement within Ekurhuleni Metropolitan Municipality in Gauteng Province?

1.6.3 Research Objectives

Research objectives are described as the specific steps one takes to achieve the goals of a study (Green & Thorogood, 2018). This definition is also supported by Doody and Bailey (2016), who define research objectives as clear and concise statements of the specific goals and aims of a research study. Additionally, it outlines what the researcher intends to accomplish and what they hope to learn or discover through their research (Doody & Bailey, 2016). In order to explore and develop a thorough understanding of the resilience strategies used by WLWHIV to cope with their HIV diagnosis in Winnie Mandela informal settlement, the following objectives were considered:

- To explore and describe the experiences of WLWHIV in coping with their HIV-positive diagnosis.
- To explore and describe the resilience strategies of WLWHIV in coping with their HIV-positive diagnosis.
- To explore and describe the support required by WLWHIV from social workers in dealing with an HIV-positive diagnosis.
- To draw conclusions regarding the coping strategies used by WLWHIV who are resilient to the virus.
- To provide recommendations for social work interventions aimed at empowering newly diagnosed HIV-positive women with effective coping strategies.

The following section provides a brief introduction to the methodology that was used in conducting this study.

1.7 STUDY METHODOLOGY

Research methodology encompasses the plans, guidelines, selections, and practices that guide researcher's decisions during a study (Carter & Little, 2007). According to Sam-Goundar (2022), research methodology outlines the overall approach that researchers use to collect, analyze, and interpret study data in order to address the research questions. In this research study, the term "research methodology" refers to the approaches that the researcher adopted to implement the study. Below is a summary of the methods that were applied in this study. A detailed application of the research methodology will be discussed in Chapter 3.

1.7.1 Research Approach

The research approach is a plan and procedure that consists of the steps of broad assumptions justifying methods of data collection and analysis (Abutabenjeh & Jaradat, 2018). There are two main forms of data, each requiring a unique approach to collection. These two forms are qualitative and quantitative forms of data. Quantitative is concerned with data that can be quantified, whereas qualitative is concerned with textural data whose meanings can differ across people (Lowe, Norris, Farris, & Babbage, 2018).

Qualitative research approach was selected for this study. This research approach focuses on studying human behavior and attitudes in their natural settings (Braun & Clarke, 2021). Choosing this paradigm was appropriate because the researcher wanted to gain a deep understanding of the resilience strategies used by WLWHIV to cope with their HIV diagnosis at Winnie Mandela informal settlement. Additionally, the researcher opted for this approach because researchers, such as Yilmaz (2013), argue that the best way to gather information about people’s lived experiences is through a qualitative approach.

The research design is presented below.

1.7.2 Research Design

According to Yin (2011), research must have a design that relates to the organization and strategy of an investigation. Usage of phenomenological design has been hailed by Ramsook (2018) as a means by which the researcher can enrich data as well as the trustworthiness and rigor of the design, especially where key informants are being used.

This study utilized a phenomenological approach as a research strategy to collect information from WLWHIV who are directly affected by the phenomenon under study. In this study, key informants were not applicable. To gain a better understanding of the findings and conclusions to be reached, the researcher first examined what other researchers say in a literature review and what participants say before drawing conclusions. It is hoped that the findings of this study will contribute significantly to the current body of knowledge, help social workers in creating intervention strategies for WLWHIV, and aid the crafting of policies that aim to enhance resilience in WLWHIV.

1.7.3 Study Setting

The study setting can be viewed as the social, physical, and cultural site in which the researcher conducts their study (Given, 2008). This description of research site resonates with the definition by Rowland and Leu (2011) who defines research site as an areas or locations where a researcher plans to carry out an in-depth study on a specific topic or existing problem.

This study was conducted in Winnie Mandela Informal Settlement in Tembisa, which is a large township located to the north of Kempton Park on the East Rand, Gauteng province. Winnie Mandela Informal Settlement has a strikingly high rate of HIV infection among women. According to the Ministry of Health (2017), out of the 16,000 residents in Tembisa, approximately 64% of the PLWHIV were women. The researcher believed that studying the resilience strategies used by WLWHIV to cope with their HIV diagnosis in this informal settlement will provide valuable insights and support for other WLWHIV who are struggling to cope with their HIV status. This will not only benefit Winnie Mandela

Informal Settlement but all WLWHIV struggling to accept their HIV status with strategies to cope with challenges associated with their condition.

1.7.4 Study Population and Sampling Procedure

1.7.4.1 Study Population

A study population is defined as the entire universe of individuals who meet the criteria for inclusion in a study (Majid, 2018). The research population, also known as the target population, refers to the entire group or set of individuals, objects, or events that possess specific characteristics and are of interest to the researcher (Eldredge, Weagel, & Kroth, 2014). Eldredge et al. (2014) further indicates that it represents the larger population from which a sample is drawn.

The study population consisted of WLWHIV residing at Winnie Mandela Informal Settlement within Ekurhuleni Metropolitan Municipality, aged between 20 and 40 years. This population was chosen based on the findings of Zuma et al. (2022), which indicated that women between the ages of 20 and 40 had the highest percentage of PLWHIV in South Africa.

1.7.4.2 Sampling Method

Purposive sampling was used to select WLWHIV from whom data was be collected. This approach is commonly used in qualitative research to identify and select individuals who can provide rich information while keeping data collection costs low (McGrath, Palmgren, & Liljedahl, 2019). There are various designs for purposive sampling (Iliyasu & Etikan, 2021), but this study utilized homogeneous purposive sampling. This type of sampling focuses on units that share similar characteristics and requires the researcher to have prior knowledge of the shared trait (Campbell, Greenwood, Prior, Shearer, Walkem, Young, Bywaters, & Walker, 2020).

In the context of this study, the researcher chose this approach because his aim was not to include all WLWHIV, but those who have shown characteristics of resilience to HIV similar to those he observed from women he used to interact with while working at Tembisa Hospital.

1.7.4.3 Sampling Process

Before the initial interaction with prospective participants, the researcher ensured that he obtained all necessary approvals from relevant authorities. Approval for conducting this study was sought from the Department of Health Ekurhuleni Metropolitan Municipality, Winnie Mandela Local Council, Department of Social Work Scientific Review Committee, and the Unisa College of Human Sciences Research Ethics Committee, all of which granted approval. After receiving all the approvals, the researcher then began the sampling process with the assistance of Decanting facilitators who were responsible for the CCMDD program and interacted with WLWHIV. The researcher had a good working relationship with the Decanting team, and they had agreed to give him slots during the sessions with WLWHIV on the CCMDD programme. In recruiting the participant, the researcher was given a slot to present the study to the prospective participants. A detailed process followed by the researcher is outlined in section 3.5.3 of Chapter 3.

1.7.4.4 Study Sample

A sample is defined as a subset of units from a population with characteristics of interest to the researcher (Hutchison, 2020). If a researcher feels they can assess the entire population, then they can skip the sampling process. However, when sampling is to be done, there will be a need to make decisions about which people, settings, and social processes the researcher need to observe (Hutchison, 2020).

In this study, the sample was drawn from WLWHIV between the ages of 20-40 years residing at Winnie Mandela Informal Settlement. These women had to be part of the CCMDD programme, collecting their ARV treatment at Winnie Mandela clinic, and had to have been living with HIV for over 5 years. The researcher believes that an individual who has been living with HIV for over 5 years has likely faced numerous challenges associated with the virus. This person may have developed resilience traits through a process of adaptation, or they may be feeling overwhelmed and unable to function optimally. The researcher considered the inclusion and exclusion criteria when selecting the study sample.

1.7.4.5 Sample size

According to Suresh and Chandrashekara (2012), sample size in research refers to the representativeness of the sample in relation to the population of interest. It is important not only for statistical power but also for the ability to generalize study findings to a larger population. A larger and more diverse sample is typically considered a more accurate representation of the population, which improves the external validity of study results (Vasileiou, Barnett, Thorpe, & Young, 2018). However, there is a trade-off between sample size and the costs, time, and practical considerations involved, necessitating researchers to carefully consider these factors when determining sample size (Vasileiou et al., 2018).

The appropriate size of the sample of the study was determined by data saturation. Data saturation is a tool used by researchers to ensure that adequate and quality data are collected to support a study (McGrath et al., 2019). According to Hennink and Kaiser (2022), This tool is frequently used in qualitative research and some researchers are of the idea that it is the best way to collect qualitative data.

The following section will discuss the process of data collection.

1.7.5 Data Collection

Peersman (2014) defines data collection as the process of gathering information from all relevant sources to find answers to the research problem, test hypotheses, and evaluate outcomes. Data collection is a method that specifies techniques to be employed, measurements to be utilized, and activities to conduct in implementing a research study (Bless, Higson-Smith & Kagee, 2007). The following processes were followed when collecting data for this study.

1.7.5.1 Preparation for Data Collection

Data collection preparation is a critical aspect of any research study as it lays the foundation for the quality and reliability of the data collected (Taherdoost, 2021). Stedman, Burns, and Pratt (2022) further indicate that in research, data collection preparation refers to the process of setting up and organizing the necessary procedures to gather data effectively.

In this study, before commencing the data collection process, the researcher sought permission to conduct a study from all relevant authorities as stated in section 1.7.4.3 (Sampling process). Additionally, in order to ensure the safety of the researcher, depending on where participants chose to be interviewed, the researcher made sure to have adequate measures in place to protect his safety.

1.7.5.2 Method for Data Collection

Data collection methods in research refer to the specific techniques or procedures used to gather information or data for a research study. Data collection methods can be divided into two categories: secondary methods and primary methods of data collection (Peersman, 2014). This technique is systematic in collecting data and includes observations, interviews, surveys, and the use of official statistics (Bless, Higson-Smith & Kagee, 2007). This study followed the primary method of data collection using interviews. In this study, face-to-face semi-structured interviews were used to gather relevant information from the participants.

1.7.5.3 Data Collection Tool

In research, a data collection tool is a structured method or instrument used to gather information or data from participants in a study (Taherdoost, 2021). According to Sukmawati (2023), these tools are essential for obtaining accurate and reliable data that can be analyzed to draw meaningful conclusions. Mwita (2022) further states that there are various types of data collection tools, including surveys, questionnaires, interview guides, and observations. Each tool has its strengths and weaknesses, so researchers must carefully choose the most appropriate tool based on the research objectives and the nature of the data being collected (Mwita, 2022).

This study used an interview guide as a tool for collecting data. This approach was used because it enables interviewees to speak in their voice and express their thoughts and feelings.

1.7.5.4 Pilot Testing

Pilot testing is a small-scale version of planned research conducted with a small group of participants who share similar traits to those who will take part in the full study (Bowes, Aryani, Ohan, Haryanti, Winarna, Arsianto, & Kristianto, 2019). In qualitative research, it allows a researcher to practice and refine their interview techniques, asking questions in a professional and non-biased manner, evaluate the effectiveness of the data collection tool and test the interview duration (Ismail, Kinchin, & Edwards, 2018).

The researcher used a pilot testing phase to enhance his interview techniques, interview duration, and interview guide questions. Initially, three participants who met the inclusion criteria were interviewed to evaluate the necessity of refining the interview guide. In addition, during this process, the researcher ensured that Covid-19 protocols were adhered to by both the researcher and the participants. After completing the three interviews, adjustments were made only to the guide. However, the data obtained from these participants was not included in this study. It was only after this process that the researcher began data collection for this study.

1.7.5.5 Data Collection Process

According to Taherdoost (2021), there are several processes that researchers follow during data collection to ensure that the gathered data is accurate and can be used to answer the research questions at hand. One key process followed during data collection is the development of a data collection plan, which outlines the specific procedures that will be followed when gathering data (Taherdoost, 2021). Additionally, this process allows the researcher to prioritize ethical considerations during data collection, such as obtaining informed consent from participants, protecting confidentiality, and ensuring that data collection procedures do not harm or exploit participants in any way (Barrow, Brannan, & Khandhar, 2017).

Before beginning the data collection process, the researcher ensured that he obtained all necessary approvals from relevant authorities, as outlined in section 1.7.5.1 (Preparation for Data Collection) above. Additional measures taken before starting the data collection process included conducting pilot testing, making necessary amendments to the interview guide, and ensuring the safety of the researcher. These steps enabled the researcher to move forward with data collection. During the data collection process, the researcher also ensured that Covid-19 protective measures were adhered to.

The following steps were followed during the data collection process:

- The researcher provided participants with the option to choose a convenient location for their one-on-one interviews in order to maintain confidentiality.
- The researcher collected the participants' addresses and contact numbers but ensured that this information remained confidential, in accordance with The Protection of Personal Information Act (POPI Act).
- Before conducting each interview, the researcher reviewed the study information sheet with the participants to ensure they fully understood the purpose of the study they had volunteered to be a part of. For participants who were unable to read, the researcher read the information sheet, explained it in their native language, and allowed them to ask questions.
- After completing the information sheet process, participants were asked to sign the consent form that the researcher had provided during the initial session when they were being assessed for inclusion criteria.
- Once all these steps were finished, the interview began. Each interview lasted between 30 to 45 minutes and was recorded using a digital audio recorder. The consent form included permission to be recorded during the interviews using a digital audio recorder.

- After each interview, the researcher checked with the participant to see if the interview had upset them or caused any negative feelings, such as resentment. The researcher had made arrangements with a private social worker who had agreed to provide free restoration sessions.

The following section will explain how the collected data was analysed.

1.7.6 Data Analysis

Busetto, Wick, and Gumbinger (2020) defines data analysis in qualitative research as a systematic process of searching and organizing interview transcripts, observation notes, or other non-textual materials that the researcher gathers. This process aims to enhance the comprehension of the phenomenon under study (Busetto et al., 2020). Qualitative data analysis is a method used in research to interpret and make sense of non-numerical data, such as descriptive, subjective, and context-dependent data (Ngulube, 2015). This allows researchers to explore complex phenomena in depth. Ngulube (2015) furher indicates that analysis involves examining patterns, themes, and relationships within the data to gain a deeper understanding of a research topic.

In this study, Tesch’s approach to data analysis (Creswell, 2016), which provides a useful process to transcribing unstructured data was adopted for data analysis. According to Zhang and Wildemuth (2009), this approach engages a researcher in a systematic process of analysing textual data.

1.7.7 Method of Data Verification

Every research study must undergo a thorough review process to ensure the accuracy and authenticity of its conclusions (Bulpit & Martin, 2010). In social science studies, researchers are required to explicitly specify that a qualitative study is good, valid, and reliable (Rolfe, 2006). Hadi and José-Closs (2016) stated that the rigor of qualitative research can be best evaluated by assessing trustworthiness, also known as true value. This helps to persuade the audience that the study findings are reliable and accurate

(Rose & Johnson, 2020). To ensure that the study findings are accurate, reliable, and authentic, the researcher used trustworthiness.

1.7.7.1 Trustworthiness

According to Rose and Johnson (2020), trustworthiness is utilized in qualitative research and serves the same purpose as validity in quantitative research. Wood, Sebar, and Vecchio (2020) explain that trustworthiness refers to whether the participants' perceptions of the setting or events align with the researcher's portrayal of them in the research report. Historically, qualitative studies have been seen as "soft" science lacking scientific rigor when compared to quantitative research. Qualitative research is often considered subjective, anecdotal, and susceptible to researcher bias (Prasad, 2019), which compromises the credibility of qualitative research. However, there are measures that can be taken to enhance trustworthiness.

In this study, trustworthiness was enhanced using the framework proposed by Lincoln and Guba (1986). According to this framework, a study can be deemed trustworthy if it is credible, transferable, dependable, and confirmable (Lincoln & Guba, 1986).

1.8 ETHICAL CONSIDERATION

In research, ethics are very important as the researcher studies humans who are typically associated with morality and matters of right and wrong, defined according to standards (O’Grady, 2017). Additionally, the researcher has an ethical responsibility towards those who participate in the research, those who fund the research, and those who may benefit from the research (Yip, Han, & Sng, 2016). The ethics considered relevant to this study include informed consent, confidentiality, anonymity, beneficence, debriefing, and avoidance of harm.

The following section will provide definition of key concepts in this study.

1.9 DEFINITION OF KEY CONCEPTS

1.9.1 Resilience

Resilience is the ability to bounce back from negative experiences and be flexible in adapting to the demands of stressful situations (Van Breda, 2018). Additionally, resilience is defined as the ability to recover, spring back, or return to previous circumstances after encountering problems or stresses (O'Cleirigh, Ironson, Weiss, & Costa, 2007). In this study, the researcher defined resilience as the ability to function like any other individual, regardless of one's HIV status.

1.9.2 Women

A woman can be defined as an individual whose anatomy is designed to bear children (MacKay, 2020). Alternatively, using the genetic approach, a woman is defined as an individual who possesses Y chromosomes (Byrne, 2020). For the purposes of this study, the term "women" refers to individuals who self-identify as such and are living with HIV, aged between 20 and 40 years.

1.9.3 Living with HIV

Vaillant and Gulick (2022) define living with HIV as a chronic condition that affects individuals and is caused by the HIV virus. This virus targets the immune system of the body, specifically focusing on CD4 cells, which play a critical role in fighting infections (Montagnier, 2002). As a result, people living with HIV experience a compromised immune system, making them more susceptible to various infections and illnesses Centers for Disease Control and Prevention [CDC], 2020). In this study, participants who were interviewed have been living with HIV for more than 5 years.

1.9.4 Human Immunodeficiency Virus (HIV)

The Human Immunodeficiency Virus (HIV) is a retrovirus that infects cells of the immune system, destroying or impairing their function (Montagnier, 2002). As the infection progresses, the immune system becomes weaker, and the person becomes more susceptible to infections (Centers for Disease Control and Prevention, 2020). According to the CDC (2020), as a virus that attacks the immune system and, if left untreated, can lead to AIDS (acquired immunodeficiency syndrome). This study sampled WLWHIV at Winnie Mandela informal settlement to explore their resilience strategies to cope with their HIV diagnosis.

1.9.5 Informal Settlement

Informal settlements are defined as areas with a functioning geographical space below the required planning standard (Soyinka & Siu,2017). They are densely populated communities that exist outside of the government's legal structures and are often a result of economic constraints that prevent residents from participating in the formal housing market (Alsayyad, 2021). In this study, the term "informal settlement" specifically refers to the residential area named after Winnie Mandela, where the research was conducted. Compared to other areas, this local community has a high population density and relies heavily on non-formal employment. The informal settlements in Thembisa are characterized by inadequate housing that fails to meet even the basic requirements for urban planning, which are necessary even in Africa. Many families in these villages often have to share ablution and water access facilities.

The following section will outline the structure of the study report.

1.10 STRUCTURE OF THE STUDY REPORT

The study consists of five chapters, and the contents of each chapter are described below.

- Chapter 1: The first chapter includes the introduction and the background of the study. In this chapter, the researcher outlines aspects such as the problem statement, the rationale behind the study, the theoretical framework, and the research aim, question, and objectives. Additionally, this chapter introduce the methodology applied in the study, ethical considerations, and define key concepts.
- Chapter 2: Chapter 2: This chapter consists of a literature review.

- Chapter 3: In this chapter, the researcher outlines the research methodology which includes the research approach and design which systematically discusses the nature and type of the research, the study population, sampling methods, pilot testing, data collection methods, data collection processes, the method of data analysis, data verification, and ethical considerations.
- Chapter 4: This chapter presents the findings of the study based on the collected and analyzed data. The findings are organized into themes and sub-themes and are supported by recent literature that aligns with the findings.
- Chapter 5: This chapter comprises a summary of the study. Additionally, it presents the conclusion of the research questions, discusses the limitations of the study, provides recommendations, and suggests areas for further research.

1.11 CHAPTER SUMMARY

This chapter provided a concise overview of what the study is about. It included the background of the study, the problem statement, the rationale behind the study, the theoretical framework, and the research aim, question, and objectives. Additionally, the chapter briefly introduced research methods applied in this study, ethical considerations, define key concepts, and provide an outline of the report's structure. The following chapter will discuss the literature review.

CHAPTER TWO

2. LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, the researcher conducted an extensive review of the existing literature to gain a thorough understanding of the phenomenon being studied. The following sections offer further details on the literature pertaining to the resilience strategies of WLWHIV. The chapter will provide a comprehensive overview of the background of HIV, the general prevalence of HIV globally, in Africa, and specifically in South Africa. It will also discuss the prevalence of HIV among women. Furthermore, this chapter will explore the risk factors associated with HIV for women, available treatments for HIV and the number of women accessing them, challenges experienced by WLWHIV, resilience as a coping strategy for women in the face of HIV and conclude with the crucial role of social workers in supporting women living with HIV.

2.2 THE BACKGROUND OF HIV

Acquired Immune Deficiency Syndrome (AIDS) was first observed in 1981 when a growing number of young homosexual men began to succumb to peculiar opportunistic infections and unusual cancers (Sharp & Hahn, 2011). Subsequently, HIV-1 was identified as the causative agent of one of the most destructive infectious diseases in recent history (Sharp & Hahn, 2011). The prevailing theory regarding the origin of AIDS suggests that a Simian Immunodeficiency Virus (SIV), carried by an African monkey, was transmitted to humans where it persisted and developed into the human immunodeficiency virus (HIV) (Martin, 1993). According to Martin (1993), multiple factors contributed to the transmission, including the consumption of undercooked African monkey meat, monkey bites, entry of monkey blood into human blood through cuts, and the injection of monkey blood into humans during sexual practices.

There are two primary variants of HIV: HIV-1 and HIV-2, as explained by Jaffar, Grant, Whitworth, Smith, and Whittle (2004). HIV-1 was identified first and is prevalent worldwide, while HIV-2 is mainly found in West Africa and is less harmful (Jaffar et al., 2004). Therefore, when HIV is mentioned, it usually refers to HIV-1, which weakens the immune system that protects the body from infections (Ngalamika, Mukasine, Kamanzi, Kawimbe, Mujajati, Lidenge, & Mumba, 2022). Moreover, Ngamamika et al. (2022) suggests that if this virus is left untreated, it infects and destroys CD4 cells, a type of T cell, making the immune system vulnerable to other bacteria and viruses that worsen the condition. This increases the risk of developing cancers and other fatal infections.

The transmission of HIV from one individual to another occurs when infected blood, semen, or vaginal fluids enter the body of another person during unprotected sexual intercourse, whether vaginal, anal, or oral (Showa, Nyabadza, & Hove-Musekwa, 2019). Additionally, HIV may be transmitted during blood transfusions or organ transplantation, through sharing needles, syringes, or other drug injection equipment with an infected individual (Showa et al., 2019). The virus can also be transmitted from mother to child during pregnancy, childbirth, or breastfeeding (Showa et al., 2019). Showa et al. (2019) further explain that the virus enters target cells once it has infiltrated the body, either as a free viral particle or in an attached form. To reduce the risk of HIV transmission, it is essential to take precautions such as using condoms during sexual activity, avoiding sharing needles or other drug equipment, and regularly getting tested for HIV (Naik, Zu, & Owolabi, 2020).

Since the emergence of HIV, the scientific community has yet to discover a cure for the virus. However, the prognosis for individuals with HIV has significantly improved due to the discovery and widespread use of ARV drugs (Schatz, David, Angotti, Gómez-Olivé, & Mojola, 2022). Introduced in the late 1980s, ARVs are standard anti-HIV drugs that have transformed HIV from a potentially fatal infection to a manageable chronic condition (Buh, Deonandan, Gomes, Krentel, Oladimeji, & Yaya, 2022). ARVs prevent further virus replication, reduce viral load, increase CD4 counts, lower the risk of opportunistic infections and hospitalizations, improve patients' quality of life, and reduce mortality (Buh et al., 2022). According to the World Health Organization (WHO) HIV treatment guidelines, ARVs should be initiated for all HIV-positive individuals, regardless of their clinical stage or CD4 cell count, at no cost in all public sector health facilities (WHO, 2021). Treatment initiation should be offered on the same day or within seven days of HIV diagnosis to individuals who are ready to begin treatment (WHO, 2021).

2.3 THE PREVALENCE OF HIV

The HIV epidemic has caused immense devastation to individuals, families, and communities, resulting in the orphaning of millions of children, disruption of village and community life, and an increasing erosion of civil order and economic growth (Gayle and Hill, 2001). The global impact of this epidemic is staggering, as of the end of 2022, 39.0 million people were reported to be infected with HIV, with 53% of them being women and girls (Payagala & Pozniak, 2024). According to Ej (2017), this number has slightly increased in recent years, a trend attributed to prolonged life expectancy due to effective treatment and ongoing new HIV infections. Recent data also shows that more than 40.4 million individuals worldwide have succumbed to HIV-related diseases since the onset of the epidemic (Huynh, Vaqar, & Gulick, 2024). According to Pandey and Galvani (2019), the occurrence of HIV differs considerably across different regions.

In recent years, there has been a rise in HIV prevalence in the Asia and Pacific region (Phanuphak, Lo, Shao, Solomon, O'Connell, Tovanabutra, Chang, Kim, & Excler, 2015). According to Phanuphak et al. (2015), the number of individuals living with HIV in this region was approximately 5.8 million in 2022, which accounted for 14.8% of the global HIV burden. The increased risk of HIV in the region can be attributed to stigma, discrimination, and legal barriers that hinder key populations, including men who have sex with men, people who inject drugs, and sex workers, from accessing HIV prevention and treatment services (Choi, Poonkasetwattana, & Phanuphak, 2023). In Latin America and the Caribbean region, the prevalence of HIV has remained relatively stable in recent years (García, Bayer, & Cárcamo, 2014). According to García et al. (2014), it is estimated that around 1.9 million individuals were living with HIV in these areas in 2022, which accounts for 4.8% of the worldwide HIV burden. Western and Central Europe, along with

North America, are some of the regions that are experiencing a higher impact from the epidemic compared to others (Govender, Hashim, Khan, Mustafa, & Khan, 2021). According to recent data, approximately 2.3 million people in these regions were living with HIV in 2022, which represents 5.9% of the global burden (Tian, Chen, Wang, Xie, Zhang, Han, Fu, Yin, & Wu, 2023). Although efforts have been made to decrease new diagnoses and enhance treatment accessibility in these areas, there are still obstacles to be overcome, particularly in addressing disparities among key populations (Tian et al., 2023). Sub-Saharan Africa has been the region most heavily impacted by HIV for a long time, with certain countries experiencing some of the highest prevalence rates globally (Kharsany & Karim, 2016). An estimated 21 million people are currently living with HIV in this region as of December 2022, accounting for 54% of the global burden (Joint United Nations Programme on HIV/AIDS, 2022).

In sub-Saharan Africa, the prevalence of HIV varies by country, but in many countries in this region, the rates are higher than the global average. In 2022, Eswatini, Lesotho, South Africa, Botswana, and Mozambique were the top five countries with the highest rates of HIV in the region (Elflein,2023). Table 2.1 below shows the HIV prevalence in those countries as of December 2022, along with their contribution to the global burden of the virus according to Elflein (2023).

Table 2.1: Number of people (all ages) living with HIV in Sub-Saharan countries

Countries	**No. of PLWHIV**	**Contribution to the global burden**
Eswatini	295,628	0.8%
Lesotho	567,297	1.5%
South Africa	8.4 million	21.5%
Botswana	594.342	1.5%
Mozambique	2.8 million	7.2%

Despite efforts to increase prevention and treatment programs, these countries continue to struggle with the challenges of the HIV epidemic (Kharsany & Karim, 2016). They have encountered difficulties in controlling the transmission of the virus and providing adequate care and support for PLWHIV, with women being the most affected (Ramjee & Daniels, 2013).

South Africa has the highest rate of HIV globally, not just in Sub-Saharan Africa (Zuma, Simbayi, Zungu, Moyo, Marinda, Jooste, North, Nadol, Aynalem, Igumbor, Dietrich, Sigida, Chibi, Makola, Kondlo, Porter, Ramlagan, & Sabssm, 2022). Reports from Statistics South Africa show that the number of PLWHIV in South Africa tragically increased by 61.5% from 2010 to 2022. In 2010, an estimated 5.2 million people were living with HIV (Stats SA, 2010). By 2015, this number had grown by 19.2% to 6.2 million people infected with the virus (Stats SA, 2015). By December 2022, it was estimated that approximately 8.4 million people were living with HIV in this country, accounting for 13.5% of the total population (Stats SA, 2022). Additionally, Elflein (2023) indicates that in 2022, South Africa accounted for 21.5% of the global HIV burden.

Within South Africa, the province of Gauteng, where this study was conducted, had the third-highest provincial HIV prevalence in the country in 2020, with the Eastern Cape leading (Uni24.co.za, 2020). Gauteng had an estimated 15.5 million people living with HIV in 2020, accounting for 33% of the total number of people living with HIV in South Africa at that time (Uni24.co.za, 2020). According to Mshweshwe-Pakela et al. (2020), the Ekurhuleni Metropolitan Municipality, where participants of this study were sampled, bears the greatest burden of HIV among Gauteng Province municipalities. In the year 2020, it was estimated that 2.2 million people were infected with HIV. This can be due to the fact that Ekurhuleni Metropolitan Municipality is one of the most densely populated areas in South Africa. Additionally, factors such as poverty, lack of access to healthcare, high unemployment rates, and migration patterns can all play a role in the high prevalence of HIV in this area. Some of these factors will be discussed in detail under a section on risk factors for HIV in women.

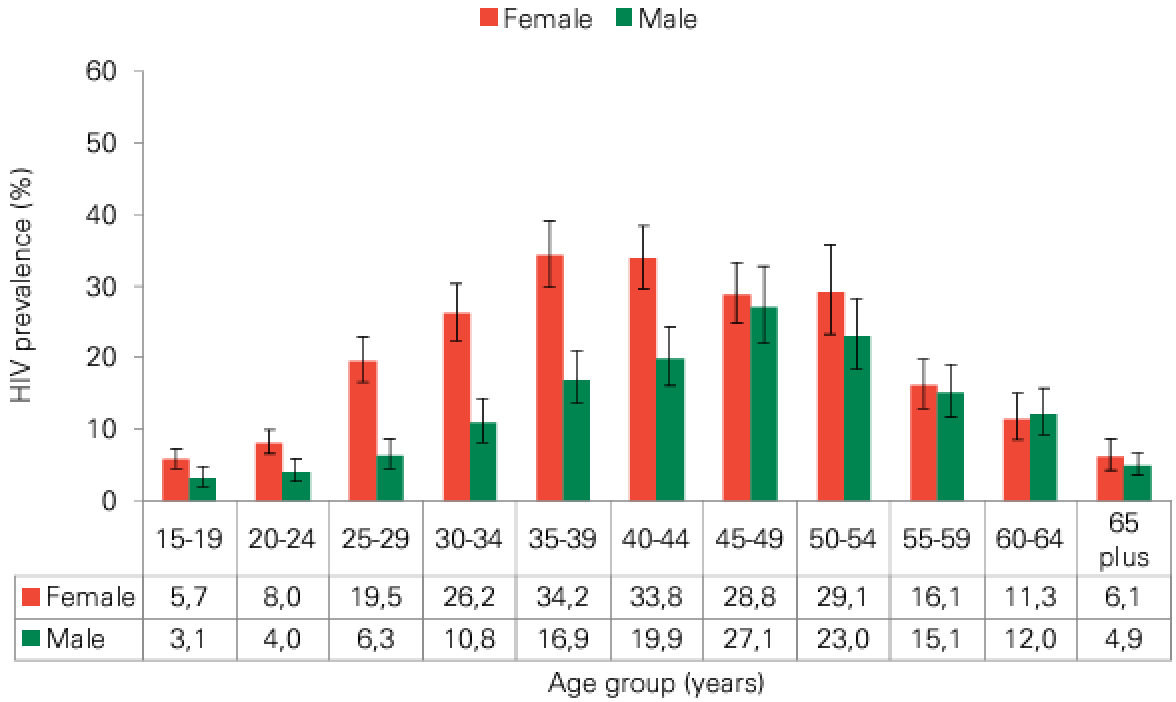
The next section will discuss the Prevalence of HIV in Women.

2.3.1 The Prevalence of HIV in Women

Women consistently have higher rates of HIV infection compared to men and are at a greater risk of contracting the virus (Mannell, Willan, Shahmanesh, Seeley, Sherr, & Gibbs, 2019). According to recent statistics from reputable sources such as the WHO (2022), the prevalence of HIV among women continues to be a matter of concern. As of 2022, it is estimated that 20.6 million WLWHIV, making up approximately 53% of all PLWHIV globally (WHO,2022). According to Project (2023), although women account for more than half of all PLWHIV globally, the percentage of women who are living with HIV varies widely among countries. Estimates suggest that one in three PLWHIV in the United Kingdom are women; almost four out of ten PLWHIV in India are women; and almost six in ten PLWHIV in sub-Saharan Africa are women (Project, 2023a).

The Sub-Saharan African region continues to be the most heavily impacted, with women being disproportionately affected compared to men (UNAIDS, 2022). In Lesotho, a population-based study demonstrated that the odds of acquiring HIV for women increased with each year of age, starting at 15 and peaking at 44 years (Schwitters, McCracken, Frederix, Tierney, Koto, Ahmed, Thin, Dobbs, Sithole, & Letsie, 2022). The same study also revealed significantly lower rates of new HIV infections in men compared to women. Additionally, a study conducted across 308 different Kenyan communities showed that HIV prevalence among women was 32% higher than that of men, with women between the ages of 20 and 40 years being most affected by the virus (Kwena, Njuguna, Ssetala, Seeley, Nielsen, De Bont, Bukusi, & Team, 2019).

In the same region, South Africa is globally ranked as having the highest HIV prevalence, with women having a higher prevalence of people living with the virus (Palanee-Phillips, Rees, Heller, Ahmed, Batting, Beesham, Heffron, Justman, Makkan, & Mastro, 2022). In 2022, it was estimated that there were 6 million WLWHIV, compared to 2.4 million men (Statistics South Africa, 2022). The figure compares the prevalence of HIV among women and men in South Africa.



	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65 plus
🟥 Female	5,7	8,0	19,5	26,2	34,2	33,8	28,8	29,1	16,1	11,3	6,1
🟩 Male	3,1	4,0	6,3	10,8	16,9	19,9	27,1	23,0	15,1	12,0	4,9

Figure 2.1: South Africa 2022 HIV prevalence by sex and age by Sixth South African National HIV Prevalence, Incidence, Behaviour, and Communication Survey [SABSSM IV] (2023)

Figure 2.1 illustrates the findings of a study conducted in South Africa across all nine provinces from January 2022 to April 2023 by The Sixth South African National HIV Prevalence, Incidence, Behaviour, and Communication Survey (SABSSM VI). The aim of the study was to compare HIV prevalence between women (females in red) and men (females in green) across different age groups in South Africa. The study found that women consistently have a higher HIV prevalence than males across all age groups, except for the 60-64 age group where men were found to have a higher rate by 6% (SABSSM VI,2023). The largest gap was observed in the 30-34 age group, which was the age group sampled for this study as indicated in chapter 1 (1.7.4.4).

Prior to this, a similar study was conducted by Vandormael, Akullian, Siedner, de Oliveira, Bärnighausen, and Tanser (2019) to understand the rate at which HIV prevalence in South Africa declined between 2005 and 2017. The study revealed that the prevalence of HIV declined by 43% in the South African population. However, there was a decline of 37% in HIV prevalence for women, compared to a decline of 59% in men. Another study was conducted by Vandormael et al. (2019) in the Hlabisa sub-district of KwaZulu-Natal to compare the decline of new HIV infections between 2012 and 2017. The study also found that men experienced a 62% decline in new infections, while women only experienced a 34% decline. This information highlights a disheartening reality that unequivocally demonstrates how HIV disproportionately affects women compared to men. The gender disparity in HIV prevalence is primarily due to various social and economic factors that place women at a higher risk of HIV transmission (Girum, Wasie, Lentiro, Muktar, Shumbej, Difer, Shegaze, & Worku, 2018). According to Girum et al. (2018), these factors include gender-based violence, poverty, limited access to education, and HIV prevention, as well as treatment options, which are discussed in detail in the section below.

2.4 RISK FACTORS FOR HIV AMONG WOMEN

Understanding the causes and effects of most diseases starts with a thorough evaluation of the risk factors associated with the specific disease (Ignatowicz, Odland, Bockarie, Wurie, Ansumana, Kelly, Willott, Witham, & Davies, 2020). By understanding the risk factors, such as gender-based violence, socioeconomic factors like poverty, limited access to education, HIV prevention and treatment options, as well as religious beliefs, we can identify individuals who may be directly impacted by the disease. This understanding also aids in developing effective interventions to support those who are infected and affected by reducing these risk factors. Consequently, this section of the literature review will examine some of the primary risk factors for HIV infection among women.

2.4.1 Gender-based Violence

Gender-Based Violence (GBV) is a phenomenon deeply rooted in gender inequality and remains one of the most prominent human rights violations across all societies (Rights, 2014). GBV encompasses any form of harm inflicted upon an individual due to their gender, with women and girls constituting the majority of victims (Rights, 2014).

Numerous studies have highlighted GBV as a significant contributor to HIV infection, particularly among women and young girls (Andersson, Cockcroft, & Shea, 2008). According to Hassen and Deyassa (2013), women and girls who are exposed to gender-based violence, especially sexual violence, are at a higher risk of contracting HIV. This is due to various factors, including trauma, increased vulnerability to HIV infection, and reduced control over sexual activities (Hassen & Deyassa,2013). Traumatic events related to gender-based violence, such as physical and emotional abuse, also increase the risk of HIV transmission by disrupting the body's immune system through the release of stress hormones (Hassen & Deyassa, 2013).

According to Karanja (2003), women, especially young women, face challenges in ensuring their partners use condoms and other forms of protection. They have limited control and decision-making power, as well as limited access to health and social services (Karanja, 2003). A study conducted in Uganda by Karanja in 2003 revealed that many women are hesitant to seek available HIV/AIDS services due to fear of physical attacks or threats from their husbands or partners. In another study conducted in Soweto, South Africa, among women attending prenatal care, it was found that those who experienced intimate partner violence and controlling behavior were nearly 1.5 times more likely to contract HIV compared to those who did not (Dunkle, Jewkes, Brown, McIntyre, Gray, & Harlow, 2003).

To mitigate the impact of HIV and gender-based violence, it is crucial to ensure that individuals, regardless of their gender, do not experience any difficulties in accessing comprehensive and integrated services that effectively address both gender-based violence and HIV (Leddy, Weiss, Yam, & Pulerwitz, 2019). These services should include HIV counseling, testing, prevention, and treatment. The researcher is of the opinion that successfully resolving this issue would create a world where everyone has the opportunity to live a healthy and fulfilling life, free from violence and HIV. Additionally, individuals who are already affected can openly disclose their status and develop resilience towards HIV.

2.4.2 Socio-Economic status

Socioeconomic status (SES) has emerged as one of the most extensively studied risk factors for HIV infection among women (Davies, 2020; Santelli et al., 2021). SES refers to an individual or group's position within the socioeconomic hierarchy, determined by various social and economic factors (Miyamoto, Yoo, Levine, Park, Boylan, Sims, Markus, Kitayama, Kawakami, & Karasawa, 2018). Poverty, insufficient income, limited knowledge about HIV, and marital status have been identified as socioeconomic factors contributing to the rising prevalence of HIV among women (Avvisati, 2020; Nam & Terrie, 2021). The following sub-section will explore these socioeconomic factors.

2.4.2.1 Poverty or Lack of income

There are strong bi-directional linkages between HIV and poverty in impoverished settings. HIV is both a consequence of the relentless effects of the epidemic on social and economic conditions and a manifestation of the poverty that thrives in unsustainable livelihoods (Mufune, 2015). Poverty serves as a source of both HIV and HIV-related deaths, while HIV acts as both a cause and a consequence of poverty (Mufune, 2015). Studies indicate that HIV prevalence rates in impoverished areas are as high as those in many low-income countries with widespread epidemics (Ruggles et al., 2014). According to Latkin, German, Vlahov, and Galea (2013), the risk of HIV infection among the impoverished is elevated due to poverty-related factors such as limited education and lack of knowledge about preventing HIV infection. Additionally, individuals who are poor and less educated are more likely to forgo condom usage compared to non-poor individuals (Latkin et al., 2013).

Women are reportedly at a greater disadvantage, as they are financially dependent on their partners (Latkin et al., 2013). Research has shown that women who receive financial support from their partners, as well as those who come from families where there is frequent hunger, are more likely to abstain from using condoms due to their partner's dislike of them, compared to those who do not receive such support (Latkin et al., 2013). Furthermore, women are also subjected to subservient gender norms that limit their freedom, experience a higher prevalence of sexual violence, and have fewer privileges in terms of employment and education (Rodrigo and Rajapakse, 2010).

Therefore, poverty or lack of income is intertwined with various social, economic, and cultural factors that increase women's vulnerability to HIV infection. Addressing poverty and its associated determinants is crucial for mitigating the disproportionate burden of HIV among women in impoverished settings.

2.4.2.2 Lack of Information about HIV

Sustaining a healthy lifestyle and improving one's quality of life heavily relies on understanding health (Baker, Leon, Smith Greenaway, Collins, & Movit, 2011). Factors that affect a person's knowledge of health and illness, as well as how they use that knowledge to maintain healthy behavior (such as adopting a risky lifestyle or abstaining from it, or managing personal health), are typically linked to their socioeconomic situation, community, and family environment (Baker et al., 2011). Researcher had directly addressed the question of whether HIV knowledge influences one’s chances of contracting HIV.

Studies suggest that general knowledge about HIV contributes to the prevention of HIV transmissions and is associated with a 60% reduction in transmission risk behavior (Cherutich, Kaiser, Galbraith, Williamson, Shiraishi, Ngare, Mermin, Marum, Bunnell, & Group, 2012). For individuals who are already infected, this knowledge is vital for care and treatment (Cherutich et al., 2012). A study conducted in Bangladesh identified low literacy rates and a lack of public awareness of HIV as major barriers to health promotion programs (Gilchrist, Gruer, & Atkinson, 2005). Without knowledge and awareness of the epidemic, especially regarding the risk factors, it becomes impossible to design comprehensive and contextual prevention frameworks that are relevant to the people (Gilchrist et al., 2005).

In Malawi, a study conducted by Chirwa (2019) revealed a link between lack of knowledge and HIV transmission. Chirwa (2019) found that individuals from poor families are likely to be less educated, resulting in poor knowledge of HIV. The study also noted an increase in understanding of HIV from 28% to 44% between 2004 and 2016. However, it was discovered that many poor individuals were still unaware of HIV, putting them at a higher risk of contracting the virus (Chirwa, 2019). One significant finding was that men had more knowledge of HIV than women, placing women at a greater risk of HIV contraction (Chirwa, 2019). A similar study in Ghana revealed that women with poor understanding of HIV lack the knowledge to protect themselves and struggle to negotiate safe sex (Agangiba & Agangiba, 2019).

In South Africa, a study conducted in two HIV burden districts by Shamu, Khupakonke, Farirai, Slabbert, Chidarikire, Guloba, and Nkhwashu (2020) focused on the knowledge, attitudes, and practices of young adults towards HIV prevention. The study found that young adult women lack basic information about the virus, such as how it is transmitted and how to protect themselves. This lack of knowledge leads to risky behaviors that increase their chances of contracting HIV. The study attributed this lack of knowledge to societal norms and gender inequalities that hinder women's access to accurate information about HIV. Additionally, young adult women face stigma and discrimination when seeking information about HIV, further perpetuating the cycle of HIV transmission as they remain unaware of their risk factors and fail to take necessary precautions to protect themselves.

This discovery supports the long-held belief that women often have lower levels of education than men, especially in underdeveloped nations, which is why we see more WLWHIV than men. This lack of knowledge about HIV significantly contributes to the risk of HIV infection, as evidenced by various studies across different contexts.

2.4.2.3 Marital Status

In recent decades, there has been a significant shift in marriage trends, marked by a decline in the number of people getting married in many countries around the world (Ortiz-Ospina and Roser, 2020). In South Africa, Statistician-General Risenga Maluleke indicated that there were 18,208 divorces granted in 2021 (Independent Online, 2024). Of those divorces, 50.4% were from the black African population, followed by whites at

20.1%, coloureds at 17.6%, Indians/Asians at 4.8%, and divorces from mixed marriages at 2.7% (Independent Online, 2024).

This is concerning because marital status has been identified as a contributing factor in the spread of HIV (Setume, 2016). Most studies globally indicate that the risk of HIV infection is twice as high in those who are not married as it is in those who are married (Tlou, 2019). In a national South African population-based survey of HIV, the prevalence of HIV was found to be lower among married people at 10.5%, in contrast to 24.3% among those in steady relationships and living together, and 14.3% among single people (Shisana, Rehle, Simbayi, Zuma, Jooste, Zungu, Labadarios, & Onoya, 2014). The same report also showed that the practice of having Multiple Sexual Partners (MSPs) has increased in recent years, increasing susceptibility to sexually transmitted infections, including HIV (Shisana et al., 2014). MSPs may be more common among single individuals than among married individuals, as there is typically an assumed long-term sexual exclusivity in marriage, suggesting that marriage would be associated with a lower risk of HIV (Gumbo, Duri, Kandawasvika, Kurewa, Mapingure, Munjoma, Rusakaniko, Chirenje, & Stray-Pedersen, 2010).

Despite all of these risk factors contributing to the increasing prevalence of HIV among women, the scientific community has been developing intervention strategies aimed at reducing the impact of HIV. With the absence of a cure for HIV, the introduction of ARVs has revolutionized the healthcare system's approach to managing HIV. The next session will focus on HIV treatment.

2.5 HIV TREATMENT – ANTIRETROVIRALS

Due to the increasing number of people becoming infected with HIV, the rising number of HIV-related deaths, and the above-mentioned risk factors for HIV, the scientific community has been motivated to continue searching for an HIV cure (Bekker, Alleyne, Baral, Cepeda, Daskalakis, Dowdy, Dybul, Eholie, Esom, Garnett, Grimsrud, Hakim, Havlir, Isbell, Johnson, Kamarulzaman, Kasaie, Kazatchkine, Kilonzo, Beyrer, 2018). This is to save PLWHIV from the medical and social challenges they face daily as a result of their HIV status.

While a cure has not yet been found, in the 1980s, the scientific community discovered a treatment for HIV known as ARVs (Schatz et al., 2022). According to Buh et al. (2022), ARVs are standard anti-HIV drugs that have completely transformed the course of HIV disease. They have changed it from a potentially fatal infection to a manageable chronic condition. These drugs prevent further viral replication, suppress the viral load in the body, reduce the risk of opportunistic infections and hospitalization, improve the patient's quality of life, and decrease mortality rates (Buh et al., 2022). The WHO has recommended that ARVs be provided for free to all PLWHIV in all public health facilities worldwide on the same day of diagnosis, regardless of their clinical stage (WHO, 2021). In 2022, it was estimated that approximately 29.8 million people living with HIV globally had access to antiretroviral drugs (ARVs), up from 7.7 million in 2010, with 70% of them located in Africa (UNAIDS,2023). Sub-Saharan Africa accounted for 56% of those with access, with the majority being women (UNAIDS, 2023). In South Africa, 5.3 million PLWHIV were reported to have access to ARVs in 2021(Vandormael et al., 2019). Of these, 3.7 million were women, which is more than double the number of men receiving treatment, at 1.6 million (Vandormael et al., 2019).

Most countries, including South Africa, now use a new fixed-dose formulation as the standard treatment for HIV. This has replaced the previous regimen of multiple pills (WHO, 2018). The new fixed-dose combination consists of three drugs that prevent HIV from multiplying in the body: tenofovir (TDF) emtricitabine (FDC) combination 300 mg + lamivudine (3TC) 300 mg + dolutegravir (DTG) 50 mg (TLD). This combination is recommended for all eligible adults, adolescents, and children aged 10 years or older, weighing 20 kg or more (WHO, 2018). In South Africa, the Department of Health (DoH) has adopted dolutegravir/lamivudine/tenofovir (TLD) as their first-line treatment for most adults and children starting treatment after the age of 10. This replaces a regimen called tenofovir/emtricitabine/efavirenz (TEE) or tenofovir/emtricitabine/efavirenz (Department of Health, 2019).

Adherence to ARVs and attending clinical appointments is crucial for achieving optimal HIV outcomes and an effective HIV prevention strategy. It leads to a significant reduction in HIV transmission, improved survival rates, and fewer hospitalizations for those living with the virus (Robbins, Spector, Mellins, & Remien, 2014). To promote adherence to HIV treatment and improve accessibility, the South African Department of Health established the Central Chronic Drug Dispensing and Distribution (CCMDD) program in 2014. This program allows clinically stable patients (who have been on treatment and attending clinic appointments for more than six consecutive months) to receive ARVs through outside pickup locations (such as post offices, churches, community-based organizations, and Clicks pharmacies) or designated clinic pickup queues. It also reduces the frequency of clinic visits to once or twice a year instead of monthly (Department of Health, 2022). Being part of the CCMDD program was one of the inclusion criteria for participants in this study.

Despite the efforts of the scientific community in discovering antiretroviral drugs (ARVs) and governments in making treatment more accessible, women living with HIV (WLWHIV) face additional challenges in living with the virus. These challenges often lead to non-adherence to HIV treatment and failure to attend clinic appointments, putting them at high risk of morbidity and death from HIV-related diseases. The following section discusses the daily challenges faced by WLWHIV as a result of their HIV status.

2.6 CHALLENGES FACED BY WLWHIV

According to Bouabida, Chaves, and Anane (2023) chronic illnesses, such as HIV, pose a unique set of challenges for individuals affected by the condition. Specifically, within the context of HIV, WLWHIV encounter a range of difficulties, including stigma, financial strain, and psychological barriers. This section will explore these challenges in depth.

2.6.1 HIV and Stigmatization

Individuals who suffer from illnesses that separate them from the general population, and are often incurable, frequently face stigma (Manzou, Schumacher, & Gregson, 2014). According to Goffman (2014), stigma is a deeply discrediting attribute that alters how others perceive the individual, changing them from a whole and typical person to someone tainted and devalued. Those who experience stigma often struggle with feelings of isolation, prejudice, low self-esteem, and limited opportunities (Goffman, 2014). Stigma can manifest in various forms, each with a unique impact on behavior and well-being (Earnshaw & Chaudoir, 2009). Parcesepe, Tymejczyk, Remien, Gadisa, Kulkarni, Hoffman, Melaku, Elul, and Nash (2018) suggest that WLWHIV experience the following three primary types of stigma.

(a) Anticipatory stigma

This type of stigma captures people's fears of rejection and devaluation from others if their secret identity is discovered (Earnshaw, Quinn, & Park, 2012). This stigma tends to be more severe when a person believes that others treat them unfairly because of who they are, or when they fear abuse and devaluation from others if their secret identity is revealed (Earnshaw et al., 2012). In WLWHIV, the likelihood of experiencing this kind of stigma is relatively high. This is because HIV has a history marked by labeling sufferers as promiscuous. As a result, some women living with the virus may believe that the world views them in that way or that they can expect to be stigmatized (Earnshaw et al., 2012).

(b) Enacted stigma

Enacted stigma is another type of stigma experienced by WLWHIV. According to Veale, Peter, Travers, and Saewyc, (2017), enacted stigma refers to the expression of concrete, observable acts and behaviors towards stigmatized individuals or groups. It encompasses the bias and discrimination that individuals face when they are seen as outliers or deviants from the norm (Veale et al., 2017). This can manifest in various ways, such as exclusion, marginalization, verbal abuse, and physical violence (Veale et al., 2017). The health, well-being, and opportunities of those who encounter this type of stigma can be significantly impacted, reflecting the negative views and beliefs held by society towards the stigmatized group (Qiao, Nie, Tucker, Rennie, & Li, 2015).

(c) Internalized stigma

Internalized stigma refers to the internalization of negative attitudes and beliefs about oneself due to being labeled as different or deviant from the norm, such as being HIV positive (Crockett, Kalichman, Kalichman, Cruess, & Katner, 2019). This occurs when individuals or groups are stigmatized by society and internalize these negative beliefs and attitudes towards themselves (Crockett et al., 2019). Internalized stigma can lead to feelings of shame, guilt, and low self-esteem, as well as cause individuals to distance themselves from others and avoid seeking help or support (Crockett et al., 2019). This stigma can greatly impact the mental and physical health of those who experience it and limit their ability to fully participate in society and reach their full potential (Crockett et al., 2019).

Despite medical advancements in HIV treatment over the past three decades that have led to WLWHIV having life expectancies comparable to those without the disease, widespread stigmatization of WLWHIV continues (Sullivan, Rosen, Allen, Benbella, Camacho, Cortopassi, Driver, Ssenyonjo, Eaton, & Kalichman, 2020). HIV-related stigma hinders every stage of the HIV continuum of care, particularly in identifying those who are infected so that they can receive treatment (Sullivan et al., 2020). Prejudice, stereotypes, and discrimination against WLWHIV lead to societal devaluation and personal safety concerns, feelings of shame, social exclusion, and other unfavorable social conditions that make their living conditions more challenging (Closson & Boutilier, 2017).

In Iran, a study was conducted to determine the impact of HIV-related stigma on the Quality of Life (QOL) of PLWHIV. The study examined the physical, psychological, level of independence, social relationships, and environmental domains using a QOL measuring tool. The study found that PLWHIV face significant challenges in all five categories, making it incredibly difficult for them to live the life they want. The study also revealed that cultural conservatism contributes to the challenges faced by PLWHIV, which is prevalent in parts of the Arab world and Africa (Ebrahimi Kalan, Han, Ben Taleb, Fennie, Asghari Jafarabadi, Dastoorpoor, Hajhashemi, Naseh, & Rimaz, 2019). Brener, Broady, Cama, Hopwood, de Wit, and Treloar (2020) also conducted a study to identify how internalized stigma affects the well-being of PLWHIV. The findings showed that internalized stigma has negative impacts on the psychological well-being of individuals, particularly women. Additionally, the study found that individuals with higher levels of education reported less internalized stigma.

In South Africa, a study was conducted focusing on the negative impacts of stigma on WLWHIV and adolescent girls (Armstrong-Mensah, Hernandez, Huka, Suarez, Akosile, Joseph, & Ramsey-White, 2019). The study revealed that society, particularly immediate family members, stigmatize and reject these women and girls. Additionally, there is a belief that they are unable to have healthy offspring. The study concluded that women facing less HIV-related stigma are 2.27 times more likely to adhere to their ARV treatment compared to those experiencing higher levels of stigma.

Therefore, it can be argued that the stigmatization of WLWHIV has adverse effects on their overall health as they are less likely to adhere to HIV treatment. This ultimately prevents them from achieving viral suppression and resilience to HIV.

2.6.2 HIV and Psychological Impediments

In addition to the phenomenon of stigmatization, an expanding body of knowledge indicates that WLWHIV experience an elevated level of mental health concerns (Turan, Budhwani, Fazeli, Browning, Raper, Mugavero, & Turan, 2017). Anxiety, depression, and suicidal ideation are among the diverse range of mental health conditions faced by WLWHIV (Gamassa, Steven, Mtei, & Kaaya, 2023). Reports show that mental health conditions are now the most prevalent comorbidities associated with living with HIV, and these conditions, triggered by a positive HIV diagnosis, are gradually becoming one of the primary causes of disability in WLWHIV globally (Turan et al., 2017).

2.6.2.1 Depression in WLWHIV

Depression is a highly prevalent mental health issue among PLWHIV (Nyamukoho, Mangezi, Marimbe, Verhey, & Chibanda, 2019). Compared to men in the general population, women are particularly vulnerable to experiencing depression (Unnikrishnan, Jagannath, Ramapuram, Achappa, & Madi, 2012). While there is no definitive explanation for why women are more prone to depression than men, there are several plausible causes (Swetlitz, 2021). One of these causes is the responsibility that many women take on as primary caregivers for their loved ones, often prioritizing their care over their own self-care (Swetlitz, 2021). Additionally, factors such as lower household income, personal life events and experiences, inadequate education, and insufficient social support can all be significant sources of stress that impact overall well-being and contribute to depression (Swetlitz, 2021).

In addition to women's responsibilities, receiving an HIV diagnosis is a life-altering announcement that can be extremely difficult to accept and process (Waldron, Burnett-Zeigler, Wee, Ng, Koenig, Pederson, Tomaszewski, & Miller, 2021). Upon receiving an HIV diagnosis, some women may feel powerless, overwhelmed, or ill-equipped to cope with the situation (Coates, Richter, & Caceres, 2008). Others may have concerns about their long-term health or struggle with disclosing their status to loved ones (Coates et al., 2008). The stigma faced by many WLWHIV can lead to social isolation, loneliness, anxiety, and hopelessness, all of which are significant indicators of depression (Waldron et al., 2021). It is important to note that depression not only affects the well-being and quality of life of WLWHIV but also has implications for HIV management and prevention of transmission (Waldron et al., 2021).

A study conducted by Mokhele, Nattey, Jinga, Mongwenyana, Fox, and Onoya (2019) compared the rates of Post-Partum Depression (PPD) in WLWHIV and HIV-negative women in the Gauteng province of South Africa. The study included 690 WLWHIV and 461 HIV-negative women. PPD was found to be more common in WLWHIV (28%) compared to their HIV-negative counterparts (23%). The primary living arrangements of WLWHIV were identified as the main predictors of PPD, which is another significant finding from this study that is relevant to social workers. Research suggests that women who live alone are more likely to experience PPD than those who live with a roommate, family, or friends (Mokhele et al., 2019).

The prevalence of depression among WLWHIV is a significant concern, as research indicates that they are particularly vulnerable to experiencing this mental health issue. Factors such as the responsibility of caregiving, lower household income, personal life events, inadequate education, and insufficient social support contribute to their susceptibility to depression. Additionally, being diagnosed with HIV and the stigma associated with living with the virus can lead those women feeling powerlessness, overwhelmed, difficulty coping, social isolation, loneliness, anxiety, and hopelessness. These feelings are all significant indicators of depression among this population. This information highlights the importance of addressing depression in WLWHIV, not only for their well-being and quality of life, but also for effective HIV management, prevention of transmission, and their ability to become resilient to the virus.

2.6.3 Financial burden in WLWHIV

Major global health issues, such as HIV, impose a significant financial burden on people living with the virus and their families (Danforth, Granich, Wiedeman, Baxi, & Padian, 2017). Although most public health facilities offer free treatment and services, living with HIV can be expensive, particularly for those who are poor and unemployed (Pillai, Foster, Hanifa, Ndlovu, Fielding, Churchyard, Chihota, Grant, & Vassall, 2019). Considering the chronic nature of their condition, PLWHIV spend considerable amounts of money on healthcare, diet, and transportation to healthcare facilities, among other things (Poudel, Newlands, & Simkhada, 2017). This can lead to a reduction in savings and productive assets, as well as an increase in debt (Poudel et al., 2017). Furthermore, the higher healthcare expenditures of PLWHIV can lead to poverty in their families, a reduction in investment opportunities, and a negative impact on education for themselves or their children (Stelmach, Rabkin, Abo, Ahoba, Gildas Anago, Boccanera, Brou, Flueckiger, Hartsough, & Msukwa, 2021). As a means of coping, some PLWHIV resort to asset sales, loans, borrowing, and removing their children from school (Poudel et al., 2017).

In Nepal Poudel et al. (2017) conducted a study to compare the economic burden of PLWHIV to those without the disease. The study revealed that PLWHIV in Nepal suffer an additional economic burden compared to those without the condition. This is because

PLWHIV are expected to spend an equivalent of US$20.10 (R375.89) monthly for their HIV treatment. This is a significant burden given that the average monthly wage in the country is just above US$100.00 (R 1870.10) (Hu, Stauvermann, Nepal, & Zhou, 2023)

A similar study conducted in Nigeria by Adedigba, Naidoo, Abegunde, Olagundoye, Adejuyigbe, and Fakande (2019) reached comparable conclusions. Participants in the study were divided into three categories: the unemployed, civil servants, and self-employed artisans. They were asked to complete a questionnaire about their financial expenditures related to HIV. The study revealed that participants faced a significant decrease in disposable household income due to the expenses associated with HIV care. Additionally, it was noted that the financial impact of the illness varied among the three groups. The artisan group experienced the most significant financial loss, followed by the unemployed and civil servants. The unemployed individuals were the most likely to report precarious financial situations resulting from HIV (Adedigba et al., 2019). The study highlights the heightened impact of HIV on the unemployed and self-employed individuals.

The economic burden also impacts the care and treatment of PLWHIV, which is a top priority for governments globally (Shaaban & Martins, 2019). According to Shaaban and Martins, these economic challenges make it difficult for patients to adhere to their ARV medication regimen. Poverty and unemployment often lead to PLWHIV being unable to afford food to eat before taking their medication (Azia, Mukumbang, & Van Wyk, 2016). In India, the high cost of transportation to health facilities is a significant reason why PLWHIV may stop taking their ARV treatment (Kumarasamy, Safren, Raminani, Pickard, James, Krishnan, Solomon, & Mayer, 2005). Some PLWHIV resort to selling their belongings to cover costs before eventually defaulting on treatment (Kumarasamy et al., 2005). A study in Malawi also found that financial burdens contribute to treatment default among PLWHIV. While some facilities in Malawi offer free ARV medications, patients are required to pick them up in person, leading to challenges in treatment adherence (Chirambo, Valeta, Banda Kamanga, & Nyondo-Mipando, 2019). In Zambia and South Africa, PLWHIV have also mentioned the financial strain of transportation expenses and additional services at ARV dispensing centers as barriers to treatment adherence (Van Wyk & Moomba, 2019).

The challenges outlined above are more prominent in the female population than in the male population. Women face greater economic burdens associated with living with HIV compared to men. This is due to various risk factors mentioned earlier, such as gender-mediated inequalities in education, patriarchal systems favouring men in employment opportunities, and the increased responsibilities of child-rearing placed on women (Russell & Sun, 2020; Ningrum & Mas'udah, 2021). This narrative is supported by Wodon and De La Briere (2018), who argue that in many countries, girls' educational achievements are lower than those of boys, and adult women have lower literacy rates than adult men. Alongside these educational disparities, discriminatory practices and societal norms also affect women's participation in the workforce (Wodon & De La Briere, 2018). Women are less likely to enter the workforce than men, and when they do, they are more likely to work part-time, in an unorganized setting, or in lower-paying positions (Wodon & De La Briere, 2018). These inherent disadvantages lead to significant wage gaps between men and women, diminishing women's voice and bargaining power. This combination of economic disadvantages, caregiving responsibilities, wage disparities, treatment costs, and social norms creates a disproportionate burden on WLWHIV compared to men.

2.6.4 Gender Disparities on WLWHIV: Motherhood and Pregnancy

Women typically experience a greater burden when they are HIV positive compared to men, largely due to their societal position. Additional reasons for this higher burden can be attributed to both physiological and socio-structural factors (HIV/AIDS, 2002). In many underdeveloped countries, women are responsible for household tasks such as cooking, cleaning, taking care of children, collecting water, and caring for their partners (Dilli, Carmichael, & Rijpma, 2019). With all of these responsibilities, some women struggle and, when combined with the challenges brought on by their HIV status, they may not survive. As a result, they suffer from depression, struggle with treatment adherence, and experience a poor quality of life (O'Mahen, Grieve, Jones, McGinley, Woodford, &

Wilkinson, 2015). In extreme cases, some women may even resort to suicide ((O'Mahen et al., 2015).

For WLWHIV who become pregnant, the challenges they face are even greater compared to those who are HIV-negative and pregnant (Ashaba, Kaida, Coleman, Burns, Dunkley, O’Neil, Kastner, Sanyu, Akatukwasa, & Bangsberg, 2017). Pregnancy and the postpartum period bring significant biological, social, and psychological changes for women, and having HIV adds another layer of complexity (Slot, Sodemann, Gabel, Holmskov, Laursen, & Rodkjaer, 2015). A study conducted in the USA showed that up to 13% of women reported symptoms of depression after childbirth, and up to 43% of depressed pregnant and postpartum women also experienced anxiety (Manso-Córdoba, Pickering, Ortega, Asúnsolo, & Romero, 2020). These conditions are among the most common complications during pregnancy, and they can have significant effects on the health of both the mother and her child (Lara, Le, Letechipia, & Hochhausen, 2009).

Moreover, pregnancy can be a time of heightened psychological vulnerability due to various factors such as disclosure issues and HIV-related stigma (Lara et al., 2009). In addition to the usual pressures of new motherhood, these women must also manage stressors related to their health, the unknown infectious status of their infants, and attending to their infants' special needs, such as administering prophylactic antiretroviral drugs (Ion, Greene, Mellor, Kwaramba, Smith, Barry, Kennedy, Carvalhal, Loutfy, & Team, 2016). Depression is a common stress state during pregnancy and can impact the physical and emotional well-being of the mother. It can also have negative consequences for the child's behaviour and emotions (Goodman, Rouse, Connell, Broth, Hall, & Heyward, 2011). Negative mental health outcomes may also affect the treatment of HIV-related illnesses during pregnancy or after childbirth for WLWHIV (Kapetanovic et al., 2014). A study by Zhu, Huang, Lv, Guan, and Bai (2019) found that globally, optimal adherence to antiretroviral therapy was reported as 76% during pregnancy and 53% postpartum for WLWHIV. Depression and emotional distress were identified as barriers to adherence.

The challenges that women face due to their HIV status, along with the burdens discussed earlier, can sometimes overwhelm them and hinder their ability to function optimally

(Ross, Ingabire, Umwiza, Gasana, Munyaneza, Murenzi, & Anastos, 2021). However, some women are able to maintain a stable level of health and positive adaptation even in the face of extreme stress and adversity. These women are commonly referred to as resilient (Dale & Safren, 2018). The following section will discuss the concept resilience.

2.7 UNDERSTANDING THE CONCEPT RESILIENCE

The concept of resilience emerges from the field of psychology and the social sciences (Höltge, Theron, Cowden, Govender, Maximo, Carranza, Kapoor, Tomar, van Rensburg, & Lu, 2021). According to Mendy (2022), resilience refers to the ability to recover from stressful situations and bounce back positively, while maintaining stability despite experiencing those situations (Ginsburg, 2016). A resilient person is someone who can utilize their resources, seek assistance when needed, and find solutions to the problems they face (Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014). In daily life, many individuals have to cope with various difficulties due to stressful experiences they have endured (Kang, 2020). Psychologically resilient people can respond to life's obstacles, which may include illness, divorce, death, financial issues, medical emergencies, job loss, and the loss of loved ones (Southwick et al., 2014). Resilient individuals confront these challenges directly instead of succumbing to despair or resorting to unhealthy coping mechanisms (Southwick et al., 2014). Resilient people do not experience less distress, grief, or anxiety compared to those who are not resilient. However, they handle these challenges in ways that promote strength and growth through healthy coping mechanisms, often emerging stronger than before (Ginsburg, 2016).

2.7.1 Characteristics of Resilience

According to Woods (2017), resilient individuals often possess a variety of characteristics that help them overcome obstacles in life. These characteristics include:

- **A survivor mentality** - Resilient individuals see themselves as survivors. They know that even when things are difficult, they can persevere until they make it through.
- **Effective emotional regulation** - Resilience is marked by the ability to manage emotions in the face of stress. This doesn't mean that resilient individuals don't

experience intense emotions such as fear, grief, or rage. It means they recognize that these emotions are temporary and can be controlled until they pass.

- **Feeling in control** - Resilient individuals typically have a strong internal locus of control and believe that their choices can influence outcomes.
- **Problem-solving skills** - Resilient individuals analyze situations logically when problems arise and work to develop effective solutions.
- **Self-compassion** - Having self-acceptance and self-compassion is another indicator of resilience. Resilient individuals are kind to themselves, especially during challenging times.
- **Social support** - Another indicator of resilience is having a strong support system. Resilient individuals understand the importance of support and know when to seek assistance.

2.7.2 Types of Resilience

Resilience is a broad term used to describe the ability to adapt and cope with life's challenges. However, there are different types of resilience that can impact a person's ability to handle various types of stress (Whitson, Duan-Porter, Schmader, Morey, Cohen, & Colón-Emeric, 2016). According to Whitson et al. (2016), the following are types of resilience:

- **Physical Resilience**: This refers to the body's ability to adapt and recover from physical damage, illnesses, and injuries. Research shows that physical resilience is essential for good health and influences how people age, respond to physical stress, and recover from medical issues. Making healthy lifestyle choices like eating well, exercising, and getting enough sleep can help improve physical resilience to some extent.

- **Mental Resilience**: Mental resilience is the ability to adjust to change and uncertainty. People with this type of resilience are adaptable and composed under pressure. They rely on their mental strength to overcome obstacles, stay on track, and maintain a positive outlook.

- **Emotional Resilience**: Emotional resilience involves the ability to regulate emotions during stressful times. Resilient individuals are in touch with their inner selves and aware of their emotional responses. This allows them to quiet their minds and control their emotions when facing difficult circumstances. People with emotional resilience are also better able to stay positive in challenging situations, knowing that hardships and negative emotions will eventually pass.

- **Social Resilience**: Social resilience, also known as community resilience, refers to a group's ability to recover from adversity. It involves interacting with others and working together to find solutions to issues that affect individuals both personally and collectively. Actions such as coming together after disasters, providing social support, understanding community hazards, and fostering a sense of community are all important aspects of social resilience. These actions can be crucial when communities or large populations face challenges like natural disasters.

Overall, understanding and cultivating different types of resilience can greatly enhance an individual's ability to cope with life's difficulties and bounce back from adversity.

2.7.3 Resilience and Gender

Studies conducted on resilience and gender suggest that men and women respond differently to adversity and trauma (Smyth & Sweetman, 2015). According to Smyth and Sweetman, men generally exhibit higher levels of psychological resilience compared to women. It has been reported that women are twice as likely to develop Post-Traumatic Stress Disorder (PTSD) following a traumatic event (Ayşe & KOĞAR, 2021). North (2016) further states that women are more prone to experiencing Stress-Related Psychological Sequelae (SRPS) such as symptoms of Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD) compared to men. Women often face biases and societal expectations that hinder their ability to grow and demonstrate resilience (Hirani, Lasiuk, & Hegadoren, 2016). Global cultural norms frequently place women in caregiving roles, which can increase their responsibilities and limit the time and resources available for building resilience (Hurley, 2020). Moreover, structural biases like pay inequities and gender discrimination can have lasting effects on women's emotional well-being, impacting their resilience in the long run (Hurley, 2020). Failing to acknowledge the multitude of challenges that women encounter, these social and cultural factors contribute to a perception of women lacking resilience (Hurley, 2020).

Gendered socialization also plays a significant role in shaping resilience disparities between men and women (McKinley, Lilly, Knipp, & Liddell, 2021). Girls are often discouraged from taking risks or asserting themselves from a young age, which limits their range of experiences and may hinder their ability to develop resilience (Maclean, 2004). On the other hand, boys are encouraged to explore, solve problems, and take on challenges, which may make them appear more resilient (Maclean, 2004).

While resilience is a personal quality, it can be enhanced with various support systems. Women often have strong social networks and utilize emotion-focused coping strategies, such as seeking help and social support. These characteristics demonstrate adaptability and resourcefulness in handling life's challenges, rather than a lack of resilience. By acknowledging and bolstering women's strengths, they can be empowered to navigate situations that might otherwise be perceived as evidence of lower resilience. The following section will discuss resilience in the context of HIV.

2.8 WOMEN RESILIENCE IN THE FACE OF HIV

Resilience, in the context of HIV, refers to the ability to successfully cope with the negative circumstances that arise from receiving an HIV diagnosis (Brito & Seidl, 2019). Additionally, resilience encompasses the ability of individuals, communities, and systems affected by HIV to withstand and adapt to the challenges posed by the virus (Dulin, Dale, Earnshaw, Fava, Mugavero, Napravnik, Hogan, Carey, & Howe, 2018). This includes maintaining physical health, adhering to treatment, managing emotional well-being, dealing with prejudice and stigma, maintaining social support systems, and engaging in activities that enhance overall well-being (Dulin et al., 2018). Resilience encompasses various dimensions, such as physical, psychological, social, and behavioral aspects, that contribute to a person's ability to navigate the complexities of living with HIV (Shriharsha & Rentala, 2019). Resilience can also be influenced by genetics, exposure to and experience with adversity, the drive to succeed, the presence of mentors or role models, and prosocial abilities that enable individuals to seek help from others (De Santis, Florom-Smith, Vermeesch, Barroso, & DeLeon, 2013).

Living with HIV involves facing various challenges that require women to develop and utilize resilience to cope with stigma, potential health issues, and the lifelong management of the condition. Understanding the different types of resilience can help social workers, healthcare professionals, policymakers, and society as a whole in providing comprehensive support and enhancing the overall health of WLWHIV.

2.8.1 Types of Resilience for WLWHIV

As described by Dulin et al. (2018), there are three different types of resilience for WLWHIV, which are listed below.

2.8.1.1 Personal Resilience

Personal resilience is essential for enabling WLWHIV to cope and thrive. It refers to the internal resources and skills women develop to handle the emotional and psychological effects of an HIV diagnosis and treatment. Building personal resilience involves setting achievable goals, practicing self-care techniques, cultivating self-efficacy, and maintaining a positive outlook. By developing their own resilience, WLWHIV can better manage daily challenges, adhere to treatment, and live high-quality lives.

2.8.1.2 Social Resilience

Social resilience is a crucial component for WLWHIV. It involves the ability to maintain and foster strong connections, create support systems, and access healthcare services. WLWHIV often face stigma, rejection, and prejudice, which can negatively impact their mental health. Promoting social resilience can be achieved through open communication with loved ones, attending counseling sessions with social workers, participating in HIV support groups, engaging in peer mentoring, and utilizing local resources. By developing strong social support networks, WLWHIV can overcome gaps in emotional and practical support, thereby increasing their resilience and overall well-being.

2.8.1.3 Cultural Resilience

Cultural resilience is an often overlooked yet important aspect of life for those living with HIV. It refers to the capacity to utilize cultural norms, values, and traditions to overcome HIV-related obstacles. Cultural resilience can be fostered through participation in cultural events and festivals, finding solace and strength in religious or spiritual activities, utilizing traditional healing techniques, and feeling a sense of belonging to one's cultural community. Embracing and integrating cultural resources allows WLWHIV to access unique forms of support that promote dignity, optimism, and resilience in the face of HIV-related challenges.

Resilience plays a crucial role in managing HIV and ensuring the overall well-being of those living with the virus. Personal, social, and cultural resilience all work together to enable WLWHIV to lead fulfilling lives despite the challenges they face. Recognizing and valuing the various types of resilience demonstrated by these individuals allows social workers and other healthcare professionals to provide informed and compassionate support to this population. Fostering personal empowerment, cultivating strong social connections, and acknowledging the importance of cultural resources are essential steps in promoting the ongoing growth and well-being of WLWHIV.

2.8.2 The importance of building Resilience on WLWHIV

HIV continues to pose a serious threat to the health of vulnerable groups, particularly women (Klaas, Thupayagale-Tshweneagae, & Makua, 2018). Women are most affected by HIV, especially in sub-Saharan Africa, where they account for the majority of HIV cases compared to other parts of the world (Sia, Onadja, Hajizadeh, Heymann, Brewer, & Nandi, 2016). This increasing HIV prevalence among women requires special attention and prioritization to address their unique vulnerabilities and challenges (Karim, Sibeko, & Baxter, 2010). Prioritizing HIV resilience in women is key to reducing gender inequalities and achieving equal access to healthcare (Dale, Cohen, Kelso, Cruise, Weber, Watson, Burke-Miller, & Brody, 2014). This inequality is created by various sociocultural factors that not only increase women's vulnerability to HIV infection but also impede their access to prevention, treatment, and care services (Sajadipour, Rezaei, Irandoost, Ghaumzadeh, Salmani nadushan, Gholami, Salimi, & Jorjoran Shushtari, 2022).

One of the main reasons why women should be prioritized in building HIV resilience is because they face gender inequalities, which are a major contributor to the high HIV prevalence among women (Dale et al., 2014). In their daily lives, women experience unequal power in relationships that limit their control over sexual rights (Dale et al., 2014). They also face obstacles such as economic dependency, lack of bargaining power in relationships, and limited access to sexual and reproductive health services, including regular HIV testing (Dale et al., 2014). Installing resilience in WLWHIV will not only address the problems of social norms but also improve women's access to education, economic opportunity, and comprehensive sexual and reproductive health services.

Resilience in WLWHIV is crucial in preventing the Prevention of Mother to Child Transmission (PMTCT) (Hurst, Appelgren, & Kourtis, 2015). According to Teasdale, Marais, and Abrams (2011), approximately 95% of children living with HIV acquire the virus through vertical transmission, primarily during pregnancy, childbirth, or lactation. When pregnant WLWHIV have access to PMTCT services and ARVs, the risk of transmission to their infants is significantly reduced (Teasdale et al., 2011). Therefore, resilient WLWHIV will be aware of available resources to manage HIV, the importance of counseling, and will promote early HIV testing and prenatal care, which could make a significant difference in preventing new HIV infections in children.

WLWHIV often face unique challenges that require tailored support and care (Waldron et al., 2021). Stigma and discrimination, along with social norms, can lead to women being denied social support, employment opportunities, and even healthcare (Hay, McDougal, Percival, Henry, Klugman, Wurie, Raven, Shabalala, Fielding-Miller, & Dey, 2019). Mental health issues such as depression and anxiety are more prevalent among WLWHIV (Waldron et al., 2021). Therefore, prioritizing women in resilience-building efforts involves providing comprehensive care that extends beyond medical treatment and addresses their psychosocial needs, including mental health support and counseling.

Lastly, the HIV epidemic continues to hinder economic development, with women bearing much of the burden. The role of women as a crucial part of the workforce cannot be underestimated, especially in developing countries (Verick, 2014). Placing women at the forefront of HIV resilience initiatives and providing them with access to care and support will not only enhance their well-being but also prevent economic setbacks from disability and premature death (Dale et al., 2014). This, in turn, can help boost productivity and economic growth (Dixon, McDonald, & Roberts, 2002). In order to achieve resilience in WLWHIV, these women must implement specific strategies.

The following section discusses strategies that women living with HIV utilize to be resilient in the face of the virus and the challenges that come with it.

2.8.3 Resilience Strategies for WLHIV

Living with HIV presents a multitude of challenges that require constant attention to physical, emotional, and social concerns. However, developing resilience is crucial for promoting positive attitudes and overall well-being for women living with the virus. By implementing different strategies, such as accepting one's HIV status, disclosing it to others, seeking social and professional support, adhering to HIV treatment, and participating in support groups, WLWHIV can effectively strengthen their resilience in dealing with the virus.

2.8.3.1 Accepting one’s HIV status

Accepting one's HIV status is the process of acknowledging and accepting the reality that one is HIV positive, meaning they have been diagnosed with HIV (Kutnick, Gwadz, Cleland, Leonard, Freeman, Ritchie, McCright-Gill, Ha, & Martinez, 2017). It involves embracing the truth and understanding the potential implications of living with HIV (Qiao, Nie, Tucker, Rennie, & Li, 2015). Acceptance goes beyond simply acknowledging the diagnosis; it also involves coming to terms with the emotional and psychological aspects of living with HIV (Kutnick et al., 2017). This means understanding that HIV is a chronic condition and that taking proactive steps to manage one's health is crucial (Kutnick et al., 2017).

Maseko and Madiba (2020) indicate that acceptance is not a one-time event; rather, it is an ongoing process that may involve a range of emotions, including fear, sadness, anger, or heartache. It's important to give oneself the time and space to experience these emotions and to seek support from social workers, HIV support groups, or family members who can offer guidance, understanding, and empathy (Maseko & Madiba, 2020). At the beginning, WLWHIV often experience anxiety, fear, and shock (de Los Rios, Okoli, Castellanos, Allan, Young, Brough, Muchenje, Eremin, Corbelli, & McBritton, 2021). However, once they accept their HIV status, it enables them to come to terms with and process their emotional responses to the diagnosis (de Los Rios et al.,2021). By acknowledging and addressing these emotions, WLWHIV can seek support from social workers, HIV support groups, and other healthcare providers to develop strategies for emotional well-being (Ford, Lam, John, & Mauss, 2018). This also enables them to confide in family, friends, and trusted acquaintances for support with confidence, fostering stronger social networks. Social support helps alleviate feelings of isolation by providing an opportunity to express emotions, offer advice, or just provide reassurance that you are not alone in your journey (Zamir, Hennessy, Taylor, & Jones, 2018).

In addition, accepting one's HIV status can help reduce self-stigma and internalized feelings of shame (Turan, Budhwani, Fazeli, Browning, Raper, Mugavero, & Turan, 2017). Choosing to embrace one’s illness enables WLWHIV to challenge societal misconceptions about HIV and actively counteract stigma (Turan et al., 2017). In turn, this gives WLWHIV confidence and allow them to speak openly about their HIV status, which helps educate the public, dispel myths, and promote greater acceptance and understanding (Hellen, 2015). Individuals who accept their diagnosis often become active participants in the HIV community, engaging in peer support, awareness campaigns, and social activism on HIV (Iryawan, Stoicescu, Sjahrial, Nio, & Dominich, 2022). By accepting their HIV status, WLWHIV become empowered to take control of their health and prevent potential transmissions (Bhatta & Liabsuetrakul, 2016). It prompts them to adopt safer behaviors, such as consistent condom use, regular medical check-ups, and practicing harm reduction strategies (Rosenberg, Pettifor, De Bruyn, Westreich, Delany-Moretlwe, Behets, Maman, Coetzee, Kamupira, & Miller,2013).

The researcher concurs with the sentiments expressed above that acknowledging one's HIV status can help build resilience and enable WLWHIV to be more adaptable to future challenges. By accepting their status, WLWHIV can develop a heightened sense of self-efficacy that allows them to face not only medical hurdles but also personal and professional goals with more confidence. Acceptance is also a vital and transformative process that greatly aids in becoming resilient to living with HIV. The path to acceptance offers emotional stability, access to support systems, increased healthcare engagement, reduced stigma, safer behaviors, empowerment, and resilience.

In conclusion, accepting one's HIV status builds resilience and adaptability to future challenges, allowing WLWHIV to face medical, personal, and professional goals with more confidence. Acceptance is a transformative process that provides emotional stability, access to support systems, increased engagement with healthcare, reduced stigma, safer behaviors, empowerment, and resilience.

2.8.3.2 Disclosing one's HIV status

HIV disclosure is the process of sharing accurate and comprehensive information about one's HIV status with others, regardless of whether they are positive or negative (Obermeyer, Baijal, & Pegurri, 2011). This can occur in various contexts, such as informing sexual partners, family members, friends, support groups, or healthcare providers (Ssali, Atuyambe, Tumwine, Segujja, Nekesa, Nannungi, Ryan, & Wagner, 2010). Sharing this personal information can be stigmatizing due to societal misconceptions about HIV. However, it also contributes to a more inclusive society that promotes compassion and understanding, ultimately reducing the stigma and discrimination faced by WLWHIV (Ssali et al., 2010). This allows for a more nuanced and compassionate understanding of their experiences (Kontomanolis, Michalopoulos, Gkasdaris, & Fasoulakis, 2017). Disclosing one's HIV status is a critical step in promoting communication and trust because it allows WLWHIV to make informed decisions and live freely without worrying about others knowing their status. It also grants them access to support and appropriate healthcare (Obermeyer et al., 2011).

HIV disclosure has the potential to build resilience by challenging WLWHIV to confront their fears and societal prejudices (Earnshaw, Bogart, Dovidio, & Williams, 2015). When these women share their HIV status, they gain strength, resilience, and courage to navigate the complexities of living with HIV (Lee, Yamazaki, Harris, Harper, & Ellen, 2015). Additionally, building resilience enables WLWHIV to effectively cope with adversity and maintain a positive outlook on life (Lee et al., 2015). It promotes psychological and emotional well-being by reducing the burden of secrecy and fostering a sense of personal authenticity (Jia, Jiao, Ma, Liao, Wang, Kang, Lin, Yan, Li, & Cheng, 2022). HIV status disclosure also leads to increased social support, which plays a crucial role in successfully managing this chronic condition (Maman et al., 2014). Sharing your status with supportive friends, family members, or partners allows for the creation of a network of WLWHIV who can offer emotional support, practical help, and acceptance (Maman, Van Rooyen, & Groves, 2014). Constructive feedback, encouragement, and empathy from these supportive individuals create an environment conducive to effective coping and overall well-being (Maman et al., 2014).

Moreover, HIV disclosure plays a crucial role in fostering empowerment and advocacy among WLWHIV. It enables them to actively participate in various HIV-related activities, such as support groups, awareness campaigns, and public discussions (Sunguya, Munisamy, Pongpanich, Yasuoka, & Jimba, 2016). By openly sharing their stories and experiences, individuals raise awareness, educate others, advocate for their rights, and contribute to creating a more just and inclusive society (Sunguya et al., 2016). It also promotes self-acceptance and self-love as women reveal their HIV status. Through this act, those living with HIV develop a deeper understanding of themselves, embracing their resilience and accepting their condition as an integral part of their identity (Qiao et al., 2015). This transformative process encourages personal growth and enhances overall coping mechanisms (Qiao et al., 2015). By engaging in HIV disclosure, WLWHIV empower themselves to take control of their lives and actively participate in shaping their own narratives (Mburu, Hodgson, Kalibala, Haamujompa, Cataldo, Lowenthal, & Ross, 2014).

The researcher concurs with the sentiments expressed above. The process of HIV disclosure among WLWHIV goes beyond simply revealing one's medical condition; it is a transformative journey with profound implications for both individual well-being and societal attitudes towards HIV. By sharing their HIV status, WLWHIV contribute to breaking down barriers and challenging stigma, fostering empathy and understanding in society. This act of disclosure empowers women to live authentically, access necessary support services and healthcare without the burden of secrecy. Additionally, HIV disclosure fosters resilience, enabling WLWHIV to confront societal prejudices and navigate the challenges of living with HIV. By building supportive networks, women find strength and encouragement, enhancing their ability to thrive despite adversity. Furthermore, HIV disclosure empowers WLWHIV to advocate for their rights, raise awareness, and contribute to a more inclusive society where individuals affected by HIV/AIDS are supported and respected.

2.8.3.3 Seeking Social and Professional Support

Social support seeking in the context of HIV involves actively seeking emotional, informational, and practical help to cope with the challenges of living with HIV (Qiao, Li, & Stanton, 2014). This support can come from various sources, such as family, friends, social workers, support groups, healthcare providers, or online communities (Qiao et al., 2014). The purpose of seeking social support is to find understanding, compassion, and guidance as one navigates the physical, emotional, and social aspects of living with HIV (Li, Zhang, Liao, Liang, He, Liu, Yang, Zhang, Ma, & Wang, 2021). It can help individuals reduce feelings of isolation, manage emotional distress, access relevant information, address stigma and discrimination, and promote overall well-being and quality of life (Li et al., 2021).

Social support is vital to the well-being of WLWHIV as it has a positive impact on their mental and physical health (Adedimeji, Alawode, & Odutolu, 2010). It includes providing empathy, love, and understanding, and helping affected individuals express their thoughts, fears, and concerns related to the disease (Moudatsou, Stavropoulou, Philalithis, & Koukouli, 2020). Studies consistently show that people who seek social support are less likely to experience depression, anxiety, and stress, and are more likely to adhere to their ARVs (Waldron et al., 2021). Trusted friends, supportive family members, or even online communities can serve as sources of support and provide a safe space for WLWHIV to share their experiences, find solace, and ease their emotional burdens (Lee et al., 2015). Through emotional support, WLWHIV gains a sense of belonging and security, enabling them to manage the complexities of their illness more effectively (Lee et al., 2015).

Additionally, the support of family and friends helps WLWHIV cope with challenges in their daily lives or with specific HIV-related problems (Li et al., 2006). This support can take various forms, such as transportation to doctor's appointments, assistance with managing and adhering to medication, or help with housework (Li et al., 2006). This type of support not only reduces the burden on WLWHIV but also promotes their independence so they can focus on maintaining their health without being overwhelmed by logistical hurdles

(Palmer, Wehrmeyer, Florian, Raison, Idler, & Mascaro, 2021). Moreover, when dealing with HIV, women often encounter a wealth of medical and treatment-related information, making information support an indispensable part of their social support networks (Mabachi, Brown, Sandbulte, Wexler, Goggin, Maloba, & Finocchario-Kessler, 2020). Finding accurate and up-to-date information helps develop a full understanding of the disease, its transmission, prevention, treatment options, and potential side effects (Balogh, Miller, & Ball, 2015). Social workers, healthcare workers, specialized support groups, and reliable online resources can help WLWHIV receive and interpret relevant information so they can make informed decisions about their healthcare (Bateganya, Amanyeiwe, Roxo, & Dong, 2015). By receiving factual information, WLWHIV can feel in control and take an active part in managing their health, thereby improving their overall well-being (Bateganya et al., 2015).

Finding social support is crucial for individuals living with HIV, especially for women. By cultivating and nurturing supportive relationships, engaging with HIV support groups, social workers, healthcare professionals, and community organizations, WLWHIV can conquer the obstacles posed by their diagnosis and develop resilience in dealing with HIV.

2.8.3.4 Adherence to HIV Treatment

HIV treatment adherence refers to how consistently PLWHIV follow their prescribed medication regimens (Iacob, Iacob, & Jugulete, 2017). According to Iacob et al. (2017), this includes taking ARVs as directed by healthcare providers, attending clinic appointments, following lifestyle recommendations, and undergoing regular monitoring and check-ups. Adherence to HIV treatment plays a crucial role in managing HIV infection, as it helps control the virus, prevents disease progression, reduces the risk of drug resistance, and lowers the chance of transmitting HIV to others (Yu, Luo, Chen, Huang, Wang, & Xiao, 2018). Maintaining a high level of adherence is important for WLWHIV to maximize the effectiveness of their treatment and maintain their long-term health (Iacob et al., 2017).

Adhering to HIV treatment empowers WLWHIV to take control of their health, fostering a sense of self-efficacy and resilience (El-Mallakh & Findlay, 2015). Adherence practices include developing coping strategies such as integrating medication routines into daily life, setting reminders, and seeking support from social workers, healthcare professionals, and HIV support groups (El-Mallakh & Findlay, 2015). El-Mallakh and Findlay (2015) further state that these strategies empower women to address the complex challenges associated with HIV and build resilience in overcoming obstacles on their treatment journey. Adhering to ARVs as prescribed by healthcare professionals and taking them regularly according to the recommended schedule ensures sustained suppression of viral loads (Byrd, Hou, Hazen, Kirkham, Suzuki, Clay, Bush, Camp, Weidle, & Delpino, 2019). This helps reduce the risk of opportunistic infections, AIDS-related diseases, and builds resilience against HIV (Günthard, Saag, Benson, Del Rio, Eron, Gallant, Hoy, Mugavero, Sax, & Thompson, 2016). HIV targets the immune system and destroys the CD4 cells; adhering to HIV treatment plays a significant role in improving immune function, as ARVs strengthen the immune system (Günthard et al., 2016). ARVs target the viral replication cycle, helping restore CD4+ T cell counts and the immune system's ability to fight off infection and maintain overall health (Günthard et al., 2016).

Moreover, adherence to HIV treatment extends beyond medication and includes a comprehensive approach to health management (Chen, Chen, & Kalichman, 2017). Adopting a healthy lifestyle with regular exercise, a balanced diet, adequate sleep, and stress reduction techniques further enhances HIV resilience (LaGrange, Mitchell, Lewis, Abramowitz, & D'Angelo, 2012). These complementary practices have been shown to positively impact immune function, mental and emotional well-being, and overall quality of life for WLWHIV (Lagrange et al., 2012). Tailored adherence counseling and personalized care plans can optimize adherence outcomes, leading to improved health outcomes and increased HIV resilience (Fletcher, Sherwood, Rice, Yigit, Ross, Wilson, Weiser, Johnson, Kempf, & Konkle-Parker, 2020).

Adherence to HIV treatment is vital for effectively managing HIV infection and ensuring long-term health outcomes for WLWHIV. It encompasses various aspects such as taking

ARVs as prescribed, attending clinic appointments, following lifestyle recommendations, and undergoing regular monitoring and check-ups. Maintaining high adherence levels significantly contributes to controlling the virus, preventing disease progression, reducing the risk of drug resistance, and decreasing the likelihood of transmitting HIV to others. It empowers WLWHIV to take charge of their health, fostering self-efficacy and resilience. Strategies such as integrating medication routines into daily life, setting reminders, and seeking support from healthcare professionals and support groups enable women to navigate the challenges associated with HIV treatment effectively. Consistent adherence to ARVs also ensures sustained suppression of viral loads, thereby reducing the risk of opportunistic infections and AIDS-related diseases and building resilience against HIV. It also extends beyond medication and includes adopting a healthy lifestyle with regular exercise, a balanced diet, adequate sleep, and stress reduction techniques. These complementary practices positively impact immune function, mental and emotional well-being, and overall quality of life for WLWHIV.

2.8.3.5 Attending HIV support groups

An HIV support group is a community-based gathering where individuals affected by HIV, regardless of their HIV status, come together regularly to share their experiences with the virus (Bateganya et al.,2015). These groups are typically organized by social workers, Community-Based Organizations (CBOs), healthcare facilities, or Non-Profit Organizations (NGOs) that focus on HIV (Akeju, Nance, Salas-Ortiz, Fakunmoju, Ezirim, Oluwayinka, Godpower, & Bautista-Arredondo, 2021). They can meet in various settings such as clinics, hospitals, community centers, or virtual platforms, and are facilitated by experienced social workers or healthcare professionals (Bateganya et al., 2015).

HIV support groups are essential in providing support to individuals affected by this life-changing condition, including WLWHIV. These groups serve as safe spaces where WLWHIV, along with their friends, families, and caregivers, can come together to share experiences, offer emotional support, and provide valuable resources (Coulson & Buchanan, 2022). Bateganya (2015) suggests that the primary goal of these groups is to promote mutual support, understanding, and empathy among members who have encountered similar challenges such as stigma, discrimination, physical and mental health issues, and societal isolation. These challenges can significantly impact women's resilience to HIV (Bateganya et al., 2015).

One of the main benefits of participating in an HIV support group is the opportunity to connect with other people who are also living with HIV (Bateganya et al., 2015). This connection creates a sense of belonging and social support, which is critical to building resilience (Bateganya et al., 2015). The opportunity to share experiences, fears, and successes with others who understand can bring great comfort and strength (Bateganya et al., 2015). In addition, participation in support groups promotes the development of coping mechanisms, WLWHIV can learn new strategies to manage the stress, anxiety, and stigma associated with their condition (Mazambara, Chagwena, Mudzviti, Sithole, Monera-Penduka, Maponga, & Morse, 2022). By learning healthy coping mechanisms, such as practicing mindfulness, seeking social support, or engaging in creative outlets, individuals are better able to cope with the challenges they face and, over time, build resilience (Mazambara et al., 2022). Mental health is also a crucial part of the resilience of WLWHIV (Brown, Martin, Knudsen, Gotham, & Garner, 2021). This platform offers an open discussion about the emotional and psychological impact of the condition. Sharing feelings, fears, and struggles with a supportive group can be cathartic and therapeutic, leading to improved psychological well-being and ultimately building resilience in dealing with HIV (Bateganya et al., 2015).

Another important aspect of participating in an HIV support group is that it can help improve self-esteem (Madiba & Canti-Sigaqa, 2012). Sharing experiences and hearing stories from others who have overcome challenges can inspire and encourage WLWHIV (Madiba & Canti-Sigaqa, 2012). When they witness the resilience and successes of others, they begin to believe in their own ability to be successful despite living with HIV (Bateganya et al., 2015). This increased self-esteem is a key protective factor against the negative effects of the virus (Bateganya et al., 2015). In addition, the groups can also help WLWHIV overcome feelings of isolation and loneliness (Yuldashev, 2021). By interacting with other women who have had similar experiences, women can form meaningful connections and friendships (Yuldashev, 2021). This social support network is critical to fostering resilience, as a sense of community and knowing you are not alone can go a long way in contributing to overall well-being (Ozbay, Johnson, Dimoulas, Morgan Iii, Charney, & Southwick, 2007).

Lastly, HIV support groups often offer a wealth of reliable information and resources (Bateganya et al., 2015). Group members can learn about the latest medical advances, treatment options, and behaviors that can positively impact their health (Bateganya et al., 2015). This knowledge enables group members to make informed decisions about their care, increasing their resilience in dealing with HIV (Bateganya et al., 2015). Group discussions can empower WLWHIV to take an active role in decision-making related to their health and overall well-being (Krist, Tong, Aycock, & Longo, 2017). This empowerment enables them to stand up for themselves and assert their rights, which directly contributes to their resilience in addressing various HIV-related challenges (Krist et al., 2017).

In summary, participating in an HIV support group offers numerous benefits that significantly enhance women ability to cope with HIV. These benefits include social support, accurate information, coping mechanisms, increased self-esteem, improved mental well-being, greater independence, and reduced isolation. These groups are essential in creating a safe and empowering environment that helps WLWHIV lead fulfilling lives.

Among these strategies, various professionals such as social workers, nurses, doctors, and others in similar roles play a crucial role in supporting WLWHIV to build resilience through their involvement in providing a range of services. The following section will explore the contributions that the social work profession can make to assist WLWHIV.

2.9 THE ROLE OF SOCIAL WORKERS IN PROMOTING RESILIENCE IN WLWHIV

According to Okafor (2021), social work is a multidisciplinary profession that aims to improve the well-being of individuals, families, and communities. It encompasses a range of activities aimed at providing support, advocacy, and resources to vulnerable populations, such as those affected by HIV, poverty, discrimination, or mental health problems (Okafor, 2021). Social work also promotes individual well-being, social justice, and advocacy for marginalized groups and individuals (Saxena & Chandrapal, 2022).

Brill (2001) indicates that the social work profession is based on several basic principles. One of these principles is the belief in the dignity and worth of all individuals. Social workers recognize that every human being has inherent worth and should be treated with respect and compassion. Another principle is a commitment to social justice and the promotion of justice. Social workers strive to eliminate discrimination, oppression, and poverty, and work toward the creation of a fairer and safer society. They also emphasize the importance of human relationships and the interconnectedness of individuals with their families, communities, and society at large.

The explanation above is particularly significant in the context of this study, as women are often marginalized compared to men. In order to achieve the objectives of enhancing the lives of these marginalized group (WLWHIV), social workers are responsible for providing emotional support, connecting them with available resources, and advocating for their rights. Social workers main goals are to improve WLWHIV overall well-being, provide them with coping skills to increase their resilience, and help them lead fulfilling lives. The following discussions will explore the role of social workers in promoting resilience among WLWHIV.

2.9.1 Providing HIV Counselling and Testing

Social workers play a crucial role in HIV counseling and testing, providing valuable support and assistance to WLWHIV (Manganyi, 2021). With a comprehensive understanding of the psychosocial aspects of HIV, they are able to offer client-centered counseling services during the testing process (Manganyi, 2021). Social workers offer emotional support to clients, help them process their feelings, and address any concerns and fears they may have about HIV (Chippindale & French, 2001). Through nonjudgmental conversations and active listening, social workers create a safe and trusted environment for clients to disclose important information related to risk behaviors, disclosure challenges, and potential stigmatization (Chippindale & French, 2001). Additionally, they educate clients about HIV testing, its benefits, and the available testing options (WHO, 2015). They also answer questions, address potential barriers or misconceptions, and discuss concerns regarding confidentiality (WHO, 2015).

After conducting HIV testing, social workers offer emotional support, guidance, and education about treatment options, emphasizing the importance of adherence to HIV treatment and encouraging healthy behavior practices (Rouhani, O'Laughlin, Faustin, Tsai, Kasozi, & Ware, 2017). Post-HIV counseling is crucial in helping newly diagnosed women with HIV to cope with the challenges they will encounter after being diagnosed with the virus (Kanekar, 2011). During this process, social workers provide newly diagnosed women with accurate and up-to-date information about HIV transmission, prevention strategies, and risk reduction techniques. They also empower these women to engage in safer sexual practices and protect their health by building resilience through personal empowerment and agency (Flickinger, Berry, Korthuis, Saha, Laws, Sharp, Moore, & Beach, 2013). Additionally, by creating a safe and supportive space, social workers assist WLWHIV in developing effective strategies to manage stress, anxiety, and depression. These coping mechanisms help individuals regain a sense of control, resilience, and optimism, allowing them to navigate the complex emotional landscape associated with HIV (Ozbay et al., 2007). Post-HIV counseling also provides newly diagnosed women with the opportunity to openly express their concerns, fears, and insecurities. Through a non-judgmental approach, social workers actively listen, evaluate emotions, and provide empathetic support (Rujumba, Mbasaalaki-Mwaka, & Ndeezi, 2010). This environment fosters a sense of belonging and acceptance, promoting social bonding and developing resilience by alleviating feelings of isolation (Rujumba et al., 2010).

The researcher echoes with what has been stated above, social workers play a crucial role in HIV counseling and testing, especially in supporting WLWHIV. They provide client-centered counseling services during testing, offering emotional support, addressing concerns, and creating a safe space for WLWHIV to discuss risk behaviors and potential stigmatization. Additionally, social workers educate those women about the benefits of testing, treatment options, adherence, and healthy behavior practices. Post-HIV counseling is also important, as social workers help newly diagnosed women cope with challenges, provide accurate information, empower them to engage in safer practices, and develop coping strategies for stress and emotional well-being. This comprehensive support helps WLWHIV regain control, resilience, and optimism in managing HIV-related challenges.

2.9.2 Promoting HIV Treatment Adherence

Adherence to HIV treatment plays a crucial role in the management and prevention of HIV. Social workers have a deep understanding of the diverse needs and circumstances of WLWHIV and are equipped with unique skills and expertise that help them support WLWHIV in consistently following their treatment plans (Lekganyane & Manganyi, 2023). By addressing psychosocial, behavioral, and financial barriers to adherence, social workers significantly contribute to improving clients' outcomes and the overall quality of life of WLWHIV (Lekganyane & Manganyi, 2023). Adherence counseling is fundamental in fostering treatment adherence among WLWHIV (Musayon-Oblitas, Carcamo, & Gimbel, 2019). Social workers conduct both individual and group adherence counseling sessions, providing emotional support as WLWHIV navigate the complex challenges associated with a chronic illness (Gill, Ndimbii, Otieno-Masaba, Ouma, Jabuto, & Ochanda, 2022). These counseling sessions create safe spaces for discussing fears, concerns, and anxieties related to treatment, helping to build resilience and self-efficacy (Gill et al., 2022). By promoting emotional well-being, social workers empower WLWHIV and enhance their motivation to follow treatment regimens (Olem, Sharp, Taylor, & Johnson, 2014).

Furthermore, social workers are responsible for conducting comprehensive assessments, including psychosocial assessments, to identify barriers to HIV treatment adherence and adjust interventions accordingly (Okonji, Mukumbang, Orth, Vickerman-Delport, & Van Wyk, 2020). This personalized approach allows them to address specific challenges such as mental health issues, substance abuse, poverty, stigma, and limited social support networks that can hinder treatment adherence for WLWHIV (Okonji et al., 2020).

Peer support networks play a critical role in ensuring adherence to HIV treatment (Kanters, Park, Chan, Ford, Forrest, Thorlund, Nachega, & Mills, 2016). Social workers are responsible for establishing and facilitating peer support networks, also known as adherence clubs, which provide a platform for WLWHIV to connect and share their experiences (Kanters et al., 2016). These networks create a sense of community, alleviate feelings of isolation, and promote treatment adherence (Kanters et al., 2016).

Social workers frequently organize and lead these peer support groups and community engagement initiatives, empowering women to learn from each other and find mutual encouragement. This approach also helps mitigate the stigma and discrimination that continue to be prevalent challenges faced by WLWHIV (Pulerwitz, Michaelis, Verma, & Weiss, 2010). Stigma and discrimination present significant obstacles to treatment adherence, and social workers proactively address this issue by increasing awareness, educating communities, and advocating for policies that foster inclusivity and reduce discrimination (Pulerwitz et al., 2010). By addressing these fundamental social determinants of health, an environment is established that encourages treatment adherence and empowers WLWHIV to access the necessary care.

Strict adherence to HIV treatment is a fundamental pillar in the journey towards achieving HIV resilience, and social workers play an important role in promoting HIV treatment adherence. By addressing psychosocial, behavioral, and financial barriers to adherence, improving treatment outcomes, and creating a more inclusive and supportive environment, social workers enhance the overall well-being of WLWHIV.

2.9.3 Advocating for WLWHIV

Social workers are essential advocates for the rights and welfare of WLWHIV. As frontline professionals in the field of social work, their intelligence and understanding are crucial in addressing the complex challenges faced by this population. To fully grasp the present-day importance of social workers in HIV advocacy, it is essential to recognize the historical context. During the early stages of the epidemic, social workers played a pivotal role in providing support services, creating community resources, and challenging prejudicial policies that affected those living with HIV (Sharma, Small, Okumu, Mwima, & Patel, 2022). According to Tayo and Work (2014), social workers continue to lead the charge in advocating for comprehensive healthcare, social equity, and enabling WLWHIV to live fulfilling lives.

One of the essential roles of social workers advocating for WLWHIV involves challenging discriminatory policies and advocating for policy reform (Pulerwitz et al., 2010). Leveraging their extensive knowledge of legal and ethical frameworks, social workers engage in lobbying activities to promote legislation that protects the rights and dignity of affected women (Reyneke, 2020). They work alongside policymakers and participate in grassroots initiatives to bring about systemic changes that align with the principles of social justice (Reyneke, 2020). Additionally, social workers collaborate with healthcare teams to ensure the comprehensive addressing of the medical needs of WLWHIV (Pinto, Witte, Filippone, Choi, & Wall, 2018). Their expertise enables them to effectively bridge the gap between clients and healthcare providers, ensuring that clients receive appropriate medical interventions, adherence support, and continuous care (Pinto et al., 2018). This collaborative effort by social workers promotes holistic well-being and improved health outcomes (Pinto et al., 2018). Chibonore and Chikadzi (2017), social workers further enhance their advocacy efforts by establishing collaborative partnerships and networks with community organizations, government agencies, and other significant stakeholders. These partnerships enable them to efficiently utilize resources, share best practices, and collectively promote social transformation. Social workers with advanced knowledge and expertise actively engage in research initiatives, contributing to evidence-based advocacy and policy formulation (Chibonore & Chikadzi, 2017).

2.9.3.1 Contribution of Social Work Advocacy to HIV Resilience

Advocacy for WLWHIV is a critical component in fostering resilience among this population (Harrison, Li, & Vermund, 2019). Through advocacy efforts, healthcare providers, support groups, and policymakers collaborate to enhance treatment accessibility, diminish stigma, and promote holistic wellness for HIV patients (Dalrymple & Boylan, 2013).

Advocacy for WLWHIV is a crucial factor in improving healthcare outcomes, ultimately leading to increased resilience (Harrison et al., 2019). This involves ensuring access to high-quality and free treatment, including ARVs, as well as supporting the development of comprehensive healthcare services (Kitahata, Tegger, Wagner, & Holmes, 2002). By advocating for appropriate healthcare policies, funding, and research, these efforts help to ensure timely diagnosis, effective treatment, and management of HIV-related conditions (Harrison et al., 2019). The resulting enhanced healthcare outcomes through advocacy can alleviate the burden of the disease, empowering patients with knowledge and resources to manage their conditions (Harrison et al., 2019). This, in turn, leads to increased resilience by fostering a sense of control over their health and a positive outlook for the future.

Advocating for WLWHIV is a crucial component in mitigating the effects of stigma and discrimination, ultimately promoting HIV resilience. The negative societal attitudes surrounding HIV can lead to social isolation, discrimination, and diminished self-worth. Advocacy initiatives aim to increase awareness, provide education, and dispel misconceptions about HIV (Kitahata et al., 2002). By challenging these attitudes, advocacy efforts create a supportive and inclusive environment, thereby reducing the harmful impact of stigma (Pulerwitz et al., 2010). Building resilience in this context involves empowering WLWHIV to confront and overcome internalized stigma, enabling them to lead fulfilling lives and actively participate in their communities without fear of judgment or rejection (Sayles, Ryan, Silver, Sarkisian, & Cunningham, 2007). Additionally, advocating also serves to mitigate socioeconomic disparities and inequalities, thereby promoting enhanced resilience for WLWHIV (Earnshaw et al., 2015). This facilitates equitable access to education, employment prospects, and social services. Through the promotion of policies that address poverty, homelessness, and discrimination, advocacy can assist WLWHIV in meeting their fundamental needs and attaining financial stability (Andermann, 2016). Addressing these socioeconomic factors is crucial for fostering resilience, as it empowers women to manage their health, reduces stressors, and enables them to cultivate a more secure and optimistic outlook for the future (Andermann, 2016).

Advocating for WLWHIV is crucial for fostering resilience. This can be accomplished through different methods, including improving healthcare outcomes, decreasing stigma, setting up peer support systems, involving patients in decision-making, and addressing social determinants of health. Providing advocacy efforts gives those impacted by HIV the tools and support they need to adjust and succeed despite challenges. By recognizing their basic rights, providing comprehensive care, and establishing inclusive environments, advocacy helps empower women, allowing them to live a fulfilling life and overcome the obstacles presented by HIV.

2.10 CHAPTER SUMMARY

This chapter provided an in-depth review of the existing literature to gain a thorough understanding of the research study. The discussions in this chapter were supported by recent literature on WLWHIV and their strategies for resilience against the virus. The chapter presented a comprehensive review of the background of HIV, the general prevalence of HIV and among women, risk factors for HIV among women, HIV treatment, and challenges faced by WLWHIV. Additionally, the chapter discussed the concept of resilience and its application in the context of HIV, women's resilience strategies in the face of HIV, and concluded by discussing the role of social workers in promoting resilience among WLWHIV. The next chapter will discuss the methodology followed when conducting this study and ethical considerations.

CHAPTER THREE

3. RESEARCH METHODOLOGY

3.1 INTRODUCTION

According to Kumar (2018), research methodology refers to the practical "how" of a research study. It involves how a researcher systematically designs a study to ensure valid and reliable results that address the research aims, objectives, and research questions (Kumar, 2018). This includes deciding on the type of data to collect (e.g., qualitative or quantitative data), who to collect it from (i.e., the sampling strategy), how to collect it (i.e., the data collection method), and how to analyze it (i.e., the data analysis methods) (Denzin & Lincoln, 2011).

This chapter provides a detailed discussion of the methods employed in conducting the study. The discussion includes a description of the chosen research approach and design, as well as a comprehensive explanation and implementation of the research technique. Additionally, the chapter will cover the study site, the study population, the type of sampling employed, and the sampling procedure followed. Other aspects addressed in this chapter are the sample size, pilot testing, data collection, method used to analyze data, the overall validity of the research, and ethics that were considered when conducting the study.

3.2 RESEARCH APPROACH

The researcher utilized a qualitative approach for this study. Maxwell (2013) explains that qualitative research focuses on studying human behavior and attitudes within their natural settings. De Vos et al. (2011) also argue that qualitative researchers aim to uncover the meaning of a phenomenon for those involved, understanding how people interpret their experiences, construct their worlds, and attribute meaning to their experiences. In short, qualitative researchers strive to deconstruct and understand the multiple interpretations of reality by studying participants in their specific contexts and timeframes. In this study, participants who were WLWHIV were consulted in their natural settings, specifically at

Winnie Mandela informal settlement. These participants described and explained their experiences and impressions of the phenomena being studied through a naturalistic inquiry approach.

In some cases, a qualitative technique is used when the research question is ambiguous about the information needed to elicit a response (Ganong & Coleman, 2014). According to Randles (2012), the researcher should be able to observe changes over time, comprehend people's meanings, and adapt to new concerns and ideas as they evolve. Therefore, this method was deemed acceptable for this study because participants were allowed to share their opinions about their resilience as WLWHIV and create a social reality based on their actual experiences. Additionally, this approach was considered relevant for this study due to its ability to identify important aspects of WLWHIV that may be easily overlooked or missed in a quantitative study (Schmidt & Brown, 2015).

Moreover, in qualitative research, researchers are co-participants in identifying and understanding the realities of the phenomenon under study (Holland & Rees, 2010). Furthermore, according to Mack, Woodsong, MacQueen, Guest, & Namey, (2005), respect is also a fundamental human value when conducting a qualitative study or any other study. In line with the authors mentioned above, the researcher recruited participants and developed a rapport of trust with them. He also ensured that participants were treated with respect during the interviews, recognizing them as subject-matter experts regarding their personal experiences.

Creswell (2016) suggests that researchers should reflect on their personal beliefs and cultural background throughout the inquiry. In this study, the researcher was mindful of his background and how it can influence the study. Using qualitative research methods, the researcher able to capture the participants' narratives about their beliefs and experiences regarding the resilience of WLWHIV. The researcher listened to the participants' authentic voices through the verbatim responses reported in Chapter 4 (Presentation of the Empirical Findings), which presented the study findings and results. The researcher was particularly interested in how the participants described their experiences and perceptions in their own environment. This study rigorously considered the participants' circumstances, as is typical in qualitative investigations.

Lastly, the use of qualitative research was appropriate because it helped the researcher gain a deeper understanding of the subjective experiences and perceptions of WLWHIV regarding resilience to the virus. This was done at participants' homes, where they felt comfortable, ensuring privacy and relaxation as suggested by Creswell (2014), making it easy for the researcher to understand complex phenomena.

3.3 RESEARCH DESIGN

A research design provides a strategic framework that guides the process of conducting a study, ensuring alignment with the research questions, objectives, methodology, data collection methods, sampling strategies, data analysis techniques, and ethical considerations (Sileyew, 2019). Goundar (2012) argues that the study design plays a vital role in ensuring that the research is well-organized and produces valid, reliable, and ethically sound results. In qualitative research, each study is likely to have a unique design, allowing researchers to customize it as they see fit.

In this study, the researcher used a phenomenological research design to gain a deep understanding of the resilience of WLWHIV. The researcher chose this approach because he wanted to collect data from women who were directly impacted by the phenomenon being studied, which involved their experience of living with HIV and their resiliency strategies towards the virus. This choice is supported by Ramsook (2018), who stated that qualitative researchers use phenomenological design to understand a phenomenon by exploring the perspectives of those who have experienced it. The use of phenomenological design by the researcher enhanced the richness of the data and the trustworthiness and rigor of the study (Ramsook, 2018). This description captures the essence of the experiences of several women who have all encountered this phenomenon. This design has strong philosophical underpinnings and typically includes interviews. The researcher interviewed WLWHIV who, according to him, are information bearers of the phenomenon being studied. To gain a better understanding of the findings and reach appropriate conclusions, the researcher first examined what other researchers have said in a literature review, as well as what the participants themselves have expressed.

The utilization of the phenomenological method also allowed the researcher to study human experiences as they are lived and to ascertain how these experiences affect the participants' lives. The researcher agrees with Emery and Anderman (2020) in believing that the phenomenological design provides the researcher with the opportunity to gather essential information about individuals' actions and interactions through semi-structured, face-to-face interviews and observations. The findings of this study will contribute to the existing body of knowledge, and it is hoped that it will also help social workers in creating intervention strategies for WLWHIV, and aid in crafting policies that aim to enhance resilience in WLWHIV.

3.4 STUDY SITE

According to Creswell and Creswell (2017), the physical or virtual location where data collection occurs during a research study is known as the research study site. The research study site can encompass various elements, such as specific geographic areas, institutions, communities, organizations, or online platforms (Taherdoost, 2021). These are the places where researchers engage with participants, gather data, and carry out experiments (Taherdoost, 2021). This study was conducted in the Gauteng Province of South Africa, specifically in the Tembisa Winnie Mandela Informal Settlement (marked with an orange arrow) within the Ekurhuleni Metropolitan Municipality (see figure 3.1 below).

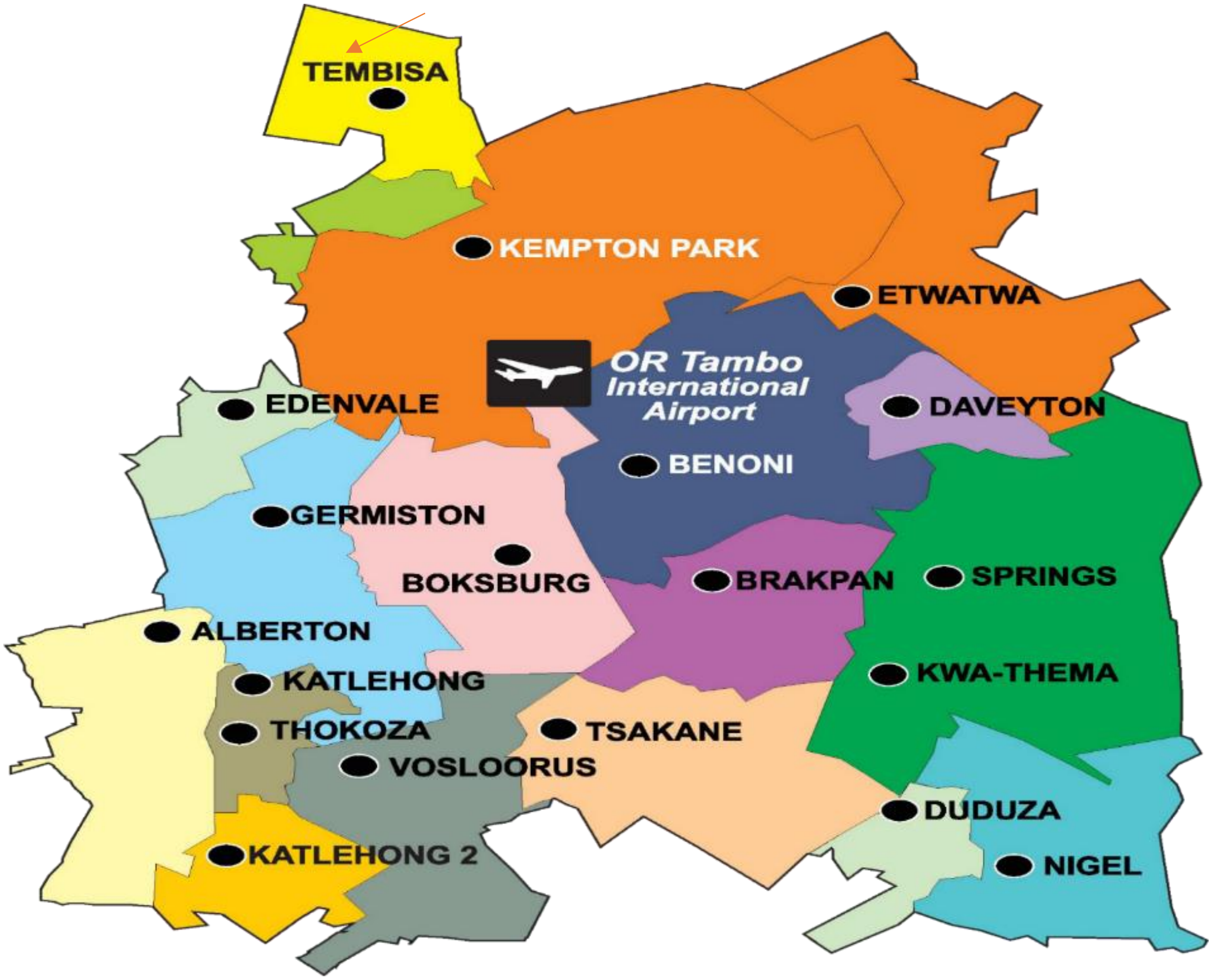


Figure 3.1: Ekurhuleni Metropolitan Municipality map

(Adopted from Map data 2018 AfriGIS (Pty) Ltd, Google South Africa)

The Winnie Mandela informal settlement, where the study took place, is located within the Tembisa Township. Tembisa Township is highlighted in yellow on the map above and is indicated by an orange arrow. It was established in 1957 under the administration of the Germiston City Council (South African history online, 2021). This council oversaw the forced relocation of black people from areas designated for white residents (South African history online, 2021). The affected areas included Dindela, Tikkieline, Phelindaba, and Modderfontein, which covered Edenvale, Modderfontein, and Kempton Park (South

African history online, 2021). According to Philip (2014) Tembisa Township is the second largest township in Gauteng, after Soweto.

Philip (2014) further states that in 1977, the government introduced Community Councils, which were later upgraded to Town Councils in 1982 under the Black Local Authorities Act. These councils were given limited powers and lacked financial resources. As a result, the councils increased rent and service charges in order to generate revenue for township development. This led residents from various townships, including Thembisa, to establish civic structures to resist the rent and service charge hikes (Philip,2014).

The Winnie Mandela informal settlement was established in 1996, just two years after the democratic government replaced the apartheid regime (South African history online, 2021). The settlement was named in honor of the freedom fighter, Mama Winnie Nomzamo Madikizela Mandela, who was married to South Africa's first black president, democratically elected by the people of South Africa.

Figure 3.2 and 3.3: Arial view of Winnie Mandela Informal Settlement
(Adopted from Photo credit to African News, 2021)

Tembisa also has a significantly high rate of HIV infection among women, especially in the Winnie Mandela informal settlement where the study was conducted (Department of Health Tier.net, 2022). The researcher believed that studying the resilience of WLWHIV in this area would provide valuable insights and help those struggling to cope with their

HIV status. In 2017, it was reported that 16,000 people in Tembisa were living with HIV, with nearly 64% of them being women (Zuma et al., 2022). The Winnie Mandela clinic, where study participants were sampled, had 4,085 active patients in the CCMDD in 2022, with 1,475 being male and 2,610 being female (Department of Health Tier.net, 2022).

3.5 STUDY POPULATION AND SAMPLING PROCEDURE

3.5.1 Study Population

The term "study population" refers to the specific group of people or entities that a researcher intends to study and to which their findings will apply (Sukmawati, Salmia, & Sudarmin, 2023). All experimental, observational, and qualitative research designs involving human subjects should clearly define the study population to determine individuals' eligibility for participation in the study (Eldredge, Weagel, & Kroth, 2014). Garg (2016) emphasizes that defining the study population is crucial to ensure that the research findings are relevant and can be applied to the intended group.

For this particular study, the population consists of WLWHIV between the ages of 20 and 40 years residing in the Winnie Mandela informal settlement, Tembisa within the Ekurhuleni metropolitan municipality. These individuals are also part of the CCMDD programme and receive their ARV treatment at the Winnie Mandela clinic. Additionally, the population that the researcher sampled had to be living with HIV for over 5 years. The researcher selected this population because Zuma et al. (2022) found that women between the ages of 20 and 40 years had the highest percentage of PLWHIV in South Africa. Furthermore, the Ekurhuleni metropolitan municipality, where this study was conducted, is the most affected metropolitan municipality by HIV within the Gauteng province, with an HIV prevalence rate of 63% (Chimoyi et al., 2022). Moreover, the Department of Health Tier.net (2022) reported that the Winnie Mandela clinic, where the study population was sampled, had 4,085 active patients in the CCMDD programme in 2022, with 1,475 being men and 2,610 being women.

3.5.2 Sampling Method

Purposive sampling was used to select individuals from whom data was collected. Purposive sampling is a non-probability sampling technique in which researchers intentionally select participants or elements for inclusion in the study based on specific criteria relevant to the research objectives (Palinkas, Horwitz, Green, Wisdom, Duan, & Hoagwood, 2015). According to Etikan and Bala, (2017), in purposive sampling, units are intentionally chosen "on purpose" to serve a specific purpose in the sample. This method relies on the researcher's judgment when identifying and selecting individuals, cases, or events that can provide valuable information to achieve the study's goals (Etikan & Bala, 2017).

Purposive sampling encompasses several distinct designs, each tailored to meet specific research objectives and requirements (Benoot, Hannes, & Bilsen, 2016). Some common designs for purposive sampling include maximum variation sampling, homogeneous sampling, critical case sampling and typical case sampling (Benoot et al., 2016). This research study employed homogeneous purposive sampling due to the fact that this design entails the selection of participants who possess similar characteristics or attributes. Homogeneous sampling proves to be beneficial when researchers intend to examine a specific subgroup within the population that exhibits common traits or experiences (Jager, Putnick, & Bornstein, 2017).

Homogeneous purposive sampling was deemed appropriate for this study because it aimed to sample WLWHIV who shared the trait of resilience to HIV. Additionally, the lower cost associated with this type of sampling and the need to gather data solely from individuals with firsthand experience of living with HIV motivated the researcher to utilize this sampling strategy.

3.5.3 Sampling Process

Before the researcher could begin sampling prospective participants for the study, he ensured that he obtained all the relevant and necessary approvals from various authorities involved or affected by the study. The researcher first sought permission to conduct the study from the local councilor of the Winnie Mandela informal settlement, which was granted (refer to Appendix 1). Subsequently, the researcher approached the Department of Health Ekurhuleni Metropolitan Municipality to seek permission to conduct the study at the Winnie Mandela clinic and to request assistance from the Decanting facilitators for participant recruitment, both of which were approved (refer to Appendix 2).

The researcher has a good working relationship with Decanting facilitators responsible for the CCMDD program, who interact with WLWHIV, making it easy for them to agree to assist with participant recruitment. This good working relationship was established during the period when the researcher was working at Tembisa hospital for the Aurum Institute. Lastly, the researcher submitted the research proposal to the Department of Social Work Scientific Review Committee and the Unisa College of Human Science Research Ethics Committee for approval to carry out the study, and the research proposal was approved (refer to Appendix 3a and b). These two committees are made up of a team of impartial professionals whose job is to ensure that research participants' rights and well-being are maintained and that the study is conducted ethically. The ethical committee warns researchers about foreseeable repercussions that require prompt attention. After obtaining all of these approvals, the researcher proceeded with the sampling process. Therefore, in recruiting the participants, the researcher followed the process below:

- The researcher requested slots during the treatment collection dates of CCMDD patients to present the purpose of the study to the whole group. The time slots to present the study to prospective participants were scheduled for January 2023.
- For confidentiality purposes, the researcher provided his contact details to prospective participants and requested them to send free call-backs. The participants who ultimately took part in this study were the ones who expressed their willingness to be a part of the study by sending free callbacks.

- Once the researcher received callbacks from prospective participants, individual arrangements were made to determine if they met the inclusion criteria. A total of 25 callbacks were received, all of which met the inclusion criteria. However, data saturation was reached after 15 interviews.
- The purpose of the study, as well as its benefits and risks, were explained to prospective participants. It was during these meetings where clarity was provided to them regarding the study.
- Prospective participants were issued consent forms in person and instructed to take them home to read and consider the study before signing. The researcher collected the signed consent forms on the day of the interview, prior to commencing data collection.

3.5.4 Study Sample

Babbie (2020) defines a study sample as a subset of individuals or items selected from a larger population to represent and draw inferences about that population. Researchers use samples because studying an entire population can be impractical, expensive, and time-consuming (Simkus, 2022). By analyzing a sample, researchers can draw conclusions and make generalizations that can then be applied to the wider population (Martínez-Mesa, González-Chica, Duquia, Bonamigo, & Bastos, 2016).

For this study, the sample was drawn from a population of WLWHIV between the ages of 20 and 40 years residing at Winnie Mandela settlement. These women were part of the CCMDD programme, receiving their ARV treatment at Winnie Mandela clinic, and have been living with HIV for over 5 years. The researcher believes that individuals who have been living with HIV for over 5 years have likely experienced numerous adversities associated with the virus. They may have developed resilience traits as a result, or they may be overwhelmed and unable to function optimally. The researcher considered the following inclusion and exclusion criteria when selecting the study sample:

3.5.4.1 The criteria for Inclusion

- Participants had to be WLWHIV aged between 20 and 40 years.
- Participants had to have been living with HIV for over 5 years. To confirm this, the researcher asked confirmation question like, "How long have you been living with HIV?"
- The participants had to be residents of Winnie Mandela informal settlement.
- The participants had to be part of the CCMDD programme at Winnie Mandela clinic in Tembisa.
- Participants had to be able to speak English, Xitsonga, Tshivenda, Sepedi, or Isizulu. The researcher is fluent in all of these languages.

3.5.4.2 The criteria of Exclusion

- Women aged 20 to 40 years who were not living with HIV.
- WLWHIV who were below 20 years or above 40 years of age.
- WLWHIV who met the criteria but were not enrolled in the CCMDD programme at Winnie Mandela clinic.
- WLWHIV who met the criteria but did not live in Winnie Mandela informal settlement.
- WLWHIV who met the criteria but did not speak English, Xitsonga, Tshivenda, Sepedi, or Isizulu.

3.5.5 Sample Size

Sample size in research refers to the number of observations or participants included in a research study (Andrade, 2020). Gravetter and Forzano (2018) further states that the sample size is determined based on the research design, objectives, and statistical considerations to ensure that the study can effectively answer the research questions and draw meaningful conclusions. The size of the sample is crucial as it can impact the reliability and generalizability of the study's findings (Babbie,2020).

The sample size for this study was determined based on the principle of data saturation.

Data saturation is the point in qualitative research where new data stop providing additional insights or information relevant to the research questions (Saunders, Sim, Kingstone, Baker, Waterfield, Bartlam, Burroughs, & Jinks, 2018). It signifies that enough data have been gathered to fully comprehend the phenomenon under investigation, and further data collection is unlikely to significantly change or improve the understanding gained from the existing data (Saunders et al., 2018). Rahimi (2024) Data saturation is commonly used as a criterion for deciding when to conclude data collection in qualitative studies, particularly in interviews or observations where researchers seek to capture the breadth and depth of participants' experiences or perspectives. In this study, it was expected that a minimum of 25 participants would be needed as the sample size, but data saturation was reached with only fifteen participants.

3.6 DATA COLLECTION

Data collection in research involves gathering information and data points from various sources to address a specific research question or hypothesis (Taherdoost, 2021). According to Creswell and Creswell (2017), data cillection involves selecting appropriate methods and tools to collect data, such as surveys, interviews, observations, or experiments, and ensuring the data's accuracy, reliability, and validity. The methods for data collection may vary depending on the research design, objectives, and the type of data being collected (Sutton & Austin, 2015). The following processes were followed during the data collection for this study:

3.6.1 Preparation for data collection

Data collection preparation in research refers to the phase where researchers plan and organize the process of gathering data before actually collecting it (Taherdoost, 2021). This includes establishing data collection procedures, ensuring ethical considerations, and implementing safety measures for both the researcher and the participants (Fleming & Zegwaard, 2018).

Before commencing the data collection process for this research, the researcher obtained authorization to conduct the study from various relevant bodies, as outlined in section

3.5.3 (sampling process). Additionally, the following measures were adopted to ensure the safety of the researcher before starting the data collection process.

- Before going to conduct the interviews, the researcher asked participants for the following useful information over the telephone: who else would be present during the interview, if there were any pets, and directions to the participant's home or the chosen location for the interview.
- The interviews were scheduled for as early in the day as possible and within office hours.
- The researcher used Google Maps to locate the home that was to be visited, and familiarized himself with the area, including the entry and exit points.
- The researcher ensured that the vehicle to be used was in good working order, had sufficient fuel, and did not have any visible items on display that could compromise the confidentiality of participants.
- The researcher carried only the essential equipment for the interview - a cellphone and a digital audio recorder - as well as a minimal amount of cash for emergencies.
- The researcher ensured that he dressed appropriately for the research setting.
- The researcher made sure that this mobile phone was fully charged, had emergency contact numbers saved, and kept it switched on at all times.

3.6.2 Method for Data Collection

Babbie (2020) defines a data collection method as a systematic approach or procedure used to gather information or data for research purposes. Taherdoost (2021) adds that whether you are conducting research for business, governmental, or academic purposes, data collection allows you to obtain firsthand knowledge and unique insights into your research problem. This process may involve techniques such as surveys, interviews, observations, experiments, and document analysis, among others (Babbie, 2020).

In this study, face-to-face semi-structured interviews were conducted to gather relevant information from the participants. A semi-structured interview is a qualitative method that combines a predetermined set of open questions to stimulate discussion, with the interviewer capturing the respondent's answers (Rafati, 2017). This approach allowed the researcher to deeply engage with the participants and obtain as much information as possible while staying focused on the study objectives (Bryman, 2006). Semi-structured interviews are designed to gather extensive information, as the open-ended questions encourage discussion. Therefore, the use of semi-structured interviews is ideal when investigating a complex subject.

According to Magaldi and Berler (2020), semi-structured interviews offer the following advantages:

- Semi-structured interviews provide participants with ample time and opportunity to express their diverse views. They also allow the researcher to react to and follow up on emerging ideas and unfolding events.
- Results obtained through semi-structured interviews can be compared among different subjects because all subjects are asked the same questions and given the opportunity to fully express their views on the same general themes.
- Open-ended questions enable participants to freely voice their experiences and minimize the influence of the researcher's attitudes and previous findings.
- Semi-structured interviews not only allow for assessing participants' opinions, statements, and convictions but are also effective in eliciting narratives about the personal experiences of the interviewees.

Based on information gathered from the literature, the researcher determined that semi-structured interviews were the most suitable method for collecting data in this case. However, like any data collection method, using semi-structured interviews has its drawbacks that could potentially impact the reliability of the data obtained. A significant source of error when conducting face-to-face, semi-structured interviews is the possibility that participants may feel uncomfortable discussing sensitive topics such as sexuality, HIV, or their health condition. To mitigate this issue, it is crucial to establish an environment that fosters openness and honesty which is what the researcher did (Lancaster, 2017).

3.6.3 Data Collection Tool

A research data collection tool is any device, approach, or procedure used to gather data from research subjects or resources (Loraine, Wick, & Christoph, 2020). This includes surveys, questionnaires, interviews, observations, experiments, and archival records, among other methods (Paradis, O'Brien, Nimmon, Bandiera, & Martimianakis, 2016). Paradis et al. (2016) further indicate that these tools are designed to collect specific types of data relevant to the research goals and often include standardized processes to ensure consistency and reliability in data collection.

This research utilized an interview guide as a means to gather data. An interview guide in research is a structured set of questions or topics created to aid in a consistent and focused conversation with research participants (Jamshed, 2014). According to Adeoye-Olatunde and Olenik (2021), interview guide acts as a framework for interviews, offering guidance on question order, wording, and covered topics. The main aim is to gather relevant information systematically and in an organized way, assisting researchers in effectively addressing their research questions or objectives by collecting data (Adeoye-Olatunde & Olenik, 2021).

The researcher chose to use an interview guide for this study because it provides a structured framework for conducting interviews, ensuring that all essential topics and questions are covered systematically. This decision helped the researcher to maintain focus and consistency across interviews, reducing the risk of overlooking critical information. It also allowed for flexibility within the structure, enabling the researcher to adapt questions based on participant responses or emerging themes, thereby fostering deeper exploration of relevant topics. Additionally, the researcher selected this tool to promote reliability by ensuring that all participants were asked the same core questions, facilitating comparability of responses and enhancing the credibility of findings. Overall, the researcher believed that using an interview guide would enhance the rigor, depth, and coherence of qualitative research, making it a valuable tool for collecting rich and meaningful data from research participants.

According to Siedlecki (2022) , the researcher should ensure that they obtain relevant information about the research phenomenon without threatening or annoying the participants. This can be achieved by employing good interpersonal attitudes and skills during one-on-one interviews. To achieve this, the researcher utilized communication techniques during the semi-structured one-on-one interviews outlined by (De Vos, Delport, Fouche, & Strydom, 2011).

- The researcher utilized paraphrasing to verify the participants' statements. This involved restating the participants' descriptions using simpler and more concise language, without introducing any new concepts, particularly at the conclusion of each question.
- The participants were given time to share their perceptions without any interruptions, allowing them to finish communicating their thoughts fully.
- The researcher utilized tracking skills to demonstrate interest and encourage participants to freely communicate about the content and meaning of their verbal and nonverbal interactions.
- The researcher also utilized periods of silence to give both the participants and the interviewer time to reflect, share their thoughts, and encourage the participant to open up.
- The researcher also used probing skills to encourage participants to provide more information in order to clarify any misunderstood responses.

Before collecting data from the fifteen individuals who participated in the study, the researcher conducted a pilot testing phase. This phase aimed to assess various elements of the interview guide, such as content validity, effectiveness, relevance, reliability, usability, applicability, and adequacy. The following section will discuss how the pilot testing was conducted.

3.6.4 Pilot Testing

Pilot testing in qualitative research involves conducting a preliminary or trial run of research methods, instruments, or procedures before implementing them on a larger scale (Lowe, 2019). This process includes testing the feasibility, functionality, and effectiveness of data collection tools, interview guides, survey instruments, or other research protocols with a small sample of participants (In, 2017). Additionally, the main aim of pilot testing is to identify and address potential issues, refine research methods, enhance the quality of data collection, and ensure that the research process is practical and well-suited to achieve the research objectives (Malmqvist, Hellberg, Möllås, Rose, & Shevlin, 2019).

The researcher pilot-tested the interview guide with three participants who met the selection criteria mentioned above. The purpose of the interview was explained to the participants through an information sheet (refer Appendix 4). After obtaining informed consent (refer Appendix 5) from the three WLWHIV participants, the interviews were audio-recorded and later transcribed. Upon analyzing the data, the researcher made minor modifications to the items in the interview guide. It was discovered that the three participants needed clarification on the concept of "resilient". The phrase "tell me", especially in question 1, was rephrased to avoid sounding confrontational. Instead, the researcher asked the participants to "share with me" their experiences.

During this process, the researcher ensured that COVID-19 protocols were followed by both the researcher and the participants. According to Lai, Shih, Ko, Tang, & Hsueh, (2020), COVID-19, short for "Coronavirus Disease 2019, is an infectious disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). It was first identified in December 2019 in Wuhan, China, and quickly spread globally, leading to a pandemic declared by the World Health Organization (WHO) in March 2020 (Cucinotta & Vanelli, 2020). COVID-19 primarily spreads through respiratory droplets when an infected person coughs, sneezes, or talks, and it can also spread by touching surfaces contaminated with the virus and then touching the face, particularly the mouth, nose, or eyes (Jayaweera, Perera, Gunawardana, & Manatunge, 2020). The following measures were implemented to prevent either the researcher or participants from acquiring COVID-19 from each other in case one is infected.

- Availability of sanitizers: Before and after the interviews, both the researcher and participants cleaned their hands with sanitizer.
- Seating arrangements: The chairs for the participants and the researcher were separated by 1.5 meters.
- Ventilation: During interviews conducted inside the room, windows were left open to allow for air flow into and out of the room.

The process of pilot testing, as discussed above, is also supported by Turner (2010) and Kim (2011). They stated that pilot testing helps researchers detect flaws or weaknesses in the interview design, check the duration of the interview, and test the researcher's interviewing skills allowing for necessary adjustments and modifications before the main study. Since the pilot test was not meant to produce results, the data collected from the three interviews was destroyed and not included in the main study's data. The following section will discuss how the data collection process for this main study unfolded after amending the interview guide.

3.6.5 Data Collection Process

The data collection process refers to the systematic procedure that researchers follow when collecting data from participants or a data source (Sutton & Austin, 2015). Kaiser (2009) suggests that this method enables the researcher to prioritize ethical factors when gathering data, such as obtaining informed consent from participants, ensuring confidentiality, and making sure that data collection methods do not harm or exploit participants in any way.

On this study, data collection process began after the researcher obtained all necessary approvals to engage with the study participants, as outlined in section 3.5.3 (sampling process). Additionally, the researcher ensured that the data collection tool (interview guide refer to appendix 6b) was tested through a pilot testing to ensure the reliability and validity of the data collected, aligning with the research objectives, and addressing the research question. Throughout the data collection process, the researcher also ensured adherence to Covid-19 protective measures as detailed in section 3.6.2 (pilot testing). The researcher followed the steps outlined below during the data collection process.

During the data collection process, the researcher allowed participants to choose a convenient location for their one-on-one interviews to maintain confidentiality. Most participants opted to be interviewed in their own homes, feeling it was more private and secure. The researcher collected participants' addresses and contact numbers and ensured that this information remained confidential in line with the POPI Act. Before each interview, the researcher went over the study information sheet (refer to Appendix 4) again with participants to ensure they comprehended the study's purpose. For those who couldn't read, the researcher read the sheet aloud and answered any questions. All 15 participants confirmed their understanding of the information on the sheet and expressed their willingness to proceed with the interviews.

After completing the information sheet process, participants were asked to sign the consent form that the researcher had provided during the initial session when they were being assessed for inclusion criteria. The consent form included permission to be recorded during the interviews using a digital audio recorder, to which all participants signed to show their agreement. Once all these steps were finished, the interview began. Each interview lasted between 30 to 45 minutes and was recorded using a digital audio recorder. These recordings were stored in a cloud-based system that the researcher had full control over. The recorded data were only destroyed after being transcribed verbatim and analyzed.

The depth of information provided by participants is significantly influenced by the researcher's interviewing techniques (Rutledge & Hogg, 2020). The researcher, a social worker by profession, possesses strong interviewing skills due to their training in social work. These skills are crucial because they allow the researcher to remain impartial and avoid displaying approval, disapproval, judgment, or prejudice towards participants' responses to the questions asked (Barrow, Brannan, & Khandhar, 2017).

Attentive listening was also employed during the interviews. According to Yin (2015), attentive listening is the main source of qualitative data. In qualitative research, listening requires intensive effort to truly hear and understand what the participant is saying (Yin, 2015). Therefore, listening goes beyond mere hearing. Consequently, the researcher paid attention to participants' nonverbal behavior, such as body language, facial expressions, and voice-related behavior, in addition to their verbal speech during the interviews.

In addition to using effective listening techniques, the researcher also obtained a significant portion of the research data by asking the right questions. According to Yin (2015), researchers are more likely to overlook important information if they do not ask thoughtful queries. In this study, the researcher utilized a variety of interview questions, including opening statements, follow-up inquiries, probing inquiries, defining inquiries, and structuring inquiries. Probing questions allowed the researcher to gather additional information without influencing the participant's response, while follow-up questions encouraged participants to provide more details about their experiences. Semi-structured questions were used to thoroughly explore a topic before moving on to the next one. For example, the researcher asked, "What are the challenges faced by women living with HIV?" and followed up with, "Please share your thoughts on why women living with HIV experience these challenges”. As suggested by Gibson and Brown (2009:88), the researcher was able to guide the conversation towards the topics covered in the interview guide without impeding its natural flow.

According to Elmir, Schmied, Jackson, and Wilkes (2011), it is crucial for the researcher to establish a rapport with the participants so that they feel comfortable sharing their experiences and perspectives. The researcher also considered the emotional needs of the participants by giving them enough time to fully respond to the open-ended questions. To avoid offending or putting participants on the defensive, the researcher should avoid asking "why" questions (Yin, 2015). Therefore, "why" questions were not included in the interview guide (refer to Appendix 6b) or the study.

The one-on-one interviews were conducted in English, Tshivenda, Xitsonga, Sepedi, and IsiZulu. The researcher did not outsource the services of an interpreter during the interviews because he can speak fluently in most South African languages, including those mentioned above, which are spoken in the study area. The researcher is also familiar with the study area as the worked at Tembisa Hospital for the Aurum Institute, which facilitated easy access to participants' homes for data collection. However, prior to the study, the researcher had never interacted with all the participants who took part in this study, so there was no conflict of interest.

During the interview process, it was arranged that individuals who felt emotionally affected by the interview or who the researcher observed to be emotionally distressed, given the sensitivity of the topic, had the option of meeting with a social worker. The researcher had secured the services of a private social worker who agreed to provide a free counseling session (refer to Appendix 7) for study participants if necessary. Among all the participants interviewed, none mentioned or appeared to be distressed. This may be because they are already receiving psycho-social support from professionals at the clinic or other supportive organizations. The following section will explain how the collected data was analysed.

3.6.6 Data Analysis

According to Engle (2015), in qualitative research, data analysis involves the systematic examination and interpretation of non-numerical data (e.g., text, images, audio) to uncover patterns, themes, insights, or meanings. This process is largely interpretive and subjective, aiming to delve deep into participants' perspectives, experiences, and the context of the study (Engle, 2015). Unlike quantitative analysis, which focuses on numerical and statistical techniques, qualitative data analysis seeks to understand the underlying reasons, opinions, and motivations of the research subjects (Tenny, Brannan, & Brannan, 2017). Ngulube (2015) further states that data analysis in a qualitative study involves arranging and examining data to identify patterns, themes, links, explanations, interpretations, criticisms, and ideas.

In this study, the researcher initiated the data analysis process immediately after completing the first interview, rather than treating it as a distinct step from data collection. This approach was essential because of the substantial amount of material that required sorting, making it a demanding, labor-intensive, time-consuming, and continuous procedure. Charlesworth and Foex (2016) propose integrating the two processes, carrying out data collection and analysis simultaneously. The researcher adopted a comparable method, conducting an interview, transcribing it, and commencing the analysis before proceeding to the next participant.

There are various methods available for analyzing qualitative data (Holland & Rees, 2010; Sassler & Miller, 2011). Some researchers follow standard data analysis methods, while others opt for a more creative and flexible approach (Moule & Goodman, 2014). In this study, the researcher adhered to the eight phases of Tesch's recommended qualitative data analysis (Cresswell, 2009).

- The researcher transcribed the 15 audio-recorded interviews in a verbatim format, which took two months to complete. The researcher chose to transcribe and translate the data into English himself to fully engage in the process and establish themes.
- After transcribing, the researcher read through each transcript to gain a general impression of the interview and took notes of ideas. This process helped the researcher become more familiar with the data, as the interviews were conducted over a longer period of time.
- It was important for the researcher to accurately convey the voices of the participants, as emphasized by Schmidt and Brown (2015) and Barnsley (2016), who highlighted the significance of avoiding transcription errors that could inadvertently alter the meaning of a sentence. The researcher also paid close attention to the participants' use of language, idioms, slang, and jargon, as well as their cultural and individual connotations. Tappen (2011:359) cautions that without careful consideration, there is a risk of losing meaning, especially in terms of

cultural and personal significance. Therefore, the researcher took great care to ensure that the transcripts faithfully captured the participants' statements. This process was time-consuming, complex, and involved multiple revisions while listening to the audio recordings. Subsequently, the researcher meticulously reviewed each transcription to verify accuracy against the audio recordings. Transcribing went beyond simply documenting what participants said, it also entailed making analytical decisions about which information to include in the findings and how to effectively convey the participants' experiences.

- The researcher examined a randomly selected transcript interview and asked, "What is the underlying meaning being conveyed?" The first step in this process is to find the central concept behind the participant's narratives. This also involves searching the data for major themes and ideas (Saldana, 2015).
- The researcher prepared a list of all the issues after conducting numerous interviews, grouping related themes together. For example, the following themes emerged: Life after testing HIV positive, Challenges of WLWHIV, Strategied that WLWHIV apply to be resilient to HIV and Support required by WLWHIV from social workers to be resilient to HIV. The subjects were then separated into columns classified as significant topics, unique topics, and leftovers (Dashu, 2005; Lesch & Furphy, 2013; Sniezek, 2013). It is crucial for researchers to avoid imposing preexisting motifs on the data. As noted by Sassler and Miller (2011) and Lapan et al. (2012), the researcher instead organized the data according to various themes, concepts, subjects, and typical patterns of behavior to carry out this procedure. The researcher revisited the original data and, using the list of subjects as a guide abbreviated the topics in code form next to the appropriate passages of text. The researcher established the most descriptive wording for topics and applied them to themes, subthemes, and categories.
- The researcher condensed topics into code form and created descriptive labels for them, which were then applied to themes, subthemes, and categories. This process is in line with the phase of condensing topics and assigning codes.

- The researcher gathered data material related to each theme or category in one location and conducted a preliminary analysis. This aligns with the phase of sorting material into corresponding topics and conducting analysis.
- The researcher was satisfied with the themes, subthemes, categories, and subcategories, and then proceeded to compile the report. This aligns with the phase of integrating topics, categorizing them, and finalizing the analysis.
- The researcher documented the data.

The in-depth analyzed data was reported in Chapter 4 of this study, following the procedure outlined above.

3.6.7 Method of Data Verification support

Every research study must undergo a comprehensive evaluation process known as data verification to ensure the accuracy and authenticity of its findings (Reed, Ferré, Martin-Ortega, Blanche, Lawford-Rolfe, Dallimer, & Holden, 2021). Johnson, Adkins, and Chauvin (2020) define data verification as a mechanism used during the research process to incrementally contribute to ensuring reliability and validity, and thus, the rigor of a study. In qualitative studies, this process involves confirming the accuracy, reliability, and trustworthiness of collected data using various techniques and procedures (Patton, 2014). The rigor of qualitative research can be most effectively assessed by evaluating trustworthiness, which is also referred to as true value (Maher, Hadfield, Hutchings, & De Eyto, 2018).

3.6.7.1 Trustworthiness

According to Connelly (2016), the trustworthiness and rigor of a study refer to the level of confidence in the data, interpretation, and methods used to ensure the quality of the study. Trustworthiness is a method that researchers use to convince both themselves and their audience that their research results deserve consideration (Nowell, Norris, White, & Moules, 2017). The fundamental components of trustworthiness in qualitative research include credibility, transferability, dependability, and confirmability (Ahmed, 2024). In this research, trustworthiness was improved by applying the fundamental components as suggested by Ahmed (2024) which states that a study is considered trustworthy when it demonstrates credibility, transferability, dependability, and confirmability.

3.6.7.1.1 Credibility

In the qualitative field, credibility has been proposed to play the role of validity, which is commonly used in quantitative investigations. Validity, according to Holland and Rees (2010) and Schmidt and Brown (2015), is a scientific term that refers to the "everyday notion of truth" and indicates how truthful and accurate the results of a study are. Credibility allows others to understand and acknowledge the experiences documented in the research by interpreting the experiences of participants (Thomas & Magilvy, 2011). It aims to address the question of how consistent the findings are with reality (Shenton, 2003). In order for readers to understand the opinions and experiences of participants, it is important for the conclusions and information presented to accurately reflect them (Moule & Goodman, 2014). However, research can never claim to have indisputable truth, but validity in research is closely linked to truth (Gomm, 2008).

To ensure credibility, the researcher employed the concept of triangulation and consulted various sources, including individuals, available literature and organizations such as Aurum institute which are knowledgeable about HIV issues and the theoretical framework. Additionally, the researcher provided a detailed and comprehensive explanation of the experiences and perspectives of the participants, allowing readers to draw their own conclusions about the phenomena being studied. To confirm the truthfulness and legitimacy of the results, the researcher also utilized the member-checking approach. Member checking involves going back to the participants with the transcripts, as needed, to ensure that the researcher accurately captured their opinions (Holland & Rees, 2016; Charlesworth & Foex, 2016).

During data analysis, the researcher opted to conduct the coding process independently rather than enlisting an outside coder. Collaborative discussions were then held between the researcher and supervisor to compare and merge the emerging themes, sub-themes, and categories derived from the data. The results were subsequently organized into main themes and subthemes. Some of the themes that emerged during data analysis included

"Life after testing HIV positive," "Challenges faced by WLWHIV," "Support needed by WLWHIV from social workers to cope with HIV," and "Additional support required by WLWHIV to manage HIV." Sub-themes included “denial of one's HIV status,” “blaming others,” “lifestyle adjustments,” “stigma and rejection,” “financial difficulties,” and “intensive HIV testing and counseling,” among others. A detailed discussion of these themes and sub-themes is provided in Chapter 4.

3.6.7.2 Transferability

Munthe-Kaas, Nøkleby, Lewin, and Glenton (2020) argue that transferability is the ability to apply qualitative research findings from one context to another similar context. Additionally, transferability refers to thick descriptions of all aspects of the study were provided so that users can assess its relevance to their own situations (Newman et al., 2022).

In this study, credibility was ensured by accurately capturing participants' statements and actions during the interviews. The results section included a detailed description to enhance transferability, offering a deeper understanding of participant perspectives. Additionally, the study acknowledged relevant literature.

3.6.7.2.1 Dependability

In Stahl and King's (2020) study, dependability refers to the consistency of results if the study were replicated in a different setting or context. Additionally, dependability is linked to the specific process used between data collection and data analysis (Abooyee Ardakan, Bairamzadeh, & Soltan Mohammad, 2020).

To ensure reliability in this study, the researcher accurately presented findings that reflected the participants' experiences. A rich and detailed description of the research methodology and process used in the study was provided. Additionally, an audit trail of the processes conducted in this research study was maintained. Meticulous record-keeping is crucial as it helps to establish a clear and auditable decision trail and ensures that interpretations of the data are both consistent and transparent. As an additional measure to comply with the audit trail, the researcher stored interview transcripts in a password-controlled OneDrive cloud storage.

3.6.7.2.2 Confirmability

The concept of conformability in qualitative research is comparable to the concern of objectivity in quantitative research. Confirmability requires a researcher to ensure the study findings match the experiences and ideas of the study subjects not and are not inclined to the characteristics and preferences of the researcher (Haven & Van Grootel, 2019). Nguyen, Ahn, Belgrave, Lee, Cawelti, Kim, and Villavicencio (2021) explain that confirmability relates to the idea that as a researcher, one must take appropriate steps to ensure that he/she does not affect the research outcomes. To ensure confirmability in this study, the researcher conducted member checking.

Member checking, also known as participant or informant validation, is a method used in qualitative research to enhance the accuracy, trustworthiness, and validity of collected data (Birt, Scott, Cavers, Campbell, & Walter, 2016). According to McKim (2023), member checking involves sharing the results, analyses, or conclusions of a study with the original data contributors. The goal is to validate the accuracy and relevance of the researcher's analyses with the participants' perspectives or experiences (McKim, 2023). This process allows participants to confirm the findings, suggest modifications, or provide additional insights, ensuring that the researcher's interpretations accurately represent their viewpoints and experiences.

In this study, the researcher employed member checking as a critical step to ensure the accuracy and validity of the findings. After the initial data analysis, a summary of the key themes and interpretations that emerged from the interviews was compiled. The researcher then went back to the study participants, shared the summary, and asked for feedback. Participants were asked to comment on the accuracy of the interpretations of their experiences and to highlight any aspects they felt were misrepresented or overlooked. All participants involved agreed with the study findings. This iterative feedback process not only enhanced the credibility of the research findings but also deepened understanding of the nuanced experiences, ensuring that the study conclusions were authentically grounded in the participants' perspectives.

Below are all the ethics that were deemed applicable and adhered to in this study.

3.7 ETHICAL CONSIDERATION

David (2015) explains that ethical considerations in research involve the principles and guidelines that researchers must follow to conduct their studies in an ethically responsible manner. Throughout their research, researchers often interact face-to-face with individuals, observing behaviors and studying the impacts of specific phenomena on a particular population (Sutton & Austin, 2015). Dhakal (2016) emphasizes the importance of these considerations in protecting the rights, safety, and well-being of research participants, maintaining scientific integrity, and preserving public trust in research. Ethical considerations also guide the quality of these interactions to ensure that research is conducted in line with established rules and principles. This study considers several ethical issues, including informed consent, confidentiality, anonymity, beneficence, debriefing, and avoidance of harm. These concepts are discussed below:

3.7.1 Informed Consent

Informed consent involves informing potential research participants about the key elements of a research study and what their participation will entail (Xu, Baysari, Stocker, Leow, Day, & Carland, 2020). Gupta (2013) states that this process usually includes providing a written consent document with the necessary information (i.e., elements of informed consent) and presenting that information to participants. In addition, to uphold the aspect of informed consent (Dankar, Gergely, & Dankar, 2019), several steps must be taken. Participants need to receive proper information about the study and the researcher must ensure that they have sufficient knowledge to understand the topics being discussed (Siegle, 2015).

In this study, the researcher ensured informed consent by providing participants with detailed information about the purpose of the study and emphasizing that participation was voluntary (refer to appendix 4). The researcher understood the importance of participants being aware that they had the freedom to withdraw from the study at any time and that participation was entirely voluntary. Participants who felt comfortable after reading and asking questions about the purpose and ethical considerations of the study were asked to formalize their consent in writing by signing the consent form (refer to appendix 5), which included consent to be recorded. According to the researcher, informed consent is based on the professional relationship between the researcher and the participants of the study. For those who were unable to read, the information sheet and consent form were read aloud for them in a language they were familiar with.

3.7.2 Confidentiality

Every person has the right to privacy, and it is their responsibility to decide when, where, with whom, and to what extent their attitudes, beliefs, and behavior will be made public (Pietilä, Nurmi, Halkoaho, & Kyngäs, 2020). Turcotte-Tremblay and McSween-Cadieux (2018) emphasize that information exchanged between a patient/client, researchers and healthcare providers should be kept confidential to promote strong therapeutic relationships.

To ensure the confidentiality of the data collected during the research process, the researcher took precautions by storing the data (interview transcripts) on a cloud-based system, and voice recordings were deleted after transcribing verbatim. This was done to minimize the risk of physical theft and protect the confidentiality of the participants. Before the researcher started data collection, participants were informed that only the research project supervisor and the researcher would have access to their interview data. They were also informed that this information would be deleted at least five years following the University of South Africa policy.

3.7.3 Anonymity

Anonymity refers to omitting the names of participants in the study (Walford, 2018). Turcotte-Tremblay and McSween-Cadieux (2018) further indicate that guaranteeing anonymity is more than just hiding a name; it also entails ensuring that the true identity of an individual cannot be deciphered by looking at their profile.

In this study, maintaining anonymity was crucial due to the sensitivity of the topic and the stigma associated with having HIV. The participants' names were not used; instead, they were identified by numbers. No questions were asked that could potentially reveal the respondents' identities. The researcher used numbers to protect the participants' anonymity and assured them that their names and personal information would remain confidential. Furthermore, no identifying information would be included in the final report of the study.

3.7.4 Beneficence

In social science, as well as in any research endeavor, the primary objective should be to maximize the benefits for both individuals and society, while simultaneously minimizing potential risks and harm (O'Grady, 2017). This concept is largely known as beneficence (O'Grady, 2017). According to Barrow, Brannan, and Khandhar (2017), beneficence involves ensuring that the research is structured in a way that maximizes potential advantages and reduces risks, and that participants are fully informed and participate voluntarily (Barrow, Brannan, & Khandhar, 2017).

To adhere to ethical principles in this study, the researcher was truthful with the participants that they would not receive any kind of compensation for taking part in the study. However, they were also informed that the study would help other WLWHIV who are struggling to accept their diagnosis, as well as those who are newly diagnosed, by equipping them with resilient skills.

3.7.5 Debriefing participants

Debriefing participants in research involves giving them the chance to reflect on and discuss their experiences after completing a study (Evans, Burns, Essex, Finnerty, Hatton, Clements, Breau, Quinn, Elliott, Smith, Matthews, Jennings, Crossman, Williams, Miller, Harold, Gurnett, Jagodzinski, Smith, & Weldon, 2023). According to Melville and Hincks (2016), all research, especially studies on sensitive topics, can evoke strong emotions. Engaging research participants in debriefing sessions can help address any emotions or concerns that may have arisen during their participation in the study (Raemer, Anderson, Cheng, Fanning, Nadkarni, & Savoldelli, 2011). Failure on the part of the researcher to acknowledge these emotions could be seen as irresponsible (Melville & Hincks, 2016).

In order to avoid triggering emotional responses, the researcher refrained from asking sensitive questions during interviews or data collection related to the participants' experiences living with HIV. However, the researcher’s responsibility to help the participants return to a stable emotional state after the process was complete. This was important because discussing traumatic events can place an additional emotional burden on participants (Jennings, 2018). To assist with this, the researcher arranged for a social worker with a private practice to offer free debriefing sessions to those who may have felt uncomfortable discussing their most traumatic experiences, which she agreed to (refer to Appendix 7a and 7b). However, none of the participants were interested in a debriefing session, so the social worker did not conduct any sessions.

3.7.6 Avoidance of Harm

Ethics in social science research encourage researchers to take responsibility for ensuring that their research does not leave participants in a worse position, both materially and emotionally (Walford, 2018). This definition aligns with the one provided by Barrow, Brannan, and Khandhar, 2017) which emphasizes that researchers should ensure that their studies does not cause harm to the research subjects and the researcher.

To prevent harm, the researcher thoroughly explained each step of the research process. Additionally, the researcher sought advice from an experienced expert in the research field to ensure that none of the interview guide questions were inflammatory. Involving an expert in the field of research was helpful because the expert not only advised on arranging questions to avoid being inflammatory, but also provided guidance on changing some questions and including others that would address the research question and objective (refer to Appendix 6a: old interview guide and 6b: new interview guide).

During the interviews, two participants became emotional and started crying. The researcher promptly ended the sessions with them and asked if they would like to continue or postpone the interview to another day, giving them time to process their feelings. Additionally, the researcher suggested that the participants see the arranged social worker for counselling, however, these participants did not consider this suggestion.

In terms of the researcher's safety, measures outlined in section 3.6.1 (preparation for data collection) were implemented. Furthermore, due to COVID-19, the researcher also ensured that both the researcher and the participants adhered to COVID-19 protocols as outlined in section 3.6.4 (Pilot testing).

3.8 CHAPTER SUMMARY

A qualitative research approach was used to gain a comprehensive understanding of resilience as perceived and understood by women living with HIV. The research methodology and techniques employed were thoroughly explained, providing a clear outline of the empirical process followed and validating the choices made to ensure the authenticity of the study. The qualitative research approach was considered suitable for the study's objective as it effectively captures the participants' experiences and perspectives on women living with HIV and their resilience. Throughout the process, the researcher ensured strict adherence to all relevant ethical considerations.

CHAPTER 4

4. PRESENTATION OF THE EMPIRICAL FINDINGS

4.1 INTRODUCTION

The current chapter presents the findings on the resilience of WLWHIV at Winnie Mandela Informal Settlement in the Ekurhuleni Metropolitan Municipality. It will discuss the data collected through face-to-face, semi-structured interviews using interview guide as a data collection tool with fifteen resilient WLWHIV. To protect their identity and comply with confidentiality principles, participant names were not used. Instead, the researcher used numbers assigned to each of them. The collected data was meticulously scrutinized following Tech's eight steps of qualitative data analysis, as explained by Creswell (2009). It is important to note that self-coding of the data during the analysis resulted in a consensus on four themes and fifteen sub-themes.

The first section of this chapter describes the sample by providing the biographical background of the research participants. The second section discusses the study findings based on the themes and sub-themes that are in line with the study objectives. These findings are then compared and contrasted with literature related to the phenomenon being studied.

In addition, the researcher used verbatim quotations to support the participants' statements regarding the issue being studied. This approach was selected to obtain a thorough understanding of the participants and to address the following research question:

- *What resilient strategies do WLWHIV use to cope with their HIV diagnosis at Winnie Mandela Informal settlement within Ekurhuleni Metropolitan Municipality in Gauteng Province?*

The following objectives guided the data collection:

- To explore and describe the experiences of WLWHIV in coping with their HIV-positive diagnosis.
- To explore and describe the resilience strategies of WLWHIV in coping with their HIV-positive diagnosis.
- To explore and describe the support required by WLWHIV from social workers in dealing with an HIV-positive diagnosis.
- To draw conclusions regarding the coping strategies used by WLWHIV who are resilient to the virus.
- To provide recommendations for social work interventions aimed at empowering newly diagnosed HIV-positive women with effective coping strategies.

Objectives number 4 and 5 will be addressed in the following chapter, Chapter 5: Summary, Conclusion, and Recommendations, along with the response to the research question.

4.2 BIOGRAPHICAL BACKGROUND OF PARTICIPANTS

The following section presents the biographical profiles of the research participants, as outlined in the interview guide (Appendix 6b).

4.2.1 Participants Biographic Background

The demographic information presented in Table 4.1 below reflects the age, ethnic group, period of living with HIV, and whether the research participants are part of CCMDD. A detailed explanation of the participants' biographic background is provided.

Table 4.1: Participant Biographic Background

Participants	Age	Ethnic group	Period living with HIV	Part of CCMDD
1	37	Venda	5	Yes
2	32	Zulu	6	Yes
3	39	Pedi	13	Yes
4	35	Venda	12	Yes
5	40	Tsonga	19	Yes
6	31	Tsonga	7	Yes
7	32	Zulu	10	Yes
8	29	Tsonga	6	Yes
9	39	Tsonga	11	Yes
10	40	Venda	15	Yes
11	33	Pedi	5	Yes
12	32	Pedi	8	Yes
13	27	Tsonga	7	Yes
14	35	Pedi	8	Yes
15	29	Tsonga	5	Yes

Table 4.1 shows the details of all participants involved in the study. Participants were assigned numbers instead of using their names. The participants were WLWHIV from the Winnie Mandela informal settlement in the Ekurhuleni Metropolitan Municipality, Gauteng province. Since the study was conducted in an area predominantly inhabited by black Africans, resilient WLWHIV from other racial backgrounds were not interviewed as they did not meet the inclusion criteria and did not reside in the area.

4.2.1.1 Participants

A total of 15 women living with HIV in Winnie Mandela Informal Settlement participated in this study. The researcher initially aimed to interview 25 participants, but data saturation was achieved after interviewing 15 participants. All participants were fully informed about the study details and voluntarily agreed to take part. None of the participants withdrew from the interview after giving their consent.

4.2.1.2 Participants age

Participants in the study ranged in age from 27 to 40 years. The targeted population was WLHIV between 20 and 40 years old, based on 2016 statistics showing this age group had the highest percentage of PLWHIV in South Africa (Statistic South Africa, 2016). However, during recruitment, only participants aged 27 to 40 volunteered. One participant was 27, two were 29, one was 31, three were 32, one was 33, two were 35, one was 37, two were 39, and two were 40 years old.

Women in this age group may have a greater sense of stability in their lives compared to younger women, leading to a higher willingness and ability to participate in research studies (Wood, Crapnell, Lau, Bennett, Lotstein, Ferris, & Kuo, 2018). As women move into their late twenties and thirties, they may become more aware of health concerns like HIV, prompting them to actively engage in relevant research (Psaros, Barinas, Robbins, Bedoya, Safren, & Park, 2012). Additionally, women in this age range may have more knowledge and a deeper understanding of how HIV impacts their daily lives, which could enhance their readiness to contribute to research on improving HIV care and treatment (WHO, 2010). As individuals age, they may feel a stronger urge to make positive changes in their community and healthcare system, increasing their motivation to take part in research studies focused on enhancing HIV care and support services.

4.2.1.3 Ethnic groups

Four South African ethnic groups were selected as participants for the study: Vhavenda (3 participants), Vatsonga (6 participants), Bapedi (4 participants), and Zulu (2 participants). These groups were chosen because they are the dominant ethnic groups in the area where the study took place. It is important to clarify that the researcher did not intend to exclude any ethnic group or race. However, the study area is primarily inhabited by black Africans, so WLWHIV from other ethnic groups and races were not interviewed as they do not reside in the area.

The content above aligns with Marutlulle's (2017) findings, which state that the predominant ethnic groups in the Winnie Mandela informal settlement in the Ekurhuleni Metropolitan Municipality are primarily made up of Zulus, Vendas, Tsongas, Pedis, Xhosas, and Ndebeles. These groups are some of the largest ethnic groups in South Africa and are commonly found in both urban and rural areas across the country (Marutlulle, 2017). However, obtaining detailed demographic data specifically for the Winnie Mandela informal settlement may necessitate reaching out to local authorities, community organizations, or consulting census data for accurate information.

The researcher interacted with the participants using their vernacular languages, rather than English as the medium of instruction. The researcher is proficient in all the language as stated in section 3.5.4.1 (criteria of inclusion). Among the participants who were interviewed, Xitsonga was the most commonly used language for communication, as most participants were Vatsonga. The researcher believed it was important to conduct the interviews in the participants' preferred languages in order to allow them to fully express themselves.

4.2.1.4 Period of living with HIV

The participants had to have been living with HIV for at least five years. The researcher noted that individuals who have been living with HIV for over five years have likely experienced numerous challenges associated with the virus. As a result, they may have developed resilience or may be overwhelmed and unable to function optimally. In this study, participants who took part have been living with HIV for 5 years (3 participants), 6 years (2 participants), 7 years (2 participants), 8 years (2 participants), 10 years (1 participant), 11 years (1 participant), 12 years (1 participant), 13 years (1 participant), 15 years (1 participant), and 19 years (1 participant).

According to Project (2023), women who have been living with HIV for an extended period often develop a profound understanding of their condition. They actively participate in self-care, diligently follow treatment plans, and prioritize their health (Project, 2023b). This awareness allows them to make informed decisions and effectively manage their well-being, making them resilient to the virus.

4.2.1.5 Part of CCMDD

All participants in this study were stable (viral load suppressed) WLWHIV who are registered to collect their antiretroviral medications at Winnie Mandela Clinic and are enrolled in the CCMDD program. CCMDD offers an alternative method for providing ARVs to patients who are in stable condition (viral load suppressed). The researcher chose to focus on this specific population because he believed that women who are stable are more likely to demonstrate resilience against HIV.

According to the National Department of Health (2019), WLWHIV who are on ARVs must have a Viral Load (VL) below 50 copies/mL in the last 6 months to be eligible for enrollment in the CCMDD program. These women must also be stable on a regimen that includes either Dolutegravir (DTG) or Efavirenz (EFV). The CCMDD program offers an alternative method for obtaining repeat medication, allowing WLWHIV to use external Pick-up Points (PuPs) that are closer to their residences or workplaces (Hlongwana & Gray, 2022). This helps reduce transportation expenses and wait times providing a no-cost, secure, fast, and convenient way to collect chronic medication at authorized sites (Enoos, 2023). CCMDD ensures that the correct medicine is delivered to the right patient in the proper packaging, which promotes adherence, improves health outcomes, and strengthens resilience against the virus (Bogart, Shazi, MacCarthy, Mendoza-Graf, Wara, Zionts, Dube, Govere, & Bassett, 2022).

The following section provides a summary of the themes and sub-themes that emerged during the data collection and analysis process from the participants mentioned earlier.

4.3 THEMES AND SUB-THEMES

The development of themes and sub-themes aligned with the study's objectives and research question. The themes and sub-themes will be initially presented in summary form (refer to Table 4.2), followed by a detailed discussion. Below is a summary of the four themes and fifteen sub-themes that emerged from the collected and analyzed data.

Table 4.2: Summary of Themes and Sub-themes

Objectives	**Themes**	**Sub-themes**
To explore and describe the experiences of WLWHIV in coping with their HIV-positive diagnosis.	1. Life after testing HIV-positive	1.1 Denial of one's HIV status 1.2 Blaming others. 1.3 Lifestyle Re-adjustment
	2. Challenges of WLWHIV	2.1 Stigmatization and rejection 2.2 Lack of trust on men 2.3 Financial difficulties
To explore and describe the resilience strategies of WLWHIV in coping with their HIV-positive diagnosis.	3. Strategies that WLWHIV applied to be resilient to HIV	3.1 Disclosure of one's HIV status 3.2 Attendance of HIV support groups 3.3 Acceptance of one's HIV status 3.4 Adhering to HIV treatment 3.5 Maintaining a healthy lifestyle
To explore and describe the support required by WLWHIV from social workers in dealing with an HIV-positive diagnosis.	4.Support required by WLWHIV from Social Workers to be resilient to HIV	4.1 Intensive HIV Adherence counselling. 4.2 Addressing lengthy queues at the clinic. 4.3Community empowerment on HIV 4.4 Family Support

4.3.1 Discussion of study Findings: Themes and Sub-themes

THEME 1: LIFE AFTER TESTING HIV-POSITIVE

Research objective 1: To explore and describe the experiences of WLWHIV in coping with their HIV-positive diagnosis.

In order to establish a foundation and ensure participation of the participants, it was imperative to explore the experiences of WLWHIV in coping with their HIV-positive diagnosis. It is undeniable that changes in our lives have a significant impact, resulting in either positive or negative outcomes. One example is the discovery of one's HIV status, which can cause a great deal of fear and anxiety, especially if the test results are positive. Living with HIV can have profound emotional effects, so it is important to develop strategies for coping with this diagnosis. The following three sub-themes were identified as common reactions derived from the findings: denial of one’s HIV status, blaming others, and adjusting to new lifestyle changes. These reactions will be further explored in the following discussion.

Sub-theme 1.1: Denial of one’s HIV status

The results reveal that prior to acceptance, participants experienced a state of denial upon discovering their HIV positive status. The following was reported by the participants:

> *“Well, my life has not changed much, the only difficulty I had was in the beginning because I was frightened, it took me a little longer to accept that am HIV positive.” (Participant No.14).*

This is a common response, as individuals typically do not anticipate contracting HIV until after receiving a positive diagnosis. However, it is important to note that people cope with the outcomes of HIV testing in different ways. While some individuals are able to confront their denial quickly, others may remain in a state of denial for a long time, which can hinder their initiation of treatment. Denying one's HIV status is a complex phenomenon that often stems from psychological distress and fear associated with a positive diagnosis, despite advancements in medical knowledge and growing acceptance of HIV-positive individuals (Nam, Fielding, Avalos, Dickinson, Gaolathe, & Geissler, 2008). A significant factor contributing to this denial is the powerful psychological defense mechanism known as denial, which acts as a protective barrier against overwhelming emotions and difficult realities (Nam et al., 2008).

The phenomenon of denial, as reported by the participants, includes not only accepting one's HIV test results but also requiring some kind of intervention, such as seeking support from others, to help accept the new reality and begin treatment quickly. According to Varni, Miller, McCuin, and Solomon (2012a), individuals who learn they are HIV-positive may feel intense fear, shame, and stigma, leading them to use denial as a way to cope with this psychological distress. By refusing to acknowledge their HIV status, individuals try to protect themselves from the negative consequences of facing their diagnosis directly (Varni et al., 2012a).

> *"Social workers really helped me, the counselling the first day saved me, after I accepted and started attending counselling session, I got to learn a lot about HIV which I also believed played a role in me accepting my status. Learning about the importance of talking medication and available support (HIV support groups) really helped me". (Participant No.7).*

One factor that emerges from the study as contributing to an individual's denial is their lifestyle. Some participants assess their likelihood of testing positive or negative for HIV based on their personal choices, disregarding the fact that they may have intimate connections with others who may not necessarily adhere to their lifestyle practices. An individual's perception of their own sexual behavior may clash with their recognition of being HIV-positive, leading to defense mechanisms such as denial (Varni, Miller, & Solomon, 2012b). This conflict arises from the inconsistency between their prior beliefs about their sexual health and the reality imposed by the diagnosis (Varni, Miller, & Solomon, 2012a). In order to resolve this cognitive dissonance, individuals may deny their HIV status in order to maintain their self-image and hold onto their existing beliefs (Varni et al., 2012b), as alluded to by the following participant.

> *“It was very difficult for me to accept (pause) I am one person that I know that things like HIV are far from me because of my lifestyle, I have one boyfriend, so I kept on asking myself what happened. It was very difficult for me”. (Participant No.8).*

The fear of the unknown and uncertainty about the future can be paralyzing, leading some individuals to engage in self-deception and denial (Stanborough, 2020). By rejecting their diagnosis, individuals may aim to maintain a sense of control and avoid the emotional turmoil that accompanies confronting their mortality (Remien, Stirratt, Nguyen, Robbins, Pala, & Mellins, 2019). Additionally, cognitive dissonance, which refers to the discrepancy between one's beliefs and actions, serves as another psychological mechanism that contributes to the denial of an HIV diagnosis (Remien et al., 2019).

Sub-theme 1.2: Blaming others

The research findings have shown that a significant number of participants in the study were unable to take responsibility or demonstrate accountability upon receiving a positive HIV test result. Interestingly, the study revealed that men played a significant role in transmitting HIV to the women who were interviewed. However, it was heartening to discover that some participants felt hopeful due to the support they received from their partners, despite their HIV-positive status. The issue of anger also emerged as a prominent theme among the participants, as evidenced by the following quotes.

> *“I was very angry from my past relationship because my then-boyfriend used to abuse me, learning that am HIV positive fueled the anger because I knew that I got it from him because I have never cheated, but after attending church and counselling I managed to deal with the anger and forgave him, so if I was not positive, I would have been still with full of anger now”. (Participant No.9)*

It is not surprising that participants may attribute the outcomes of their HIV status to external factors and shift the blame onto others. This phenomenon can be attributed to the significant social stigma associated with HIV. Living with HIV poses a range of complex emotional, psychological, and social challenges (Dejman, Ardakani, Malekafzali, Moradi, Gouya, Shushtari, Alinaghi, & Mohraz, 2015). Some individuals may find solace in holding others accountable for their HIV diagnosis. However, navigating blame becomes a complicated and contentious aspect when dealing with the devastating reality of an HIV diagnosis. It is understandable that, for various reasons, individuals may assign responsibility to others for the consequences of their HIV status. This behavior is widely recognized as being more prevalent.

Furthermore, research findings indicate that discovering one's HIV status may result in a heightened sense of victimization by current or former partners. Most participants believed that, if it weren't for their partners, they would not find themselves in the predicament of living with HIV. The following statements testify to this:

> *"I would say that yes, I have accepted that I am HIV positive, but it has changed how I view men because I believe that my ex-boyfriend is the one that gave me HIV. In addition to that, I separated with the supportive boyfriend that I was with, we were not having sex, I think he was afraid because he was there when I tested positive and he thought I will infect him, but I do not blame him. Now it is not easy to get a man that accepts me with my status because I make sure that I disclose when we start dating, and as soon as they hear that then they disappear." (Participant No.13)*

> *"(Taking a deep breath) Yoh! I do not know where to begin (silence) at that moment I felt like everything in my life just turned upside down, first I was very angry because of how I got infected, He was my high school boyfriend, and we dated for 2 years, and we were married for 18 years. All my life I had never cheated on him, I loved and respected him so much, and even though I always forgave him for cheating I did not know that I will end up getting HIV because of him". (Participant No.15)*

Holding others accountable can be a natural psychological response when confronted with a life-altering diagnosis (Stuewig et al., 2010). It often serves as a way to ease emotional distress and cope with feelings of fear, shame, and guilt (Stuewig, Tangney, Heigel, Harty, & McCloskey, 2010). In some instances, individuals may resort to placing blame on others in order to protect their self-esteem and retain a sense of control over their circumstances (Stuewig et al., 2010). Blaming others following a positive HIV test reflects the intricate and gradual process of acceptance. Despite the initial inclination to assign blame, it becomes evident over time that individuals build resilience and come to accept the challenges of living with the virus.

One of the main reasons why individuals may assign blame to others for their HIV diagnosis is the pervasive stigma surrounding the disease (Kontomanolis, Michalopoulos, Gkasdaris, & Fasoulakis, 2017). HIV is often unfairly associated with promiscuity, drug use, or immorality in society (Fauk, Hawke, Mwanri, & Ward, 2021). Consequently, those diagnosed with HIV may internalize this stigma, leading to a distorted sense of self and increased feelings of shame (Kontomanolis et al., 2017). Additionally, widespread misconceptions about HIV transmission can further fuel the inclination to blame others, as individuals may perceive their exposure as a result of someone else's negligent behavior or malicious intent (Ekstrand, Bharat, Ramakrishna, & Heylen, 2012).

Sub-theme 1.3: Lifestyle Re-adjustment

The research findings provide evidence for the common adage that change is a challenging process. Specifically, the findings reveal that individuals living with HIV are compelled to modify their lifestyles from their previous norm to a new standard of living. These adjustments may include dietary changes that have financial consequences, as well as modifications to treatment adherence. In certain cases, participants ultimately ended up single due to their partners' inability to sustain the relationship. This is confirmed by the following story lines:

> *“Eeeh! The was a time I had to sit down and think of what is it that I want to achieve in life and I then noticed that living with HIV does not stop me from achieving my dreams, this also was after the counselling I received which made me see that this is not the end of me, am still young, at 29 I can still achieve a lot. So, I accepted that am HIV positive and that is not going to change. It doesn’t mean that am different from other people, we are the same, the only difference is taking HIV treatment and others are not taking but when we look at lifestyle, it is the same thing. What I can encourage other women living with HIV is that they should not only adhere to their HIV treatment, but they must also maintain a healthy lifestyle.*

> *If you are living with HIV, you are expected to exercise and eat proper healthy food in order to boost your immune system". (Participant No.8).*

Upon receiving a diagnosis of HIV, it is common for stress levels to escalate, which can have adverse effects on both mental and physical well-being (NIOMH, 2019). To address this issue, it becomes crucial to learn effective stress management techniques, such as mindfulness meditation, deep breathing exercises, or engaging in stress-reducing activities like yoga or tai chi (Can, Iles-Smith, Chalabianloo, Ekiz, Fernández-Álvarez, Repetto, Riva, & Ersoy, 2020). Stress management not only improves psychological resilience but also helps prevent immune system suppression, which can be exacerbated by chronic stress (Segerstrom & Miller, 2004).

Incorporating a diet that includes a variety of fruits, vegetables, whole grains, and lean sources of protein provides the essential vitamins, minerals, antioxidants, and amino acids necessary for strengthening the immune system (Duggal et al., 2012). It is important to pay particular attention to consuming enough calories and macronutrients to prevent malnourishment and maintain a healthy weight (Duggal et al., 2012). Additionally, optimizing gut health by incorporating prebiotics and probiotics can enhance immune function and minimize gastrointestinal complications commonly associated with HIV (D'Angelo et al., 2017). Participants 2 and 7 have also expressed concern about the need to readjust their lifestyle according to the following storylines.

> *"The only thing I knew was that HIV does not kill you when you take your medication consistently, However, I did not know about changing your whole lifestyle, adjusting food, and the possibility of being reinfected, Yoh! I felt like I did not know anything". (Participant No.2).*

Individuals living with HIV are at a greater risk of experiencing serious health complications due to substance abuse (Durvasula & Miller, 2014). This is because substance abuse can negatively interact with antiretroviral therapy, exacerbate medication side effects, and impair immune function (Durvasula & Miller, 2014). To safeguard their health, individuals should prioritize maintaining a substance-free lifestyle (Durvasula & Miller, 2014). Strategies for achieving this may include seeking professional help for substance abuse issues and actively avoiding environments where drug or alcohol misuse is common. Additionally, cultivating healthy coping mechanisms and engaging in activities that promote well-being can help individuals maintain a substance-free existence (Donald, Fernandez, Claborn, Kuo, Koen, N., Zar, & Stein, 2017), as supported by the following statement.

> *"Uhm, I was one person who was not too picky when it comes to food, I ate anything I liked, I drank alcohol, and liked partying. So, as I was doing my research, I found out that I have to eat healthy food and stop drinking alcohol as these are some of the things that would deteriorate my health. So, after getting that information, I changed my lifestyle". (Participant No.6).*

Receiving a diagnosis of HIV is a life-altering experience that requires significant adjustments in various aspects of a person's life (Tsevat, Leonard, Szaflarski, Sherman, Cotton, Mrus, & Feinberg, 2009). In addition to medical treatment and emotional support, adopting healthy lifestyle habits is crucial for individuals living with HIV. After an HIV diagnosis, maintaining a balanced and nutrient-rich diet plays a vital role in managing the virus and promoting overall well-being (Duggal, Chugh, & Duggal, 2012). Research has shown that regular physical exercise can boost the immune system, alleviate HIV-related symptoms, and improve overall quality of life for those affected by HIV (Hand, Lyerly, Jaggers, & Dudgeon, 2009). Engaging in moderate-intensity cardiovascular workouts, such as brisk walking or swimming, improves cardiovascular fitness and helps prevent conditions associated with a sedentary lifestyle (Hand et al., 2009). It is also important to include strength training exercises to preserve muscle mass and bone density, as HIV can contribute to muscle wasting and osteoporosis (Lopes, Farinatti, de Oliveira Lopes, Paz, Bottino, de Oliveira, Bouskela, & Borges, 2021). Physical exercise not only enhances physical health but also reduces stress levels and promotes mental well-being (Hand et al., 2009).

THEME 2: CHALLENGES OF WLWHIV

Research objective 1: To explore and describe the experiences of WLWHIV in coping with their HIV-positive diagnosis.

The following sub-themes also emerged from the first objective. The study participants identified several primary obstacles faced by WLWHIV. These include HIV-related stigmatization and rejection, fear of disclosing their HIV status to others, and a lack of confidence in men. Furthermore, the literature suggests that these individuals also struggle with financial difficulties, dietary challenges, and other related issues. Within this main theme, three sub-themes emerged, which will be further explored and highlighted below.

Sub-theme 2.1: Stigmatization and Rejection

The findings of the study show that WLWHIV frequently encounter various forms of social stigmatization and rejection. In fact, some participants even experience social isolation or are unwelcome within the larger community because of their HIV status. This stigmatization and rejection of WLWHIV is also observed within their immediate circles, including family members, friends, and partners. As a result of the fear of facing stigmatization and rejection, WLHIV expressed a preference to remain single due to apprehension about potential rejection based on their HIV status.

> *"Yes, I feel like it is just like any illness, the only thing that will change is knowing at the back of your mind that you have this illness, (silence) also for me the only thing that has been difficult is getting in a relationship with a man, because I now must disclose, what if he rejects me?". (Participant No.2)*

> *"Yes, another challenge I had as HIV positive woman has been getting into a new relationship because disclosing was the first thing to do, even now it is still a challenge because no matter how much you can explain about HIV to another person at the end of the day people still have a decision and different opinions to yours about HIV". (Participant No.3)*

In the realm of HIV, individuals living with the virus continue to face significant challenges in the form of stigma and rejection (Fauk et al., 2021). This is despite the progress made in medical treatments and public health education (Fauk et al., 2021). Stigma is evident through discrimination, prejudice, and rejection, which can have serious psychosocial and health consequences for those affected (Turan, Budhwani, Fazeli, Browning, Raper, Mugavero, & Turan, 2017).

The issue of stigmatization and rejection faced by WLWHIV has its own set of consequences. The harmful effects of this stigmatization and rejection can lead to hesitancy in disclosing one's HIV-positive status to partners or family members due to fear of negative consequences. This fear of discrimination may deter WLWHIV from seeking testing and treatment, resulting in delayed diagnoses and increased transmission rates (Golub & Gamarel, 2013). Furthermore, the fear of societal judgment and rejection compels WLWHIV to conceal their status, often resulting in isolation and a lack of social support networks (Audet, McGowan, Wallston, & Kipp, 2013). Consequently, the absence of support and meaningful connections can have adverse effects on their mental, emotional, and physical health, contributing to higher rates of depression, anxiety, and substance abuse (Audet et al., 2013).

Sub-theme 2.2: Lack of trust on men

The study findings reveal that one of the key factors contributing to the trust deficit among WLWHIV is the fear of stigmatization and discrimination. Society often attaches significant social stigma to individuals with HIV, particularly women, due to harmful gender norms and stereotypes. This stigma not only results in negative societal attitudes but also creates self-stigmatization and a feeling of shame among WLWHIV. Consequently, as found in this study, WLWHIV hesitate to trust men or disclose their HIV status due to the fear of being stigmatized, abandoned, judged, or treated differently. The experiences of stigmatization and rejection create a hostile environment where restoring trust in potential relationships becomes challenging as confirmed by the following responses:

> *“For I struggled with trusting men, after what happened I even stopped dating for almost 2 years. Mmmmh! other challenges would be the same as everyone who is living with HIV, some people don’t know about HIV, so they discriminate us and don’t want to be associated with that, but for me now, I have accepted. (Participant No7).*
>
> *“I will say it is no longer easy for me to trust men and also challenge of men leaving me after they know my status. I am now single and happy; I don’t want any relationship because I fear that it won't last after they know my status and they start to stigmatize me”. (Participant No.9).*

The lack of trust that women experience after an HIV diagnosis can have severe psychological and emotional consequences (Waldron et al., 2021). The fear of transmitting the virus may lead to self-imposed isolation and the decision to abstain from pursuing intimate relationships altogether (Closson, Mimiaga, Sherman, Tangmunkongvorakul, Friedman, Limbada, Moore,A. T., Srithanaviboonchai, Alves, & Roberts, 2015). This isolation significantly compounds the emotional burden of the diagnosis, potentially resulting in depression, anxiety, and decreased quality of life. Understanding the intricate interplay between trust, HIV, and mental well-being is essential for developing effective interventions and support systems (Closson et al., 2015). Participants 7 and 9 expressed similar viewpoints.

Trust is a fundamental component of any healthy relationship, and an HIV diagnosis can profoundly challenge this core concept for both parties (Robinson, 2016). Typically, trust encompasses expectations of loyalty, honesty, and emotional support (Robinson, 2016). However, the involvement of men may cause women to question these notions due to apprehensions regarding sexual infidelity, non-disclosure of HIV status, or being blamed for their infection (Ssali et al., 2010). Such uncertainties can make it challenging for women to restore trust or initiate new relationships, further isolating them from potential support networks (Ssali et al., 2010).

Additionally, the societal perception of gender roles and power dynamics can have a significant impact on women's trust in men following an HIV diagnosis (Pulerwitz, Michaelis, Verma, & Weiss, 2010). Throughout history, women have often depended on men for emotional and financial support, making them vulnerable to unequal power dynamics in relationships (Becker, 1999). As a result, the introduction of HIV can worsen these power imbalances and increase feelings of betrayal and mistrust. The fact that men are distrusted by participants shows that they are being held responsible for the spread of HIV among women. Trust is a crucial aspect of any relationship, and its absence can lead to separation. The study findings shows that some WLWHIV are forced to stay single because their partners don't trust them, blaming their infection on their partners' infidelity. Interestingly, some individuals see being single as a positive thing, as it can lead to happiness.

Sub-theme 2.3: Financial Difficulties

Participants in this study also mentioned financial hardships as one of the obstacles preventing some women from developing resilience against HIV. They pointed out that expenses related to transportation to the clinic for medication collection and adhering to a prescribed diet were especially difficult for those who were unemployed. Consequently, this hindered their adherence to the treatment plan and their ability to attend clinic appointments as scheduled, which is contrary to what someone resilient to HIV would do.

> *“Yes, another challenge was the issues of food as they say you need to eat specific foot types which I couldn’t afford because I was unemployed. I had my boyfriend money also for taxi fares so I can go collect my medication”. (Participant No.4).*

> *“Most challenges that I encounter is that when you disclose yourself to a man that is interested in you, he starts to pull himself back because he thinks that the disease spreads easily, so if he is not well informed about the disease, he judges me and leaves so it becomes hard to find love. Another thing is, I never have money to go to the clinic because I am unemployed but with the help of my family, they lend me the money”. (Participant No.6).*

According to the definition of resilience, a resilient person is someone who can use their resources to find solutions to the problems they are facing (Southwick et al., 2014). In this case, economic disparities play a crucial role in worsening the situation for WLWHIV. Women often have less economic independence and face more financial obstacles compared to men, especially in developing countries (Verick, 2014). This economic disadvantage limits their ability to access necessary healthcare, follow treatment plans, and have a stable income (Azia et al., 2016). Additionally, the lack of economic resources increases their vulnerability to other health challenges, like malnutrition and poor mental well-being, which further amplifies the impact of HIV on women's overall well-being (Azia et al., 2016).

The financial difficulties that WLWHIV experience, which in turn affect their overall well-being, are one of the contributing factors to the majority of WLWHIV failing to be resilient to HIV. Limited access to a support system, poor adherence to HIV medication, mental health issues, and a weakened immune system as a result of poor diet and medication adherence, if addressed, can play a vital role in enhancing resilience and improving health outcomes for WLWHIV.

THEME 3: STRATEGIES THAT WLWHIV APPLIED TO BE RESILIENT TO HIV.

Research objective 2: To explore and describe the resilience strategies of WLWHIV in coping with their HIV-positive diagnosis.

Resilience refers to an individual's ability to endure, adapt, and perform effectively in the face of challenges, traumas, tragedies, threats, or stressors (Sisto, Vicinanza, Campanozzi, Ricci, Tartaglini, & Tambone, 2019). According to Southwick et al. (2014), the level of resilience can influence how well someone adapts after experiencing trauma, and it can be seen as a personality trait, a process, or an outcome. Participants in a study have identified several strategies they use in their daily lives to overcome the difficulties of living with HIV. Five sub-themes have emerged within this overarching theme: disclosing one's HIV status, participating in HIV support groups, accepting one’s HIV status, adhering to HIV treatment, and maintaining a healthy lifestyle.

Sub-theme 3.1: Disclosure of HIV status

The research findings indicate that disclosing one's HIV status to individuals such as loved ones or experts is significant because it can result in gaining support from those who are informed. Participant 8 emphasized the importance of disclosure as a key strategy in their comprehensive approach.

> *"I will say acceptance and focus on what one wants to achieve, again taking treatment in order to live long, I still want to have children so it will help that I give birth to healthy children and that I don't infect others. Disclosure it is also important because it makes one receive support which is important if one is living with HIV". (Participant No.8)*

Revealing one's HIV status can have therapeutic effects, primarily by alleviating the emotional burden and secrecy associated with the virus (Chaudoir, Fisher, & Simoni, 2011). Findings further indicate that sharing one's HIV status may allow individuals to form genuine connections based on trust, accessing emotional support, and contributing to resilience by reducing feelings of isolation and fostering networks that provide empathetic understanding. Additionally, disclosure can facilitate open discussions about living with HIV, challenging stigma and promoting emotional healing, ultimately leading to improved mental health and well-being (Knight & Schatz, 2022).

It cannot be ignored that when someone discloses their HIV status, there is a possibility of facing stigma or rejection. However, Participant 2 emphasizes the positive aspects of disclosure, such as receiving support.

> *"So, first, disclose your HIV status especially to your family as they are the closest people who can offer you any form of assistance". (Participant No.2).*

The participants in the study emphasized the importance of disclosing one's HIV status. They suggested that, in addition to the potential support from others, there is also a valuable benefit of achieving inner freedom. This highlights the significance of acknowledging and accepting one's status. By disclosing their status, women can inspire others WLWHIV to do the same, creating a ripple effect that fosters collective resilience (Lee et al., 2015). These self-advocacy efforts also provide opportunities for individuals to engage in broader advocacy, advocating for better HIV education, improved healthcare services, and more inclusive policies (Lee et al., 2015).

Recognizing that disclosure can foster resilience involves acknowledging the beneficial transformations it brings about in individuals (Schatz, 2022). Sharing one's HIV status promotes personal development by instilling a sense of self-advocacy and empowerment, motivating WLWHIV to actively engage in their healthcare by seeking medical advice and support (Ssali et al., 2010).

> *“Abuti! (Brother) I would say first they should accept themselves, disclose to people close to them, live free without thinking of dying, attend support groups, take their medication, and love themselves”. (Participant No.7).*

Disclosing one's HIV status can also help combat the pervasive stigma associated with the virus (Kontomanolis et al., 2017). By openly sharing their experiences, WLWHIV initiate conversations about HIV within their social circles, workplaces, or educational institutions. Such revelations serve to humanize the virus and challenge stereotypes, promoting acceptance and normalizing the experiences of WLWHIV (Kontomanolis et al., 2017). When disclosure leads to increased acceptance, WLWHIV experience a stronger sense of belonging, which can significantly bolster their resilience and ability to navigate societal challenges (Kontomanolis et al., 2017).

Sub-theme 3.2: Attendance of HIV support groups

In Sepedi, there is a proverb that states "mphiri o tee ga o lle", which can be interpreted as "no man is an island". This adage aligns with the findings of the present study, where participants emphasized the significance of having a support system upon discovering their HIV status as follows.

> *“I would advise them to take their medication as prescribed. Acceptance is so important when you’re in this situation. Speak to someone you trust and tell them how you’re feeling. Find ways to help relieve your stress like joining support groups and participating in activities during sessions”. (Participant No.5).*

Concealing one's condition or being hesitant to discuss it can lead to various challenges, such as suicidal tendencies and other difficulties. Mundell, Visser, Makin, Forsyth, & Sikkema (2012) emphasize that attending HIV support groups has been shown to be a beneficial and effective approach for many individuals, rather than isolating oneself. Participating in an HIV support group can enhance emotional well-being among women living with HIV (Bateganya et al., 2015).

The diagnosis of HIV is often accompanied by intense emotions such as fear, sadness, or guilt (Thapa & Yang, 2018). HIV support groups provide a non-judgmental environment where participants can freely express their emotions and receive validation from others who have had similar experiences (Bateganya et al., 2015). Sharing personal stories and hearing from others can reduce feelings of isolation and provide comfort and understanding (Bateganya et al., 2015). This, in turn, fosters emotional resilience and helps individuals cope with the stressors associated with their condition (Bateganya et al., 2015).

Furthermore, it is highly recommended to educate the public about HIV in order to prevent stigmatization within the community. By sharing information and stressing the importance of safe sexual practices, individuals can find the courage to focus on the positive aspects of life and understand that they are fulfilling their purpose by helping to save the lives of others.

> *“(Silent) honestly what works for me is that I don’t hide my status, everyone that knows me knows that am HIV positive, I even go to the clinic for health talk to educate others about HIV and the importance of using condoms. Again, the support I received and continue receiving from home and HIV support group is what made me to be strong as I am today, I was accepted because I was open to them and also educated them about HIV, so they understand it. I would say accept*

> *that am sick and I can reverse it also helped a lot and the counselling that I received from the clinic also contributed a lot. Yes, challenges are there but when you share with those close to you, they assist with guidance, also with the nurses and social workers at the support groups". (Participant No.13).*

Support groups serve as a platform for exchanging knowledge and information, empowering WLWHIV to take control of their health (Permwonguswa, Khuntia, Yim, Gregg, & Kathuria, 2018). HIV support groups provide access to educational resources where participants can learn about the latest treatment options, side effects, and management strategies (Bateganya et al., 2015). Engaging in discussions with healthcare professionals and peers can help WLWHIV make informed decisions about their treatment and explore alternative therapies (Bateganya et al., 2015). Additionally, participants can benefit from practical advice on maintaining a healthy lifestyle, such as exercise, nutrition, and stress reduction techniques (LaGrange, Mitchell, Lewis, Abramowitz, & D'Angelo, 2012). By expanding their knowledge base, attendees can improve their overall well-being and actively participate in their healthcare decisions (Permwonguswa et al., 2018).

Sub-theme 3.3: Accepting one's HIV status

In this study, most participants identified accepting one's HIV status as essential for WLWHIV to become resilient to the virus. The findings indicate that a significant proportion of WLWHIV succumb to the disease because they fail to accept their status, making it challenging for them to undergo appropriate HIV treatment.

> *"Honestly what is working for me is acceptance that I am HIV positive and that is not going to change it whether I hide it or not people will end up knowing. So that why I am so open about it and don't hide it from anyone". (Participant No.10).*
>
> *"(Laughs) the same challenges that people experience. Being HIV positive does not make you different, if you were poor, you remain the same. After acceptance I don't have any challenge that I will say I experience that is HIV related except*

> *same challenges that everyone goes through such as lack of employment, relationship problems yeah". (Participant No.14).*

In the global fight against HIV, acceptance of one's HIV status has emerged as pivotal approach to enhancing the overall well-being of WLWHIV (Iacob et al., 2017). Meeks and Jones (2020) alludes that accepting and understanding one's HIV diagnosis can improve emotional well-being and mental health. Embracing their HIV status allows WLWHIV to access the necessary resources, treatment, and support services for effective condition management (Safer & WHO, 2010). This acceptance promotes empowerment and control over their health, enabling WLWHIV to manage their treatment and adopt healthy behaviors for a fulfilling and healthy life despite the diagnosis (Jones, 2020). Moreover, accepting one's HIV status can help WLWHIV establish a strong support system including healthcare professionals, family, friends, and other HIV-positive individuals (Maman, Van Rooyen, & Groves, 2014). This network of support can provide emotional assistance, guidance, and motivation as WLWHIV navigate life with HIV. Embracing and being open about their status allows WLWHIV to break down the stigma surrounding HIV and create a safe space for open discussions about their experiences, challenges, and victories with those who can relate. This sense of community can greatly enhance resilience to HIV and help WLWHIV effectively manage the complexities of living with the infection.

Sub-theme 3.4 Adherence to HIV treatment

Most participants in this study indicated that they adhered to ARV treatment as prescribed by healthcare professionals, which significantly contributes to their resilience to HIV. The findings suggest that a significant proportion of WLWHIV succumb to the virus because they struggle to accept their status, making it difficult for them to undergo appropriate HIV treatment. Furthermore, participants stated that testing positive for HIV has become less daunting in recent times. This is primarily due to the Department of Health's proficient management of HIV, as ARVs are readily available in all public healthcare facilities. Additionally, the fact that only one pill needs to be taken each day makes it easier to build resilience against HIV.

> *“I will say acceptance and focus on what one wants to achieve, again taking treatment in order to live long, I still want to have children so it will help that I give birth to healthy children and that I don’t infect others. Disclosure it is also important because it makes one receive support which is important if one is living with HIV”. (Participant No.8)*
>
> *“Uhm, if they could go to the clinic and get the medication prescribed, disclose their status and acceptance help a lot”. (Participant No.6).*

Adherence to HIV treatment is crucial for achieving viral suppression, a key element in reducing the risk of transmitting the virus to others (Iacob et al., 2017). Research indicates that WLWHIV who adhere to their prescribed medication are less likely to transmit HIV to sexual partners or unborn children (Ramjee & Daniels, 2013). By maintaining viral suppression, WLWHIV can safeguard themselves from disease progression and contribute to curbing the virus's spread within their communities (WHO, 2018). This underscores the pivotal role that adherence plays in public health endeavors to combat the HIV epidemic.

In addition to its medical and public health advantages, adherence to HIV treatment profoundly influences the quality of life for those infected with the virus (Lahai, Theobald, Wurie, Lakoh, Erah, Samai, & Raven, 2022). Through consistent medication adherence, individuals can enhance their physical health, mental well-being, and overall quality of life (Kvarnström, Westerholm, Airaksinen, & Liira, 2021). Maintaining adherence to treatment enables WLWHIV to lead longer, healthier lives and partake in meaningful activities without being burdened by severe HIV-related complications, thereby fostering resilience against the virus.

Sub-theme 3.5: Maintaining a Healthy lifestyle

The findings of the study also suggest that WLWHIV can enhance their resilience to the virus by adopting a healthy lifestyle. Participants indicated that a combination of regular physical exercise and a balanced diet, as prescribed by healthcare professionals, can contribute to improved immune system functioning. This, in turn, reduces the risk of opportunistic infections and increases the efficacy of HIV treatment. Participants emphasized that a healthy lifestyle is crucial not only for personal well-being but also for maintaining resilience to HIV.

> *“What can encourage other women living with HIV is that they should not only adhere to their HIV treatment, but they must also maintain a healthy lifestyle. If you are living with HIV, you are expected to exercise and eat proper healthy food like fruits and vegetables in order to boost your immune system”. (Participant No.8).*
>
> *“It has changed my life a lot because now am careful of the food I need to eat, it has to be healthy, I also need to exercise and to make sure that whenever I have sex, I need to protect myself”. (Participant No.10).*

Maintaining a healthy lifestyle is crucial for WLWHIV. This includes regular physical exercise, a well-balanced diet, and effective stress management techniques (Stults-Kolehmainen & Sinha, 2014). These practices work together to promote overall well-being and are vital for developing resilience to HIV (Stults-Kolehmainen & Sinha, 2014). It is important to understand that building resilience to HIV is not solely dependent on medical interventions; individual responsibility in maintaining a healthy lifestyle is essential. By adopting positive habits, WLWHIV can better manage HIV and improve their overall well-being, enabling them to live life to the fullest (Lagrange et al., 2012).

THEME 4: SUPPORT REQUIRED BY WLWHIV FROM SOCIAL WORKERS TO BE RESILIENT TO HIV

Research objective 3: To explore and describe the support required by WLWHIV from social workers in dealing with an HIV-positive diagnosis.

The discussion below will focus on five sub-themes that have emerged from the study: social workers providing intensive HIV adherence counseling, addressing lengthy queues., social workers and provision of Community Empowerment on HIV. The importance of family support for WLWHIV also emerged under this theme.

Sub-theme 4.1 Providing Intensive HIV Adherence counselling

The findings of the study suggest that a contributing factor to WLWHIV's failure to be resilient to HIV is the inadequate provision of information during HIV counseling and testing. This lack of information hinders individuals from effectively navigating their HIV status, whether it is negative or positive. As a result, a significant number of newly diagnosed women with HIV struggle to come to terms with their HIV status or resort to suicide after discovering that they are HIV positive, which can be attributed to the substandard counseling services. Participants expressed that social workers should put more emphasis on adherence counseling during the testing process. Currently, what has been observed by those who took part in this study is that the priority is no longer the provision of quality service, but rather the number of people they test. This is in contrast to adhering to the comprehensive procedures outlined in the HIV testing and adherence counseling guidelines.

> *“For me, social workers helped me understand my status better, as I said counselling helped put a lot in perspective the CBO that I was volunteering at I was mainly assisting with coming up with topics for discussions for the Support groups, that helped to answer a lot of questions I also had for my own curiosity”. Our social workers should focus more on providing information about HIV because most of the people these days are just tested and if they test positive, they are not given detailed information about HIV”. (Participant No.3).*

Social workers provide intensive HIV counseling, which has been shown to offer numerous benefits and significantly contribute to the overall well-being of WLWHIV (Remien et al., 2019). The specialized knowledge and training of social workers are crucial in supporting WLWHIV throughout their journey of living with HIV (Remien et al., 2019). Their intensive HIV counseling for those diagnosed with HIV offers tailored emotional support, empowering clients to cope with the psychological impact of living with the virus (Remien et al., 2019). WLWHIV often face immense stress, depression, and stigma associated with HIV, and social workers provide a safe and understanding space to address these concerns (Remien et al., 2019).

Additionally, the study findings indicate that most of the WLWHIV who participated in the study gained resilience to HIV through the HIV adherence counseling sessions facilitated by social workers. HIV adherence counseling refers to the support and guidance that social workers provide to individuals living with HIV to ensure they adhere to their medication and treatment regimen (Chippindale & French, 2001). Participants suggested that individuals who have difficulties adhering to their HIV treatment should be referred to such counseling services. These services would enable them to comprehend the significance of adhering to treatment and to realize that being diagnosed with HIV does not mean the cessation of life.

> *"Social workers really helped me, the counselling the first day saved me, after I accepted ad started attending adherence counselling sessions, I got to learn a lot about HIV which I also believed played a role in me accepting my status. Learning about the importance of talking medication and available support (HIV support groups) really helped me. (Clear throat) so I will say the support from social workers would be to educate people who are living with HIV because a lot don't survive as a result of not having information. Counselling on medication is also important (adherence counselling) which is what they should provide more to people living with HIV". (Participant No.7)*

> *“I think social workers should spend enough time providing counselling for HIV positive women to understand what HIV and explaining that testing positive does not mean they are going to die. Most of the people are hiding that they are HIV positive because they are not well informed, the people who assisted them didn’t give themselves enough time to explain and tell them about the importance of taking HIV treatment. I think if those are addressed, most of the people will live freely with HIV”. (Participant No.10)*

The reason why social workers' HIV adherence counseling sessions are crucial is that they directly impact the health outcomes of WLWHIV. Adherence to HIV treatment slows down the progression of the virus and minimizes opportunistic infections (Musayon-Oblitas, Carcamo, & Gimbel, 2019). Attending adherence counseling sessions facilitated by social workers contributes to overall public health efforts in combating HIV. Adherence counseling helps minimize the viral load in the body, thus reducing the risk of transmission (Diress, Dagne, Alemnew, Adane, & Addisu, 2020). Social workers also play a critical role in advocating for WLWHIV, ensuring their access to healthcare, and promoting their rights. By addressing psychosocial factors such as stigma, discrimination, mental health, and substance abuse, social workers create a supportive environment that fosters adherence and reduces the burden of the disease on WLWHIV and society.

Sub-theme 4.2: Addressing lengthy queues at the clinic.

Participants expressed that one of the primary obstacles encountered at the Winnie Mandela clinic is the issue of overcrowding. The findings indicate that at the Winnie Mandela clinic, there is a dedicated area for PLWHIV. However, this provision fails to alleviate the challenge due to the significant number of individuals who receive their HIV treatment at this clinic on a daily basis. Participants further asserted that while the situation is more favorable for them as they are enrolled in the CCMDD program, qualifying for this program proves to be exceedingly difficult. It necessitates consistent adherence to clinic appointments and HIV treatment that effectively suppresses the viral load. Participant 4 additionally highlighted that it is even more difficult for women to stand in long queues at the clinic, particularly when they have household responsibilities awaiting their attention. Participants suggest that a collaborative effort between social workers and clinic management is essential to devise a solution that addresses the issue of prolonged waiting times at the clinic. This would facilitate the provision of necessary assistance and HIV treatment.

> *“Another thing, here at the clinic we queue for a long time. And seems like, I just do not know what can be done because for us queuing with the color distinguished cards, is like they already know where we are going. But our counsellors need to address this long waiting time on the que, you come in the morning here and leave at 5pm or sometimes you don’t get assistance and have to come back again the following day”. (Participant No.4).*

> *“Ooh another thing is, there is always a long queue when we go get our medication, so we would appreciate it if they could find a way to shorten the amount of time we spend at the clinic”. (Participant No.6).*

The findings of this study align with those of the study conducted by Azia et al. (2016) at a regional hospital in Cape Town regarding barriers to HIV treatment for PLWHIV. The study at the Cape Town hospital revealed that lengthy waiting times and queues significantly affected adherence to ARV medication among PLWHIV. This situation tends to frustrate HIV patients, leading to a lack of motivation to attend their hospital appointments, ultimately resulting in missed doses of ARV medications. Consequently, this non-adherence decreases the overall effectiveness of the prescribed treatment and potentially raises the risk of developing drug resistance.

Treatment adherence is vital for WLWHIV to effectively manage their condition. To achieve this, social workers can advocate for increased allocation of financial resources and additional provisions to enhance the healthcare system's ability to support women affected by HIV. They can collaborate with community-based organizations, policymakers, and healthcare professionals to raise awareness of this issue and work towards policy changes that prioritize reducing waiting times.

Sub-theme 4.3 Provision of Community Empowerment on HIV

The study reveals a need for intensive HIV training within the community. Participants indicated that many women hide their HIV status, do not go to the clinic to collect their treatment, and do not disclose their status to those close to them due to fear of rejection and judgment from society or the community. The participants acknowledged that the community has some knowledge of HIV, but they do not believe that the knowledge is extensive. This suggests a need for social workers to conduct community awareness campaigns on HIV.

> *"Eish, the community is another story (laughs), the community would be of great help if they were educated about HIV in a more extensive manner, however the gap is very big when it comes to community's knowledge and understanding of HIV". (Participant No.2).*

> *"Maybe if those can be targeted as people who will create awareness to the society about HIV like if they can be used as messengers who will educate communities about this HIV maybe the community will get used to hearing about it and understand it better and be able to offer genuine support to us". (Participant No.3).*

Empowering community members to tackle HIV requires a multifaceted approach that encompasses medical interventions and community empowerment (Kerrigan, Kennedy, Morgan-Thomas, Reza-Paul, Mwangi, Win, McFall, Fonner, & Butler, 2015). This approach promotes a comprehensive and sustainable response to mitigate the impact of HIV while fostering a society that is knowledgeable, compassionate, and actively engaged in the fight against the virus (Kerrigan et al., 2015). Prioritizing educational initiatives that provide accurate and up-to-date information about the virus is necessary to achieve community empowerment (Madhav, Oppenheim, Gallivan, Mulembakani, Rubin, & Wolfe, 2017). Equipping individuals with comprehensive knowledge enables them to make informed decisions regarding prevention, transmission, and treatment options (Madhav et al., 2018). Education programs should aim to promote factual understanding about the virus, dispel myths and misconceptions, and reduce the dangers of misinformation (Caceres, Sosa, Lawrence, Sestacovschi, Tidd-Johnson, Rasool, Gadamidi, Ozair, Pandav, & Cuevas-Lou, 2022).

> *"Eix at the community, the challenge is that people are not informed about HIV, they are judgmental because they still believe that if you are HIV positive, it means you have multiple partners or you love men. Community members still need to be educated about HIV, so the social worker can conduct awareness campaigns to educate them about HIV so that they change how they view and treat HIV-positive people because they will be informed". (Participant NO.8).*

Stigma and discrimination continue to impede progress in the fight against HIV (Fauk et al., 2021). Therefore, efforts to empower communities must address these social barriers by increasing awareness and promoting understanding of the realities of living with HIV (Kerrigan et al., 2015). Community members need to learn to see WLWHIV through a lens of compassion, empathy, and support, rather than judgment or fear (Visser, Makin, Vandormael, Sikkema, & Forsyth, 2009). By reducing stigma, women are encouraged to undergo regular testing, receive early diagnosis, and access treatment without fear of isolation or discrimination (Li, Liang, Lin, Wu, Rotheram-Borus, & Group, 2010).

Furthermore, it is crucial to establish robust support systems for ILWHIV, as well as their families and friends (Chippindale & French, 2001). These support systems should include access to healthcare facilities that provide specialized treatment and care, psychosocial support services, and resources to help individuals maintain a good quality of life. By ensuring that community members have access to these support systems, they can better navigate the challenges associated with HIV, maintain their physical and mental well-being, and actively participate in their communities (WHO, 2011).

Encouraging active engagement in advocating for HIV-related issues on various platforms is also an essential component of community empowerment (Kerrigan et al., 2015). Community members should be equipped with skills to advocate for policies that support access to affordable treatment, increased funding for prevention programs, and comprehensive sexual education in schools (Kerrigan et al., 2015). By engaging community members in advocacy efforts, they become instrumental in shaping policies that address the socio-economic determinants of HIV, promoting social justice and equity, and ensuring a conducive environment for all individuals affected by the virus.

Sub-theme 4.4: Family Support

In addition to the support needed by WLWHIV from social workers to build resilience against HIV, the study findings also revealed a strong need for support from family members. The study discovered a notable correlation between disclosing one's HIV status and receiving social support from family members. Participants indicated that WLWHIV who share their HIV status with family members may receive reminders to take medication and financial assistance to cover transportation costs for medical appointments, particularly if they are unemployed. Additionally, family support may also involve helping with dietary changes, thus establishing a supportive network for WLWHIV.

> *‘Uhm, personally, I would say the support I get from my family since I’m unemployed, would be that they help me with taxi fare to the clinic and money to buy nutritional food, uhm, they remind me to take my medication on time, they remind me of my appointments at the clinic. They show me love and support at all times. They’ve never judged me when I told them that I was sick, and they never treated me like I have the disease”. (Participant No.6).*

The family serves as a reminder for WLWHIV to consistently take their medication as prescribed. Family support is essential for providing psychological assistance to those living with HIV (Xu, Ming, Zhang, Wang, Jing, & Cheng, 2017). The diagnosis itself can be overwhelming, leading to feelings of anxiety, depression, and denial (Singer & Thames, 2016). During these challenging moments, family support systems allow individuals living with HIV to confide in their loved ones, creating a space for emotional release (Nyongesa, Nasambu, Mapenzi, Koot, Cuijpers, Newton, & Abubakar, 2022). By creating a non-judgmental environment and actively listening to their concerns, family members can promote self-reflection and acceptance (WHO, 2011). Psychological support from family members helps to increase their loved ones' self-esteem, build resilience, and empower them to actively participate in their treatment and overall health management (Avasthi, 2010).

Participant 7, who focused on providing emotional, financial, and dietary assistance, emphasized the crucial role of familial support.

> *"Abuti (brother) my family is my everything, everyone at home does not treatment me like a sick person, I am still treated like participant 7 who is not HIV-positive. Family should support emotionally, they should also ensure that they assist financially especially for us who are not working, you have to go to the clinic, you have to buy healthy food, so you need money. (Coughs) so sometimes you forget to take medication, so at home they remind me when is time to drink medication and they also ask me when am going to the clinic to collect medication. I am not too much into friend but the friends I have now give me love and support like the one I get from home". (Participant No.7).*

Enduring the emotional rollercoaster associated with HIV can be a challenging journey for WLWHIV (Bassett, Brody, Jack, Weber, Cohen, Clark, Dale, & Moskowitz, 2021). Family support provides a crucial source of emotional stability and comfort amidst the turbulence (Modak, Ronghe, Gomase, Mahakalkar, & Taksande, 2023). Regular expressions of love, empathy, and understanding from family members can significantly contribute to reducing stress, feelings of loneliness, and depression (Modak et al., 2023). Participant 9 expressed similar viewpoints. Family support helps to build a sense of belonging and normalcy in the lives of those living with HIV, countering the social stigma they may face outside their immediate circle (Turan et al., 2017). This emotional reinforcement enables WLWHIV to develop a more positive outlook, promoting mental well-being and facilitating overall healing (Turan et al., 2017).

> *"Currently, I am not working, when I have to go to the clinic to collect medication need transport money and my family covers. As I said, they are involved and very supportive. (Pause), they remind me to take medication most of the time, my little sister will even bring the medication to e because she knows the time that I am supposed to drink. My medication is not hidden, it is stored where they normally store the family medication". (Participant No.9).*

Apart from the emotional and psychological dimensions, family support also encompasses practical assistance, which helps women living with HIV (WLWHIV) cope with the demands of their medical condition (Huang, Chen, Shiu, Sun, Candelario, Luu, & Ah-Yune, 2021). This support may involve accompanying them to medical appointments, helping with medication adherence, or managing financial obligations related to treatment and care (Huang et al., 2021). Not only does practical support alleviate the burdensome tasks associated with daily living, but it also affords WLWHIV the opportunity to focus on their health and well-being (Knight & Schatz, 2022). By sharing responsibilities, family members create room for resilience and enable their loved ones to devote time and energy to maintaining a balanced lifestyle (Knight & Schatz, 2022).

4.4 CHAPTER SUMMARY

This chapter presented findings of the fifteen WLWHIV who are resilient to HIV from Winnie Mandela Informal Settlement in the Ekurhuleni Metropolitan Municipality who participated in this study. The first section of the chapter described the biographical background of the research participants. To protect the identity of the participants, the researcher complied with the principle of assigning numbers as names to participants instead of using their real names. The second section discussed the study findings based on the four themes and fifteen sub-themes that emerged through Tech's eight steps of qualitative data analysis, as explained by Creswell (2009), which were in line with the study objectives. These findings were compared and contrasted with literature related to the phenomenon being studied.

CHAPTER 5

5. SUMMARY, CONCLUSION, AND RECOMMENDATIONS

5.1 INTRODUCTION

The chapter provides conclusive insights derived from a study conducted on the resilience of women living with HIV in the Winnie Mandela informal settlement under the jurisdiction of the Ekurhuleni Metropolitan Municipality. A summary of the study, conclusions regarding research questions, study limitations, study recommendations, suggestions for future research, and a summary of the chapter are all discussed below.

5.2 SUMMARY OF CHAPTERS

This research report consists of five chapters, each systematically designed to ensure the credibility of the study. The study followed the processes outlined in the research proposal approved by the Department of Social Work Scientific Review Committee, Unisa College of Human Science Research Ethics Committee and Ekurhuleni District Department of Health. Additionally, this study adhered to all the processes of conducting a qualitative study and followed all stipulated ethics as outlined in chapter 3. Below are summaries of each chapter:

Chapter 1: General Introduction of The Study

Chapter 1 provided a general introduction to the study. The chapter began with a background of the study, reviewing literature on the phenomenon titled “The Resilience of Women Living with HIV at Winnie Mandela Informal Settlement”. The researcher then presented the problem statement and the study rationale outlining in detail the motive of conducting the study (refer to chapter 1, section 1.3 and 1.4), and theoretical framework considered for the study. The chapter also outlined the main research question that the researcher sought to answer, the study aim/purpose and objectives. Research methodology and ethics applied in the study were introduced in this chapter, and further discussed in detail in Chapter 3. Key concepts used in the study were defined and the chapter concluded by illustrating how the research reported is structured.

In conclusion, chapter 1 introduced the study topic, the researcher’s interest in conducting the study, the study location, the population of interest with, how the study would be conducted and the benefits of the study to WLWHIV, Department of Health, social workers and academia.

Chapter 2: Literature Review

Chapter 2 presented a detailed literature review focusing on the phenomenon that the researcher was studying. To gain a better understanding, literature from various scholars was reviewed. The chapter begins by providing background information on HIV/AIDS, including its origins and the different types of HIV. The transmission of the virus from one person to another and the introduction of HIV treatment, as there is currently no cure for the virus, were also covered in section 2.2 of this chapter. The second section, 2.3, outlined the prevalence of PLWHIV and also focused on that of WLWLHIV globally, in Africa, in South Africa, and specifically in the Gauteng Province where the study was conducted. The prevalence of HIV in the Ekurhuleni Metropolitan Municipality, as well as the number of PLWHIV categorized by gender who are part of CCMDD at Winnie Mandela clinic, were indicated. Under the prevalence of HIV, the number of PLWHIV and those dying due to HIV-related illnesses were shocking. Women, who were the population of interest for this study, were found to have the highest number of PLWHIV, particularly in Africa and as part of the CCMDD programme at Winnie Mandela clinic.

Additionally, this chapter helped to understand the risk factors for HIV among women that are contributing to the increasing number of women getting infected by HIV. The risk factors included gender-based violence, socio-economic status, poverty, lack of information about HIV, and marital status. In addition to their everyday life challenges, section 2.6 outlined additional challenges that WLWHIV experience, namely being stigmatized, depression, and financial difficulties, among others. Despite all these challenges, there are some WLWHIV who rise above and do not allow these challenges to make them succumb to HIV. These women are referred to as resilient women. Section

2.7 of this chapter outlined what resilience is, different types of resilience, and characteristics of resilience. Towards the end of the chapter, the researcher discussed women's resilience in the context of HIV, focusing on the types of resilience and the importance of building resilience in WLWHIV. Different strategies used by WLWHIV to be resilient to HIV were also outlined. Those strategies included acceptance of one's HIV status, disclosure, seeking social and professional help, adhering to HIV treatment, and attending HIV support groups. The chapter concluded by discussing the pivotal roles that social workers play in helping WLWHIV be resilient to HIV.

In conclusion, the chapter reviewed literature from various scholars, providing a comprehensive understanding related to the study title. It outlined what HIV is, who the most affected population is, the risk factors contributing to the increase in new infections, and the challenges faced by those who receive a positive diagnosis. What is particularly interesting about this chapter is that it demonstrated that despite the changes brought about by the virus, there are strategies that individuals can utilize to build resilience. This discovery significantly contributed to answering the main research question of the study.

Chapter 3: Research Methodology

Chapter 3 presented the research methodology that was applied when the study was conducted. The study was qualitative, and phenomenological design was employed. The study was conducted in Winnie Mandela Informal Settlement in Tembisa Township that is within Ekurhuleni Metropolitan Municipality in Gauteng province. This location was chosen because Ekurhuleni Metropolitan Municipality has the highest rate of HIV as compared all municipalities within Gauteng province as stated in Chapter 2, section 2.3. Additionally, the researcher while working at Tembisa hospital for Aurum Institute interacted with WLWHIV shown characteristics of resilience which prompted the idea to conduct a study on the resilience of women living with HIV at Winnie Mandela Informal Settlement.

The study population consisted of WLWHIV between the ages of 20 and 40 years who resided in the Winnie Mandela informal settlement within the Ekurhuleni Metropolitan

Municipality. Fifteen WLWHIV were purposively selected to participate in this study with the assistance of Department of Health officials. Additional criteria for inclusion in the study were that they had to be registered to collect their ARV medications at the Winnie Mandela clinic through the CCMDD program and have been living with HIV for over 5 years. The researcher selected this population based on statistics as stated in Chapter 2, section 3.5.1, which showed that women between the ages of 20 and 40 years had the highest percentage of PLWHIV in South Africa. The researcher chose those who had been living with HIV for over 5 years because he believed individuals who have lived with HIV for an extended period are likely to have faced various challenges related to the virus. Some may have developed resilience from these experiences, while others may feel overwhelmed and struggle to perform at their best.

Before commencing data collection, the researcher made sure to obtain all necessary approvals from the relevant authorities involved in the study. These approvals included those from Winnie Mandela Councilor, Ekurhuleni Department of Health, Department of Social Work Scientific Review Committee, and the Unisa College of Human Science Research Ethics Committee. Additionally, safety measures for the researcher were implemented as outlined in chapter 3.6.1. Data was collected over a month through semi-structured one-on-one interviews guided by an interview guide as the data collection tool. Pilot testing was conducted with three participants who met the inclusion criteria to ensure the feasibility, functionality, and effectiveness of the data collection tool and to address any potential issues with the research methods. Minor adjustments were made to the interview guide based on the pilot test findings, which were not included in the study.During the pilot testing and data collection period, the researcher ensured that COVID-19 protocols were adhered to.

The data collected was analyzed following eight phases of Tesch's recommended qualitative data analysis. From the analyzed data, four themes and fourteen sub-themes emerged which were discussed in detail in chapter 4. Trustworthiness was applied in this study as a method of verification for accuracy and reliability. The chapter concluded by outlining all the ethics that were considered during and after data collection. These ethics included informed consent, confidentiality, anonymity, beneficence, debriefing participants, and avoidance of harm.

In conclusion, the research method applied in this study enabled the researchers to conduct an effective study that achieved its main purpose: exploring and developing a thorough understanding of the resilience strategies used by WLWHIV to cope with their diagnosis.

Chapter 4: Presentation of the Empirical Findings

Chapter 4 presented the study findings. This study findings were reported based on the data collected from the fifteen participants, compared with literature from other scholars, and the researcher interpretation of the presented data. After data analysis, four themes and fifteen sub-themes were generated from the collected data. Detailed discussion of the themes and sub-themes was outlined on section 4.3 of Chapter 4. The following is a summary of each theme and its sub-theme.

Theme 1: Life After Testing HIV Positive

This theme consisted of three sub-themes that mainly described how participants felt after discovering they were diagnosed with HIV, linked to objective 1 (To explore and describe the experiences of WLWHIV in coping with their HIV-positive diagnosis). These sub-themes included denial of one's HIV status, blaming others, and adjusting their lifestyle.

Theme 2: Challenges of WLWHIV

This theme consisted of three sub-themes that mainly described the challenges experienced by women as a result of living with HIV linked to objective 1 (To explore and describe the experiences of WLWHIV in coping with their HIV-positive diagnosis). The sub-themes included stigmatization and rejection, lack of trust in men, and financial difficulties.

Theme 3: Strategies that WLWHIV applied to be resilient to HIV

This theme consisted of five sub-themes that described the strategies used by the interviewed WLWHIV to be resilient in the face of the virus linked to objective 2 (To explore and describe the resilience strategies of WLWHIV in coping with their HIV-positive diagnosis.). These sub-themes included disclosure of one's HIV status, attendance at HIV support groups, acceptance of one's HIV status, adherence to HIV treatment, and maintaining a healthy lifestyle.

Theme 4: Support required by WLWHIV from Social Workers to be Resilient to HIV

This theme consisted of four sub-themes that described the support that WLWHIV require from social workers to build resilience to HIV linked to objective 3 (To explore and describe the support required by WLWHIV from social workers in dealing with an HIV-positive diagnosis.). These sub-themes included providing intensive HIV adherence counselling, addressing lengthy queues at the clinic, community empowerment on HIV and family Support.

In conclusion, this chapter presented findings that emerged from four themes and fifteen sub-themes after analyzing data collected from fifteen WLWHIV from Winnie Mandela Informal Settlement in the Ekurhuleni Metropolitan Municipality who participated in this study. The findings from these themes and sub-themes assisted the researcher in answering the main research question and addressing all the objectives of this study as outlined in Chapter 1, sections 1.6.1 and 1.6.2. The following section provides a summary and conclusion related to the research findings.

5.3 SUMMARY AND CONCLUSION IN RELATION TO RESEARCH FINDINGS

This study was conducted at Winnie Mandela Informal Settlement with the aim of exploring and developing a thorough understanding of the resilience strategies used by WLWHIV to cope with HIV diagnosis. To identify those strategies, the researcher developed one main question and three research objectives to assist in achieving the what the study aimed to achieve. That research question and objectives are addressed below.

Objective 1: To explore and describe the experiences of WLWHIV in coping with their HIV-positive diagnosis.

The study findings indicate that all participants have experienced and continue to experience various challenges after being diagnosed with HIV. The most common challenge reported by participants is stigma and rejection due to their HIV status, which persists to this day. To make matters worse, some participants also mentioned being stigmatized and rejected by their own family members. As a result, many women who are newly diagnosed with HIV either take their own lives or hide their status.

Another challenge mentioned by most participants is the denial of their HIV status. This denial often stems from psychological distress and fear associated with being diagnosed as HIV positive. During the denial process, some participants even blamed their male partners for infecting them with HIV, justifying it by claiming they had always been faithful. The study participants also expressed a lack of trust in men as a challenge they had experienced. Some indicated that they reached a point where they lost interest in dating, while others were unable to sustain relationships due to a lack of trust. This lack of trust stemmed from their belief that their previous male partners had infected them with HIV and fear of being rejected, stigmatized, and accused of sleeping around.

Additionally, the study found that most participants struggle with lifestyle readjustment after learning that they are HIV positive. Being diagnosed with HIV required them to make changes to their diet and engage in physical activities such as exercising. The issue of finances was reported to be a continuous challenge, as most of them are unemployed as illustrated in Chapter 2, section 2.6. Maintaining a healthy diet is financially demanding due to the expensive cost of food. Additionally, going to the clinic every month to collect ARVs requires money, which is difficult for many of the WLWHIV since they are unemployed.

Research Question: What resilient strategies do WLWHIV use to cope with their HIV diagnosis at Winnie Mandela Informal settlement within Ekurhuleni Metropolitan Municipality in Gauteng Province?

Research Objective 2: To explore and describe the resilience strategies of WLWHIV in coping with their HIV-positive diagnosis

According to the literature reviewed in Chapter 2, specifically section 2.7, resilience is defined as an individual’s ability to effectively endure, adapt, and perform in the face of various challenges, including being diagnosed with HIV. The study found that despite the challenges brought by an HIV diagnosis and other life challenges faced by WLWHIV, there are women who persevere through these difficulties and are considered resilient to HIV. The study findings indicate that participants in the study used several strategies in order to be resilient to HIV.

The study found that disclosing one's HIV status, first to close family and friends, and later to the community, helped participants alleviate their emotional burden. Furthermore, this disclosure helped them develop genuine connections based on trust, allowing them to access emotional support. This support contributed to their development of resiliency against the virus because it reduced feelings of isolation and fostered the creation of networks that offer empathetic understanding. Attending HIV support groups was emphasized as an important measure that helped most participants to be resilient against HIV. Participants indicated that attending these support groups promotes emotional well-being because the platform allows individuals to share their challenges with others who understand their situation and exchange information. This can boost confidence for WLWHIV, improve understanding of their conditions, enhance treatment adherence, and improve their overall well-being.

The study also found that accepting one's HIV status and adhering to HIV treatment play vital roles in maintaining HIV resilience among WLWHIV. Most participants indicated that a significant number of WLWHIV succumb to the disease due to their failure to accept their status, resulting in them not taking HIV treatment or defaulting from treatment. The study findings also indicated that living with HIV in recent times has made it easier for

WLWHIV to be resilient to the virus. This is because the government, with the support of NGOs, has made ARV medication easily accessible by providing it for free in all public health facilities. Additionally, the fact that only one pill needs to be taken each day makes it easier for WLWHIV to build resilience against HIV.

Adopting a healthy lifestyle was also found in this study to enhance resilience to the virus. The findings suggest that physical exercise and a balanced diet contribute to improved immune system functioning, reducing opportunistic infections, and increasing the efficacy of HIV treatment. Study participants emphasized that a healthy lifestyle is crucial not only for personal well-being but also for maintaining resilience to HIV.

Objective 3: To explore and describe the support required by WLWHIV from social workers in dealing with an HIV-positive diagnosis.

The study found that social workers play a vital role in supporting WLWHIV. Participants indicated that one of the main reasons these women struggle with HIV is due to inadequate adherence counseling after testing positive. HIV adherence counseling should include detailed information about HIV. Participants stated that this lack of information hinders WLWHIV from effectively managing their status. As a result, a significant number of them struggle to accept their status, with some even resorting to suicide due to poor counseling and social workers prioritizing reaching daily testing targets. The study participants emphasized that social workers should provide intensive adherence counseling, especially for those who are newly diagnosed or struggling to accept their status.

Another obstacle mentioned by participants is the long waiting time and overcrowding at the Winnie Mandela clinic. Although there is a designated area for PLWHIV at the clinic, this provision does not effectively address the challenge due to the high number of PLWHIV who come to the clinic daily for appointments. This situation affects WLWHIV more because they have to wait in long queues all day, while also having other household responsibilities waiting for their attention at home. Participants suggested that social workers, as professionals who interact the most with WLWHIV, should collaborate with clinic management to find a solution to this problem. Furthermore, the study findings suggest that there is a lack of knowledge about HIV among community members. This lack of knowledge leads to WLWHIV not disclosing their HIV status out of fear of stigmatization and rejection from the community. Participants emphasized that one of the supports they need from social workers is to educate and empower community members about HIV. This can be achieved through conducting more frequent community HIV awareness campaigns.

5.4 RECOMMENDATION BASED ON THE RESEARCH FINDINGS

Based on the findings from the interviews, this study offers recommendations for intervention strategies that social workers and other professionals can use to assist women who have recently been diagnosed with HIV and those who are struggling to cope with living with HIV. These intervention strategies aim to enhance their resilience towards HIV and are outlined below.

5.4.1 Recommendation for Social Work practice

Objective 4: To provide recommendations for social work interventions aimed at empowering newly diagnosed HIV-positive women with effective coping strategies.

- **Social work interventions for empowering the newly diagnosed to be resilient to HIV.**

Being newly diagnosed with HIV can be a daunting and overwhelming experience for many WLWHIV as they struggle to come to terms with their new reality (Katz, Essien, Marinda, Gray, Bangsberg, Martinson, & De Bruyn, 2011). The study found that stigma and fear surrounding HIV can create a sense of shame and isolation, making it difficult for those affected to accept their diagnosis. For some, the initial reaction may be denial or disbelief as they grapple with the implications of living with a chronic illness, making it difficult for them to navigate their new reality with confidence and resilience. The following recommendations should be executed by the social workers working with WLWHIV.

The study found that Empowerment and resilience are crucial factors in managing HIV. By providing the necessary tools and support, these can help newly diagnosed women build confidence, develop resilient strategies, and take control of their lives. This not only improves their mental and emotional well-being but also enhances their ability to adhere to HIV treatment plans and maintain overall health. Social work interventions are essential in supporting newly diagnosed women with HIV by connecting them to the healthcare system, support services, and community resources. Social workers address the psychosocial challenges these women face, helping them navigate the complexities of living with HIV and empowering them to actively participate in their healthcare decision-making. The discussion below outlines intervention strategies recommended by the study to improve the resilience of WLWHIV.

- **Provide intensive adherence counselling**

The study has identified that social workers are not providing intensive adherence counseling. As a result of the substandard counseling, some WLHIV and those who are newly diagnosed with HIV fail to accept their status, leading to poor adherence to HIV treatment due to a lack of information. The provision of intensive adherence counseling can be highly beneficial in helping women navigate their emotional, social, and psychological challenges that may arise as a result of their HIV diagnosis. This process creates a safe and supportive space for women to express and process their emotions, helping them cope with feelings such as fear, anxiety, and sadness. During this process, social workers can provide accurate and up-to-date information about HIV, available treatment options, and preventative measures. This further allows them to address misconceptions or doubts that the women may have, empowering them with knowledge that will help them make informed decisions about their lives.

- **Create and facilitate HIV support groups**

The study found that WLWHIV who attend HIV support groups tend to develop resilience to the virus more than those who do not attend. Those who do not attend are more likely to succumb to the virus. Creating and facilitating HIV support groups can be extremely beneficial for women who are newly diagnosed with HIV. These support groups provide a safe and understanding environment where WLWHIV can share their experiences, emotions, and concerns. Those WLWHIV can offer each other emotional support, practical advice, and coping strategies, all of which contribute to building resilience to HIV. Social workers play a critical role in establishing and facilitating these support groups. They (social workers) can help identify potential group members, establish ground rules, and act as mediators during discussions and activities of support groups which can promote resilience and well-being. Additional roles that social workers can play can be that of providing valuable information about HIV-related resources, treatment options, and community support services. By fostering a sense of community, understanding, and empowerment, HIV support groups led by social workers can contribute to the overall well-being and resilience of individuals living with HIV.

- **Strengthening Social Support Networks**

A social support network refers to the relationships that provide support, identity, and a sense of belonging to WLWHIV (Ko, Wang, & Xu, 2013). This network includes family, friends, and members of the community, and it can play a vital role in offering social support to WLWHIV (Ko, Wang, & Xu, 2013). Having a strong social support network is essential for WLWHIV, it provide emotional, practical, and informational support, helping individuals cope with the challenges of living with the virus. Moreover, social support networks promote a sense of belonging, reduce isolation from friends, families as well as community members, and enhance overall well-being.

The study found that participants experienced a lack of social support before developing resilience characteristics. This was due to their failure to disclose their status out of fear of rejection by those close to them and by the community as a whole. Social support networks play a vital role in building resilience among WLWHIV. They provide a foundation of strength and support that helps women bounce back from adversity. By having people who understand their experiences and can offer assistance, women can develop the resilience needed to navigate the challenges associated with HIV. Strengthening social support networks through the efforts of social workers leads to several positive outcomes such as:

- strong social support network positively impacts the psychological well-being of WLWHIV, it promotes self-esteem, confidence, and a sense of empowerment, enabling individuals to take control of their lives and make informed decisions.
- WLWHIV with robust social support networks are more likely to adhere to their medication regimens and achieve better health outcomes. The encouragement and reminders from their network members contribute to increased treatment adherence and overall wellness.
- Social support networks foster a sense of belonging and social connectedness among WLWHIV They create spaces where individuals can openly discuss their experiences without fear of judgment, reducing stigma and promoting acceptance within communities.

Social support networks are vital in building resilience against HIV for women living with the virus. By providing emotional, feasible, and informational support, these networks can enable WLWHIV to effectively manage their condition. Social workers play a vital role in strengthening these networks and emphasizing the importance of their involvement in HIV care and support systems.

- **Provide Community Empowerment on HIV**

Findings from the study indicate that WLWHIV continues to face discrimination, stigma, and rejection in society. These challenges have a detrimental impact on their livelihoods and overall well-being. It is crucial to empower the community to address these issues, and social workers can play a significant role in this process. Community empowerment initiatives by social workers should include the development and provision of education aimed at improving knowledge about HIV, as well as reducing the incidence of HIV through harm reduction and health promotion. Additionally, as part of community empowerment, social workers should advocate for WLWHIV to receive equal treatment and rights. This can be achieved by advocating for policies and legal changes that work to eliminate discrimination and stigma against PLWHIV and by mobilizing the community to demand change and promote human rights for WLWHIV.

5.4.2 Recommendations for Policy

Policy makers should prioritize addressing the specific challenges identified in the study by WLWHIV. By utilizing this information, they can effectively shape and guide policy decisions. The Department of Health, the Department of Social Development, and other stakeholders need to embrace a comprehensive approach that goes beyond simply modifying risky behaviors but also focuses on transforming societal attitudes and encouraging a healthy lifestyle regardless of their health circumstances.

Furthermore, the Department of Health (including clinics, community health care centers, and hospitals) must refrain from engaging in discriminatory practices, especially towards WLWHIV. It is crucial to avoid any segregation in the provision of services between those who have HIV and those who do not require HIV treatment. By ensuring equitable access to healthcare services, we can undoubtedly promote the adherence of WLWHIV to their prescribed treatment regimens and help them become resilient to HIV.

5.4.3 Recommendation for Education

This study found that there is a challenge of lack of education at the community level, which leads to community members isolating and stigmatizing those they know are living with HIV. Consequently, many WLWHIV opt to withhold their status and avoid going to the clinic out of fear that they will be seen by community members while collecting their HIV treatment. This outcome affects adherence to HIV treatment. Incorporating HIV education into the South African curriculum at a young age, with a focus on responsible sexual behavior, is crucial. The education of individuals living with HIV is greatly influenced by teachers, social workers, parents, and the community as a whole. It is recommended that the education system be used to raise awareness of HIV to learners at a young age through subjects such as Life Orientation and Life Science. This will ensure that they develop a thorough understanding of HIV, which will assist them in making informed decisions as they mature.

5.4.4 Recommendation for Future Research

The sample of participants in this research study was limited to one clinic, the Winnie Mandela clinic, and the Winnie Mandela informal settlement as the study area. Future researchers should conduct studies on the resilience of WLWHIV at other clinics and study areas in order to discover strategies that can benefit women living with HIV throughout South Africa.

Additionally, based on the finding that the Winnie Mandela clinic is consistently overcrowded with people living with HIV coming for their appointments (such as the collection of antiretroviral medications or viral load checks), there is a need to explore the contributing factors to the high rate of HIV in the Winnie Mandela area.

The study focused on WLWHIV; future research should focus on man who are living with HIV/AIDS. The optimization of ARV drugs in the last decades has dramatically improved both treatment and prevention outcomes of HIV infection, its effectiveness should be studied further. Some of the participants were around 40 years of age, research should be carried to examine what it means to age with HIV/AIDS.

5.5 LIMITATION OF THE STUDY

This study had some limitations. The study has four limitations. The first limitation is that the study participants were exclusively female; males were not included in the targeted study population. This might have caused unintentional bias but because of the sensitivity of the topic, it was anticipated that men will be reluctant to participate in the study.
In addition, the study findings are limited to the specific area of the study and clinic from which the study participants were sampled. This limitation arises because there are other government and private clinics that have WLWHIV who meet all the inclusion criteria. Therefore, the results may only be applicable to the settings in which the study was conducted.

Furthermore, given that HIV is a highly sensitive topic, identifying participants posed a challenge. It took additional time to persuade them to volunteer for the study. Finally, the study sample only included WLWHIV who speak English, Tshivenda, Xitsonga, and IsiZulu. To accommodate those who speak other languages, language translators could have been employed.

6. LIST OF REFERENCE

Adamu, A., McHunu, G., & Naidoo, J. R. (2019). Stress and resilience among women living with HIV in Nigeria. Afr J Prim Health Care Fam Med, 11(1), e1-e6. https://doi.org/10.4102/phcfm.v11i1.2046

Adedigba, M. A., Naidoo, S., Abegunde, A., Olagundoye, O., Adejuyigbe, E., & Fakande, I. (2009). The economic burden of HIV and AIDS on households in Nigeria. African Journal of AIDS Research, 8(1), 107-114.

Adedimeji, A. A., Alawode, O. O., & Odutolu, O. (2010). Impact of Care and Social Support on Wellbeing among people living with HIV/AIDS in Nigeria. Iranian Journal of Public Health, 39(2), 30.

Adeoye, D. I. (2018). HIV disclosure in the workplace among people living with HIV/AIDS in Nigeria.

Adeoye-Olatunde, O. A., & Olenik, N. L. (2021). Research and scholarly methods: Semi-structured interviews. Journal of the american college of clinical pharmacy, 4(10), 1358-1367.

Agangiba, W. A., & Agangiba, M. (2019). Assessing the Impact of Socio-economic HIV Driving Factors in Ghana: Rural Versus Urban. Ghana Journal of Technology, 3(2), 42-50.

Ahmed, S. K. (2024). The pillars of trustworthiness in qualitative research. Journal of Medicine, Surgery, and Public Health, 2, 100051.

Akeju, D., Nance, N., Salas-Ortiz, A., Fakunmoju, A., Ezirim, I., Oluwayinka, A. G., Godpower, O., & Bautista-Arredondo, S. (2021). Management practices in community-based HIV prevention organizations in Nigeria. BMC health services research, 21(1), 489.

Alsayyad, N. (2021). Bottom-up Urbanization and the Culture of Squatting. AlMuntaqa, 4(2), 80-90

Andermann, A. (2016). Taking action on the social determinants of health in clinical practice: a framework for health professionals. Cmaj, 188, E474-e483.

Andersson, N., Cockcroft, A., & Shea, B. (2008). Gender-based violence and HIV: relevance for HIV prevention in hyperendemic countries of southern Africa. Aids, 22, S73-S86.

Andrade, C. (2020). Sample Size and its Importance in Research. Indian J Psychol Med, 42(1), 102-103. https://doi.org/10.4103/ijpsym.Ijpsym_504_19

Armstrong-Mensah, E., Hernandez, P., Huka, M., Suarez, A., Akosile, A., Joseph, A., & Ramsey-White, K. (2019). HIV stigma among women and adolescent girls in South Africa: removing barriers to facilitate prevention. Madridge Journal of AIDS, 3(1), 69-74.

Ashaba, S., Kaida, A., Coleman, J. N., Burns, B. F., Dunkley, E., O'Neil, K., Kastner, J., Sanyu, N., Akatukwasa, C., & Bangsberg, D. R. (2017). Psychosocial challenges facing women living with HIV during the perinatal period in rural Uganda. PLoS One, 12(5), e0176256.

Audet, C. M., McGowan, C. C., Wallston, K. A., & Kipp, A. M. (2013). Relationship between HIV stigma and self-isolation among people living with HIV in Tennessee. PLoS One, 8(8), e69564.

Avasthi, A. (2010). Preserve and strengthen family to promote mental health. Indian J Psychiatry, 52, 113-26.

Avvisati, F. (2020). The measure of socio-economic status in PISA: a review and some suggested improvements. Large-scale Assessments in Education, 8(1), 8. https://doi.org/10.1186/s40536-020-00086-x

Azia, I. N., Mukumbang, F. C., & Van Wyk, B. (2016). Barriers to adherence to antiretroviral treatment in a regional hospital in Vredenburg, Western Cape, South Africa. Southern African journal of HIV medicine, 17(1), 1-8.

Ayşe, G. & Koğar, E. Y. (2021). A Meta-Analysis Study on Gender Differences In Psychological Resilience Levels. Kıbrıs Türk Psikiyatri Ve Psikoloji Dergisi, 3, 132-143.

Babbie, E. R. (2020). The practice of social research. Cengage AU.

Baker, D. P., Leon, J., Smith Greenaway, E. G., Collins, J., & Movit, M. (2011). The education effect on population health: a reassessment. Population and development review, 37(2), 307-332.

Balogh, E. P., Miller, B. T., & Ball, J. R. (2015). Improving diagnosis in health care.

Barrow, J. M., Brannan, G. D., & Khandhar, P. B. (2017). Research ethics.

Bassett, S., Brody, L., Jack, D., Weber, K., Cohen, M., Clark, T., Dale, S., & Moskowitz, J. (2021). Feasibility and acceptability of a program to promote positive affect, well-being and gender empowerment in Black women living with HIV. AIDS and Behavior, 25, 1737-1750.

Bateganya, M. H., Amanyeiwe, U., Roxo, U., & Dong, M. (2015). Impact of support groups for people living with HIV on clinical outcomes: a systematic review of the literature. JAIDS Journal of Acquired Immune Deficiency Syndromes, 68, S368-S374.

Barnsley, J. (2016). Grounded theology: Adopting and adapting qualitative research methods for feminist theological enquiry. Feminist Theology, 24(2):109-124.

Becker, M. (1999). Patriarchy and inequality: Towards a substantive feminism. U. Chi. Legal F., 21.

Bekker, L. G., Alleyne, G., Baral, S., Cepeda, J., Daskalakis, D., Dowdy, D., Dybul, M., Eholie, S., Esom, K., Garnett, G., Grimsrud, A., Hakim, J., Havlir, D., Isbell, M. T., Johnson, L., Kamarulzaman, A., Kasaie, P., Kazatchkine, M., Kilonzo, N., . . . Beyrer, C. (2018). Advancing global health and strengthening the HIV response in the era of the Sustainable Development Goals: The International AIDS Society-Lancet Commission. Lancet, 392(10144), 312-358. https://doi.org/10.1016/s0140-6736(18)31070-5

Benoot, C., Hannes, K., & Bilsen, J. (2016). The use of purposeful sampling in a qualitative evidence synthesis: A worked example on sexual adjustment to a cancer trajectory. BMC Med Res Methodol, 16, 21. https://doi.org/10.1186/s12874-016-0114-6

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. Qualitative Research, 15(2):219-234.

Bernard, C., Font, H., Diallo, Z., Ahonon, R., Tine, J. M., N'guessan Abouo, F., Tanon, A., Messou, E., Seydi, M., Dabis, F. & De Rekeneire, N. (2020). Prevalence and factors associated with severe depressive symptoms in older west African people living with HIV. BMC Psychiatry, 20, 442

Bhatia, D. S., Harrison, A. D., Kubeka, M., Milford, C., Kaida, A., Bajunirwe, F., Wilson, I. B., Psaros, C., Safren, S. A., & Bangsberg, D. R. (2017). The role of relationship dynamics and gender inequalities as barriers to HIV-serostatus disclosure: qualitative study among women and men living with HIV in Durban, South Africa. Frontiers in public health, 5, 188.

Bhatta, D. N., & Liabsuetrakul, T. (2016). Social self-value intervention for empowerment of HIV infected people using antiretroviral treatment: a randomized controlled trial. BMC Infect Dis, 16, 272. https://doi.org/10.1186/s12879-016-1634-8

Bhatia, D. S., Harrison, A. D., Kubeka, M., Milford, C., Kaida, A., Bajunirwe, F., Wilson, I. B., Psaros, C., Safren, S. A. & Bangsberg, D. R. (2017). The role of relationship dynamics and gender inequalities as barriers to HIV-serostatus disclosure: qualitative study among women and men living with HIV in Durban, South Africa. Frontiers in public health, 5, 188.

Bless, C., Higson-Smith, C., & Kagee, A. (2007). Fundamentals of social research methods: An African perspective. (4th ed.). Cape Town, South Africa: Juta and Co, Ltd.

Birke, L. (2017). Bodies and biology. Feminist theory and the body. Routledge.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? Qual Health Res, 26(13), 1802-1811. https://doi.org/10.1177/1049732316654870

Bodalina, K. N. & Mestry, R. (2020). A case study of the experiences of women leaders in senior leadership positions in the education district offices. Educational Management Administration & Leadership, 1741143220940320.

Bogart, L. M., Shazi, Z., MacCarthy, S., Mendoza-Graf, A., Wara, N. J., Zionts, D., Dube, N., Govere, S., & Bassett, I. V. (2022). Implementation of South Africa's Central Chronic Medicine Dispensing and Distribution Program for HIV Treatment: A Qualitative Evaluation. AIDS Behav, 26(8), 2600-2612. https://doi.org/10.1007/s10461-022-03602-y

Bott, E. (2010). Favourites and others: Reflexivity and the shaping of subjectivities and data in qualitative research. Qualitative Research, 10(2):159-173.

Bouabida, K., Chaves, B. G., & Anane, E. (2023). Challenges and barriers to HIV care engagement and care cascade: viewpoint. Front Reprod Health, 5, 1201087. https://doi.org/10.3389/frph.2023.1201087

Brener, L., Broady, T., Cama, E., Hopwood, M., de Wit, J. B., & Treloar, C. (2020). The role of social support in moderating the relationship between HIV centrality, internalised stigma and psychological distress for people living with HIV. AIDS Care, 32(7), 850-857.

Brill, C. K. (2001). Looking at the social work profession through the eye of the NASW Code of Ethics. Research on social work practice, 11, 223-234.

Brito, H. L. d., & Seidl, E. M. F. (2019). Resilience of people with HIV/AIDS: influence of religious coping. Trends in Psychology, 27, 647-660.

Bryman, A. (2006). Integrating quantitative and qualitative research: how is it done? Qualitative research, 6(1), 97-113.

Buh, A., Deonandan, R., Gomes, J., Krentel, A., Oladimeji, O., & Yaya, S. (2022). Adherence barriers and interventions to improve ART adherence in Sub-Saharan African countries: A systematic review protocol. PLoS One, 17(6), e0269252.

Bulpit, H. & Martin, P.J. (2010). Qualitative research: A school nurse perspective. The Journal of School of Nursing, 22(4):212-218.

Busetto, L., Wick, W., & Gumbinger, C. (2020). How to use and assess qualitative research methods. Neurological Research and practice, 2, 1-10.

Bygrave, H., Golob, L., Wilkinson, L., Roberts, T. & Grimsrud, A. (2020). Let's talk chronic disease: can differentiated service delivery address the syndemics of HIV, hypertension, and diabetes? Current Opinion in HIV and AIDS, 15, 256-260.

Byrd, K. K., Hou, J. G., Hazen, R., Kirkham, H., Suzuki, S., Clay, P. G., Bush, T., Camp, N. M., Weidle, P. J., & Delpino, A. (2019). Antiretroviral Adherence Level Necessary for

HIV Viral Suppression Using Real-World Data. J Acquir Immune Defic Syndr, 82(3), 245-251. https://doi.org/10.1097/qai.0000000000002142

Byrne, A. (2020). Are women adult human females? Philosophical Studies, 177, 3783-3803.

Caceres, M. M. F., Sosa, J. P., Lawrence, J. A., Sestacovschi, C., Tidd-Johnson, A., Rasool, M. H. U., Gadamidi, V. K., Ozair, S., Pandav, K., & Cuevas-Lou, C. (2022). The impact of misinformation on the COVID-19 pandemic. AIMS Public Health, 9(2), 262.

Campbell, S., Greenwood, M., Prior, S., Shearer, T., Walkem, K., Young, S., Bywaters, D., & Walker, K. (2020). Purposive sampling: complex or simple? Research case examples. Journal of research in Nursing, 25(8), 652-661.

Can, Y. S., Iles-Smith, H., Chalabianloo, N., Ekiz, D., Fernández-Álvarez, J., Repetto, C., Riva, G., & Ersoy, C. (2020). How to relax in stressful situations: a smart stress reduction system. Healthcare,

Carter, S. M. & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. Qualitative health research, 17, 1316-1328.

Centers for Disease Control and Prevention [CDC]. (2020). About HIV. https://www.cdc.gov/hiv/basics/whatishiv.html#:~:text=What%20is%20HIV%3F-,HIV%20(human%20immunodeficiency%20virus)%20is%20a%20virus%20that%20attacks%20the,care%2C%20HIV%20can%20be%20controlled.

Charlesworth, M. & Foex, B. A. (2016). Qualitative research in critical care: Has its time finally come? Journal of the Intensive Care Society, 17(2):146–153.

Chaudoir, S. R., Fisher, J. D., & Simoni, J. M. (2011). Understanding HIV disclosure: A review and application of the Disclosure Processes Model. Social science & medicine, 72(10), 1618-1629.

Chen, Y., Chen, K., & Kalichman, S. C. (2017). Barriers to HIV medication adherence as a function of regimen simplification. Annals of Behavioral Medicine, 51(1), 67-78.

Chenneville, T., Gabbidon, K., Lynn, C. & Rodriguez, C. (2018). Psychological factors related to resilience and vulnerability among youth with HIV in an integrated care setting. AIDS care, 30, 5-11.

Cherutich, P., Kaiser, R., Galbraith, J., Williamson, J., Shiraishi, R. W., Ngare, C., Mermin, J., Marum, E., Bunnell, R., & Group, K. S. (2012). Lack of knowledge of HIV status a major barrier to HIV prevention, care and treatment efforts in Kenya: results from a nationally representative study. PLoS One, 7(5), e36797.

Chettimada, S., Lorenz, D. R., Misra, V., Dillon, S. T., Reeves, R. K., Manickam, C., Morgello, S., Kirk, G. D., Mehta, S. H. & Gabuzda, D. (2018). Exosome markers associated with immune activation and oxidative stress in HIV patients on antiretroviral therapy. Scientific reports, 8, 1-16.

Chibonore, W. C., & Chikadzi, V. (2017). Enablers and barriers faced by social workers in undertaking advocacy in Johannesburg, South Africa. Southern African Journal of Social Work and Social Development, 29(2), 19 pages-19 pages.

Chimoyi, L., Chikovore, J., Musenge, E., Mabuto, T., Chetty-Makkan, C. M., Munyai, R., Nchachi, T., Charalambous, S. & Setswe, G. (2022). Understanding factors influencing utilization of HIV prevention and treatment services among patients and providers in a heterogeneous setting: A qualitative study from South Africa. PLOS Glob Public Health, 2, e0000132.

Chippindale, S. & French, L. (2001). HIV counselling and the psychosocial management of patients with HIV or AIDS. Bmj, 322, 1533-5.

Chirambo, L., Valeta, M., Banda Kamanga, T. M., & Nyondo-Mipando, A. L. (2019). Factors influencing adherence to antiretroviral treatment among adults accessing care from private health facilities in Malawi. BMC public health, 19(1), 1-11.

Chirwa, G. C. (2019). Socio-economic inequality in comprehensive knowledge about HIV in Malawi. Malawi Medical Journal, 31(2), 104-111.

Choi, J. Y., Poonkasetwattana, M., & Phanuphak, N. (2023). Overcoming challenges across the HIV care continuum in the Asia-Pacific region: expert recommendations. BMJ Glob Health, 8(7). https://doi.org/10.1136/bmjgh-2023-012722

Closson, E. F., Mimiaga, M. J., Sherman, S. G., Tangmunkongvorakul, A., Friedman, R. K., Limbada, M., Moore, A. T., Srithanaviboonchai, K., Alves, C. A., & Roberts, S. (2015). Intimacy versus isolation: A qualitative study of sexual practices among sexually active HIV-infected patients in HIV care in Brazil, Thailand, and Zambia. PLoS One, 10(3), e0120957.

Closson, L. M., & Boutilier, R. R. (2017). Perfectionism, academic engagement, and procrastination among undergraduates: The moderating role of honors student status. Learning and Individual Differences, 57, 157-162.

Coates, T. J., Richter, L., & Caceres, C. (2008). Behavioural strategies to reduce HIV transmission: how to make them work better. The Lancet, 372(9639), 669-684.

Connelly, L. M. (2016). Trustworthiness in qualitative research. Medsurg nursing, 25(6), 435.

Connor, K. M., & Davidson, J. R. (2003). Development of a new resilience scale: the Connor-Davidson Resilience Scale (CD-RISC). Depress Anxiety, 18(2), 76-82. https://doi.org/10.1002/da.10113

Coulson, N. S. & Buchanan, H. (2022). The Role of Online Support Groups in Helping Individuals Affected by HIV and AIDS: Scoping Review of the Literature. J Med Internet Res, 24, e27648.

Creswell, J. W. (2014). A concise introduction to mixed methods research, SAGE publications.

Creswell, J. W. (2016). Educational research: Planning, conducting, and evaluating quantitative and qualitative research. 5thedition. River NJ Upper Saddle: Pearson Education

Creswell, J. W., & Creswell, J. D. (2017). Research design: Qualitative, quantitative, and mixed methods approaches. Sage publications.

Creswell, J.W. (2009). Research design. Qualitative, quantitative and mixed methods approaches. (3rd ed.). USA: SAGE Publications.

Crockett, K. B., Kalichman, S. C., Kalichman, M. O., Cruess, D. G., & Katner, H. P. (2019). Experiences of HIV-related discrimination and consequences for internalised stigma, depression and alcohol use. Psychology & Health, 34(7), 796-810. https://doi.org/10.1080/08870446.2019.1572143

Cucinotta, D., & Vanelli, M. (2020). WHO Declares COVID-19 a Pandemic. Acta Biomed, 91(1), 157-160. https://doi.org/10.23750/abm.v91i1.9397

Dale, S. K., & Safren, S. A. (2018). Resilience takes a village: Black women utilize support from their community to foster resilience against multiple adversities. AIDS care, 30(sup5), S18-S26.

Dale, S. K., Cohen, M. H., Kelso, G. A., Cruise, R. C., Weber, K. M., Watson, C., Burke-Miller, J. K., & Brody, L. R. (2014). Resilience among women with HIV: Impact of silencing the self and socioeconomic factors. Sex roles, 70, 221-231.

Dalrymple, J. (2013). Effective advocacy in social work.

Danforth, K., Granich, R., Wiedeman, D., Baxi, S., & Padian, N. (2017). Global mortality and morbidity of HIV/AIDS. Major infectious diseases, 6.

D'angelo, C., Reale, M. & Costantini, E. (2017). Microbiota and Probiotics in Health and HIV Infection. Nutrients, 9.

Dankar, F. K., Gergely, M., & Dankar, S. K. (2019). Informed Consent in Biomedical Research. Comput Struct Biotechnol J, 17, 463-474. https://doi.org/10.1016/j.csbj.2019.03.010

Dashu, M. (2005). Knocking down Straw Dolls: A Critique of Cynthia Eller's The Myth

David, B. (2015). What is ethics in research & why is it important?

Davies, M.A. (2020). HIV and risk of COVID-19 death: a population cohort study from the Western Cape Province, South Africa. MedRxiv, 2020.2007. 2002.20145185.

de Los Rios, P., Okoli, C., Castellanos, E., Allan, B., Young, B., Brough, G., Muchenje, M., Eremin, A., Corbelli, G. M., & McBritton, M. (2021). Physical, emotional, and psychosocial challenges associated with daily dosing of HIV medications and their impact on indicators of quality of life: findings from the positive perspectives study. AIDS and Behavior, 25, 961-972.

De Santis, J. P., Florom-Smith, A., Vermeesch, A., Barroso, S., & DeLeon, D. A. (2013). Motivation, management, and mastery: a theory of resilience in the context of HIV infection. Journal of the American Psychiatric Nurses Association, 19(1), 36-46.

De Vos, A. S., Delport, C., Fouche, C., & Strydom, H. (2011). Research at grass roots: A primer for the social science and human professions. Van Schaik Publishers.

Dejman, M., Ardakani, H. M., Malekafzali, B., Moradi, G., Gouya, M. M., Shushtari, Z. J., Alinaghi, S. A. S., & Mohraz, M. (2015). Psychological, social, and familial problems of people living with HIV/AIDS in Iran: A qualitative study. International journal of preventive medicine, 6(1), 126.

Denzin, N. K., & Lincoln, Y. S. (2011). The Sage handbook of qualitative research. sage.

Department of Health Tier.net. (2022).

Dhakal, R. K. (2016). Responsible practice of research: Safeguarding research integrity and publication ethics. Journal of education and research, 6(2), 1-11.

Dilli, S., Carmichael, S. G., & Rijpma, A. (2019). Introducing the historical gender equality index. Feminist Economics, 25(1), 31-57.

Diress, G., Dagne, S., Alemnew, B., Adane, S., & Addisu, A. (2020). Viral Load Suppression after Enhanced Adherence Counseling and Its Predictors among High Viral Load HIV Seropositive People in North Wollo Zone Public Hospitals, Northeast Ethiopia, 2019: Retrospective Cohort Study. AIDS Res Treat, 2020, 8909232. https://doi.org/10.1155/2020/8909232

Dixon, H. (2021). To what extent is a meaningful life an integrated one?, Birkbeck, University of London.

Dixon, S., McDonald, S., & Roberts, J. (2002). The impact of HIV and AIDS on Africa's economic development. Bmj, 324(7331), 232-234.

Donald, K. A., Fernandez, A., Claborn, K., Kuo, C., Koen, N., Zar, H., & Stein, D. J. (2017). The developmental effects of HIV and alcohol: a comparison of gestational outcomes among babies from South African communities with high prevalence of HIV and alcohol use. AIDS research and therapy, 14, 1-10.

Doody, O., & Bailey, M. E. (2016). Setting a research question, aim and objective. Nurse researcher, 23(4).

Douaihy, A., Grubisha, M., Lyon, M. & Ann, M. (2017). Stress disorder: The Special role in HIV transmission. Comprehensive Textbook of AIDS Psychiatry: A Paradigm for Integrated Care.

Dubois, E. C. (2019). Chapter Six. The Fifteenth Amendment and the Emergence of Independent Suffragism. Feminism and Suffrage. Cornell University Press.

Duggal, S., Chugh, T. D., & Duggal, A. K. (2012). HIV and malnutrition: effects on immune system. Journal of Immunology Research, 2012.

Dulin, A. J., Dale, S. K., Earnshaw, V. A., Fava, J. L., Mugavero, M. J., Napravnik, S., Hogan, J. W., Carey, M. P., & Howe, C. J. (2018). Resilience and HIV: a review of the definition and study of resilience. AIDS care, 30(sup5), S6-S17.

Dunkle, K., Jewkes, R., Brown, H., McIntyre, J., Gray, G., & Harlow, S. (2003). Gender-based violence and HIV infection among pregnant women in Soweto. Gender and Health Group, Men on relationships with and abuse of women, Medical Research Council Technical Report, Medical Research Council, Tygerberg.

Durvasula, R. & Miller, T. R. (2014). Substance abuse treatment in persons with HIV/AIDS: challenges in managing triple diagnosis. Behav Med, 40, 43-52.

Earnshaw, V. A., & Chaudoir, S. R. (2009). From conceptualizing to measuring HIV stigma: a review of HIV stigma mechanism measures. AIDS and Behavior, 13, 1160-1177.

Earnshaw, V. A., Bogart, L. M., Dovidio, J. F. & Williams, D. R. (2013). Stigma and racial/ethnic HIV disparities: moving toward resilience. Am Psychol, 68, 225-36.

Earnshaw, V. A., Bogart, L. M., Dovidio, J. F., & Williams, D. R. (2015). Stigma and racial/ethnic HIV disparities: moving toward resilience.

Earnshaw, V. A., Kidman, R. C. & Violari, A. (2018). Stigma, depression, and substance use problems among perinatally HIV-infected youth in South Africa. AIDS and Behavior, 22, 3892-3896.

Earnshaw, V. A., Quinn, D. M., & Park, C. L. (2012). Anticipated stigma and quality of life among people living with chronic illnesses. Chronic Illn, 8(2), 79-88. https://doi.org/10.1177/1742395311429393

Ebrahimi Kalan, M., Han, J., Ben Taleb, Z., Fennie, K. P., Asghari Jafarabadi, M., Dastoorpoor, M., Hajhashemi, N., Naseh, M., & Rimaz, S. (2019). Quality of life and stigma among people living with HIV/AIDS in Iran. HIV/AIDS-Research and Palliative Care, 287-298.

Ej, W. (2017). - The Aging Population with HIV Infection. Trans Am Clin Climatol Assoc, 128, 131-144.

Ekstrand, M. L., Bharat, S., Ramakrishna, J., & Heylen, E. (2012). Blame, symbolic stigma and HIV misconceptions are associated with support for coercive measures in urban India. AIDS and Behavior, 16, 700-710.

Eldredge, J. D., Weagel, E. F., & Kroth, P. J. (2014). Defining and Identifying Members of a Research Study Population: CTSA-Affiliated Faculty Members. Hypothesis (Macon), 26(1), 5-11.

El-Mallakh, P. & Findlay, J. (2015). Strategies to improve medication adherence in patients with schizophrenia: the role of support services. Neuropsychiatr Dis Treat, 11, 1077-90.

Elmir, R., Schmied, V., Jackson, D., & Wilkes, L. (2011). Interviewing people about potentially sensitive topics. Nurse researcher, 19(1).

Emery, A., & Anderman, L. H. (2020). Using interpretive phenomenological analysis to advance theory and research in educational psychology. Educational Psychologist, 55(4), 220-231.

Emlet, C. A., Harris, L., Furlotte, C., Brennan, D. J. & Pierpaoli, C. M. (2017). ‘I'm happy in my life now, I'm a positive person’: approaches to successful ageing in older adults living with HIV in Ontario, Canada. Ageing & society, 37, 2128-2151.

Engle, M. (2015). Book review: Qualitative data analysis: A methods sourcebook: The coding manual for qualitative researchers. In: Sage Publications Sage CA: Los Angeles, CA.

Enoos, B. (2023). Supply chain analysis: A case study of differentiated physical distribution for chronic medicines in the public health sector of South Africa Stellenbosch: Stellenbosch University].

Escalante, L. E., Maisonnave, H., & Chitiga, M. R. (2021). Do South African fiscal reforms benefit women? Applied Economics, 53(6), 719-729.

Etikan, I., & Bala, K. (2017). Sampling and sampling methods. Biometrics & Biostatistics International Journal, 5(6), 00149.

Evans, T. R., Burns, C., Essex, R., Finnerty, G., Hatton, E., Clements, A. J., Breau, G., Quinn, F., Elliott, H., Smith, L. D., Matthews, B., Jennings, K., Crossman, J., Williams, G., Miller, D., Harold, B., Gurnett, P., Jagodzinski, L., Smith, J., . . . Weldon, S. (2023). A systematic scoping review on the evidence behind debriefing practices for the wellbeing/emotional outcomes of healthcare workers. Front Psychiatry, 14, 1078797. https://doi.org/10.3389/fpsyt.2023.1078797

Farrugia, P., Petrisor, B. A., Farrokhyar, F., & Bhandari, M. (2010). Practical tips for surgical research: Research questions, hypotheses and objectives. Can J Surg, 53(4), 278-281.

Fauci, A. S. & Lane, H. C. (2020). Four decades of HIV/AIDS—much accomplished, much to do. New England Journal of Medicine, 383, 1-4.

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

Ferguson, K. E. (2017). Feminist theory today. Annual Review of Political Science, 20, 269-286.

Fleming, J., & Zegwaard, K. E. (2018). Methodologies, methods and ethical considerations for conducting research in work-integrated learning. International Journal of Work-Integrated Learning, 19(3), 205-213.

Fletcher, F. E., Sherwood, N. R., Rice, W. S., Yigit, I., Ross, S. N., Wilson, T. E., Weiser, S. D., Johnson, M. O., Kempf, M.-C., & Konkle-Parker, D. (2020). Resilience and HIV treatment outcomes among women living with HIV in the United States: a mixed-methods analysis. AIDS patient care and STDs, 34(8), 356-366.

Flickinger, T. E., Berry, S., Korthuis, P. T., Saha, S., Laws, M. B., Sharp, V., Moore, R. D., & Beach, M. C. (2013). Counseling to reduce high-risk sexual behavior in HIV care: a multi-center, direct observation study. AIDS patient care and STDs, 27(7), 416-424.

Fox, A. M., Jackson, S. S., Hansen, N. B., Gasa, N., Crewe, M. & Sikkema, K. J. (2007). In their own voices: a qualitative study of women's risk for intimate partner violence and HIV in South Africa. Violence against women, 13, 583-602.

Gamassa, E., Steven, E., Mtei, R., & Kaaya, S. (2023). Prevalence of Depression and Suicidal Ideation and Associated Risk Factors in Adolescents Receiving Care and Treatment for Hiv/Aids at a Tertiary Health Facility in Kilimanjaro Region, Tanzania. Research Square.

Ganong, L. & Coleman, M. (2014). Qualitative research on family relationships. Journal of Social and Personal Relationships, 31(4):451-459.

García, P. J., Bayer, A., & Cárcamo, C. P. (2014). The changing face of HIV in Latin America and the Caribbean. Curr HIV/AIDS Rep, 11(2), 146-157. https://doi.org/10.1007/s11904-014-0204-1

Garg, R. (2016). Methodology for research I. Indian J Anaesth, 60(9), 640-645. https://doi.org/10.4103/0019-5049.190619

Garmezy, N. (1993). Children in poverty: Resilience despite risk. Psychiatry, 56, 127-136.

Gayle, H. D. & Hill, G. L. (2001). Global impact of Human Immunodeficiency Virus and AIDS. Clin Microbiol Rev, 14, 327-35.

Gibson, W. & Brown, A. (2009). Working with qualitative data. London. SAGE Publications Ltd.

Gilchrist, G., Gruer, L., & Atkinson, J. (2005). Comparison of drug use and psychiatric morbidity between prostitute and non-prostitute female drug users in Glasgow, Scotland. Addictive behaviors, 30(5), 1019-1023.

Gill, M. M., Ndimbii, J. N., Otieno-Masaba, R., Ouma, M., Jabuto, S., & Ochanda, B. (2022). Adherence challenges and opportunities for optimizing care through enhanced adherence counseling for adolescents with suspected HIV treatment failure in Kenya. BMC health services research, 22(1), 962.

Ginsburg, K. (2016). What is Resilience? Ashland, MA: Decisions at Every Turn Coalition. Retrieved from https://www ….

Girum, T., Wasie, A., Lentiro, K., Muktar, E., Shumbej, T., Difer, M., Shegaze, M., & Worku, A. (2018). Gender disparity in epidemiological trend of HIV/AIDS infection and treatment in Ethiopia. Arch Public Health, 76, 51. https://doi.org/10.1186/s13690-018-0299-8

Goffman, E. (2014). Stigma and social identity. In Understanding Deviance (pp. 256-265). Routledge.

Golub, S. A. & Gamarel, K. E. (2013). The impact of anticipated HIV stigma on delays in HIV testing behaviors: findings from a community-based sample of men who have sex with men and transgender women in New York City. AIDS Patient Care STDS, 27, 621-7.

Gomm, R. (2008). Social research methodology: A critical introduction. 2nd ed. Basingstoke, Hampshire; New York: Palgrave Macmillan.

Goodman, S. H., Rouse, M. H., Connell, A. M., Broth, M. R., Hall, C. M., & Heyward, D. (2011). Maternal depression and child psychopathology: A meta-analytic review. Clinical child and family psychology review, 14, 1-27.

Goundar, S. (2012). Chapter 3-Research Methodology and Research Method. Cloud Computing. Research Gate Publications.

Govender, R. D., Hashim, M. J., Khan, M. A., Mustafa, H., & Khan, G. (2021). Global Epidemiology of HIV/AIDS: A Resurgence in North America and Europe. J Epidemiol Glob Health, 11(3), 296-301. https://doi.org/10.2991/jegh.k.210621.001

Gumbo, F., Duri, K., Kandawasvika, G., Kurewa, N., Mapingure, M., Munjoma, M., Rusakaniko, S., Chirenje, M., & Stray-Pedersen, B. (2010). Risk factors of HIV vertical transmission in a cohort of women under a PMTCT program at three peri-urban clinics in a resource-poor setting. Journal of Perinatology, 30(11), 717-723.

Günthard, H. F., Saag, M. S., Benson, C. A., Del Rio, C., Eron, J. J., Gallant, J. E., Hoy, J. F., Mugavero, M. J., Sax, P. E., & Thompson, M. A. (2016). Antiretroviral drugs for treatment and prevention of HIV infection in adults: 2016 recommendations of the International Antiviral Society–USA panel. Jama, 316(2), 191-210.

Gupta, U. C. (2013). Informed consent in clinical research: Revisiting few concepts and areas. Perspect Clin Res, 4(1), 26-32. https://doi.org/10.4103/2229-3485.106373

Hand, G. A., Lyerly, G. W., Jaggers, J. R., & Dudgeon, W. D. (2009). Impact of aerobic and resistance exercise on the health of HIV-infected persons. American journal of lifestyle medicine, 3(6), 489-499.

Harris, D. E., Holyfield, L., Jones, L., Ellis, R. & Neal, J. (2019). Spiritually and Developmentally Mature Leadership: Towards an Expanded Understanding of Leadership in the 21st Century, Springer.

Harrison, S. E., Li, X., & Vermund, S. H. (2019). From surviving to thriving: the role of resilience in meeting global HIV goals. Aids, 33, S1-S4.

Hassen, F. & Deyassa, N. (2013). The relationship between sexual violence and human immunodeficiency virus (HIV) infection among women using voluntary counseling and testing services in South Wollo Zone, Ethiopia. BMC Res Notes, 6, 271.

Hay, K., McDougal, L., Percival, V., Henry, S., Klugman, J., Wurie, H., Raven, J., Shabalala, F., Fielding-Miller, R., & Dey, A. (2019). Disrupting gender norms in health systems: making the case for change. The Lancet, 393(10190), 2535-2549.

Heale, R. & Noble, H. (2019). Integration of a theoretical framework into your research study. Royal College of Nursing.

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

Hennink-Kaminski, H.J., Willoughby, J.F. & McMahan, D. (2014). Join the conquest: Developing a campaign to increase participation in clinical research in North Carolina. Science Communication, 36(1):30–55.

Hirani, S., Lasiuk, G., & Hegadoren, K. (2016). The intersection of gender and resilience. Journal of psychiatric and mental health nursing.

Hlongwana, S. I., & Gray, A. L. (2022). Barriers and facilitators to medicine collection through the CCMDD programme at a Durban Hospital. Health SA Gesondheid (Online), 27, 1-10.

Holland, K. & Rees, C. (2010). Nursing: Evidence-based practice skills. New York. Oxford University Press.

Höltge, J., Theron, L., Cowden, R. G., Govender, K., Maximo, S. I., Carranza, J. S., Kapoor, B., Tomar, A., van Rensburg, A., & Lu, S. (2021). A cross-country network analysis of adolescent resilience. Journal of Adolescent Health, 68(3), 580-588.

Hu, J., Stauvermann, P.-J., Nepal, S., & Zhou, Y. (2023). Can the Policy of Increasing Retirement Age Raise Pension Revenue in China—A Case Study of Anhui Province. International Journal of Environmental Research and Public Health, 20(2), 1096.

Huang, F., Chen, W.-T., Shiu, C., Sun, W., Candelario, J., Luu, B. V., & Ah-Yune, J. (2021). Experiences and needs of family support for HIV-infected Asian Americans: A qualitative dyadic analysis. Applied Nursing Research, 58, 151395.

Hurley, K. (2020). What is resilience? Your guide to facing life’s challenges, adversities, and crises. Everyday Health, 10.

Hurst, S. A., Appelgren, K. E., & Kourtis, A. P. (2015). Prevention of mother-to-child transmission of HIV type 1: the role of neonatal and infant prophylaxis. Expert review of anti-infective therapy, 13(2), 169-181.

Hutchison, W. D. (2020). Sequential sampling to determine population density. Handbook of sampling methods for arthropods in agriculture, 207-243.

Huynh, K., Vaqar, S., & Gulick, P. G. (2024). HIV Prevention. In StatPearls. StatPearls Publishing

Iacob, S. A., Iacob, D. G., & Jugulete, G. (2017). Improving the adherence to antiretroviral therapy, a difficult but essential task for a successful HIV treatment—clinical points of view and practical considerations. Frontiers in pharmacology, 8, 299234.

Ignatowicz, A., Odland, M. L., Bockarie, T., Wurie, H., Ansumana, R., Kelly, A. H., Willott, C., Witham, M., & Davies, J. (2020). Knowledge and understanding of cardiovascular disease risk factors in Sierra Leone: A qualitative study of patients’ and community leaders’ perceptions. BMJ open, 10(12), e038523.

In, J. (2017). Introduction of a pilot study. Korean J Anesthesiol, 70(6), 601-605. https://doi.org/10.4097/kjae.2017.70.6.601

International Labour Organization. (2017). The gender gap in employment: What's holding women back?. Retrieved from https://www.ilo.org/infostories/en-GB/Stories/Employment/barriers-women#intro.

Ion, A., Greene, S., Mellor, K., Kwaramba, G., Smith, S., Barry, F., Kennedy, V. L., Carvalhal, A., Loutfy, M., & Team, H. M. S. (2016). Perinatal care experiences of mothers living with HIV in Ontario, Canada. Journal of HIV/AIDS & Social Services, 15(2), 180-201.

Iryawan, A. R., Stoicescu, C., Sjahrial, F., Nio, K., & Dominich, A. (2022). The impact of peer support on testing, linkage to and engagement in HIV care for people who inject drugs in Indonesia: qualitative perspectives from a community-led study. Harm Reduct J, 19(1), 16. https://doi.org/10.1186/s12954-022-00595-8

Izugbara, C. O., Obiyan, M. O., Degfie, T. T. & Bhatti, A. (2020). Correlates of intimate partner violence among urban women in sub-Saharan Africa. PLoS One, 15, e0230508.

Jager, J., Putnick, D. L., & Bornstein, M. H. (2017). II. MORE THAN JUST CONVENIENT: THE SCIENTIFIC MERITS OF HOMOGENEOUS CONVENIENCE SAMPLES. Monogr Soc Res Child Dev, 82(2), 13-30. https://doi.org/10.1111/mono.12296

Jamshed, S. (2014). Qualitative research method-interviewing and observation. J Basic Clin Pharm, 5(4), 87-88. https://doi.org/10.4103/0976-0105.141942

Jayaweera, M., Perera, H., Gunawardana, B., & Manatunge, J. (2020). Transmission of COVID-19 virus by droplets and aerosols: A critical review on the unresolved dichotomy. Environ Res, 188, 109819. https://doi.org/10.1016/j.envres.2020.109819

Jia, W., Jiao, K., Ma, J., Liao, M., Wang, C., Kang, D., Lin, Y., Yan, Y., Li, Y., & Cheng, C. (2022). HIV infection disclosure, treatment self-efficacy and quality of life in HIV-infected MSM receiving antiretroviral therapy. BMC Infectious Diseases, 22(1), 937.

John, C. P. (2020). Methodology Appraisal of Experimental Research Studies in Mathematics Teaching. Asia Proceedings of Social Sciences, 5(1), 40-45.

Joint United Nations Programme on HIV/AIDS. (2022). Facts and figures: Economic empowerment. Last Updated July.

Kaiser, K. (2009). Protecting respondent confidentiality in qualitative research. Qual Health Res, 19(11), 1632-1641. https://doi.org/10.1177/1049732309350879

Kanekar, A. S. (2011). HIV/AIDS Counseling Skills and Strategies: Can Testing and Counseling Curb the Epidemic? Int J Prev Med, 2, 10-4.

Kang, L., Ma, S., Chen, M., Yang, J., Wang, Y., Li, R., Yao, L., Bai, H., Cai, Z. & Yang, B. X. (2020). Impact on mental health and perceptions of psychological care among medical and nursing staff in Wuhan during the 2019 novel coronavirus disease outbreak: A cross-sectional study. Brain, behavior, and immunity, 87, 11-17.

Kanters, S., Park, J. J., Chan, K., Ford, N., Forrest, J., Thorlund, K., Nachega, J. B., & Mills, E. J. (2016). Use of peers to improve adherence to antiretroviral therapy: A global network meta-analysis. Journal of the International AIDS Society, 19(1), 21141.

Kapetanovic, S., Dass-Brailsford, P., Nora, D. & Talisman, N. (2014). Mental health of HIV-seropositive women during pregnancy and postpartum period: a comprehensive literature review. AIDS and Behavior, 18, 1152-1173.

Karanja, L. (2003). Just Die Quietly, Domestic Violence and Women's Vulnerability to HIV in Uganda, Human Rights Watch.

Karim, Q. A., Sibeko, S., & Baxter, C. (2010). Preventing HIV infection in women: a global health imperative. Clinical Infectious Diseases, 50(Supplement_3), S122-S129.

Katz, I. T., Essien, T., Marinda, E. T., Gray, G. E., Bangsberg, D. R., Martinson, N. A., & De Bruyn, G. (2011). Antiretroviral therapy refusal among newly diagnosed HIV-infected adults. Aids, 25(17), 2177-2181. https://doi.org/10.1097/QAD.0b013e32834b6464

Kerrigan, D., Kennedy, C. E., Morgan-Thomas, R., Reza-Paul, S., Mwangi, P., Win, K. T., McFall, A., Fonner, V. A., & Butler, J. (2015). A community empowerment approach to the HIV response among sex workers: effectiveness, challenges, and considerations for implementation and scale-up. The Lancet, 385(9963), 172-185.

Kharsany, A. B., & Karim, Q. A. (2016). HIV Infection and AIDS in Sub-Saharan Africa: Current Status, Challenges and Opportunities. Open AIDS J, 10, 34-48. https://doi.org/10.2174/1874613601610010034

King, D. D., Newman, A., & Luthans, F. (2016). Not if, but when we need resilience in the workplace. Journal of organizational behavior, 37(5), 782-786.

Kitahata, M. M., Tegger, M. K., Wagner, E. H., & Holmes, K. K. (2002). Comprehensive health care for people infected with HIV in developing countries. Bmj, 325(7370), 954-957.

Klaas, N. E., Thupayagale-Tshweneagae, G., & Makua, T. P. (2018). The role of gender in the spread of HIV and AIDS among farmworkers in South Africa. African Journal of Primary Health Care and Family Medicine, 10(1), 1-8.

Knight, L., & Schatz, E. (2022). Social Support for Improved ART Adherence and Retention in Care among Older People Living with HIV in Urban South Africa: A Complex Balance between Disclosure and Stigma. Int J Environ Res Public Health, 19(18). https://doi.org/10.3390/ijerph191811473

Ko, H. C., Wang, L. L., & Xu, Y. T. (2013). Understanding the different types of social support offered by audience to A-list diary-like and informative bloggers. Cyberpsychol Behav Soc Netw, 16(3), 194-199. https://doi.org/10.1089/cyber.2012.0297

Kontomanolis, E. N., Michalopoulos, S., Gkasdaris, G., & Fasoulakis, Z. (2017). The social stigma of HIV–AIDS: society’s role. HIV/AIDS-Research and Palliative Care, 111-118.

Krefting, L. (1991). Rigor in qualitative research: The assessment of the trustworthiness. The American Journal of Occupational Therapy 45(3).

Krist, A. H., Tong, S. T., Aycock, R. A., & Longo, D. R. (2017). Engaging patients in decision-making and behavior change to promote prevention. Information Services & Use, 37(2), 105-122.

Kumar, R. (2018). Research methodology: A step-by-step guide for beginners. Research methodology, 1-528.

Kumarasamy, N., Safren, S. A., Raminani, S. R., Pickard, R., James, R., Krishnan, A. S., Solomon, S., & Mayer, K. H. (2005). Barriers and facilitators to antiretroviral medication adherence among patients with HIV in Chennai, India: a qualitative study. AIDS Patient Care & STDs, 19(8), 526-537.

Kutnick, A. H., Gwadz, M. V., Cleland, C. M., Leonard, N. R., Freeman, R., Ritchie, A. S., McCright-Gill, T., Ha, K., & Martinez, B. Y. (2017). It's a Process: Reactions to HIV Diagnosis and Engagement in HIV Care among High-Risk Heterosexuals. Front Public Health, 5, 100. https://doi.org/10.3389/fpubh.2017.00100

Kvarnström, K., Westerholm, A., Airaksinen, M., & Liira, H. (2021). Factors Contributing to Medication Adherence in Patients with a Chronic Condition: A Scoping Review of Qualitative Research. Pharmaceutics, 13(7). https://doi.org/10.3390/pharmaceutics13071100

Kwena, Z. A., Njuguna, S. W., Ssetala, A., Seeley, J., Nielsen, L., De Bont, J., Bukusi, E. A., & Team, L. V. C. f. H. R. (2019). HIV prevalence, spatial distribution and risk factors for HIV infection in the Kenyan fishing communities of Lake Victoria. PLoS One, 14(3), e0214360.

LaGrange, R. D., Mitchell, S. J., Lewis, M., Abramowitz, S., & D'Angelo, L. J. (2012). Health protective behaviors among young people living with HIV/AIDS. Journal of AIDS & clinical research (13).

Lahai, M., Theobald, S., Wurie, H. R., Lakoh, S., Erah, P. O., Samai, M., & Raven, J. (2022). Factors influencing adherence to antiretroviral therapy from the experience of people living with HIV and their healthcare providers in Sierra Leone: a qualitative study. BMC Health Serv Res, 22(1), 1327. https://doi.org/10.1186/s12913-022-08606-x

Lai, C. C., Shih, T. P., Ko, W. C., Tang, H. J., & Hsueh, P. R. (2020). Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and coronavirus disease-2019 (COVID-19): The epidemic and the challenges. Int J Antimicrob Agents, 55(3), 105924. https://doi.org/10.1016/j.ijantimicag.2020.105924

Lancaster, K. {2017). Confidentiality, anonymity, and power relations in elite interviewing: conducting qualitative policy research in a politicized domain. International Journal of Social Research Methodology, 20, 93-103.

Lapan, S. D., Quartaroli, M. T. & Riemer, F. J. (2012). Qualitative research: An introduction to methods and designs, Jossey-Bass/Wiley.

Lara, M. A., Le, H.-N., Letechipia, G., & Hochhausen, L. (2009). Prenatal depression in Latinas in the US and Mexico. Maternal and child health Journal, 13, 567-576.

Latkin, C. A., German, D., Vlahov, D., & Galea, S. (2013). Neighborhoods and HIV: a social ecological approach to prevention and care. American Psychologist, 68(4), 210.

Leddy, A. M., Weiss, E., Yam, E., & Pulerwitz, J. (2019). Gender-based violence and engagement in biomedical HIV prevention, care and treatment: a scoping review. BMC public health, 19(1), 897. https://doi.org/10.1186/s12889-019-7192-4

Lederman, N. G. & Lederman, J. S. (2015). What is a theoretical framework? A practical answer. Taylor & Francis.

Ledesma, J. (2014). Conceptual Frameworks and Research Models on Resilience in Leadership. SAGE Open, 4(3), 2158244014545464. https://doi.org/10.1177/2158244014545464

Ledesma, J. R., Ma, J., Vongpradith, A., Maddison, E. R., Novotney, A., Biehl, M. H., LeGrand, K. E., Ross, J. M., Jahagirdar, D., & Bryazka, D. (2022). Global, regional, and national sex differences in the global burden of tuberculosis by HIV status, 1990–2019: results from the Global Burden of Disease Study 2019. The lancet infectious diseases, 22(2), 222-241.

Lee, S., Yamazaki, M., Harris, D. R., Harper, G. W., & Ellen, J. (2015). Social support and human immunodeficiency virus-status disclosure to friends and family: implications for human immunodeficiency virus-positive youth. Journal of Adolescent Health, 57(1), 73-80.

Lekganyane, M. R. & Manganyi, T. S. (2023). An ecological systems approach to the difficulties faced by social workers in community home-based care organisations for people living with HIV. Health Psychol Behav Med, 11, 2236181.

Lesch, E. & Furphy, C. (2013). South African adolescents ‘constructions of intimacy in romantic relationships. Journal of Adolescent Research, 28(6):619-641.

Li, L., Liang, L.-J., Lin, C., Wu, Z., Rotheram-Borus, M. J., & Group, N. C. H. S. P. T. (2010). HIV prevention intervention to reduce HIV-related stigma: evidence from China. Aids, 24(1), 115-122.

Li, L., Wu, S., Wu, Z., Sun, S., Cui, H. & Jia, M. (2006). Understanding family support for people living with HIV/AIDS in Yunnan, China. AIDS Behav, 10, 509-17.

Li, P. (2020). Resilience theory in psychology (definition & characteristics). Parenting For Brain.

Li, Y., Zhang, X.-W., Liao, B., Liang, J., He, W.-J., Liu, J., Yang, Y., Zhang, Y.-H., Ma, T., & Wang, J.-Y. (2021). Social support status and associated factors among people living with HIV/AIDS in Kunming city, China. BMC public health, 21, 1-6.

Liebenberg, L. & Moore, J. C. (2018). A social ecological measure of resilience for adults: The RRC-ARM. Social Indicators Research, 136, 1-19.

Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. New directions for program evaluation, 1986(30), 73-84.

Lopes, K. G., Farinatti, P., de Oliveira Lopes, G., Paz, G. A., Bottino, D. A., de Oliveira, R. B., Bouskela, E., & Borges, J. P. (2021). Muscle mass, strength, bone mineral density and vascular function in middle-aged people living with HIV vs. age-matched and older controls. The Brazilian Journal of Infectious Diseases, 25(6), 101654.

Loraine, B., Wick, W., & Christoph, G. (2020). How to use and assess qualitative research methods. Neurological Research and practice, 2(1).

LoVette, A., Sullivan, A., Kuo, C., Operario, D., Harrison, A., & Mathews, C. (2023). Examining Associations Between Resilience and Sexual Health Among South African Girls and Young Women Living with and Without HIV. AIDS Educ Prev, 35(1), 1-13. https://doi.org/10.1521/aeap.2023.35.1.1

Lowe, N. K. (2019). What is a pilot study? Journal of Obstetric, Gynecologic & Neonatal Nursing, 48(2), 117-118.

Mabachi, N. M., Brown, M., Sandbulte, M., Wexler, C., Goggin, K., Maloba, M., & Finocchario-Kessler, S. (2020). Using a social support framework to understand how HIV positive kenyan men engage in PMTCT/EID care: qualitative insights from male partners. AIDS and Behavior, 24, 18-28.

Mabaso, M., Makola, L., Naidoo, I., Mlangeni, L., Jooste, S. & Simbayi, L. (2019). HIV prevalence in South Africa through gender and racial lenses: results from the 2012 population-based national household survey. International journal for equity in health, 18, 1-11.

Mack, N., Woodsongs, C. MacQueen, K. Guest, G. & Namey, E. (2005). Qualitative research methods: A data collector's field guide. Family Health International.2(7) 493-503.

Mackay, K. (2020). The 'tyranny of reproduction': Could ectogenesis further women's liberation? Bioethics, 34, 346-353.

Maclean, J. R. & Wetherall, K. (2021). The association between HIV-stigma and depressive symptoms among people living with HIV/AIDS: A systematic review of studies conducted in South Africa. Journal of affective disorders, 287, 125-137.

Maclean, K. (2004). Resilience: What it is and how children and young people can be helped to develop it. Online Journal of the International Child and Youth Care Network, 62.

Madhav, N., Oppenheim, B., Gallivan, M., Mulembakani, P., Rubin, E., & Wolfe, N. (2017). Pandemics: risks, impacts, and mitigation. Disease control priorities: improving health and reducing poverty. 3rd edition.

Madiba, S. & Canti-Sigaqa, V. (2012). Barriers to participate in support groups for people living with HIV: a qualitative study with men receiving antiretroviral treatment in a HIV clinic in Mthatha, South Africa. Glob J Health Sci, 4, 119-28.

Magaldi, D. & Berler, M. (2020). Semi-structured interviews. Encyclopedia of personality and individual differences, 4825-4830.

Maher, C., Hadfield, M., Hutchings, M., & De Eyto, A. (2018). Ensuring rigor in qualitative data analysis: A design research approach to coding combining NVivo with traditional material methods. International journal of qualitative methods, 17(1), 1609406918786362.

Majid, U. (2018). Research Fundamentals: Study Design, Population, and Sample Size. Undergraduate Research in Natural and Clinical Science and Technology (URNCST) Journal, 2. doi:10.26685/urncst.16

Malmqvist, J., Hellberg, K., Möllås, G., Rose, R., & Shevlin, M. (2019). Conducting the pilot study: A neglected part of the research process? Methodological findings supporting the importance of piloting in qualitative research studies. International journal of qualitative methods, 18, 1609406919878341.

Maman, S., van Rooyen, H., & Groves, A. K. (2014). HIV status disclosure to families for social support in South Africa (NIMH Project Accept/HPTN 043). AIDS care, 26(2), 226-232. https://doi.org/10.1080/09540121.2013.819400

Manganyi, T. S. (2021). The challenges faced by social workers working in HIV/AIDS home-based care.

Mannell, J., Willan, S., Shahmanesh, M., Seeley, J., Sherr, L., & Gibbs, A. (2019). Why interventions to prevent intimate partner violence and HIV have failed young women in southern Africa. Journal of the International AIDS Society, 22(8), e25380.

Manso-Córdoba, S., Pickering, S., Ortega, M. A., Asúnsolo, Á., & Romero, D. (2020). Factors Related to Seeking Help for Postpartum Depression: A Secondary Analysis of New York City PRAMS Data. Int J Environ Res Public Health, 17(24). https://doi.org/10.3390/ijerph17249328

Manzou, R., Schumacher, C., & Gregson, S. (2014). Temporal dynamics of religion as a determinant of HIV infection in East Zimbabwe: a serial cross-sectional analysis. Plos one, 9(1), e86060.

Martínez-Mesa, J., González-Chica, D. A., Duquia, R. P., Bonamigo, R. R., & Bastos, J. L. (2016). Sampling: how to select participants in my research study? An Bras Dermatol, 91(3), 326-330. https://doi.org/10.1590/abd1806-4841.20165254

Marutlulle, N. (2017). Causes of informal settlements in Ekurhuleni Metropolitan Municipality: An exploration. Africa's Public Service Delivery and Performance Review, 5(1), 1-11.

Maseko, Y., & Madiba, S. (2020). Pain, Anger, and the Fear of Being Discovered Persist Long after the Disclosure of HIV Serostatus among Adolescents with Perinatal HIV in

Rural Communities in South Africa. Children (Basel), 7(12). https://doi.org/10.3390/children7120261

Maxwell, J. A. (2013). Qualitative research design: An interactive approach (applied social research methods) (p. 232). Thousand Oaks, CA: Sage.

Mazambara, F., Chagwena, D., Mudzviti, T., Sithole, S., Monera-Penduka, T., Maponga, C. C., & Morse, G. D. (2022). Utility of HIV support groups in advancing implementation research in resource-limited settings: experiences from an urban-setting HIV support group in Zimbabwe. AIDS research and therapy, 19(1), 7.

Mburu, G., Hodgson, I., Kalibala, S., Haamujompa, C., Cataldo, F., Lowenthal, E. D., & Ross, D. (2014). Adolescent HIV disclosure in Zambia: barriers, facilitators and outcomes. African Journal of Reproduction and Gynaecological Endoscopy, 17(1).

Mcgrath, C., Palmgren, P. J. & Liljedahl, M. (2019). Twelve tips for conducting qualitative research interviews. Medical teacher, 41, 1002-1006.

McKim, C. (2023). Meaningful member-checking: a structured approach to member-checking. American Journal of Qualitative Research, 7(2), 41-52.

McKinley, C. E., Lilly, J. M., Knipp, H., & Liddell, J. L. (2021). “A dad can get the money and the mom stays at home”: Patriarchal gender role attitudes, intimate partner violence, historical oppression, and resilience among indigenous peoples. Sex roles, 85(9-10), 499-514.

Meeks, J., & Jones, E. (2020). HIV diagnosis: The impact on mental health and wellbeing. In Psychological Perspectives in HIV Care (pp. 64-79). Routledge.

Melville, A., & Hincks, D. (2016). Conducting sensitive interviews: A review of reflections. Law and Method, 1(1), 1-26.

Mendy, J. (2022). Bouncing back from workplace stress: From HRD’s individual employee’s developmental focus to multi-facetted collective workforce resilience intervention. Advances in Developing Human Resources, 22(4), 353-369.

Miyamoto, Y., Yoo, J., Levine, C. S., Park, J., Boylan, J. M., Sims, T., Markus, H. R., Kitayama, S., Kawakami, N., & Karasawa, M. (2018). Culture and social hierarchy: Self- and other-oriented correlates of socioeconomic status across cultures. Journal of personality and social psychology, 115(3), 427.

Modak, A., Ronghe, V., Gomase, K. P., Mahakalkar, M. G., & Taksande, V. (2023). A Comprehensive Review of Motherhood and Mental Health: Postpartum Mood Disorders in Focus. Cureus, 15(9), e46209. https://doi.org/10.7759/cureus.46209

Mohajan, H. (2022). An Overview on the Feminism and Its Categories.

Mokhele, I., Nattey, C., Jinga, N., Mongwenyana, C., Fox, M. P., & Onoya, D. (2019). Prevalence and predictors of postpartum depression by HIV status and timing of HIV diagnosis in Gauteng, South Africa. PLoS One, 14(4), e0214849.

Montagnier, L. (2002). A history of HIV discovery. Science, 298, 1727-1728.

Moudatsou, M., Stavropoulou, A., Philalithis, A., & Koukouli, S. (2020). The role of empathy in health and social care professionals. Healthcare,

Moule, P. & Goodman, M. (2014). Nursing Research: An Introduction. 2nd Ed. London. Sage Publications.

Mshweshwe-Pakela, N., Hansoti, B., Mabuto, T., Kerrigan, D., Kubeka, G., Hahn, E., Charalambous, S. & Hoffmann, C. J. (2020). Feasibility of implementing same-day antiretroviral therapy initiation during routine care in Ekurhuleni District, South Africa: Retention and viral load suppression. Southern African journal of HIV medicine, 21, 1-6.

Mufune, P. (2015). Poverty and HIV/AIDS in Africa: Specifying the connections. Social Theory & Health, 13, 1-29.

Mundell, J. P., Visser, M. J., Makin, J. D., Forsyth, B. W., & Sikkema, K. J. (2012). Support group processes: Perspectives from HIV-infected women in South Africa. Qual Res Psychol, 9(2), 173-187. https://doi.org/10.1080/14780887.2010.500350

Musayon-Oblitas, Y., Carcamo, C., & Gimbel, S. (2019). Counseling for improving adherence to antiretroviral treatment: a systematic review. AIDS care, 31(1), 4-13.

Mwita, K. (2022). Factors to consider when choosing data collection methods. International Journal of Research in Business and Social Science (2147-4478), 11(5), 532-538.

Naidu, T. (2020). The COVID-19 pandemic in South Africa. Psychological Trauma: Theory, Research, Practice, and Policy, 12, 559.

Naik, P. A., Zu, J., & Owolabi, K. M. (2020). Global dynamics of a fractional order model for the transmission of HIV epidemic with optimal control. Chaos, Solitons & Fractals, 138, 109826.

Nam, S. L., Fielding, K., Avalos, A., Dickinson, D., Gaolathe, T., & Geissler, P. W. (2008). The relationship of acceptance or denial of HIV-status to antiretroviral adherence among adult HIV patients in urban Botswana. Social science & medicine, 67(2), 301-310.

Nardi, P. M. (2018). Doing survey research: A guide to quantitative methods, Routledge.

Nasution, M. K., & Aulia, I. (2019). Design of the research problem statement. Journal of Physics: Conference Series,

Ngalamika, O., Mukasine, M. C., Kamanzi, P., Kawimbe, M., Mujajati, A., Lidenge, S. J., & Mumba, C. (2022). SARS-CoV-2-Specific T Cell Immunity in HIV-Associated Kaposi Sarcoma Patients in Zambia. Journal of Immunology Research, 2022.

Ngulube, P. (2015). Qualitative data analysis and interpretation: systematic search for meaning. Addressing research challenges: making headway for developing researchers, 131, 156.

Niomh, N. (2019). Transforming the understanding and treatment of mental illnesses. Retrieved March from Available at https://www. nimh. nih. gov/health/statistics/mental-illness.

North, C. S. (2016). Disaster mental health epidemiology: Methodological review and interpretation of research findings. Psychiatry, 79, 130-146.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. International journal of qualitative methods, 16(1), 1609406917733847.

Nyamukoho, E., Mangezi, W., Marimbe, B., Verhey, R., & Chibanda, D. (2019). Depression among HIV positive pregnant women in Zimbabwe: a primary health care based cross-sectional study. BMC pregnancy and childbirth, 19, 1-7.

Nyongesa, M. K., Nasambu, C., Mapenzi, R., Koot, H. M., Cuijpers, P., Newton, C. R., & Abubakar, A. (2022). Psychosocial and mental health challenges faced by emerging adults living with HIV and support systems aiding their positive coping: a qualitative study from the Kenyan coast. BMC public health, 22(1), 76.

Obermeyer, C. M., Baijal, P., & Pegurri, E. (2011). Facilitating HIV disclosure across diverse settings: a review. Am J Public Health, 101(6), 1011-1023. https://doi.org/10.2105/ajph.2010.300102

O'Cleirigh, C., Ironson, G., Weiss, A., & Costa Jr, P. T. (2007). Conscientiousness predicts disease progression (CD4 number and viral load) in people living with HIV. Health Psychology, 26(4), 473.

Okafor, A. (2021). Role of the social worker in the outbreak of pandemics (A case of COVID-19). Cogent Psychology, 8, 1939537.

Okonji, E. F., Mukumbang, F. C., Orth, Z., Vickerman-Delport, S. A., & Van Wyk, B. (2020). Psychosocial support interventions for improved adherence and retention in ART care for young people living with HIV (10–24 years): a scoping review. BMC public health, 20(1), 1841.

Olem, D., Sharp, K. M., Taylor, J. M., & Johnson, M. O. (2014). Overcoming barriers to HIV treatment adherence: A brief cognitive behavioral intervention for HIV-positive adults on antiretroviral treatment. Cognitive and behavioral practice, 21(2), 206-223.

Olsson, L., Jerneck, A., Thoren, H., Persson, J., & O’Byrne, D. (2015). Why resilience is unappealing to social science: Theoretical and empirical investigations of the scientific use of resilience. Science advances, 1(4), e1400217.

O'Mahen, H. A., Grieve, H., Jones, J., McGinley, J., Woodford, J., & Wilkinson, E. L. (2015). Women's experiences of factors affecting treatment engagement and adherence in internet delivered Behavioural Activation for Postnatal Depression. Internet Interventions, 2(1), 84-90.

O'Neill, J. (2017). Women's Transitions from Custody in Northern Ireland-Time After Time? Irish Probation Journal, 14.

Online, I. (2024). More black South Africans getting divorced than before, statistics show. https://www.iol.co.za/capeargus/news/more-black-south-africans-getting-divorced-than-before-statistics-show-7bfef7fe-fe2e-4645-9a9c-01c82ca11c1b

Ortiz-Ospina, E. & Roser, M. (2020). Marriages and divorces. Our World in Data.

Ozbay, F., Johnson, D. C., Dimoulas, E., Morgan Iii, C., Charney, D., & Southwick, S. (2007). Social support and resilience to stress: from neurobiology to clinical practice. Psychiatry (edgmont), 4(5), 35.

Palanee-Phillips, T., Rees, H. V., Heller, K. B., Ahmed, K., Batting, J., Beesham, I., Heffron, R., Justman, J., Makkan, H., & Mastro, T. D. (2022). High HIV incidence among young women in South Africa: Data from a large prospective study. PLoS One, 17(6), e0269317.

Palanee-Phillips, T., Rees, H. V., Heller, K. B., Ahmed, K., Batting, J., Beesham, I., Heffron, R., Justman, J., Makkan, H., Mastro, T. D., Morrison, S. A., Mugo, N., Nair, G., Kiarie, J., Philip, N. M., Pleaner, M., Reddy, K., Selepe, P., Steyn, P. S., . . . Baeten, J. M. (2022). High HIV incidence among young women in South Africa: Data from a large prospective study. PLoS One, 17(6), e0269317. https://doi.org/10.1371/journal.pone.0269317

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful Sampling for Qualitative Data Collection and Analysis in Mixed Method Implementation Research. Adm Policy Ment Health, 42(5), 533-544. https://doi.org/10.1007/s10488-013-0528-y

Palmer, P. K., Wehrmeyer, K., Florian, M. P., Raison, C., Idler, E., & Mascaro, J. S. (2021). The prevalence, grouping, and distribution of stressors and their association with anxiety among hospitalized patients. PLoS One, 16(12), e0260921. https://doi.org/10.1371/journal.pone.0260921

Pandey, A., & Galvani, A. P. (2019). The global burden of HIV and prospects for control. The Lancet HIV, 6(12), e809-e811.

Paradis, E., O'Brien, B., Nimmon, L., Bandiera, G., & Martimianakis, M. A. (2016). Design: Selection of Data Collection Methods. J Grad Med Educ, 8(2), 263-264. https://doi.org/10.4300/jgme-d-16-00098.1

Parcesepe, A., Tymejczyk, O., Remien, R., Gadisa, T., Kulkarni, S. G., Hoffman, S., Melaku, Z., Elul, B., & Nash, D. (2018). HIV-related stigma, social support, and psychological distress among individuals initiating ART in Ethiopia. AIDS and Behavior, 22, 3815-3825.

Patrão, A. L., Mcintyre, T. M., Costa, E. C., Matediane, E. & Azevedo, V. (2021). Testing the effectiveness of two psychosocial interventions on socio-cognitive risk factors for HIV/AIDS in Mozambican women: a randomized controlled trial. AIDS Education and Prevention, 33, 169-186.

Patton, M. Q. (2014). Qualitative research & evaluation methods: Integrating theory and practice. Sage publications.

Payagala, S., & Pozniak, A. (2024). The global burden of HIV. Clinics in Dermatology.

Payne, M. (2020). The origins of social work: Continuity and change, Bloomsbury Publishing.

Peersman, G. (2014). Overview: Data collection and analysis methods in impact evaluation. UNICEF Office of Research-Innocenti.

Permwonguswa, S., Khuntia, J., Yim, D., Gregg, D., & Kathuria, A. (2018). Knowledge sharing in a health infomediary: role of self-concept, emotional empowerment, and self-esteem. Health Systems, 7(3), 181-194.

Phanuphak, N., Lo, Y. R., Shao, Y., Solomon, S. S., O'Connell, R. J., Tovanabutra, S., Chang, D., Kim, J. H., & Excler, J. L. (2015). HIV Epidemic in Asia: Implications for HIV Vaccine and Other Prevention Trials. AIDS Res Hum Retroviruses, 31(11), 1060-1076. https://doi.org/10.1089/aid.2015.0049

Philip, K. (2014). A history of townships in South Africa. Economics of South African townships: special focus on Diepsloot, 31-49.

Pietilä, A.-M., Nurmi, S.-M., Halkoaho, A., & Kyngäs, H. (2020). Qualitative research: Ethical considerations. The application of content analysis in nursing science research, 49-69.

Pillai, N., Foster, N., Hanifa, Y., Ndlovu, N., Fielding, K., Churchyard, G., Chihota, V., Grant, A. D., & Vassall, A. (2019). Patient costs incurred by people living with HIV/AIDS prior to ART initiation in primary healthcare facilities in Gauteng, South Africa. PLoS One, 14(2), e0210622.

Pinto, R. M., Witte, S. S., Filippone, P., Choi, C. J., & Wall, M. (2018). Interprofessional collaboration and on-the-job training improve access to HIV testing, HIV primary care, and pre-exposure prophylaxis (PrEP). AIDS Education and Prevention, 30(6), 474-489.

Poudel, A. N., Newlands, D., & Simkhada, P. (2017). The economic burden of HIV/AIDS on individuals and households in Nepal: a quantitative study. BMC health services research, 17(1), 1-13.

Profe, W., & Wild, L. G. (2017). Mother, father, and grandparent involvement: Associations with adolescent mental health and substance use. Journal of family Issues, 38(6), 776-797.

Project, T. W. (2023a). Long term surviver of HIV. T. W. Project. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.thewellproject.org/twp-pdf-print/2059.

Project, T. W. (2023b). Women and HIV. T. W. Project. https://www.thewellproject.org/hiv-information/women-and-hiv

Psaros, C., Barinas, J., Robbins, G. K., Bedoya, C. A., Safren, S. A., & Park, E. R. (2012). Intimacy and sexual decision making: exploring the perspective of HIV positive women over 50. AIDS Patient Care STDS, 26(12), 755-760. https://doi.org/10.1089/apc.2012.0256

Pulerwitz, J., Michaelis, A., Verma, R., & Weiss, E. (2010). Addressing gender dynamics and engaging men in HIV programs: lessons learned from Horizons research. Public health reports, 125(2), 282-292.

Qiao, S., Li, X., & Stanton, B. (2014). Social support and HIV-related risk behaviors: a systematic review of the global literature. AIDS and Behavior, 18, 419-441.

Qiao, S., Nie, J. B., Tucker, J., Rennie, S., & Li, X. M. (2015). The role of social relationship in HIV healing and its implications in HIV cure in China. Health Psychol Behav Med, 3(1), 115-127. https://doi.org/10.1080/21642850.2015.1040405

Raemer, D., Anderson, M., Cheng, A., Fanning, R., Nadkarni, V., & Savoldelli, G. (2011). Research regarding debriefing as part of the learning process. Simulation in Healthcare, 6(7), S52-S57.

Rafati, F., Nouhi, E., Sabzehvari, S., & Dehghan-Nayyeri, N. (2017). Iranian nursing students' experience of stressors in their first clinical experience. Journal of Professional Nursing, 33(3), 250-257.

Rahimi, S. (2024). Saturation in qualitative research: An evolutionary concept analysis. International Journal of Nursing Studies Advances, 100174.

Ramjee, G., & Daniels, B. (2013). Women and HIV in sub-Saharan Africa. AIDS research and therapy, 10(1), 1-9.

Ramsook, L. (2018). A methodological approach to hermeneutic phenomenology. International Journal of Humanities and Social Sciences, 10(1), 14-24.

Randles, C. (2012). Phenomenology: A review of the literature. Update, 30(2):11-21.

Reed, M. S., Ferré, M., Martin-Ortega, J., Blanche, R., Lawford-Rolfe, R., Dallimer, M., & Holden, J. (2021). Evaluating impact from research: A methodological framework. Research Policy, 50(4), 104147.

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

Resilience, M. T. (2013). Stigma and Racial/Ethnic HIV Disparities.

Reyneke, R. (2020). The legal and ethical obligations of school social workers. Social Work, 56(2), 157-174.

Rights, E. U. F. F. (2014). Violence against women: an EU-wide survey. Luxembourg: Publications Office of the European Union.

Robbins, R. N., Spector, A. Y., Mellins, C. A., & Remien, R. H. (2014). Optimizing ART adherence: update for HIV treatment and prevention. Current Hiv/Aids Reports, 11, 423-433.

Rodrigo, C. & Rajapakse, S. (2010). HIV, poverty, and women. International Health, 2, 9-16.

Rolfe, G. (2006). Validity, trustworthiness, and rigour: Quality and the idea of qualitative research. Journal of Advanced Nursing, 53(3):304-310.

Rosenberg, N. E., Pettifor, A. E., De Bruyn, G., Westreich, D., Delany-Moretlwe, S., Behets, F., Maman, S., Coetzee, D., Kamupira, M., & Miller, W. C. (2013). HIV testing and counseling leads to immediate consistent condom use among South African stable HIV-discordant couples. J Acquir Immune Defic Syndr, 62(2), 226-233. https://doi.org/10.1097/QAI.0b013e31827971ca

Ross, J., Ingabire, C., Umwiza, F., Gasana, J., Munyaneza, A., Murenzi, G., Nsanzimana, S., Remera, E., Akiyama, M. J., & Anastos, K. M. (2021). How early is too early? Challenges in ART initiation and engaging in HIV care under Treat All in Rwanda—A qualitative study. PLoS One, 16(5), e0251645.

Rouhani, S. A., O'Laughlin, K. N., Faustin, Z. M., Tsai, A. C., Kasozi, J., & Ware, N. C. (2017). The role of social support on HIV testing and treatment adherence: A qualitative study of HIV-infected refugees in southwestern Uganda. Glob Public Health, 12(8), 1051-1064. https://doi.org/10.1080/17441692.2015.1132472

Rowland, M. M., & Leu, M. (2011). Study area description. Sagebrush ecosystem conservation and management: ecoregional assessment tools and models for the Wyoming Basins. Allen Press, Lawrence, Kansas, USA, 10-45.

Ruggles, D. R., Freyman, R. L. & Oxenham, A. J. (2014). Influence of musical training on understanding voiced and whispered speech in noise. PloS one, 9, e86980.

Rujumba, J., Mbasaalaki-Mwaka, C. L., & Ndeezi, G. (2010). Challenges faced by health workers in providing counselling services to HIV-positive children in Uganda: a descriptive study. Journal of the International AIDS Society, 13, 1-9.

Rutledge, P. B., & Hogg, J. L. C. (2020). In-depth interviews. The International Encyclopedia of Media Psychology, 1-7.

Safer &World Health Organization (WHO). (2010). Counselling for maternal and newborn health care: A handbook for building skills. World Health Organization.

Sajadipour, M., Rezaei, S., Irandoost, S. F., Ghaumzadeh, M., Salmani nadushan, M., Gholami, M., Salimi, Y., & Jorjoran Shushtari, Z. (2022). What explains gender inequality in HIV infection among high-risk people? A Blinder-Oaxaca decomposition. Archives of Public Health, 80(1), 2.

Saldana, J. (2015). Thinking qualitatively: Methods of mind. Thousand Oaks, California: Sage.

Sam-Goundar, S.-G. (2022). Research Methodology and Research Method.

Sassler, S. & Miller, A.J. (2011). Waiting to be asked: Gender, power, and relationship progression among cohabiting couples. Journal of Family Issues, 32(4):482 –506.

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: exploring its conceptualization and operationalization. Qual Quant, 52(4), 1893-1907. https://doi.org/10.1007/s11135-017-0574-8

Saxena, A. & Chandrapal, S. (2022). Social work and policy practice: Understanding the role of social workers. The British Journal of Social Work, 52, 1632-1642.

Sayles, J. N., Ryan, G. W., Silver, J. S., Sarkisian, C. A., & Cunningham, W. E. (2007). Experiences of social stigma and implications for healthcare among a diverse population of HIV positive adults. Journal of Urban Health, 84, 814-828.

Schatz, E., David, I., Angotti, N., Gómez-Olivé, F. X., & Mojola, S. A. (2022). From “Secret” to “Sensitive Issue”: Shifting Ideas About HIV Disclosure Among Middle-Aged and Older Rural South Africans in the Era of Antiretroviral Treatment. Journal of aging and health, 34(1), 14-24.

Schmidt, N.A. & Brown, J.M. (2015). 3rd ed. Evidence-based practice for nurses: Appraisal and application of research. Jones & Barlett Learning

Schostak, J. & Schostak, J. (2008). Radical research. Abingdon UK & New York: Routledge.

Schwitters, A., McCracken, S., Frederix, K., Tierney, R., Koto, M., Ahmed, N., Thin, K., Dobbs, T., Sithole, S., & Letsie, M. (2022). High HIV prevalence and associated factors in Lesotho: Results from a population-based survey. PLoS One, 17(7), e0271431.

Segerstrom, S. C. & Miller, G. E. (2004). Psychological stress and the human immune system: a meta-analytic study of 30 years of inquiry. Psychol Bull, 130, 601-30.

Sen, G. (2019). Gender Equality and Women's Empowerment: Feminist Mobilization for the SDG s. Global Policy, 10, 28-38.

Setume, S. D. (2016). HIV and AIDS knowledge and attitudes among different marital statuses in Botswana: Results of the fourth Botswana Aids Impact Survey of 2013.

Shaaban, A. N., & Martins, M. R. O. (2019). The Importance of Improving the Quality of Care Among HIV/AIDS Hospitalizations in Portugal. Front Public Health, 7, 266. https://doi.org/10.3389/fpubh.2019.00266

Shamu, S., Khupakonke, S., Farirai, T., Slabbert, J., Chidarikire, T., Guloba, G., & Nkhwashu, N. (2020). Knowledge, attitudes and practices of young adults towards HIV prevention: an analysis of baseline data from a community-based HIV prevention intervention study in two high HIV burden districts, South Africa. BMC public health, 20, 1-10.

Sharma, B. B., Small, E., Okumu, M., Mwima, S., & Patel, M. (2022). Addressing the Syndemics of HIV, Mental Health, and COVID-19 Using the Health and Human Rights Framework among Youth Living with HIV, in Uganda: an Interpretive Phenomenological Study. J Hum Rights Soc Work, 7(3), 285-298. https://doi.org/10.1007/s41134-022-00221-4

Sharp, P. M. & Hahn, B. H. (2011). Origins of HIV and the AIDS pandemic. Cold Spring Harbor Perspectives in Medicine:1.

Shenton, A.K. (2003). Strategies for ensuring trustworthiness in qualitative research projects. Education for Information, 22:63-75.

Shisana, O., Rehle, T., Simbayi, L. C., Zuma, K., Jooste, S., Zungu, N., Labadarios, D., & Onoya, D. (2014). South African national HIV prevalence, incidence and behaviour survey, 2012.

Showa, S. P., Nyabadza, F., & Hove-Musekwa, S. D. (2019). On the efficiency of HIV transmission: Insights through discrete time HIV models. PLoS One, 14(9), e0222574.

Shriharsha, C., & Rentala, S. (2019). Quality of life among people living with HIV/AIDS and its predictors: A cross-sectional study at ART center, Bagalkot, Karnataka. Journal of family medicine and primary care, 8(3), 1011.

Sia, D., Onadja, Y., Hajizadeh, M., Heymann, S. J., Brewer, T. F., & Nandi, A. (2016). What explains gender inequalities in HIV/AIDS prevalence in sub-Saharan Africa? Evidence from the demographic and health surveys. BMC public health, 16(1), 1-18.

Siedlecki, S. L. (2022). Conducting interviews for qualitative research studies. Clinical Nurse Specialist, 36(2), 78-80.

Siegle, D. (2015). Educational research basics by Del Siegle. University of Connecticut, 22.

Sileyew, K. J. (2019). Research design and methodology (Vol. 7). Cyberspace.

Simkus, J. (2022). Cluster sampling: definition, method and examples. Simply psychology.

Singer, E. J. & Thames, A. D. (2016). Neurobehavioral Manifestations of Human Immunodeficiency Virus/AIDS: Diagnosis and Treatment. Neurol Clin, 34, 33-53.

Sisto, A., Vicinanza, F., Campanozzi, L. L., Ricci, G., Tartaglini, D., & Tambone, V. (2019). Towards a Transversal Definition of Psychological Resilience: A Literature Review. Medicina (Kaunas), 55(11). https://doi.org/10.3390/medicina55110745

Slot, M., Sodemann, M., Gabel, C., Holmskov, J., Laursen, T., & Rodkjaer, L. (2015). Factors associated with risk of depression and relevant predictors of screening for depression in clinical practice: a cross-sectional study among HIV-infected individuals in Denmark. HIV medicine, 16(7), 393-402.

Smyth, I. & Sweetman, C. (2015). Introduction: Gender and resilience. Gender & Development, 23, 405-414.

Sniezek, T. 2013. Negotiating marriage: A process model of heterosexual engagement. SAGE Open, 1-14.

South Africa National Department of Health. (2019). 2019 ART clinical guidelines for the management of HIV in adults, pregnancy, adolescents, children, infants and neonates. Republic of South Africa National Department of Health.

South African Map online. (2021). Tembisa Township, Midrand _ South African History Online. South African history online. https://www.sahistory.org.za/place/tembisa-township-midrand

South African National HIV Prevalence, I., Behaviour and Communication Survey (2023). The Sixth South African National HIV Prevalence, Incidence, Behaviour and Communication Survey https://www.google.com/search?sca_esv=5bdde8b43c3acd18&rlz=1C1GCEU_enZA1054ZA1054&q=hromeextension://efaidnbmnnnibpcajpcglclefindmkaj/https://sahivsoc.org/Files/SABSSM+VI-SUMMARY-SHEET

Southwick, S. M., Bonanno, G. A., Masten, A. S., Panter-Brick, C., & Yehuda, R. (2014). Resilience definitions, theory, and challenges: interdisciplinary perspectives. European journal of psychotraumatology, 5(1), 25338.

Soyinka, O. & Siu, K. W. M. 2017. Investigating Informal Settlement and Infrastructure Adequacy for Future Resilient Urban Center in Hong Kong, SAR. Procedia Engineering, 198, 84-98.

Ssali, S. N., Atuyambe, L., Tumwine, C., Segujja, E., Nekesa, N., Nannungi, A., Ryan, G., & Wagner, G. (2010). Reasons for disclosure of HIV status by people living with HIV/AIDS and in HIV care in Uganda: an exploratory study. AIDS Patient Care STDS, 24(10), 675-681. https://doi.org/10.1089/apc.2010.0062

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

Stanborough, R. (2020). Understanding and Overcoming Fear of the Unknown. Healthline.

Statistic South Africa. (2021). South African labor market is more favorable to men than women [Online]. Pretoria: StatSA. Available: http://www.statssa.gov.za/?p=14606 [Accessed 13 March 2022].

Stedman, C., Burns, E., & Pratt, M. (2022). What is data preparation? An in-depth guide to data prep. In: Tech Accelerator. https://www. techtarget. com/searchbusinessanalytics

Stelmach, R. D., Rabkin, M., Abo, K., Ahoba, I., Gildas Anago, M., Boccanera, R., Brou, H., Flueckiger, R., Hartsough, K., & Msukwa, M. (2021). Financial burdens of HIV and chronic disease on people living with HIV in Côte d’Ivoire: A cross-sectional out-of-pocket expenditure study. PLoS One, 16(7), e0255074.

.

Stuewig, J., Tangney, J. P., Heigel, C., Harty, L., & McCloskey, L. (2010). Shaming, blaming, and maiming: Functional links among the moral emotions, externalization of blame, and aggression. Journal of research in personality, 44(1), 91-102.

Stults-Kolehmainen, M. A. & Sinha, R. (2014). The effects of stress on physical activity and exercise. Sports Med, 44, 81-121.

Sukmawati, S. (2023). Development Of Quality Instruments and Data Collection Techniques. Jurnal Pendidikan dan Pengajaran Guru Sekolah Dasar (JPPGuseda), 6(1), 119-124.

Sukmawati, S., Salmia, S., & Sudarmin, S. (2023). Population, sample (quantitative) and selection of participants/key informants (qualitative). Edumaspul: Jurnal Pendidikan, 7(1), 131-140.

Sullivan, M. C., Rosen, A. O., Allen, A., Benbella, D., Camacho, G., Cortopassi, A. C., Driver, R., Ssenyonjo, J., Eaton, L. A., & Kalichman, S. C. (2020). Falling short of the first 90: HIV stigma and HIV testing research in the 90–90–90 era. AIDS and Behavior, 24, 357-362.

Sunguya, B. F., Munisamy, M., Pongpanich, S., Yasuoka, J., & Jimba, M. (2016). Ability of HIV advocacy to modify behavioral norms and treatment impact: a systematic review. American Journal of Public Health, 106(8), e1-e8.

Suresh, K., & Chandrashekara, S. (2012). Sample size estimation and power analysis for clinical research studies. J Hum Reprod Sci, 5(1), 7-13. https://doi.org/10.4103/0974-1208.97779

Sutton, J., & Austin, Z. (2015). Qualitative Research: Data Collection, Analysis, and Management. Can J Hosp Pharm, 68(3), 226-231. https://doi.org/10.4212/cjhp.v68i3.1456

Swaraj, A. (2019). Exploratory Research: Purpose And Process. Parisheelan Journal.

Swetlitz, N. (2021). Depression’s problem with Men. AMA journal of ethics, 23, 586-589.

Taherdoost, H. (2021). Data Collection Methods and Tools for Research; A Step-by-Step Guide to Choose Data Collection Technique for Academic and Business Research Projects. International Journal of Academic Research in Management (IJARM), 10(1), 10-38.

Tappen, R.M. (2011). Advanced nursing research: From theory to practice. Sudburry, Mass: Jones & Bartlett Learning.

Tayo, S. Z., & Work, S. (2014). The Experience and Challenges of Women Living with HIV in the Pietermaritzburg Region, Kwazulu-Natal Province: Perspectives of Social Workers University of South Africa].

Teasdale, C. A., Marais, B. J., & Abrams, E. J. (2011). HIV: prevention of mother-to-child transmission. BMJ clinical evidence, 2011.

Tenny, S., Brannan, J. M., & Brannan, G. D. (2017). Qualitative study.

Tesch, R. (2013). Qualitative research: Analysis types and software tools.

Thapa, R. & Yang, Y. (2018). Experiences, Emotions, and Adjustments of HIV-Infected Men in HIV-Concordant Marital Relationship in Cambodia. Am J Mens Health, 12, 1215-1225.

Thomas, E. & Magilvy, J.K. (2011). Qualitative rigor or research validity in qualitative research. Journal for Specialists in Pediatric Nursing, 16:151-155.

Green, J. & Thorogood, N. (2018). Qualitative methods for health research. Qualitative methods for health research, 1-440.

Tian, X., Chen, J., Wang, X., Xie, Y., Zhang, X., Han, D., Fu, H., Yin, W., & Wu, N. (2023). Global, regional, and national HIV/AIDS disease burden levels and trends in 1990-2019: A systematic analysis for the global burden of disease 2019 study. Front Public Health, 11, 1068664. https://doi.org/10.3389/fpubh.2023.1068664

Tlou, B. (2019). The influence of marital status on HIV infection in an HIV hyperendemic area of rural South Africa, 2000–2017. African Journal of AIDS Research, 18, 65-71.

Tolmay, J., Knight, L., Muvhango, L., Polzer-Ngwato, T., Stöckl, H. & Ranganathan, M. (2022). Women's economic contribution, relationship status and risky sexual behaviours: A cross-sectional analysis from a microfinance-plus programme in rural South Africa. AIDS and Behavior, 26, 2349-2362.

Tsevat, J., Leonard, A. C., Szaflarski, M., Sherman, S. N., Cotton, S., Mrus, J. M., & Feinberg, J. (2009). Change in quality of life after being diagnosed with HIV: A multicenter longitudinal study. AIDS patient care and STDs, 23(11), 931-937.

Turan, B., Budhwani, H., Fazeli, P. L., Browning, W. R., Raper, J. L., Mugavero, M. J., & Turan, J. M. (2017). How Does Stigma Affect People Living with HIV? The Mediating Roles of Internalized and Anticipated HIV Stigma in the Effects of Perceived Community Stigma on Health and Psychosocial Outcomes. AIDS Behav, 21(1), 283-291. https://doi.org/10.1007/s10461-016-1451-5

Uni24.co.za. (2020). Which Province Has the Highest HIV Rate in South Africa. https://uni24.co.za/which-province-has-the-highest-hiv-rate-in-south-africa/?gad_source=1&gclid=Cj0KCQiAxOauBhCaARIsAEbUSQTIUq5bSDZ7eHsyDoX-9dWAe17vmQryeMSQzg51H8czGYmD6WPIlsIaAIzjEALw_wcB#google_vignette

Unnikrishnan, B., Jagannath, V., Ramapuram, J. T., Achappa, B. & Madi, D. (2012). Study of depression and its associated factors among women living with HIV/AIDS in Coastal South India. International Scholarly Research Notices, 2012.

Unnikrishnan, B., Jagannath, V., Ramapuram, J. T., Achappa, B., & Madi, D. (2012). Study of depression and its associated factors among women living with HIV/AIDS in Coastal South India. International Scholarly Research Notices, 2012.

Vaillant, A. A. J., & Gulick, P. G. (2022).HIV and AIDS Syndrome.

Van Breda, A. D. (2018). A critical review of resilience theory and its relevance for social work. Social Work, 54, 1-18.

Van Wyk, B. & Moomba, K. (2019). Social and economic barriers to adherence among patients at Livingstone General Hospital in Zambia. African Journal of Primary Health Care and Family Medicine, 11, 1-6.

Vandormael, A., Akullian, A., Siedner, M., de Oliveira, T., Bärnighausen, T., & Tanser, F. (2019). Declines in HIV incidence among men and women in a South African population-based cohort. Nature communications, 10(1), 5482.

Varni, S. E., Miller, C. T. & Solomon, S. E. (2012a). Sexual behavior as a function of stigma and coping with stigma among people with HIV/AIDS in rural New England. AIDS Behav, 16, 2330-9.

Varni, S. E., Miller, C. T., McCuin, T., & Solomon, S. (2012b). Disengagement and engagement coping with HIV/AIDS stigma and psychological well-being of people with HIV/AIDS. Journal of social and clinical psychology, 31(2), 123-150.

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. BMC medical research methodology, 18, 1-18.

Veale, J. F., Peter, T., Travers, R., & Saewyc, E. M. (2017). Enacted Stigma, Mental Health, and Protective Factors Among Transgender Youth in Canada. Transgender Health, 2(1), 207-216. https://doi.org/10.1089/trgh.2017.0031

Verick, S. (2014). Female labor force participation in developing countries. IZA World of Labor.

Visser, M. J., Makin, J. D., Vandormael, A., Sikkema, K. J., & Forsyth, B. W. (2009). HIV/AIDS stigma in a South African community. AIDS care, 21(2), 197-206.

Wabiri, N., & Taffa, N. (2013). Socio-economic inequality and HIV in South Africa. BMC public health, 13(1), 1-10.

Waldron, E. M., Burnett-Zeigler, I., Wee, V., Ng, Y. W., Koenig, L. J., Pederson, A. B., Tomaszewski, E., & Miller, E. S. (2021). Mental health in women living with HIV: the unique and unmet needs. Journal of the International Association of Providers of AIDS Care (JIAPAC), 20, 2325958220985665.

Wang, H., Zhou, J., He, G., Luo, Y., Li, X., Yang, A., Fennie, K. & Williams, A. B. (2009). Consistent ART adherence is associated with improved quality of Life, CD4 counts, and reduced hospital costs in central China. AIDS Res Hum Retroviruses, 25, 757-63.

Weaver, S. E., Sharp, E. A. & Britton, C. (2020). (Re) Honoring the Legacy of Jessie Bernard: An Analysis of Junior Scholars' Outstanding Feminist Family Scholarship. Journal of Family Issues, 41, 1759-1784.

Weinstein, E. R., Lee, J. S., Mendez, N. A., Harkness, A., Safren, S. A., & El-Sadr, W. (2021). HIV/AIDS and aging: the new frontier for HIV/AIDS research and care. AIDS (London, England), 35(12), 2043.

Wen, J., Yeh, T.-P., Xie, H., Yu, X., Tang, J. & Chen, Y. (2021). Resilience, self-esteem, self-efficacy, social support, depression and ART adherence among people living with HIV in Sichuan, China. AIDS care, 33, 1414-1421.

Whitson, H. E., Duan-Porter, W., Schmader, K. E., Morey, M. C., Cohen, H. J., & Colón-Emeric, C. S. (2016). Physical resilience in older adults: systematic review and development of an emerging construct. Journals of Gerontology Series A: Biomedical Sciences and Medical Sciences, 71(4), 489-495.

Wodon, Q. & De La Briere, B. (2018). Unrealized potential: the high cost of gender inequality in earnings.

Wolf, H. T., Halpern-Felsher, B. L., Bukusi, E. A., Agot, K. E., Cohen, C. R. & Auerswald, C. L. (2014). "It is all about the fear of being discriminated [against]… the person suffering from HIV will not be accepted": a qualitative study exploring the reasons for loss to follow-up among HIV-positive youth in Kisumu, Kenya. BMC public health, 14, 1-11.

Wood, L. M., Sebar, B., & Vecchio, N. (2020). Application of rigour and credibility in qualitative document analysis: Lessons learnt from a case study. The qualitative report, 25(2), 456-470.

Woods, D. D. (2017). Essential characteristics of resilience. Resilience engineering. CRC Press.

Woollett, N., Cluver, L., Hatcher, A. M., & Brahmbhatt, H. (2016). "To be HIV positive is not the end of the world": Resilience among perinatally infected HIV positive adolescents in Johannesburg. Children and Youth Services Review, 70, 269-275.

World Health Organization (WHO). (2011). Provider-initiated HIV testing and counselling: one-day training programme, field test version April 2011.

World Health Organization (WHO). (2015). Consolidated guidelines on HIV testing services: 5Cs: consent, confidentiality, counselling, correct results and connection 2015. World Health Organization.

World Health Organization (WHO). (2018). Updated recommendations on first line and second-line antiretroviral regimens and post-exposure prophylaxis and recommendations on early infant diagnosis of HIV: interim guidelines: supplement to the 2016 consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. World Health Organization.

World Health Organization (WHO). (2018). Viral suppression for HIV treatment success and prevention of sexual transmission of HIV. WHO News.

World Health Organization (WHO). (2021). Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach. World Health Organization.

World Health Organization. (2021). HIV/AIDS: Key Facts [Online]. Geneva. Available: https://www.who.int/news-room/fact-sheets/detail/hiv-aids#:~:text=There%20were%20an%20estimated%2037.7,in%20the%20WHO%20African%20Region. [Accessed 12 March 2022].www.health.gov.za/ccmdd/#:~:text=The%20Central%20Chronic%20Medicines%20Dispensing,to%20medicine%20for%20stable%20patients.

Xu, A., Baysari, M. T., Stocker, S. L., Leow, L. J., Day, R. O., & Carland, J. E. (2020). Researchers' views on, and experiences with, the requirement to obtain informed consent in research involving human participants: a qualitative study. BMC medical ethics, 21(1), 1-11.

Xu, J.-F., Ming, Z.-Q., Zhang, Y.-Q., Wang, P.-C., Jing, J., & Cheng, F. (2017). Family support, discrimination, and quality of life among ART-treated HIV-infected patients: a two-year study in China. Infectious diseases of poverty, 6, 1-10.

Xu, K., Li, Y., Liu, C., Liu, X., Hao, X., Gao, J. & Maropoulos, P. G. (2020). Advanced data collection and analysis in data-driven manufacturing process. Chinese Journal of Mechanical Engineering, 33, 1-21.

Yin, R.K. (2011). Qualitative research from start to finish. New York: The Guilford Press.

Yu, Y., Luo, D., Chen, X., Huang, Z., Wang, M., & Xiao, S. (2018). Medication adherence to antiretroviral therapy among newly treated people living with HIV. BMC public health, 18, 1-8.

Yuldashev, F. (2021). The Study of Socio-Psychological Problem of Loneliness. Turkish Journal of Computer and Mathematics Education (TURCOMAT), 12, 2580-2590.

Zamir, S., Hennessy, C. H., Taylor, A. H., & Jones, R. B. (2018). Video-calls to reduce loneliness and social isolation within care environments for older people: an implementation study using collaborative action research. BMC Geriatr, 18(1), 62. https://doi.org/10.1186/s12877-018-0746-y

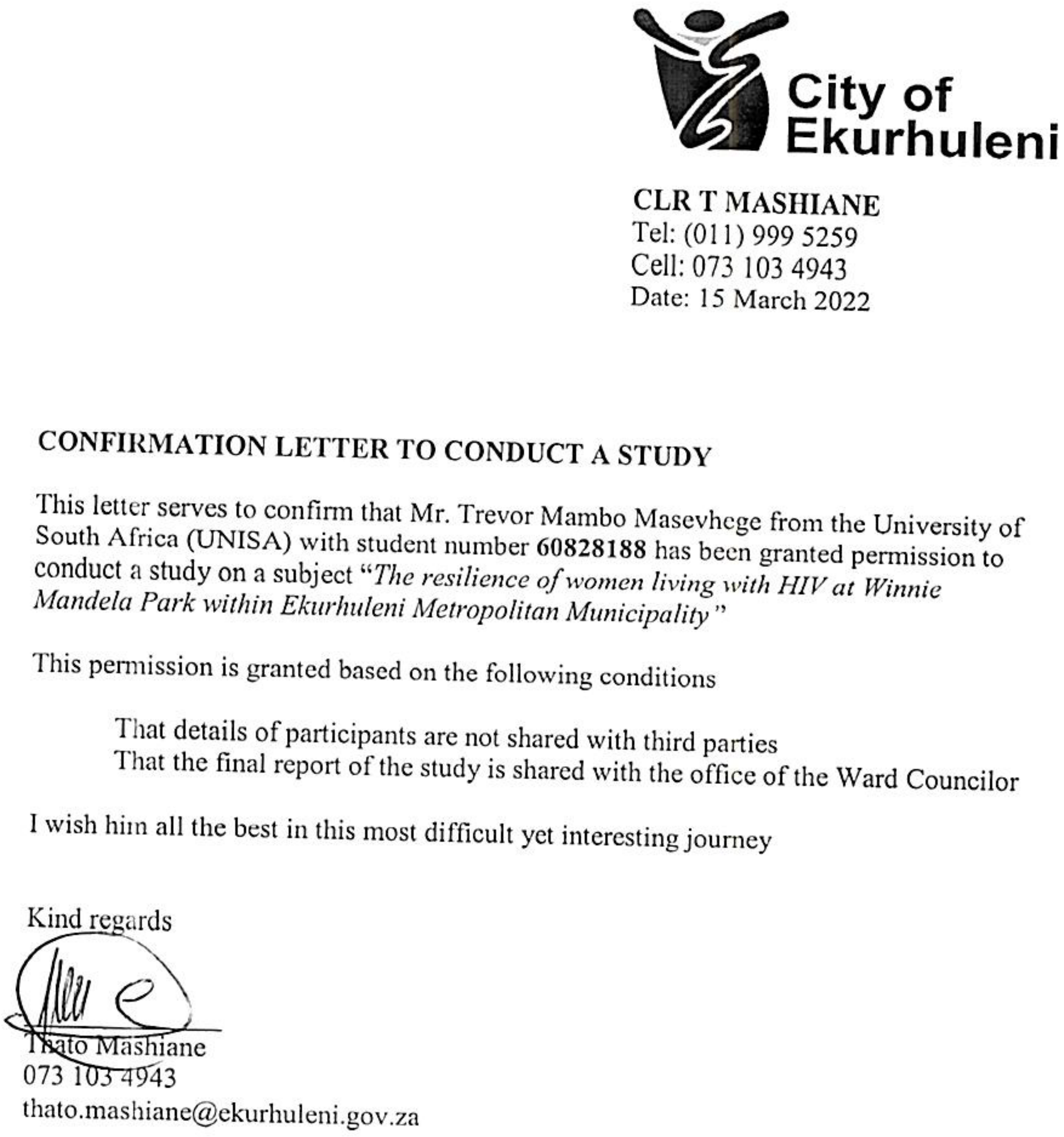
Zhang, Y., & Wildemuth, B. M. (2009). Qualitative analysis of content Applications of Social Research Methods to Questions. Information and Library Science.

Zhu, Q.-Y., Huang, D.-S., Lv, J.-D., Guan, P., & Bai, X.-H. (2019). Prevalence of perinatal depression among HIV-positive women: a systematic review and meta-analysis. BMC psychiatry, 19(1), 1-12.

Zuma, K., Simbayi, L., Zungu, N., Moyo, S., Marinda, E., Jooste, S., North, A., Nadol, P., Aynalem, G., Igumbor, E., Dietrich, C., Sigida, S., Chibi, B., Makola, L., Kondlo, L., Porter, S., Ramlagan, S., & On Behalf of The Sabssm, V. S. G. C. (2022). The HIV Epidemic in South Africa: Key Findings from 2017 National Population-Based Survey. Int J Environ Res Public Health, 19(13). https://doi.org/10.3390/ijerph19138125

7. LIST OF APPENDIXES

APPENDIX 1: COUNCILLOR PERMISSION TO CONDUCT THE STUDY



City of
Ekurhuleni

CLR T MASHIANE
Tel: (011) 999 5259
Cell: 073 103 4943
Date: 15 March 2022

CONFIRMATION LETTER TO CONDUCT A STUDY

This letter serves to confirm that Mr. Trevor Mambo Masevhege from the University of South Africa (UNISA) with student number **60828188** has been granted permission to conduct a study on a subject "*The resilience of women living with HIV at Winnie Mandela Park within Ekurhuleni Metropolitan Municipality*"

This permission is granted based on the following conditions

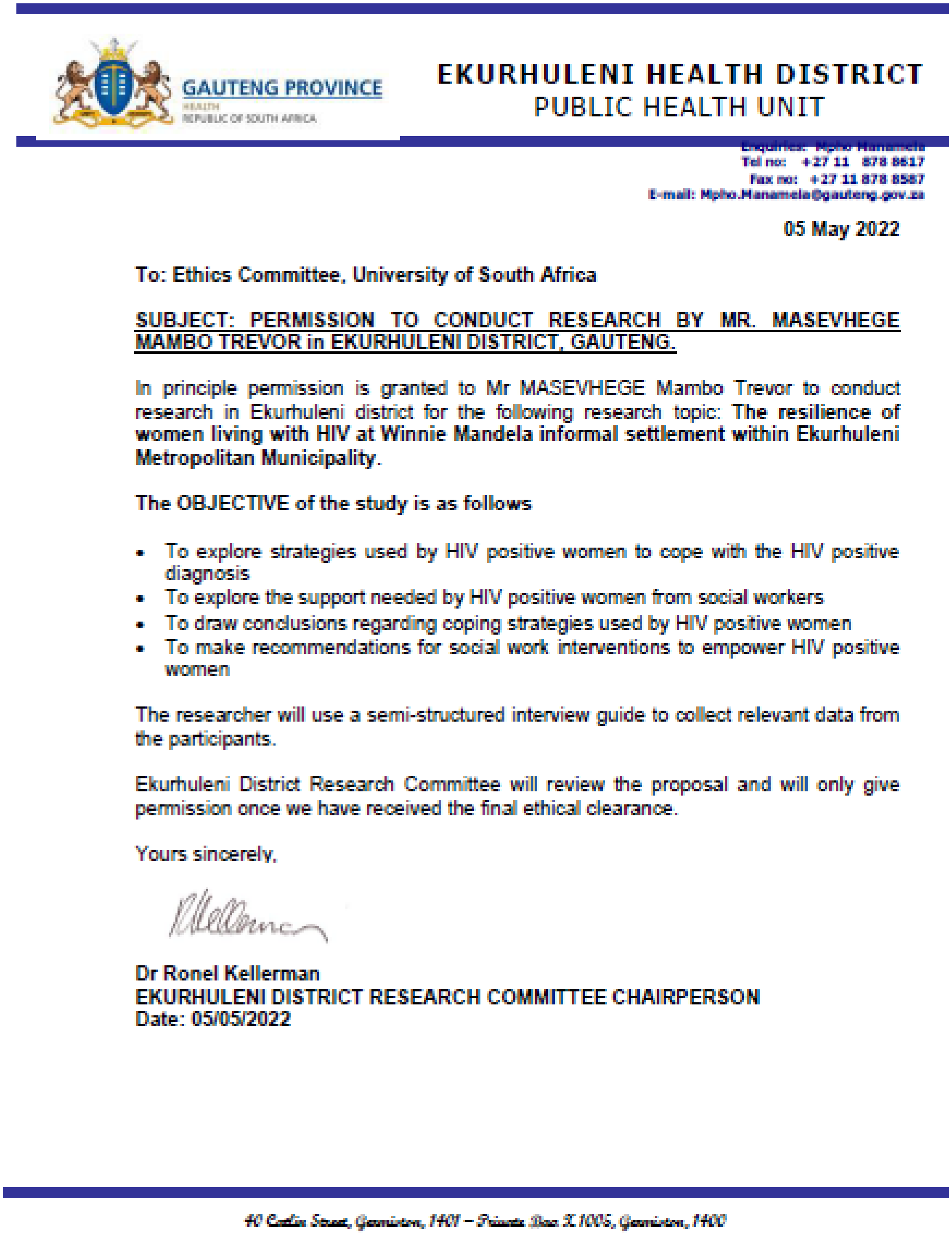
That details of participants are not shared with third parties
That the final report of the study is shared with the office of the Ward Councilor

I wish him all the best in this most difficult yet interesting journey

Kind regards

Thato Mashiane
073 103 4943
thato.mashiane@ekurhuleni.gov.za

APPENDIX 2: DEPARTMENT OF HEALTH PERMISSION TO CONDUCT THE STUDY



GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

EKURHULENI HEALTH DISTRICT
PUBLIC HEALTH UNIT

Enquiries: Mpho Manamela
Tel no: +27 11 878 8617
Fax no: +27 11 878 8587
E-mail: Mpho.Manamela@gauteng.gov.za

05 May 2022

To: Ethics Committee, University of South Africa

SUBJECT: PERMISSION TO CONDUCT RESEARCH BY MR. MASEVHEGE MAMBO TREVOR in EKURHULENI DISTRICT, GAUTENG.

In principle permission is granted to Mr MASEVHEGE Mambo Trevor to conduct research in Ekurhuleni district for the following research topic: **The resilience of women living with HIV at Winnie Mandela informal settlement within Ekurhuleni Metropolitan Municipality.**

The OBJECTIVE of the study is as follows

- To explore strategies used by HIV positive women to cope with the HIV positive diagnosis
- To explore the support needed by HIV positive women from social workers
- To draw conclusions regarding coping strategies used by HIV positive women
- To make recommendations for social work interventions to empower HIV positive women

The researcher will use a semi-structured interview guide to collect relevant data from the participants.

Ekurhuleni District Research Committee will review the proposal and will only give permission once we have received the final ethical clearance.

Yours sincerely,

Dr Ronel Kellerman
EKURHULENI DISTRICT RESEARCH COMMITTEE CHAIRPERSON
Date: 05/05/2022

40 Catlin Street, Germiston, 1401 – Private Bag X1005, Germiston, 1400

APPENDIX 3a: APPROVAL LETTER FROM DEPARTMENT OF SOCIAL WORK SCIENTIFIC REVIEW COMMITTEE

UNISA university of south africa

CONFIRMATION LETTER BY THE CHAIRPERSON OF THE SCIENTIFIC REVIEW COMMITTEE (SRC) OF THE DEPARTMENT OF SOCIAL WORK

Name of candidate: Mr MT Masevhege
Student number: 60828188
Qualification: Master of Social Work (MSW)
Supervisor: Dr EM Tabane

Working title

The resilience of women living with HIV at Winnie Mandela informal settlement within Ekurhuleni metropolitan municipality

The Departmental Scientific Review Committee (DSRC) in the Department of Social Work at Unisa has assessed the research proposal for **MSW degree** compliance for scientific validity. The DSRC confirms that:

- The research approach, design, recruitment method(s), data collection protocol(s) and relevant ethical considerations regarding informed consent, the rights of participants/ respondents to withdraw from the study, the protection of the participants' privacy, confidentiality and management of the information are clearly articulated.

The DSRC recommends that the application be reviewed for ethics acceptability.

Kind regards

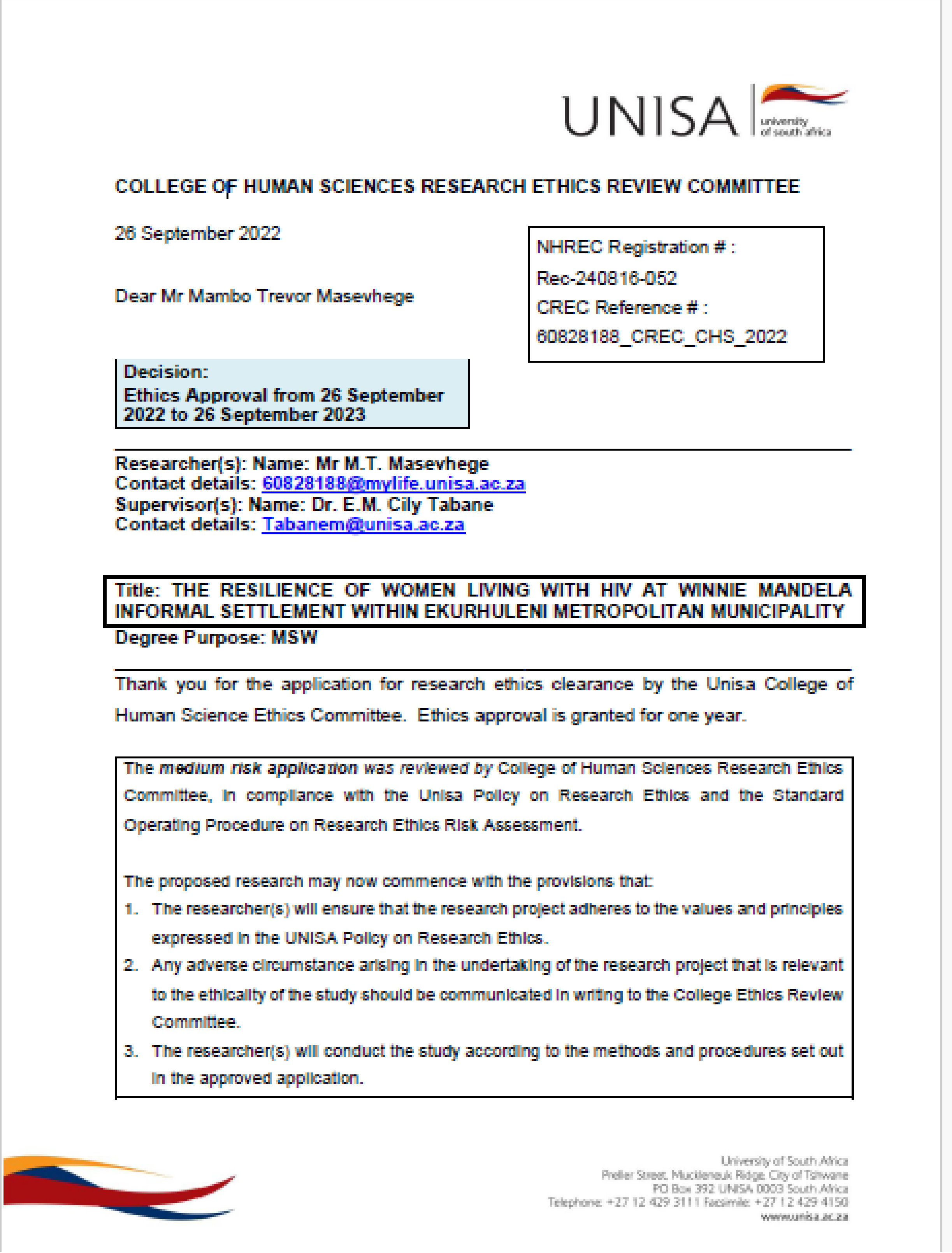
Dr M Mathebane

Chairperson: Departmental Scientific Research Committee

Date: 7 July 2022

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 429 12 429 4150
www.unisa.ac.za

APPENDIX 3b: APPROVAL LETTER FROM UNISA COLLEGE OF HUMAN SCIENCE RESEARCH ETHICS



UNISA university of south africa

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

26 September 2022

NHREC Registration # :
Rec-240816-052
CREC Reference # :
60828188_CREC_CHS_2022

Dear Mr Mambo Trevor Masevhege

Decision:
Ethics Approval from 26 September 2022 to 26 September 2023

Researcher(s): Name: Mr M.T. Masevhege
Contact details: 60828188@mylife.unisa.ac.za
Supervisor(s): Name: Dr. E.M. Cily Tabane
Contact details: Tabanem@unisa.ac.za

Title: THE RESILIENCE OF WOMEN LIVING WITH HIV AT WINNIE MANDELA INFORMAL SETTLEMENT WITHIN EKURHULENI METROPOLITAN MUNICIPALITY

Degree Purpose: MSW

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for one year.

The *medium risk application was reviewed by* College of Human Sciences Research Ethics Committee, in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.
5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No fieldwork activities may continue after the expiry date **(26 September 2023).** Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

The reference number ***60828188_CREC_CHS_2022*** *should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

Signature: Khan

Prof. KB Khan
CHS Research Ethics Committee Chairperson
Email: khankb@unisa.ac.za
Tel: (012) 429 8210

Signature: PP

Prof ZZ Nkosi
Acting-Exécutive Dean: CHS
E-mail: nkosizz@unisa.ac.za
Tel: 012 429 6758

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

APPENDIX 4: PARTICIPANTS’ INFORMATION SHEET

PARTICIPANT INFORMATION SHEET

Title of study

The resilience of women living with HIV at Winnie Mandela informal settlement within Ekurhuleni Metropolitan Municipality.

The Researcher

My name is **Masevhege Mambo Trevor**, and I am doing research with **Dr. RM Skhosana** senior lecturer in the Department of Social Work towards a master’s in social work at the University of South Africa (UNISA). We are inviting you to participate in a study entitled “The resilience of women living with HIV at Winnie Mandela informal settlement within Ekurhuleni metropolitan municipality”.

Study background

Globally, research on HIV and women has focused on the challenges or negative effects it brings whilst positive outcomes and resilience remain under-studied. The story of HIV and AIDS, for a long time, has been one of a dreaded disease with no cure and which results in great suffering and death of those it afflicts. However, amidst this background of hopelessness, uncertainty, and despair, the researcher has encountered some HIV-positive women from Winnie Mandela informal settlement who exuded confidence, spoke positively about themselves, and were hopeful about what the future holds. It can only be assumed that these women have been able to rise above the challenges of being HIV positive. These women seem to live lives, comparable to HIV-negative women, they religiously adhere to medication regimes and are open to seeking help from various support groups working in Tembisa. In short, these women can be described as resilient in the face of challenges advanced by HIV diagnosis. This study, therefore, seeks to understand the qualities that make these women resilient to the challenges that come with being HIV and live a life comparable to those who are HIV negative.

What is the purpose of this research?

The purpose of the study is to understand the strategies HIV-positive women, like yourself, use to prevail over some of the challenges that come with being HIV positive.

What is required from me?

Your participation involves availing yourself for a face-to-face interview with the researcher. The interview will be more of a discussion where the researcher asks you several question and you can choose to answer or not answer the presented questions. You are not expected to bring anything and the interview, everything you will need will be provided by the researcher.

What does participation in this research involve?

Participation in this study involves holding a discussion with the researcher on several issues related to resilience against the adversity of being HIV positive.

What are the possible benefits of taking part?

This study seeks to understand how some HIV positive women rise above the challenges that come with being diagnosed with the disease. The results, if shared with people newly diagnosed with HIV, can help them to rise above some of the challenges HIV positive people face. This will help in improving their quality of lives as well as their families.

Do I have to take part in this research project?

Taking part, I this research is not mandatory. You can withdraw your participation at any point during the study.

What will happen to the information about me?

Personal information about you will not be shared with anyone.

Risks associated with taking part in this study

It is acknowledged that being diagnosed with HIV is a traumatic life event. It is possible that some of the questions asked will upset you and this is considered a risk to your wellbeing.

What if something goes wrong?

The researcher has secured the services of a clinical psychologist in case you need counselling. You will not pay for the counselling sessions.

Compensation

You will not be compensated in cash or kind for participating in this study.

For further information, contact

Masevhege Mambo Trevor (076) 749 2236

APPENDIX 5: PARTICIPANTS CONSENT FORM

CONSENT TO PARTICIPATE IN THIS STUDY

Research title: The resilience of women living with HIV at Winnie Mandela informal settlement within Ekurhuleni Metropolitan Municipality

Researcher: Masevhege Mambo Trevor

I, __________________ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits, and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications, and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.
I agree with the digital recording of the interview using the record function of the researcher's phone.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname………………………………………… (please print)

Participant Signature…………………………………………..Date…………………

Researcher's Name & Surname……………………………………(please print)

Researcher's signature…………………………………………..Date…………………

APPENDIX 6a: INTERVIEW GUIDE

SECTION A: BIOGRAPHICAL QUESTIONS

Date of Birth

Marital status

SECTION B: TOPICAL QUESTIONS

- What changes did you realise in your life since you were diagnosed with HIV?
- What changes did you make in your life once you knew of your HIV status?
- How religion helped you in dealing with the challenges of being HIV positive?
- How did your family help in dealing with the challenges that come with being HIV positive?
- How did your friends help in dealing with the challenges that come with being HIV positive?
- How did you and your sexual partner tackle the challenges of you being HIV positive?
- Which other resources do you think should be in place to support people living with HIV?
- In your opinion, how can the community members play a role in supporting those who are living with HIV?

APPENDIX 6b: INTERVIEW GUIDE

Data collection tool: Interview Guide

SECTION A: BIOGRAPHICAL QUESTIONS

Age ………………….

Ethic Group

English	Venda	Tsonga	Tswana	Zulu	Pedi

Home language

English	Tshivenda	Xitsonga	Setswana	IsiZulu	Sepedi

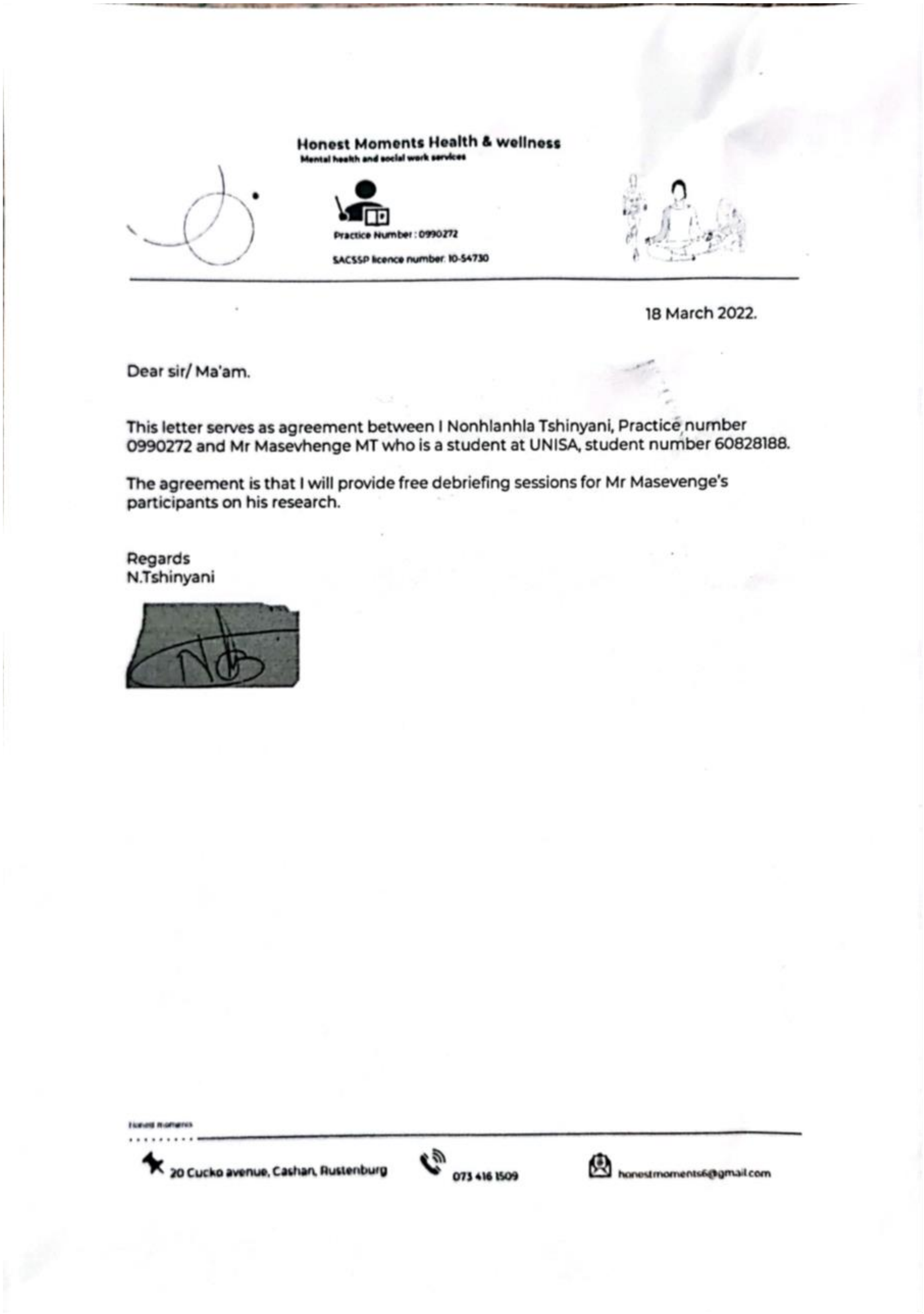
How long have you lived with HIV? ....

Are you on the CCMDD programme?.......................................

SECTION B: TOPICAL QUESTIONS

- Could you please share with me how your life changed after being diagnosed with HIV?
- What are the challenges women face when living with HIV?
- What strategies do you use to cope as a person living with HIV?
- What support do you think social workers should provide to women living with HIV in order to help them be more resilient in coping with the virus?
- What kind of support do you believe women living with HIV need from their close ones, such as family members, in order to build resilience against HIV?
- In your opinion, how can community members play a role in supporting individuals living with HIV?
- What intervention strategies can you recommend to social workers to empower newly diagnosed women with HIV to build resilience against the virus?

APPENDIX 7a: SOCIAL WORKER LETTER



Honest Moments Health & wellness
Mental health and social work services

Practice Number : 0990272

SACSSP licence number: 10-54730

18 March 2022.

Dear sir/ Ma'am.

This letter serves as agreement between I Nonhlanhla Tshinyani, Practice number 0990272 and Mr Masevhenge MT who is a student at UNISA, student number 60828188.

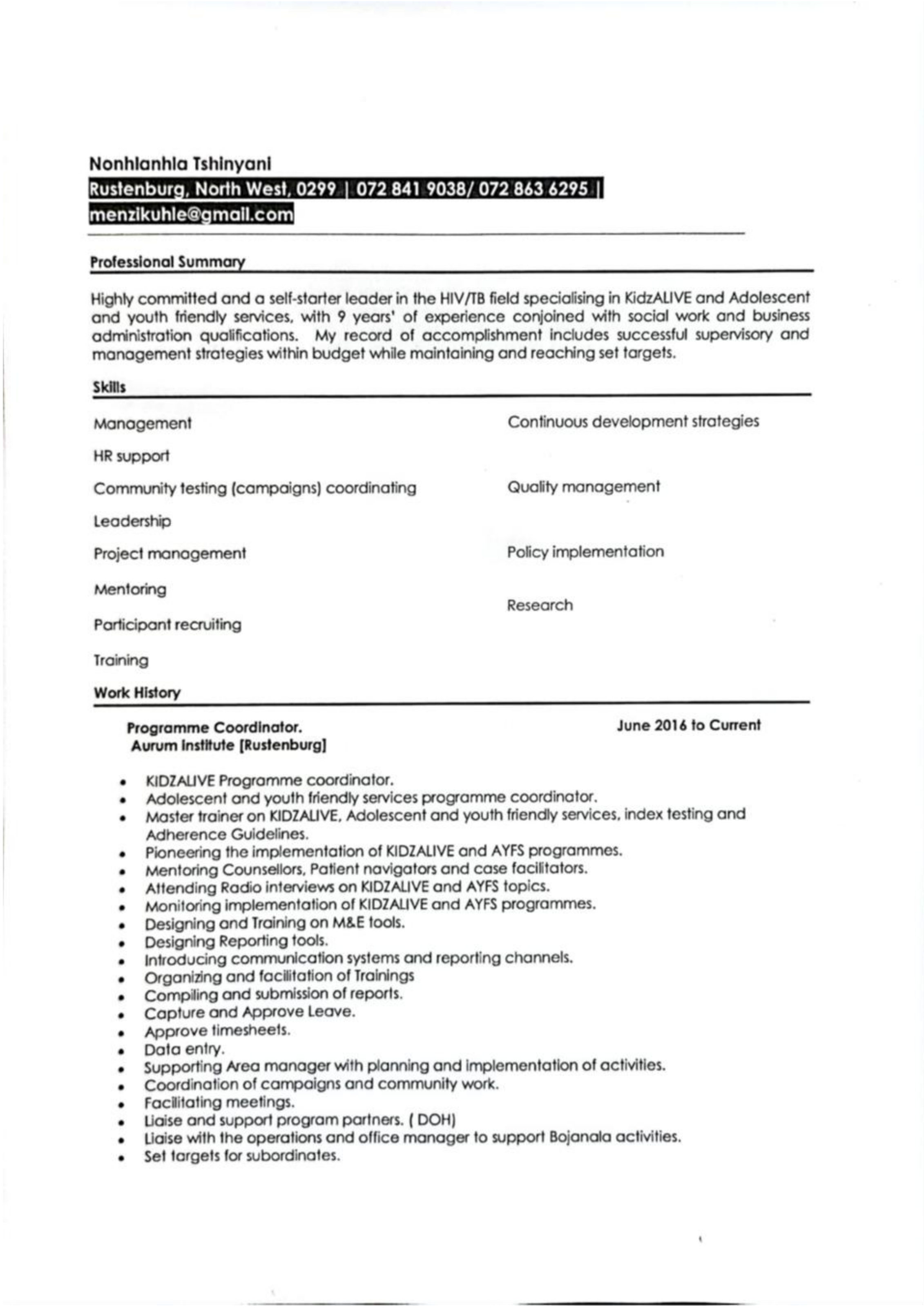
The agreement is that I will provide free debriefing sessions for Mr Masevenge's participants on his research.

Regards
N.Tshinyani

Honest moments

20 Cucko avenue, Cashan, Rustenburg
073 416 1509
honestmoments6@gmail.com

APPENDIX 7b: SOCIAL WORKER CURRICULUM VITAE



Nonhlanhla Tshinyani
Rustenburg, North West, 0299 | 072 841 9038/ 072 863 6295 |
menzikuhle@gmail.com

Professional Summary

Highly committed and a self-starter leader in the HIV/TB field specialising in KidzALIVE and Adolescent and youth friendly services, with 9 years' of experience conjoined with social work and business administration qualifications. My record of accomplishment includes successful supervisory and management strategies within budget while maintaining and reaching set targets.

Skills

Management
HR support
Community testing (campaigns) coordinating
Leadership
Project management
Mentoring
Participant recruiting
Training

Continuous development strategies
Quality management
Policy implementation
Research

Work History

Programme Coordinator. **June 2016 to Current**
Aurum Institute [Rustenburg]

- KIDZALIVE Programme coordinator.
- Adolescent and youth friendly services programme coordinator.
- Master trainer on KIDZALIVE, Adolescent and youth friendly services, index testing and Adherence Guidelines.
- Pioneering the implementation of KIDZALIVE and AYFS programmes.
- Mentoring Counsellors, Patient navigators and case facilitators.
- Attending Radio interviews on KIDZALIVE and AYFS topics.
- Monitoring implementation of KIDZALIVE and AYFS programmes.
- Designing and Training on M&E tools.
- Designing Reporting tools.
- Introducing communication systems and reporting channels.
- Organizing and facilitation of Trainings
- Compiling and submission of reports.
- Capture and Approve Leave.
- Approve timesheets.
- Data entry.
- Supporting Area manager with planning and implementation of activities.
- Coordination of campaigns and community work.
- Facilitating meetings.
- Liaise and support program partners. (DOH)
- Liaise with the operations and office manager to support Bojanala activities.
- Set targets for subordinates.

- Liaise with office manager for uniform procurement.
- Organize training material.
- Implement strategies
- Performance monitoring.
- Overseeing Daily activities.
- Preparing and performing presentations.
- Liaise with community partners and PEPFAR funded partners.

Practical work **June 2018- December 2020**
SOS children's Village.
Conducting counselling sessions (Case work)
Conducting Group sessions (Group work)
Community projects (community work)

Adherence counsellor **January 2016 to June 2016**
Aurum Institute [Rustenburg]

- HIV counselling and Testing (HTS).
- Adherence counselling.
- Community tracing.
- Telephonic tracing.
- Health talks.
- Data collection.

Programme Assistant **October 2014 to December 2015**
I-tech South Africa [Rustenburg]

- Facilitate and collection of data
- Support data entry and reporting of data
- Supporting program coordinator with planning and implementation of activities
- Scheduling meetings, events and conference calls with various partners
- Provide meeting organization, facilitation, documentation and follow-up
- Assist and support program partners and staff
- Liaise with the operations and financial team to support North west activities
- Serve as the main conduit to all service providers to maintain good relationship
- Identifying vendors at district level adhering to I-tech procurement process
- Provide support in tracking procurement request e.g. checking quality of material upon receipt and distribution of material
- Driving of staff
- implementation of vehicle safety, security and maintenance
- Office Administration.

Community outreach worker/ Adherence counsellor **March 2012 to September 2014**
Aurum Institute [Rustenburg]

- Recruiting study participants
- Performing Presentations
- Making appointments for participants
- Community work

- Counselling
- Adherence and retention counselling

Academic Qualifications

Bachelor of social work University of South Africa (UNISA)	**2020**
Diploma in Business Administration Stanford Business College	**2010**
Inbound- Outbound Call centre Comer stone	**2007**
Matric certificate Marikana Secondary School	**2006**

Summary of courses Attended.

Management development program	**2020**
INSTI	**2019**
KIDZALIVE and AYFS Master Trainer	**2017**
Basic counselling and testing	**2016**
GCP	**2013**
Participation in the Bench marks Community Monitoring Project	**2011**
Leadership Skills	**2007**

References

Msanyana Skhosana – Area manager (Aurum institute)

082 259 9694

Email: Mskhosana@auruminstitute.org

Phindile Nxumalo – District clinical Advisor (Aurum institute)

082 650 9515

Email: PNxumalo@auruminstitute.org

Bonolo Pitse- Area manager (Aurum Institute)

073 983 9371/ 083 850 1384

Email: BPitse@auruminstitute.org

APPENDIX 8: EDITOR'S LETTER

Office: 0183892451

FACULTY OF EDUCATION

Date: 12th December, 2023

TO WHOM IT MAY CONCERN

CERTIFICATE OF EDITING

I, Muchativugwa Liberty Hove, confirm and certify that I have read and edited the entire research paper titled "

THE RESILIENCE OF WOMEN LIVING WITH HIV AT WINNIE MANDELA INFORMAL SETTLEMENT WITHIN EKURHULENI METROPOLITAN MUNICIPALITY" by **MASEVHEGE MAMBO TREVOR.**

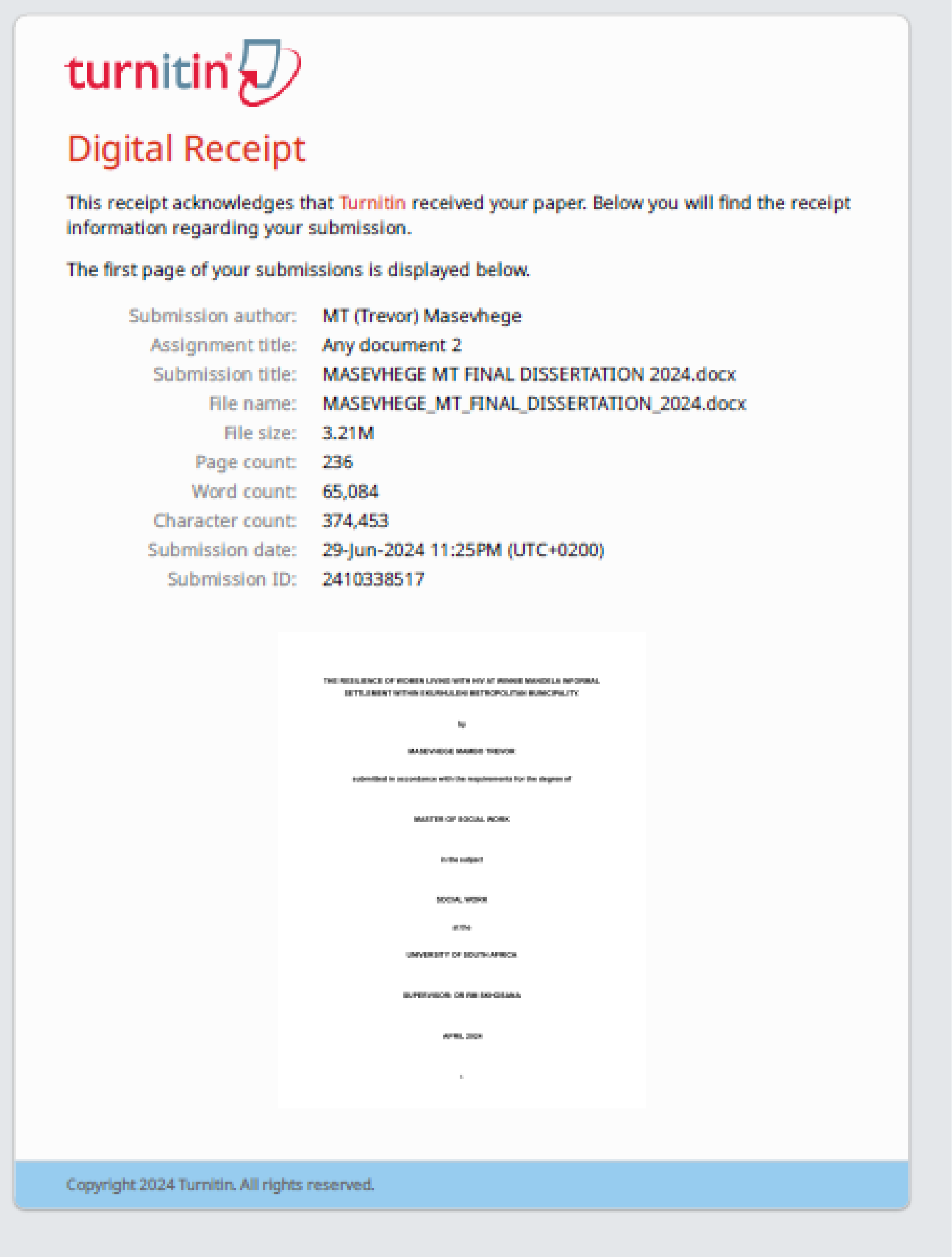
I hold a PhD in English Language and Literature in English and am qualified to edit such a thesis for cohesion and coherence. The views expressed herein, however, remain those of the researcher/s.

Yours sincerely

Prof M.L.Hove (PhD, MA, PGDE, PGCE, BA Honours – English)

1

APPENDIX 8: TURNITIN REPORTS



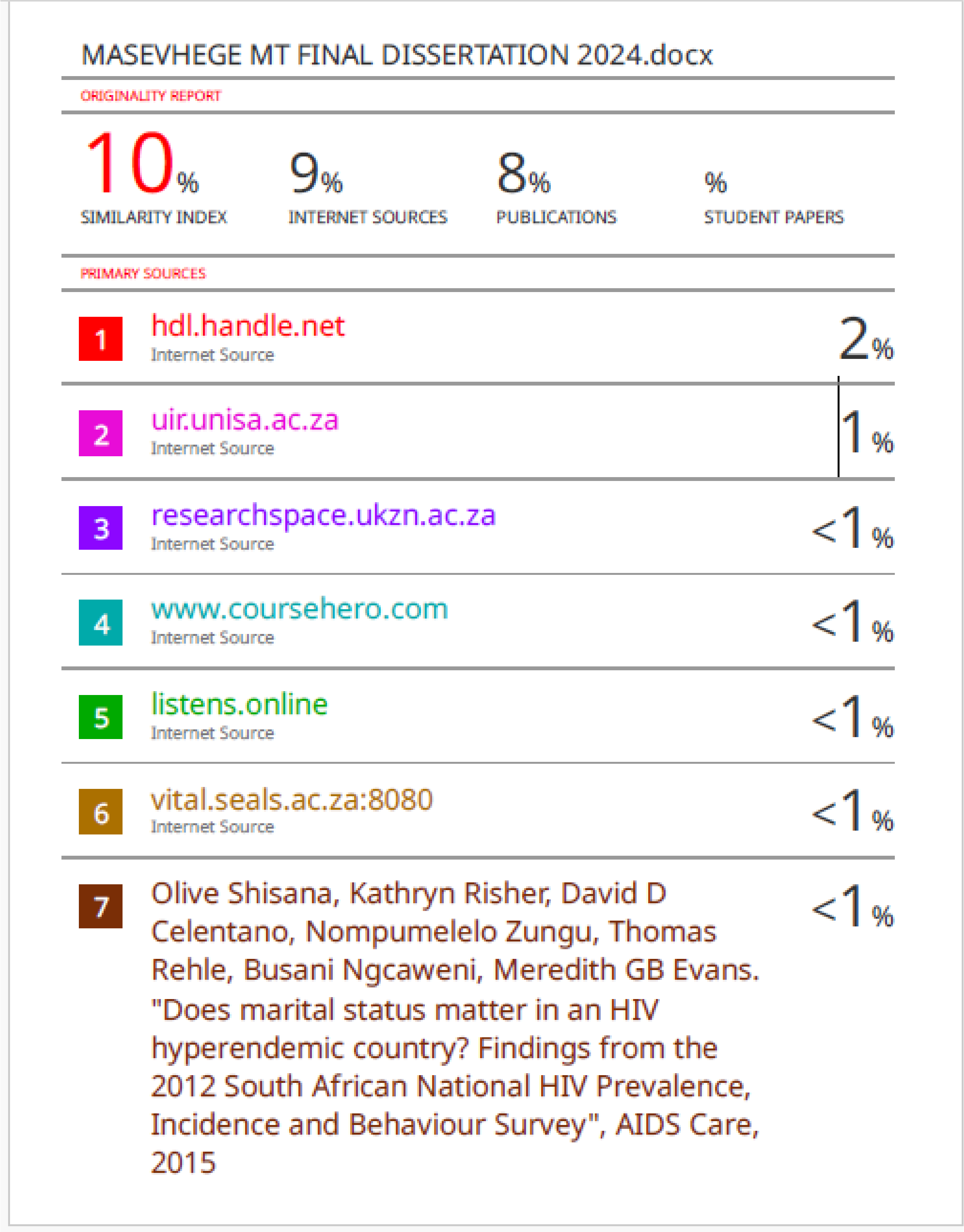
turnitin

Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission.

The first page of your submissions is displayed below.

Submission author:	MT (Trevor) Masevhege
Assignment title:	Any document 2
Submission title:	MASEVHEGE MT FINAL DISSERTATION 2024.docx
File name:	MASEVHEGE_MT_FINAL_DISSERTATION_2024.docx
File size:	3.21M
Page count:	236
Word count:	65,084
Character count:	374,453
Submission date:	29-Jun-2024 11:25PM (UTC+0200)
Submission ID:	2410338517



MASEVHEGE MT FINAL DISSERTATION 2024.docx

ORIGINALITY REPORT

10%	9%	8%	%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	hdl.handle.net Internet Source	2%
2	uir.unisa.ac.za Internet Source	1%
3	researchspace.ukzn.ac.za Internet Source	<1%
4	www.coursehero.com Internet Source	<1%
5	listens.online Internet Source	<1%
6	vital.seals.ac.za:8080 Internet Source	<1%
7	Olive Shisana, Kathryn Risher, David D Celentano, Nompumelelo Zungu, Thomas Rehle, Busani Ngcaweni, Meredith GB Evans. "Does marital status matter in an HIV hyperendemic country? Findings from the 2012 South African National HIV Prevalence, Incidence and Behaviour Survey", AIDS Care, 2015	<1%