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# Living with HIV/AIDS in King Williams Town, Eastern Cape

**Chinyama. Ephraim .P**
Department of Sociology University of Fort Hare P. O. Box 7426, 50 Church Street East London 5201,South Africa

Email ephraimchinyama@gmail.com

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**ABSTRACT**
This study examines the lifestyle decisions of people who are diagnosed with HIV/AIDS in King Williams Town, Eastern Cape. The study was motivated by the ever growing number of people who are now living with HIV/AIDS. Therefore the researcher intended to examine their decisions regarding sexual choices, reproductive health, diet, physical fitness and their coping strategies.
The study found that there is very low uptake of Voluntary Counseling and Testing (VCT). Most people only get tested if they are compelled by other factors, like illness and pregnancy. It also found that HIV positive people continue to engage in risky sexual behaviour regardless of their positive status. In addition it also found that HIV positive status does not affect sexual activity and social support from family and friends is a very important factor that is helping the respondents to cope with HIV diagnosis.

## INTRODUCTION

This study investigates the lifestyle decisions of people who are diagnosed with human immuno deficiency virus and acquired immuno deficiency syndrome (HIV/AIDS) in King William's Town, Eastern Cape. It specifically explores decisions regarding sexual choices, reproductive health, decision-making and lifestyle choices of members of Emplisweni Aids Support Center in King William's Town. This study also examines the coping strategies these HIV positive people initiate in order to improve their health and mental well-being.

### 1.1 PROBLEM STATEMENT

South Africa is in the midst of a catastrophic HIV/AIDS epidemic. It has the highest number of people living with HIV/AIDS in the world. At the end of 2009 an estimated 5, 5 million South Africans were living with HIV, (UNAIDS 2010a). The overall HIV prevalence among pregnant women was almost one third in 2006, about 320,000 people had died because of AIDS, and over a million children had been orphaned, (Annemarie, 2008:37).

Globally young people aged 15 to 24 years make up the largest proportion of HIV infected people, (World Health Organization (WHO), 2008). Of the thousands of new HIV infections each year, 58 percent of those are people younger than the age of 24, (WHO, 2008,). Females account for 55 percent of all new infections. Of all the infections in people 15 to 24 years old, 77 percent are women (Annemarie, 2008:37). The above statistics shows that the HIV/AIDS pandemic is growing and there are now a lot of people who are now affected, hence the need to study their lifestyle decisions, choices and their coping strategies in the wake of positive diagnosis.

In order to reduce the spread of HIV, the South African government and international aid organizations are investing significant prevention resources in voluntary HIV Counseling and Testing (VCT).The South African government has established more than 450 VCT centers with more than 800 counselors around the country (UNAIDS, 2007). Research has shown that VCT can reduce high-risk sexual practices and can decrease rates of sexually transmitted infections, (UNAIDS, 2007). In addition, VCT is necessary for directing HIV infected people to highly active antiretroviral therapy (HAART), which is becoming increasingly available in South Africa. While these VCT research efforts are laudable, there seem to be a death of research that explores HIV positive people's decisions regarding sexual and reproductive health choices, lifestyle choices in relation to diet and physical fitness. This study addresses this research gap.

**1.2 RESEARCH QUESTIONS**

This research answers the following research questions:
1.4.1 How does being HIV positive influence sexual and reproductive health decision–making and choices?
1.4.2 How does being HIV positive influence one's lifestyle choices in relation to diet and physical fitness?
1.4.3 How do HIV positive people cope with HIV diagnosis?

**1.3 RESEARCH OBJECTIVES**

The study aims to:
1.5.1 Investigate whether an HIV positive diagnosis affects decision making in relation to sexual and reproductive health behavior.
1.5.2 Examine HIV positive people's diet, physical fitness and life style choices.
1.5.3 Investigate strategies used by people living with HIV/ AIDS cope with their health condition.

**1.4 RESEARCH SETTING**

This research was conducted at Empilisweni Aids Support Center in King William's Town. King William's Town is a small town which falls under Buffalo City Municipality. It is situated in the Eastern Cape Province which is one of the poorest provinces in South Africa (Eastern Cape State of the Environment Report:2007).The researcher identified a Non Governmental Organization called Emplisweni Aids Support Center which provides anti retro viral treatment to HIV infected

people. This center was established in 1999 and its main activities are offering public educational programmes on HIV/AIDS, counseling, domestic violence and advocacy.

HIV/AIDS is a deadly pandemic that has affected the whole world. The effects of the pandemic are so enormous that almost every country now has a significant amount of their national budget channeled towards alleviating the effects of HIV/AIDS. It is currently one of the most devastating health conditions affecting millions of people throughout the world. At the global level the number of people infected with HIV/AIDS continues to grow from 26.2 million in 1999 to 33.3 million in 2009, (UNAIDS 2010). An estimated 25.4 million people are living with HIV/AIDS in Sub Saharan Africa and approximately 3.1 million new infections occurred in 2004 (Fredrickson et al, 2005:88). The Joint United Nations Programme on HIV/AIDS (2004), reported that Sub Saharan Africa remains by far the worst affected by HIV/AIDS. With just over 10 percent of the world's population, almost two thirds of the people in the world with HIV/AIDS are living in Sub Saharan Africa.

## GENERAL COPING THEORY IN AN HIV/AIDS COPING CONTEXT

This research employs the general coping theory. Coping is defined as the process through which a person manages demands (external or internal) that are appraised as taxing or exceeding the available resources (Lazarus and Folkman, 1986 cited in Meusing, 1997:59). Coping consists of behavioral and intrapsychic efforts to manage, to master, to minimize or tolerate stressors and demands, (Meusing, 1997:60). This theory was chosen because this study wanted to gain insight on the various coping strategies that HIV positive people adopt in order to cope with the stress of being infected with the HIV.

Coping is a dynamic process, which involves a series of reciprocal responses between the individual and the environment, (Meusing, 1997:61). Thus coping responses are not a momentary occurrence, but rather form a chain of interactions which take place over time, (Taylor, 1986:150). This was an ideal theory to use in this study because one was asking the respondents about their life style from the time that they started to suspect that they may be infected with HIV virus, to the time they chose to get tested for HIV/AIDS and to their present day lifestyle decisions.

Emotions like anger or depression can be seen as the outcome of the impact of a stressor, but also as an attitude with which an individual confronts a stressor, (Taylor, 1986:152). This is because if a person is confronted with a new event, in this case it will be the HIV/AIDS diagnosis, the first step toward coping with it is to make a 'primary appraisal' of the event, (Meusing,1997:65). To appraise is to evaluate and see whether this event poses a threat to the individual. HIV/AIDS diagnosis is indeed a status that is a threat to any individual because of its ability to weaken the immune system of anyone who is infected by the virus, (Taylor, 1986:152).

Furthermore, currently there is no cure for the HIV virus which is a factor that makes it very stressful to the person who is infected with the virus. Thus, if the event is threatening, a further appraisal is made in which the individual assesses what resources and potential coping strategies are available to deal with the stressor, i.e. The degree to which one can exercise immediate control over the stressor, (Folkman and Lazarus,1991:46). This secondary appraisal is pivotal in determining the style in which a person will approach the stressor and the choice of further coping strategies. This makes the general coping theory relevant to the current study

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because any individual who is infected with HIV has to do these appraisals in order to for him/her to cope with the new status.

If the individual judges that sufficient resources are available to deal with the stressor, which in this case is HIV, the individual is likely to engage in problem- focused coping. This means that the person tries to deal with the problematic situation itself by seeking HIV/AIDS information, planning and seeking help on how to deal with being HIV positive, (Folkman and Lazarus, 1986:46). If the individual does not have sufficient resources at that moment the next step will be to seek more resources. However, a sense of hopelessness and lack of control over the stressor may also cause the individual to turn to emotion-focused coping, (Folkman and Lazarus, 1986:47). This type of coping attempts to deal not with the stressor itself, but with emotional strain it evokes. This is more evident with HIV positive people who are without proper counseling; there is great fear that they will turn to emotion- focused coping, which will make the individual re-interpret the stressor more positively, ventilate negative emotions, or resort to denial of the stressor, (Folkman and Lazarus, 1986:48). This situation is more evident to a person who denies that he/she is HIV positive and continues to live as if there is no change of status in his/her life.

There are eight factors that affect the coping strategies, (Folkman and Lazarus, 1986:48), namely: confrontive coping which can be evaluated by the following points.

> *"I stood my ground and fought for what I wanted". "Tried to get the person responsible to change his or her mind". "I expressed anger to the person(s) who caused the problem". ( Folkman and Lazarus, 1986:48*).

This is a process by which stress-provoking thoughts are replaced with more constructive ones, (Seligman, et al 1996:220). This type of coping is usually used by a person who feels that there is no change of the status so he/she has to accept the status of being HIV positive, (Cohen at el 1979:190). It describes aggressive efforts to alter the situation and suggests some degree of hostility and risk-taking, (Folkman and Lazarus, 1986;48). This is usually noticed when a person who has been told of his/her status, accepts it, and seems as if he/she is not concerned at all.

Distancing this type of coping can be evaluated with the following points.

> *"Made light of the situation, refused to get too serious about it", didn't let it get to me, refused to think about it too much and tried to forget the whole thing". (Folkman and Lazarus, 1986:49).*

Some HIV positive people will try to use this type of coping that is refusing to accept that they are HIV positive, and just continue to live as if there are negative. This is noticed when a HIV positive person takes cognitive efforts to detach oneself and to minimize the significance of the situation. One can withdraw from family and friends and become a loner, (Folkman and Lazarus, 1986:49).

The third factor is self-controlling which can be evaluated by the following points.

> *"I tried to keep my feelings to myself" Kept others from knowing how bad things were and "I tried not to act too hastily or follow my first hunch". The fourth factor is Seeking support which is characterized with "Trying to talk to*

> *someone to find out more about the situation". "Talking to someone who could do something concrete about the situation".* (Folkman and Lazarus, 1986:50).

This coping strategy is usually used by a person who has self control that is instead of panicking and becoming emotional, the individual will accept his situation for example asking a relative or a friend for advice. This is when an individual takes efforts to regulate one's feelings and actions, (Meusing, 1997:65).

Accepting responsibility factor is characterized by "criticizing or lecturing oneself"(Meusing 1997:65). Realizing that one brought the problem on him or herself and lastly making a promise that things would be different next time. Escape or avoidance factor is characterized by wishing that the situation would go away or somehow be over with, hoping that a miracle would happen and avoiding being with people in general (Lazarus et al, 1986:50). This happens when an HIV positive person acknowledges one's own role in the problem with a concomitant theme of trying to put things right (Cohen at el 1979:133).
Planful problem solving this factor is characterized by one knowing what needs to be done, doubled his or her efforts to make things work, planning the kind of action necessary and following it and changing something so that things would turn out all right (Folkman and Lazarus, 1986:50).
Lastly there is positive reappraisal which is characterized by changing or growing as a person in a good way, coming out of an experience better than the way one went in and finding a new faith (Folkman and Lazarus, 1986:50).

The major strengths of the general coping theory are that it differentiates the coping strategies between people with resources and those without. People with practical and material resources generally use the problem focused coping strategy in both a practical and psychological sense (Meusing,1997:66)
(Billings and Moos,1981:188) found that American families with a higher level of income and education used more problem focused coping strategies in dealing with life. This suggests that access to adequate material resources is associated with more problem oriented coping whilst in contrast social economic conditions where lack of resources is a permanent fact of life the people who are in this state tend to use the emotion coping strategies. (Billings and Moos,1981:188). HIV/AIDS coping also follows the same trend. People with material and practical resources use the resources to cope with the effects of the infection whilst those without tend to use the emotional coping strategies.
The other advantage of coping strategies is that they also give room to other people who do not fall in the above two groups. This is done by the avoidance coping strategy which is defined as a strategy which focuses attention away from the stressor itself or one's psychological reactions to the stressor (Folkman and Lazarus, 1986:50). However this strategy is more valuable to short term stressors such as minor illnesses like toothache, not when dealing with a long term stressor like HIV/AIDS. Avoidance coping is not effective because it is associated with dysphoria and depression ( Billings and Moos,1981:188).

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The weakness of the general coping theory is that it is not completely satisfactory particularly when dealing with HIV/AIDS. This is because even people who have a lot of resources still use emotional coping strategies instead of the problem coping strategies because HIV/AIDS is incurable (Folkman and Lazarus, 1986:51). They also consider only the effect of coping strategies on the emotional status of the coper. This means that the effects on the stressor itself and the coper's environment are disregarded (Meusing, 1997:70). Another major point of criticism is that coping strategies focus on emotions without considering behavioral outcome. They are also individualist as they concentrate only on the coper's interest without considering the interest of his children, family and sexual partners (Meusing, 1997:70).

## HIV/AIDS IN SOUTH AFRICA PREVALENCE, IMPACTS AND INSTITUTIONAL RESPONCES

### 3.1 INTRODUCTION

This chapter discusses HIV/AIDS prevalence and impact in Southern Africa and South Africa in particular. It also discusses awareness programmes that have been done in the areas of HIV/AIDS**,** VCT and the impact of VCT in South Africa and its effectiveness in curbing the spread of HIV.

### 3.2 HIV/AIDS IN SOUTHERN AFRICA

Sub Saharan Africa has the world's highest HIV prevalence and faces the greatest demographic impact. In the worst affected countries of Eastern and Southern Africa, the probability of a 15 year old dying before reaching the age 60 has risen dramatically in some countries; up to 60% of today's 15 year olds will not reach their 60$^{th}$ birthday ( Jassen ,2003 cited in UNAIDS 2004).

Never in history has there arisen such a widespread and fundamental threat to human development as HIV/ AIDS. HIV/AIDS knows no boundaries of class, status, race or sexual preference. Both the powerful and powerless in every society are caught up in this vicious epidemic and it is now estimated that 36 million have been infected worldwide (UNAIDS 2010). Southern Africa is home to one-third of the global number of people living with HIV/AIDS and accounted for one-third of the total number of deaths due to AIDS globally (UNAIDS 2006a).

The epidemic's feminization is more apparent in sub Saharan Africa. It is estimated that 57% of adults infected are women and 75 % of young people infected are women and girls (UNAIDS 2004).There are several factors that are driving this trend. Young African women tend to have male partners much older than themselves - partners who are more likely than young men to be HIV infected (UNAIDS 2004). Gender inequalities in the region make it much more difficult for African women to negotiate condom use. In southern Africa where the general population's prevalence is high and women's social status is low, the risk of HIV infection through sexual violence is high (UNAIDS 2004). A survey of 1366 women attending antenatal clinics in Soweto, South Africa, found significantly higher rates of HIV infection in women who were physically abused, sexually assaulted or dominated by their male partners. The study produced evidence that abusive men are more likely than non abusers to be HIV positive (Dunkle et al 2004 cited in UNAIDS 2004). The researcher also agrees to the previous studies that states that more women are infected with HIV/AIDS than males because biologically women mature faster than man and are more likely to engage in sexual intercourse earlier than males.

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Currently there is on average 13 infected women for every 10 infected men in Sub Sahara Africa (UNAIDS 2004). The difference between infection levels is more pronounced in urban areas, with 14 women for every 10 men ,than in rural areas ,where 12 women are infected for every 10 men(Stover,2004 cited in UNAIDS 2004). The difference in infections levels between women and men is more pronounced among young people aged 15- 24, this ranges 20 women for every 10 men in South Africa to 45 women for every 10 men in Kenya and Mali (UNAIDS 2004). The researcher have the same views with the above writers because in Africa generally women get married when they are younger than their husbands because according to the African culture the husband is the head of the house and age gives him that authority.

The HIV/AIDS pandemic is a now a severe threat in Southern Africa because it threatens food security, productivity, human resource availability and development and may even jeopardize national and regional security (Jackson, 2002:233). It hurts the individual family and household and its impact reaches through to the macroeconomic level. This is a long term development disaster on a scale never witnessed before (Jackson, 2002:233).

**3.3 HIV/AIDS IN SOUTH AFRICA**

South Africa is said to have more people living with HIV than any other country (Dorrington 2001:76). According to UNAIDS (2010), South Africa's epidemic is one of the worst in the world, with approximately 5.5 million people living with the virus at the end of 2009. It was estimated that more than 1400 new infections occur every day, and on average 950 South Africans die each day due to AIDS-related illnesses (Dorrington, et al 2006:76).

In 2002, Shisana and Simbayi conducted a national household survey that randomly selected more than 10 197 households to be interviewed and tested for HIV upon their consent. Results from the study showed that an estimated 11.4% of South Africans (aged two years and older) were living with HIV/AIDS. Since then a second national-level household survey has been conducted (Shisana et al 2005:14). Findings from the study indicated a national HIV prevalence of 10.8% (amongst persons aged two years and older) indicating a slight decline in the rate of prevalence between 2002 and 2005. The researcher is of the opinion that the general decline in the prevalence rate may have been caused by the massive awareness that the South African government is doing in order to inform people about the dangers of HIV/AIDS. And also the availability of free condoms might also be attributed to this decline

In terms of the prevalence rates across the various provinces in South Africa, the results of the 2005 national household survey indicated that KwaZulu-Natal and Mpumalanga Provinces had the highest prevalence rates at 16.5% and 15.2% respectively (Shisana et al., 2005:15). Shisana et al. (2005:15) also reported the Eastern Cape Province as having a prevalence rate of 8.9%. Thus, despite the slight decline in prevalence rates that has been noted by the national survey (Shisana et al., 2005:16), the statistics indicate that high levels of HIV still exist across the various provinces in South Africa.

In a study conducted in order to assess the communication between mothers and their daughters 122 urban black mothers of teenagers in the Durban area of South Africa illustrated that mother's knowledge of HIV was high (95.9% knew that HIV could be transmitted through hetero sexual relations but none had engaged in sexual intercourse with her partner with a condom and none of the mothers had spoken with their children about HIV/AIDS (Campbell,

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1999:10). The results of this study show that parents are reluctant to speak about HIV/AIDS with their children this might explain the high HIV infection among the youth.
The youth are said to be the most affected by the disease, as approximately half of all new infections reportedly occur in people between the ages of 15 and 24 years (United Nations Population Fund (UNFPA) 2004). In the Eastern Cape Province alone, HIV prevalence among young people aged 15-24 years increased from 9.2% in 2002 (Shisana et al 2002:16) to 11.7% in 2005 (Shisana et al., 2005:25). The Eastern Cape was also found to have the second highest prevalence of HIV in this age group (Shisana et al., 2005:26). This finding was found to be consistent with previous research on a national survey of HIV and sexual behavior among young people between the ages of 15 and 24 conducted by (Pettifor et al (2004:12). In terms of HIV incidence, it was found that among the youth aged 15-24 years the annual incidence was 3.3%.(Shisana et al. 2005:26).The researcher is of the same view the previous writers because the youth are likely to be infected because of lack of experience and the generally carefree attitude of most youths

**3.4 HIV/AIDS IN EASTERN CAPE**

The reason that the Eastern Cape was chosen as the principal site for this study is that many areas (particularly rural areas) in the Eastern Cape have been referred to as areas of deepening poverty. It is within such contexts of poverty that the HIV/AIDS virus is said to flourish (Freudenthal, 2001:27). King William's town is no different to other small towns and rural areas in the Eastern Cape in that many of its people live under conditions of extreme poverty. Unemployment levels are very high, forcing people to find jobs in other areas. Both migrant workers and poverty contribute to the spread of HIV in King William's town. Prevalence rates in King William's town are said to range from 25% to 33% among those who attend the different voluntary counseling and test sites in the area (Beresford, 2008:288).
The Eastern Cape, which has a population of 6 302 525 people (with 65% of it's
population living in rural areas) is said to be one of the poorest and least-resourced areas in the country (Sipuka et al 2008:87). While most areas in South Africa have access to piped water, only 62.4% of households in the Eastern Cape are said to have access to this necessity (Bradshaw et al, 2004:23). Proper sanitation facilities are also limited in this area, with only 30% of its household population having access to sanitation (Bradshaw et al, 2004:24). The lack of these basic necessities consequently makes rural areas in the Eastern Cape particularly vulnerable to infectious diseases such as HIV/AIDS.
Education, which plays an important role in promoting healthy sexual behaviour, is also of major concern for the province. This is because 22.8% of people aged 20 years and over in the Eastern Cape have no formal education (Bradshaw et al, 2004:25). In addition, because many of these areas are under-developed with limited access to transportation facilities, as well as limited access to adequate health-care facilities, residents have no other option but to travel long distances in order to seek assistance from what has been termed a "fragile healthcare infrastructure" (Medecins Sans Frontieres, 2003).The other reason why the Eastern Cape has been chosen for this research, is that very few studies have been conducted in this area on the provision of adequate care and support services to address the health and social needs of people (including adolescence and youth) infected and affected by HIV/AIDS (Dickson-Tett et al , 2000:44).

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**3.5 AWARENESS PROGRAMMES THAT HAVE BEEN DONE IN THE AREAS OF HIV/AIDS IN SOUTH AFRICA**

There has been a lot of research on awareness about HIV/ AIDS and people are now encouraged to reduce the number of sexual partners, increase condom use and male circumcision. Male condom promotion is a cornerstone of HIV prevention programs in both developing and industrialized nations. They are highly effective if used consistently (Pinkerton et al 1998:77). The male condom's adoption is limited by factors including allergic reactions to the latex used in most of them, and the perception of inconvenience and diminished sexual pleasure (Mnyika et al 1995:56).

Consistent condom use reduces infection risk substantially. Strategies to provide condoms and promote their use are quite compatible with promoting abstinence and fidelity (Jackson, 2002:137). Consistent condom use is the most effective way to reduce the risk of HIV and other sexually transmitted diseases. The notable example is that of Ghana (Asiamah, 2001 cited in (Jackson, 2002:137). The Ghanaian authorities have established a condom campaign likening condom use to their use of shields in violent situations. All police have to wear a condom wallet on their belt in addition to their usual gear, and frequent inspections take place to ensure they are carrying condom. Reportedly, police use of condoms in casual sex has increased to 65% (Asiamah, 2001 cited in (Jackson, 2002:137).

Male circumcision is another effective way to fight against HIV infection. This was found in 27 studies of male circumcision and HIV risk in Sub Saharan Africa (Shillinger, 1999:98). 21 studies found a reduced risk of HIV infection in circumcised men, with circumcised men having approximately half the infection rate of non circumcised men (Weiss et al 2000,cited in (Jackson, 2002:138). The risk to uncircumcised men may be greater because the foreskin contains HIV target cells. The idea of promoting circumcision as an intervention against HIV has been resisted, in large part because of cultural obstacles (Shillinger ,1999:98) .There is also a need for resources and training to make the procedure safe and more widely available. Another obstacle is the risk of creating a sense of false security because circumcision alone will not prevent people from contracting HIV (Shillinger ,1999:98).

Research has also been done on the promotion of individual behavior change that will result in the reduction of HIV infection (Jackson, 2002:139). The most certain way of preventing HIV infection is through the promotion of abstinence and fidelity. The more sexual partner's one person has sex with the greater chance that one or more has HIV. Therefore by reducing the number of sexual partners one is likely to be at low risk of infection (Jackson, 2002:139). Couples may also avoids penetrative sex this will remove the risk of infection. It involves the man rubbing his penis between the tightly closed thighs of his partner until he reaches ejaculation (Jackson, 2002:139).

Masturbation is another safe method of reducing HIV infection. Masturbation that does not involve any penetration is essentially safe (Jackson, 2002:140). Masturbation can be between two people or undertaken alone for sexual release. It removes the risk of infection greatly but the only issue with masturbation is whether it is socially and culturally acceptable (Jackson, 2002:140). There has been a lot of research in all these areas but there is a dearth of studies on

how people who are HIV positive make their lifestyle decisions regarding their reproductive health sexual preferences, diet and physical fitness activities.

**3.6 CONSEQUENCES OF LIVING WITH HIV**

The discovery that one is infected with HIV has been shown to be associated with reduced mental health in China, the United States, and South Africa. Stress, depression, and mental illness are strongly linked to the stigma surrounding the virus (Freeman et al, 2007:12) and have residual negative effects on physical health, possibly due to reduced adherence to medications (Rintamaki, et al 2006:56). Stigma has been linked to higher risk behaviors in France, South Africa, and China (Mahajan et al, in press). In South Africa, it has been shown to deter people from testing and accessing prevention of mother-to child-transmission (PMTCT) services such as safe infant feeding (Mahajan et al, in press). HIV-positive people are at risk of social isolation (Emlet, 2006:30). Among drug users in China, this was associated with poor ART outcomes (Knowlton 2007:18).

HIV/AIDS is a long illness that can place a heavy burden on caregivers and have a disruptive effect on families in Malawi; caregivers reported that intra-household tensions and stress grew (Chimwaza, 2004:116). Children orphaned by AIDS, moreover, are at heightened risk of psychological and behavioral problems (Cluver, 2007, Stein 2003:45). AIDS also has economic effects on families, due to the costs of treatment, care, having to miss or retire from work, and funerals. Long-term economic prospects may be impaired if children are withdrawn from school because of financial constraints or the need to care for sick relatives. In Asia, the costs of treatment to households in the pre-ART era were over double national per capita income (Bloom, 1993:23). In two-thirds of AIDS-affected households in a study in Zambia, disposable income fell by 80% (Nampanya-Serpell, 2000:35). Lost earnings forced poor households in India to draw down savings and sell off assets (Basu, 1997:81).

**3.7 VOLUNTARY COUNSELING AND TESTING**

Voluntary counseling and testing for HIV was introduced in the early 1990s in most countries as a strategy to curb the spread of HIV/AIDS. It aims to provide care, support and treatment to people already living with HIV (UNAIDS/WHO, 2001): It allows people to learn their HIV status and be counseled about its implications (UNAIDS/WHO, 2001). Voluntary counseling and testing for HIV also represents a mechanism and support for those affected. It gives access to the prevention, treatment and management of HIV related illnesses, and can also lead to changes in behavior (Bagglley, 2001:146).

VCT has become a vital process in combating the spread of HIV and AIDS. HIV counseling has been defined as

> *"a confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS. The counseling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behavior." (World Health Organization [WHO], 1994*).

VCT is an effective strategy for facilitating behaviour change for both clients that test negative and positive. Different studies have shown the effects of VCT including a decrease in unprotected sexual intercourse, a reduction in multiple partners, an increase in condom use,

and more clients choosing abstinence (Solomon et al 2006). Although VCT is a relatively costly activity, it is seen to be a cost-effective intervention (Bagglley, 2001:146).

Previous literature has mainly focused on VCT as fundamentally primary prevention and secondarily as a health promotion or secondary prevention. The construction of VCT as preventative hinges on two related themes. Firstly, VCT is constructed as a preventative intervention based on the assumption that a linear relationship exists between knowledge of HIV status and behaviour change. (Solomon et al, 2006:16). This has been the traditional major focus of VCT that once people got to know their status they will be able to change their behaviour. However this study aims to investigate not only their behavioural change but also its influence on the life style decisions of HIV positive people. Secondly, the prevention construction hinges on the educational outcomes of the counselling process that are assumed to yield behavioural changes (Solomon et al, 2006:16). Because it is an essential element in controlling the spread of HIV/AIDS is through the mechanism of having everyone know their status and being educated.

The discourse in this regard is not coercive, i.e. the intention is not to force people to undergo a mandatory test. Rather, people are encouraged, whether sick or not, to come forward to receive adequate information to make a voluntary choice about being tested (Solomon et al, 2006:16). In this way the spread of the disease can be curbed and people can be educated in prevention and behaviour change methods (Solomon et al, 2006). The secondary prevention or health promotion construction of VCT is rooted in the early detection and treatment functions of testing and counselling and the access to treatment for opportunistic infections. A sub-theme in the secondary prevention construction includes the notion of psychosocial support (Solomon et al, 2006;17). The secondary health promotive construction conveys a two- part health message of benefit to individuals that simultaneously has the capacity to yield primary prevention outcomes for others (Solomon et al, 2006:17). The construction of VCT as primary prevention prioritizes the population whereas the secondary construction prioritizes the well-being and health status of HIV positive individuals (Solomon et al, 2006:17). This study will build on VCT outcomes through examining how HIV positive people view VCT and try to indentify if it is associated in behavioural changes in their life style decision making and also explore the reasons that made them choose to undergo VCT.

It has been found that there is a lack of published research decisions regarding sexual activities, reproductive health, diet and physical fitness activities of HIV positive people. In South Africa specifically, there is currently a dearth of studies that have focused on the lifestyle decisions of people living with HIV/AIDS.

There are a number of interventions which includes cancelling and VCT that have been developed in South Africa they are aimed at understanding life after HIV/AIDS diagnosis. Such research have mainly focus on the provision of counseling services to the people who are infected with the virus and research about VCT which is instrumental in facilitation behavioral change. These interventions, however, are centered on concepts and theories adopted from the West without being adequately adapted to suit the local context, thus making them relatively ineffective in the South African context. Although some evidence does exist to support these concepts and theories, they have been criticized for being eurocentric (Solomon et al, 2006:17). This is because they fail to take into sufficient somewhat inappropriate for application in the South African context.

This is because they fail to take into sufficient consideration the social contexts that make actions and behaviors meaningful (Singe et al, 1996 as cited in Freudenthal, 2001:1). In addition, the traditions, beliefs and practices that inform behavior may be different in South Africa and in the African culture from those of the American and European cultures (where these theories were developed). New alternatives need to be found that take into consideration the role of the social, political and economic contexts within which the virus is spreading (Shisana et al 2002:54). It is also evident that health-care facilities and communities alone cannot bear the burden of HIV/AIDS. What is needed is a framework that stresses a multi-sectoral approach and views HIV/AIDS not only as a health problem, but also as a general development issue" (Freudenthal, 2001, p.1). Strategies need to be developed that cater for the needs of individuals, families and communities. The study also aims to increase the awareness of both these groups of the special needs of these infected people as well as issues of, sexual activities, reproductive health, diet and physical fitness, care and support, thus enabling them to make appropriate responses in dealing with the pandemic.

## RESEARCH METHODOLOGY AND METHODS

### 4.1 INTRODUCTION

This research followed a qualitative approach. Qualitative research is a kind of research that produces findings not arrived at by any means of statistical procedures or other means of quantification (Strauss and Corbin, 1990:4). It presents facts of narrative with words, and is concerned with understanding the social phenomenon from the participants perspective (MacMillian and Schumacher,1993:19). Qualitative researchers stress the socially construed nature of reality, the intimate relationship between the researcher and what is studied and the situational constraints that shape inquiry. Such researchers emphasize the value –laden nature of inquiry (Denzin, 2005 :33). They seek answers to questions that stress how social experience is created and given a meaning (Denzin, 2005;33 ).

Qualitative research involves the studied use and collection of a variety of empirical material case studies. These can be, for example, personal experiences, introspection, life story interview, cultural texts etc (Denzin 2005:33).Qualitative researchers deploy a wide range of interconnected interpretative practices, hoping always to get a better understanding of the subject matter at hand (Denzin,2005:34).

A major strength of the qualitative approach is that, it is a able to get the actor's perspective through detailed interviewing and observation which gives it the advantages of being able to get as many views as possible and also adapt to different situations ( Denzin,2005:34 ). It focuses on naturally occurring, ordinary events in natural setting, so that we have a strong handle of what "real life" is like (Miles and Huberman, 1994:47). It enables us to understand the latent underlying on non-obvious issues because of its logical groundless proximity to a specific situation (Miles and Huberman, 1994:47). It enables us to obtain data that is rich and holistic, reveling complexity by "thick description" that are vivid nested in real context and have a ring of truth (Denzin, 2005:34).

Some of the weakness of the qualitative approach is that findings might be unique to the relative few people included in the research (Denzin, 2005:34). Data analysis is often time consuming and the results are more easily influenced by the researcher's personal biases and idiosyncrasies (Denzin and Lincoln, 2006:64).

### 4.2 POPULATION AND SAMPLING APPROACH

Larger samples enable researchers to draw more accurate conclusions and make more accurate predictions (Schaller 1998:19) The findings of the study have not been generalized over the whole population of HIV positive people in King Williams town because the researcher was using a small sample

As it is not possible to study the whole population, the sample may provide more accurate information than might have been obtained if one had studied the entire population (De Vos,1998:191). The researcher to ensure that all HIV positive people were represented used the Random selection of the participants.

### 4.3 SAMPLING METHOD

A total of 15 respondents and five key informants were interviewed in this study, (see Tables 1 and 2 below). These included eight females and seven male respondents. The respondents' ages range from 25 to 44. The five key informants work in the HIV/AIDS field in hospitals and NGOs around East London.

**Table 1: Study Respondents**

| Respondent number | Gender | Age | Marital status | Year of discovery of HIV positive status |
|---|---|---|---|---|
| 1 | female | 25 | single | 2011 |
| 2 | female | 34 | married | 2004 |
| 3 | male | 37 | single | 2007 |
| 4 | female | 30 | single | 2006 |
| 5 | Female | 36 | single | 2008 |
| 6 | male | 39 | single | 2004 |
| 7 | male | 35 | single | 2010 |
| 8 | male | 31 | single | 2003 |
| 9 | female | 44 | single | 2004 |
| 10 | female | 44 | single | 2011 |
| 11 | male | 36 | single | 2003 |
| 12 | female | 35 | single | 2007 |
| 13 | male | 40 | single | 2007 |

| | | | | |
|---|---|---|---|---|
| 14 | male | 43 | single | 2008 |

Source: Author,field data (2011)

**Table 2: Key informants of the study**

Source: Author, field data (2011)

| Key Informant number | Gender | Profession | Work place |
|---|---|---|---|
| 1 | Male | Health official | Cecilia Makiwane Hospital |
| 2 | Female | Social worker | Emplisweni support center |
| 3 | Male | Psychologist | Masimanyane women's support center |
| 4 | Male | Social worker | Child Welfare (S.A) |
| 5 | Female | Health official | Frere Hospital |

All 15 study participants were sampled using the purposive sampling technique. Purposive sampling refers to a sample that is formed based on the judgment of the researcher (Rosnow et al 1991:88). In purposive sampling, individuals are sampled based on the notion that they are likely to possess useful information for the purposes of the study (Rosnow et al, 1991:88). One of the disadvantages of purposive sampling is that it does not allow for random sampling, therefore all persons in a given category are not given an equal chance of being sampled. The study used this non- probability sampling in view of the fact that HIV/AIDS is a sensitive health condition. The researcher thus anticipated that some respondents might refuse to participate due to this sensitivity of the HIV/AIDS topic.

This study employed in depth semi - structured interviewing. In depth semi-structured interviewing is a qualitative research technique that involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea (Boyce, 2006:22). In-depth Interviews are appropriate when you want detailed information about a person's thoughts and behaviors. The primary advantage of in-depth interviews is that they provide much more detailed Information than what is available through other data collection methods, such as surveys (Boyce, 2006:22). They also may provide a more relaxed atmosphere in which to collect information people may feel more comfortable having a conversation with you about themselves as opposed to filling out a survey questionnaire (Boyce, 2006:23).This is one of the major reasons why this study used this method because the

researcher needed to create a comfortable environment for the respondents, to feel free discussing the sensitive HIV/AIDS topic.

Some of the disadvantages of in depth study are that it is prone to bias and time-intensive (Boyce, 2006:24). Interviews can be a time-intensive evaluation activity because of the time it takes to conduct interviews, transcribe them, and analyze the results ( Boyce, 2006;24). In planning your data collection effort, care must be taken to include time for transcription and analysis of this detailed data (Boyce, 2006:24).

It must be emphasised that the researcher chose in-depth interviews because the topic of HIV/AIDS is a highly emotional topic and being infected with HIV/AIDS is a stressful experience due to the fact that there is no cure of AIDS at the moment. Hence the interviewer made sure that respondents were comfortable. The researcher also used effective interview techniques, such as avoiding yes/no and leading questions, using appropriate body language, and keeping personal opinions in check. All this would not have been achieved if one had decided to use other forms of data collection like questionnaire and surveys.

## LIVING WITH HIV/ AIDS IN KING WILLIAMS TOWN

### 5.1 INTRODUCTION

This study was conducted with the aim of finding out how being HIV positive influences one's sexual and reproductive health decision – making and choices, lifestyle choices in relation to diet and physical fitness and lastly how they cope with their HIV/AIDS diagnosis. It was guided by three research questions which are:

- How does being HIV positive influence sexual and reproductive health decision – making and choices?
- How does being HIV positive influence one's lifestyle choices in relation to diet and physical fitness?
- How do HIV positive people cope with HIV diagnosis?

Among other major findings it emerged that HIV positive status does not influence sexual behavior. As people who are HIV positive still have the desire to have children. Also most HIV positive people are aware of the diet that they are supposed to follow but they are not aware of the importance of physical fitness activities. The research also found that social support from family and friends plays a pivotal role in assisting HIV positive people to cope with the diagnosis.

### 5.1 REASONS FOR HIV TESTING AND SEXUAL BEHAVIOR AFTER DIAGNOSIS

One of the questions that respondents were asked was how they discovered their HIV status. The reasons that made them choose to know their status was important for this study as it helped the researcher to understand the attitudes of people towards VCT. The researcher found out that five out of the 15 respondents were pregnant and upon the compulsory testing at the clinic that was when they discovered that they were HIV positive. Eight

respondents said that the reason that made them to discover their HIV status was because they had been ill for some time and thus went for HIV testing.

The researcher found out that all the respondents were all mature people because the youngest respondent is 25 years old. This shows that although previous studies show that the HIV infection rate is more prevalent in youths from the ages of 15 years to 24 years. as noted by (UNAIDS 2004). Only the people who are above that age know their status, as shown from this research there are no respondents that are below the age of 25.This shows that more effort must be done to encourage the youths to get tested and know their status. It also shows that a number of the youths are living without knowing their status which might be the reason why the HIV virus is spreading faster among the youths than the older people.

**Box 1 Reasons for HIV testing**.

| |
|---|
| "I was pregnant with my second child" (respondent number two). |
| "*I went for testing because my partner died". (Respondent number six).* |
| *"I went for testing because I was suffering from TB" (respondent no13).* |
| *"After I broke up with my boyfriend I decided to go and get tested because he was not faithful" (respondent number 1).* |

Other reasons why people get tested are having unprotected sex with more than one partner, injecting drugs, either now or in the past, having sex with someone to get money or drugs in return, or having sex with someone who has traded sex for money or drugs, having sex, now or in the past, with someone who has HIV, is bisexual, or injects drugs and having another sexually transmitted infection (STI) (Woman's Health, 2010).

**SEXUAL BEHAVIOUR**

In view of respondent's HIV positive status, the study sought to understand their sexual activity. It found out that 14 of the respondents were currently sexually active and only respondent number 13 said that he was not sexually active. This was because he had some pimples on his sexual organs which prohibited him from engaging in any sexual activity. But he said he still have strong sexual desires.

**Box 2; Sexual Behavior**

| |
|---|
| *"Sometimes I am using condoms and sometimes I am not using them because I am married, and my husband does not like condoms" (respondent number two).* |
| *"We always use condoms so that we don't re-infect ourselves "(respondent number seven).* |
| *"I use condoms because I do not want to get pregnant again" (respondent number five).* |

A similar research in KwaZulu Natal, found out that nearly 50% of HIV-infected patients in a single clinical setting were sexually active and 30% of those reported having unprotected sex in the previous three months (Lurie, 2008:42). This study's findings differ with previous literature

which had noted that HIV-seropositive people have been found to experience more sexual difficulties (Catalan *et al.*,1992:120), and show poorer levels of adjustment within vocational, domestic, sexual and social domains, than do seronegative people (Pakenham *et al*.,1995:36).
When respondents in this study were asked if they were using protection, 13 of them said that they were using protection (condoms) because it prevents re-infection as well as protection from other STIs. In a study conducted in Kwazulu, it was found that consistent condom use with regular partners for men was significantly associated with urban site, increased level of education, and the absence of a casual partner. (Lurie 2008:42).HIV positive people are encouraged to use condoms because they have none of the medical side-effects that some other birth control methods may have (Avert international AIDS charity, 2010).
When respondents were asked if their partners know about their HIV positive status, 14 of the respondents said that their partners do know about their status because they told them so, while respondent number five said that her partner know about her status because she showed him her ARVs. Respondent number one said "I told my partner to go and get tested and he said he is not going to go and get tested unless if he is involved in an accident or he is sick". This shows that some people will never choose to go for VCT unless something pushes them. These sentiments were also noted earlier on when 14 of the respondents only discovered about their status when they were ill or when they were pregnant. When the respondents were asked if they sometimes use non- penetrative sex, ten respondents said they do not engage in non-penetrative sex they gave reasons of being old for that and staying away from each other as a result they will not be having time to do non penetrative sex. Four said that they do it sometimes. None of the respondents said that they use it as a substitute of penetrative sex because having non-penetrative sex - like kissing, mutual masturbation, stroking or rubbing - means you can't get pregnant or contract most sexually transmitted infections (STIs). But there are still some infections such as herpes and genital warts that can be transmitted by skin-to-skin contact (WHO 2009).
Studies into the determinants of unsafe sex in HIV-infected people suggest that to some extent the same determinants are operative as among people who are HIV negative. These include intention and self-efficacy regarding safe sex (Schiltz 2000:11). Recreational drug use also affects safe sex regardless of sero status. However, safe sex as well as sex in general is different for sero positive persons than for people who are sero negative or have an unknown sero status (Schiltz 2000:11). Among sero positive people, sex is also related to dilemma's involving disclosing their sero status to potential sex partners, and their motivation to protect their partners as well as themselves against surinfection and STIs( Schiltz 2000:11). Furthermore, having to cope with a serious disease induces negative mood states (particularly depression) and may compromise sexual functioning ( Schiltz 2000:11).

**5.2. REPRODUCTIVE HEALTH BEHAVIOR**

Respondents were also asked whether they had children after knowing their HIV status. Five respondents said that they were not aware that they were HIV positive but only discovered their status when they were pregnant. One respondent said that she had the baby knowing her status. When asked about the dangers of infecting her partner or re-infection herself, she said that she would only sleep without protection towards her monthly periods when she knew that she was likely to get pregnant during that time. Key informant four said that HIV positive people

still bear more children because of societal pressure. He noted that the African society expects a married woman to bear children and barren women can suffer some form of discrimination and low self esteem.

**Box 3: Reproductive Health Behavior**

*"No I did not know, when I got pregnant and I got tested that was when I found out that I was already HIV positive" (respondent number seven).*

*"The first one I was negative but the second one I was positive because they tested me when I was pregnant" (respondent number two).*

*"I was negative because it was not there this HIV virus, my first born was born in 1983".(respondent 10).*

*"I still want to have kids, I will go to the doctors so that they make the children HIV negative" (respondent number 15).*

*"people still want to have children because African culture expects a married woman to bear children" (key informant four)*

The above scenarios are also supported by studies from industrialized countries suggesting that some HIV-infected individuals, even after learning of their positive status, continue to engage in risky sexual behaviour (Lurie, 2008:188). In developing countries, experience is limited, although similar patterns are emerging. Research from West Africa and Uganda suggests that patterns of high-risk activity are common among those with known and unknown HIV status (Lurie 2008:188).

Respondent number four said that she had the baby after knowing that she was HIV positive. Respondent number six stated that they still want to have more babies. These feelings were also noted in some women in Cape Town where it was noted that, being HIV positive modified but did not remove reproductive desires, and diversity existed in reproductive intentions (Cooper, 2007:18**)**. Some HIV positive individuals wished to avoid pregnancy. Fears of partner and infant infection and having a previously infected baby were important factors deterring some individuals from considering having children (Cooper, 2007:18**)**. There was also strongly perceived community disapproval associated with HIV and reproduction. Strong desires to experience parenthood, mediated by prevailing social and cultural norms that encouraged childbearing in society more broadly, were reported by others (Cooper, 2007:19**)**. Motherhood was an important component of married women's identity and important for women's social status. Family, husbands' and societal expectations for childbearing were important influences on women's reproductive intentions, for some counterbalancing HIV as a factor discouraging reproduction (Cooper, 2007:19).

When respondents were asked about mother to child transmission (MTCT), 12 of the respondents said that they know about MTCT. Four respondents who had children after

knowing their status said that they had tested their children and were all HIV negative. Ten respondents who wish to have children said they were prepared to use scientific methods to prevent MTCT.

### 5.3 HOW DOES BEING HIV POSITIVE INFLUENCE ONE'S LIFESTYLE CHOICES IN RELATION TO DIET AND PHYSICAL FITNESS?

#### 5.3.1 ACCESS TO FOOD AND DIET QUALITY

The study also sought to understand respondent's access to food. Fourteen of the respondents said that they were not working and someone else in the household was buying food for them. This resulted in 12 of them having controlled or limited access to food. When the respondents were asked if there was a difference between their previous diet before being HIV positive and now, eight respondents said that there was a difference since they now make it at priority to include vegetables and fruits in their meals. Respondent number nine said that she was aware of the recommended diet but she was not following it because she could not afford it. Her sentiments were also echoed by five other respondents (respondent 4, 6, 7, 11, and 13) who also said that they were aware of the recommended diet but could not afford it because they were not bread winners.

**Box 4; Diet Quality**

*"Yes the doctor said I must eat healthy food like vegetables and fruit" (respondent number two).*

*It is different now I am eating vegetables, it was not my priority but now it is now my priority" (respondent no 14).*

*"They said I must eat meat, vegetables and cheese but I cannot afford it" (respondent number nine).*

Respondent number 13 said that even though she knew of the recommended diet she was not following it and there was no difference between her previous diet and now. However two respondents (respondents 14 and 8) said they were not aware of the recommended diet and that were not told about it.

An HIV positive person should eat all types of food items that are recommended as part of the balanced diet. It means one must eat correct quantities of cereals, pulses, eggs, milk, meat, chicken, green leafy vegetables, seasonal fruits (Singh, 2010:14). From the list provided by Singh(2010:14) and comparing it with the meals that the respondents are eating, one can notice that they seem only to know about eating fruits and vegetables ignoring milk and cereals.

### 5.3.1 PHYSICAL FITNESS ACTIVITIES

Experts suggest that 30–60 minutes of moderate-intensity activity, 3–5 times a week benefits blood pressure and hypertension, blood lipids and lipoproteins, blood coagulation, cancer, depression and anxiety (WHO, 2004. More activity is necessary to reduce all-cause mortality (WHO, 2004). This is the recommended amount of physical fitness activities that must be done by people to keep healthy. However I3 of the respondents said that they were not engaging in any physical fitness activities. All of the respondents also said that they had no gym membership. Only respondent number eight said that he was lifting some homemade weights.

Box 5; Physical Fitness Activities

| |
|---|
| *"I am lifting some weights twice each day and four times a week" (respondent number eight).* |
| *"I am a netball coach, I coach them every day for 1 hour" (respondent number one).* |

Respondent number one said that the only form of physical fitness she was doing was coaching a netball team. When the respondents were asked about the hours they sleep, 14 of them said that they sleep a normal eight hours a day except respondent number 13 who said he wakes up at 2 am every day because he loses his sleep after that. This trend is almost similar with the general world trends towards physical fitness. Sixty percent of adults and over two-thirds of young people globally are not sufficiently active to protect their health (WHO, 2004)

The lack of any physical fitness activities among the respondents is one area that must be reviewed because recent studies have shown that physical inactivity is the most common of all cardiovascular risk factors across countries. After tobacco use, inactivity is the greatest contributor to mortality and morbidity from all causes (Giannini, 2008:38). Physical activity is, therefore, increasingly viewed as the least expensive and most effective preventive "medicine" for combating the increasing worldwide problem of obesity and, with physical fitness, may represent the most effective strategy to prevent chronic disease (Giannini, 2008:38). The benefits of physical activity in relation to non-communicable disease are irrefutable. These include the primary and secondary prevention of chronic diseases, such as cardiovascular disease, diabetes, cancer, hypertension, obesity, depression andosteoporosis, as well as individual and societal economic benefits such as reduced health-care costs and increased productivity (WHO, 2004).

### 5.4 COPING AND LIVING WITH HIV

### 5.4.1THOUGHTS AND FEELINGS ABOUT HIV

When the respondents were asked about how they felt when they were first told that they were HIV positive,12 of them said that they were very hurt and felt a lot of pain and that it was hard to embrace: *"It was not easy at all ,I* thought I was going to die and that there is nothing I can do with my hands", said respondent number eight.

**Box 6 Thoughts and Feelings about HIV**

*"I was shocked at first but late, I thought it has already happened" (respondent number seven).*

*"That night I was angry but I told myself that nothing was going to change I must accept my status". (respondent number four).*

*"I did not even go for counseling ,I just went home ,I wanted to think about it" (respondent no 10).*

*"I was so relieved that I now know my status and I knew it earlier so I would seek help sooner." (respondent no 1)*

Previous studies also confirm these feelings: "no matter how much you prepare, it is a shock to learn that you have HIV or AIDS, you may feel very confused and not know what to do. It is good to be with someone you trust at this time" (WHO 2010). However other respondents had different opinions, some were in denial about their status.Respondent number 13 said that "I did not put it in my heart and I just took it as if I don't have it". This type of coping strategy is also noted in previous research which states that at first some people cannot believe that they have HIV or AIDS. They say:"The doctor must be wrong"."It can't be true, I feel so strong"(WHO 2010).These respondents would be using the coping method called "distancing" which notes that if a person is facing a stressful condition one way of coping with the stressor is to take the stressor as not real.

When asked how they were feeling at the moment, all the respondents said they were happy now and have accepted their status . Respondent number one said "I am alright because I attend workshops" Respondent number seven said "I think properly now that I know I can live". Respondent no 15 said "I am happy, I take my medication". This shows that people who are infected with HIV will eventually come to accept their status and learn to live with it. Workshop attendance and the taking of medication are noted as two things that is helping respondents to cope with HIV infection.

When respondents were asked about how their families felt about their status,10 of them said that their families accepted their H.I.V status and were helpful. Respondent two said that "when I told them about my status they did not panic but just said I should change my life style, otherwise there is nothing wrong with you" . Respondent nine said that her family was ok with it and only encouraged her to go and collect her ARVS. However four respondents (respondent 5, 10, 12 and 15) said their families felt very sad. Respondent 12 said

her family felt very sad because she was not the first one ,there was also another member of her family who was also HIV positive . Respondent no two said that "my family felt very sad, but my mother is a role model, she told me that "I can start my life afresh". These responses also show the importance of family support in helping people to cope with HIV.

When respondents were asked whether they were getting any form of social support, two respondents said that they were getting support from the government in the form of grants. Respondent 14 said that he was getting the HIV disability grant and respondent 12 said that she was getting the child support grant. These two respondents said that their grants were their only source of income. The research shows that social grants from the government helped them to cope with the infection. This coping strategy was also note in past researches because considerable evidence that has been accumulated suggests that social support is a means of buffering the negative health outcomes that result from stressors (Cobb, 1976:143).

People with HIV/AIDS have special stressors to which supports can be directed but they have an added difficulty in that their disease impacts directly on the support they receive (Cobb, 1976:143). For example, the stigma attached to the illness makes it difficult to gather some forms of support, the high incidence of the disease within their social network reduces potential sources of support, and the erratic progression of the disease makes it difficult for care givers to sustain the high levels of support needed (Folkman *et al*., 1994:57).This maybe is the reason why only respondent 12 and 14 are receiving support from government.

All respondents said they were receiving informal support from family, friends and neighbours. They said that they receive support in the form of material things likes clothing, medication, food and also emotional support like encouragements and sympathy. This helped them to cope with HIV infection. According to (Cobb, 1976:143) social support, is defined as the feeling of being cared for and loved, valued and esteemed, and able to count on others should the need arise. From the interviews one can conclude that respondents were coping because of the social support from their families. As respondent two put it: "my mother is a loyal mother she told me that this is not the end of life." This all shows that social support is a very important way of helping HIV positive people cope with the infection.

## CONCLUSION AND RECOMMENDATIONS

The study found that there is very low uptake of VCT. Most people only get tested if they are compelled by other factors, like illness and pregnancy. The research also found that HIV status does not affect sexual behavior as some HIV positive people continue to engage in risky sexual behaviour. It also noted that some HIV positive people's desire to have children is motivated by the fact they are able to have HIV negative children due to the prevention of mother to child transmission (PMTCT) methods. The study also found that while respondents know of their recommended diet which includes vegetables and fruits, some face the problem of money to be able to follow this recommended diet. The respondents are not aware of the importance of physical fitness activities. All do not have gym membership and they are not aware of the importance of regular physical fitness activities.

All the respondents have accepted their HIV positive status and are now living positively. This was shown by the way they participated in the research and also from their comments like "I am now very happy because I attend workshops" (respondent number one). This shows that workshops and regular associations with other HIV infected people and organizations that offer

support help them to cope with their HIV status .The respondents also noted that their strongest strategy for coping with the HIV infection was the social support they are receiving from their families, friends and the community where they live.

Knowledge which was produced by the study will be useful to people who are HIV positive as they will learn how others have managed to cope with their HIV positive status. It will also help planners, counselors and all the people who are involved in helping those who are infected with HIV/AIDS to come up with polices which will be conducive and relevant since its recommendations are informed by people who are already infected hence they have personal experiences to share. The findings will also be beneficial to organizations that have interest in promoting VCT. The findings might also contribute to behavior changes among HIV positive people by emphasizing on the positive experiences that are done by other HIV positive people.

### 6.1 RECOMMENDATIONS

- HIV positive people must be encouraged to have physical fitness activities because the study found out that the respondents are not engaging in any form of exercises.
- They must also be informed of the correct diet because most of them only think that if they eat fruits and vegetables they are following the correct diet that must followed by a person who is HIV positive.
- The government must provide grants to HIV positive people who are not working because they have a special diet that they must follow and they cannot afford it if they are not working.
- The government should open up more centers like Emplisweni support center where HIV infected people can get support as this research has shown that such support structures help people cope with their infection through experience sharing, association workshops and seminars.

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