

# **HIV/AIDS and Impoverishment: A study in Mpumalanga Province in South Africa**

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**DECLARATION**

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## SUMMARY

The challenges brought by HIV/AIDS across the world have created a strong divisions and inequalities between employers and employee, young and adults, men and women , black and white, employees and employees, teachers and students and also employers themselves. It has changed the shape of the world. Poverty too, has taken its course. The usage of condoms as a preventive measure against the contracting of STD's is undermined by young generations. Children become orphans due to the outcome of HIV/AIDS. Young children left school early for farm labourers due to poverty dimensions. Siblings are family headed because parents died and relatives are not willing to care for them. Food insecurity becomes a challenge among the infected and affected poor household. Is it HIV/AIDS or poverty that has changed the world forms? The cause for all the consequences remains rhetorical. Sub-Saharan is declared as highest country with PLWHA and in poverty. This paper examined how the poor communities cope under the umbrella of the HIV/AIDS and Poverty world. The paper also provides suggestions that programmes and policies on anti-poverty be developed. Project such as home based care for PLWHA from poor communities who cannot afford for caring should be instituted as one remedy to keep girls at schools than to care for the sick household members. Educating girls will a tool to minimize the spread of HIV/AIDS they will know about their rights.

## **OPSOMMING**

Hierdie studie ondersoek wyses waarop die armes in een provinsie van Suid-Afrika die pandemie kan hanteer en argumenteer dat programme en beleid ontwikkel moet word om die armes te help om doeltreffend op die pandemie te reageer.

‘n Sterk saak word uitgemaak vir die betrokkenheid van die gemeenskap in hierdie verband en riglyne vir die opleiding en opvoeding van gemeenskappe word aangebied.

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## ACRONYMS

AIDS	: Acquired Immune deficiency Syndrome
ARV	: Anti-retroviral
BER	: Bureau of Economic Research
CDW	: Community Development Workers
DoH	: Department of Health
FAO	: Food and Agriculture Organization of the United Nations
HH	: House Hold
HIV	: Human Immunodeficiency Virus
ILO	: International Labour Organization
KAP	: Knowledge, Attitude and Practice
NGO	: Non-government Organization
PLWHA	: People Living with HIV/AIDS
STD	: Sexual Transmitted Disease
UNAIDS	: United Nations Programme on HIV/AIDS
UNDP	: United Nations Development Programme
UNFPA	: United Nations Population Fund
UNIFEM	: United Nations Development Fund for Women
WHO	: World Health Organization

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## **CHAPTER 1**

### **1.1 INTRODUCTION**

In this paper the effects that HIV/AIDS has an influence or drive the poor to be impoverished are being investigated. Considering the wide range of poverty lines and measures, the most interpretation of data for farm labourers in South Africa in general is that poverty has remained stagnant. Studies have confirmed that poverty drives the HIV/AIDS epidemic. The study would investigate if HIV/ADS as we know that is a threat to our future, does have an impact on poverty or it does furthers the impoverishment and have impact at the workplace. Do the people who are poor if contracted HIV/AIDS become drowned to be poorest?

#### **1.2. Epidemiology of HIV/AIDS in Sub-Saharan Africa.**

Focus on South Africa at Mpumalanga Province (Bushbuckridge at Thulamahashe location)

##### **1.2.1. Objectives**

Studies indicate that Sub-Saharan Africa is the worst country that has contributed globally to the high rates of HIV/AIDS and an area of large international debt and poor health resource. Does Thulamahashe location under Bushbuckridge also contributed to this statistics as higher rates of the problem? Does the area have high rates of poverty? Are they employed, if not, how do they make their living? Is there any motive behind to be engaged in such practices? What do the community and government's reaction over this matter?

In the context of the problem under review, that is whether HIV/AIDS furthers the process of impoverishment within Mpumalanga Province at Bushbuckridge under

Thulamahashe location, villages around the township would be visited. The study would also extend to research on poverty in general if it does have influence on their social activities. Some workers are not able to access existing support services. Is it true that those who are rich will die rich, and the poor mainly are victims of the virus (HIV/AIDS).

### **1.3. Hypothesis**

HIV/AIDS has been a serious threat to the world. People suffering and are being led to poverty due to the death of the breadwinner(s) at household level. According to UNAIDS they emphasized that poverty exacerbates the impact of HIV/AIDS. The experience of HIV/AIDS can readily lead to an intensification of poverty and can push some non-poor into poverty (African studies centre, 2003). Poor people are likely to contract HIV/AIDS due to their lower status and lack of knowledge to control their lives. Affected families have less access to food, women and children resort to sex in exchange for food (Dr.Njelesani, 2002:5)

### **1.4. Research problem questions**

The paper examined the following issues:

1. Do the household have an access to existing support services from the government or any other organizations?
2. What challenges do you encounter within your households?
3. How do the household cope with the household member's funerals that died?
4. What is the total of the funeral cost?
5. Who cares for the deceased while he/she was ill at home?
6. How many working days lost by the caregivers while caring for the sick member(s) in the month?

The following types of questions were asked:

1. Factual questions: would be used to get a background mostly on the family (e.g. level of education, number of years in the village/farm).
2. Multi coded question
3. Opinion and attitude question (such as, do you think support on HIV/AIDS staff is important) to get views of respondent as regards to supporting PLWHA.
4. Open-ended questions (such as, what are usually the reasons for non-adherence of government and community to HIV issue) would be asked to try and gain insight of the general views of the respondents.

#### **1.4 Aims and objectives of the study**

##### **1.4.1. Aims**

This study aims to investigate whether HIV/AIDS furthers impoverishment.

##### **1.4.2. Objectives**

To provide evidence on the issue of HIV/AIDS if it has influence on furthering impoverishment to the poor infected and affected communities.

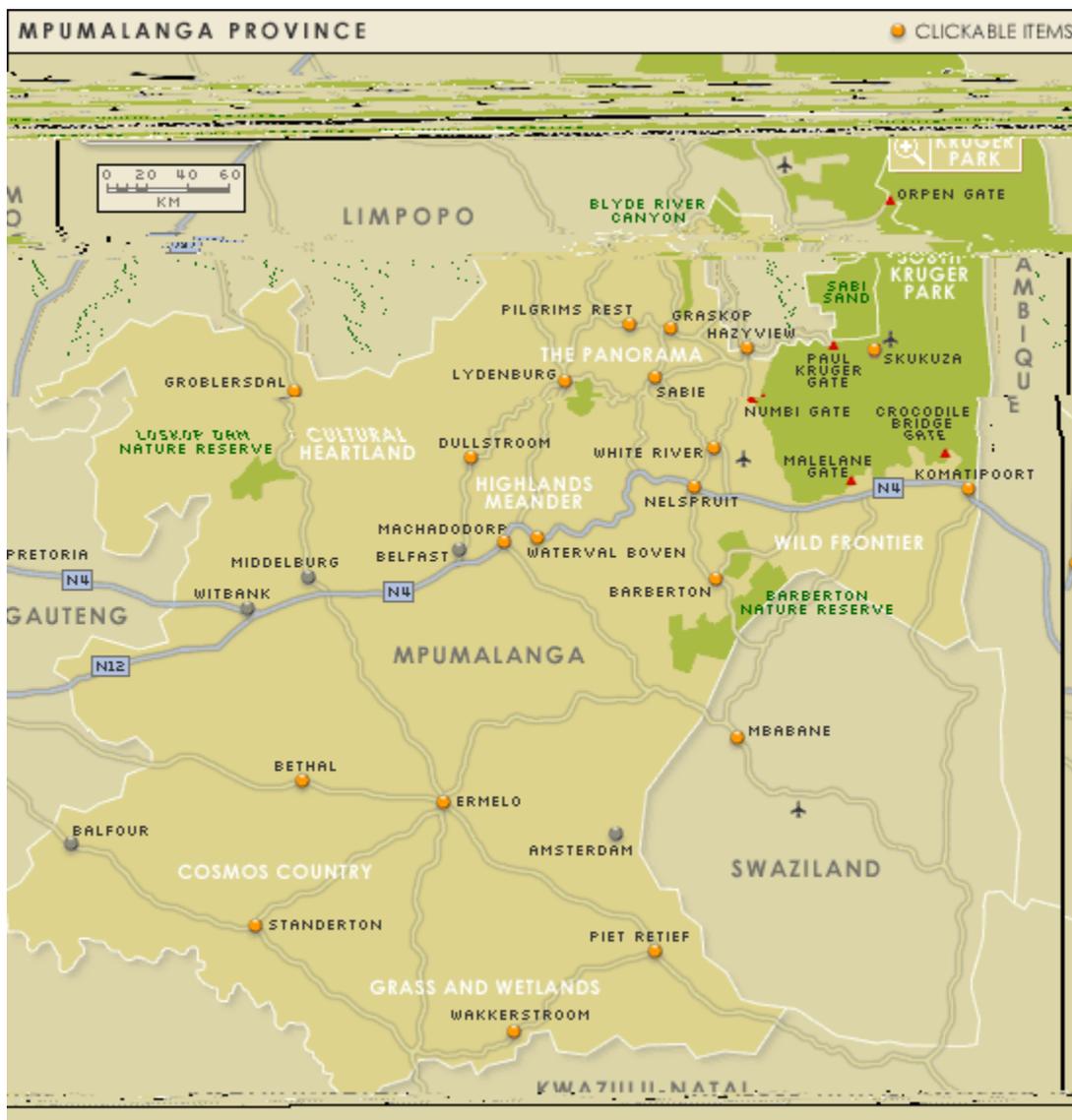
#### **1.5. Significance of the study**

The findings of the study will assist the government and the NGO's to unite and develop more strategic plans to mitigate poverty among the poor communities. The communities that have already been impoverished by HIV/AIDS would benefit from the study to adopt a positive lifestyle that would possibly help them fight back from their disastrous situations.

### 1.6. Area of study

The study was conducted in Mpumalanga Province at Thulamahashe under Bushbuckridge region. The below map will assist in locating the area of Bushbuckridge. The study area is not displaced on the map but it is situated between Hazyview and Graskop.

**Mpumalanga Province Map: South Africa**



**Figure 1: Mpumalanga Map**

Source: [www.safarinow.com](http://www.safarinow.com)

### **1.7. Definitions (Conceptualization)**

Abbreviations and glossaries that are used in the study such as follows:

**HIV** : Is a human Immune deficiency virus. It is a virus that attacks and destroys cells that protect the human body against infections and other illnesses. To be HIV does not mean that you have AIDS.

**AIDS** : Is an Acquired Immune Deficiency Syndrome. Acquired: means anything that you can get infected with it, Immune: something that is protected, and deficiency: it is a weakness in the body's system that fights disease and syndrome: group of health problem that make up a disease.

**Impoverishment** : This is a state of having little or no money or assets. The people in this regard are unemployed and hard to make better living.

**Stigma**: An attribute that is deeply discrediting within a particular social interaction (Goffman, 1963:3)

**Poor/Poverty**: Lack of access to the resources for food and productive resources.

**Remuneration**: Reward that you get from your employer after you have worked on an agreed task.

**Interview**: Formal or informal meeting between two people or among group for the purpose of obtaining information about something in particular

**Orphan**: Children who have lost either mother or father or both parents to AIDS before age, orphan-hood is often accompanied by stigma, prejudice and increased poverty (Department of Economics and Social Affairs).

**Evidence**: A things help in forming a conclusion or judgement.

**Exhausted**: Over utilized the given credits

**Commercial sex workers**: Engaging in transactional sex in return for workplace favors, employment, money or other forms of payment (Department of Health, Mpumalanga Province)

## **1.8. Delimitation and Limitation of the study**

### **1.8.1. Delimitation**

The study was conducted among the infected and affected poor community that resides at Mpumalanga Province under Thulamahashe location. Thulamahashe is constituted by many villages, but for the purpose of the study, all villages were not reached.

### **1.8.2. Limitation**

In some areas the issue of HIV/AIDS as a sensitive matter is still treated confidential whereby an individual feel not freely to articulate his views in a group. Participants feel that the group may pressurize the individual in expressing his views within the group.

## **1.9. How the limitations were dealt with**

Interviews were conducted at their HH without observing that neighbours have being interviewed.

## **1.10. Disposition of the study**

This report consists of five chapters.

Chapter 1: Introduces the study with comprehensive background and orientation to the study.

Chapter 2: Describes the literature review, what the other studies had argued on the same idea or notion.

Chapter 3: Described the methodology that was used from the study.

Chapter 4: Describes about the findings from the data analysis.

Chapter 5: Discussion of the study, conclusion and recommendations that needs to be considered and further research.

### **1.11. Summary**

The Chapter gave a clear picture on the geographical location about the selected study area. It also highlighted a detailed discussion about the hypothesis. The next chapter would detail the literature reviews on the problem identified.

## **CHAPTER 2: Literature Review**

### **2.1. Overview**

This chapter would point out the association between poverty and HIV/AIDS and what the other studies had revealed about the two factors with their impacts. The study provides related link between HIV/AIDS and poverty, the impact at workplace and discussions on economic and socio-economic matters such as health care, income, assets, coping during bereaved moments, education, gender inequalities, housing infrastructures and food/nutrition.

### **2.2. Objectives**

The study investigates the association between poverty and HIV/AIDS and the potential risks that furthers impoverishment around Thulamahashe location under Mpumalanaga.

### **2.3. Characteristics and defining poverty**

Poverty is defined in different ways considering the geographical background of the particular population. Cohen (2002) defines poverty as associated with weak endowment of human and financial resources such as low levels of education associated with low levels of literacy and few marketable skills generally poor health status and low productivity as a result. Poverty is characterized by unemployment, low educational attainment, illiteracy, low skills levels, and a lack of access to basic services and economic opportunities. (DoH, Mpumalanga, 2006:22) Rawson in World Bank Development Report (1980) defines poverty as a condition of life so characterized by malnutrition, illiteracy and diseases as to be beneath any reasonable definition of human decency. While other studies, defines poverty as a lack of access to the resources for food and productive resources. The above definitions emphasized on one factor, poor health status and lack of financial resources. Lack of money, you can not have access to anything. The

study would research on the mentioned characteristics on poverty among the Thulamahashe communities and the impact it has on working environment.

## **2.4. Contextual Factors**

### **2.4.1. Poverty**

Many people in Mpumalanga are living in poverty. (DoH, Mpumalanga, 2006:20). Poverty operates through a variety of mechanisms as a risk factor for infection with HIV/AIDS. Its effect needs to be understood within a socio-epidemiological context. It works through a myriad of interrelations, including unequal income distribution (Gie et al,1993: 223-224), economic inequalities between men and women which promote transactional sex (Halperin and Allen, 2001: 1,3,15), relatively poor public health education and inadequate public health system (Mitton,2000: 17-26). Poverty related stressors arising from aspects of poverty in township such as poor and dense housing, and inadequate transportation, sanitation and food, unemployment, poor education, violence, and crime, have also been shown to be associated with increased risk of HIV transmission ( Kalichman, Simbayi, Kagee, 2006: 62,1641-1649). Poverty appears to be the most prevalent in rural arrears and informal settlements located adjacent to towns. (DoH, Mpumalanga, 2006:22)

### **2.4.2. Impact on economic development**

The ILO demonstrated in 2004, and again with more recent data in 2006, that the rate of economic growth in countries heavily affected by HIV/AIDS has been reduced by the epidemic's effects on labour supply, productivity and investment over the last decade or more. According to this assessment, 3.7 million labour force participants aged 15 to 64 years were living with HIV or AIDS in South Africa (ILO,2006). However, there is no clear evidence of the actual economic impact of HIV and AIDS in South Africa. BER, (2001) identifies some types of

poverty that occurred around the working environment. Such poverty is as follows:

- Service poverty: where people are unable to access or are not provided with the services such as health and education.
- Resource poverty: where though they have sufficient incomes people are unable to access resource because they may be poor in terms of their representation/government.

AIDS has the potential to push economies into decline and then keep them there. The reduction in savings and loss of efficiency associated with the spread of the disease is a kin to running Adam Smith in reverse. Due to the epidemic, the government will have spends between 7-18% of resources more by 2010 because of the AIDS assuming the current levels of service that are maintained (BER,2001).

#### **2.4.3. Employment and Unemployment status**

According to the studies, it is indicated that unemployment rate in Sub-Saharan Africa is very high. This led the public to engage themselves to informal sector activities. Fernandez (2006:1) mentioned that Latin America and Sub-Saharan Africa have high unemployment levels which means the majority of people live in poverty. These people participate in informal sector activities such as prostitution and intravenous drug-use which has implications for HIV. Infected working employees productions are very detrimental because of their pattern of attendants. The humanitarian Abraham Maslow once recommended that a health family should get basic needs such as food, shelter, protection, clean water and medication. Poor families do not have access to the basic needs. Due to illness employees are not on duty as it is expected. Rowson (undated):3 indicated that illness prevents people from working or affects their productivity, lowering their income. This is supported by UNIFEM (2005:17) that income does decline if the individual is unable to work. At Mpumalanga most households have one person who is the breadwinner for the entire family

(DoH, Mpumalanga, 2006:21). As power is an amalgam of capacity and opportunity, poor people may experience the former without the latter in case the desire to work is insufficient to overcome poverty (Lustig, 2001 and Sen., 1999a, b). Unemployment is far higher amongst women than men (Coombe, 2002 and Steinberg, 2000). Previous studied area at Mpumalanga named Gert Sibande District had also high rate of unemployment with 32% rate in 2005.

## **2.5. Recruitment at workplace**

Recruitment becomes a burden in government and private entities. To get skilled labour is difficult. Keeping on re-advertising posts timeously is costive. New staff is hired but they are not retainable due to the epidemic. Mpumalanga has the most major sectors in the region, such as mining, quarrying, agriculture, forestry, tourism and few to mention. These workers have very low levels of skills or none and this is a recipe for 'poverty-jobs and heightened vulnerable to HIV and AIDS. The land has a considerable potential for agriculture, yet unemployment is relatively high and skill levels low. (DoH, Mpumalanga, 2006). HIV is not just a public health matter but also a workplace and development challenge and this is creating insecurity to the employers and departments itself(Rau,2002).

## **2.6. Productivity**

Aids-related illness and death of workers and their family members could have a significant impact on enterprises and productivity level (Shisana et.al, 2004:35). According to the study conducted by the SABCOHA, 39% of company representatives confirmed that they have already experienced reduced labour productivity or increased absenteeism among employees (Bureau for Economic Research, 2003:7).

Employee's production is very low because the affected staffs are infected indirectly. Reverting to their household situations, they are also affected. Studies emphasized that; the productivity of uninfected employees could suffer indirectly

as they struggle to deal with the emotional strain caused by HIV/AIDS illness and death among their colleagues and families.

Some workers are not permanent while some are permanent. Many of these men work on contracts for as long as construction are underway, at times lasting more than six months. Often these men live in temporary housing, with extremely poor living conditions (Shisana and Letlape, 2004:19). HIV/AIDS have a psychological effect on affected employees and their colleagues contributing to lower productivity (Badcock-Walters et.al, 2000). HIV/AIDS has strong impact on working environment both to the infected and affected staff. Employers are struck by the shock of being conquered by HIV/AIDS (ILO, 2004). As it continues to destroy the staff morale, top management too also got discouraged to make their turnaround strategies timeously and failing to be completed or to meet the objectives due to the deaths rate (ILO, 2004).

## **2.7.Income**

Income is what an employee's receives after they have worked for according to the agreement made between the employee and employer. Light house argued that the poor are not without an income what they lack is the ability to accumulate assets and expertise to run economic activities for income generation. Employed PLWHA group are not benefiting from their income due to the expenses of the disease. Health bills are higher and with unsatisfied income they are receiving, it cannot cover the costs and transport to the health service centre. The costs of obtaining health care can also be substantial, both in terms of time off from work clinics are often a long distance from the household( Rawson, undated). The concept of income poverty has recently been extended to include economic vulnerability, describing households or individuals pushed into permanent poverty by temporary spells of unemployment, ill health or other misfortune (UNFPA, 2002).

## **2.8. Impact of Poverty and HIV/AIDS in poor HH**

While HIV/AIDS is a threatening disease, is ironically, it was thought that new generation would be caring for the old age but its not. The old ages are caring for the young generation due to the informal practices they are engaged. Despite the impact of HIV/AIDS on the macro-economy, HIV/AIDS also have impact greatly on human capital because it cause premature death, it destroys the human capital progressively built up in young adults through investments in child-rearing, formal and informal education and training (Shisana et.al,2004:56).

## **2.9. Impact of HIV/AIDS and Poverty on education for poor HH**

There is a serious scarcity of empirically-based research assessing the extent of the impact of HIV/AIDS on the public education sector. Most of the studies are based on projections (Shisana at.al, 2004: 48). The relationship between poverty and HIV/AIDS need not to be ignored. However, the two factors are interlinked. Education is the key success of future victory if it's not power that is acquired through knowledge received from education for every individual. When a parent dies the transmission of knowledge and expertise across generations is disrupted. Million of children are not receiving basic education and two thirds of them are girls.

The challenges that education sector is facing is that HIV/AIDS epidemic generates orphans. (Shisana et.al, 2004: 48). Since children are left orphans, they are deprived by the situation where counseling in all schools is required. If beneficiaries are not educated, the likely hood to loose the benefits is higher. By loosing the income, the household becomes impoverished. The situation fuelled the children not to attend schools due to the lost of parents. This contributes to household poverty because under skilled and illiterate youth would find themselves entering the labour market prematurely with few or no skills and in

highly marginal work (Shisana et.al, 2004: 50). In Focus-Youth livelihoods & HIV/AIDS, 2001 highlighted two vital points that:

- Girls generally have fewer economic and educational opportunities than boys.
- Girls are more likely to engage in formal or informal sex work or practice involuntarily or risky sexual behaviour.

By engaging themselves to risky sexual behavior the victims sees as the solution to heal poverty. Poverty prevents millions of children especially girls from attending school (UNFPA, 2001:9).

#### **2.10. Impact of HIV/AIDS and Poverty on infected and affected HH**

HIV/AIDS is pushing the world economic health status down despite of the age, status, race and gender. The group that is more challenged by the pandemic is girls, women and marginalized people. Poor families are facing challenge within their household for not accessing healthy sanitation, nutrition, access to health facilities that worsen their situation (Gelband and Stansfield, 2001) further argues that poor nutrition, poor sanitation and crowded living conditions combined with lack of adequate access to health care make the poor in the developing world susceptible to significantly higher disease burden. Poor people have worse health outcomes than better-off people Narayan (2000). Marginalized people are more vulnerable to different diseases such as HIV/AIDS, TB, diarrhea, bronchitis and pneumonia etc. Further indicated that tuberculosis and HIV/AIDS are amongst the health related shocks that can drive people into poverty (UNIFEM, 2004:8)

A study conducted in India revealed that poverty is the main reason why babies are not vaccinated; clean water and sanitation are not provided. (UNIFEM: 2004:8). A sanitary issue in poor community causes serious threat in their conditions. Shortage of water results in cholera and other related illness. Good

sanitary practices are relatively difficult to maintain if the conditions of water supply and sanitation in the local community are poor (Narayan, et.al 2000). They further argued that at HH level, poor are more likely to be disadvantaged. Poor household are likely to undermine and stigmatized themselves. Women have low level of control over household resources, which seems especially likely in poor households, often harms health outcomes for them and their families (Narayan et al, 2000).

Culturally, “health is wealth”. To sustain the economical development, it requires that people who are economically active be healthy and live long enough to contribute to society (Shisana et al, 2004:33). HIV/AIDS continues to undermine our future, supported by the community that discriminates towards PLWHA. Some PLWHA to date have not disclose their status due to the unfairly treatment they receives from communities. Health professional also add burden to PLWHA by the bad treatment. Rawson (undated) raised a concern that has been raised by poor people for not using health services that health professionals treat them with disrespect and offer them substandard treatment. Poor people would remain stable with untreated conditions, due to this unacceptable behavior by health professionals. HIV/AIDS also places an extraordinary burden on health sector.

### **2.11.Caring for HIV/AIDS patients at HH level**

On a long run, caring for the beloved household member is a good idea. But this is a stressful task and need a professional body to carry it. Care giving involves significant levels of effort within the home (UNIFEM, 2005:13). The vast majority of women and girls who are shouldering the responsibility of HIV/AIDS care in HH do so with very little material or moral support. They receive no training, support from formal programmes or hard inputs such as gloves, medication and school support for children. When household member diagnosed to be HIV+, women and girls pay high opportunity cost when undertaking unpaid care work for HIV/AIDS related illness as their ability to participate in income

generation, education and skill building diminishes sharply (Global Coalition on Women and AIDS, 2004). This results at withdrawing girls from schools to care for the sick family members. Education is abandoned and sacrifices their lives. Shisana et al, 2004 had experience the same problems in some communities they studied.

Caring the sick members suffering from AIDS is a burden to caregivers and relatives. Caring for patients at home also involves material costs, notably for food and bedding (FAO, chapter 6). Some household do not prefer to care for sick members at home, its unlike women from other country such Zambia that they prefer those who are sick to be at home, as it disrupts their production activities less and removes the cost of transport to the hospital, FAO reported.

HIV/AIDS is like any other chronic disease that needs adherence and monitoring. Fredriksson and Kanabus argued that taking care of a sick person with AIDS is not only an emotional strain for household members, but also a major strain on household resources. Loss of income additional care-related expenses then reduced ability of caregivers to work, mounting medical fees and funeral expenses push affected household deeper into poverty. Moreover, families often remove girls from school to care for sick relatives or assume other family responsibilities, jeopardizing the girl's education and future prospects (HIV/AIDS Sub-Saharan Africa, report 28-31 January 2002)

## **2.12 Coping with funeral costs**

Like sustainability, the idea and language of 'coping' has to be questioned in relation to HIV and its impacts. Yes, people 'cope'; the alternative – not coping means households dissolving or people dying. But it is odd, and indeed offensive, for the wealthy to suggest the poor should 'cope' and the rich will show them how to do it. The idea of 'coping' originates from the unwillingness of the rich to do anything more than apply sticking plaster to the wounds of global inequality when, what has been required for a

very long time is expensive surgery. This surgery requires major transplantation and reorganization of resources. Rugalema (1999) argues that coping is often a myth because:

1. Many households affected by HIV do not cope. On the contrary, they break up and their members, orphans, widows and the elderly join other households.

During the bereaved moments in poor household, they get confused like the better-off households. But for them having the stigma of being poor and HIV infected, the confusion is doubled to the normal one. Whatever the case, two points should be noted. The first is that people who are driven to sell the clothes of the dead or their own clothes can hardly be said to be coping:

these are the actions of the desperately impoverished. And, following from this, we have to be aware that the very notion of 'coping' is deeply ideological and may smack of the rich telling the poor how to manage their poverty (Rugalema 1999).

Household members tend to sell their assets such as cattle, TV, cars, borrow money in order to honor the funeral for the member. In a study conducted by ILO, 2003, that the impact of HIV/AIDS on the affected households indicate that 37% depleted their savings for treatment, 23% borrowed money and 2% resorted to selling their physical assets as final resort.

This turn lead them to cascade of impoverishment event such as further selling of assets. The little that they receive from the grants can not pay hospitalization bills. The more they engage themselves in borrowing is the more the family get deeper in poverty. High service costs also push families into poverty and deepen impoverishment (UNFPA, 2001).World bank emphasized that:

- HIV/AIDS has a greater economic impact on poor households than on better-off ones because it forces them to draw on their assets to cushion the shock of illness and death.
- Households with fewer assets are likely to have more difficult coping than thousand with more assets.

Due to fluctuation of the inflation, food prices has increased, houses are expensive, cars cannot be afforded hence poor families resorted the medical challenges by engaging livestock activities jeopardized by family members selling off their livestock to finalize medical care for AIDS patients (FAO argued) failing paying the bills or debts, AIDS-affected families may be forced to liquidate their assets in order to repay the credits. Rural families hit by the epidemic often are forced to sell productive assets in order to pay for health care and funerals (HIV/AIDS in Sub-Saharan report, 2002)

### **2.13 The impact of poverty and HIV/AIDS over orphans from poor HH**

The death of parents in poor families leaves children in hopeless and entrusted world. Siblings become headed families. Studies show that ± 13 million children in Sub-Saharan Africa are orphaned due to AIDS. After the death of parents, children suffer most profoundly by the trauma. In addition to the emotional impact, they face extremes of poverty and food insecurity, loss of their home to relatives, loss of connection with the education system, loss of access to health care and social services (DoH,Mpumalanga,2006).

### **2.14.Nutrition**

Food also adds a great challenge to poor household. HH shifts to crop production for survival. But due to shortage of water, crop production is poor. Infected people cannot adhere and comply with medical precautions without the balanced diet. Another challenge is on the disability grant, around 40% of South African are unemployed and poverty is deeply entrenched, with the poorest of the poor typically rural women. Many HIV+ South African whose CD4 counts have dropped to below 200 receive a monthly disability grant to ensure that they can afford appropriate nutrition and medical check-ups; in practice the grant often supports entire families. Once the CD4 counts recovers to above 200

they no longer qualify for the grant, their standard of living and nutritional status drops reducing their immune status ( DoH, Mpumalanga,2006: 21).

### **2.15. HIV/AIDS perceived as diseases for poor**

HIV/AIDS is alleged as disease for the poor. In most cases HIV/AIDS illness is mainly stigmatized as a “disease of poor”. World Bank argued that:

- Most people with HIV/AIDS are poor.

Kelly and Still wagon, 2001 argues that HIV/AIDS is not a disease of the poor but the poor are at higher risk of infection, the poor are more vulnerable to HIV infection and the disease makes the poor poorer. Most people with HIV are poor. This is why AIDS is characterized a “disease of poverty” argued UNDP, Implications of HIV for Rural Development Policy, chapter 3.

Poverty drives the HIV/AIDS epidemic. Poor people might more accurately be referred to as impoverished people. They are impoverished by inequitable social and economic structures on the household village national and global levels that often deprive the majority of people access to productive resources (Simmons and Schoepf, 1996)

### **2.16.Survival Strategies.**

Different strategies across are being used by the poor communities for survival. Some are receiving the grants from government, but due to the situation they facing at home it turned to be “zero” base. Despite a doubling and redoubling of national income in most nations a significant percentage of their children is still living in families so materially poor that normal health and growth are at risk. (UNICEF, 2000:5). Relative poverty refers to families with income below 50% of the national median. All over the world poor people engage in incredible acts of courage to sustain their families and communities. (Feuerstein, 1997; Lustig,

2001). Studies discovered that in developing countries women sell their body to feed their children while from young age go to work to support their parents (Feuerstein, 1997). Poor people engage themselves to different strategies for survival, some leads them to high incidence exposure to STI's including HIV/AIDS. The areas that are associated with the highest risk groups such as commercial sex workers, truck drivers, migrant mine workers (DoH, Mpumalanga, 2006:25). In effect all factors that predispose people to HIV infection are aggravated by poverty that creates an environment of risk argued IFAD strategy paper on HIV/AIDS the paper further emphasized that poverty is a key factor in HIV transmission. The fact remains that many households becomes entirely dependant on an old age pension or other social supports grants (SABCOHA, 2004:01).

### **2.17. Impact of HIV/AIDS and poverty on health status for the poor HH**

Poor people are more vulnerable to external forces. Access to affordable treatment and adequate health services has become one of the most important differentiating factors between in rich and poor countries and communities (Loewenson and Whiteside, 2001). The epidemic is a development crisis which deepens poverty and increases inequality at every level from household to global, regional and sectoral. The epidemic undermines efforts at poverty reduction income and asset distribution, productivity and economic growth (Barnett and Whiteside, 2002). The further argued that epidemic disease like any illness has the potential to increase poverty but AIDS is the most dangerous illness that has no cure. The human assets of knowledge, literacy and education whose levels tend to be lower among the poor also influenced household decision with regard to the proximate determinants of health. A low level of control over household resources by women which seems especially likely in poor households often harms health outcomes for them and their family. (WHO, 2002, 80; 2).

## 2.18. Impact of HIV/AIDS and poverty on gender and inequality

The gender relations within the society also help to spread the scourge of HIV/AIDS as in most cases women not in power position to negotiate for protected and safe sex either because they are unemployed, poverty stricken or illiterate. Rural areas such as most in Mpumalanga Province are particularly affected by gender inequality with factors such as low status of women conservative disposition and traditional beliefs system (DoH, Mpumalanga, 2006:22). The latest global statistics compiled by WHO and UNAIDS (2008) shows that 50% of people living with HIV are women. The study indicated that Sub-Saharan Africa comprises of 60% of women that are HIV positive. They further argued that women face barriers due to their lack of access to and control over resources, restriction mobility and limited decision-making power. Men continue to have final word. Women are left with no option but to obey and even worse the female condoms is not accepted in Uganda. We need more males to accept that AIDS does exist. Sob ( Nakibumba, City Press, 2008: 26). According to Paul Farmer he added that poverty and gender are inextricably intertwined.

Below, the researcher managed to extract 2001 data that shows how various provinces are affected by poverty in South Africa. The statistics collected by Craig Schwabe from Human Science Research Council. Although the researcher could not manage to get the current statistics but it will assist.

Poverty indicators by Province: Poverty in South Africa

Province	No. of poor persons (million)	% of population in poverty	Poverty gap (R-billion)	Shared poverty gap
E.Cape	4.6	72%	14.8	18.2%
F State	1.8	68%	5.9	7.2%
Gauteng	3.7	42%	12.1	14.9%
KZN	5.7	61%	18.3	22.5%
Limpopo	4.1	77%	11.5	14.1%
Mpumalanga	1.8	57%	7.1	8.7
N.West	1.9	52%	6.1	7.5

N.Cape	0.5	61%	1.5	1.8
W.Cape	1.4	32%	4.1	5.0
<b>SOUTH AFRICA</b>	<b>25.7</b>	<b>57</b>	<b>81.3</b>	<b>100%</b>

Table1

Source: Statistics South Africa; 2001

According to the statistics above, it indicate the rate of poverty on different provinces. In 2001 data showed that Limpopo had a higher rate of poverty of 77%, followed by Eastern Cape with 72%. If you follow up the reason of the high rate of poverty, is HIV/AIDS matter. Parents died and left children being heading the families. Poverty has a strong racial dimension with a far greater proportion of African being poor (Minister of Finance Trevor Manuels, Congress held at National Treasury, PTA on the 28 June 2004). Studies indicated that AIDS affected countries, present relatively poor socio-economic indicators. This has been proven by the AIDS-affected African countries where the statistics showed that on average one third of children of primary school age are not at school, 40% of the adult population is illiterate, one quarter of the children under age five are under weight for age and one third of the population is undernourished.

## 2.18. Summary

Different literature revealed their views emphasizing the cause and causal factor about HI/AIDS and poverty. Strong links between HIV/AIDS and poverty have been demonstrated with AIDS or poverty deepening other factor.

## **CHAPTER 3: Research design and Methodology**

### **3.1. Introduction**

The study produced a descriptive framework examining whether HIV/AIDS does furthers impoverishment (based on socio-economic factors, economic factors i.e gender and inequality, access to resources, poor housing, education, health infrastructures, coping during the bereaved moments).

### **3.2. Survey methodology**

**This is a method of collecting information about human population. Descriptive survey has been used, as its objective is simply to obtain certain about large group(Public Health Encyclopedia).**

- Affected and infected families at Thulamahashe (Mpumalanga Province) have been selected as a study area.
- Approach Social workers from Department of Health and Social Development, CDW, Colleagues who provided the researcher with a list and particulars of all the relevant families.
- Only selected families from Thulamahashe location participated.
- The families were assigned randomly. Selected HH started to be counted from 1, 2 and the third HH was assigned. That is 3,6,9,12 and so forth until reach 120.
- The first appointments were done telephonically as an introduction.
- The study was represented by females, males and youth.
- Both qualitative and quantitative designs had applied.
- Questionnaires were designed and distributed to the participants.
- Family participant's interview was used to collect data.

### **3.3. Research design**

The study used qualitative method. Qualitative design is used mainly because is a direct contact with the participants involved. De Vos (2003:19) defines qualitative method as a method which aims mainly at understanding social life and the meaning that people attach to everyday life. Grinnell (1997:448) defines a research design as a plan or procedure for collecting and analyzing data to investigate a research question or test a hypothesis. It is conducive since it needs a save environment to allow the participants to participate freely. A challenge for a qualitative sampling was to build a shared vision where participants at all levels are of the out most importance both implementation there after. Major classifications are single systems and group design. To dig depth information about the hypothesis stated, qualitative design was used in the study.

This method was used because of the following reasons:

- It provides the most direct evidence of face-to-face interaction with the respondents.
- It yields high percentage of returns, as most people are willing to cooperate.
- The interviews have opportunity to explain the question to respondents.
- Complete answer to all questions can usually be obtained this contribute to statistical accuracy, validity and reliability.

### **3.4. Ethical Consideration**

Ethical issues were not ignored and it was considered such as confidentiality, anonymity and privacy. McCormick and Schmitz (2002) noted that participation in the research project should be based on informed consent. Participants were promised to keep information confidential and secret. HH were treated identically to avoid stigma (HSRC, 2007).

### **3.5. Informed consent**

Informed consent was compiled and each participant was explained about the content of the document. Agreement were reached and signed by the participants and the researcher. The goal of the study was stated that the aim of the research was for academic purpose and that the information will not used from any other purpose.

### **3.6. Sampling and Procedures.**

Knoke and Bornstein (1991:12) defines sample as a subject of cases or elements selected from the population. While Bless and Higson-Smith (1995:95) define purposive sampling as sampling is based on the judgement of a researcher regarding the characteristics of a representative sample. 120 families were interviewed. The sample is chosen on the basis of what the researcher thinks to be an average percent. The strategy is to select units that are judged to be typical of the population under investigation. Thulamahashe location composed of farm workers, administration officials and road workers. The participants had been given chance to express themselves freely. Traditionally, women have no strong voice to rise in the presence of men visa-verse. Men, women and youth were represented in the interview.

### **3.7. Focus group**

In this study a sample of focus group was made up of participants from Thulamahashe location. The researcher's notion for the focus group was intentionally done to determine if there were certain geographical influences that lead them to be poorer. The researcher explained that the research was for academically purpose. No remunerations would be given to the participants. During the discussion, participants shared their experiences on the same interviews, the advantages and disadvantage, the sensitivity of the matter as

well as confidentiality. The notions were considered not forgetting the importance of ethics, confidentiality and informed consent were implemented. Appointments were arranged to visits their respective HH secretly and interviews proceeded smoothly.

### **3.8. Data collection.**

The researcher used questionnaires as a method of collecting data. Since the study was represented by literate and illiterate participants, the researcher assisted the illiterate HH with the reading out of the questionnaires. Grinnell (1997:325) defines data collection method as a procedure specifying technique to be employed measuring instruments to be utilized and activities to be conducted in implementation research study

### **3.9. Data analysis**

The data collected through questionnaires was analyzed using different graphs and tabular forms. The information was qualitatively analyzed as the researcher had heard the stories from the participants and had observed their housing building materials. The researcher had comply with what Glesne and Peshkin (1992:127) has mentioned about data analysis that it involves organizing what you have seen, heard and read so that make sense of what you have learned.

The true sense of what Glesne et al has indicated is supported by Tesh (1990:142) when he also refers to the idea organizing data into relevant meaningful units so that you get a sense of the whole. The based analysis was based on a continuous process of organizing and reorganizing material, including the researchers' notes, in order to create categories, themes and patterns McCormick & Schmitz, 2002:188). The results on the next chapter 4 are organized according to their categories and themes such as economic status, health status, infrastructure and demographic matters. The collected

data was then interpreted by using the Microsoft Excel to obtain the percentage of respondent's been able to interpret by using the graphs.

### **3.10. Summary**

The researcher had applied the qualitative and quantitative designs in the study to enable to collect data from participants in a descent manner without leaving some in question mark. Questionnaires were designed in English and then translated into indigenous languages spoken in Thulamahashe area. Researcher assisted the illiterate participants by reading the questionnaires to them. Thulamahashe is a huge location to obtain the data the researcher went house to house which was not a simple task to do. Descriptive method was used to obtain information about the selected study area. While interpreting the data, the researcher also focused on the literature review.

## CHAPTER 4: PRESENTATION OF DATA

### 4.1. INTRODUCTION

This would present what the survey has detected from the selection area around Mpumalanga Province on a special focus to Thulamahashe location. The aim of this chapter is to present that was collected from participants from Thulamahashe location from the hundred and twenty infected and affected HH under Bushbuckridge region .The result of the questionnaires from different HH members will be analyzed using thematic approaches according to their feelings in order to find the reliability and the validity of the research findings and the relationship that the topic has between the two variables.

### 4.2. Background on part of demographic status

The following section profiled 120 respondents who were administration details questionnaires in Mpumalanga Province at Thulamahashe location under Bushbuckridge region.70% of the respondents were women and 30% of the respondents were men Woman wee between 23-47 of age and men were between 25-45 of age .Infected and poor participants were 73 (60.80) and affected and poor made 47(39.2%) below is an explanatory analysis on their level of education.

#### 4.2.1. Level of education among affected and infected HH members

Sex of the HH members	No.of educational level	Primary school	High school	Tertiary level	Total	%
Males	9	21	06	0	36	30
Females	35	40	14	0	84	70

**Table 2**

According to the above table, the indication is that the women in particular are keen for education but because of their unforeseen circumstances they do not get a chance to further their education. Most of them are caring for their household members who are sick. This was emphasized by Cohen when indicated that poverty is fuelled by the lack of financial resources as a results of low level of education. Lack of financial resources is an added burden to the Thulamahashe women that leads them to have less education knowledge in their use. The statistic above shows that men are not enthusiastic for education, although they are the ones who always have high opportunity in all levels. The evidence is provided by the In focus-youth livelihood & HIV/AIDS 2001 those girls generally have fewer economic and educational opportunities than boys.

#### 4.2.2. Building Materials/Infrastructures.

The researcher had an opportunity to observe participants buildings as their dwelling places. The situation was not good. Luckily the questionnaires about the building infrastructures were attended by the participants. The outside walls, roof and floor will be analyzed collectively. The following tables 2-5 will illustrate briefly the outcome.

##### 1. Out -side walls

Concrete/bri cks %		Mud %		Wood %		Galvanised iron	Other	% Total
56	46.7	60	50	4	3.3	0	0	100%

Table 3

##### 2. Roof

Thatch %		Mud %	Wood %		Tiles/slate %		Galva nised iron	Con crete	othe r	% Total	
69	57.5	0	6	5	14	11.7	31	25.8	0	0	100%

Table 4

**3. Floor**

Earth %		Wood %		Stone	Cement		Tile/slate		% Total
30	28.3	0	0	0	85	67.5	5	4.2	100%

Table 5

Statistic above reveals that the buildings of the poor house hold are of poor quality in really sense .The marginalized are neglected .Some studies indicated that houses of poor communities are mainly overcrowded and low quality. Those that are residing in house that are in good condition were built by the bread winners before they passed away. Lives itself from the related household are not good. Statistic shows that 46% of the household rooms are shared and they consist of 2 bedrooms.

**4.2.3. Drinking water**

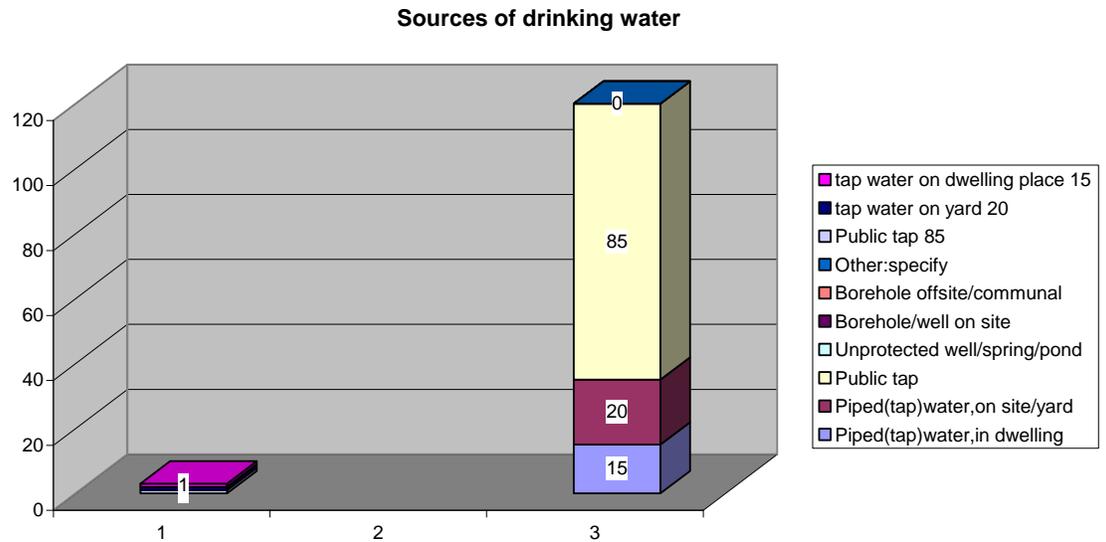


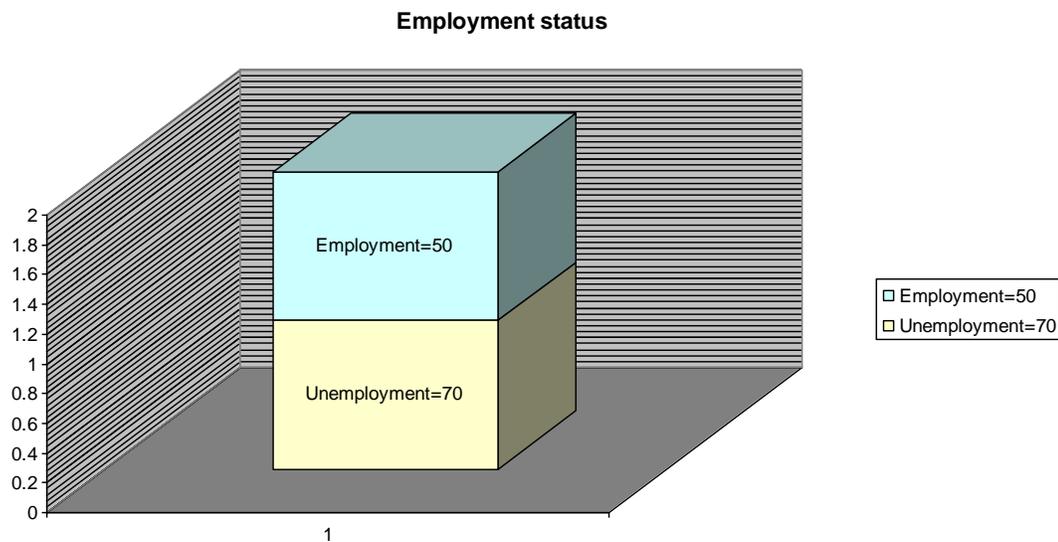
Figure 2

“Health is wealth” a friendly reminder from the macro-economic for Africa 2004.The figure above represents the sources of drinking water the poor community at Thulamahashe area has an access from. About 85

household that constitute 70.8% utilize public taps, 20 households that constitute 16.7% utilize water taps on their yards and 15 household that's constitute 12.5% utilize water taps that are in their dwelling places. From the poor communities services are undermined comparing to the developed areas. Thulamahashe is a location that is facing with a shortage of water as challenges and had influence on poor communities .The 17.75 HH that had on sites, do not have water on day to day services .This supported by UNIFEM when they argued that poverty is the main reason why babies are not vaccinated, clean water and sanitation are not provided.” this does not occurred in Indian only UNIFEM explained but Thulamahashe also experience water shortage that results in hindering of services.

In all the challenges that this communities are facing, it pauses questions on cost of living how do they cope is there family members who is working, any support that they get from any organization or government? The next figure 4.4 is all about the employment status among the infected and affected poor communities at Thulamahashe. And it will provide the details from the passed questions above.

**4.2.4. Employment and Unemployment status**



**Figure 3**

Above 58.33% constitutes unemployment rate at Thulamahashe location among the PLWHA. Only 41.7% constitutes employment rate between PLWHA and the affected HH members. The group that is employment was not professional job but casual laborers. Based on the statistics it shows that many people in the area are living in poverty. Rate of unemployment levels which means the majority live in poverty. Production from sick employees is mainly poor. As Rawson, emphasized that illness prevents people from working or affects their productivity, lowering PLHWA income. Evidence on the matter is the employment group, their incomes declined due to their absenteeism from work. The farmers applied the “no job no pay” strategies regards their status. In terms of food, health facilities such affordability of medical bills (the employed group) healthy diet (nutrition).

The researcher had able to collect data about the poor community survival strategies. To sow that life is very vital to every individual, all the participants despite of their status they were keen to fight for their by trying to get something to keep life going. They had different that the poor community utilizes for their HH.

#### 4.2.5. Survival strategies



Figure 4

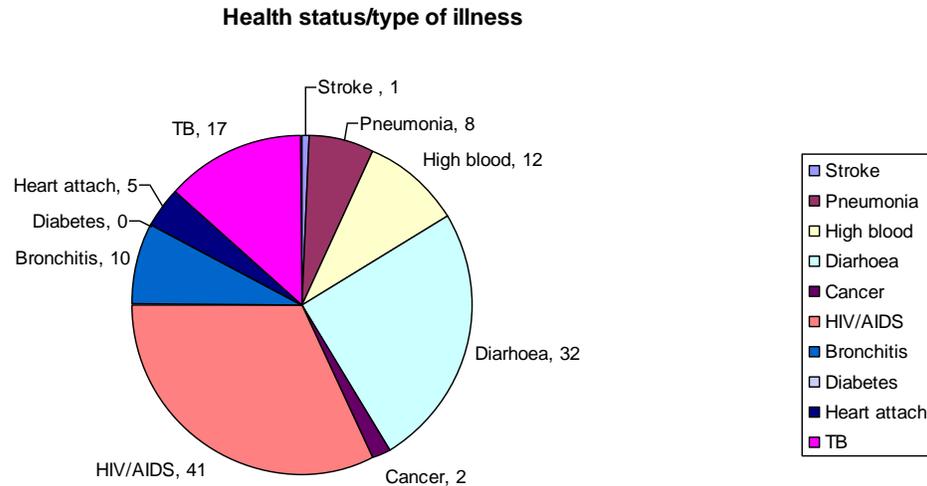
Food security is a challenge to poor HH. The graph duly indicated the different strategic types for survival used by the participants from the studied areas. The graphs show that for survival about 44 respondents indicated that they depend on child grants and it holds 38 of which has the high rate among the strategies.

Apart from child grant there is old age grant that has 23%, disability grant 12.5%, some participants indicated that they depends on informal/commercial sex workers as their means for survival. The poor are at a risky situation by resolving their problems with a wrong behavior practice. These are how they contract the diseases by putting their lives in greater risk. They perpetuate the cycle of poverty by getting jobs that are at risky and dangerous that required less pay or not pay.

HH members that are engaged in agricultural activities constitute 17.5%. The researcher had rhetorical questions that since they are not permanently

employed how do they cope during illness circumstances? Different types of illness have been captured provided by the participants. The next graph display types of illness that the affected and infected poor household members are vulnerable to them.

#### 4.2.6. Health status



**Figure 5**

Most of the illness associated with poverty is infections diseases such as diarrhea, malaria and tuberculosis. Lack of healthy nutrition among poor families result in generating diseases some becomes chronic while others are curable. Poor nutrition sanitation and crowded living condition combined with lack of adequate access to health care make the poor in the developing world susceptible to significantly higher disease burden .(Gelband and Stansfield,2001) The above figure shares that poor people have worse health problems than the people. The same health problem was reported by UNIFEM that tuberculosis and HIV/AIDS are amongst the health related shocks that can drive people into poverty.

#### **4.3. Caring of HIV/AIDS patients at HH level**

This “unpaid care work” is being executed mainly by women and girls at household. Performing the task without experience and formal training provided. About 68% of the respondents from the survey showed that HIV/AIDS patients from households are cared by the girls and women. 20% indicated that orphans are family headed. 32% of the households are women headed.

#### **4.4. Coping during bereaved moments**

Poor households cannot cope during the dark days of their loss of the family member(s). Every minor or major asset to be executed needs money. During the bereaved time from infected and affected household it was found that 39% managed to cope their funerals by selling their assets, 19% borrowed money, 10% assisted by the relatives. Some families were assisted by Municipality with the help from Department of health and Social Development at Thulamahashe location.

#### **4.5. Summary**

The chapter dealt with the data analysis that was collected from the participants at Thulamahashe location. Both qualitative and quantitative designs were applied to analyze the data. The participants showed a highly interest when answering the questionnaires. They had revealed their concerns and frustrations by attempting to answer the questionnaires. Distributions of questionnaires, had time with the focus group and conducting the interview for this study was a useful exposure to know more about the focus group. With a special focus on their behavior, feeling about this epidemic, future planning as well as sharing views on mitigations of poverty and HIV/AIDS. Furthermore, the study findings about whether

HIV/AIDS does further impoverishment had been substantiated by different literatures as it do.

## **CHAPTER 5: Findings, Recommendations and Conclusion**

### **5.1. Introduction**

This chapter presents the summary of the study and conclusion with the recommendations by the researcher.

### **5.2. Overview of the study**

The aim of the study was to investigate whether HIV/AIDS have influence on furthering impoverishment to poor community. The source of information in this study was infected and affected poor community residing at Thulamahashe location under Mpumalanga Province. The researcher used random sampling with the assistance from CDW, Social workers and Caregivers identifying the related household. Questionnaires was drafted and distributed to the participants and used as methodology to collect data. The researcher rest ensured the participants that information would be kept confidential and anonymous (where names were appended on the questionnaires). Participation was voluntarily with no benefits attached. The aim and purpose of the study was clearly explained to the participants. The study was non-funded.

### **5.3. Overview of the findings**

In Mpumalanga Province, Thulamahashe location the state of poverty in general and in the context of HIV/AIDS in particular is extremely distraught to the infected and affected poor community. HIV/AIDS and poverty in this are interlinked. The discussions will be based on the interpretations of the data analyzed by the study. Tables and figures will be of utmost important and helpful in this regard. Literature will also be used to emphasize the reliability of the interpretations.

#### **5.4. Employed communities (poor HH)**

Information provided by the study it shows that those who are farm labourers are facing severe social and economic crisis because of the impact of HIV/AIDS and poverty. The results indicate that casual labourers spent more time by attending to the sick household member(s) or being sick. Employers had applied the strategy of “no work, no pay” which adds burden as they already struggle to get balanced food for the sick family members. With disease often further impoverishment the poor are prevented from working and affects their productivity that is lowering their income. The death of the bread winners deprives the household. Care givers indicated that during the caring process sometimes they are affected emotionally as it cause strain to them. The study detected that five days in a month are been utilized by workers as sick leave or family responsibility. This means that about 60 days are being utilized for caring the sick household members annually. Workers are exhausting their benefits (sick and vacation) before year end.

#### **5.5. Socio-economic**

##### **5.5.1. Employment status**

Higher unemployment rate is a base line of poverty and it creates a common factor to country wide. It pushes old and young people to migrate with the search for jobs. Young people from the area are unemployed hence they are attracted in informal sectors which increase their risk of HIV contraction. The employed group is temporary based. There is no investment that could be saved among the poor community. Assets such as cars, houses and furniture cannot be purchased on credit since their income is low. These findings mean that, with low income, there is a lack of food security. Children drop out from school mostly among the infected and affected poor community because the family cannot afford to pay school fees, children go hungry to school. The

financial constraints in those household changed its life styles. Unemployment is far higher amongst women than men in Thulamahashe location.

### **5.5.2. Health status.**

There is a short fall on the knowledge about the epidemic among the poor household. Their attitude about HIV is much less. However, some are positive about their status the problem lies with the health services that is far from their area and the treatment they receive from health professionals. Women are being victimized by the STD's but there is a huge ignorance on the treatment as indicated. Participants indicated that health professionals treat them with disrespect and other offers them substandard treatment. The study detected that poor community are less likely to be able to take seriously an infection that destroys their future, instead they care much focusing on their daily survival. Household are not willing to share information as far as illness is concern. Stigma within this group is dominant. Illness such as diarrhea, tuberculosis, pneumonia and HIV/AIDS are common among the poor families. The diseases are linked to under nutrition. PLWHA are vulnerable as without good diet they cannot prolong good health and live for them will be short.

### **5.5.3. Education**

The study reveals that educational background from the area is low. Poor communities are not educated. Chances to go to school are limited. According to the findings, it shows that women are educated better than men because 8.16% of women reached high school level while 1.5% men reached high school. The motive behind being that women and girls are withdrawn from schools to care for the sick family members while boys participate on cattle shepherds. There is a lack of knowledge about the usage of condoms. Condoms are perceived differently and differently by the poor people. Insufficient knowledge of KAP among the marginalized people as they are reveals sidelined. Supporting education was seen to be the best way for

companies to repay communities in which they prospered and to train new generation of employees (Prof. Du Toit, 2006)

#### **5.5.4. Caring of the HIV/AIDS at HH**

When parents are sick, children especially girls are forced to drop out from school to care for them. Relatives are not committed to care for their next of kin. This is a common factor around the studied area. Community is neglecting poor household.

#### **5.5.5. Coping with funeral cost.**

Coping mechanisms among the poor families are not effective. The experience serious strain if a household member dies, they even asked assistance from Municipality and Social Welfare for funeral arrangement and conditions apply. The economic impact of HIV/AIDS is higher between the infected and affected communities.

#### **5.5.6. Nutrition**

Poor HH have food but unhealthy and few. They can't adhere to their medications due to shortage of food to be eaten and follow the prescriptions regularly. Sometimes medications are taken in an empty stomach. Some receive food grant whereas some families do not. On their gardens made, vegetables are not rich due to the shortage of water.

#### **5.5.7. Gender inequality, poverty and HIV/AIDS**

There is a lack of women empowerment around the area through social services such as education, health, training and markets. Women have a low socio-economic status in the context of HIV (Guerny et al, 1993: 1027-1034). World Bank argued that low-income, income inequality and low status of women are fairly highly associated with high levels of HIV infections.

## 5.6. Recommendations

In this study the researcher recommend that the society/community, government and NGOs should take into considerations the points highlighted by the study findings.

The study has provided a valuable insight on the different impact that drives poor household that are infected and affected by HIV/AIDS to be poorer. The study findings and literature review discussed, provided the evidence about the research topic. The recommendations are as follows:

- Government should develop programmes and policies that will reduce rural poverty and that will ease the economic constraints particular faced with poor community.
- Arrange workshop at community levels about the relationship between HIV/AIDS and poverty together with the impact.
- Nutrition as one of the challenge among infected and affected poor household, information booklets should be designed on how; when type of food should PLWHA and caregivers need to follow. These information booklets should be easy accessible i.e Government and NGOs should start planning on how the information can be delivered to the communities. It can be typed on the exercise books leaflets (inside the cover pages), dairies and calendars. Since calendars are free, peer educators and CDW should deliver direct to the poor communities.
- A great challenge is on women's condoms, at the farms and health centres or clinic. Poor communities cannot afford to buy condoms it should be addressed as soon as possible.
- On mitigations of poverty, policy on anti-poverty should be developed to assist every body across the level.
- Policy for caregivers to HIV/AIDS household members should be developed (entails the care route, treatment, recognitions, access to

care material, coping during death and after) and provide formal training.

- Create employment on infrastructures (Thulamahashe) and develop the infrastructure policy that will guide the employees on how to execute it to mitigate the migrant labourers to be susceptible and vulnerable to HIV/AIDS.
- Government should encourage the farmers to develop farmer's policy on HIV/AIDS at their workplace
- Health department should encourage poor people to start crop plantations projects to mitigate poverty (food crisis) and provide training to health professionals to implement "batho pele principles" to every person infected and affected.
- Community involvement on workplace activities involving HIV/AIDS to empower the usage of KAP to infected and affected people.
- Social events for farm labourers to promote well being i.e. soccer, netball, chess, volleyball across the board.
- Building of home based centres for infected people from poor communities administered by the government for the households that cannot manage to care for the sick, to avoid disturbing girls' education-girls should be educated to minimize the spread of HIV/AIDS through the acquired knowledge and practice their rights.

## **5.7. Conclusion**

The study managed to outline the relationship and the influence that the two variables, poverty and HIV/AIDS have especially on poor community. The impact it has on economy changing the behavioral style on households of living from bad to worse under the umbrella of poverty and HIV/AIDS. The community is affected direct or indirectly. HIV/AIDS epidemic is regarded as

a large scale-event that has effects on wider social, economic and environmental systems. In a community that is hard hit there are changes and costs at the levels of the farming system, social infrastructure and the maintenance of physical infrastructure. The study tend to agree with the literatures when they argues that HIV/AIDS is likely to push some non-poor into poverty, deepen the poverty of already poor individuals, households and communities and drive the very poor into destitution. It appears as a cycle that is devastating to human life. Thus HIV/AIDS can push people in such a way as to intensify the epidemic itself. Based on the statistics conducted by the researcher together with Craig Schwabe's , there is a strong link between the two factors that HIV/AIDS has an influence to another factor.

#### **5.8. Suggestions for further research**

This research was mainly focusing on poor affected and infected household, employed and unemployed. It was conducted over a short of time. It is suggested that for a broader or comprehensive view on how the two factors has influence on the other, further studies should be conducted.

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**APPENDIX A**

**QUESTIONS ON PERCEPTION OF PEOPLE WITH HIV/AIDS**

**1. LOCATING INFORMATION**

Town/City	_____
Location/Surburb	_____
Household Address	_____
Telephone number	_____
Number of people living in the household	_____
First name of respondent (optional)	_____
Gender	_____
Age	_____
Highest Standard passed	_____

**2. HOUSING TYPE**

How many living and sleeping rooms does this household have use in total?  
\_\_\_\_\_

Indicate the type of main dwelling that the household occupies.

Type of dwelling	
Dwelling/brick house on a separate stand or yard	
Dwelling/house /flat/room in the backyard	
Dwelling house mud house shared with other household(s)	
Other, please specify	

**OBSERVE MAIN BUILDING MATERIALS**

Outside Walls:		
	Brick/concrete	
	Mud	
	Wood	
	Galvanised iron	
	Other: specify	
Roof:		
	Thatch	
	Mud	
	Wood/planks	
	Tiles/slates	
	Galvanised iron	
	Concrete/cement	
	Other:specity	
Floor:		
	Earth	
	Wood	
	Stone	
	Cement	
	Tiles/slates	

3. **INFRASTRUCTURE**

3.1. What is the main source of drinking water? Tick the appropriate one

Piped (tap) water, in dwelling	
Piped (tap) water, on site/yard	
Public tap	
Unprotected well/spring/pond	
Borehole/well on site	
Borehole/well off site/communal	
Other: specify	

4. **DEMOGRAPHIC/HOUSEHOLD ROSTER**

I would now like to gather some information about the people in your house hold. ( By “household” we mean people who normally live together and share resources such as food and money.)

Are there any family members who are employed? \_\_\_\_\_  
 If yes, what kind of employment are they doing?  
 \_\_\_\_\_  
 \_\_\_\_\_

If no, how do you survive?  
 \_\_\_\_\_  
 \_\_\_\_\_

Within the household, how many children are at school? \_\_\_\_\_  
 How many children are not at school? \_\_\_\_\_  
 For the question 2 above, what are their ages? \_\_\_\_\_  
 What are the reasons for not attending school? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. For all children in the household (< 18 years) If no children go to Q6

Are  
 their  
 natural  
 parents  
 alive? Yes  
 [ ]  
 No [ ]  
 If  
 alive, does  
 their  
 natural  
 mother  
 live in this  
 household?  
 Yes [ ]  
 Is the  
 natural  
 father  
 alive?  
 Yes [ ]  
 No [ ]  
 If  
 alive, does  
 the natural  
 father live  
 in this  
 household?

Yes [ ]
No [ ]

**6. HUNGER**

I would now like to speak about the household and what it can afford?

6.1 Would you say that the people here ever go hungry? Yes [ ] No [ ]

If yes, how often does this happen? Tick the right one

**If no, go to Q6.3**

often	
sometimes	
seldom	
never	

6.2 Does your household ever run out of money to buy food? Yes [ ] No [ ]

**7. ASSETS**

Does your household own any of the following :

**1. Assets in household**

Tick

1.1 Radio		
1.2 Television		
1.3 Cellular phone		
1.4 Telephone		
<b>2. Tools</b>		
2.1 Plough		
2.2 Tractor		
2.3 Power tools		
3. 1. Bicycle		
3.2 Car		
3.3 Truck		
3.4 Donkey/horse		
3.5 Cattle		
3.6 other livestock		

**8. HEALTH STATUS**

Now I would like to ask you about the health status of the household members.

8.1 Has anyone in this household been told by a doctor or a nurse that they have or had any illnesses in the past 12 months? Yes [ ] No [ ]

8.2. If there is more than one illness per person ,complete two lines per person

Household members	What was their illness? Insert codes	Are they/were they given medication? Yes[1] No [2]	Illness codes
1.			Bronchitis
2.			Cancer
3.			Diabetes

4. 5				Diarrhoea	
				Heart attach	
				HIV/AIDS	
				Pneumonia	
				High blood pressure	
				Stroke	
				TB	
				Don't know	
			Other: specify		

**9. CHRONIC ILLNESS**

9.1. Is anyone in the household suffering from any chronic or long term illness ( longer than 3 months) including mental or physical disability? Yes [ ] No [ ]

9.2 What is the illness? Choose from Q8 above.

**10. SURVIVAL STRATEGIES**

Looking to your situation, what means do you use for survival?			
<b>Source of food</b>	Yes	No	
10.1 Child grant			
10.2. Crop production			
10.3. Informal sector (commercial sex worker)			
10.4. Old age pension			
10.5. Disability			
10.6. Other specify			

**11. ECONOMIC SHOCKS**

11.1. Have any of the following events or situations occurred in this household over this year?	Tick
11.1.1. Increased family/household size	
11.1.2. Serious injury or chronic illness keeping member from doing normal activities	
11.1.3. Increased in food prices	
11.1.4. General joblessness in the house field	
11.1.5. Loss of possessions, theft	
11.1.6. Serious accident	
11.1.7. Death of many livestock	
11.1.8. Eviction and/or threat of eviction from the dwelling	
11.1.9. Death of an adult household member ( go to 12 )	
11.1.10. If more than one death please note number of deaths and record all causes of death	
<b>12. Do you know what the cause of the death was? ( DO NO READ OUT) TICK</b>	
Old age [ ]      Diarrhoea [ ]      Diabetes [ ]      Pneumonia [ ]	
Motor accident [ ]      HIV/AIDS [ ]      Infuenza [ ]      Other[ ]	
TB [ ]      Cancer [ ]      Cholera [ ]	
<b>13. Did the deceased require home nursing prior to their death? Yes [ ] No [ ]</b>	
<b>14. If the deceased had to be nursed at home foe any time:</b>	
1. Who cared for the deceased while he/she was ill at home? -----state the relationship -----	
2. How many hours per day were spent caring for the deceased?( during the month before death? ---	

-----
3. Did caring for the deceased result in loss of income? Yes [ ] No [ ]
4. Number of working days lost by the caregiver while caring for the deceased in the month? -----
<b>15.</b> What did the household do to cope with the medical costs? Circle multiple response possible
1. Use own income 2. Use existing savings. 3. Sold assets 4. Medical insurance 5.Help from friends
6. Help from relatives. 7.Help from employer 8. Borrowed money. 9.Other
<b>16.</b> How did the household meet the funeral cost?
1. Use own income 2. Use existing savings. 3. Sold assets 4. Medical insurance 5.Help from friends
6. Help from relatives. 7.Help from employer 8. Borrowed money. 9.Other

**That brings us to the end of the questionnaires. Thank you for your cooperation**

## APPENDIX B

### INFORMATION AND INFORMED VOLUNTARY CONSENT DOCUMENT

Title of Research Project: **Does HIV/AIDS furthers impoverishment?**

You are invited to participate in the study “Help to fight against poverty and HIV/AIDS”. The project is being carried out by Khosa Patricia.

Aim: The purpose of this research study is to determine whether HIV/AIDS does have an influence on poor people to engage themselves in sexual practices to get food or not.

#### Procedures

- All aspects of this project will occur at this community where you are now.
- If you agree to take part in this study, you will answer a questionnaire which takes about 45 minutes to complete questionnaire.
- The questionnaire contains questions about demographic, health, economic and social behaviors.
- Your name is not compulsory to append on the questionnaires, but it's not going to be used on this study.
- Your answers/ speech would never be recorded on tape or any device machine.
- CDW (Community Development Workers Officials) and Department of Health and Social Services (Social Workers) had assisted me to identify you within this community to come and had interview with you.
- There is only one session of completion of the questionnaires.

#### Risks and Inconveniences

- The discomforts and risks that you might reasonably expect as part of the study is to complete questionnaires that include sensitive topics about you and your family.

#### Possible benefits

- The information that is obtained in this study may be useful scientifically and possibly helpful to others. The benefits that you may reasonably expect from participating in the study are learning methods to improve your health and gaining knowledge and support for issues related to poverty and HIV/AIDS, but this is not guaranteed.

Cost incurred to participate: This is non-funded projects hence there won't be any reward .I appreciate your contribution and providing with the most valuable information.

**Confidentiality:** You are promised that any information obtains from this study that can be identified within me will remain confidential, or will be disclosed only with my permission.

- However, I am in agreement that scientific data or information not identified with me resulting from the study may be presented to other staff so that information can be useful to others.
- You also understand that there are certain ethical limits to confidentiality .If you tell that you plan to in any way physical or sexually harm an identifiable person including a spouse, it will be required that the researchers take steps to protect that person .Also if, you state that you believe an identifiable person is going to physically or sexually harm you steps will be taken to protect you.
- Even though we are assuring confidentiality, there is always the possibility that confidentially information and comments made by the revealed outside of this community members so please don't say anything during the discussion that might you might be uncomfortable having associated with you.

You will not be pressured to consent to participate in this project and you must understand that your participation is completely voluntary. Therefore, you are free to decline and if you agree to participate you may stop your participation at any time without penalty and without incurred costs.

Interviewer: Khosa Patricia	Supervisor: Prof JCD Augustyn
Box 47	University of Stellenbosch
Thulamahashe	Stellenbosch
1365	
South Africa	South Africa

You have had all of the above information explained and you understand the explanation. You have been offered to answer any of your questions concerning the procedures involved in the study

-----  
Participation Name(optional)

-----  
Date of Birth

-----

-----

Signature of Participation

Date

**If verbal consent is provided, the interviewer must sign below in the presence of the participant and a witness.**

-----	-----
(Signature of interviewer certifying that informed Consent has been given by respondent)	Date

-----	-----
(Signature of witness certifying that informed Consent has been given by respondent)	Date

**Statement by or on behalf of the investigators**

**I -----, declare that I have explained the (Researcher name)**

**Information given in this document to ----- (Participant name)**

**He/She was encouraged and given ample time to ask me questions. Conversation was conducted in English / Shangaan language.----- And no translator Used.**

**Signed at----- on----- (Place) (Date)**

-----	-----
Signature of Research staff	Witness

**Source on informed consent form sample: HSRC**