THE IMPACT OF HIV/AIDS ON LOW INCOME EARNERS AND THEIR PROPENSITY TO SAVE: A CASE STUDY OF HIV-POSITIVE PERSONS IN CHIAWELO, SOWETO TOWNSHIP, GAUTENG.

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Assignment presented in partial fulfilment of the requirements for the award of the Degree of Master of Philosophy (HIV/AIDS Management) at Stellenbosch University

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MARCH 2010

Declaration

By submitting this assignment electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety, or in part, submitted it for obtaining any qualification.

Abstract

The highest number of HIV and AIDS cases is recorded in Southern Africa and more specifically in the republic of South Africa. Likewise the highest levels of poverty are recorded in South Africa among the majority of historically disadvantaged black people. These people have a poor culture of saving and in the face of a new epidemic of HIV and AIDS, the situation is becoming worse.

This research report assessed the impact of HIV and AIDS on low-income earners and their propensity to save by analysing the incomes of a sample of 120 men and women between 18 and 55 years of age, who were HIV-positive and earned not more than R 3000 per month. This was a retrospective descriptive review of the routinely collected clinical records of the clients falling in the category mentioned above, who were receiving antiretroviral drugs over a period of 4 years. In-depth interviews were conducted on respondents to determine what their savings were before contracting the disease and during the period they were sick. This method was conducive because of the sensitivity of the subject matter.

Having analysed the data collected, the impact of HIV and AIDS on the saving capacity of low income earners was assessed. Results indicated that low income earners' propensity to save is affected because they have to spend much of their income on medication, transport costs to clinics and hospitals for regular check-ups and possible admissions. HIV-positive low income earners consequently suffer AIDS related financial hardships as they are left with very little or none at all to save.

Opsomming

Die hoogtste MIV en Vigs gevalle is in Suidelike-Afrika en meer spesifiek in die Republiek van Suid-Afrika. Eweneens kom die hoogste vlakke van armoede in Suid-Afrika onder die histories minder bevoorregte swart bevolking voor. Hierdie mense het 'n swak kultuur van geld spaar en weens die epidemie van MIV en Vigs, vererger hierdie situasie.

Hierdie navorsingsverslag het die impak bereken van MIV en Vigs op persone met lae inkomste en hul geneigdheid om te spaar deur die inkomstes van 'n steekproef van 120 mans en vroue tussen die ouderdom van 18 en 55 jaar, wie MIV-positief is en wie nie meer as R 3000 per maand verdien nie. Dit was 'n retrospektiewe beskrywing van kliniese optekenings van bogenoemde kliënte wat volgens roetine versamel is, en wie antiretrovirale medisyne oor 'n periode van 4 jaar ontvang het. Diepte onderhoude is met respondente gevoer om vas te stel wat hul spaarpeil was voor hulle die siekte opgedoen het en gedurende die periode wat hulle siek was. Hierdie metode is bevorderlik weens die sensitiwiteit van die kwessie.

Na analise van die data, is die impak van MIV en Vigs op spaar-kapasitiet van persone wat min verdien beraam. Resultate wys dat die neiging tot spaar van persone wat min verdien geaffekteer is omdat hulle so veel van hul inkomste moet spandeer op medikasie, transport na klinieke en hospitale vir gereelde ondersoeke en moontlike toelatings. MIV-positiewe persone met lae inkomstes ervaar dus Vigs-verwante finansiële swaarkry weens die feit dat hulle so min geld, of geen geld, oor het om te spaar.

ACRONYMS

ABC	Abstinence, Be faithful, Condomize
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retroviral
HIV	Human- Immune-deficiency Virus
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
PLWH/A	People living with HIV/AIDS
UNAIDS	United Nations Agency for AIDS
USAID	United States Agency for International Development
NGOs	Non-Governmental Organizations
CBOs	Community Based Organisations
CSOs	Civil Society Organizations

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CHAPTER 1
INTRODUCTION, BRIEF BACKGROUND, PROBLEM STATEMENT AND OBJECTIVES OF THE STUDY

1.1 Introduction

In this Chapter, an overview of the global HIV/AIDS epidemic is outlined with specific reference to Southern Africa to set the basis for the current study. The case of low-income countries, and particularly those of sub-Saharan Africa, where HIV prevalence is highest and access to care is the most precarious, merits the most careful attention. These countries, in which all the negative factors are combined – scarce government resources, insecure and often dilapidated healthcare systems and illiteracy – are also those with the highest HIV prevalence rates (Coriat, 2008). HIV prevalence and incidence data are necessary at different levels, for monitoring the epidemics, understanding their dynamics, determining priorities of actions, modelling AIDS impact on populations and so on.

Nowhere is the catastrophic impact of HIV/AIDS more apparent than in the region of Southern Africa. Botswana and Swaziland have infection rates in excess of 40% of its population – a figure that was widely regarded as inconceivable a few years ago as far as epidemics go. The fact however is that South Africa has in absolute numbers, the highest rate of infection in the world (Benatar, 2005).

One of the factors that contribute to the spread of HIV infection is poverty which is characteristic of developing countries like South Africa. Many parts of Soweto including Chiawelo rank as the poorest in Johannesburg, although individual townships tend to have a mix of wealthier and poorer residents. In general, residents in the outlying areas to the North-west and South-east have lower incomes. In 1994, Sowetans earned on average almost six and a half times less than their counterparts in wealthier areas of Johannesburg (Department of Health estimates, 1994).

The researcher here put more emphasis on the impact of HIV and AIDS epidemic on HIV positive low-income-earners. Their propensity to save was examined and possible interventions to mitigate the impact of reduced savings recommended.

Literature on the impact of HIV and AIDS was obtained from various sources. The library was one of the sources of information as regards scientific journals, textbooks, magazines and academic papers presented in seminars and workshops. The internet search helped to serve as an additional search mechanism. Works of scholars and specialists who have written material related to HIV/AIDS have also been made use of. The Department of Health and Social Welfare was consulted for data material on HIV and Aids. The last part of this Chapter ends with the aims and objectives of the Study.

1.2 Background

According to UNAIDS Report (2000), almost five million people worldwide became newly infected with HIV in just 2003, the greatest number in one year since the beginning of the epidemic. A staggering 20 million people have been killed by AIDS since the first cases of AIDS were diagnosed in 1981. By far the worst affected region, Sub-Saharan Africa is home to an estimated 25 million people living with HIV/AIDS. In South Africa between 15% and 20% of all adults are estimated to be infected with HIV. Given the high HIV infection rate and the size of the population, South Africa has the largest number of people, about 5 million, living with HIV and AIDS in the world. The social and economic consequences of these figures are far reaching and will affect almost every facet of life in South Africa (Bureau of Economic Research, 2004).

The number of HIV and AIDS cases in Sub-Saharan Africa is estimated to be close to 24.5 million people and the number of orphans is estimated to be over 12 million. In the absence of any major behavioural and cultural changes that could significantly alter the course of the epidemic, this figure is expected to rise between 6-7.5 million by 2010 (Steinberg, et al., 2000). The number of deaths each year due to HIV/AIDS is likely to increase rapidly from about 90,000 in the year 2000 to between 350,000 and

380,000 five times later, and as high as 550,000 and 630,000 in the year 2010 (Conway, et al., 2000).

It was predicted that death due to AIDS would soon exceed all other causes of death put together among the workforce of South Africa and that this would impose significant direct and indirect costs of business in the country. Such direct costs include absenteeism due to illness and funeral attendances, lost skills, low productivity, reduced work performance, training and recruitment costs (Steinberg, et al., 2000).

HIV/AIDS especially in resource-constrained settings results in physical and psychological suffering of the infected and eventually the affected. Consequently, HIV/AIDS morbidity and mortality has negatively affected development initiatives at individual, household, sector and eventually national levels as individual and household savings are depleted to access care for the sick while income inflows from affected adults are cut off as they attend to the sick (Uganda AIDS Commission, 2000).

The South African Government adopted a five-year strategy in 2000 to address HIV/AIDS and sexually transmitted infections with two primary goals: To reduce the number of new infections and to reduce the impact of HIV and AIDS on individuals, families and communities. The primary activities presented include:

- Implementing an effective and culturally appropriate information, education and communication strategy;
- Increasing access to and acceptance of voluntary counselling and testing;
- Improving the management of sexually transmitted infections and treatment for opportunistic infections and promoting condom use to reduce transmission of HIV and sexually transmitted infections;
- Improving the care and treatment of persons living with HIV and AIDS to promote a better quality of life and limit their need for hospital care (USAID, 2005).

USAID/ South Africa provides assistance in the following areas:

- Technical Assistance for Provincial level care and support training programmes for home-based care;
- Hospice services for the indigent; community-based support groups for people living with HIV and AIDS;
- Training for home-based care providers;
- Support to Non-Governmental organisations to provide home-based care services, including palliative care and nutritional support;
- Psycho-social services for those infected and affected by HIV/AIDS;
- Promotion of ABCs of prevention;
- Self-help income generating projects.

The South African Government has embarked on a comprehensive anti-retroviral roll-out programme for HIV positive individuals in order to improve their quality of life and continue being productive. The total cost of providing the drugs to everybody needing them is high, according to the findings of a joint Health and Treasury Task Team. The same Task Team estimated that 1.7 million lives could be saved by 2010, if ARV drugs were given to everyone needing them (USAID, 2005).

1.3 Statement of the Problem

The incidence of HIV and AIDS among low-income-earners negatively impacts on their propensity to save.

1.4 Rationale for the Study

In the face of a new epidemic of HIV and AIDS there is need to investigate and establish the fact that HIV and AIDS can really affect low-income-earners' savings during the time of illness. This will provide useful information for the purpose of formulating HIV and AIDS related policies at the work-place in order to cater for those low-income-earners who are infected with HIV.

The government prioritisation of Poverty Reduction requires an in-depth assessment of the impact of this pandemic since there are all chances that savings is directly

related to poverty eradication. This means that government programmes to alleviate poverty could improve low income earners' savings despite the HIV and Aids epidemic.

1.5 Study Set-up

Chiawelo, which is located in Soweto, has a population of approximately 200,000 people. Soweto is a sprawling conglomeration of townships developed in 1940s to house Black workers for the region's gold mines. Just like any other community in Soweto, Chiawelo is serviced by an HIV and AIDS clinic. This clinic provides VCT services for the inhabitants in order to know their HIV status and also as a measure of preventing further transmission of HIV. A greater percentage of patients attending this clinic for treatment are low-income-earners who have to spend money on transport in order to collect their tablets every month.

1.6 Objectives of the Study

The objectives of the Study with respect to Chiawelo Community covering the period January 01, 2005 to July 2009 being:

To examine the effect of HIV and AIDS on low-income-earners propensity to save;

To analyse and evaluate the impact of reduced savings on health and productivity level of those who are infected with HIV;

To suggest intervention strategies to policy makers so that such policies they make mitigates the negative effects of the disease on low-income-earners infected with HIV towards revival of savings;

To examine the effect of reduced savings on the overall poverty situation within the community.

CHAPTER 2
LITERATURE REVIEW

It is predicted that the number of HIV positive people in South Africa between the ages 15 and 19 will rise from some 3.5 million this year to 5.5 million by 2010. Full blown AIDS cases in the age group, which currently stands at 180,000 people, will rise to 700,000 people. Average life expectancy will drop from the current 48 for women to 32 and from 52 for men to 36. There will be almost 2 million orphans (Goss, 2009). HIV/AIDS mainly wipes out that portion of the population which is most productive in the economic sector. Of the 40,3 million people living with HIV and Aids worldwide, it is believed that approximately 25 million are of working age, between the ages of 15 and 49. HIV/Aids is destroying the most variable business asset – human capital. By 2020 the workforce in countries with high levels of HIV infection could be 25% smaller. In South Africa it is predicted that half of today's 15 to 24-year-olds will die from Aids. Africa's population is a young population because of high birth rates, with the result that Africa has the highest youth dependency/EAP ratio in the world, the smaller economically active. In other words, most of the population consists of children who are relying on economically active population (EAP), those people who are working and contributing to the economy. The dependency ratio for children under the age of 15 is 0,8 (80%) in Africa. In South Africa it is 0,5 (50%). The high youth dependency alone slows down economic growth and social development because they are too many children to feed, to educate and to provide basic health care for (Page et al, 2006). An obvious recipe for poor savings arising from increased expenditure towards family members who are either infected or affected by HIV and Aids.

Illness, disease and sickness have a major impact on the economic situation and the well-being of an individual in any society. This is particularly true in lower income regions of countries. Improvements in health may boost productivity and the individual's level of income and capacity to save (Tellness, 2009).

AIDS has had a devastating effect on individuals, families and communities everywhere the disease has spread. At the individual level, it leads to loss of income-earning opportunities because of sickness and the need to care for the sick. Savings is diverted away from food, schools and other household expenditure to pay for medical costs, funeral expenses and caring for orphans (Hubley, 2002).

HIV and AIDS reduces household income to buy food as well as the availability of food in communities by taking its toll on the bread-winners and agricultural labour force living the elderly and children to raise orphans (Keeton, 2002). Savings that had been accumulated over time by a person infected with the HIV could be used within a shorter period of time due to HIV and AIDS. This immediate expenditure does not only apply to the individual but also to his family members some of whom may be suffering from HIV and AIDS.

While public savings and infrastructure are likely to diminish – because of the pressure on current expenditure – the impact on the household savings and firm profits is more difficult to predict and likely depends on the extent to which the additional Health and welfare expenditures due to AIDS are borne by the households or by the public sector. In principle, HIV and AIDS should raise the pressure to increase household savings (for future health-care, funerals, and obligatory bequest) as well as to reduce them (due to impoverishment and increased current health costs) (Cornia & Zagonari, 2002).

Referring to “AIDS in the Twenty First Century” Disease and Globalisation by Barnett and White, the understanding of the impact of HIV and AIDS on low income earners’ savings is not explained properly in economic terms. The Researchers here were more concerned with affordability of an HIV positive individual to continue to survive. An example of Judge Edwin Cameron given in this book expresses the fact that although he fell severely ill, his access to good healthcare and drugs enabled him to pursue a vigorous healthy and productive life (Barnett & White, 2006). Judge Cameron was not a low income earner and there is no comparison between his expenditure and savings before and after contracting HIV/AIDS. Otherwise, the threat of HIV/AIDS for Judge Cameron may not be as severe as compared to a low-income earner’s situation.

> *"I can obtain these tablets because on the salary I earn as a Judge, I am able to afford their cost. … In this I exist as a living embodiment of the iniquity of drug availability and access in Africa. … My presence here embodies the injustices of AIDS in Africa because on a continent in which 290 million Africans survive on less than a dollar a day, I can afford monthly medication costs of about US $ 400 per month. Amidst the poverty of Africa, I stand before you because I am able to purchase health and vigour. I am here because I can afford to pay for life itself"* (as cited: Barnett % White, 2006).

Nattrass discusses the economic impact of HIV and AIDS on households by saying that the impact of AIDS on the economic security of poor households in South Africa is thus felt primarily through declining income rather than food production (Nattrass, 2004). This does not however, examine the situation whereby the income is constant, while expenditure is soaring and savings declining due to HIV and AIDS. That is why this research intended to deeply analyse the situation.

According to Cohen, individuals, families and communities are impoverished by their experience of HIV and AIDS in ways that are typical for long-drawn-out and terminal illnesses. It is a feature of HIV infection that it clusters in families with often both parents HIV positive (who in time experience morbidity and mortality). There is thus enormous strain on the capacity of families to cope with psycho-social and economic consequences of illness, such that many families experience great distress and often disintegrate as social and economic units. This experience is well reflected by the testimony of Lucy as follows:

> *"By the time my sons became ill with AIDS, one of my daughters-in-law had already died of tuberculosis and the other had become mentally sick. So I was the closest person to my sons. I had to resume the role of a mother, caring for her sick children. I was the only one who could ensure that their physical and emotional needs are met. It was very touching having to nurse my sons again and watching them bed-ridden and deteriorating day by day. My heart*

shrunk whenever I thought of caring for my grandchildren after the death of their fathers. Their sickness had started encroaching on the savings I had made for my own welfare in old-age. It was painful watching them die …"

"My sons left behind 6 orphans and now I am once again a mother to children ranging in age from 8 to 15. Two of my grandchildren were also HIV infected. One has already died and one is still living at the age of 8, though she has started falling sick. I am taking care of them alone because in our culture, it is the family of the father who must care for orphans. This is a great challenge having to look after young children again after counting myself among those who had graduated from the responsibility of being a mother."

"Before my sons became ill, I had hoped that my role as a grandmother would be to care for my grandchildren occasionally during school holidays, but now I am alone caring for them. In the old days, children were not exposed to so many outside influences, but now, Ugandan society has changed so much. I find that some of the tactics I used to instil discipline in my own children no longer yield the desired response from my grandchildren. I find the children less respectful and undisciplined in spite of my efforts. I feel so sad that I have gone back to the beginning and I have to struggle to get resources to ensure that their basic needs are met, such as school fees, medical care, clothing and other needs" (Cohen, 2000).

Poor families have a reduced capacity to deal with the effects of the morbidity and mortality than do richer ones for very obvious reasons. These include the absence of savings and other assets which can cushion the impact of illness and death. The poor are already on the margins of survival and thus are unable to deal with the consequent health and other costs. These include the costs of drugs when available to treat opportunistic infections, transport costs to health centres (Cohen, 2002). Lucy's experience as indicated above is testimony to the fact that HIV/AIDS negatively impacts on the savings of low-income-earners.

In South Africa's Free State Province, a long-term study reported AIDS-affected households maintain food, health and rent expenses by reducing spending on clothing and Education (Bachmann & Booysen, 2003). To cover increased AIDS-related medical costs, members of households often reduce spending on food, housing, clothing and toiletries (World Bank, 1999). On average, AIDS-care related expenses can absorb one-third of a household's monthly income (Steinberg et al, 2002).

Much of the efforts of social scientists over the past 15 years have been directed at understanding the costs to the society of the AIDS epidemic. Impacts are usually compared to a 'no-AIDS' scenario and the difference is understood to be the impact of the epidemic. This kind of analysis has typically failed to take into account the responses of the society to the epidemic, in modelling impact and in determining the costs to the society. It is important to understand the response of the society for a number of reasons: The impact of the epidemic is mitigated by a range of responses designed to prevent infections and to mitigate impact at individual, familial, community, infrastructural and societal levels. Until the scope and extent of response is measured and understood, it will be difficult to accurately predict the impact of the epidemic. Until we seriously turn our attention to monitoring and evaluating the response framework, we are in a weak position to plan further. At the moment we have very little information about how the society is responding to the epidemic and second generation surveillance systems have yet to be entrenched. The AIDS epidemic is widely believed to be capable of having a devastating impact on South African society in almost all areas of social development. AIDS is usually described as a crisis or a threat, even a catastrophe. It is obviously important to respond in all areas where there is impact, but there appears to be little understanding beyond what is likely to happen. Inevitably the society is going to need to move beyond managing a crisis and it is going to need to do this by integrating AIDS response with development planning. AIDS responses are likely to have generalised effects, beyond the immediate field of AIDS impact. Equally, some examples of outcomes of AIDS response that are likely to have positive ramifications for the society are; a sense of urgency and fast-tracking of development of health and social services and infrastructure; funding for health systems and infrastructure; funding of CBOs; improvements in efficacy of inter-departmental functioning at local and provincial

government levels; and the creation of higher degrees of social capital. Poverty alleviation and its effects and the focus on healthier lifestyles and positive social values are also positive outcomes that are fortunate by-products of social development programmes aimed at reducing susceptibility to AIDS. The struggle against AIDS in development countries is increasingly used as a further force behind the debt relief to highly indebted poor countries (USAID, 2002).

A South African study found more than 5% of AIDS-affected households were forced to spend less on food to cover these costs. This finding is even more distressing because almost 50% of the households already reported experiencing food shortages (Steinberg et al, 2002).

CHAPTER 3
METHODOLOGY

3.1 Study Population

The study population consisted of adult low-income earning men and women between 18 and 55 years of age in Chiawelo vicinity and infected with HIV. It specifically focuses on low income earners of the above population who earn between R1, 000 – R3, 000 per month. Their earnings and savings are vital for the maintenance of themselves, their families and personal good health. Yet their HIV status presents a big challenge that requires to be attended to, they certainly provide the better experience and ideas if efforts to mitigate the declining propensity to save and poverty generally have to be undertaken.

3.2 Sampling

A sample of 120 people was selected and used in this study through a random sampling method. The sample included adult males and females between 18-55 years of age who are HIV positive. Individuals in this sample were selected from the database records which to date has 2,340 HIV/AIDS patients attending Chiawelo HIV Clinic since June 2006 to the end of July 2009.

This sample of 120 respondents is quite representative since it constitutes 5% of the names in the register namely 2,340 names in the sample frame. In view of the limited financial resources and time, this is certainly a reasonable size and it comprises of representation from all the areas in Chiawelo.

The interview of each respondent required an average of two hours and thence the whole exercise took approximately ten working days. The researcher recruited 4 research assistants to help in the process of one-on-one interview of the 80 out of the above number of respondents. The researcher trained the research assistants for a full day to ensure that the interviewing was of the same standard.

Out of the remaining 40 respondents 20 were organised in two groups of ten each, in age ranges 18-29 and 30-44 years respectively. The other 20 were also in two groups of 10 each, with one group comprising of females and the other of males. In other words the focus group discussions were not drawn from the one-on-one interview group but were selected, from the 120 sample as such. This arrangement provided an unbiased opportunity for both diversity and debate in generation of ideas as well as the chance to assess the validity of information coming from the one-on-one interviews in a discussion environment.

Given the above total population in the database, the researcher chose the sample through picking every 10^{th} person in the register, followed by going through the sample list choosing one male and one female in succession to balance the sample selected.

Additional criterion of age aggregation was also taken into account to ensure that all respondents fall within the above given age bracket and the sample was therefore able to provide a set of divergent views to assist in the development of suggestive conclusions while aiming at obtaining data from different sources in order to achieve the most reliable research results.

The researcher also interviewed a social worker and an engineer and recorded their responses to offer a comparative view from professionals regarding the behavioural traits of people living with HIV/AIDS in employment environs.

3.3 Data collection methods

Given the sensitivity of the topic, qualitative methods for conducting the research Interviewing comprised the main technique for soliciting data from respondents. To obtain more comparative data, four focus groups were organised and guided by the researcher using the same interview questions. Some level of discussions especially in the focus groups was encouraged to clarify issues and ascertain the authenticity of issues raised.

Nevertheless a limited quantitative data on earnings of respondents was also sought to assess and monitor the actual trends of savings as in the semi-structured instrument (interview schedule) developed in English.

The data collection was done through a one-on-one oral interview of 80 of the 120 respondents while the remaining 40 were broken into 4 groups of 10 each to undertake the process in focus groups. The need for focus groups was very appropriate to enable the researcher obtain critical views of respondents in a debate/ discussion environment. Some additional questions not necessarily in the interview schedule were asked as necessary to clarify some issues as the interview progressed.

The response rate of the proportion of the people in the sample interviewed was typically high, partly because of the intrinsic attractiveness of being interviewed and the need for an appropriate size for meaningful deductions and conclusions of such research of qualitative nature.

The researcher piloted with 15 of his clients and one focus group discussion to assess the effectiveness of the interview schedule. This pilot phase also provided an opportunity to assess the approximation of time each interview and or discussion would take. It was as a result of this piloting that the researcher was able to provide the approximate time frames for questions in each objective category.

The one-on-one interview method was also particularly helpful with respondents whose writing skills were weak or had none at all or who were less motivated to make the effort to respond fully.

3.4 Limitation of the Study

The subject matter is so sensitive due to issues of stigma and discrimination attached to HIV and AIDS that it needed extra caution.

Time insufficiency for the researcher to interrogate individuals who seemed to have forgotten what happened in the past. It could take them time to remember vital information and therefore ultimately time consuming.

The study was limited to Chiawelo and patients who presented themselves to this clinic from 2004. The results cannot therefore, be generalised to others who accessed health care earlier or attended other HIV/AIDS clinics elsewhere beyond Chiawelo.

It was difficult to ascertain the validity of some of the information in the patients' records and revelations especially those related to addresses and financial earnings many of which were oral and not backed by documentary evidence. Much of this could be attributed to fear of being turned away or lack of trust despite the assurance of utmost confidentiality in the treatment of information received. Some respondents also desired anonymity but knowing that their details were in the register made them rather reluctant to give relevant information.

Because of low literacy and cognitive levels, some respondents could not have given their correct employment and financial statuses for fear that it could influence their hospital bills.

The researcher encountered some financial and logistical constraints. He also had to use his meagre resources which were not very sufficient for such an elaborate research project.

Just like in any social research project, practical considerations such as time, research personnel insufficiency as well as the fact that the Researcher was also a working person committed to full-time service of a medical doctor all played their part.

There might have been errors while distinguishing between high and low income earners due to possible effects of the current economic recession.

3.5 Research Ethics

Anonymity and confidentiality were used through-out the study. The researcher observed and abided by the three major areas of ethical concern: ethics of data collection and analysis, treatment of human subjects and the ethics of responsibility to society.

The names of the patients were not mentioned in this study and the unique patient identifiers used in the data extraction sheets were not the same as their clinic registration numbers

In short, this study was guided by the University of Stellenbosch ethical guidelines for Research.

CHAPTER 4
RESEARCH DATA, FINDINGS, ANALYSIS AND INTERPRETATION

4.1Introduction

The topic at hand requires adequate evaluation of the issues that arise from the research question(s) through collection of critical qualitative data in a systematic way. Such data is obtained in relation to each particular research objective in line with the relevant comprehensive interview questions as formulated in the interview schedule. The data obtained is then analysed to assess whether or not a qualitative change has taken place over time in order to ascertain the validity of the research hypothesis. Quality in this case refers to what the Little Oxford Dictionary (2002) calls “degree of excellence of something as measured against other similar things.” In other words the research issue requires measurement of change in view of savings in the life of the individual affected by HIV/AIDS. If such change is positive, then the issue of effect on propensity to save is minimal while a negative change denotes a significant impact on propensity.

Deliberate mechanisms called instruments for analysis have also been developed to enable systematic interpretation of the findings. Note McMillan & Schumacher (1993) call this a process that aims at analysing and interpreting data to test and achieve research objectives and provide answers to research questions, basis for any such research such as the one now in presentation.

The research data collected has been analysed objective by objective beginning with the presentation of findings in each group as outlined in 4.2.1-4.2.3 below and then the systemic results assessed are presented in graphic tabular format to enable ease of understanding of the relevant analysis. The findings in each group are discussed using research instruments developed by the researcher to provide a basis for some conclusive lead direction and or recommendations on each objective, thereby yielding the critical purpose of the research in recommendations thereafter.

The researcher developed categorical research instruments for discussion of the findings as follows:

The first category instruments test for attitudinal impact in respect of the issue of propensity, productivity, and poverty level determination which are inherent in objectives 1, 2 and 4 in respect of the population strata and the sample as chosen for generic development of findings and determination of conclusive decisions and recommendations.

The second category instruments are to do with societal influences that affect the stated individual in view of propensity, productivity and input to mitigation of poverty as well as development. Such would provide a basis for findings and conclusions that relate to policy and societal action in view of objective 3 and issues related thereat.

The specific instruments are explained and graphically demonstrated within the relevant area of findings as below.

4.2 Demographic Data on Participants

As presented in the research methodology chapter above, this research was conducted through the interviewing method in three grouped settings namely: one on one; in focus groups and in groups of informed professionals. The input in terms of each group yields the required data for analysis and interpretation with the resultant findings as presented in 4.3 below. It is important to state that the demographic constitution of each of the groups described immediately below, provides not only meaningful assessment criteria but also enables the researcher to understand and present findings on whether or not there are some unique qualitative expositions arising from the data obtained within the peculiar demographic characteristics such as age, gender and disease experience once a person is found to be HIV positive and is likely to develop into a situation of AIDS and how the behavioural quality evolves within each of such category.

4.2.1 One on One Group

The researcher allocated to each of the 4 research assistants 15 respondents from the sample identified to be interviewed on one-on-one basis and he retained 20 for himself. This allocation took into account consideration of the above mentioned characteristics of age, gender and disease experience to ensure that each interviewer takes notation of any unique findings arising in such case to help determine the imposing conclusions on the issues raised for research.

At the end of the 5 day process of the one-on-one interview exercise, the researcher was able to interview 17 respondents while the research assistants succeeded in interviewing 13, 13, 12 and 11 giving total response coverage of 66 out of 80 respondents (82.5%). This was quite a good and comfortable coverage to enable meaningful assessment, derive notable findings and present conclusive recommendations worth generality taking into account, the characteristic attributes of the affected general population of South Africa which has 10.9 % of its population affected by HIV/AIDS according to the Human Sciences Research Council (UNAIDS Report 2007) and that Soweto Township – whose estimated population is about 1.5 million people, is worst hit being a settlement area of diverse people in terms of race, tribe, nationality and even origin. As presented in the registers used for sample selection over 90% of these people have come from various parts of South Africa. Soweto happens to be the catchment's area for Chiawelo Community Health Centre with a population of about 200,000 people. If one takes the above estimate of 10.9% of the Chiwelo Community, 66 diversely spread sample in a population of about 21,800 represents an appropriate sample given this number is added to by the focus group discussion sample. It is also important to mention that 8 of the 14 missing respondents sent notices of absence arising from their declined health status which was certainly excusable and regretted.

Of the 66 respondents, 38 were female constituting approximately 57.6% and providing a proportionately significant input in the data for analysis and interpretation. The remaining 28 male respondents (42.4%) is also quite formidable number considering the fact that men are presumed in African societies to be family heads and therefore speak their families. They are also deemed to be breadwinners

and people responsible to save for families. It is probably in this light that Frank (1989) said: “The role of women as breadwinners has often been overlooked … the African father and husband everywhere is recognised as the head of the household” and yet he states further “the economic support for the family – especially for subsistence – is often provided by the wife and mother.” The father then “grants the woman land on which to farm, he has permanent rights not only to her but also to her children but also to many years of her free labour.” This therefore puts in light the issues that are to explain the expected position of the man in savings in the context of his personal and leadership role in family.

In terms of age aggregation one could say that the sample also represented a comparative aggregation of ages under survey. Ten (15.2%) within 45-55 bracket, thirty (45.5%) in the 34-44 age bracket and 39.3% were below 34 years given the actual number was 26 out of 66. This is good aggregation in terms of soliciting the input of the relatively old (45-55 years), the mature (34-44 years) and the youth (below 34 but sexually active). Many of those in the youth group are not always keen on monetary savings but derive qualitative value from buying new clothes and status property in respect of their peers such as vehicles, motorcycles or even bicycles. The issue of how far one is seen in clubs, drinking places and night clubs or simply places of enjoyment (as they would refer to them) such as movie theatres etc also qualify to be referred to as psychological saving centres since the youth gain high level of prestige from such action. This is what they presume to be fundamental saving.

4.2.1.5 It is with these in mind that the researcher has also got to examine whether or not the various forms of savings or the conventional ones of keeping part of monetary income for future is noticeable or diminishes when the respondents acquire HIV/AIDS status.

The response mode was very good since all the interviewees actively participated and presented answers that are quite rich and genuine since they were confident with both the researcher and research assistants who have all been well trained counsellors with substantial knowledge in handling HIV/AIDS positive people.

The analysis as well as interpretation of the data obtained from the interview and focus group discussions, is a comprehensive review of the presentation of the research process after the feedback workshop of the research team that collated and finalised the findings for the research report.

Focus Groups

As stated earlier, the research process involved four focus groups for in depth interviews based on gender and age characteristics. One group comprised of women, another of men and two other groups for age groups 18-29 and 30-34 being the most active age-groups. Each group was meant to comprise of 10 respondents.

At the time of the actual group exercise, the women's focus group had 8 respondents, men 6; the 18-29 age group had 4 while the 30-34 had 7. In short the focus groups had an average of 62.5% attendance arising from the fact that the women's group had 80%, the men's group 60%, the age group 30-34 with 70% and the 18-29 age group, least participation of only 40%. The discrepancies in number of attendance did not however deter the proceedings. If anything it enabled more participation of the respondents and better observation by each researcher.

While the principal researcher conducted discussions in the women's group, one research assistant each conducted the men's group discussions and that of the age group of 18-29. The fourth and fifth research assistants conducted the discussions of the age group 30-34. This last group was given such attention because it constitutes the most active age group in terms of productivity and even sex life and is usually more open for discussion on such topic as sex which many times is considered immoral. It should be noted “reasons for rapid spread of HIV infection in South Africa include high levels of poverty, income inequality and also sexual activity at early ages (Baxen & Breidlid, 2009). In the Bureau of Economics Research (2003) report it is states: “A particularly important characteristic of the epidemic is the fact that it is found mainly among adults between ages 20 and 40 years which are some of the most productive years of a person’s life.” The issue here of age is of special importance to this research since it represents the time an individual is most productive individually, in family, in society and indeed nationally.

The Professional Group

The researcher conducted interview with two professionals in order to get an experiential and comparative perspective on the research.

While the first professional is a social worker the other is an engineer. The first works as a social worker in Chiawelo Health Centre while the second works as a computer engineer in ABSA Bank. These two provided quite invaluable respondent views with professional observations of behavioural traits about People Living with HIV/AIDS (PLWH/A) to the research since they have had both vast experience and very useful insights in the research area to assist the researcher in analysis, interpretation and formulation of findings.

4.3 Findings

4.3.1 The critical test of the effects of HIV/AIDS on propensity to save

The basic issues in objective 1 of the research relate to savings by the individual in view of his/her status with HIV/AIDS. This makes it imperative that one defines this key word, identifies the critical elements therein and finally puts the hypothetical presumption of propensity to save to test.

Savings is defined in Oxford English Dictionary (2002) as "storing for future use; reduction in money time or some other resources" and or simply put savings is "money saved" where money according to the same source translates as a "medium of exchange' or means of paying for things" or simply put "wealth." In essence savings in the context of money denotes a broad action of keeping part of any income either as cash or in some possession that could be put to sale with a purpose of being used or to assist in future. A definition which brings out three key elements, namely: income; expenditure and the balance of an income that has not been expended or kept as savings in various forms. The fourth element in this research is to do with analysing the trends of such savings over time and interpreting it in relation to HIV/AIDS impact from the perspective of the individual interviewed, or individuals in the focus group or from the perspective of such professional so interviewed.

There is also the issue of attitude of the individual and or group in this process as crucial since it determines the aspect of propensity. Attitude in this case being the way the individual or group thinks or feels and or even believes in a concept like savings. According to The Oxford Advanced Learners' Dictionary of Current English (2005) attitude contains the elements: thought, feeling, belief and behaviour portrayed at something. In short what respondents' feelings or thoughts exist therein on savings? It is also a mechanism to deduce whether or not the respondent believes savings must be a routine in the determination of his/her future if the issue of impact has to be assessed.

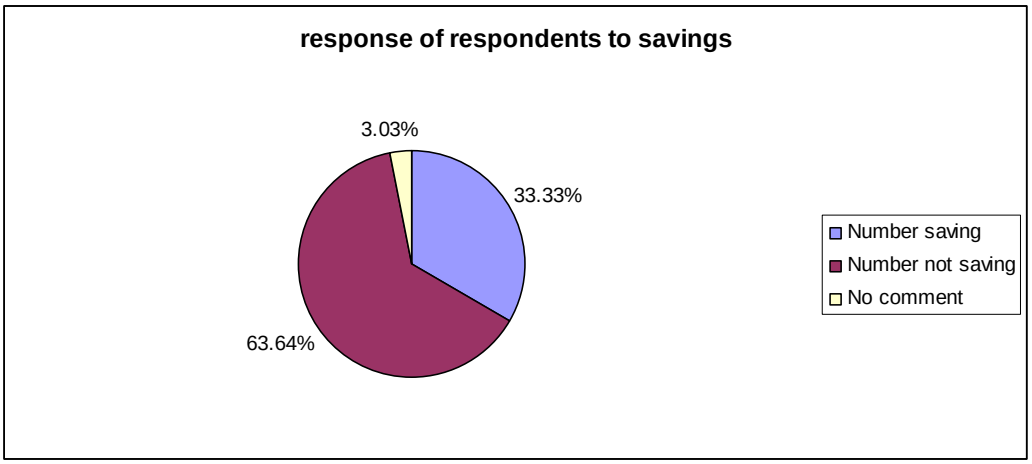
The key questions to answer in response to determine the authentic issues in objective 1 are: whether the respondents are earning income and in the low-income category as required? What is the level of expenditure of such income earned and the consequent pattern? Are the savings if done substantial and what is the trend of such savings over time? It is in answering these questions that the researcher generates the findings as follows:

4.3.1.4(a) One on one interviews

The findings in this process are in respect of; general issues as obtained from one-on-one respondents and specific issues as obtained from age aggregated notations namely ages 18-29, 30-44 and 44-55 (this is done to make a comparative assessment of the findings of the focus groups) and finally in respect of gender disaggregated data. The general findings on income, expenditure and savings information are plotted in the table below as follows:

Table 1: Showing the response of respondents to savings as such.

Respondents	Monthly Income	Number saving	Number not saving	No comment	General Remarks
66	Not more than R 3,000	22	42	2	Substantial savings rate
%	100%	33.33%	63.64%	3.03%	Variance in amounts saved



The table and the immediately following pie chart reveal generally that, at the time of conducting this research, the greater number of respondents in the sample is not

saving from their meagre income (63.64%) while only one third (33.33%) is saving but with a lot of variance in amounts saved which is however not stated in the table but shall be of relevance in the study of trends.

What is also very crucial to present as a general finding is that most of those that are actively saving regularly are respondents that have worked and lived for long with the disease especially those who have been counselled and clearly know that one does not immediately get condemned to death on finding that he/she is positive with HIV. Namely, those who got exposure to counselling early enough on knowing their status (81.82% of the total sample), or those who are of relatively of advanced age at least above 30 years (75.75%), and or those with family and or investment responsibilities like some permanent housing, business etc. can certainly live longer and save enough for the future.

One important revelation came from one of the respondents who said the following:

> *"I follow the example of my friends and peers who are HIV positive but they are running their businesses as if there is nothing wrong with them because at the ages between 30-34 if you do not make an achievement then count yourself as a failure."*

This is a very innocent but important utterance emphasizing the centrality of age in human behaviour and indeed a determinant in effective contribution to economic development in terms of scale and output.

Following an analysis of the trend of earnings by the respondents who are in saving category, it has also been found that the trend of savings has been consistently declining in monetary terms and or such other savings as putting money into other forms of investment (such as building, business, land acquisition etc). This last set of savers, constitute 24.5 % of the savers generally in this research, since they are 6 out of 22. It is also important to state that this form of saving is also a major form of saving.

The other significant finding comes from the following important exposition by two savers, given their statement was chorused in various detailed revelations by the others. It is an important revelation that provides a good summary of the greater number as follows:

> *"The situation has changed. We no longer save money like we used to do because we are no longer strong to work hard due to our AIDS disease and the demands it has brought to bear on us in terms of food and other requirements."*

This is therefore an indication towards the issue of obvious decline in the amount of saveable income by the various respondents which is a very relevant affirmation of the notion providing the baseline to assess whether or not this was a continuous behavioural attribute to impute on propensity.

At this stage it becomes important to state the case for those who declined to comment as it explains the observation of the respondents which response also acts to justify the consequent deductions. The following was a statement from one of the two respondents who declined to comment:

> *"What comment do you expect from me given my present survival is owed to my wife on the one hand and friends whom I visit and offer for me alms of sustenance."*

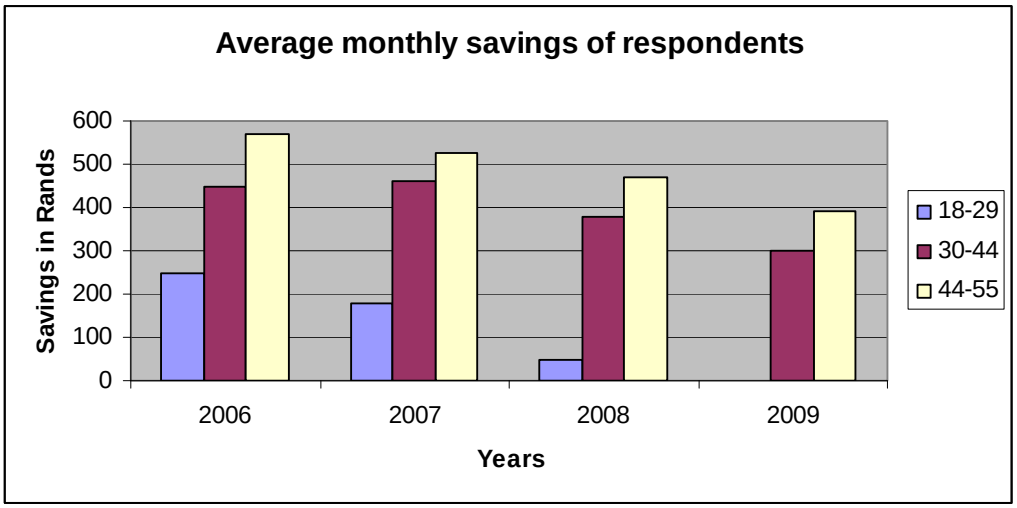
This is not to state that the respondent was not working and earning neither does it suggest, that he does not save but that he survives on the added charity of others. Thence he had no comment but clearly that conceiving that he was among those saving is out of question but left for the reasonable deduction of the interviewer.

Another telling finding relates to the age disaggregated information of the savers. To ease its presentation the researcher has calculated the average monthly savings within each age category and plotted it for years 2006 to date. The graphic presentation of the data is telling given the figures generated as presented in table 2 below:

Table 2: Showing the average monthly savings of respondents within specific age groups

Age Bracket	2006	2007	2008	2009	Remarks
18-29	250	180	50	-	The financial demand of youth is daunting and given they are not grounded in the disease.
30-44	450	460	380	300	The respondents seem to have coped with their situation and have taken responsibility
44-55	570	525	470	390	The respondents are more confident and mature in handling the impact of the disease

The above situation can be presented in Bar Graph as follows:



Overall the trends were all declining, but the trend within the younger age group is clearly more drastic. The finding has been corroborated by a revelation by the professional respondents to the effect that the demands of the younger age group is so vast that whatever income they earn usually falls short of their demands. Besides, it has also been observed by the youth themselves that they are individualistic in attitude, self-based and not well grounded in the idea of savings. This provides such an important finding to further expound on in the focus group of this category as presented below.

Although one would have required a more intense data collection with actual figures of earnings and expenditure by respondents, unfortunately most of that could not

come out since most of the respondents did not have records and had scanty unsubstantiated knowledge of earnings. It should be pointed out that most of the respondents such as drivers, compound cleaners, domestic and construction workers are in employment category where there are no such things as payment slips which could be produced over time for such research. Rather they are paid either weekly or monthly and on payment forms kept by the various employers.

Nevertheless they are able to state that in the early times i.e. 2006 and 2007, they recall well that they could save. Then, they were also relatively strong enough to work for two or more employers such that they could clean a number of compounds on each day for the case of compound cleaning jobs and earn between 400-700 Rand weekly from such engagements. Some have also been engaged as construction workers who are paid according to the level of input one makes in the labour demanding tasks. But as time went on the disease has had effect on their physical fitness to undertake such labour intensive employment exercise for two to three different employers on different days.

One respondent stated:

"In this way we were able as individuals to open bank accounts and save."

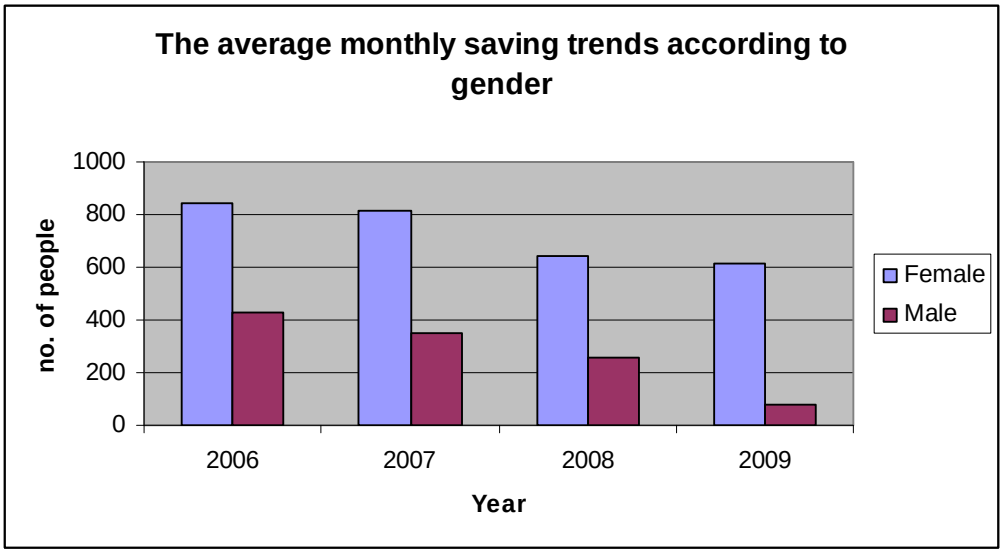
The same was also true for domestic workers who also now (2009) find it difficult to register themselves to work three days in a week in three houses to earn some reasonable rate weekly ultimately adding into monthly wage average payments not exceeding 3,000 Rand. It is on the basis of this exposition that the researcher computed and stated the average savings figures in real terms as per Table 2 above. The calculations in the gender disaggregated data on the other hand presented yet another very interesting set of findings as the follows:

Table 3: Showing the average monthly saving trends according to gender

Gender	2006	2007	2008	2009	Remarks
Female	840	815	640	615	The women groups locally known as stokvels are very instrumental
Male	430	350	260	75	The males disclosed savings in capital investments that could not be quantified in

					this interviews
Annual Total	1,270	1,165	900	685	

The bar graph below represents the average monthly saving trends according to gender



The role played by the women groups in their local groups called stokvels were quite instrumental in the monthly saving trends despite the decline in trends overall which happens to be even more pronounced among their male counterparts. In any case they were almost twice in number (14 out of 22) compared to the males (8 out of 22). In other words the female respondent savers were more effective than their male counterparts.

Further on the issue of declining trend over time, it is relatively less emphatic for the female folk compared to the males many of whom argued that they have children to look after in terms of fees and other capital investments like housing, land development activities etc all of which unfortunately they could not quantify coherently to present as authentic monthly savings outlay.

Besides the research was not about the extra incomes from engagements other than that income which is regular and easily quantifiable in monetary terms. This could therefore be an issue for added research.

Further calculations of the rate of decline for female respondents over the time shows approximate percentage figures of 3% in 2006/07 period, 21.5% in 2007/08 and 4% in 2008/09 using the previous year as the base year in each case while for the male respondents it was 17.8% in 2006/07, 25.7% in 2007/08 and 75.5% in 2008/09. This finding provides yet another very useful data for deriving interpretation on propensity to save based on gender considerations.

But it is important to mention in this particular finding that the emphatic decline in the 2007/2008 year was attributable to the regime change since the respondents intimated that the regime being changed then was not very keen on HIV/AIDS issues and one was not sure of the subsequent one. “For example, there were no clear guidelines from government under Mbeki on how to fight the epidemic. Mbeki told Time Magazine that “a whole variety of things can cause the immune system to collapse” and he said “ARVs could poison people who took them (Noleen, 2007). A lot of money had to be spent seeking for ARVs and such other items to keep in the event of the unforeseen future.

On the other hand the male respondents argued that their propensity to save was impaired further by the financial crunch and the effect on increased costs in transport, food and all other amenities that must be met and therefore hindrance to savings. What James (2009) states in the following quote “the global recession has created an underwriting environment best described as strenuous” seems to be at the core of the view of the male respondents. But it should be stated that the male respondents who are saving are doing so individually other than the stokvel arrangement of the female counterparts. Thence, there is no consistency in terms of regular monthly savings. They actually approve the stokvel arrangement of women folk as an important mechanism for savings especially for such people as are impaired by HIV/AIDS scourge. This was even more pronounced in the current year 2009 since many of them claimed they needed to keep afloat with the financial downturn.

On the side of those who are no longer saving which comprises approximately two thirds of the total (42 out of 66), 22 are female while 20 are male.

While the males in this group averaged well in the monthly incomes with none earning less than R 2,800 regularly, most of the females were no longer in regular monthly income either because many had progressively become weak from the disease impact or they had lost mode of regular income. The monthly average of such irregular incomes among the female respondents in this category was hardly over R 2,000. It should be also stated herein that over 80% of the female respondents are domestic workers many of whom are no longer employable by virtue of their deteriorated health state or are either declined employment by prospective employers since they no longer looked healthy or even confident enough to deliver the housework which clearly is labour intensive. They can therefore not get regular employment to yield income to yield regular savings. Such circumstance consequently denotes the adverse impact of HIV/AIDS on savings.

It however suffices to say as a general conclusion in relation to the findings from the one on one interviews that, clearly there is declining trends in savings overall. Attributing this to HIV/AIDS or not is left for more in-depth analysis and interpretation in paragraph 4.3.1.5 below.

4.3.1.4(b) The Focus Group Discussions

The findings of the various age groups in respect of this objective were quite varied due to the varied level of demands in each group; the kind of responsibilities in hand; the amount of knowledge and disease experience about the HIV/AIDS pandemic; and also level of organisation existing for coping. It is in view of these issues that the findings below given come out.

For the age group 18-29 which we shall for the purpose of this Research call the youth group, it came out clear in the discussions that:

- The youth have very many demands such as survival (making sure that one is comfortable with what one earns and self sustained) socially active (sexually and generally out to enjoy life with less encumbrances of dependency except girl friends (for the males) or good dressing and bodily

requirements especially for the females.) These requirements could not enable the youth to save from a mere monthly earning like R 3,000. Besides Hubley (2002) states: “When they leave school, young people become more independent from their parents and begin to earn some money. They are more likely to become active than school children at the same age.”

- In any case many of them were full of life and often liked going out to enjoy through drinking, evening outings, to dances etc. There is therefore a lot of demand for cash among the youth especially given the usual peer pressure is to expend than save. This situation worsens once they discover they are HIV positive because the youth feel let down and they therefore use whatever resources they have to equally pass the disease on to those others because they find themselves accusing the society for the presence of HIV/AIDS that is a terminal problem to end their short-lived life. In short there is a level of recklessness and so no savings. Note an outburst of one of the respondents who narrated the following:

  “ One evening as we were having good time one of my fellow HIV/AIDS positive friends under the influence of alcohol shouted to us that he could not keep the so called virus to himself as if he was created with it. He also has a duty to pass it onto as many girls as he can before it catches up with him. Why does he have to die alone when the girl whom he trusted got him into it.”

This statement is of special importance because there are quite many who have not marshalled courage to say such a thing but they are doing exactly what is being said. This calls for the need to develop an important mechanism to address this category of patients, if the idea of mitigating the process of deliberate transmission of the disease has to bear fruit or should be eradicated.

- Even then, they argue, getting to attend to clinical attention is an added expense that they can not afford. Note:

"Nowadays most of the money we earn is spent on transport to clinics and buying healthy foods."

Another narrated her experience as follows:

"I have to borrow money to attend clinic and I spend long hours at the clinic instead of doing piece jobs which is my source of regular income"

- The others suggested that they should at least be given three months supply of ARVs in order to save their transport money to be used for other survival requirements like good food and outings to forget the frustration occasioned by the virus!

- The kind of jobs that this group presented include: Employment as compound cleaners, or housekeeping weekly, or at construction sites. These jobs by their nature are labour intensive and require good feeding in terms of healthy food and mind. HIV/AIDS is therefore clearly seen as a contaminant in the presence of the virus in the life of the youth and hence they take to spend what ever either because they presume no future or because they must keep afloat by good looks, feeding, lifestyle etc.

To sum up the revelation of this group, the disease is an expensive intrusion in one's life that needs more resources than what one earns and it is therefore not sensible to expect a person in such group to save. This therefore corroborates the findings among the youthful people in the one-on-one interviews as stated earlier.

The middle age group of 30-44 years comprised only of mixed male and female respondents and they presented the following as findings:

- Again characteristically many demands fall on people in this category given many of them have got partners and young families to cater for. The

demands of these families in terms of: food, accommodation and dressing are prohibitive for savings.

- They also assert the issue of the current so-called global financial crisis as an additional encumbrance although they are quick to add that ultimate performance at the place of work whilst with the virus is untenable. In that the employers demand more and more labour with no increase in pay since such demand for more pay amounts to getting a dismissal from the employment for the employers treat such as insensitive and unrealistic behaviour. Employees especially the HIV/AIDS positive ones also acknowledge that employment is needed in their status more than people who are not living with HIV/AIDS because they are infected and in more dire need. So one of them (35 years old unmarried) narrated:

  "If you have money you live better life and young girls are looking for guys who can afford their needs. The situation has changed. We can no longer save money as we used to because we are no longer as strong since we were infected with the HIV. We are grateful to government for providing us free ARV drug but the need to come over to collect the treatment and eat well enough to make the medicine to work has disorganized our plan to save and develop ourselves for the future."

Others even added:

"There are even those of us in this life (People Living with HIV/AIDS) who are frustrated, stressed, no longer cope and have committed suicide."

- This situation explains the reason for the fact that the male group in the one-on-one interview above Table 3 reached the level of very low saving. Note the declined trend from 17.8% to 25.7% ending up with 75.5% in 2006/07, 2007/08 and 2008/09 respectively. Over 50 percentage points in the last year from only 7.8 percentage points in the previous year.

The third focus group of only men – that we later continue to refer to as the Men Group – corroborated the statement just made above when they stated that they could not be expected to save given the uncertainties associated with the disease. Nevertheless they presented an interesting scenario that they could only afford to save by giving their small balances to their wives who were better organised in their stokvels.

- They argue that the issue of saving in banks that are interested in making profits is even not tenable.

  "The likely balances of expenditure if not given to the wives as above will certainly be used off in the many other demands brought to bear on us by the disease."

The last focus group which comprised of Women was the only one that had a lot of hope in saving through their stokvel groups. They explained that they contribute monthly R 100 of which some is partly given to a member in turns to handle unique personal needs. Some of the balance is then kept, banked and shared out at the end of the year in order to take care of the issue of end of year festivities, school requirements for dependants as well as the many new requirements that come with the new-year. It is also a mechanism of insurance for times of misery.

- One of them summed up the importance of this mechanism as:

  "The family that does not save will face the music in time of sorrow"

This was quite revealing in terms of anticipating the disease end being death due to no cure and also talking about a family. Thence it corroborates what the men headed households alluded to in terms of giving their savings to wives to keep in the relevant findings above.

- The group further revealed that to evade the current crime rate occasioned by the unbearable economic situation, the group opens a group account in

bank to keep their savings assured and earning some interest although the group also complained about the low rate of interest on their savings which is of low level.

- The group is able to assert the role HIV/AIDS impacts in eating away their savings due to the fact of the costs involved with VCT at private sites as well as the expensiveness of ARVs at the Chemist given the other varied family needs. That the family must also eat good food to sustain the weak immunity and to prepare a person taking ARVs to withstand the debilitating effect of the drug if on poor diet.

These are a few of the prominent issues cited for the declining trend of savings occurring year after year.

4.3.1.4(c) The Professionals' Revelations

The professionals looked surprised that at the given level of earnings (not more than R 3,000), some respondents are still able to save but strongly stated that if anything the savings must have declined significantly in amounts and coverage since HIV positive people always complain of increased transport costs, healthy food, medication and other amenities and always wonder whether they could survive longer. In any case they contended:

> *"These are critical requirements that they must procure to enable them live longer. Government and employers need to take into account the need to provide social grants to them as their saving and safety net."*

They further back their contention by explaining that HIV/AIDS patients are a consequence of three critical processes: shock, shame and stigma which call for more expenditure than saving.

This provides an adequate finding for the following conclusion to the first objective of the research thus:

4.3.1.5 The Interpretation and Conclusion on findings – Objective 1

The requisite instrument for analysis and consequent interpretation of findings in this case involves assessing the respondent's income in relation to the workload as in question 1 bullets 1-3; the use of the income in terms of expenditure as in bullet 4; the savings made in relation to bullets 5-6; trend of savings over time as out of bullet questions 7-8; and finally an assessment of the role played by HIV/AIDS in terms of impact in bullet questions 9-10.

The findings are presented in the sequence of one on one interviews, Focus Group interviews and finally that of the professionals.

Through presentation of averaged incomes generated from totals as well as expenditure and savings of respondents in the categorical age brackets and gender,

one is then able to analyse and make some interpretation of findings as well as determine trends. Aggregation in terms of the age groups or gender is also a mechanism for comparative deduction worth generality through the use of the findings from the focus groups. The professional revelations provide as it were authoritative basis to validate the named conclusions.

In conclusion:

- The findings presented above clearly go all the way to show that the respondents were regular income earners in the category of low monthly income not exceeding R 3,000, who had the motive to save but are disabled in the main by the devastating effect of the HIV/AIDS scourge.

- That the disease as the professionals explain above, has different effects and impact arising from what could be summarised as triple **"S"** phenomenon namely: shock, shame and stigma. ***Shock*** in that the knowledge that one has acquired a disease which has no cure and will end up in death; ***Shame*** in the sense that most of the transmission from one person to the other is through sex makes it appear a disease of immoral people and therefore has a lot of psychological dimension on the sufferer who therefore takes to spend whatever he or she earns to enhance her wellbeing; and ***Stigma*** especially from the fact that the severe effects of HIV result in excessive weight loss and so they become outcasts shunned in society.

- There is therefore a tendency for PLH/A to want to feed well and have great weight. This comes with an accompanying great expense on good food, dressing well, changing lifestyle in terms such things as going out for movies since they find themselves adapting new lifestyles in the wake of stigma and loneliness and indeed getting to spend extravagantly to get a partner as well as survival.

- The need for critical counselling to understand the disease and appreciate that it is not a death sentence is also clearly exposed as is the reality of longer successful experience of living with the disease as factors that can inculcate confidence and reignite the idea to make into savings again.

4.3.1 The analytical impact of HIV/AIDS in reduced savings arising from issues of health and productivity.

This is a matter of national importance since no growth or no development can take place in poor health and disabled productivity with definite implications on savings. Thence it is not possible to talk about positive change in the basic lifestyles of citizens in terms of their livelihood. As has been shown in the findings of objective 1 above, there is gloomy picture of savings especially among HIV positive persons. The disease HIV/AIDS is indeed poised to not only undermine the potent and capabilities of the most important factor in development – the human being – but to eliminate its very existence through weakened health and reduced productivity, reduced savings, less taxation and thence impaired government performance.

Since the basic idea of savings is a preparatory process for the future, one therefore needs to ascertain how such future shall be assured/ insured and the way to do this is through ensuring good health and productivity of the human factor.

A comparison done in 2003 of the results from four forecasting methods predicted the differentiation between an HIV/AIDS scenario versus a no HIV/AIDS scenario for annual growth rates between 2002 and 2015 and it revealed that real growth in GDP would be 0.6 percentage points lower than if there was no HIV/AIDS but percentage per capita would be 0.9 percentage points higher according to The Study of South Africa: HIV/AIDS Impact by Gender (2002). This indeed offers a fertile ground to find out more about such expression since the latter scenario denotes a result of declined population while the former a state of high probability of poor health and less productivity.

In the same study, the South African branch of Daimler-Chrysler Company estimated that in 2002, expenses related to HIV/AIDS were equivalent to 4% of all its salaries in

South Africa while another study on SASOL (the second largest single South African Company) in 2000 indicated that 15% of its local workforce was HIV positive of which 11% had fully blown AIDS. According to the CEO of the largest South African Company SAB Millers, the cost of HIV/AIDS includes debilitating factors like increased absenteeism, reduced productivity, increased labour turn over, and increased healthcare costs. In the ultimate therefore the corporate persons would become less effective, produce less and therefore be of ill health as well as project negative national productivity.

The Human Research Council of South Africa estimates that 10.9% of all South Africans have HIV/AIDS (UNAIDS Report, 2007). That it is more prevalent among female adults under the age of 40 in nearly all age groups. That roughly four in every five people with HIV/AIDS, aged 20-24 are women and only one-third of people with HIV/AIDS aged 25-29 are men. And more worrying is the fact that between 2005 and 2008 the number of older teenagers with HIV/AIDS has nearly halved while between 2002 and 2008 prevalence among South Africans over 20 years old have increased whereas the figure for those under 20 years old have dropped over the same period.

The presentation of the above statistics provides the background for understanding the forthcoming findings, analysis, interpretation as well as conclusions arising from the research process. It also provides a basis for a more succinct direction to ascertain the impact of the disease on health and productivity as occasioned by the issue of propensity to save either individually or in groups similar to the expositions in the interview process of one-on-one.

The professional opinion then generates a basis to assist the researcher make an authoritative deduction and conclusion.

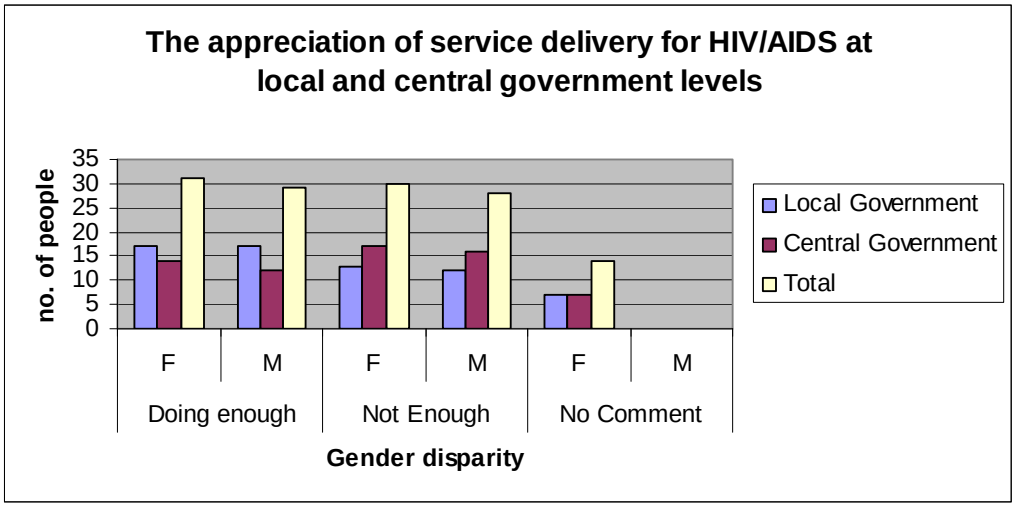
4.3.2.7.1 The one-on-one interviews

As a general basic finding, the following is the tabular presentation of the respondents in terms of those who are coping at the moment, those who are not coping and then those who declined to comment, thereafter generating the other key findings as follows the table.

Table 4: Showing the distribution of the sample into coping number by Gender

Sample	Coping	Not Coping	No comment	Total	Remarks
Female	18	18	2	38	Almost evenly distributed
Male	11	16	1	28	Seemingly hard to balance
Total	29	34	3	66	The need for social grants seems emphatic

The graph below represents coping number by gender:



The table 4 and the bar graph following it present clarity on the following interpretations:

1. Overall the coping level is also on the decline since those coping, is just 44% of the total meaning that the society is put at the risk of caretaking many of its own since such infected and affected persons cannot save nor take full care of themselves. If they have to continue to live they are obviously some form of burden.
2. While the female gender seems to be and relatively balanced in terms of distribution between those coping and those not coping, the male gender is clearly denoting level of loss of hope. A contention that affirms the position as presented in the findings of the first objective wherein the number of those saving among the female gender is not only higher but more balanced and adept at the subject of savings, more than their counterparts.

3. The reasons for the above situation as given by the respondents, include:

    a) The stress arising from the impact of the disease namely: the disease demands so many unique provisions such as good food, medicaments, transport, level of hygiene etc that cannot simply be met adequately from the meagre monthly income. What Nattrass (2004) discusses in a presentation on the economic impact of the disease on households as being "felt primarily through declining income" that makes the households ultimately vulnerable. It is also relevant to bring in here the contention of Keeton (2002) that "HIV/AIDS reduces household income to buy food as well as the availability of food in communities by taking its toll on the breadwinner, the agricultural labour force, … savings that had been accumulated over time by a person infected with HIV could be used within a shorter period." This is very telling as further developed by Cohen (2002) thus: "The poor are already on the margins of survival and thus are unable to deal with the consequent health and other costs." It is therefore in the light of these quotations that the first summary finding from the one-on-one interview falls bare, namely: it is a proven predicament on health and productivity due to impaired savings.

    b) The second summary finding in addressing this objective relates to the impact of HIV/AIDS on the physical ability of the person so affected to be healthy and or productive since his physique is questionable and rather defective. According to Hubley, (2002): "At the individual and family level, it *(HIV/Aids)* leads to loss of income earning opportunities because of sickness and the need to care for the sick." In other words, whereas "improvements in health may boost productivity and the individual's level of income and capacity to save." HIV/Aids presence in the individual debilitates him/her because "illness, disease and sickness have major impact on the economic situation and the well-being of an individual in any society" (Tellness, 2009). In short the respondents are saying this debilitating effect of the disease on the individual cannot be ignored.

    c) The third summary finding is to do with isolation by not only family and relatives but also the society in the form of stigma. While blame for this could

be attributed to those that isolate, the infected and or affected person(s), such person(s) has definitely to bear the burden of loneliness and defective innovativeness which are critical attributes of productivity, the burden once emphatic, imposes socio-psychological threat on this person to cope. Cohen (2002) states this by saying "individuals, families and communities are impoverished by their experience of HIV/AIDS in ways that are typical for long-drawn-out and terminal illness" which makes many families to experience great distress and often disintegrate as social and economic units. This is very stressful and therefore not easy to cope with.

d) The last notable finding has to do with the current economic recession that has played part in terms of making goods and services unbearably expensive and more imposingly unbearable for low income earners who are further burdened by the disease. In this particular circumstance of stagnant income level the HIV/AIDS affected person is doomed to decline in level of coping basically because the sudden crunch has made an upward pressure on prices but not on income which employers would if possible wish to reduce and especially so for the low income earners given they do not have specialized professional skills to remunerate further. The case for expenditure requirements rising suddenly against constant low level income does not therefore need any further explanation much as it states the obvious of no balance to save.

4. Although clearly the above portrays a gloomy picture, the respondents have very convincing optional solutions offered as hereunder to enable people so affected to cope based on their varied experiences in the circumstances:

a) The positive impact of the counselling services at both: Chiawelo Health Centre and or that of the mobile team makes it imperative that it must be made readily available at all times for the people needing it. They observed that those people who present themselves to the clinics or at mobile team sites cope more readily as a result of such prompt service delivery even if the person in point only presented for basic testing. The psychological nourishment from the regular process of counselling has been of paramount support and exposes any person affected and infected to realistic options for

coping with undoubted positive results to show. It is as a result of this that many of the respondents argue they are still alive.

b) The formation of support groups such as stokvel, family or even some organised local groups among those HIV positive persons has been of great advantage in terms of building confidence and shared experience.

c) The role of government in providing free treatment for HIV/AIDS patients, provision of free ARV services are major contributors in the sustenance of life. In the circumstance of the meagre earning as shown above, and the circumstance of expensiveness of the drugs, this would have been an impossible task. The HIV/AIDS positive persons therefore either use their income for other requirements or saving or even for very productive pursuits given their primary health requirement is safeguarded.

d) The active engagement of many members in food gardening in the vicinity of their residential places by many of the respondents has been instrumental in improving the quality of food intake on the one hand and easing resources for either saving or other uses in the coping sphere. This has even been more valuable since many of the respondents have been able to produce more than the amount they need, thence selling the excess to gain more income to top up the meagre earnings and or save. This is a business motive initiative that has direct bearing on productivity.

e) Churches, civil society organizations as well as non-governmental organizations operating in the area have supported not only counselling support but material support in terms of seeds, clothing, shelter as well as other inputs and training in gardening techniques. Such guidance and support has proven life enrichment and sustenance impact beyond doubt and necessary for healthy living and productive engagement.

f) Government social grants have also been instrumental along with support to community based projects that offer additional support. As said earlier in Department of Health Estimates (1994), “One of the factors that contribute to

the spread of HIV infection is poverty which is characteristic of developing countries like South Africa." Innovative projects to help boost income for the poor and the sick through such projects of income generation are vital. USAID (2005) programme clearly therein states: "Improving the care and treatment of persons living with HIV/AIDS to promote a better quality of life and limit their need for hospital care" particularly by way of "support to Non-Governmental Organizations to provide home-based care services including nutritional support, … self-help income generating projects" is of paramount contribution for community development as well as national development.

From the above findings and conclusions, the following preliminary recommendations are drawn from the interviewees in respect of this particular group's assessment of issues of health, productivity and propensity to save:

- That, women are coping more than men. They are therefore the best safety net for channelling social grants that can be used profitably and in group formations. The how and effectiveness factor may need an in-depth feasibility but it is a worthy consideration for further research.

- That, men easily give up hope and therefore do not cope well with trying times like that brought about by HIV/AIDS. Extensive counselling for men and men groups is desirable and should be part of any intervention targeting men.

- That, counselling is so crucial that it deserves encouragement at every level of the disease development. It is also useful for even those who are not HIV positive but affected in terms of the disease impact.

- That society and or all levels of government need to turn concerted attention to the plight imposed by HIV/AIDS scourge in terms of both support: material, financial and moral.

- That the active involvement of CSOs and NGOs in offering support to the people affected and infected by the disease is a worthy cause that must be

encouraged and offers tangible dividends in coping of the persons so affected to effectively contribute in terms of health and productivity and revamping the possibility of savings.

Ultimately, the pursuit of the above offers the hope for recovery in the process of savings.

4.3.2.7.2 The Focus Group Discussions Findings

The groups in summary revealed similar findings to the one-on-one above with the greater contributions from the Women Group basically because they represent the group which is better organized and freer than the rest. Another factor is the fact that they do not only have the lesser number failing to cope but also in terms of their bigger number's commitment to saving through their stokvels. In other words the Women are better prepared to assist each other cope and also save. The following basic suggestions were made by each group:

4.3.2.7.2(a) The Youth:

- They are only coping through borrowing from friends and family members especially to cover transport, essential foods and upkeep.

- That in some instances one copes through sacrifice such as having one major meal a day instead of three. This in itself is a contributor to declined health and productivity since it is not possible to be positive in both fields with an empty stomach.

4.3.2.7.2(b) The 30-34 year olds:

- Support groups among Members and those brought about by the intervention of NGOs, CSOs, Church-based organizations and even get-together functions are all important avenues for shared experience, collective raising of material resources for those badly off etc. To them, they have to make choice to rely on such limited team of friends because seeking support from other people not properly known, ends up invoking stigma and or unnecessary misunderstanding. Note:

  "The friends we are talking about in development of support groups must be true friends who can love and care during tough times otherwise you end up with those who just simply laugh at you."

This revelation tells a lot since it brings out the aspects of love and care as important components for good health as well as productivity. It also demonstrates the idea of saving in terms of group Members raising resources to assist fellow Members in need and therefore baking for their future.

- The second key coping mechanism that this group dwelt a lot on besides some of those mentioned in the one-on-one interviews had to do with family support. The group stated that family counselling was enriching and brought family members to take up the burden ushered by HIV/AIDS.

4.3.2.7.2(c) The Men Group

- Find it more difficult to cope because:

> *"Being sick with people that depend on you, is so painful. It is like you are a cruel father who cannot afford to support your own family."*

Another of them cements this further by saying the following:

> *"Going to another man to borrow money is so hard. It is like you are really not a man enough to support your family."*

The men besides being individualistic are full of self-remorse, pity and pride that they will deny the benefit of group support mechanism to cope. They therefore remain lonely, psychologically stressed, physically weak, unhealthy, consequently less productive and ultimately not able to make any savings and rather seek for support from elsewhere. They therefore prefer to die silently.

4.3.2.7.2(d) The Women Group

- Their revelations fully reinforced the findings in objective 1 on the one hand and their sense of responsibility for one another as a group on the other in such a way as:

> *"We have been coping as women by contributing some money to a common pool monthly – usually R 100 monthly – and keeping it in a Bank. During the month of December our money has made some profit which we then share among ourselves."*

It is this stokvel concept which makes the women folk stand out different in the human persons in South Africa. Although they note the issue of high bank charges and or restrained interest amount, they are resolved in savings direction in confidence.

- The same group is also steadfast in utilizing the human societal values like families, clans and or common dialect groups towards coping advantage.

- The third issue the group revealed has to do with the fact that the women had more stable jobs since they are generally more patient and faithful to their employers than their counterpart men folk. They are also more focussed in terms of chasing supplementary incomes than the men.

- Thrift in expenditure is yet another. While men generally put their income to unplanned issues, women like to plan an expenditure line and they always work towards it. This further assists them to save without being split in mind.

- The last issue stated was that women once in a religious group tend to come together and form groups fashionably compared to men. It is then easier to approach the religious leaders like pastors, sheiks and or prophets as a group for assistance than as individuals. Such religious leaders, then take such groups not only more seriously but also label their support to such groups as part of their own calling.

In conclusion the focus group discussions offered a mixed bag but with more or less similar recommendations as compared to the one-on-one interviews.

4.3.2.7.3 The Professionals

The professionals began by invoking the dictum:

> *"Expecting the HIV/AIDS positive person to maintain good health and productivity is like attempting to obtain milk from a dehydrated cow that is not even able to reach the area of pasture."*

For them the respondents in this research are people basically dependent on families and friends whose health status is compromised and thence impaired productivity. It is not fair to expect them to save since their continued survival is owed to the free treatment and ARVs from government on the one hand and the support of charity organizations like NGOs, CSOs, Religious Organisations as well as some Community Based Support Groups on the other. Moreover the latter are even strengthened by contributions from elsewhere. In short the issue to be sought should rather be: how to assist the respondents in this research to cope rather than whether they are healthy and or able to be as productive to yield savings?

4.3.2.7.4 Conclusions in respect of Objective 2

a) The remark by Cornia & Zagori (2002) is very instructive here, namely: "While public savings and infrastructure are likely to diminish – because of increased pressure on the current expenditure – the impact on household savings and firm profits is more difficult to predict and likely depends on the extent to which the additional health and welfare expenditures due to AIDS are borne by the households or by the public sector. In principle, HIV/AIDS should raise the pressure to increase household savings (for future healthcare, funerals and obligatory bequests) as well as to reduce them (due to impoverishment and increased current health costs). It is a catch 22 position since savings ultimately can never incline but rather decline to almost negative. Note further the verbatim of Lucy as published by Cohen (2002) thus:

   "It was very touching having to nurse my sons again and watching them bed-ridden and deteriorating day by day. … Their sickness had started encroaching on my savings I had made for my own welfare in old age. It was very painful."

b) This situation is even worse given the selected low-income category for this research, as seen in Judge Cameron's observation (Barnett & White, 2006):

"I can take these tablets because on the salary I earn as a Judge, I am able to afford their cost … in this I exist as a living embodiment of the iniquity of drug availability and access in Africa … My presence here embodies injustices of AIDS in Africa."

c) Based on the data analysis above, the self-help efforts of PLWH/A either as individuals or as groups in the wake of compromised health and reduced ability to produce, is certainly in downward tendency and thence societal and government effort is the only sure way.

Understanding and assessment of the role of Policy Makers in mitigating HIV/AIDS and the policy impact on low income earners and their propensity to save i.e. Objective 3.

The basis for handling this objective arises from the revelation by the "Human Research Council of South Africa estimate that "10.9% of all South Africans have HIV/AIDS … it is more prevalent among female adults under the age of 40 in nearly all age groups. That roughly four in every five people with HIV/AIDS, aged 20-24 are women and only one-third of people with HIV/AIDS aged 25-29 are men. And more worrying is the fact that between 2005 and 2008 the number of older teenagers with HIV/AIDS has nearly halved while between 2002 and 2008 prevalence among South Africans over 20 years old have increased." (The UNAIDS Report 2007). This presentation offers a situation that puts South Africa among the worst cases in respect of this scourge. It is a situation that needs concerted effort in both macro and micro approach. In other words it requires society and government perspective in terms of both practical engagement, in policy development and implementation.

The government policy is guided by government understanding of the pandemic and its response within the Khomanani doctrine of "Caring together for life" translated as a policy into the "Strategic Plan for HIV/AIDS 2000 – 2005." It covers a whole range of interventions including:

- Information, education and communication;

- Prevention Programmes, including access to barrier methods such as male and female condoms;
- Increased access to voluntary counselling and testing;
- Prevention of mother to child transmission of HIV;
- Robust nutritional interventions; and
- An emphasis on individual choice of treatment.

The policy framework and plan issues that are critically relevant in the case of this research chosen for analysis are inherent in bullets 1, 3, 5 and 6 since they have inevitable bearing on the issue of the subject of propensity to save.

The research engagement consequently has used the same methodology of interview as in schedule basically to seek for information on government efforts (in HIV/AIDS sphere) at Local and Central levels as assessed through the felt requisite service delivery from the perspective of the recipients of services and how this could be improved from their perspective. This indeed is a societal assessment of the level of delivery since it strengthens the same society to not only live healthy lifestyle, produce more effectively but also enable them to save for future development. Information obtained has been analysed at each level namely: one-on-one interviews; the focus group discussions and then the view of professionals. Critical opinions sought from individuals have been tabulated to assess the appreciation of government delivery and hence assist the researcher determine whether or not the government efforts is rewarding for the populace to reinvigorate propensity to save.

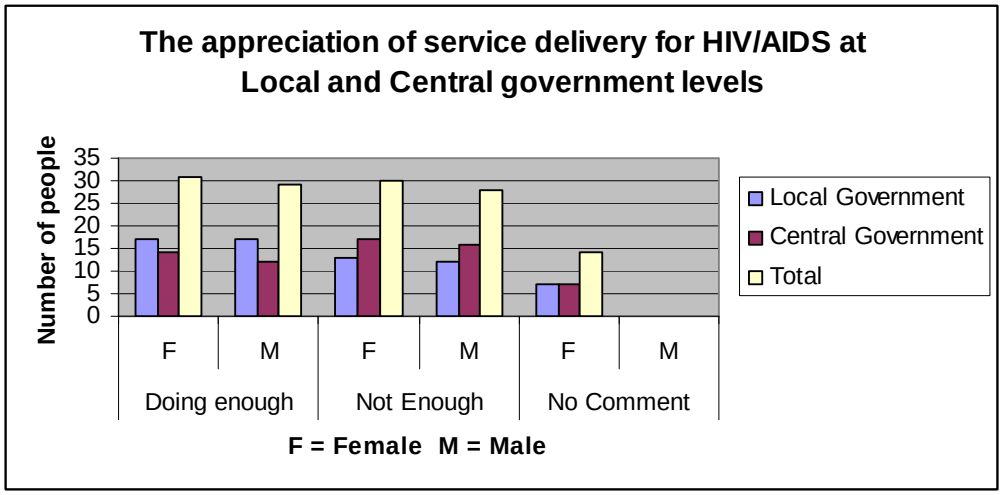
4.3.3.1 .1 One-on-one findings

a) In general the researcher sought the perception of interviewees regarding service delivery first at the local government and later at central government levels tabulated as follows:

Table 5: Showing appreciation of service delivery for HIV/AIDS at Local and Central Government levels.

Level of Government	Doing enough		Not Enough		No Comment		Remarks
	F	M	F	M	F	M	
Local Government	17	17	13	12	7	0	Fairly balanced
Central Government	14	12	17	16	7	0	Fairly balanced
Total	31	29	30	28	14	0	Generally Balanced

The bar graph below as demonstrating the information in Table 5, represents the appreciation of delivery for HIV/AIDS at Local and central government levels:



b) The following observations can be made from the perceptions as drawn from table 5 and the graph immediately above as stated by respondents:

- There is generally a balanced view that local government is doing some work but needs to improve since 34 out of 66 deem it performing i.e. 51.5% compared to 25 out of 66 i.e. 37.9% who feel it is not doing enough. The remaining 10.6% that was non-committal is still a major proportion given the importance of the service. Presumably however the general category of the respondents denotes the fact that they are not a group that can easily renege out of government action to enable productive engagement worth raising income to the level of ability to save.

- The central government delivery has however not filtered through appropriately since it presents a reverse of the perception of service recipients compared to local government namely: 39.4% deem central government is delivering enough; 50% say it is not delivering enough and still 10.6% is non-committal. It thence presents a situation for which hope may result only from intense review of the policy framework along with requisite plans and implementation if the people living with HIV/AIDS are to renew productivity that can generate savings.

- While both female and male respondents seem more satisfied with the performance of the local government, there is a pronounced level of dissatisfaction at the central government delivery. This sets one to perceive the non-committal persons in a more negative than positive light taking into account the facial observations and likely issues of despondency i.e. the situation is irredeemable. Yet policies are meant to address societal changes that tackle both challenges and problems which in this particular case are to do with health, productivity and savings.

c) Added to the above observational findings the respondents offered the following suggestions as made by the respondents:

c-i) Local government to improve service delivery that can make the people living with HIV/AIDS to renege should:

- Provide ARVs to all who need without discrimination.
- Provide all patients with healthy food;
- Initiate community projects that can generate income for all households affected by the pandemic;
- Increase the number of VCT sites and employ the requisite manpower to manage them all over the country;
- Emphasis must be put on HIV/AIDS awareness and education;
- NGOs and churches must be encouraged to get involved in the fight against HIV/AIDS;

- A special programme to cater for HIV positive pregnant women should be initiated as a matter of urgency;
- Home-based care should be strengthened.

c-ii) Central government should on the other hand undertake the following measures not only singly but better still collectively:

- Support Groups for HIV/AIDS must be both supported and encouraged by government as a necessary mechanism;
- There must be a deliberate programme by government to improve quality of life;
- In view of the impact of the global recession, a disability grant to support HIV/AIDS affected persons should be created to aid the existing social grant;
- Corruption among high-ranking officials in government must be dealt with mercilessly;
- Labour laws must be reviewed and strengthened to restrain employers from firing employees who are HIV positive;
- Government must attract foreign investors to create more job opportunities for everybody;
- Government must deal with crime with the seriousness it deserves to provide not only safety of person but security for job environment and better service delivery;
- HIV status of individuals should be a critical criterion in the allocation of RDP houses especially those in the low-income category.

d) Based on the above findings and suggestions it is opportune to offer a preliminary conclusion that existing policy framework on HIV/AIDS requires tailored review, improvement and implementation to guide service delivery.

4.5.3.5.2 The Focus Group Discussion Findings

As is the case for the previous objectives the specific focus groups came up with some specific and unique expositions besides the ones stated in the one-in-one interviews immediately preceding. They also came up with specific suggestions that could be attended to by policy makers be it at local or national levels which are stated as follows:

a) 18 – 29 years' age (Youth) group

The major observation by the group was to do with confidence building and physical as well as financial support to enable the youth rediscover themselves and engage in meaningful, productive and healthy activities. In this connection they thus recommended the following:

4.5.3.5.2(a-i) Local Government Policy Makers should:

- Put in place mechanism to train care givers such as counsellors to support HIV positive people more effectively and efficiently;
- Food parcels should be given to the people who so need and this will address the case for the youth giving up regular taking of meals in order to address the many issues brought to bear on HIV positive youth. In this way they are strengthened to chase menial jobs, make more money and possibly save.

4.5.3.5.2(a-ii) The National Government Policy Makers should:

Increase and make available disability grant to be given on monthly rather than for the current three months to restore the HIV positive youth to the level where they can take up productive engagements like their counterpart HIV negative ones.

b) 30 – 34 years' age group

As earlier stated this being the most productive and familial group was more focussed at making suggestions that also draws governments both local and national towards improving their productive capacity and health to generate better income as well as reinvigorate capacity to save as follows:

4.5.3.5.2(b-i) Local Governments should:

- Review the disability grant criteria to focus particularly at the low-income-earners since they are the core of productive process;
- Make health-care centres easily accessible to all and particularly the HIV positive;
- Make rules, regulations and guidelines for employers to deduct a percentage of salaries of their employees to be saved in a pool for future use by the employees. A kind of pension scheme for the low-income-earners especially those that are never covered by other statutory social security schemes;
- Create and facilitate crisis centres to cater for emergencies and cases of rape since many times victims of rape turn out as HIV positive;
- Establish and enforce a mechanism to trace ARV treatment defaulters to avoid becoming resistant.

4.5.3.5.2(b-ii) The National government should:

- Build houses for low-income-earners especially for those who are HIV positive. Such houses should be located in good environments with water availability;
- Mount national education on ARVs and related treatment so as to improve the health of people living with HIV on the other hand and to reduce defaulting rate on the other;

- Mount concerted fight against crime to enable investors come to invest in South Africa, create jobs and engage without discrimination against HIV positive people;
- Organizations involved with workers should engage a process of making low-income-earners have a voice in union activities.

c) The Men Group

This group in view of their vulnerability was more concerned about sustenance of their lives and so recommended as follows:

4.5.3.5.2(c-i) Local Government Policy makers:

- Assist in provision of healthy food parcels so that ARV treatment is not taken on an empty stomach;
- People living with HIV should be given communal land allocation to grow vegetables and other food items.

4.5.3.5.2(c-ii) Central Government

Review the disability grants provision in order to increase both the amount to cater for the HIV positive person and family under care.

d) The Women Group

The group's general emphasis was in the direction of better health and increased productivity of people living with HIV, thus:

4.5.3.5.2(d-i) Local government:

- Take a deliberate to involve people in all their communities to engage in programmes to increase food growing to cheapen cost of livelihood;

- Crisis centres for interventions should be created and made accessible to all cases especially rape and other women abuse for psychological support and provision of post exposure prophylaxis (PEP);
- Training for health-care workers to equip them to handle the above be made mandatory;
- Health education should be provided to all community members regardless of their HIV status;
- Land should be availed to all on community basis to grow vegetables and other food staff to mitigate the menacingly expensive food prices in current market.

4.3.3.5.2(d-ii) Central Government:

- The amount of disability grant should be reviewed because it is so little and cannot sustain HIV positive persons with their families.

4.3.3.5.3 The Professionals

The professionals are mindful of the existing policy environment at both local and national levels and offered the following possible areas of: enactment, review or improvement:

a) Increase government funding for Health especially to handle the workload and support to people living with HIV and Aids;
a) Government should increase its efforts in HIV/AIDS education and communication in terms of awareness campaigns and modes of management of cases through television and all other existing forms of media;
b) Provide for more training of technical staff to provide counselling and other required service delivery personnel in HIV/AIDS management;
c) Improved delivery of free medication in government hospitals for people living with HIV to enable them continue productively engaging in their areas of employment and maintain a capacity to possibly save;

d) Government should review the social and disability grants policies especially in view of the raving HIV pandemic to bring it in consonance with the existing economic conditions;
e) Provide free VCT sites that are accessible;
f) Increase provision of reliable condoms for all categories of people.

4.3.3.5.4 General conclusion on Focus Group Discussion Findings Objective 3

HIV/AIDS is a national pandemic for which governments at both local and national levels must undertake a corresponding emergency response in review of policies, developing adequate plans and implementing the activities therein to the letter. Issues of age, gender and communal response that must involve the society is crucial.

4.3.4 Assessment of impact of poverty on savings of low income earners as in Objective 4

The objective touches a very widely talked-of concept which has had several meanings – none of which is complete and concise – namely: poverty's impact has to be assessed in respect of our research issue. It is also a word that varies from context to context whether from the perspective of an economist, a sociologist, a scientist a politician or even just a development practitioner. The simplest of the definitions that the Researcher chose to use is from Oxford English Dictionary (2002) which calls it "the state of lacking in particular quality." A definition, which describes: status; issue of lack and quality of a particular issue and in our case – the low-income. Another key definition states it as a "relative measure within society being the state of having income and or wealth so low as to be unable to maintain what is considered a minimum standard of living" The Business Dictionary states that it is "in absolute terms having income and or wealth too low to maintain life and health at a subsistence level." The World Bank and the Economist often quantifies it as "living below the dollar a day."

This is therefore a study to discuss the status, items lacking and quality of the person who happens to be infected with HIV/AIDS. It should be remembered that Ministry of Health Report (1994) states clearly "One of the factors that contribute to the spread of

HIV infection is poverty." Baxen & Breidlid (2009) state: Reasons for the rapid spread of HIV infection in South Africa include: high levels of poverty, and income inequality and also sexual activity at early ages." As a matter of this research objective, the questions to answer are therefore: In view of the low-income-earner, what is his/her status? Does he/she get all or at least enough of the life requirements to survive well monthly? And finally, what is the quality of his life even having set aside part of the low-income-earned to be saved for future?

In the same set pattern the researcher finds the following in answer to the above questions including suggestions by the interviewees in respect of the subject.

4.3.4.1 (a) One-on-one Interview

The presentation of the findings arising from answering the issue questions begins with a summary of the understanding of the subject by the 66 respondents in terms of its meaning. Thereafter one seeks their assessment of the role of poverty in respect of the 3 issues raised and concluding with their perceived solutions.

4.3.4.4(a-i) Definition

The study has picked nine statements from the sample interviewed as summary understanding of the word by the interviewees as follows:

> *"It is going to bed on an empty stomach"*
> *"It is lack of income to purchase food, stay in a place of poor sanitation and shelter"*
> *"It is where one is not employed"*
> *"It means hunger"*
> *"It means lack of food"*
> *"It is inability to afford life needs"*
> *"It is the situation where people cannot afford the cost of living"*
> *"It means the survival without food, clothes, and other important stuff."*

Comparing the above varied definitions to the dictionary ones in 4.5.4.1 above one is tempted to say in view of the research subject that poverty signifies the lack of capacity to procure the critical items of need like food, shelter, clothing and even social environment. A definition which given the World Bank one could mean that one person should at least have a dollar a day to be counted out of absolute poverty. Absolute in the sense that a bicycle rider who can afford meals, clothing and shelter is poor compared to one who has all the above but with a motorcycle calling the former in the circle of poverty. In other words if one has a dollar a day he/she can afford the necessities and the figure above can be saved without necessarily causing serious strain. The study however has given rate of earning level of its respondents being at least above the dollar a day margin and is not therefore wrong to presume that employees in such earning bracket could save if it were not for the intervention of HIV in the life of the respondent.

4.3.4.4 (a-ii) The Status

As is already known, the respondents except for the professionals are infected with HIV and therefore the majority not able to work harder and use their income to the extent of saving monthly. But they also clearly allude to poverty as one major cause of the disease. The following expositions by the respondents are evident:

> *"Poverty leads to HIV infection. For example prostitution for survival can cause spread of HIV infection."*
> *"Poverty leads to frustration. One as a result, may seek comfort with extra sexual relations thereby becoming more vulnerable to HIV infection."*
> *"Orphanage as a result of HIV/AIDS leads to perpetual poverty."*
> *"Poor families are being headed by children or grandparents since the parents died due to AIDS"*
> *"AIDS patients cannot afford school fees to their children due to the illness. As a result their children become redundant and could easily engage in sexual behaviour which could lead them to acquire HIV."*

Thence if one finds a situation like "A combination of historical, socio-economic and developmental factors have made and will continue to make South Africa more

susceptible to a severe HIV epidemic than most other countries around the world. These factors include disrupted family and communal life-due in part to apartheid, migrant labour patterns and high levels of poverty; the low status of women in society and the high prevalence of violence against women; resistance to the use of condoms; social norms that do not frown on high numbers of sexual partners ,especially in the case of men; high levels of other sexually transmitted diseases, which increase the likelihood of the transmission of HIV; and the most developed transport infrastructure of any African country, which facilitates the easier spread of the virus into new communities" (Bureau for Economic Research, 2003).

These revelations from the interviews manifest the desperate state HIV brings to bear on people. Thence one cannot expect people with this state to be able to save from the referenced low income beyond what has been revealed earlier.

4.3.4.4 (a-iii) Ability to save

As can be seen from the above revelations, it is certainly analogous to expect such disabling influence of HIV in a person infected, to have ability to save, from such low-income earned, but the exception to this expectation is obtainable also from the following expositions:

> *"The only way one can save is to do so in a group spirit. Our stokvel allows us to do so because when in dire need the group will provide you some relief from the group coffer."* One Female respondent revealed.

This view summarises the expression of many of the men and women respondents who were saving and yet the saving rate has been on the decline over time and thence not healthy.

4.3.4.4 (a-iv) Quality of Life

The pattern of quality of life was written all over the faces of the respondents who echoed the remarks of the Judge as stated by Cameron thus:

> *"My presence here embodies the injustices of AIDS in Africa because on a continent in which 290 million Africans survive on less than a dollar a day, I can afford monthly medication costs of about US $ 400 per month. Amidst the poverty of Africa, I stand before you because I am able to purchase health and vigour. I am here because I can afford to pay for life itself."* (As cited: Barnett and White, 2006)

This research group falls short even of the cost the Judge spends on medication since the average monthly earning in the category of choice is about US $ 375 – 400 only. In other words the respondents in our study have to survive only on drugs if they had to use their monthly income exclusively for it. The good side of the situation in South Africa is that the respondents get free drugs from Chiawelo. Their earning is then left for procurement of the other essentials like food, shelter and clothing. But, they said in chorus:

> *"Nowadays most of the money we earn is spent on transport to clinics and buying healthy foods."*

Another narrated her experience as follows:

> *"I have to borrow money to attend clinic and I spend long hours at the clinic instead of doing piece jobs which is my source of regular income"*

The obvious observation is of course that the quality of life for the low-income earner is not tolerable.

4.3.4.4 (a-v) Suggestions

In view of the foregoing the one-on-one suggested:

- Policy makers should take serious view of the issues suggested in 4.3.3 above and act on them;

- Free education at all levels especially for orphans and children of people living with HIV should be made mandatory.

4.3.4.4 (b) The Focus groups

There is full concurrence on the definition of poverty, and its effect on savings as is given in 4.3.4.4 (a) above. The additional issues found are to do with suggestions, thus:

- Deliberate action to improve sex education, counsel communities and create awareness in schools and community gatherings to improve awareness on the disease and make people more responsive and responsible. In particular, the case to undertake a mechanism to stop resistance to ARVs due to neglect deserves emphasis.
- Education should emphasize skills development since many children now find themselves in positions of responsibility once the parents are either weakened or die from the disease.
- Government must create jobs so as to make people earn more than the meagre amounts.
- HIV positive people should be supported to form their own support groups and initiate methods of self-reliance if they have to rediscover themselves and reinvigorate savings. In this particular instance NGOs, CBOs, religious organizations should be encouraged with government subvention to establish and run community based organizations for people living with HIV/AIDS.

4.3.4.4 (c) The Professional Group

4.3.4.4 (c-i) Definition

The following were the simple definitions offered:

The social worker: *"earning a low income, being unable to obtain basic needs or simply having no formal income and or being unemployed."*

The engineer: *"Having less than enough income to survive. Living under poor conditions"*

The two echo the sentiments of the rest.

4.3.4.4 (c-ii) Status

In the professional opinion:

"HIV makes poverty worse. It makes prostitution a mechanism to make money and thence a recipe for HIV spread."

4.3.4.4 (c-iii) Ability to save

In both instances the professionals lamented that whatever chance there would be to save is corroded since such income has to be used on other imminent expenditures such as regular travel to clinic, healthy food and medicaments.

4.3.4.4 (c-iv) Quality of life

HIV positive people are under daily stress and therefore not qualified to be said to have good quality of life.

4.3.4.4 (c-v) Solutions

- Government should provide support to HIV positive people in terms of accommodation, water and electricity.
- Government should create jobs, provide free education and build more facilities to cater for the over load imposed by HIV/AIDS
- Funding should be raised by government and other development partners like NGOs and religious organizations to start awareness campaigns,

health education and community projects to make HIV positive persons self-sustaining..

- Government should review and better social and disability grants and food parcels to HIV/AIDS positive persons to make them survive.

4.3.4.4 (d) Preliminary conclusions on Objective 4

In the context under which the research question is being pursued, respondents generally referred to poverty as "lack of something". This could be in form of food, shelter, clothing or any other environmental concerns as evident in the nine statements from the sample interviewed during a one on one interview.

Owing to the respondents' views and revelations, there is some evidence to suggest that the spread of HIV infection could have been mitigated if there was no poverty. The following exposition from one of the respondents can confirm the latter.

> "*Poverty leads to HIV infection. For example prostitution for survival can cause the spread of HIV infection"*.

Likewise, there is sufficient evidence from the respondents leading to the fact that HIV and AIDS impoverishes people especially low income earners as the disease encroaches on their little savings in terms of expenses on healthy food, medicaments, transport to clinics and hospitals etc. The respondents confirmed this by saying in chorus:

> *"Nowadays most of the money we earn is spent on transport to clinics and buying healthy food"*.

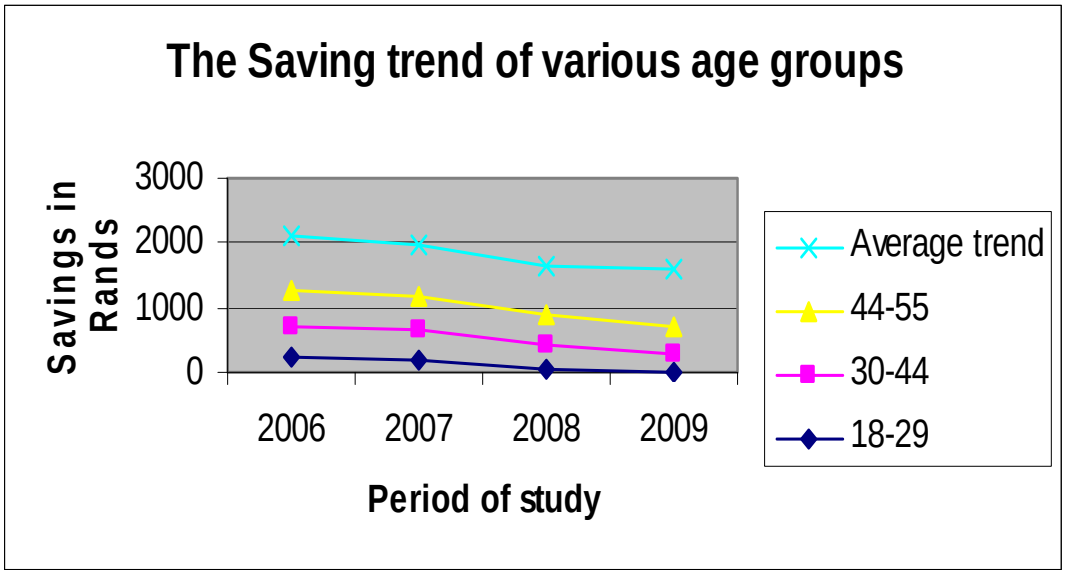
The general view from respondents indicate that HIV positive low income earners will find it difficult to improve their quality of life without collaborative effort from the community, local and central governments, CBOs, NGOs, CSOs, Churches and International organisations.

CHAPTER 5
CONCLUSIONS AND RECOMMENDATIONS

Considering the literature reviewed, the findings of this study as well as the observations of the researcher, the following conclusions arise in order to provide the basis for the recommendations to ensure improvements in the lifestyle of low income earners who are PLWH/A:

5.1 Conclusions

HIV positive low income earners experience devastating effects of HIV and AIDS as a disease. The society tends to isolate these people who further experience shock, stigma and shame. Hence HIV positive people faced with the onslaught of this disease find themselves increasingly spending their meagre income on health food, medication, transport to clinics and hospitals, buying clothes and leisure in order to avoid stress. Continually little or even none of the income is left to be saved as shown in the linear graph below.



One may wish to challenge this conclusion from the premise of the global financial crunch as stated earlier, but the fact that the declined savings for this group began well before this saga is in view, namely – since 2006 or even earlier is indeed instructive. Besides one may need to note such important research finding as:

> *"In two separate surveys conducted by the UCT Unilever Institute of Strategic Marketing and Bateleur Khanya Research Solutions, the majority of South Africans believe the recession is not yet near the end of its cycle and they are even more cautious about spending than they were nine months ago…. About 47%of the respondents reported that they were finding it difficult to save, compared to 37% earlier last year while 72% said they were cautious about spending compared to 66% of the respondents in April"* The Citizen Newspaper (2003).

The steeper decline in 2009 overall can only help but emphasize the fact that HIV/AIDS imposes on the individual compulsory expenses that can never be ignored, price changes or not. The conclusion is thus proved right.

The fact that HIV/AIDS raises the compulsory expenditures as mentioned above may promote leverage in health status but impacts negatively on the productivity of PLWH/A. As the expenditures rise against constant monthly income, the employer takes note of the declined state of the employee's productivity and is forced to take remedial measures that certainly impinge on the employee's income and thence less payment and diminished chance of any possibility of making savings. Key saving strategies like the women's stokvel activities are not spared either. Thence the continued decline in trends for the female respondents as clearly demonstrated in Table 3 and the accompanying bar graph on page 28.

HIV/AIDS is a national pandemic involving both local and national governments. There is no denial that a National HIV/AIDS policy is in place but it is overwhelmed by the rapid spread of HIV infection. It should be stated that the respondents do

appreciate the great effort especially at local government level as shown in bar graph related to Table 5 on page 52 but, there are now some issues arising from the impact of this pandemic that need to be addressed. For example, the provision for disability grants offers no specific consideration for the category of HIV positive people who are indeed not with equal ability with people who are HIV negative. It is even worse for those that are in this category of low income earning.

It is in the affirmative that high levels of poverty, income inequality and also early sexual activity all partially contribute to the spread of HIV infection. Poverty for HIV positive low income earners' contribute to poor health and hence reduces the ability to work leading to the low level of production. They consequently are more vulnerable for severe effect of price changes since they have several compulsive issues to purchase if they have to maintain some level of health. HIV/AIDS definitely impacts negatively on income and therefore the savings of the HIV positive low income earners.

5.2. Recommendations

These are both: of specific nature as are related to the key objectives of the research and general as they relate to ideas relevant to the research topic on which further research is recommended as follows:

5.2.1 To mitigate the adverse effect of the disease on the savings for HIV/AIDS low-income earners:

a) The criteria for provision of disability grant must be reviewed to accommodate low income earners who are HIV positive.

b) Health education, HIV prevention programmes and VCT must be extended and accessible to all communities. The idea is to build confidence in the PLWH/A against shock so as not to feel they have acquired an immediate death warrant and thence cannot waste time living productive life. It should also be able to fight issues of stigma so that the PLWH/A feel at home and not dejected. No room should also be left for shame since it has been proven over

time that it is just like any other disease that one can live with for a long time productively.

c) Mount national education on ARVs and related treatment so as to improve the health of PLWH/A on one hand and to reduce the defaulting rate on the other.

d) HIV status of individuals should be a criterion in the allocation of RDP houses especially those in the low income category.

e) Make rules, regulations and guidelines for employers to deduct a percentage of salaries of their employees to be saved in a pool for future use by the employees. A kind of pension schemes for the low income earners especially those that are never covered by other statutory social security schemes.

5.2.2 In the area of improved health and productivity of PLWH/A the following recommendations should be pursued:

a) The institutions responsible for welfare of workers at all levels including trade union organisations should advocate for both legislative and policy provisions to safeguard the employment of PLWH/A with specific reference to issues pertaining to their frequent unfair treatment in terms of wages and or pay.

b) Support groups initiated by PLWH/A must be supported while a deliberate programme by government to improve the quality of life of its people is implemented.

c) CBO, CSO and NGO support formations must be encouraged for PLWH/A with specific reference to programmes that are designed for improving the productive capacity of PLWH/A like better gardening techniques, income generating activities and savings societies and or cooperatives using the stokvel arrangement.

5.2.3 To assist either in review or development of government and other stakeholder legislation or policies:

a) Review the relevant national policies regarding HIV and AIDS with a view to accommodate low income earners who are HIV positive. In particular to note is the opinion of Economist Colen Garrow who says in The Star Newspaper (January 2010): "focus on assisting private business to create jobs by providing state incentives for employment… could be more dependable than providing state grants … which is a burden to tax paying base."

b) At both local and national level government and other stakeholders like NGOs, bilateral and multi-lateral agencies, CSOs should adopt a multi-sectored approach to HIV and AIDS. An approach that should make it obligatory for any project planned to be implemented within South Africa to have a component to handle this pandemic such that ministries and or all such stakeholders make an undertaking to provide for mitigation of the disease impact of HIV/AIDS.

c) Government must deal with crime to enable foreign investors to start their businesses as it is another way to create more jobs.

d) Labour laws must be reviewed and strengthened to restrain employers from firing employees based on their HIV status.

5.2.4 To mitigate the impact of poverty on low income earners who are PLWH/A:

a) Corruption amongst public officials, community leaders and or any relevant organization must be dealt with mercilessly to safeguard funds intended for HIV/AIDS programmes.

b) Poverty eradication programmes must be initiated and implemented by government, CSOs, NGOs and CBOs in all provinces.

5.3 To support full realisation of the recommendations of this research the following relevant areas need greater study:

- The impact of the global economic crunch on HIV/AIDS with reference to those endowed with limited income.

- A qualitative inquiry into the resource use by low income earners to assess the best area of intervention to improve their productivity.

- An in-depth study of women's stokvels to assess the strengths for replication.

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Annex 1

CRITICAL INTERVIEW SCHEDULE QUESTIONS TO ASSIST EVALUATE EACH OBJECTIVE.

Introduction

a) The researcher introduced himself, the research issue and assured the respondent of the strict observance of secrecy and confidentiality in the treatment of information so received from each respondent.

b) As further assurance the respondent was informed that the names used in the interview shall be encoded names and not revealed to any body other than the researched information and presentations only.

c) The interview schedule was designed in response to the four objectives of research in order to ascertain the authentic issues for guidance towards the hypothesis advanced.

d) For each objective the researcher allocated time lines that must be adhered to for effectiveness.

e) Rapport establishment was at call in commencing each interview.

1. **To examine the effect of HIV/AIDS on low-income earners' propensity to save. (*40 minutes)*.**

- What work do you do?
- What is your average monthly earning?
- For how long have you been in the current form of employment?
- How do you spend the above earning i.e. food, clothing, transport, rent, dependants (school fees, other support) other?

Food	Clothing	Transport	Rent	Dependants/Family	Other	Balance

- What do you do with the balance after procuring your requirements? Monthly
- Have you ever saved from your earnings since you started to work?
- How do you compare the saving trends since you started earning?
- Any idea on why the trends are the way you have stated/ explained?
- What is your opinion regarding the role your HIV status has played in relation to the trends you have stated/ explained? (*optional if the respondent has already stated this in the immediate question above)*

- What advise do you have to improve this trend?

2. **To analyse and evaluate the impact of reduced savings on health and productivity level of low-income earners who are infected with HIV and AIDS. (** ***20 minutes)***
   - Given the above state of affairs, how have you been coping?

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     ……
   - What other suggestions/ options would assist you to cope?

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     ……
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     ……
     ……

3. **To suggest intervention strategies to policy makers so that such policies they make mitigates the negative effects of the disease on low income earners infected with the HIV virus towards revival of savings.** ***(30 minutes)***
   - What is your understanding of the role government (local / central) has been playing in respect of people living with HIV/AIDS?

     a) local

     ……
     ……
     ……
     ……
     ……

     b) Central

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     ……

……
……
……

- What are your suggestions to improve the situation you have described?

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  ……
  ……
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  ……

4. **To examine the effect of reduced savings on the overall poverty situation within the community. (30 minutes)**
   - What do you understand by the term poverty?
   - How would you describe the community where you stay in relation to the description of poverty you have just given?
   - How could this be improved?
   - How do you assess HIV as a factor in this poverty situation?
   - What advise do you give to both the people living with HIV and government that could rejuvenate the poverty status?