

**The effect of female poverty on HIV/AIDS prevalence in the rural community of the
UGU-district**

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Assignment presented in partial fulfillment of the requirements for the degree of Master
of Philosophy (HIV/AIDS Management) at Stellenbosch University



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March 2008

DECLARATION

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously, in its entirety or in part submitted it at any University for a degree.

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Date:

ACKNOWLEDGEMENTS

I would like to extend a special thanks to my study leader, Dr Thozamile Qubuda, for the support and guidance that kept me going.

A sincere gratitude is extended to the participants, who would go an extra mile spending hours, sharing their time, experiences and feelings with me on very sensitive issues that are close to their hearts. Without your participation, this study would not have been possible.

I would like to thank my precious daughter, Anita, for acknowledging that 'mom needs to be left alone with her studies, sometimes', my niece Ayanda, my sisters, Va and Shy, for being supportive during difficult times.

Lastly, I would like to extend a special thanks to my dear friends, Dr Dave and Cheryl Glass, Ps Derrick Glass and family for their input and guidance and the ongoing support from the beginning of the study. I would not have managed without you.

SUMMARY

HIV/AIDS epidemic is a serious health and development problem in many countries, with South Africa amongst the countries that are hit hard by the epidemic and the impacts thereof. HIV/AIDS within Kwa-Zulu-Natal has always been higher than any other province in South Africa, with areas of higher HIV prevalence associated with major transport routes and areas of severe poverty (Susan Erskine 2005)

A lot of studies and research has been done and the programs on advocacy, prevention and care are being implemented for the people infected and affected by HIV/AIDS. We are now on the third decade of HIV/AIDS in South Africa, yet there are still the rural communities where the interventions have not reached. South Africa is marked with a lack of political will in its engagement on the fight against HIV/AIDS; this is evident in the stance that the government pulled against the roll out of ARV s, the controversial statements by the Minister of Health and the irresponsible statements by the policy makers.

Some of the HIV/AIDS programs hardly reach the poor communities, even if they do, they sometimes do not address the underlying socio-cultural issues of the poor women. The HIV/AIDS programs that would make sense to the poor women in the rural communities are those that are linked with poverty alleviation, rural women empowerment and the issues of gender inequalities.

The Department of Social Welfare and Department of Health have taken much effort in empowering the Home Community Based Care organizations within the rural communities, making them drop-in centers, but there is still a lot to be done. The HCBC s need to be capacitated on issues of governance to ensure sustainability of the programs.

The study indicated that the underdevelopment, marginalization and the isolation of the poor communities form a barrier to interventions. There is a need for a pro-poor community programs that seek to address the issues of unemployment and the conditions

of being unemployable amongst the rural poor women and assisting women to form co-operatives.

The study supports the fact that certain types of human behaviors spread HIV/AIDS; therefore, the epidemic can be controlled by the changes in those behaviors (USAID 2001). The risky behaviors that were exposed by this study calls for a need to involve all sectors of society to promote interventions that reduce high risk sexual behavior, control and treat STI s and empower women as they are the most susceptible and vulnerable to HIV/AIDS.

Community mobilization may be used to increase awareness among men of how HIV/AIDS can affect the lives of their daughters, wives, mothers and friends (Kim Rivers and Peter Aggleton, 1999). Heise and Elias, 1995, Ankrah and Attika, 1997 purports that other women have reported that suggesting condom use to a partner may be tantamount to accusing him of infidelity resulting in men being violent when safe sex is requested.

The study has exposed the issue of gender inequalities as a factor that increases women's vulnerability to HIV/AIDS.

OPSOMMING

Die MIV/VIGS epidemie is 'n ernstige gesondheid- en ontwikkelingsprobleem in baie lande, met Suid-Afrika wat swaar onder die epidemie en sy gevolge ly. Binne Kwa-Zulu Natal was MIV/VIGS nog altyd hoër as enige ander provinsie in Suid-Afrika, veral langs hoofroetes en in areas wat aan erge armoede ly (Susan Erskine 2005).

'n Groot aantal studies en navorsing is reeds gedoen en programme rakende bepleitings; voorkoming en sorg vir persone wat geïnfecteer en geïmpak is deur MIV/VIGS word geïmplementeer. Ons het nou reeds drie dekades van MIV/VIGS in Suid Afrika, maar daar is nog steeds landelike gemeenskappe wat nog nie deur intervensies bereik is nie. Suid-Afrika word gekenmerk deur 'n gebrek aan 'n politieke wil in sy verbintenis tot die stryd teen MIV/VIGS. Dit blyk veral in die regering se houding in die beskikbaarstelling van ARV's, die omstrede uitlatings van die minister van gesondheid en die onverantwoordelike verklarings deur beleidmakers.

Sommige MIV/VIGS programme het skaars arm gemeenskappe bereik. En indien wel, word die onderliggende kwessies van verarmde vroue nie aangespreek nie. Die MIV/VIGS programme wat deur arm vroue in landelike gemeenskappe begryp word is dié wat gekoppel word aan armoede-verligting, bemagtiging van landelike vroue en kwessies rakende geslagsgelykheid.

Die departement van sosiale welsyn en die departement van gesondheid het reeds baie gedoen om die "Home Community Based Care" (HCBC) organisasie onder die landelike gemeenskappe as instapsentrums te bemagtig, hoewel daar nog steeds baie is wat gedoen kan word. Die HCBC's behoort bygestaan te word in regeringskwessies vir die volhoubaarheid van die programme.

Die navorsing het aangedui dat onderontwikkeling, marginalisering en isolasie van gemeenskappe intervensie verhinder. Daar is 'n behoefte aan armgesinde

gemeenskapsprogramme wat kwessies aanspreek soos werkloosheid, opneembaarheidstoestande en die vorming van koöperatiewe verenigings vir vroue.

Die studie ondersteun die feit dat sekere soort menslike gedragspatrone MIV/VIGS versprei. Gevolglik kan die epidemie beheer word deur gedragswysiging (USAID, 2001). Die riskante houdings wat deur hierdie studie blootgelê is, vra vir die betrokkenheid van alle sektore van die gemeenskap om intervensies te bevorder wat hoë risiko geslagsgedrag sal verminder, seksuele oordraagbare siektes sal beheer en behandel, en vroue te bemagtig, aangesien hulle die vatbaarste en kwesbaarste is vir MIV/VIGS.

Gemeenskapsmobilisering kan gebruik word om bewuswording te bevorder onders mans oor hoe MIV/VIGS die lewens van hulle dogters, vroue, moeders en vriendinne affekteer (Kim Rivers and Aggleton, 1999). Heise en Elias, 1995, Ankrah en Attika, 1997, beweer dat ander vroue het gerapporteer dat wanneer aan 'n lewensmaat voorgestel word om 'n kondoom te gebruik, gelykstaande is aan 'n beskuldiging van ontrouheid. Dit lei daartoe dat mans hulle tot geweld wend wanneer veilige geslagsverkeer aangevra word.

Die studie het die kwessie van geslagsgelykhede toegelig as 'n factor wat die kwesbaarheid van vroue vir MIV/VIGS verhoog.

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CHAPTER 1: INTRODUCTION

1.1 THE BACKGROUND OF THE PROBLEM

Anton A van Niekerk refers to poverty as a social context within which the HIV/AIDS thrives. When looking at the characteristics of poverty, it is ascertained that poverty is associated with low levels of education, unemployment, illiteracy, few remarkable skills if any at all, poor living conditions and poor health status which results in untreated STD s that promote the transmission of HIV.

UNAIDS 2003, purports that the awareness and prevention programs hardly reach the poor communities, even if they do, the access to recommended interventions is always a nightmare because of the less developed health infrastructures.

It is further alluded that poverty manifests itself in the lack of power, which leads to vulnerability; hence we find poor women and girls being unable to negotiate frequency in sex and condom use with their partners. These poor females are nursing fears that they may lose their partners and the financial assistance could they not comply. Poverty leads to degradation; hence the risky behaviors. We also have girls and young women who sell sex for survival.

Quoting Virginia van der Vliet, Anton A van Niekerk avers that it is highly impossible to reach a poor, isolated, illiterate rural woman who is neither at school, not at work, not at church nor a clinic attendee.

The interventions in the form of prevention and care programs that are normally communicated through newspapers, television and other kind of media are not possible in the poor communities. The high level of illiteracy and the unavailability of resources pose a great challenge when thinking about interventions in poor communities.

Sidebe (2000) concurs that the women are vulnerable to HIV/AIDS due to the early sexual activities, financial dependence on partners because of limited schooling and limited viable alternatives.

The financial implications that are dealt with when facing HIV/AIDS are very complex. The above line of thought is echoed by Anton A van Niekerk who avers that if for example we look at the US\$16 that an American Aids patient pays per day on HIV drugs, it is obvious that the African countries are not able to afford the drugs without significant aid from abroad.

The relationship between HIV/AIDS and the financial stability, if viewed in a global sense is evident in the high prevalence of HIV/AIDS in the Sub Saharan Africa versus the developed countries.

It is further maintained that clear disease free drinking water is regarded as a luxury in poor communities, hence the cholera that hit most of the rural communities of the Kwa-Zulu Natal. Poverty manifests itself in the inability to write, read, and grasp non-evident concepts and high level of dependency.

Illiteracy impedes transference of information, education and communication on issues of HIV/AIDS prevention care and support. It is alluded that a map in the Education Atlas of South Africa shows that illiteracy rate is between 60 and 80 percent in the rural areas with Kwa- Zulu Natal having the highest level of illiteracy and of HIV/AIDS prevalence.

1.2 THE STATEMENT OF THE PROBLEM

The researcher has observed that the rural communities of the Ugu District in Kwa-Zulu Natal have a high HIV/AIDS prevalence. The communities at the outskirts of Kwa-Zulu Natal are ravaged by poverty, a high level of illiteracy, and unemployment mostly among the women. The men work in relatively far cane farms as migrant labourers who would come home either once or twice in a year.

Desmond Cohen avers that the poorest communities are least capable to cope with the effects of HIV/AIDS. The poor communities are struggling with unavailability of health care centers to access the condoms and the STI treatment or other related assistance.

Anton A van Niekerk who maintains that 80 percent of the poor in 1994 had no piped water to their homes, no modern toilets system or electricity and had children under the age of five that are nutritionally stunted, echoes the above. The communities that the researcher observed can identify with what is maintained above.

When we talk about poverty amongst the females of Kwa- Zulu Natal and its relationship with HIV/AIDS, we need to break it into the following piece meals:

- What is poverty
- Manifestation of poverty in relation to HIV/AIDS
- What are the barriers to interventions
- How does poverty lead to susceptibility and vulnerability to HIV/AIDS
- What are the most practicable sustainable interventions to improve female poverty and their vulnerability to HIV/AIDS

1.3 RESEARCH OBJECTIVES

The researcher had to formulate the following set of objectives in order to respond the research question.

- The relationship between female poverty and HIV/AIDS
- The effect of the lack of financial income in relation to HIV/AIDS
- To determine the underlying gender inequalities and socio-cultural barriers in the complexities of HIV/AIDS
- To assess the factors that lead susceptibility and vulnerability of females

1.4 THE SCOPE OF THE STUDY

For the sake of this study, the researcher has looked at the five rural communities of the Ugu District in Kwa- Zulu Natal, namely: Izingolweni, Enyandezulu, Nongidi, Kwa-Machi and Ntokozweni.

These communities form part of the rural communities that are ravaged by high levels of illiteracy, unemployment, poverty and HIV/AIDS. The concentration is on the females of the said communities.

1.5 THE VALUE OF THE STUDY

The research will contribute in helping either the policy makers or the governmental departments and non-governmental organizations in making informed decisions on the kind of interventions that need to be implemented in addressing poor females in relation to HIV/AIDS.

Theoretically, the underlying socio- cultural issues that lead to susceptibility and vulnerability of females to HIV/AIDS could form the basis for integrated effort and collaboration by departments towards activism against women and children abuse.

The results of the study can be used in addressing gender inequalities and therefore informed decision can be made in empowering the females with sustainable interventions.

Much as there is a need to embrace our cultures and heritage but this study will also contribute in informing the policy makers on the underlying threats that is posed by other cultures to the mitigation of the spread of HIV/AIDS.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

If one looks at the impact of HIV/AIDS, the women either HIV positive or HIV negative are the most affected by HIV/AIDS. The women have less secured jobs if any, lower incomes, poorly educated and have less access to credit or land (Rene Loewenson & Alan Whiteside, 2001). Lesley Doyal (2005) looking at the hazards of female gender concurs that the gender inequalities in income and wealth make women especially vulnerable to poverty.

Women are overburdened by HIV/AIDS, as they would try to sustain food security within the household. Researchers have explored the wide range of stress that the women are subjected to, showing how the women would go to the extent of selling the assets, engage in sexual networking, and taking the girl child out of school, in trying to cope with the impact of HIV/AIDS within the household. The said strategies of survival are themselves intensifying female poverty.

2.2 WHAT IS POVERTY

Desmond Cohen (2000) avers that poverty is associated with weak endowments of human and financial resources. Poverty manifests itself in the low levels of education, low levels of literacy, very low remarkable skills, if any, and poor health status and low labour productivity.

Being poor is characterized by social and financial exclusion. Hlatshwayo T, et. al (2004) avers that the extreme struggles of women living under extreme poverty is loneliness and fear to disclose their status and the fear of rejection. The above line of thought is echoed by Anton A van Niekerk quoting Virginia van der Vliet, that, it is highly impossible to reach a poor isolated illiterate rural woman, who is neither at school, not at work, not at church nor a clinic attendee.

2.3 RELATIONSHIP BETWEEN FEMALE POVERTY AND HIV/AIDS

USAID (2001) alluded that young women are physiologically more prone to HIV infection. Poverty and high rates of unemployment has been associated with high-risk sexual behavior and the spread of HIV/AIDS.

The above could be associated with submissiveness of women to their sexual partners in the fear that they might lose the partners and the financial support if they object to what the partner wants. USAID (2001) maintains that the low status of women contributes to the spread of HIV/AIDS in that the women are marginalized in societies due to their low levels of education, which leads to their being unemployable despite the availability of jobs. This condition usually leads to sell sex for survival.

It is further concurred that poverty and low health status, including malnutrition, high levels of unemployment has been associated with high risk sexual behaviors and the spread of HIV/AIDS.

The poor communities are marred with high sexually transmitted diseases. The infections like STI facilitate the spread of HIV/AIDS; these kinds of illnesses are left untreated due to weak health care systems. Despite the fact that Africa has the highest level of STI in the world (USAID 2001) the condom use would prevent the spread of HIV/AIDS, but this is not the case because of relatively low use of condoms in Africa.

The Demographic and Health Survey for Malawi supported the above, where it is reported that only 38 percent of men and 20 percent of women used condoms in their last sexual relationship with a non-spouse.

Let us look at the following Sub Saharan countries:

Zimbabwe, Zambia, Lesotho, and Malawi and see their HIV prevalence in relation to their levels of poverty. It is alluded that the World Bank found that one quarter of the

population of Zimbabwe lived below poverty line in 1991 and its HIV prevalence among adults 15-49 years in 2001 was 25 percent.

50 percent of the population in Lesotho and Malawi lived below poverty line in 1991 and HIV prevalence among adults 15-49 years in 2001 was 28 percent and 15 percent respectively. Two thirds of population in Zambia lived below the poverty line in 1991 and also had the HIV prevalence among adults 15-49 years in 2001 of 20 percent.

The same scenario prevails with Botswana and Swaziland which lived below the poverty line and has 35 percent of HIV prevalence among adults 15-49 years in 2001.

The above illustration shows the relationship between poverty and HIV/AIDS prevalence. In trying to cope with the life below poverty line and the impacts of HIV/AIDS within the household, the poor women resort to selling sex for survival. The young girls will have sex in exchange for gifts.

USAID (2001) concurs that poverty manifests itself in very low standards of living which promote the spread of HIV/AIDS. It is concurred that in Botswana (one of the countries with highest HIV/AIDS prevalence) most of the population lives in narrow corridors between Francistown and Gabarone. This kind of congested way of living is an underlying factor that perpetrates the spread of HIV/AIDS.

It is further alluded that the cultural practices are also a contributing factor towards the spread of HIV/AIDS, which amongst other things include the young age start of sexual activities among young boys and girls and also the practice of dry sex.

It is sad to highlight that in most cases the females have no say in the cultural practices mentioned above. It is alluded that the research indicates that women are two to four times more vulnerable to HIV infection than men during unprotected sex because of their larger surface areas exposed to contact. Likewise when it comes to STD's, the females' STD remain untreated for a long time as it would not show any recognizable symptoms.

USAID (2001) purports that women are taught at a very young age to be obedient and submissive to males, never to refuse having sex with their husbands regardless of the number of sexual relationships the husband might have. This kind of socialization manifests itself in the females' lack of assertiveness as they live to please their male partners even if it is to their detriment, hence the inability to negotiate condom use and succumb to dry sex.

The research done on the age sex distribution of reported Aids cases reveal that there are more than four times as many females as males reported to have Aids in the group 15-19 years, and about one third more females than males in the group 20-29 years. The implications of the above statistics could suggest the early sexual engagement of females. The question is, why females???

Won't it be the submissiveness of the females to older males, sell-sex for survival, the inability to refuse engagement in sexual activities and the socio-cultural issues that are embraced at the expense of the female autonomy?

2.4 ILLETERACY AS A MANIFESTATION OF POVERTY

The studies done regarding the knowledge of Aids and perception of risk reveal that much as the women and man know about HIV/AIDS but their perceived risk of getting Aids is small or non existent. In Malawi 53 percent of women who know about Aids have their perceived risk of getting Aids small or non-existent. In Zambia 70 percent of women who know about Aids perceive that their risk of contracting Aids is none at all. In Zimbabwe 77 percent of women who know about Aids perceive that their risk of contracting Aids is none at all. In Mozambique 85.7 of women who know about Aids perceive that their risk of contracting Aids is none.

The above perception of contracting Aids is very scary. One wonders if this perception is not due to illiteracy. How can one perceive that one is not at risk of contracting HIV/AIDS yet one is in multiple sexual relationships, unable to negotiate condom use, or

any kind of control over one's sexuality? Can't these perceptions perpetrate the spread of HIV/AIDS, with illiteracy being the underlying factor?

USAID (2001) avers that in the above mentioned countries there is an evidence of traditionally low use of condoms, high prevalence of STD and Polygamous relationships, yet the women perceive that they are not at risk of contracting Aids. The underlying factor in the above perceptions of the risk of contracting HIV/AIDS is illiteracy, which is the manifestation of poverty.

Desmond Cohen (2000) alluded that of the global total of 30 million persons living with HIV/AIDS in 1997, 21 million are in the Sub Saharan Africa, with more women infected than men. This high infection among women is evident in the increasing number of children with HIV through MTCT, according to Desmond Cohen.

Much as the impact of HIV/AIDS have social and economic consequences to both the poor and non-poor, but with the poor there is least ability to cope with the effects of HIV/AIDS. Dealing with morbidity due to HIV/AIDS related illness drains the much compromised finances that the poor household has, leaving them in a devastating state of need.

Caring for an HIV positive individual through his long drawn illnesses and HIV/AIDS related illnesses requires change of lifestyle. The balanced diet that is required, the money spent traveling to health care centers and buying drugs.

All the above combined lead to a total financial collapse in a poor household, hence the inability to cope with effects of HIV/AIDS. This kind of gloomy scenario demoralizes the numbers of families more especially if the sick person happens to be the bread winner.

STD's are proven to be one of the illnesses that fuel the spread of HIV/AIDS. It is concurred that amongst the many African states STD's remain undiagnosed and therefore untreated, which perpetrates the spread of HIV/AIDS.

Desmond Cohen (2000) purports that the programs that aim at the change of sexual behaviors hardly reach the poor. Even if they do, the access to the recommended health care centers becomes a nightmare to the poor.

Hallman Kelly (2004) echoes the above line of thought, concurs that young women of KZN had less access to the radio, publications that contain family planning and safe sex messages. In poor countries there is hardly a care center let alone the infrastructure, equipment and drugs. The programs that do not promise food on the table now, would fall on deaf ears to poor communities. There is so much suffering that engaging in sexual activities becomes a form of recreation to the poor regardless of safety or dangers of contracting HIV/AIDS.

It is alluded that many of the poorer are women who would head the poorest household. Because of these women's inability to sustain them financially, they resort to sell sex for survival, due to the high level of unemployment or being unemployable because of low levels of education and illiteracy. Inevitably these women are more susceptible and vulnerable to HIV / AIDS. Rene Loewenson and Alan Whiteside (2001), purports that in the Central African Republic and Swaziland, school enrolment is reported to have fallen by 20 percent to 36 percent, due to AIDS with girl children being the most affected.

2.5 POVERTY LEADS TO SUSCEPTIBILITY AND VULNERABILITY TO HIV/AIDS

The relationship between HIV/AIDS and poverty is very complex in that high levels of poverty perpetrates vulnerability and susceptibility to HIV/AIDS, Aids itself generates poverty. Rene Loewenson and Alan Whiteside (2001) concur that the effects of

HIV/AIDS on household is evident in the loss of income, diversion of assets to caring for those affected or infected.

The poor families will sell the assets like bicycle, radio, and cattle in order to cope with the financial impacts of HIV/AIDS. Through the sale of the said assets, the possibility of regaining or rebuild is close to nil, in which case poverty is deepened, as it cause a fall of below 10 to 15 percent of average income.

The high level of HIV/AIDS infection amongst women is evident in the increasing numbers of children infected through MTCT. This kind of HIV transmission is preventable through the administration of AZT which unfortunately is not available to the poor. Breast feeding is also another form of HIV transmission. It is also a transmission that can be avoided but the poor women cannot afford to buy milk formula, would not have access to clean water so breast feeding to them is the only option they have, thus deem their children susceptible and vulnerable to HIV/AIDS.

Rene Loewenson and Alan Whiteside (2001) alluded that poverty resulting from Aids interacts with other dimensions of poverty to generate a vicious downward cycle. The above scenario sadly demonstrates the relationship between poverty and HIV/AIDS. By virtue of being born by the poor, a baby has to be susceptible to HIV/AIDS. Desmond Cohen echoes the above and maintains that there is a culture of poverty where children of the poor become the poor of the succeeding generations. It is further alluded that more than a third of children orphaned by HIV/AIDS drop out of school.

HIV/AIDS is said to reinforce the gender inequalities more especially amongst the poor communities. This is manifest in the inability to negotiate condom use.

2.6 WHAT ARE THE BARRIERS TO INTERVENTIONS

GENDER INEQUALITIES: Gender inequalities in personal relationships, in the community, within the workforce and in the political circles affect the women all over the

world; this is suggested by the International Community of Women living with HIV/AIDS. (2004) Gender inequality leads to women poverty and their vulnerability and susceptibility to HIV/AIDS.

Women are socially marginalized whilst men masculinity and bossy behavior is embraced by the communities. The women hardly have sustainable employment, if any, they have high levels of illiteracy and are characterized by submissiveness and inability to take control of their sex and negotiate condom use. This forms a huge barrier to interventions. The programs that seek to promote safe sexual behaviors sometimes do not reach to the underlying factors that fuel the spread of HIV/AIDS, that is, gender inequalities.

POVERTY: Poverty forms a barrier to interventions as it manifests itself in social exclusion, marginalization and other forms of discrimination. Illiteracy is the manifestation of poverty and it forms a barrier to interventions. The interventions that are either communicated through radios, television, internet and other forms hardly reach the poor. The poor communities hardly have the health care centre, infrastructure or the drugs or the health personnel for that matter. Anton A van Niekerk echoes the above suggests that poverty is the social context through which HIV/AIDS thrives and as such forms a barrier to interventions.

SOCIO-CULTURAL ISSUES: Researchers maintain that there are cultures in the Sub Saharan Africa that still embrace widow inheritance with or without the woman's consent. Women are socialized not to refuse sexual engagement with the husband regardless of the number of sexual relationships the husband might be having. This is done under the cloak of respect for the husband or any male that commands respect by virtue of being a relative, be it an uncle, guardian, or father- in – law, at the expense of the women autonomy. The practice of dry sex is also a cultural issue that undermines the interventions and fuels the spread of HIV/AIDS.

LOW LEVELS OF CONDOM USE: The programs that focus on prevention and advocacy mostly have the use of condoms as a practice that contributes to the mitigation of the spread of HIV/AIDS. USAID (2001) avers that there are low levels of condom use amongst most of the Sub Saharan African countries. Such behaviors form barriers to the interventions.

2.7 PRACTICABLE INTERVENTIONS TO ALLEVIATE WOMEN POVERTY AND THEIR VULNERABILITY TO HIV/AIDS

Rene Loewenson and Alan Whiteside (2001) alluded that in dealing with poverty and HIV/AIDS there is a need for the strengthening of HIV prevention, treatment and mitigation within poverty reduction strategies. It is further suggested that the above should go hand in hand with the strengthening of pro poor policies to reduce the impact of HIV/AIDS.

In the rural communities of KZN where the study was conducted, it is evident that Aids is reinforcing the existing problems of household poverty, aggravating the hurt and more stress to the poor who are heading the poorest households.

This calls for sustainable poverty reduction strategies to mitigate the impact of Aids that are backed by pro poor policies as suggested by Rene Loewenson and Alan Whiteside

The suggested pro poor policies is said to reduce susceptibility and vulnerability to HIV/AIDS. Let us look at the suggested pro poor policies:

- Focus on the health problems of the poor people and structured health systems that are accessible to the poor
- Access to education particularly the female children
- Provision for safe water, sanitation, food security to improve living and working environment of the poor
- Promote employment opportunities

- Promote infrastructure and social organizations in poor communities
- Intensify interventions to reduce poverty, inequalities, social exclusion and improve access to public service.
- Build institutional framework for government leadership and ability to deliver essential services.

The above pro poor policies will only make sense if there is leadership commitment and if the above strategies lead to female employment, development of infrastructure and improved access to social services.

Sighting one example of unavailability of germ free water in the rural communities of KZN which led to cholera and other diseases, if the pro poor policies could aim at ensuring that these poor communities have access to clean germ free water and job opportunities for women, this intervention would enable the women to buy and prepare the milk formula for their babies, implying that at least the HIV transmission through breastfeeding can be curbed.

The programs that would address gender inequalities and seek to affirm women would make sense if they revisit the different cultures that seem to fuel the spread of HIV/AIDS. The cultural beliefs that promote susceptibility and vulnerability of women to HIV/AIDS should be re addressed and be embraced only if they do not prejudice one partner or compromise one's autonomy.

The pro poor policies that acknowledge that the poor women are the most hit with the impacts of HIV/AIDS would seek to ensure security of food production. Women could be empowered into forming co operatives through which they can engage into farming, have access to loans to start small businesses and be capacitated with management skills, operations and governance. This on its own contributes towards social and economic empowerment of women.

Rene Loewenson and Alan Whiteside (2001) suggest that such actions promote opportunities for women through gender equity in relation to social norms and economic factors that make women susceptible to HIV/AIDS. Women could be affirmed by law to exercise control of their sexual lives and be able to negotiate safe sexual practices with their partners.

International Community of Women living with HIV/AIDS (2004) avers that in empowering the women living with HIV/AIDS, the idea of the income generating projects could be a viable intervention, the support for women groups and challenging the violence and abusive behaviors towards women could affirm the women.

2.8 CONCLUSION

If poverty can be alleviated, that would impact positively in the lives of women in particular, as they are the most susceptible and vulnerable to HIV/AIDS. Women would have control over their bodies and sexuality in general. The improvement of health care systems to ensure availability of resources, drugs, health care personnel would play a bigger role in the treatment of STD more especially in more marginalized communities.

If we look at poverty in relation to growth and development and also in relation to HIV/AIDS, it gives us a picture and a reason why the developed countries are not as badly affected by HIV/AIDS as the Sub Saharan Africa. The most effective way of responding to HIV/AIDS and its devastating impacts more especially on women, is to ensure that globally, nationally and within the communities, our women are empowered socially and economically with sustainable projects.

Alleviation of poverty will restore dignity and control amongst women. Bridging the gap between the rural poor communities and the urban by strengthening the collapsing health care centre, infrastructure, availability of drugs and health personnel in the rural communities could help in the treatment of STD and other Aids related illnesses.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

Christensen Larry B. (2007) alluded that objectivity is one of the prerequisites that own research process. Much as the perfect objectivity seems hard to attain due to the researcher's expectancies and gender, but there should be a severe attempt to eliminate bias so that we attain what we would call a good research.

This chapter is going to take us through the methodological approach, research design, and the sampling method, and the ways of data collection that were used in this research. The researcher has used correlation study, which consists of measuring two variables and then determining and describing the degree of relationships that exist between the said variables (Christensen Larry B. (2007)). The description and determining of the degree of relationship is done without manipulation of the variables.

3.2 RESEARCH DESIGN

The research design is a strategy or a plan that is developed for collecting information from which the relationship between the independent and the dependent variables can be inferred Christensen Larry B. (2007).

In looking for a strong research design, the researcher took cognizance of the following criteria of a strong design as described by Christensen Larry B. (2007)

- Ability to answer the research question & adequately test the hypothesis
- Ability to control extraneous variable
- Generalisability

This study seeks to ascertain the degree or the level of relationship between female poverty in the rural communities of the Ugu district and the HIV/AIDS prevalence.

The use of quantitative approach in this study was necessary for the collection of the numerical data and quantitative approach was deemed very necessary. Creswell (1998) and Patton (1990) argue that the research that collect only quantitative data often provide an incomplete analysis of the situation being investigated.

For the purpose of gaining in-depth understanding of the complex and sensitive details of the risky behaviors that the poor women engage in, the researcher had to use the qualitative approach as well.

The researcher used the qualitative approach because of its being a multi method. The researcher, through this approach was able to tap into participants' account of a personal experience, introspective analysis, individual's life history, and interviews with individuals & observation. For the purpose of the study it was necessary for the researcher to get to know the background to the women's submissiveness, be it socialization, cultural issues or otherwise a "mere" respect, hence the need to source the historical information.

The Within Participants Post-test Only Design has been used for the testing of the degree of relationship between female poverty in the rural communities of the Ugu district and HIV/AIDS prevalence. In this design the same research participants are subjected to all experimental treatment conditions. Christensen Larry B. (2007) alluded that in this design the participants serve as their own control and variables like age, gender, previous experience, remains constant, which ensures perfect matching of participants. This design is maximally sensitive to the effects of the independent variables.

3.3 SAMPLING

The population refers to, in the case of this study all the poor women in the five rural areas of the Ugu district. It was not possible to engage all the 1500 females from the five rural communities due to time constraints, financial implications and human resources.

SAMPLING METHODS

In view of the above constraints, a sample had to be randomly selected from the population. The randomization benefits the research in that it is a control technique that equates groups of participants by ensuring every member an equal chance of being assigned to a group, Christensen Larry B. (2007).

The above is echoed by Ferguson (1966) cited by Christensen Larry B. (2007) that a random sample is such that every member of the population has equal probability of being in it. It is further alluded that the use of the random selection ensures that the sample is the representative of the population from which it is drawn. Through this type of sampling the researcher was able to generalize the results of the experiment back to the population. It is suggested that the term 'random' theoretically refers to assumption about equi -probability of events

Christensen Larry B (2007) purports that haphazard sampling is a non- probability sampling where the participants selection is based on convenience as it includes participants that are readily available. For the purpose of generalisation and inference the Researcher did not use the haphazard sampling technique but used the random sampling.

SAMPLING SIZE

Out of 1500 females from the five rural communities of Kwa-Zulu Natal, the researcher interviewed 400 females, which is approximately 30 percent of the female population.

The decision on the issue of sample size, that is 400 participants rested upon the probability of rejecting a false null hypothesis that is; the power. Christensen Larry B. (2007) purports that the power increases as the number of participants increases. It was on this basis that the researcher opted for the 400 research participants.

3.4 DATA COLLECTION METHODS

The researcher made use of both the qualitative and quantitative methods to complement each other. This study necessitated various methods of data collection including the questionnaires, interviews, naturalistic observations, documentary analysis, survey and other methods

The level of literacy among the research participants made the researcher to explore various methods of data collection, as it is concurred that exploring multiple sources would result in a good research study, Yin (1994).

AN OVERVIEW OF THE DATA COLLECTION METHODS USED

Naturalistic Observation

Christensen Larry B. (2007) avers that the naturalistic observation is a technique that enables the investigator to collect data on naturally occurring behaviors, as the participants are in their natural environment. Due to time constraints the researcher could not spend much time on this method, nevertheless, much has been gained out of it. The idea was to observe issues of gender inequalities as they unfold within the community setting through behaviors that are underlying factors of women's vulnerability.

Christensen Larry B. (2007) argues that naturalistic observation does not only provide a description of the characteristics and range of behavior, but also the significance of the behaviors. Naturalistic observation enables the observer to remain unobtrusive when recording natural behavior.

Survey

Christensen Larry B. (2007) alluded that the survey is a method of collecting standardized information by interviewing a representative sample of a population.

The various methods of collecting survey data include personal interview that is face-to-face, telephone method, mail method and electronic survey. For the purpose of this study the face-to-face method was used.

The participants were interviewed at their homes; this allowed both confidentiality and the ease of expression. Groves & Kahn, (1979) suggest that the telephone method is about half as expensive as the face-to-face interview. Rogers (1976) echoes the above and further suggests that information collected through the telephone method is comparable to that obtained face-to-face.

Much as the telephone method seems to be more adequate, but the level of development and infrastructure in the communities where the research is conducted could not allow for the telephone method. This also is the case with the mail method and the electronic survey, which are the e-mail surveys and web-based surveys.

Documentary Analysis

Documentary analysis entails a broad coverage of events. The researcher made use of the following Home Community Based Care organisations:-

- Umtshinga drop-in centre for the Nyandezulu community
- Masakhane Home Based Care for the Izingolweni community
- Ubuntu abande drop-in centre for the Nongindi community
- Ntokozweni village for the vulnerable for the Ntokozweni community
- Nobantu resource centre for the KwaMachi community

The above HCBCs were used as primary sources of documentary data. The literature review with different books, programs on HIV/AIDS, documents on women poverty were also sourced as secondary source of documentary data.

This method of data collection is recommended as it allows the researcher to obtain information through unobtrusive research.

Questionnaires

The questions were structured into two categories, namely; the open ended questions and the closed ended questions. The questions were structured such that they get to the issues of vulnerability, susceptibility, illiteracy, financial dependence, gender inequalities and socialization.

The open ended questions were used to enable the participants to answer in any way they please. The answers were either recorded or written down by the Researcher. Using this category of questioning enabled the Researcher to get to the underlying issues in answering the research questions. The participants do not only answer the said questions, but also give their in – depth knowledge of the issues gained through socialization or historical influence

Interviews

The study was based on naturalistic observation, questionnaires and interviews. The level of literacy amongst the participants allowed the Researcher to engage in direct contact with the participants in interviews. The questions were presented orally and the responses were either written down or recorded during the interviews.

CHAPTER 4: ANALYSIS AND FINDINGS

4.1 INTRODUCTION

We are going to look at the answers from the participants and interpret the data collected. There is going to be further analysis of the population and then the sample that was used for the research.

4.2 AN OVERVIEW OF THE RESEARCH POPULATION

Five communities in the rural outskirts of the Ugu district were identified for the purpose of this study, namely; Nyandezulu, Izingolweni, Nongidi, Ntokozweni and KwaMachi communities. The above mentioned communities are ravaged by poverty, unemployment and HIV/ AIDS. There are Home Community Based Care organisations in each of the said communities.

At Nyandezulu community there is Umtshinga drop in center that is currently servicing approximately 200 OVC s, doing home based care to approximately 150 homes and palliative care. The majority of visited homes are headed or managed by women and girl children. 20% of the personnel at Umtshinga drop-in centre constitute the volunteers that come from the Nyandezulu community.

Izingolweni community has Masakhane Home Based Care that visits approximately 180 homes and offer help to approximately 150 OVC s. The devastating effects of HIV/AIDS at Izingolweni community is evident in the number of homes that need palliative care, the number of women – headed house holds and girl children that do not attend school because they are caring for their siblings and terminally ill mothers.

Nongidi community has Ubuntu Abande drop - in centre that is caring for the OVC s and home based care as its core function with approximately 300 OVC s and 150 homes that are being visited.

Ntokozweni community is serviced by Ntokozweni Village for the Vulnerable which is also a drop – in centre with its core function being caring for the elderly and OVCs.

Ntokozweni is servicing approximately 280 OVCs and housing 75 elderly. The palliative care is offered to the terminally ill.

Kwa Machi community has Nobantu Community Centre which also a drop in centre that services the OVC s and visit homes for Home based care. The 20 percent of the organization’s personnel constitutes the females from Kwa Machi community who work as volunteers in the organization.

The above mentioned communities are poverty stricken due to unemployment and underdevelopment, even the HCBC s that are in the communities cannot cope with the numbers of households and OVC s that need care.

The statistics acquired from the HCBC s in the research communities reveal that most of the households visited are headed by women and girl children.

4.3 DEMOGRAPHIC PROFILE

TOTAL POPULATION

The total population of the women in the five poor rural communities of the Ugu district is 1565. This population is distributed among the five research communities.

GENDER

For the purpose of this study the concentration is on females of the five rural communities in the Ugu district

AGE GROUP

The study covers a broad spectrum of the poor females across the following age groups, that is; starting from girl children between 9 to 15 years up to the elderly women of approximately 60 years

MARITAL STATUS

The study revealed that 60 percent of the participants are married and 30 percent of which are in polygamous relationship. 25 percent of the participants are single and are in multi-sexual relationships. 15 percent are the girl children, 10 percent of which are engaged in sexual relationships with partners that are older than their age group.

EDUCATIONAL LEVEL

The study established that 85 percent of the participants have very low levels of literacy with 60 percent of which are unable to read and write. 10 percent have standard four as their highest level of education and 5 percent are the girl children who have just dropped out from school with grade 5 and grade 7 being their highest level of education.

OCCUPATIONAL LEVEL

The study indicated that 70 percent of the participants are unemployed and have never been employed. 25 percent have been in short term kind of employment that is not sustaining them, their employment is either dependent on availability of jobs to be done or are just seasonal. 5 percent are working as volunteers without any pay or they sometimes get a form of a stipend.

4.4 THE RELATIONSHIP BETWEEN POVERTY AND HIV/AIDS

The relationship between poverty and HIV/AIDS was assessed: the manifestation of poverty in the inability to read and write, being unemployed or unemployable, and thus leading to perpetual financial dependence, being isolated and marginalized leading to underdevelopment and the lack of infrastructure.

4.5 HOW DOES POVERTY LEAD TO SUSCEPTIBILITY AND VULNERABILITY TO HIV/AIDS

The participants were asked how much control they have on their sexuality and their engagement in sexual intercourse.

It was established that 60 percent of the participants have no control over when, where and how to engage on sexual intercourse. 12 percent of the participants say that they sometimes contribute or are allowed by their partners to raise any form of concern that they have during sexual engagement. 28 percent of the participants would rather not talk about sexual activity as that was the men's prerogative.

The participants were asked if their financial independence would have an effect in their ability to exercise control over their sexuality and their engagements in sexual intercourse. The study revealed that 72 percent strongly believed that financial independence would give them power to exercise control over their sexuality. 18 percent feel that financial independence might or might not give them power to exercise control over their sexuality. 10 percent were just indifferent as they do not internalize or phantom the idea of being financial independent.

The participants were asked if the ability to read and write would have an impact in their protecting themselves against HIV/AIDS. The study revealed that 65 percent of the participants strongly felt that the ability to read and write would enable them to read more about the measures of preventing the spread of HIV/AIDS and thus protecting themselves. 20 percent felt that the ability to read and write might help in increasing their knowledge about HIV/AIDS, but protecting themselves is dependent upon their men or husbands. 15 percent felt that the ability to read and write might or might not help.

The participants were asked whether having access to health care centre would have an impact on their susceptibility to HIV/AIDS. The study established that 75 percent strongly felt that access to health care centre would reduce their susceptibility to HIV/AIDS. 20 percent felt that access to health care centre might or might not help. 5 percent felt that access to health care centers might help only those individuals that are still HIV negative.

The participants were asked if easy access to condoms would enable them to negotiate condom use with their partners. It was indicated that 52 percent strongly believe that

access to condoms would enable them to negotiate condom use. 45 percent felt that access to condoms might or might not enable them to negotiate condom use with their partners. 3 percent said that to use or not use a condom is the prerogative of men.

The participants were asked if they feel prejudiced by living in the outskirts, in as far as HIV/AIDS knowledge is concerned. The study indicated that 68 percent strongly feel that their living in the outskirts prejudice them in as gaining information about HIV/AIDS. 30 percent do not feel prejudiced. 2 percent feel that being in the outskirts or not has nothing to do with the knowledge about HIV/AIDS

The participants were asked how often they get STI s and how do they access the treatment thereof. The study revealed that 52 percent acknowledge having had STI s quite frequently and do not get treatment for it. 18 percent remember having STI s and they would visit the hospital (if they have money) to get the treatment thereof. 30 percent said they often have STI s but do not get treatment from their mobile clinic.

The participants were asked if they know any relationship between STI s and HIV/AIDS. It was established that 85 percent of the participants did not know the relationship between STI s and HIV/AIDS. 10 percent said that STI s may be related to HIV/AIDS because people living with HIV/AIDS sometimes have STI s. 5 percent were not comfortable to 'disclose issues of their sexuality'

4.6 WHAT ARE THE BARRIERS TO INTERVENTIONS

The participants were asked how comfortable or uncomfortable they feel with being in polygamous relationships. The study reveals that 72 percent of the participants do not feel comfortable with being in a polygamous relationship but there is nothing they can do about it because they are financially dependent on their husbands. 20 percent said they feel comfortable being in polygamous relationship because their culture endorses it. 8 percent feel indifferent but maintain that they were socialized in polygamous relationships.

The participants were asked if they do not perceive a risk of contracting HIV/AIDS when engaging in sexual intercourse, without using a condom, with a partner that has multi-sexual relationships.

The study established that 48 perceived no risk, maintaining that they were socialized not to deny their husbands or partner to have sex. 23 percent strongly believed that their husbands or partner would not infect them. 20 percent perceived a risk but are nursing fears of losing their partners and the support if they would negotiate condom use. 9 percent were indifferent.

The participants were asked the sources of information about HIV/AIDS. The study revealed that 68 percent of the participants learn about HIV/AIDS only from their health care centers. 20 percent say from the Home Community Based Care that is within the community. 12 percent say from the hospitals.

The participants were asked if they have access to the pamphlets that have information about HIV/AIDS. The study established that 67 percent have seen the pamphlets but could not read them was because of illiteracy, they only view the pictures. 20 percent have accessed the pamphlets from the Home Community Based Care. 13 percent have never seen such pamphlets.

The participants were asked whether they do view the programs on television about HIV/AIDS. The study indicated that 68 percent do not have electricity within their communities; they also do not have television sets, so they do not view television programs about HIV/AIDS. 32 percent are not in possession of television set, so do not view programs about HIV/AIDS, though they have electricity within the communities.

4.7 THE FINDINGS

The study has established that the poor women of the five rural communities of the Ugu district, namely; Nyandezulu, Izingolweni, Nongidi, Ntokozweni and Kwa- Machi, are

solely and perpetually financially dependent on either their husbands or their partners. The high levels of unemployment amongst these women perpetrate their vulnerability to HIV/AIDS. There are strong socio-cultural issues that are being embraced within the communities. The issue of gender inequalities is evident in the responses such as 'men's prerogative' that are consistently coming up from the participants.

Barriers to intervention have been established as being illiteracy; this stems up in the inability to read the pamphlets on HIV/AIDS. The research communities are in the outskirts, they are isolated, marginalized and underdeveloped hence the 66 percent of which do not have electricity; this state of the communities forms a barrier to interventions. The poor women's inability to negotiate condom use with their partners that is embedded in their historical and cultural values forms a barrier to interventions.

Poverty at large has been found to form a barrier to interventions.

CHAPTER 5: THE FINDINGS OF THE RESEARCH

5.1 INTRODUCTION

This chapter draws our attention to the findings of the research in relation to the research objectives which were outlined in the introduction of the study, summarized as follows; the relationship between the women poverty and HIV/AIDS prevalence, determination of the underlying gender inequalities, socio- cultural barriers in the complexities of HIV/AIDS that lead to women susceptibility and vulnerability to HIV/AIDS.

The aim is to compare and evaluate the research findings with the literature that has been reviewed, with a view to analyzing the validity and the reliability of the research findings.

The random selection of the 400 participants out of a population of 1500 poor women rested upon the probability of rejecting the false null hypothesis i.e. the power. It is upon this understanding that one could generalize on the basis of the said sample. The various methods of data collection that were explored during the study contributed towards the in-depth understanding of the underlying issues that could answer the research question.

The researcher is also mindful of the fact that 14 percent of the participants could not respond to other questions as they felt that they would not divulge issues of their sexuality; for example, the issue of the relationship between STI and HIV/AIDS.

5.2 THE RESEARCH FINDINGS

The study has established that 85 percent of the participants surveyed felt that the inability to have control over their sexuality deems them susceptible to HIV/AIDS, whilst the 15 percent felt that they are somewhat in control of their sexuality.

The findings also reveal that 87 percent of the participants surveyed strongly feel that the inability to read and write contribute towards their vulnerability to HIV/AIDS as they are

unable to read pamphlets that aim at raising the awareness and advocacy on HIV/AIDS. 13 percent feel that the inability to read and write might or might not contribute towards their vulnerability to HIV/AIDS.

The findings of the study revealed that the majority of the women surveyed acknowledged that their financial dependence on men lead to their inability to have control over their engagement in sexual intercourse. The study found out that this perpetual dependence on men due to the women's being unemployed or unemployable and being in seasonal jobs, manifests itself in women's inability to negotiate condom use.

The study established that 68 percent of the women surveyed strongly feel that their being in the outskirts prejudice them in as far as knowledge about HIV/AIDS is concerned, whilst 32 percent acknowledged their limited knowledge about HIV/AIDS, but did not attribute that to their being in the outskirts.

The findings revealed that the overwhelming 100 percent of the women surveyed acknowledged having had STI s, 82 percent of which never got any treatment thereof, and 18 percent had visited distant hospitals to have their STI s treated

The literature reviewed regarding the above issues states that poverty is seen as a social context through which HIV/AIDS thrives (Anton A van Niekerk 2007). It is further suggested that poverty and relatively high levels of unemployment are associated with high risk sexual behaviors and the spread of HIV/AIDS (USAID 2001)

Women are said to be marginalized in societies due to their low economic status and low levels of education which leads to their being submissive and perpetually dependent on men thus fuelling the spread of HIV/AIDS (USAID 2001). The discrimination against women, unequal power relations between men and women constitutes the basis of gender inequalities that fuel the feminization of the epidemic (Inter press News Service 2007)

Desmond Cohen (2000) concurred that an aspect of the poor health status manifests itself in the undiagnosed and untreated STI s which is a very significant component of HIV. He further argues that the poor households experience the conditions of social and political exclusion which increase the problems of reaching these populations through programs that aim at advocacy and prevention of the spread of HIV/AIDS and behavioral change.

Tony Carnie (September 2006) when analyzing the KZN, HIV prevalence alluded that the medical researchers are finding unbelievable rates of HIV/AIDS infection among the women in several parts of KZN, for example; in the Bothas Hill area outside Durban, 66 percent of women infection, 55 percent at Inchanga, 40 percent at Chatsworth and 50 percent at Mabhokweni in the Hlabisa district of the Northern KZN. (www.iolhivaids.co.za)

Abeysekere (2007) alluded that unequal power relationships make women more vulnerable to coercive and violent sex, which often put them at a disadvantage and leave them with little or no option to refuse sex, much less negotiate for safe sex and protected sex with her partner. (Inter press News Service 2007) Vicci Tallis (2002) echoes the above, avers that the epidemic flourish in the context of power dynamics that oppress women and add their vulnerability.

5.3 BARRIERS TO INTERVENTIONS

The study revealed that the 72 percent of the participants acknowledged that being in polygamous relationships is in itself a barrier to HIV/AIDS prevention and further suggested that there is nothing they can do about being in such relationships, whilst 28 percent of the participants were embracing being in polygamous relationships as form of their cultural value, but also realize that a polygamous relationship forms a barrier to interventions.

On the issue of condom use, 43 percent of the participants said condom use is a prerogative of their male partners, 42 percent strongly feel that condom use is a viable

intervention that can prevent the spread of HIV/AIDS and non condom use forms a barrier to intervention. 15 percent feel that condom use might or might not prevent the spread of HIV/AIDS.

On access to information about HIV/AIDS, the study revealed that 86 percent of the participants feel that underdevelopment of the health care centers and infrastructure form a barrier to interventions.

60 percent of the participants do not have electricity within their communities, so there is no access to television programs on HIV/AIDS. 30 percent have electricity within the communities but do not own television sets and therefore cannot access television programs on HIV/AIDS. 10 percent do not even have a health care centre within the community and are just dependent on mobile clinic that comes on certain days and they hardly access information on HIV/AIDS.

Illiteracy has been identified by the study as a form of barrier to intervention; 65 percent of the participants said their inability to read and write form a barrier to intervention whilst 35 said illiteracy might or might not form a barrier to intervention.

The findings of this study support the previous studies done on the relationship that exist between poverty and HIV/AIDS:

Desmond Cohen (2000) suggested that rural poverty and absence of access to sustainable livelihoods contribute to the conditions in which HIV transmission occurs. He further averted that information, education and communication activities are unlikely to reach the poor and even if the poor understood what they are being urged to do, but the resources to adopt recommended behaviors might not be available.

It is very crucial to examine the condition of women poverty and its manifestation in order to be able to see the relationship that exists between poverty and HIV/AIDS and its complexities

Vicci Tallis (2002) argues that poverty limits people's access to sexual health information, prevention technologies and treatment.

It is further alluded that some poor communities embrace men's masculinity and women's submissiveness up to the level of widow inheritance and other levels of gender inequalities.

Marriage is far from being a guarantee of safety from HIV for women. O' keeffe citing examples in Cambodia, India and Thailand where studies have shown that husbands were a primary source of HIV for women, and once the women became HIV positive, the prevailing gender norms also increase the likelihood that they will be blamed, ostracized and rejected by their families (Inter press News Service 2007)

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

The literature review on the women poverty has been done, with the focus on how women poverty leads to their vulnerability and susceptibility to HIV/AIDS.

The study revealed that the issue of unemployment, illiteracy, gender inequalities, socialization, cultural values norms and standards are being the underlying issues that the poor women are struggling with, in silence.

The underdevelopment, lack of infrastructure, marginalization and isolation of the poor communities form a barrier to interventions, thus making the poor women more vulnerable to HIV/AIDS.

The women's inability to exercise control over their sexuality has been evident amongst the participants, suggesting that there is a need for multi facet approach in trying to curb the spread of HIV/AIDS.

The challenge that South Africa is facing is to transform the unequal power between men and women and create a situation where women have equal power, not only amongst the elite, but amongst the poor women of the rural communities.

It became glaring during the interviews that the interventions should be tailor made to suite different communities, taking cognizance of the diversity of cultures and the levels of the people targeted for intervention, otherwise most of our rural population will miss the boat.

The study has established that the poor rural communities of the Ugu district in KZN have deep rooted cultural beliefs that are embraced at the expense of the women and thus fuelling the spread of HIV/AIDS.

The perpetual financial dependence of women on men deem them susceptible and vulnerable to HIV/AIDS, and marriages do not form any protection against HIV/AIDS to women, as the husbands engage in multi sexual relationships that go unchallenged.

The interventions that do not seek to address gender inequalities, financial sustainability, and socio- cultural issues in the poor rural communities of the Ugu district in KZN might not yield the desired results. The issue of women unemployment and their being unemployable is very critical and it leads to their perpetual dependence on men and vulnerability to HIV/AIDS.

Women poverty and its manifestations have been identified in this study as a factor that leads to their susceptibility and vulnerability to HIV/AIDS.

6.2 RECOMMENDATIONS

The following recommendations have been made on the basis of the findings of the research:

- Gender inequalities should not only be addressed at national or provincial levels but be scaled down to the communities
- Programs on advocacy and prevention should be tailor made to fit the level of each community
- Greater involvement of men on HIV/AIDS programs should be sought
- The socio- cultural issues relevant to each community should be addressed when making programs on HIV/AIDS
- Activism against women and children violence and abuse should not be a 16 day affair but a 365 days program for the rural poor communities.
- Programs on poor women empowerment should be linked with HIV/AIDS programs
- Poor women should be assisted in forming co- operatives to ensure involvement in small sustainable businesses

- There should be financial institutions that aim at assisting the women from rural communities
- There is an urgent need for political commitment in assisting the rural poor women
- Various governmental department should commit to engaging in pro poor women programs i.e. Education department with Adult Based Education, Department of Labour should ensure the skills development and Department of Agriculture should assist the poor women with farming, just to mention a few.
- Monitoring and evaluation mechanism should be put in place to ensure sustainability of the projects
- The support groups should be established where poor women share and educate each other on mechanisms of dealing with HIV/AIDS
- Health care centers are a necessity in every community

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ANNEXURE

What effects does the female poverty in the rural communities of the Ugu district have on the HIV/AIDS prevalence?

QUESTIONNAIRE FOR THE PARTICIPANTS

By: PUMLA NOLUTANDO RODOLO

Supervisor: Dr THOZAMILE QUBUDA

STELLENBOSCH UNIVERSITY

This interview was conducted for research purposes, upholding high levels of confidentiality and respect for the participants' dignity.

Taking cognizance of the level of literacy amongst the participants, the questions were administered orally and the responses were also orally.

A DEMOGRAPHIC PROFILE

1. GENDER

FEMALE	MALE

2. AGE GROUP

15-18	19-25	26-45	46-60

3. MARITAL STATUS

SINGLE	MARRIED	DIVORCED	WIDOWED

4. EDUCATIONAL LEVEL

NEVER ATTENDED FORMAL SCHOOL	Grade 1--3	Grade 4-7

5. OCCUPATIONAL LEVEL

NEVER EMPLOYED	
CURRENTLY UNEMPLOYED	
ON SEASONAL EMPLOYMENT	
ON PERMANENT EMPLOYMENT	

B. SUSCEPTIBILITY AND VULNERABILITY TO HIV/AIDS

1. IN YOUR SEXUAL RELATIONSHIP WHO DECIDES WHERE, HOW AND WHEN TO ENGAGE ON SEXUAL INTERCOURSE?
2. WHAT CONTRIBUTES TO YOUR INABILITY TO HAVE CONTROL OVER YOUR SEXUALITY AND ENGAGEMENT IN SEXUAL INTERCOURSE?
3. ARE YOU EMPLOYED? IF NOT, WHAT CONTRIBUTES TO YOUR UNEMPLOYMENT?
4. ARE YOU ABLE TO READ THE INFORMATION ON HIV/AIDS PREVENTION?
5. HOW DO YOU FEEL ABOUT YOUR INABILITY TO READ ABOUT MEASURES OF HIV/AIDS PREVENTION?
6. WHAT DO YOU THINK WOULD BENEFIT YOU IN HAVING WELL DEVELOPED HEALTH CARE CENTERS WITH IN YOUR COMMUNITY?
7. DO YOU REGARD YOURSELF AS BEING PREJUDICED BY LIVING IN THE RURAL COMMUNITY? IF YES, WHY?
8. HOW OFTEN DO YOU GET SEXUALLY TRANSMITTED INFECTION?
9. HOW DO YOU ACCESS THE TREATMENT OF SEXUALLY TRANSMITTED INFECTION?
10. DO YOU PERCEIVE ANY RELATIONSHIP BETWEEN SEXUALLY TRANSMITTED INFECTION AND HIV/AIDS?

C BARRIERS TO INTERVENTIONS

1. WHAT KIND OF RELATIONSHIP ARE YOU IN?
2. HOW DO YOU VIEW YOUR MULTISEXUAL OR POLYGAMOUS RELATIONSHIP IN RELATION TO THE SPREAD OF HIV/AIDS?
3. IN HIV/AIDS ADVOCACY AND PREVENTION, CONDOM USE IS ALWAYS SUGGESTED. HOW DO YOU FEEL ABOUT CONDOM USE DURING ENGAGEMENT IN SEXUAL INTERCOURSE?
4. DO YOU PERCEIVE ANY RISK OF CONTRACTING HIV IF YOU ENGAGE IN SEXUAL INTERCOURSE WITHOUT USING A CONDOM?
5. WHAT CONTRIBUTES TO YOUR LEAVING YOUR SEXUALLY TRANSMITTED INFECTION UNTREATED?
6. HAVE YOU EVER VIEWED HIV/AIDS PROGRAMS THAT ARE BEING BROADCAST ON TELEVISION? IF NOT, WHY?
7. DO YOU ACCESS ANY INFORMATION ON HIV/AIDS FROM YOUR HEALTH CARE CENTRES?
8. HOW DO YOU FEEL ABOUT THE PAMPHLETS (IF ANY) ON HIV/AIDS THAT YOU GET AT THE HEALTH CARE CENTRES?
9. WHY DO GIRLS ENGAGE IN SEXUAL ACTIVITIES AT AN EARLY AGE?
10. WHAT ARE THE CONSEQUENCES OF THE EARLY ENGAGEMENT OF GIRLS IN SEXUAL ACTIVITIES?