

**AN EVALUATION OF THE RELATIONSHIPS BETWEEN POVERTY AND
HIV/AIDS IN KWA-LANGA, CAPE TOWN.**

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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.

Signature:

Date: 24 January 2008

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ABSTRACT

This study sets out to establish and explain the empirical link between HIV/AIDS and poverty using data collected in Kwa-Langa, Cape Town, South African. Analysis is restricted to women of reproductive age (15 – 49 years). The results indicate an increased risk of HIV infection among the poor, due to poverty-related characteristics of low education and low knowledge of the means of avoiding HIV infection, as opposed to the non-poor. Moreover, the poor and the less educated were found to be more likely not to use condoms than the non-poor. The results do not, however, provide the reasons for these relations and as such further research is required. One possible explanation was financial dependence on their partners, as it was found those women who received money from their partners, as well as those who came from households where hunger was a common phenomenon, were more likely not to use condoms because their partners disliked condoms, than those who did not receive money from their partners. The results also hinted at the intricacy of the poverty-HIV/AIDS relationship, so that it was not only low socio-economic status that increased susceptibility to HIV infection but also high socio-economic status.

Keywords: HIV/AIDS, poverty, HIV knowledge, condom use.

OPSOMMING

Die doelwit van hierdie studie is om die empiriese verband tussen HIV/VIGS en armoede te bevestig. Die data vir die studie is in Langa, Kaapstad, Suid-Afrika versamel. Analiese is beperk tot vroue van 'n reproductiewe ouderdom (15 tot 49 jaar oud). Die resultate toon 'n hoër risiko in die geleedere van die armes, as gevolg van lae opvoedingsvlakke en gebrekkige kennis oor die praktyke rondom die vermyding van HIV infeksie, in kontras met die meer welgestelde deel van die bevolking. Die resultate toon ook dat die armer deel geneig is om in 'n mindere mate kondome te gebruik en dat die meer gegoede deel van die bevolking meer geneig is om kondome te gebruik. Hierdie studie het egter nie die doel om die redes vir die bogenoemde verwantskap te bewys nie; daarvoor is 'n verdere empiriese ondersoek nodig. 'n Moontlike verklaring vir die bogenoemde verskynsel is die finansiële afhanklikheid van een seksuele vennoot teenoor die ander. Die studie ondersteun hierdie aanname in die sin dat vroue wat geldelike ondersteuning vanaf seksuele vennote ontvang en vroue wat uit gesinne kom waar daar 'n nood van honger heers, minder geneig is om van kondome gebruik te maak. Die resultate toon ook die ingewikkeldheid van die HIV/VIGS verwantskap, aangesien die studie ook wys dat die meer gegoede gemeenskap toenemend vatbaar raak vir infeksie, soortgelyk aan die toenemende vatbaarheid vir die HIV/VIGS virus van die armer dele van die gemeenskap.

Kernwoorde: HIV/VIGS, armoede, HIV kennis, kondoom gebruik

1. INTRODUCTION.

In South Africa, as in the rest of sub-Saharan Africa, HIV/AIDS is predominantly transmitted through sexual relations between men and women, which facilitates a secondary mode of transmission, namely from mother to child. Because HIV/AIDS attacks the immune system and leads to ill health and, ultimately, death, HIV/AIDS has initially been approached as a health concern. This emphasis on the health aspects of HIV/AIDS still dominates current policy debates on HIV/AIDS. There has also been a strong emphasis on curbing the spread of the epidemic. Because of the nature of HIV transmission in South Africa, prevention efforts tend to focus on changing sexual behaviour through the ABC of prevention: abstain, be faithful and use a condom. However, this approach assumes that sexual behaviour is a matter of rational individual choice. In reality, sexual behaviour is itself influenced by a range of factors, which include social, cultural, economic, political and technological factors. These factors further determine the extent to which people can access and use methods of HIV prevention, such as condoms, mutual faithfulness and abstinence. The purpose of this paper is to explore HIV/AIDS as an urban development concern, with a particular focus on the link between HIV/AIDS and urban poverty. The next section looks at the concentration and manifestation of HIV/AIDS in urban areas. It examines why HIV/AIDS is concentrated in urban areas and which social groups are most vulnerable to HIV infection. In doing this, it highlights factors in the urban context that influence sexual behaviour and may constrain individual choice in sexual behaviour and access to HIV prevention methods. Poverty and inequality, particularly gender inequality, are identified as core factors in enhanced vulnerability to HIV infection.

2. BACKGROUND

South Africa remains the highest in HIV/AIDS epidemic in the region. Poverty, social instability, mobility, happens to be the major contributors. More over South Africa has the fifth highest prevalence of HIV/AIDS in the world, with 21.5% of the population

infected. New infections are still increasing with no signs of reaching a natural limit. (AIDS Foundation South Africa, 2006).

Langa Township is one of the African townships in Cape Town. This township is believed to be the most infected with HIV/AIDS in the Western Cape Province, and this is accompanied by high rate of unemployment. The unemployment rate is + or – 60%, and people survive by means of (ukuphanda or ukuromola) which means to rob Paul and pay Peter or not to pay him at all. Some survive by means of (uku mailer) which means to carry liquor from bottle stores to the taverns or shebeens, and be paid with a bottle of wine and a plate of meal.

Some depend on government pensions like old age, disability, disease like T.B etc. People want to be sick and be disabled, so that they can qualify for government grants. If a person has one or two coughs he or she would rush to hospital to find out if it is T.B. so that he or she should qualify for medical pension.

Most of the unemployed people hang around in shebeens and where African liquor is brewed. People are also using Jabulane, which is a substitute for umqombothi the real African beer. Jabulane it's like a slow poison, no reasonable human being can drink that stuff except those that have given up on themselves, and the poorest of the poor.

This type of beer is produced by white companies and sold to black Africans township only. Why people opt for that? The answer is simple; it is the cheapest they can afford.

In the past Western Cape was declared coloured preferential area, and that means black Africans were seen as foreigners, and fourth-class citizens in every sphere of life. In Factories and construction companies, trades men jobs were reserved by law for whites, coloured and Indians. African people were only allowed to work as labourers or migrate labourers, who were staying in compounds and flats at Langa township. Migrate labourers from rural areas become the pillar of South African labour force. Some become Bas-boys, who were responsible for labourers and ensure compliance. Later become recruiters for their companies or construction companies. Nepotism was rife in terms of

employment, and as a result township fellows suffered the most, and slowly become unemployed. It is for that reason township fellows resorted into crime. They survive by means of shoplifting; pick pocketing, and of course petty crimes.

Shoplifters and pick pocketers were role models in the location, and that influenced young boys and girls to envy such skills. This situation had some influence in school children to drop at school, especially those who come from poor families. They forward to be shoplifters and pickpocketers in order to support their families. Now that they are old and such skills do not work anymore, they roam the street of Langa, unemployed, uneducated miserable and no future. This group later joined the unemployed group, which survive by means of begging and ukuphanda, or government grants.

Then there are those that come from countryside with hope of finding jobs. This is the group of people that formed informal settlement. They formed shantytowns in the periphery of the township. They leave in crowded and unhygienic conditions with no recreational facilities. Another group is the group that stayed in hostels and crowded flats with no privacy. They leave with out their wives for long period of time.

3. AIM OF THE STUDY

The overall aim of the study is to address the relationship between poverty and HIV/AIDS and to address the role of HIV/AIDS in reducing the possibility of attaining the poverty reduction.

4. RESEARCH OBJECTIVE

- To provide empirical evidence on the relationship between poverty and HIV/AIDS;
- To provide empirical evidence on the role of poverty as an added risk factor for HIV transmission.

5. SCOPE OF THE STUDY

The study will be limited to the people of Langa, and its three sections within Langa i.e. that old location, compounds and flats as well as informal settlement around Langa

location. These involve unemployed, shebeen patrons. Domestic or single parents and people between 15 – 25 years of age.

6. SIGNIFICANCE OF THE STUDY

People who are poor have little option to maintain their dignity. Many women who are single and unemployed are forced into sex work to keep their families alive. These people have to make some choices in order to survive. This study is supposed to highlight the role played by poverty to the escalation of HIV/AIDS. There is a general believe that poverty does contributes to the spread of HIV/AIDS. Some studies indicated that people, who depend on others for survival, tend to have a tendency of being submissive to those that have the power of money (Usdin, 2003).

7. LITERATURE REVIEW

7.1 Poverty: Definitions

Poverty can be a risk factor for and a consequence of HIV infection. The poor frequently live in high-risk social environments and HIV-infected persons experience adverse economic impacts. Typically, poor people have less access to the services they need most, e.g. health care, welfare support, education, and agricultural extension services. The problem is compounded by indirect costs of access, such as transport and time, and lack of knowledge about services. Worst hit are communities that are already poor, with inadequate infrastructure and limited access to basic services.

Defining poverty is a great challenge to researchers because of its complex nature. How researchers define poverty depends mainly on the theoretical framework researchers adopt. Those coming from the economics point of view will look at economic factors like income, expenditure and poverty lines as a basis for measurement. Others will look at issues of social exclusion, deprivation and incapability to measure poverty. Here are some definitions of poverty to gain a broad overview of the meaning of poverty.

The World Bank defines poverty as “the inability to attain a minimum standard of living” and produced a “universal poverty line”, which was “consumption-based” and comprised of two elements: “the expenditure necessary to buy a minimum standard of nutrition and other basic necessities and a further amount that varies from country to country, reflecting the cost of participating in everyday life of society (Duy Khe et. Al., 2003). The World Bank uses this definition largely for inter-country comparisons, and is not necessarily depicting what happens in households.

Amartya Sen has characterized poverty as a “capability deprivation”, where a person lacks the “subsistence freedoms” he/she needs to lead the kind of life he or she has reason to value (in Bloom & Canning, 2003, Simonen, 2005). They further assert that this freedom has two facets: opportunity and security. Opportunity requires education and a range of political and economic freedoms. Security is viewed as a consequence of effective utilization of the opportunities provided to a person and/or the household. The above definition implies that poverty is not only a state of existence but also a process with multiple dimensions and complexities. It is usually characterized by deprivation, vulnerability (low capacity to cope with risks), and powerlessness (Verner & Alda, 2004).

Deleeck et al (1992) defines poverty as a relative, multi-dimensional and dynamic phenomenon. Following the gender debate in measuring poverty, Ruspini (2001) asserts that poverty is also a gendered phenomenon. This is because women’s causes of poverty are to be found in a peculiar combination of risk factors in labour markets, in domestic circumstances and in welfare systems. Traditional research methodologies that seek to measure poverty have been largely incapable of fully revealing the true picture of female poverty in modern society (Ruspini, 2001). The author further argues that what is needed is the elucidation of the different processes by which both women and men fall into, experience and escape poverty, as opposed to the paradigm we have now, which is an analysis of the way in which households experience poverty.

The above definitions show that at the heart of poverty is an idea of basic needs. Typically, a person is considered as poor if he/she does not have the capabilities to meet the basic needs. Poverty is not a paucity of income only, but goes beyond that to consider the social context in which the person lives that determines the extent of poverty a person or family experience. Poverty can be chronic and transient, but transient poverty, if acute can trap succeeding generations. The poor adopt all kinds of strategies to mitigate and cope with poverty, hence to understand poverty, it is essential to examine the social and economic context of the households (Verner & Alda, 2004).

7.2 The Link between Poverty and HIV/AIDS

Like poverty, HIV/AIDS epidemic is affecting the sub-continent of Saharan Africa more severely than any other parts of the world (Lugalla et al, 1999) with 63% of global AIDS cases occurring in the region. Surely poverty and HIV/AIDS are cause for concern for the African continent. Sub-Saharan Africa is the only region of the world where the proportion of people living in extreme poverty is increasing. The number of Africans living below the poverty line (less than 1 US dollar per day) has almost doubled from 164 million in 1981 to 314 million people today (Jooma, 2005). She further contends that 32 of 47 African countries are among the world's 48 poorest nations. The impact of extreme poverty is felt even more at household level. Households may find themselves spiraling into extreme poverty, making it impossible for the household to assume its "normal" functioning.

Poverty and HIV/AIDS do not occur in a vacuum, but rather in a social context (Lugalla et al, 1999). Lwihula (1992) as quoted in Lugalla et al linked the AIDS epidemic with the years of economic crisis in the early 1980s that saw the scarcity of essential commodities. These economic hardships intensified poverty, destabilized families, and increased people's movements between countries. The situation widened the web of sex networking, and in this way facilitated the early rapid spread of HIV. Understanding poverty within the context of HIV/AIDS is critical as it is viewed in this paper as both a risk factor for and the consequence of HIV infection. As a risk factor, poverty is associated with weak endowments of human and financial resources such as low levels of

education, low levels of literacy and few marketable skills, generally poor health status and low labour productivity (Cohen, 1998).

The inability to attract endowments, through engaging in income generating activities by adults, as a result of HIV infection, morbidity and mortality sinks poor households into even deeper poverty. Poor households may find it even more difficult to exonerate themselves from dire poverty for many more years and generations to come. Poverty, as a consequence of HIV infection could see the poor adopting various mitigation strategies to cope with the disease that often exposes them to HIV infections. Cohen (1998) argues that it is not surprising that the poor adopt behaviours that expose them to HIV infection. And that it is not simply that the IEC activities are unlikely to reach the poor but that such messages are often irrelevant and inoperable given the reality of their lives.

Whiteside (2002:320) suggests that illness and poverty affect household resources and income. One sees rising costs of medical care/treatment, and an increased need for nutritious foods. With the progression of the illness, the demand for care also rises. Children are often withdrawn from schools to care for sick adults, further compromising their basic right to education. The deprivation of education could place the household at further long-term risk for poverty, lack of skills and disempowerment.

The latter results in a cycle of household impoverishment that may take decades to reverse. Lack and/or limited education and skills also appear to influence vulnerability to HIV infection. A national household survey in South Africa has found that those with tertiary educational qualifications had lower rates of HIV infection than those with only school level qualifications (Shisana and Simbayi, 2002). The assumption here might be that people with the necessary educational qualifications, thus acquiring economic independence/freedoms for survival do not engage in risky behaviours than those with limited education.

Cohen (1998) argues that HIV intensifies poverty, leads to its persistence and over time generates a culture of poverty. When parents are sick and die from AIDS-related

complications, little or no transfer of skills and knowledge to the younger generation. The circle of poverty is likely to repeat itself and felt over generations. Barnett et al (2001) argue that interventions to mitigate the effects of the pandemic on the rising generations are needed. Loewenson & Chikumbirike (2005) argue that persistent poverty leads to what is termed “new variant famine” where chronic poverty and ill health are increased reducing household mechanisms and resources for coping with illness and mortality and further undermining long term prospects for food security and household well-being. Nicoli Nattrass (2004:28) uses the term “sexual economy” to describe sexual activities that men and young women engage in, in exchange for money.

The participation in the sexual economy activities, as a result of poverty, places young women, in particular, at higher risk of HIV transmission and infection. Nattrass quotes Akeroyd (1997) who asserts that sexual culture places women in a vulnerable situation regarding HIV infection, and poverty exacerbates it by encouraging women to engage in sex as an economic strategy for survival. Dixon-Fyle & Mulanga (2004) concurs with this by stating that young women sell their bodies to help families, and men take advantage of the opportunity, or express feelings of powerlessness and despair through sexual violence when they are not driven by a mistaken belief in the healing power of the virgin female body.

Gender inequality and poverty deprives women of their ability to fulfill their socially designated responsibilities, and therefore debases them, often forcing them into prostitution (Lugalla et al, 1999). Shelton et al. (2005) commented in the *Lancet* that the poor especially women are vulnerable to sexual exploitation because HIV prevalence is partly a function of survival. They further contend that people with HIV eventually tend to lose wealth because of loss of employment and increased expenses related to the disease, thus blunting a positive relation between wealth and HIV.

A decline in government expenditure on health in many African countries translates into an increase in a number of untreated STDs that are known to facilitate the rapid transmission of HIV. This could have serious long-term health implications resulting

from the rapid spread of HIV (Lugalla et al, 1999 & Munyako, 1994). Children raised in poor households face a large risk of achieving a low level of educational attainment and dropping out of school (Verner & Alda, 2004). Girls especially are removed from school as a coping strategy, and also because the girls education is viewed as “less of a priority”, since it is expected that they will marry and will belong to another family (Grant & Palmiere, 2003). This is also largely due to economic factors such as loss of income due to HIV/AIDS amidst high education costs, and the direct costs like school fees, textbooks and uniforms. HIV/AIDS appears to interact strongly with poverty and has increased the depth of vulnerability of those households already vulnerable to shocks. HIV/AIDS has acted to intensify the disadvantages imposed on the poor households and communities.

7.3 The Impacts of HIV/AIDS and Poverty on Households

HIV/AIDS and poverty continue to exceed all expectations in the severity and the scale of their impact on the households and countries in general. Piot et al (2001) already predicted then that AIDS constitutes one of the most serious crises currently facing human development, and threatens to reverse progress in the mostly affected countries by decades. There is no reason to believe that Africa as a continent is not feeling the effects of this pandemic right now especially when considering the death toll due to AIDS and the ever increasing number of orphans as a result of HIV/AIDS.

HIV/AIDS and poverty impact significantly especially on the household and its ability to cope with the epidemic. Household impact is one of the points at which AIDS and poverty demonstrate their intertwined relationship (Piot et al, 2001). They assert that AIDS exacerbates and prolongs poverty in every context. For example in poorer households, AIDS takes a greater proportion of available expenditure, and limits access to food and health care. In education, it has a negative impact both in the supply of teachers and on the capacity of children to continue in school.

7.4 Direct Economic Impacts

While HIV/AIDS crosses all socio-economic groups, its economic impacts are greater on the poor, powerless and marginalized (Grant & Palmiere, 2003:213). From the time of

diagnosis, poor households feel the economic impact of the disease. Wyss, Hutton and Diekhor (2004) found in their study in Chad that the average costs of AIDS to patients and their families are very high. On average, a household spends USD78.6 (R521.66) a month directly on AIDS treatment and care. Cross (2001) in her study on rural households in South Africa further asserts that the de facto per capita income may fall to as low as R50 per month. The households therefore spend considerable amounts of money on consultation and treatment fees, and transport. Households see a greater spending on health care and associated costs (Save the Children, 2004; Wyss et al. 2004).

The chronically ill person is often unable to work leading to reduced income and output in agricultural production. Chronic illness coupled with the need to care for the ill, by other household members, takes valuable time away from productive activities leading to double loss of income thus exposing households to risks such as food insecurity and exposure to HIV transmission (Save the Children, 2004). In addition, De Waal & Whiteside (2003) have found that diversion of labour coupled with the care of children orphaned as a result of the death of their parents to AIDS related diseases further impoverishes the household. HIV/AIDS strikes persons at the prime of their lives thus exerting a heavy toll on the economic well-being of the household.

The death of a productive member comes with a reduced or loss of income (Cross (2001); Save the Children (2004)); absence of savings and other assets to cushion the impact of illness and death (Cohen, D.). For households that are solely dependant on agriculture, the death of the member means that the contribution to agricultural production and income from that person is permanently lost. However, this may also be the case for people working in the industry. Grant & Palmiere (2003) found in their study in Bulawayo (Zimbabwe) that HIV/AIDS affected households experience a 40% drop in household income, which is bound to impact the decisions and the psychological outlook of the household. The lack of time is viewed as the contributory factor to dip in household income. Although the households attempt to diversify, they are unable to add a lucrative income-generating project.

Households may be forced to change their livelihood strategies to counter the impacts of the loss and reduced household income. As it was found in Grant & Palmiere (2003) study households were forced to cut back on their livelihoods to accommodate a lower average monthly income, and an increase in the number of people living within the household. This effectively means that households sink deeper into poverty and likely chances to avert the economic impact are very low or non-existent for some very poor households. The HIV/AIDS epidemic undercuts the ability of the households to cope with shocks. Assets are likely to be liquidated to pay for the costs of care. Sickness and caring for the sick prevent people from migrating to find additional work (Wiggins, 2005).

7.5 Indirect Economic Impacts

People Living with HIV/AIDS (PLWHA) may suffer from considerable stigmatization in their homes, communities and workplaces when their HIV+ status is known. This may lead to various forms of social and political discrimination/exclusion including reduced chances for employment and in some cases dismissal from work, and insensitive and biased institutional policies. Lau & Wong (2001) have found that almost 20% of companies in their study would dismiss HIV+ employees to avoid anxiety and unrest among the rest of the staff. They further found that HIV+ employees would be transferred to other posts/positions against their will once their HIV+ status is known.

This indicates that stigmatization may impact on the financial resources of the household that could otherwise be generated through formal employment. Following the gender bias argument, women come out the worst in-terms-of income generating activities available to them. Because there is a general expectation on women to care for others including the sick, valuable production time is lost thereby impacting on the economic ability of the household to offset the ill effects of the pandemic (Grant & Palmiere, 2003). Wyss et al (2004) found that time lost due to illness was 15.8 days a month, and family members spend time caring for the ill person instead of engaging in income generating activities. Household members provided assistance at an average of 8.3 days thus abandoning their

daily activities or occupations. Average monthly productivity loss attributable to AIDS equaled 21.6 days per household.

The HIV/AIDS epidemic reduces farm production and incomes. In farming, labour is lost to sickness and death, as well to the time taken by those caring for the sick. Affected households plant smaller areas and use less intensive production methods (Wiggins, 2005). Capital to buy inputs is likely to be spent first on medicines, visits to hospitals, and eventually on funerals.

7.6 Food Security, Nutrition and Health

Household livelihood is a critical factor in understanding the impact of poverty and HIV in the overall functioning of the household and its ability to provide for the basic needs of its members. Ellis as quoted by Niehof (2004:322) defines livelihood as comprising of assets (natural, physical, financial and social capital), the activities, and the access to these (mediated by institutions and social relations) that together determine the living gained by the individual or household. The concept of livelihood is therefore multi-faceted in that it considers the activities that the household engages in and the outcomes thereof. It also reveals the interconnectedness and/or the interplay between the household activities, environmental and the social institutions in community/society that determine the outcome or living of the household.

7.7 Food security/insecurity

Food security is an important element for the survival of any household across the spectrum of wealth. Households affected by HIV and poverty may find it difficult to maintain their food security. Both HIV and poverty exert tremendous pressure on the household's ability to provide for the basic needs like food. Agricultural activities contribute to the welfare of households in two ways. Firstly, the production of food crops and ownership of livestock contributes to food security, and secondly it provides income (Samatebele, 2005). HIV/AIDS and poverty combined have a debilitating effect on agricultural sector of the poor countries, and more so on the households.

A major impact on agriculture includes the depletion of human capital, diversion of resources from agriculture, and loss of farm and non-farm income, together with other forms of psychological impacts that affect productivity (Jooma, 2005). The decline in agricultural production is attributable to the effects of HIV/AIDS (De Waal & Whiteside, 2003). They further assert that households with a chronically ill person see an income reduction of between 30 & 35%.

HIV/AIDS and poverty affect the food security of the household. HIV is often associated with morbidity leading to labour shortage and loss of income. Households affected by HIV/AIDS are vulnerable to increased risk of HIV infection and the resultant poverty. Niehof (2004) argues that households with vulnerable livelihood systems have neither enough assets, nor capabilities to create or access them. The situation further impoverishes the household. The cycle of poverty and AIDS entrenches the system of chronic impoverishment (Jooma, 2005). Families may not recover previous levels of social functioning, and may even resort to strategies that may imperil them further. These strategies may include engaging in commercial sex that puts women especially in danger of HIV infection.

Food shortages in Southern Africa are an ongoing problem, and long-term projections suggest that regional food production per capita is likely to diminish into the future (Rosegrant et al., 2001). Food crisis is undoubtedly made worse and malignant by a fully-fledged HIV/AIDS epidemic. The disease leads to competition within a household for its resources – money and productive capacity must compete between care-giving and health-care costs on the one hand, and agricultural inputs and labour on the other (Stewart, 2003). Food shortages could severely hamper the health of HIV infected individuals. The quality of life of people infected with HIV has implications for national productive capacity, and for the stability of family and social structures (Stewart, 2003).

7.8 Nutrition

Poor nutrition is often linked with adverse outcomes in HIV/AIDS. Poor nutritional status is linked to vulnerability to progression from HIV infection to mortality (Bates et al,

2004). Poor nutrition weakens the body's defence against infection, and infection in turn weakens the efficiency of absorption of nutrients. Micronutrient deficiencies undermine the body's natural defenses against infections, thus contributing further to the vulnerability to HIV infection (Nattrass, 2004). Households experiencing food shortages as a result of poverty and effects of HIV/AIDS increase the chances of fast progression of the illness and inevitable death of the ill person.

Given that malnutrition is a function of poverty, there is thus a good reason to assume that poverty helped hasten the spread of HIV in sub-Saharan Africa (Nattrass, 2004). Parasite infection, mainly malaria, and intestinal parasites undermine the nutritional status and compromise the immune system yet further, effectively exhausting it. Such parasite infections are endemic in Africa, but the situation is made worse by inadequate health care and infrastructure – itself a function of poverty and low levels of development that leaves most parasite infections untreated (Nattrass, 2004).

7.9 Health

HIV/AIDS is having a devastating effect on health in many countries in sub-Saharan Africa. The report “World Health Organization's (WHO) Commission on Macroeconomic and Health” sees ill health as a dimension of poverty, and advocates investing in health as a means of working towards poverty reduction and raising living standards of the poor (Bloom & Canning, 2003). The authors further contend that the physical body is the poor people's main asset, but one with no insurance and ill-health therefore imposes a higher level of risk on the poor when the principal asset is struck down by a disease, they cannot earn the money needed to provide themselves (and usually others too) with food or medicine, and the health shock is likely to be catastrophic.

Increased adult morbidity and mortality associated with HIV infection are likely to have important consequences for households, communities and health systems (Ngalula et al, 2002). One such consequence is economical, as households have to pay for health care services. A study in Tanzania revealed that terminal illness associated with HIV/AIDS is

associated with high levels of modern and traditional levels of health services use, mainly because of the longer duration of the illness (Ngalula et al, 2002). The more an HIV infected person is suffering from morbid acuteness of the disease; it is likely that the sick person will seek help from health institutions. In some Central African states, 60% of hospital beds are occupied by patients with HIV/AIDS related conditions (Sibanda, Stanczuk & Kasolo, 2003). The treatment costs related to these admissions may lead to further impoverishment especially at household level.

Poverty is associated with vulnerability to severe diseases like HIV, through its effects on delaying access to health care and inhibiting treatment adherence (Bates et al, 2004). The costs incurred while seeking diagnosis and treatment for HIV/AIDS are common causes of delays in accessing health care especially for the poor. Poor households may not necessarily have the financial resources to seek help from health centers, nor food security to enable members to adhere to their treatment. The lack of these resources is significant cause of the delays in accessing health services by poor households. Poverty limits the options for treating infectious diseases like HIV. Infection with other sexually transmitted diseases is an important co-factor of HIV, and it provides a point of entry for HIV (Stillwaggon, 2001). Poor households become even more vulnerable when unable to raise the necessary funds to pay for treatment as they largely depend on the state to provide these services. Conway & Norton (2002) contend that social protection policies and programmes, including health service provision, should be provided as right thus obliging the government to provide for the services. Most importantly, these services should be accessible to the poor financially, geographically and otherwise.

The strong biomedical evidence shows that malnutrition and parasite infection increases HIV susceptibility, not only to opportunistic infections after HIV infection, but also to HIV transmission (Nattrass, 2004). Parasite infection plays a dual role in suppressing the immune response. Borkow et al. (2001) have found in their study that helminthic infections are associated with increased CTLA-4 expression and impaired cellular immunity to both HIV and PPD and that such immunity can be recovered by de-worming or application of anti-CTLA-4 antibodies in vitro.

7.10 Child Rights

Poverty and HIV/AIDS predispose children to violation of their basic rights. Children are dependant on adult members of the household for food security. Failure of the households to provide children with nutritious foods may hamper their nutritional status thus placing children at risk of various infections that would undermine their health status. Access to Health Services: Chronic illness in children can lead to physical, social and developmental delays (Warwick et al. 1998). This can contribute to longer-term challenges that have to be addressed by households and family members. If the chronic illnesses remain untreated, this could lead to further impoverishment of the household in the long-term. Children may be ill and unable to go to school and attain better educational qualifications that could be utilized to the betterment of the quality of life of the household.

7.11 Education

Existing studies show that children raised in poor households face a large risk of achieving a low level of educational attainment and dropping out of school (Verner & Alda, 2004). The intergenerational transfer of low levels of education is high in poor households.

7.12 Care and Support

Where the impact of AIDS has been greatest, and where there are few if any adults to care for the bereaved children, a few households may be constituted of children alone (Warwick et al., 1998). Children are therefore deprived of warm and caring homes, and forced into situations where children have to lead households irrespective of their experience and need to be cared for as children. The authors further assert that poverty may force childcare to be provided outside preferred social networks.

HIVAIDS is changing the age distribution of the labour workforce with an increasing number of children facing economic uncertainty and hardship. The early entry of orphans into the labour workforce exacerbates the worst form of child labour, and the epidemic is

forcing older persons back into the workforce due to economic need (Dixon-Fyle & Mulanga, 2002:3).

7.13 Household Responses.

Households respond in various ways when trying to cope with or mitigate the effects of poverty and HIV/AIDS. Various authors have written on the responses of the households, which are going to be summarized in this section. Rural livelihood diversification is defined as a process by which rural households construct an increasingly diverse portfolio of activities and assets in order to survive and to improve their standard of living (Ellis, 2000). Diversification is generally recognized as an important strategy for decreasing livelihood vulnerability. The poor are left with little chance for survival hence diversification gives them an opportunity for revival and/or recovery.

As a result of desperation for household survival following the severe socio-economic impacts of HIV and poverty, households may sell their moveable assets to pay for medical costs and funeral expenses. In time, households dig deeper into poverty and impoverishment as a result of the sale of their assets and may reach a point at which economic recovery becomes impossible. For example, in agricultural communities, once households have sold all their livestock, they may resort to selling their tools, which can mean that they are even unable to sell their labour, since they do not have the implements with which to work.

Households revert to borrowing credit from the informal sector to offset the immediate impact of HIV and poverty. This offers a short-term solution to long-term problems households are faced with. Households need to be assisted to engage in sustainable activities to deal with the long-term effects of HIV and poverty.

7.14 Identifying HIV Affected Households

Save the Children (2004) identified three sets of circumstances to define affected households viz. chronic illness, death and support of orphans.

7.15 Chronic Illness

The inability of the HIV infected person to work contributes to the reduced household income and output from agricultural activity. Shortage of labour as a result of illness could lead to role restructuring within the household. Drimie (2003) notes that women, elderly and young people often assume greater burden of ensuring household survival, in addition taking the burden of caring for the ill.

Caring for the ill could mean time taken away from productive activities, land utilization and education. The above factors create a circle of dependency among members of the household. The severity and amount of strain put on other members to care for the ill and the members' endurance will determine the duration of survival of the household. The inability to endure such pressure may render the social support networks inoperable. Children may find themselves in the center of this situation when they are withdrawn from school to fill the gaps. The situation would then severely compromise the right of the child to education.

When children are withdrawn from school to care for the ill and fill the gaps where additional labour is needed, the household may be faced with "double loss of income". The ideal of utilizing education as a means of fighting off poverty, in the longer term, is then diminished. The household is likely to go deeper into poverty with little or no hope of recovery.

7.16 Death

A contribution to agricultural production and income from that member is permanently lost. Borise et al., as quoted by Drimie (2003), have found in their study in Kenya a significant reduction in the land cultivated on account of death of breadwinners and adults who were formerly active in agricultural production. De Waal & Whiteside (2003) put forward an argument that AIDS put households at increased vulnerability to famine.

The direct costs of death due to AIDS are substantial. Firstly, the household would have used substantial amounts of money in health-related costs prior to the death of an ill

person. By the time a person dies the financial resources of the household might have been exhausted already. The immediate economic impact in the event of death to AIDS related complications on the household is the funeral expenses. Grant & Palmiere (2003) argue that the primary economic cost of HIV/AIDS-related death is the foregone income of the deceased. This is assuming that the deceased person was economically active and contributing to the livelihood of the household.

7.17 Support of Orphans

Households across the entire spectrum of wealth can take in orphans reflecting the facts that HIV/AIDS affects all types of households. Poor households are hit harder as they are forced to make ends meet with the little resources they have. The addition of orphans into an already impoverished household drains the household financial resources. However, taking in an orphan, depending on his/her age, gender and health, may bring a net economic benefit to household income or food production (Save the Children, 2004). So taking in orphans is not necessarily a bad thing to do since it can enhance the livelihood of the household. However, in many Africa societies, tradition demands that households take in orphans of relatives regardless of whether they have the means to support them.

Loss of one or both parents, depending on specific cultural traditions and levels of household endowments, is likely to decrease physical, emotional and mental welfare of the child (Barnett et al. 2001). In poor households where food consumption is reduced for economic reasons, this may severely impact the physical and health status of the child. Some children may have not been immunized because parents were sick and unable to access health services for their children (unpublished article: Challenges faced by households in Caring for Orphans and Vulnerable Children).

The inclusion of orphans into an impoverished household has an impact on the household food security (Save the Children, 2004). Younger children require more care and support than older children. There is a need for interventions to mitigate the effects of HIV/AIDS and poverty on orphans and households.

7.18 Measuring Poverty

This section sets out how poverty can be measured at household level. However, there exist difficulties in defining poverty depending on the approach and theoretical framework that one uses. Different interpretations of reality translate into different poverty measures, and in part, reflect different views of what constitutes a good society and good lives (Laderchi, Saith & Stewart, 2003:244). The authors further assert that at theoretical level, the choice of a definition of poverty relies mainly on the crucial assumption that there is some form of discontinuity between the poor and non-poor that can be reflected in poverty line, and capabilities of individuals and/or households to maintain a reasonable lifestyle.

7.19 Monetary Approach

This is the most commonly used approach to poverty measurement and identifies poverty with the shortfall in consumption (or income) from some poverty line (Laderchi et al. 2003: 247). The users of this approach hold the view that any attempt to measure adequacy of resources or the prevalence of poverty requires that a threshold be established against which the living standards of an individual, family or household can be measured (Saunders, Bradshaw and Hirst, 2002). This threshold is necessary to determine whether they are in poverty, and how far below the poverty threshold they are.

Welfare and wellbeing can then be measured as the total consumption enjoyed proxied by either income expenditure or income data. The use of this approach can be justified using the minimum rights approach, where a certain basic income is regarded as a right without reference to utility but rather for the freedom of choice it provides (Atkinson, 1989; van Parijs, 1992 as quoted by Laderchi et al.). The choice of this approach takes the view that it can proxy other aspects of welfare and poverty. One of the criticisms of this approach is that the measurement of poverty on the basis of the possession of monetary resources is biased by the fact that it systematically overestimates the number of poor individuals and groups who count on 'hidden resources' (Ruspini, 2001). Conversely, it underestimates poverty in urban areas where the average cost of living is higher. Relying on income as a measure of poverty ignores the fact that there are other resources that can profoundly

affect people's standard of living: gift exchanges, income from relatives and friends, and services/benefits in kind. It is indeed extremely difficult to estimate both the magnitude and the distribution of income received from hidden transfers/resources.

Key Issues:

- Better measured by consumption data as it approximates welfare more closely than income.
- How do we differentiate between the poor and non-poor, and whether there is an objective way of doing so. There would be a need to clarify monetary values to utilise this approach.

7.20 Capability Approach

According to Sen (1985, 1997, and 1999) who pioneered this approach, development should be seen as the expansion of human capabilities, not the maximization of utility or its proxy, money income. This approach focuses on indicators of the freedom to live a "valued" life. This approach views individual well-being as the freedom of individuals to live lives that are valued, i.e. the realization of human potential. This emphasis on the outcomes characterising the quality of life of individuals implies a shift away from monetary indicators and a focus on non-monetary indicators for evaluating well-being or deprivation. If the emphasis is on final outcomes, poverty assessments should therefore take into account the fact that some people need more resources than others to obtain the same achievements (Laderchi et al, 2003). The emphasis is therefore put on the idea of adequacy of monetary and other resources for the achievement of certain capabilities rather than their sufficiency, and the roles of externalities and social goods are brought into the picture as other influences over capabilities.

The vulnerability of the households to poverty situations can be better understood or assessed through a degree of access the households have to different kinds of goods and amenities and to the fulfillment of needs (Ruspini, 2001). The incapability dimension is very important in understanding the economic hardship and the connection between low incomes and lack of resources.

Key Issues

- The important key issues to deal with when using this approach (CA) to measure poverty is translating capability approach into an operational framework. It requires the definition of capabilities and the levels of achievement that are to be considered. The pioneer of this approach, Sen does not provide a definition and/or a list of specifications, thus allowing room for choice across societies and ensure the relevance of the approach to different persons and cultures (Alkire, 2002). The minimal essential CA can be interpreted as constituted by health, nutrition and education. CA presents a major contribution to poverty analysis because it provides a coherent framework for defining poverty in the context of the lives and the freedoms people enjoy. It draws attention to a much wider range of causes of poverty and options for policies than the monetary approach.

- **Social Exclusion**

The concept of social exclusion is used to describe processes of marginalization and deprivation in societies. This method was pioneered by Townsend (1979), who defined poverty not simply as a lack of money, but also as exclusion from the customs of society. Mack and Lansley (1985) further improved and developed this method by defining poverty as a situation in which people had to live without the things which society as a regarded as necessities. Conceptualising poverty as social exclusion is a criterion for an ideal measure of poverty. Brady (2003) argues that social exclusion is polysemic, having multiple meanings in different contexts and for different purposes. Social exclusion is the antithesis of the Durkheimian concept of solidarity and connotes marginalization and irrelevance.

Atkinson (1998a) asserts that social exclusion should be understood as “people being prevented from participation in the normal activities of the society in which they live or being incapable of functioning”. Gore (1995), as quoted in Brady (2003) summarized social exclusion as incomplete citizenship and unequal access to the status, benefits, and experiences of typical citizens in society. Researchers need to be cautious with the application of this concept in developing countries like South Africa as the poor people

are engaged in processes to alleviate poverty, but governments have limited resources as a result of their history of colonization and the apartheid system.

The EU defines social exclusion as a “process through which individuals and groups are wholly or partially excluded from full participation in the society in which they live (European Foundation, 1995). The dynamic focuses on the processes that engender deprivation are distinguishing features of this approach. It recognizes the interplay of different dimensions that foster poverty in communities or groups of people. SE indicators could include unemployment, access to housing, minimal income and social contacts, lack of citizenship or democratic rights. Ruspini (2001) further maintains that this approach tries to make a direct assessment of deprivation by collecting data on a certain number of fields, e.g. health, education, social contacts, transport infrastructure and leisure activities.

The use of this approach in developing countries poses various difficulties. For example, exclusion from the formal sector employment or social insurance coverage does not imply exclusion from normal social patterns or relationships. Problems of definition are especially great in applying the concept to developing countries because “normality” is particularly difficult to define in multipolar societies, and because there can be a conflict between what is normal and what is desirable. The analysis of exclusion lends itself to the study of structural characteristics of society and the situation of groups that can generate and characterise exclusion. In a way, SE leads to a focus on distributional issues – the situation of the deprived relative to the norm generally cannot improve without some redistribution of opportunities and outcomes (Laderchi et al, 2003).

Key Issues

- The concept of social exclusion necessitates a relative measure of poverty. Relative measures reflect the difference in living conditions between the poor and the majority of the society, rather than some abstract standard (Brady, 2003:722). Brady further asserts that relative measures advantageously measure deprivation

according to a particular society's cultural norms and customary, prevailing standards and necessities.

- Social exclusion and the economic market are strongly connected. A. Sen (1992: 110) asserts that “poverty is not a matter of low well-being, but of the inability to pursue well-being precisely because of the lack of economic means” – as quoted by Brady (2003:725). A study by Pahl (1999) aimed at exploring ways in which new forms of money are altering the financial arrangements of couples and shaping the access which individual men and women have to household resources and to the market, three sources of information were used – 1. Analysis of Family Expenditure Survey (FES) for quantitative data, 2. Focus groups and 3. Face-to-face interviews for more qualitative data.

8. RESEARCH METHODOLOGY

In order for a research study to be successful, it needs to establish a methodological approach and develop a research design. This chapter considers the research methodology of the research: the research design; what type of approach was adopted, what sampling method was used, and what sample size taken, types of data collection, who was involved, and how it was collected, and finally how the data was analyzed and assessed. Mouton and Marisa (1990) pointed out that any methodological approach needs to be seen in light of the fact that specific choices will result in depending on methods of data collection, data analysis and inference depending on the methodology that is chosen. In this particular study, the research design and methodology together are shaped towards both quantitative and qualitative analysis (Pillay, 2003).

8.1 Research Design

The methodology process involves research design, a strategy that has plan, which specifies procedures to be taken in an investigation that will seek proofs and answers through research questions. Furthermore, it helps in collecting data that is to be analysed (Christensen (2004).

The purpose of this study is to research the influence of poverty to the escalation of HIV/AIDS. Therefore, the survey method used was to explore, and describe, the dangerous strategy behaviours used by poor people in order to survive the harsh and impoverished conditions under which they live. The study was of both qualitative and quantitative approach. This approach was used because qualitative methods allow the researcher to obtain an in-depth knowledge about the study, whereas quantitative methods make use of a standardized approach to obtain responses from a larger number of individuals.

Myers (1997) indicated that qualitative methods are particularly useful where the subject is not well understood, complex, sensitive, and requires details as in this case of Langa Township. Giving the research purpose stated above, the qualitative approach was appropriate, because it enabled the researcher to gain in-depth analysis about the behaviours that are influenced by impoverished conditions.

8.2 Population

Population in research methodology is the total group of target people that would need to be investigated if the views of everyone in a particular situation were to be measured (Grein et al, 2004). In this study, however, researching the views of the total population of Langa location is not possible due to constraint of time, manpower and financial resources. Therefore, the target population groups who live in appalling and extremely poor conditions, was sampled and from that a representative group was selected.

8.3 Sampling

There are two types of sampling techniques, namely probability and non-probability sampling. In the probability sampling, each subject of the total population has the equal chance to be selected for the sample. It is a deferent thing with non-probability sampling because each member of the population does not have an equal chance of being selected as sample subjects (Grein et al, 2004). According to (Sekaran 1992) probability sample design is used where representatives of the sample is of importance for purpose of wider generalization. Then (Kerlinger, 1992) indicated that non-probability sampling is used

when generalization is not the primary requirement. In this study, the probability sampling was used and the target group was derived from extremely poor sections. The sample size was 120, which were randomly selected from the four sections.

8.4 Data Collection Methods

The study aimed to obtain different viewpoints of the interviewees on how they survive the harsh and impoverished conditions, and the strategy adopted to achieve these objectives. This was done by means of interviews. The researcher ensured those questionnaires, documentary analysis, interviews, and where appropriate, other techniques were to be used if necessary to ensure success. This idea is also supported by (Yin, 1994: 78) who suggested that it is a sure case if multiple sources of evidence that entails a variety of data collection techniques, especially if they are highly complementary in nature, then they will result in a good research study.

8.5 Nature of data designed is stated below.

OUT OF EVERY GROUP OF SHEBEEN PATRONS 30 ARE RANDOMLY SELECTED.

- 10 shebeen patrons from old location,
- 10 shebeen patrons from compound,
- 10 shebeen patrons from informal settlement,

OUT OF EVERY GROUP OF DOMESTIC WORKERS 30 IS RANDOMLY SELECTED

- 10 domestic workers from old location,
- 10 domestic workers from compound,
- 10 domestic workers informal settlement,

OUT OF EVERY GROUP OF UNEMPLOYED 30 IS RANDOMLY SELECTED

- 10 unemployed people from old location,
- 10 unemployed people from compound,
- 10 unemployed people from informal settlement,

OUT OF EVERY GROUP OF YOUNG GIRLS AND MEN BETWEEN THE AGE OF 15 AND 20, 30 IS RANDOMLY SELECTED

8.6 Field Research

This is another broad technique, which was employed, in operation. The field research, which involved active research in the field or area of enquiry, was used to achieve objectives of the research work. Specific techniques included participant observation. The participant-observation was the first method to be used in order to ascertain if it is the right group of people to be interviewed. This technique presented an opportunity for me as a researcher to be part of events, and situations at hand especially with young men, and women between the ages of 15 – 25 years.

8.7 Interview Methods

Structured and focused interviews and surveys formed the thrust in the information gathering for this research. The study was both interactive and research based, and hence the formulation of interviews and relevant questionnaires. Interviews involved direct contact between, researcher and interviewees. Some questions were presented orally especially for those who were lazy to read, or could not understand the questions. Response and answers were recorded on the questionnaires. This type of interview style allowed the researcher to fully attend the questions, and clarify issues that were misunderstood during the interview period.

The quantitative interview method encouraged active participation between the researcher and the interviewee. It was important to ensure that the interviewee was not led. Hence questions were given to interviewees to read and respond. Some people refused to be taped and their views were respected.

8.8 Survey Techniques

A survey technique was used to gather the data from the township. One of the fundamental methods of data collection in social sciences is survey. (Guy et al, 1987: 220). Suggested that surveys can be utilised to investigate, describe explore, or explain

respondents' knowledge about a particular subject, their past or current behaviour. The most important issue here was the questionnaire design and administration, and the various types of interviews.

8.9 Ethical consideration

No information was revealed without the permission of the client. Participants were not exposed to pains and inhuman experience. The fore I can confirm that during the survey no coercion was used to get the data, instant people supported the idea with hope that this will exposes conditions under which they live.

8.10 Limitation

Some people did not want to be asked about sex activities, and some refused to be typed.

8.11 Participatory Methods

The conventional poverty estimates, including both monetary and capability estimates have been criticised for being externally imposed, and for not taking into account the views of poor people themselves (Laderchi et al. 2003). The aim of this method is to get people themselves to participate in decisions about what it means to be poor and the magnitude of poverty (Chambers, 1994 & 1997).

Contextual methods of analysis are involved i.e. data collection methods that “attempt to understand poverty dimensions within the social, cultural, economic and political environment of a locality” (Booth et al., 1998). Participatory mapping and modelling, seasonal calendars, wealth and well-being ranking are a few tools that could be used to measure poverty using this model/approach.

9. RECOMMENDATION

- On the basis of the above findings and conclusions reached, the following recommendations are made.
- The HIV and AIDS policies should be monitored and be implemented.

- People who live in poor conditions need to be educated and empowered so that they can understand the consequences of casual sex and multiple partners.
- The department should encourage and introduce skills development so that such people can be engaged in small business.
- National government should monitor the provincial governments, and ensure that services are delivered, to ensure quick housing development.
- Government should assist NGO' s, so that they can identify such catastrophes, and assists in finding ways, or means to address the situation, or reduces the impact of poverty.
- Government must consider job creation to ensure that people do work, and be independent so that they can be able to make their choices.
- The department of labour should ensure that the policies regarding a minimum salary for the domestic workers are implemented to ensure that exploitation has no place in new South Africa.
- Transport subsidies for unemployed to assist them in jobs seeking, and alleviate pressure from domestic workers, and other low earning citizens.
- The department of education should ensure that school kids, and students do get unwavering and sustainable support, so that they stay at school.
- South African business should be educated on the issues of philanthropic involvement, and should be encouraged to be true South Africans, and stop giving people crumbs from the dinner table, whilst they are making million and billions from the South African societies.
- Companies should have programmes where by employees will be encouraged and allowed to do community work among the old and poor.

10. CONCLUSION

The concluding chapter reflects back to the objectives of the study. The chapter therefore concludes the study, and offers recommendations that will assist the government to effectively, and efficiently handle the indicators that impact to HIV and AIDS epidemic. The researcher investigated the literature on HIV/ AIDS and poverty phenomenon in

other parts of the country and abroad. There is a huge volume of literature on poverty and on HIV/AIDS. However, literature explaining the interactions between the two is almost non-existent. This was found to be similar to the situation at Langa. Therefore it means that it is true that poverty does play a role in the acceleration of HIV/AIDS pandemic.

Examining these interactions, and their directions, it is useful for informing interventions that are going to work. The situation is complex and therefore it requires the government's role and effective methods of empowering women with tool of survival. Interventions are required at Individual, Family/Community and Policy levels. Empirical evidence will require both qualitative and quantitative approaches because poverty has much broader implications than mere income. The major cause is the unemployment, which leads to poverty. Poverty and liquor can reduce people into resorting to bad behaviour. Therefore intervention by the government is required, in order to come up with programmes that can help people to focus on developing activities.

Poverty does not cause AIDS but is an accompanying factor, which has side effects like prostitution. (South African Health review, 1999, p.3), poor living conditions, education, health and health care, pre-dispose poor people to HIV/AIDS. Poverty is indirectly responsible for the spread of HIV/AIDS. It does not cause HIV/AIDS. Understanding people's connectednesses, or social capital, is a crucial part of understanding HIV risk and response. The next step is to empirically examine the interactions between poverty and HIV/AIDS within a socio-cultural context.

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