Economic Impact of HIV/AIDS on Rural Households in KwaDlangezwa

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DECLARATION

I declare that this study is my own work, unaided and has not been submitted in whole or in part, for any degree. Each significant contribution and quotation in this study from other people's works are cited, referenced and acknowledged.

Signature..... Date:.....

DEDICATION

This work is dedicated to my dear mom, brother, sister and fiancé who supported me during my study together with the Research Committee for sponsoring my studies. They have supported me and encouraged me during my study period. It is also dedicated to all those who assisted me during my study period including all the respondents.

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Acronyms

AIDS:	Acquired Immune Deficiency Syndrome
ASO:	AIDS support organization
CBO:	Community-based organization
CIDA:	Canadian International Development Agency
DANIDA:	Danish International for Development Agency
DFID (UK):	Department for International Development
HIV:	Human immunodeficiency virus
GACO:	Gomba AIDS Care Organization
GNP +:	Global Network of People Living with HIV/AIDS
GTZ Deutsche:	Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation)
HIVOS:	Humanistic Institute for Cooperation with Developing Countries (Netherlands)
IDS:	Institute of Development Studies, University of Zimbabwe
IGP:	Income-generating project
KISA:	Kisa Farm Women's Group
MTCT:	Mother-to-child transmission
NACWOLA:	National Community of Women Living with HIV/AIDS
NAP+:	Network of African People Living with HIV/AIDS
NAPWA:	The National Association of People with HIV/AIDS

NGO:	Nongovernmental organization
NIP:	National Integrated Plan
NORAD:	Norwegian Agency for Development Co-operation
PLWHA:	People living with HIV/AIDS
PRA:	Participatory Rural Appraisal
ROSCA:	Rotating Savings and Credit Association
SAfAIDS:	Southern Africa AIDS Information Dissemination Service
SAFO:	Society for AIDS Families and Orphans, South Africa
SHG:	Self-help group
SIDA:	Swedish Agency for International Co-operation
STOGA:	St Theresa's Old Girls Association
TASO:	The AIDS Support Organization, Uganda
UNICEF:	United Nations Children's Fund
USAID:	United States Agency for International Development
US$:	United States dollar
WAMATA:	Walio Katika Mapambano na Ukimwi, Rubya Branch
	(Those at War with AIDS in Tanzania)
WANN:	Women Alive National Network
WB:	World Bank
WHO:	World Health Organization
ZNNP+:	Zimbabwe National Network of People living with HIV/AIDS

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Abstract

This study investigates the economic impacts of HIV/AIDS on the rural households in KwaDlangezwa. The study also investigates the hypothesis that Aids has massive economic impact on families infected and affected by HIV/AIDS. At the level of the household, AIDS results in the loss of income, assets, savings and an increase in spending on health care by the households. HIV/AIDS epidemic slows down the pace of economic growth. UNAIDS (2009) estimated that the number of people living with HIV worldwide continued to grow in 2008, reaching an estimated 33.4 million (31.1 million–35.8 million). The total number of people living with the virus in 2008 was more than 20% higher than the number in 2000, and the prevalence was roughly threefold higher than in 1990.

South Africa is one of the countries most severely affected by the AIDS epidemic, with the largest number of HIV infections in the world. UNAIDS estimated that in 2009, the total number of persons living with HIV in South Africa was 5.7 million. South Africa's generalised HIV epidemic is defined as being hyper-endemic due to the high rate of HIV prevalence and the modes and drivers of HIV transmission. Heterosexual sex is recognized as the predominant mode of HIV transmission in the country followed by mother-to-child transmission, and drivers of the epidemic include migration, low perceptions of risk, and multiple concurrent sexual partnership (UNAIDS, 2010).

The HIV/AIDS epidemic is a global concern of every country in the world particularly, in most African countries where the spread of the virus is increasing at an alarming rate. Coupled with other socio economic and political problems such as poverty, high fertility, low literacy and, the incidence of HIV/AIDS in most African countries like South Africa is becoming a serious challenge. The rural households are the most affected because of the lack of service delivery.

Data is collected using quantitative and qualitative method. Quantitative results are in consensus with qualitative results. Results reveal that seventy one percent (71%) of the respondents believe that AIDS has a negative impact on the level of income, and fifty seven percent (57%) of the respondents believe that AIDS has negative impact on assets and household members who are infected with HIV/AIDS do not get any assistance. The overall results reveal that HIV/AIDS has negative economic impact on the rural household in KwaDlangezwa.

CHAPTER 1

1.1 Introduction

This study investigates the economic impact of HIV/AIDS on the rural households in KwaDlangezwa. In the rural KwaZulu Natal, South Africa, Where AIDS is the primary cause of death (Hosegood et al., 2004) evidence suggests that maternal and double orphans have worse educational outcomes than non-orphans (Case and Ardington, 2006) and higher mortality, even where they are HIV negative (Newell et al., 2004).

There is consensus in the literature, as stated by Russel (1988), Weiss (1993) and confirmed by Sepkowitz (2001), that Acquired Immune Deficiency Syndrome or Acquired Immunodeficiency Syndrome (AIDS) is a disease of the human immune system caused by the Human Immunodeficiency Virus (HIV).

Kallings (2008) stated that AIDS is the first post-modern pandemic. The United Nations-AIDS (UNAIDS) and the World Health Organization (WHO) estimated that 33.2million people lived with the disease worldwide in 2007, and that AIDS had killed an estimated 2.1 million people, including 330,000 children. It was further ascertained that over three-quarters of these deaths occurred in Sub-Saharan Africa (SSA). A clear indication of how the pandemic is destroying human capital and slowing down economic growth in Africa was indicated by Bell, Devarajan and Gersabach (2003).

HIV/AIDS is now the leading cause of death in South Africa. Epidemiological models predict that HIV prevalence in South Africa is currently near its plateau but that most AIDS cases and deaths have still to occur (Dorrington et al., 2001). There is an agreement in the literature (Gao et al.,1999 and Worobey et al., 2008) according to generic research, that HIV originated in west-central Africa during the late nineteenth or early twentieth century. It is believed that AIDS was first recognized by the U.S. Center for Disease Control and Prevention in 1981 and its cause, HIV, branded in the early 1980s was indicated by (Gao et al., 1999).

According to a report by the United Nations UNAIDS (2000) although HIV/AIDS infection is a global problem, the epicenter of the disease lies in Africa. About 70 percent of the global HIV/AIDS infected population can be found in Sub-Saharan Africa (UNAIDS, 2000). The reported HIV/AIDS Seroprevalence rate for South Africa was estimated at 23, 5 percent in 2000 (Department of Health, 2000). This high rate of HIV/AIDS infection raises enormous problems and challenges for the economic development of the country, more so because HIV/AIDS affects the most economically productive sector of population.

Greener (2002) believes that, without proper nutrition, health and care and medicine which are easily available in developed countries, large numbers of people will suffer and die from AIDS-related complications. They will not only be unable to work, but will also require significant medical care. The forecast is that this will probably cause a collapse of economies and societies in countries with a significant AIDS population. In some heavily infected areas, the epidemic has left behind many orphans cared for by elderly grandparents. AIDS seriously weakens the taxable

population, reducing the resources available for public expenditures such as education and health services not related to AIDS, resulting in increasing pressure for government finances and slower growth of the economy.

Over (1992) found that, at the level of the household, AIDS results in both the loss of income and increased spending on healthcare by the household. The income effects of the disease lead to a reduction in expenditures, while the substitution effects will be to shift expenditures away from education and towards healthcare and funeral spending. FAO (2001) reported that HIV/AIDS epidemic and strategies for mitigating its impact are often not given specific attention by rural development workers. Projects operating in high-prevalence areas inadvertently bypass the households struck by the epidemic, as those households have neither time nor resources to participate in, and benefit from, project activities. This frequently leads to further marginalization and destitution of affected households.

According to Sehgal (1999), the effects of HIV/AIDS within a rural economy may include:

- Redistribution of scarce resources with an increasing demand for expenditure on health and social services;
- A collapse of the educational system due to high morbidity and mortality rates amongst educators and learners;
- Younger and less experienced workers replacing older AIDS related casualties, causing reduction in productivity;

- Employers becoming more likely to face increased labour costs because of low productivity, absenteeism, sick leave, attending funerals, early retirement and additional training costs.

AIDS is affecting sections of the population that were previously healthy; thus the number of people requiring health services is on the increase rendering serious implications for the health sector (Leblanc et al., 1997).

In their study, Bollinger, Stover, Kerkhoven, Mutangadura and Mukurazita (1999) talk about the economic impact of AIDS on households. They believe that impacts on household begin as soon as a member of the household starts to suffer from HIV-related illnesses including: a) loss of income of the patient (who is frequently the breadwinner); b) substantial increases in household expenditures on medical care goods; c) Other members of the household, usually daughters and wives, missing school or working less in order to care for the sick person; d) death resulting in a permanent loss of income, less labour being available for farming or lower remittances; funeral and mourning costs; and the withdrawal of children from schools in order to save on educational expenses and an increase in household labour (resulting in a severe loss of future earning potential). In 1995, 62% of the national population in Zimbabwe existed below the national total consumption poverty line of Z$2132.33 per person per year. About 46% of the population lived below the national poverty line, indicating these households' inability to meet their basic nutritional needs. A bed-ridden AIDS patient is an additional burden and is estimated to cost an additional US$ 23-34 per patient per month. In low-income households, additional

expenditures on transport, food and medical costs meant cutting down on meals (Hansen et al., 1998, Harnmeijer, 1997).

The study by Bachmann and Booysen (2003) on health and economic impact of HIV/AIDS on South African households, show that affected and rural households tended to be larger and poorer and have lower employment rates than unaffected and urban households. Affected households' incomes per person were about half, and their expenditures per person were about a third lower than unaffected households. Affected households were 10% more likely to have members from outside the nuclear family, but did not differ in age or gender composition.

HIV appeared to affect income more than expenditure, presumably because HIV imposes additional costs on households, most important of which are health care and funeral costs. The importance of these costs has previously been shown in Rwanda (Nandakumar et al., 2000), Ivory Coast and Uganda (Topouzis, 2000), Ethiopia and Tanzania (Bollinger and Stover, 1999). Few other studies have precisely quantified household costs of health care, an exception being the Rwandan study (Nandakumar et al., 2000). A striking finding in the study by Bachmann and Booysen (2003) is the high cost of funerals compared with the low cost of free government health services.

HIV and AIDS present a unique challenge to society (Tshabalala, 2007). No disease in recent times has produced more ethical dilemmas, been responsible for such destructions of family life or placed greater demands on health, education and social

services than has this viral affliction, and its complications. HIV and AIDS are already putting a break on economic growth in the worst hit areas.

A report from the Department of Health (2003) indicates that a large sum of health care spending will be on HIV and AIDS. Presently, South Africa is already battling with a shortage of skills. AIDS will exacerbate this and raise remuneration and replacement costs for companies. There will be a smaller labour force with lower productivity and income as the demand for services such as health and welfare grows (Bezuidenhout, 2004).

1.2 Motivation for the study

In his book, “How the poor are dying,” Poku (2005) found that HIV/AIDS is costly to most households and communities. During periods of illness, medical costs rise, work and incomes are disrupted, family members are withdrawn away from work to provide care and, in some instances, children have to work to supplement household incomes.

The objective of the study is to investigate the economic impact of HIV/AIDS on the households’ income, expenditure, assets, savings and lending. There are many studies that have been conducted in relation to this including those by Greener (2002), Over (1992), Poku (2005), Weiss (1993) and UNAIDS (2000). The findings of the economic impact on households are similar in most studies, indicating that HIV/AIDS imposes serious financial burden on families, societies, nation, continent and the world at large. KwaDlangezwa has been chosen as the study area mainly because there has never been study of this nature in the area.

1.3 Statement of the problem

Research reveals that the presence of HIV and AIDS has a negative economic impact on households with members infected by HIV and AIDS. These economic impacts include those on households' income, savings, expenditure, assets and lending .How then do KwaDlangezwa household members respond to these economic impact of HIV and AIDS?

1.4 Objectives and hypothesis of the study

According to Kumar (2005), objectives in a research means the following: the goals one sets out to attain in study. The main objective is an overall statement of the thrust of one's study. It is also the statement of the main associations and relationships that one seeks to discover or establish. In this study, the main objectives and research questions may be summarized as follows:

- To assess the economic impact of HIV/AIDS on rural households in KwaZulu-Natal with reference to KwaDlangezwa (e.g., the impacts of HIV/AIDS on households size, income, expenditures, savings, assets and borrowing). In other words, how does the presence of HIV/AIDS affect households' income, savings, assets, expenditure and borrowing?

- To identify rural households' responses for mitigating the adverse economic impacts of HIV/AIDS. In other words, what kinds of responses do rural households have to mitigate the impact of HIV/AIDS?

- To put forward appropriate policy recommendations to mitigate the economic impact of HIV/AIDS on rural households of KwaZulu-Natal. In other words, what is the role of the government in mitigating the economic impacts of HIV/AIDS on rural households?

- To strengthen resilience of households to the shock of HIV and AIDS. In other words, what are the coping mechanisms to shocks among rural households?

1.5 Hypothesis

The study has the following assumptions:

- Aids has massive economic impact on families infected and affected by HIV/AIDS
- At the level of the household, AIDS results in the loss of income, assets, savings and an increase in spending on health care by the households.

1.6 Research Methodology

The target population for this study will consist of 300 KwaDlangezwa residents. Data will be collected using interviewer-administered questionnaire, which will cover both qualitative and quantitative aspects of household characteristics and behavior. Data will also be collected using focus groups. Data will be analyzed using SPSS.

1.7 Organization of the study

According to Kumar (2005), a research proposal is an overall plan, scheme, structure, and strategy designed to obtain answers to the research questions or

problems that constitute the research project. A research proposal should outline the various tasks one plans to undertake to fulfill the research objectives, test hypotheses or obtain answers to one's research questions**.** The organization of this study will be as follows:

Chapter 1: Introduction

The introductory chapter will introduce the research topic, background of the study, aim of the study, motivation for the study, statement of the problem, objectives, hypotheses of the study and research methodology.

Chapter 2: Literature Review

This chapter will cover the research work or findings that have been done on the topic under investigation.

Chapter 3: Sample procedure, Data and Methodology

This chapter will be about data collection and the method that will be used in the collection of data.

Chapter 4: Empirical results

This chapter will focus on the analysis of the results.

Chapter 5: The role of the government

This chapter focuses on the role the national, provincial and local government has in mitigating the impact of HIV/AIDS.

Chapter 6: Findings, recommendations and limitations of the study.

Chapter 7: Conclusions

This chapter is about conclusions drawn by the researcher in the study.

CHAPTER 2

HOUSEHOLD RESPONSES TO HIV/AIDS: AN OVERVIEW

2.1 Introduction

According to Nkurunziza and Rakodi (2005) the livelihood strategies and well-being of urban households in sub-Saharan Africa have been affected by short-term shocks and long duration stresses due to economic decline, increasing poverty, deteriorating living conditions and the HIV/AIDS epidemic. Some households are more able to adapt and recover from shocks and stresses than others. Their responses are likely to depend on the assets available to the household; the economic context; past migration history and contemporary rural links; the prevalence of disease and whether the household itself is afflicted, affected or unaffected; the social/ethnic group to which the household belongs, with its associated patterns of kinship, marriage, access to land, inheritance etc; the nature of associational life in the settlement in which the household lives and beyond; the capacity of government to deliver services and the activities of NGOs.

According to UNAIDS (1999) households adopt a wide variety of strategies to mitigate the effects of HIV/AIDS. This chapter is about the studies that have been conducted regarding the impact of HIV/AIDS and types of coping strategies adopted by households, the sequencing of the strategies and their costs and effectiveness.

2.2 Types of household coping strategies

There are many ways in which coping strategies can be categorized. They are divided into three basic categories:

- strategies aimed at improving food security
- strategies aimed at raising and supplementing income so as to maintain household expenditure patterns, and
- strategies aimed at alleviating the loss of labour.

The literature on the impact of adult illness and death and the way households cope suggests that individuals and households go through processes of experimentation and adaptation as they attempt to cope with immediate and long-term demographic changes. The HIV/AIDS impact in Zambia in particular and Africa in general is described as a long-wave disaster (Barnett and Blaikie, 1992). Over a five-year period one episode of illness may be followed by others which gradually deplete the resources and labour supply of one or more interdependent households. The Kagera (Tanzania) study showed movements of household or family members into and after their study on strategies of coping (Sauerborn et al., 1996) with illness-related costs in rural Burkina Faso, a coping strategy sequence was developed which fits well with the stages identified by Donahue (1998). The generated sequence was as follows:

1. Use of savings
2. Sale of assets (livestock, equipment, etc)
3. Borrowing
4. Wage labour

5. Community assistance

6. Doing nothing (on the verge of calamity).

What is important to note from the studies is the factors determining a household's ability to cope, which include: access to resources, household size and composition, access to resources of extended families, and the ability of the community to provide support. Households that have higher incomes or better alternative resources are better able to cope with the impact of HIV/AIDS. Poor, small households that have no margin to absorb the extra costs of HIV illness are the most vulnerable to the epidemic. They do not have the assets, particularly livestock assets, which influence the choice of subsequent coping strategies such as borrowing or hiring labour. These households were identified to be at risk (at the verge of calamity) and require special assistance to help strengthen their coping capacity (UNAIDS, 1999).

2.3 Household coping strategies aimed at improving food security

Reduced consumption of food, substitution with cheaper alternatives and reliance on wild food when a breadwinner dies, households are faced with limited food to meet consumption requirements. Rugalema (1998) in Tanzania, Sauerborn et al. (1996) in Burkina Faso, and Barnett et al., (1995) in rural Uganda, found that some households cut back the number of meals when faced with food shortages. This was also reported to be a common strategy used by households to cope with a shortfall of income from one sector or individual following an unexpected crisis in Ethiopia (Webb and Reardon, 1992). SAfAIDS research in Zambia in 1998 found that households were buying less expensive foods as an alternative or were

substituting purchased relish (a side dish served with the staple carbohydrates e.g. maize or cassava) with indigenous or wild vegetables (UNAIDS, 1999).

Begging

SAfAIDS research in Zambia (SAfAIDS, 1998) identified begging as a survival strategy in times of need. Sauerborn et al., (1996) indicates that this survival strategy is practised when the households that are at risk have been pushed into calamity.

2.4 Household coping strategies aimed to raise income

2.4.1 Income diversification

Sauerborn et al., (1996) in rural Burkina Faso, SAfAIDS (1996) in rural Zambia, and Barnett et al., (1995) in Uganda, found that rural households that cannot meet their food requirements, or obtain cash, through agricultural production, undertake a range of income-generating activities such as selling firewood, brewing millet beer, selling livestock, building fences, handicrafts, tailoring, and petty trade to supplement their income. In Malawi, Munthali (1998) reports that households cope by doing ganyu (casual labour). In rural Zambia, some members of rural households were reported to have migrated to urban areas in search of employment so that they can remit some income to their rural area, while some work in neighbours' fields as casual labour so as to earn some income (SAfAIDS, 1996). Households that do not have the ability to diversify the source of income are particularly vulnerable to the epidemic. Prevailing poverty drives women into sex work as a source of income. In Malawi, 12-year-old girls were driven to have sex to fulfil short-term income needs (Little, 1996).

2.4.2 Sale of agricultural produce and use of savings

In a study in Zimbabwe by Kwaramba (1997) sale of agricultural produce was reported to be a dominant coping strategy to raise income to meet additional health costs. Barnett et al., (1995) in rural Uganda, Drinkwater (1993) in Mpongwe rural area, Zambia, Rugalema (1998) in Bukoba district, Tanzania, and Sauerborn et al. (1996) in Burkina Faso, report similar findings and indicate this widely used coping strategy to be among the first strategies used. Tibaijuka (1997) in Kagera Tanzania reports that households sold bananas (their staple food) in desperation to raise money to meet medical costs. The same studies also indicate that households use up savings to raise money to meet health and funeral costs.

2.4.3 Loans

Sauerborn et al., (1996) indicate that the informal financial sector is an important source of income used during times of need. Sauerborn et al., (1996) in rural Burkina Faso, SAfAIDS (1996) in rural Zambia, and Rugalema (1998) in Bukoba district, Tanzania, Tibaijuka (1997) in Kagera Tanzania identify the informal financial sector to include:

1. relatives, friends and neighbours
2. rural cooperatives
3. rotating and savings club associations
4. rural traders and
5. rural money lenders.

Loans are given without much bureaucracy and with minimal paperwork. Interest rates are non-existent or very low for sources (1), (2) and (3), but can be substantial for sources (4) and (5) (levels higher than 100% per annum have been reported). When interest rates are high, not all households borrow, as indicated by the following reports from a socioeconomic impact study conducted in Zambia (SAfAIDS, 1996).

“When we are stranded and have no food we borrow money from Kaloba [a 100% interest rate credit facility run by individuals]” (SAfAIDS, 1996).

2.4.4 Sale of assets

Tibaijuka (1997) in Kagera, Tanzania and Rugalema (1998) in Bukoba district, Tanzania, report that households that did not have enough income to buy food or to pay for health care, funeral expenses or education costs sold assets in response to the crises. The amount and type of assets so disposed vary across households. Evidence shows that a wide variety of assets, except land, were disposed off to generate cash for use in seeking treatment. In a study by Rugalema in Tanzania and by SAfAIDS in Zambia, the range of assets most commonly sold included cattle, bicycles, chickens, furniture, carpentry tools, radios and wheelbarrows. Some households report pledging future crops to meet immediate cash needs (Rugalema, 1998, SAfAIDS, 1996).

“After mother died we were left with no means of survival. She was the one who looked after us. My brother had just completed school and could not go to college because there was no money to pay for his fees. I cannot get a job myself-jobs are difficult to find these days. We decided to sell blocks that were meant for extending

our house. There were 500 and we sold them for K150,000.00 and used the money to set up a business. We started selling charcoal by the roadside near our house. At least we are able to have a meal a day" (SAfAIDS, 1996).

"Since I am the eldest, I started doing small jobs for people to earn something (he took on a task of becoming the head of the household). But people do not pay me in time, life is just difficult. My aunt, who used to take care of my mother, is now paying school fees for our youngest brother. I spend more time looking for money to make ends meet" (SAfAIDS, 1996).

2.4.5 The role of the extended family

Throughout history the family, or in economic parlance the household, has formed the crucial social and economic unit on which most human societies have been based. The extended family as safety net is still by far the most effective community response to the AIDS crisis (Mukoyogo and Williams, 1991). Literature reveals that affected households in need of food send their children to live with relatives: Sauerborn et al., (1996) in rural Burkina Faso, SAfAIDS (1996) in rural Zambia, Barnett et al., (1995) in Uganda, Lwihula (1998) in Kagera region, Tanzania, Rugalema (1998), Drinkwater (1993) in Zambia, Kwaramba (1997) in Zimbabwe and SAfAIDS (1998) in Zambia. Relatives will then be responsible for meeting the children's food requirements. However, according to UNAIDS report these studies did not probe into the types of relatives, or the length of time the children stayed with those relatives. Relatives and friends may provide both moral and material support to the sick on the assumption of future reciprocation. Preparation of food, work on land or overseeing livestock will be done by another family member or neighbour in

addition to their own tasks. Over time the ability of families and social networks to absorb these demands will decrease as more adults die young of HIV/AIDS.

2.5 Household coping strategies aimed at alleviating the loss of labour

Intra-household labour reallocation and taking children out of school

Sauerborn et al., (1996) in Burkina Faso reported that reallocation of tasks among household members was the most frequently used strategy to cope with expected production losses resulting from adult morbidity and mortality. Children may be taken out of school to fill labour and income gaps created when productive adults become ill or are caring for terminally ill patients or are deceased. In Tanzania (Rugalema, 1998) intensive use of child labour was a major strategy typically used by the afflicted household during care provision.

Although children are not directly involved in care provision they are involved indirectly, by fulfilling mothers and fathers' roles in some domestic and agricultural activities (such as collecting water and firewood and harvesting crops). They also prepare food for the rest of the household, gather food, tend livestock and run errands (UNAIDS, 1999).

Removal of children from school is a common coping strategy and was mentioned by teachers at the local primary school as one of the major factors of low school attendance among orphans and children whose parent(s) were sick. (Rugalema, 1998; SAfAIDS, 1996). Girls are more likely to be taken out of school than boys.

Postponement of registration at school of children of school-going age due to parental illness was also common. Whether children withdrawn from school are able to go back to school in the future is not known and this warrants research. In some hard-hit households, young orphans might inherit considerable resources but cannot manage them. In a study in Kagera region in Tanzania, Tibaijuka (1997) found that some young orphans inherited large farms which were rapidly degenerating into bush because of lack of care. Traditionally such farms would have been maintained by the clan, but such institutions were breaking down because of shortage of labour.

2.5.1 Hiring labour and draught power

In Zambia, Burkina Faso, Tanzania, Malawi and Zimbabwe, affected households reported hiring labour and draught power to meet their production requirements (SAfAIDS, 1996; Sauerborn et al., 1996; Rugalema, 1998; Kwaramba, 1997). Labour was hired to meet the needs of the most labour-constraining activities, namely land preparation, weeding and harvesting. However, hiring labour depends on the availability of income to pay the workers. Only households with a stable income or source of remittance were able to hire labour and draught power. Some households had to pay the labour in kind, e.g. using maize or other commodities. Poor households relied on free labour from relatives and supportive and sympathetic community members.

2.5.2 Changing household crop production and substitution of crops

Research in East Africa reports that households involved in any agricultural production may cultivate a mixture of subsistence and cash crops (Barnett et al., 1994; FAO, 1995). The demand for labour varies as some crops are more sensitive

to timing services than others. For example, a delay in planting maize, beans or groundnuts greatly reduces yields and impacts on food security. Bananas, yams and cassava, on the other hand, do not require activity at such specific periods and can be left unattended for some time without affecting the harvest.

Extended interruption of the labour supply may also affect important activities such as land preparation or maintenance of irrigation systems which in turn affects future production. FAO studies in East Africa (FAO, 1995) have shown that affected families substituted cash crops for crops which required less labour and expensive inputs such as fertilizer and pesticides. As a result, crops like coffee were abandoned by affected households in Gwanda and Nakyerira regions of Uganda and households depended on food crops such as cassava and bananas. Topouzis (1994) in a different study in Uganda found that widows stopped growing tomatoes, a major cash crop, owing to lack of fungicides and rice and millet, which are labour intensive, in favour of maize and cassava which require less labour. In Zimbabwe, Kwaramba (1997) found that affected households were substituting cash crops like cotton and groundnuts with maize.

2.5.3 Decreasing area cultivated

A socio-economic impact study (Black, 1997) in Burkina Faso and Côte d'Ivoire found that cultivated areas declined in response to labour shortages caused by illness and death in both countries. Topouzis (1994) found similar results in rural Uganda. Depending on the price balance, households chose between food and cash crops to economise on labour. In some countries, however, innovative coping

strategies have been adopted, such as sharecropping, illustrated by the following case.

“Jane is a widow aged 45 living with her two children, a son aged 22 and a daughter of 11. She had eight children. Four died of AIDS and the others left home and married. Jane owns a coffee plot, but it has largely returned to bush because there is no labour available to maintain it. The main labour input is her own and that of the 11-year-old daughter. But she also hires some labour on a sharecropping basis and this allows some coffee to be cultivated. Having adequate land has enabled this woman to enter into sharecropping agreements with landless or land-short people. This is an effective method of coping with agricultural production in cases where there is land surplus. However, she has changed her cropping pattern, and largely abandoned coffee production in favour of food crops. She has also taken her daughter out of school to contribute more labour on the farm and to the home” (Barnett and Blaikie, 1992).

2.5.4 Lengthening of the working day

Topouzis (1994), in Uganda and SAfAIDS (1998) in Zambia, found that many affected households put in extra hours to make up for the labour shortages and loss of income. For example, a son with a sick mother in Zambia reported that he spends more time looking for money to make ends meet by working in the field and doing casual jobs and in addition he has to contribute an average of three hours a day towards caring for his mother and stay up part of the night attending to her needs. “The overall time allocated to tasks has increased with very little time for me to sleep” he says (SAfAIDS, 1998).

2.6 Most common coping strategies

Coping strategies not requiring any cash were most frequently adopted (Sauerborn et al.,1996). Examples of these strategies include intra-household labour reallocation, taking children out of school, diversifying household crop production and decreasing the area cultivated. In other studies (Rugalema, 1998; SAfAIDS, 1996; Webb, 1992; Barnett and Blaikie, 1992) the dominant coping strategies were, in order of importance, income diversification, reduced food consumption, use of savings and sale of assets particularly livestock and household goods such as bicycles and radios. UNAIDS (1999) reports the following common coping strategies:

2.6.1 Policy implications on strengthening the household's coping capacity

Several policy options arise out of the literature review that can be taken up to strengthen the capacity of rural households to cope with HIV/AIDS. Policy and programmes should seek to support households to overcome negative coping responses (such as withdrawing children from school) and reinforce households' positive responses. The overall aim of the policies and programmes should be to improve the short- and long-term well-being of the household in ways which do not create dependency, and to minimize the risk of household members being infected with HIV. This section presents a range of possible policy and programme options that can be adopted. There is need for country- and local-specific policies and programmes and the ones presented below merely give a broad indication of possible strategies that can be promoted to mitigate the impact of AIDS.

2.6.2 Improving agricultural production

Since most rural households are dependent on agricultural production for their livelihood (as a source of income and food), strengthening the household's agricultural production capability is one way in which the impacts of AIDS can be mitigated. Agricultural production ability of the household can be reinforced by improving their access to labour, land, capital, draught power, and management skills, promoting use of existing labour- and capital-saving technologies, and by developing technologies that can make optimal use of the available limited resources.

2.6.3 Promotion of existing labour- and capital-saving technologies

The technology is already available that makes optimal use of available resources and can be adopted by these resource-poor agricultural systems. This technology can be promoted by extension officers for use by AIDS-affected households. This technology includes:

- inter-cropping to reduce weeding time
- promoting use of high-yielding crop varieties which are not labour-intensive
- zero or minimum tillage to reduce the need for expensive ploughs and oxen
- promoting natural pest management, thus reducing the need for expensive chemical inputs, e.g. pesticides.

2.6.4 Technology development for resource-deprived households in the small farming sector

Agricultural research institutions need to consider the emerging technological needs of smallholder farmers resulting from the AIDS epidemic. In planning the technology that will lessen the impact of HIV/AIDS, it is important that the technology proposed should be based on an appropriate analysis of the local situation. The following techniques should assist households to maintain and improve production:

- selection of the appropriate variety of crop (e.g. early maturing, disease-resistant, easily threshed or pounded)
- improvement of existing inter-crops
- concentration on high-value food crops which are drought-resistant
- the introduction of farm equipment that can be used by the weak or by donkeys (e.g. lighter ploughs and planters and a modified hoe)
- improved indigenous technologies in mulching, inter-cropping, and seed selection
- improved technologies of animal husbandry, such as cattle dipping at individual levels.

2.6.5 Strengthening draught power and labour-sharing clubs

Draught power, labour-sharing and money-lending clubs help alleviate the major constraints of AIDS-affected households, which are labour, capital and draught power. Policy and programmes that support such activities will help affected households cope with the impacts of AIDS.

2.6.6 Implications of human resource losses

To reflect the change in the rural environment, all formal and non-formal rural development institutions need to review their human resource programmes and policies. It is important that institutions respond to the AIDS epidemic by planning for the impact on labour. The central responses to the AIDS epidemic must involve HIV prevention, prolonging life and reducing morbidity from HIV: this includes creating awareness and introducing prevention policies. There is a need to plan for skills, managerial and professional losses, and to introduce multi-skilling at all levels so that rural agricultural production does not suffer unduly.

2.7 Income-generation and diversification of source of income

Several studies have revealed that there are programmes which help improve and diversify the source of income of affected households help mitigate the impacts of AIDS. Such programmes help maintain household expenditure patterns and thus help the household avoid further losses in welfare. The programmes are as follows:

2.7.1 Improve households' income-generating capacities

The first line of response should be to mitigate the impact of AIDS on households by improving their income-earning capacities (Donahue, 1998). The aim is to maintain household expenditure patterns and promote savings. This can be achieved through micro-credit projects which are typically small, short-term and rapid turn-over in nature (such as handicraft production). Another response could be to increase the asset buffer of households by expanding their opportunities to own livestock and by protecting existing herds through good veterinary care (Sauerborn et al., 1996). For example in Uganda, Addo (1998) reported that under a project, trickle-up micro-

grants of US$ 100 were given to 30 families or a group of People living with HIV/AIDS (PLWHA) to finance non-capital-intensive income generating activities such as knitting, weaving, gardening and fish mongering.

UNAIDS (1999) believes that the economic empowerment can boost the morale of PLWHAs who have lost hope. Schemes to empower communities must specifically be targeted to women and youths who perform most of the caring work. There is need to encourage self-sustenance of such schemes through training the participants and recycling funds. Social assistance funds need to be part of a comprehensive national social policy, with well defined priorities and institutional co-ordination to ensure production of better designed projects that are sustainable. Short-term strategies do not address the most crucial problems, so there is need therefore for a combination of relief-oriented and investment-oriented strategies to ensure that, when the funds are finished, the projects can continue.

It is true that some households depend on casual labouring as a main source of income for the family. This in turn is dependent on the creation of employment opportunities in the area.

2.7.2 Promotion of income diversification

Promoting income diversification can strengthen households' coping capacities. Provision of wage employment may be a strategy to provide households with additional sources of income (Sauerborn et al., 1996). In risky agricultural climates, households with more diversified off-farm income are less vulnerable to food insecurity. Another strategy is to encourage crop diversification and promote a

reduction in external input requirements. Non-farm sources of income, particularly home-based income-generating and petty trading activities (after a sound analysis) are other options. Given the low success rate of income generating project (IGP) in many countries, these activities should be promoted with considerable care, planning and realism.

2.7.3 Schemes to finance health services

The introduction of prepayment schemes in which payments are collected after the harvest season to cover medical costs throughout the year (Sauerborn et al., 1996) could be recommended.

2.8 Reducing demands on women's labour

UNAIDS (1999) believes that there is a need to explore ways of reducing women's work burden, through the development of labour-saving methods of food preparation and improving access to water and fuel supply. Development and promotion of efficient stoves can reduce the time women spend collecting firewood; the time saved can be used to undertake productive activities such as harvesting, transport, storage, processing (particularly hulling and milling) and marketing of produce. In some areas the use of donkeys for transporting has helped women undertake other essential activities. Making more water points available reduces the distance walked to fetch water and can benefit women in a similar way. Some programmes aimed at providing substitute caregivers or child minders can free women to undertake other productive activities.

2.9 Improving the welfare of children in need

The effectiveness of most social programmes could be improved by targeting specific needy populations. It is only through targeted relief that desperate households can be reached. This means decentralisation and reformed screening techniques. Assistance in the form of education, health and nutrition can facilitate long term human development. One important aspect of social assistance is the fact that poor households which are not facing AIDS need the same type of assistance as their children are also malnourished and drop out of school. Equity can be achieved if the government targets social assistance to the most needy regardless of the immediate cause of their poverty. Thus, as suggested in reviewed literature (Over, 1998; Donahue, 1998), targeting of assistance should be based on both direct poverty indicators, not just the presence of AIDS in the household.

2.10 Community responses to HIV/AIDS

Most communities have developed a wide range of complex and innovative strategies to survive the adverse impacts of HIV/AIDS. The literature revealed that in many areas, communities have spontaneously joined together to support and assist families and children affected by HIV/AIDS. The paradox is that community-based responses may be the most cost-effective interventions while being the least visible (Hunter and William, 1997a). Even before the advent of HIV/AIDS, food security in sub-Saharan Africa was under threat (Kadonya, 1998). Droughts and floods are some of the disasters with which rural communities have had to cope. African families have shown resilience in coping with disease and illnesses (Barnett & Blaikie 1992, Sauerborn et al., 1996).

According to UNAIDS (1999) some community coping mechanisms are initiated from within the communities-one might refer to them as being indigenous or grassroots responses-and some are introduced into the communities and are financially supported by outside agencies such as NGOs, international development agencies, the government or churches. Depending on how communities are mobilized and how receptive they are to the initiatives, such projects can be successful and be sustainable when the donors withdraw.

According to the literature reviewed, e.g. Hunter and Williamson, (1997b); Barnett & Blaikie (1992); Sauerborn et al. (1996); Donahue (1998), different community initiatives have sprung up to support and mitigate the impact of HIV/AIDS. Reviewed studies show that people affected by HIV/AIDS access help principally from family, neighbours, community institutions and local informal organizations. The World Bank Kagera study in Tanzania found that families who lost breadwinners through AIDS reported that 90% of their material and other assistance came from family and community groups such as savings clubs and burial societies. Only 10% of assistance was supplied by NGOs and other agencies.

The major forms of community support and mitigation activities include the following:

- community-based child care: co-operative day care and nutrition centres to free women to work in or outside the home
- orphan support in the form of nutritional and educational support
- repair of deteriorating houses
- home care and visiting orphans and HIV/AIDS patients
- preparation and distribution of school uniforms

- apprenticeship and training in marketable skills for orphaned adolescents
- agricultural projects at various levels to increase output
- labour sharing
- income-generating projects to produce food and cash
- credit schemes for funeral benefits.

According to Altman (1994), community coping responses take the form of different organizational groupings, i.e. social support groups, informal associations, self-help groups, community-based organizations supported by external development agencies, and AIDS support organizations (ASOs). While the differences between the different groupings is not necessarily clear, the first three groups tend to be grassroots or indigenous responses to AIDS by the community, where membership is by choice rather than inscriptive and the groups attempt to solve social problems through local participation, social action, resource mobilisation and building a sense of community. The other two tend to be formal grassroots organizations which rely to some extent on external support from NGOs or other agencies who act as intermediaries in the development process in which some decisions may be made externally.

ASOs is a term developed by WHO's Global Programme on AIDS to describe all those organizations other than government which provide services related to HIV/AIDS. The following section will first present the role of the grassroots/ indigenous groups which do not depend on external sources of finance, and then that of the more formal groups which depend on external financial sources (Altman, 1994).

2.10.1 Informal grassroots community organizations

Different forms of informal and traditional grassroots social security systems have been in existence in many societies in developing countries for a long time. Examples of such organizations include social support groups such as burial societies, grain saving schemes and labour-sharing clubs, and savings associations such as rotating savings and credit associations. Operation of such organizations is not governed by any legislation. They operate in accordance with rules agreed by the membership (UNAIDS, 1999).

2.10.2 Social support groups

Lwihula (1998) in Kagera, Tanzania, indicates that most communities have social support groups organized by men or women or both. Members of such groups support one another in routine ways, for example, by helping cultivate one another's fields, and by contributing labour, food and money to one another in times of special need (such as sickness and funerals), or on special occasions (such as marriage ceremonies). The amount of assistance such groups can provide is very small and, in the case of a death, is limited to the period of mourning. Some social support groups are formed for specific activities, for example, burial societies, grain-saving schemes and labour-sharing schemes.

Madembo (1997) in Zimbabwe, and Rugalema (1998) in Tanzania, found that burial societies are established indigenous social support organizations that provide mutual assistance to members in rural areas in the event of death and illness. They offer a measure of financial security in the event of bereavement and also cater for some of the other social needs of their members. As part of the package, burial society

members also devote part of their time to assisting the bereaved by cultivating their fields.

Grain-saving schemes have a very long history in Africa's rural areas, and for many years have been used to cater for the requirements of people in the community. In Zimbabwe, Madembo (1997) and Ncube (1998) report that grain-saving schemes have been revitalized as an adapted form of the traditional system of zunderamambo (literally, the king's field) in which people in a community would contribute labour in the field of the chief or headman, and store the produce for when it was needed. In Zimbabwe, these grain-saving schemes have formed an important source of community support to affected households.

Rugalema (1998) in Tanzania, SAfAIDS (1998) in Zambia; and Ncube (1998), in Zimbabwe, found free community labour-sharing to be a common community coping response adopted by communities to help support affected households. In Zimbabwe, these labour-sharing schemes (nhimbe) have been in existence for a long time and formed a major source of social security for households in times of disaster.

2.10.3 Indigenous savings associations

Lwihula (1998) in the Kagera area, Tanzania, Ncube (1998) in Zimbabwe, and SAfAIDS (1998) in Zambia, found that many communities have indigenous savings clubs which play a major role in helping households cope with the HIV/AIDS epidemic. The major forms of indigenous community savings association are the rotating savings and credit associations (ROSCAs), and conventional savings clubs.

Madembo (1997) indicates that ROSCAs have been in existence for a long time in many African countries. A ROSCA is a group of people who agree to make contributions to a fund which is given in whole or in part to each contributor in turn; each member makes the same contribution. After everyone has had their turn in receiving the contributions, the group may disband or start another cycle. Among rural people, the contributions are either in cash or in kind (e.g. food, agricultural inputs, kitchen utensils, etc). Madembo emphasizes that ROSCAs are popular because they impose few transaction costs on members, they build mutual trust, they provide insurance and reciprocity that can be called upon in times of emergency, and they give members access to a relatively large amount of money that would otherwise be difficult to accumulate. In Cameroon, the ROSCAs have a social fund which provides life and health insurance to members (Kaseke, 1997). This is done by placing part of the contributions in a fund to be accessed as grants or loans in the event of death or sickness of members or their dependants.

In addition to ROSCAs, savings clubs are an important informal source of finance for rural households during emergencies. The funds are usually used for buying agricultural inputs such as seeds and fertilizer, for paying school fees, for buying clothing or are reserved for eventualities such as medical treatment, births and deaths. The funds can also be used as working capital in small enterprises and for starting up income-generating projects. The use of savings as security against low and uncertain incomes is the prime motive for participating in savings clubs. Most rural farmers receive their income only once a year: the savings club pool offers

finance after the marketing of agricultural produce and so acts as a buffer during difficult periods (UNAIDS, 1999).

According to Madembo (1997) members hold a pre-savings meeting to decide what they want to save for during a twelve-month period; they then decide on their requirements for seed, fertilizer and insecticides, which are ordered in bulk to benefit from quantity discounts. Zimbabwe experienced severe droughts in the 1991/92 and 1994/95 seasons; Madembo (1997) observed that many savings club members were able to keep their children in school and also start their new investments more quickly after the rains had come, because of their prudence and the self-help orientation of their clubs. Savings clubs thus play a vital role, both directly and indirectly, in meeting the social security requirements of communal farmers.

2.10.4 Indigenous emergency assistance associations

The World Bank-sponsored Kagera household demographic study in Tanzania found that, in addition to the pre-existing traditional saving and mutual assistance associations, the inhabitants of many villages, particularly in the hardest hit areas (Bukoba rural, urban and Muleba districts), had launched new organizations specifically in order to cope with the costs of the AIDS epidemic (Lwihula, 1998). Lwihula's major findings, based on focus group discussions, reveal that:

- Traditional savings and mutual assistance associations already existed but specific organizations had sprung up in villages hard hit by the AIDS epidemic, especially among the Haya and Nyambo.
- Even households that had not yet had a member die are participating in these

- organizations to insure themselves because of anticipated deaths in future.
- The associations are mostly run and organized by women.
- These associations have a wide range of specific objectives and agendas (e.g. coping with crisis and burial ceremonies, and communal farming activities).
- Assistance associations among the Haya and Nyambo have regularised assistance practices (e.g. monthly meetings and contributions as insurance for imminent deaths).

Barnett and Blaikie (1992) found that informal women's counselling groups and impromptu meetings had sprung up, where women assist each other in the plantations, caring for the sick and relieving the care giver (**see example 1**). Neighbourhood women will appear unannounced to weed and trim the banana gardens of a woman who is ill. They have persuaded the local Resistance Councils to solicit outside help for the orphans and some have assumed the responsibility of caring for them in their homes. Informal counselling sessions enable women to share their experiences and concerns and keep them sane. (Barnett and Blaikie, 1992) There is need for public space for women since it is felt that most of the public spaces available belong to men.

Example 1: Mothers' Unions in Zimbabwe

"Many religious denominations in Zimbabwe have women's sections known as the Mothers' Union. They are guided by the principle of providing spiritual, economic and social support to those facing economic hardships. The members contribute a certain amount of money each month and the benefits range from financial

assistance during funerals and weddings to visiting the sick, praying and counselling. These women's groups have been very active in taking care of children whose parents are dying of HIV/AIDS-related illnesses" (Gumbo, 1998).

2.10.5 Self-help groups of people with HIV/AIDS

UNAIDS (1999) indicates that in a number of African countries, AIDS organizations formed by infected and affected people play an increasing role in the response to the epidemic although the number of PLWHA involved is still tiny compared with the full scale of infection. In reality an estimated 90% of the population do not even know they are infected and of those who do know, the majority try to keep their HIV status private and do not join open PLWHA groups. In Côte d'Ivoire, the country with the highest prevalence of AIDS in western Africa, two self-help groups (SHGs) of people with AIDS were created in 1994. In other parts of Africa, some of the motivations to belong to a SHG of PLWHA are: the search for psychological, social and material support and the need to avoid stigma. Self-help groups play an important social role which includes:

- provision of services to other PLWHA;
- acting as an intermediary between PLWHA and relatives;
- HIV prevention and mobilisation among non-infected and non-affected people;
- division of labour with health care professionals;
- lobbying and advocacy (interactions with local authorities, international organizations and donors).

According to UNAIDS (1999) SHGs of PLWHA in Côte d'Ivoire and elsewhere are a collective response to an individual crisis, providing psychosocial support to people who very often are, or feel, socially rejected. Self-help groups in general have to cope with cultural and organizational problems and economic problems, as they may have little funding. A further source of that tension is that most members are poor and SHGs are regarded as a source of income. Indeed the motivation to join is often primarily an economic one, rather than a collective response to human rights violations.

It is noticeable how few middle class, affluent or professional people are active in HIV/AIDS support groups in most countries. An exception is South Africa, where NAPWA, the National Association of People with HIV/AIDS was initiated by relatively affluent gay white males, although its membership is changing. In 1998, an organization for women with HIV/AIDS was initiated by Mercy Makhalamele called Women Alive National Network (WANN). This network seeks to respond to the cultural, socioeconomic and psychosocial needs of disempowered and often impoverished women and their dependants (UNAIDS, 1999).

At the wider level, African Chapter of GNP+, the Global Network of People Living with HIV/AIDS, is based in Nairobi. Called NAP+, the Network of African People Living with HIV/AIDS, this body tries to support the role of national networks in advocacy for human rights of people with HIV (UNAIDS, 1999).

In Zimbabwe, The Centre was established in 1994 by PLWHA to promote counselling and health services and assist the emergent Zimbabwe National

Network of People Living with HIV/AIDS (ZNNP+). Now ZNNP+ has hundreds of members in support groups across the country and, as in South Africa, an independent network for women is being formed to address their needs (UNAIDS, 1999).

According to UNAIDS (1999) the informal groups do not generally have documented records of costs or effectiveness, but they tend to have lower transaction costs because they are more informal, based on mutual understanding and involve less paperwork and organizational costs. These groups can be a major source of support in communities experiencing the impact of the AIDS epidemic by providing important inputs to agricultural production, such as labour and capital and food needs. Besides material support, these informal groups are a major source of psychosocial support.

UNAIDS (1999) believes that as the number of AIDS-related deaths increase, these existing local strategies are increasingly under pressure and there is need to design policies and programmes that are capable of providing support when existing strategies become inadequate. The literature reviewed did not provide extensive empirical information on what proportion of PLWHA are members of SGHs or to what extent they can cope before they collapse. Some authors (Webb 1995; Sabatier 1997) indicate that some communities are failing to cope, particularly as far as absorbing AIDS orphans. This is particularly true in communities where the number of orphans has rapidly increased to levels which tend to overburden the community's capacity. Drought and economic decline are factors that weaken communities' coping capacity. However, the exact threshold level when a community

starts to feel strained is not known, neither is the type of coping capacity that gives in first. This is an information gap which warrants investigation.

2.11 Formal community-based organizations

Many of the community-based programmes assisting those affected by HIV/AIDS are developed and run by community-based organizations (CBOs). These organizations generally aim at being democratic, to represent the interests of their members, and to be accountable to them. They are formed as a response to shared experiences. In some areas where inter-household cooperation has not been the norm, NGOs have assisted the development of self-help groups which are a form of CBOs. They are usually local but can spread and grow into networks of grassroots organizations. In 1993 the United Nations Development Programme (UNDP) estimated that there were at least 100 000 CBOs worldwide (Hunter and Williamson, 1997b).

UNAIDS (1999) states that agencies working with CBOs and ASOs in some countries include Action Aid, Inter Aid, PLAN, SIDA, HIVOS, GTZ, DANIDA, OXFAM, European Union, Catholic Relief Services, CIDA, NORAD, UNICEF, USAID, Red Cross and World Vision, CBOs and ASOs. Activities vary from country to country, ranging from home-based care through psychological support to material assistance. In the rural areas of southern Uganda, World Vision has encouraged the formation of small self-help groups engaged in agriculture and off-farm income-generating activities such as handicrafts, bee-keeping, carpentry, tailoring, and building construction.

According to UNAIDS (1999) in Kagera, Tanzania, WAMATA (a voluntary non-profit grassroots survivor assistance organization) is open to anyone who either has HIV/AIDS, or has helped to care for a relative or friend with the disease. Members contribute small amounts of money and food for some of the most needy AIDS-affected families, carry out house repairs and bring medical supplies from the local dispensary to the bedridden. However such programmes have limited local resources for sustainable services, and need external assistance in the form of food supplements, school fees, uniforms, clothing and bedding and revolving funds to enable AIDS-affected families to start schemes such as vegetable production, raising poultry and cattle, carpentry and tailoring.

In South Africa, the Society for AIDS Families and Orphans (SAFO) was formed in Soweto in 1992 to provide care and support to affected families (Gilks et al., 1998). Many CBOs depend on a number of volunteers and a few paid staff.

According to UNAIDS (1999) some CBOs have grown to become NGOs, for example The AIDS Support Organization (TASO) in Uganda. TASO started off as a small community-based organization in 1987 in Kampala, today it has expanded to six sites covering the south-eastern part of Uganda and servicing both rural and urban areas with a staff of 150 and 2 000 volunteers. TASO provides a range of services which include counselling, day-care centres for children, treatment and care, home-based care, social support such as school fees for needy children and income-generating activities such as sewing, pig-farming, and banana and vegetable cultivation. In the evaluation of TASO in 1994, treatment and care (including counselling and nursing care) were cited as the most helpful TASO services by 86%

of the 619 interviewed clients, 10% indicated social support and 4% indicated other services (TASO, 1994). Its main sponsors include Action Aid, DANIDA, USAID, DFID and Australian International Development Agency Bureau.

Although it should be easier to obtain the costs and the cost-effectiveness of community based organizations that are supported by external development agencies since they are more formal, this proved to be a difficult task. The 1994 evaluation of TASO provided no information on costs or cost-effectiveness of TASO activities. The 1998 evaluation of Action Aid's Strategies for Action community-based programmes in Uganda and Malawi also provided no information on costs or cost-effectiveness of the community-based support activities (UNAIDS, 1999).

2.11.1 Child and orphan support

According to UNAIDS (1999) the two main forms of support to orphaned children in especially difficult circumstances are institutional support such as orphanages and traditional fostering and adoption by relatives and the community. The following section first discusses programmes that are aimed at strengthening traditional fostering and care by the extended family and the community, followed by those that support institutional support programmes.

Webb (1995) believes that traditionally it is assumed that the extended family and the community at large assist the household socially, economically, psychologically and emotionally. This is a common practice in most parts of eastern and southern Africa. As more households are affected by the AIDS epidemic, the literature indicates that some communities are failing to absorb all orphans from AIDS

because of lack of resources, urbanisation and migration. This failure is seen, for instance, in the existence of unsupported child-headed households or, in the World Bank Kagera study, of the disappearance of some households. Nevertheless many community-based orphan support organizations have been initiated as the number of orphans increase.

The development of orphan and child care support in the community is illustrated by case studies from Malawi and Tanzania **Example 2**. Where orphans do not have any extended family safety net, residential institutions or orphanages are a last resort to meet their requirements. Orphanages may be run by community churches, particularly for the under-threes, or by NGOs, government, or private individuals. As the number of children orphaned by AIDS increases, the demand for orphanages may well increase (UNAIDS, 1999).

The review revealed that orphanages are unlikely to be sustainable on financial grounds because of the heavy, long-term burden which they place on the Department of Social Welfare or other organizations responsible for running them. According to Over (1998), the cost of supporting a child in an orphanage was about eight times the cost of support in a foster home. The demanding nature of caring for infants necessitates lower child: care giver ratios in infants' homes (Powell et al., 1994). This Zimbabwe national survey of formal children's homes found that infants in homes are at a great risk of recurring infections. Powell report states that a survey of two homes with a total of 100 infants revealed that 42 infants had been admitted into hospital once and 26 had two or more admissions. It is also clear that such

orphanages are rarely in the best interests of the children, either on economic or social grounds.

Example 2:

In Malawi, the COPE programme of the Save the Children Federation USA, also stands as an example of projects designed to strengthen community capacity. The purpose of the COPE intervention is to mobilize community action to mitigate the impact of HIV/AIDS on families and children. The first phase involved setting up the programmatic strategy, which involved formation of community care coalitions that united government, religious leaders, business, community elders and other stakeholders to respond to needy families' health, psychological and economic requirements. The second phase of the programme involved strengthening the capacity of the coalitions to identify and mobilize internal resources, access external resources and organize the CBOs that would drive the initiative forward (Krift and Phiri, 1998).

In Kagera region, Tanzania, 12 community based and international NGOs assist about 47% of all orphans. External aid seems to create some degree of dependency: people or communities are likely to wait for external NGOs to come to their aid. The UKIMWI Orphan Assistance project provides limited assistance to communities to help them solve their own orphan problems. Family and community resources are mobilized, primarily to increase food production, this includes cultivation of plots and keeping two cows, and bananas/coffee cash crop farming. Other activities include organising community support to carry out housing repairs for orphans, providing school fees for a number of orphans, medical assistance for orphans, and income-

generating activities for women's groups or female orphans (tailoring, needlework, basketwork and so forth) (Ng'weshemi et al., 1997).

2.11.2 Income-generating projects (IGPs)

According to UNAIDS (1999) local and internationally funded NGOs strive to improve the income of community members through supporting income-generating projects which will mitigate the effects of HIV/AIDS. NGOs can work through CBOs and offer assistance to either group IGPs or individual IGPs. In Uganda, CBOs with group IGPs supported by Action Aid tend to comprise members with distinct characteristics (e.g. widows, PWAs and women). On the other hand, individual IGPs are operated by individuals in the CBO Asingwire and Muhangi (1998) evaluated five CBOs directly supported by Action Aid Uganda which included NACWOLA, GASCO, TASO Kumi, STOGA and KISA.

Evaluation findings by Asingwire and Muhangi (1998) indicate that the rabbit rearing IGP does not seem to be a worthwhile venture for PLWHAs. NACOWLA is a national NGO formed in 1991 by women living with AIDS. At the time of the evaluation by Asingwire and Muhangi (1998) the IGP had been in existence for about 10 months, and no member had yet benefited in terms of income although they had expended time, money and labour on rearing the rabbits. Despite this limitation, there were some advantages in that the group offered strong psychosocial support to people living with HIV/AIDS.

The goat-rearing scheme operated by TASO-Kumi was found not to benefit PLWHAs

either, because of the nature of the project. It takes two years before a PLWHA can profit from the sale of the goats, and as beneficiaries received very young goats this placed a heavy burden on the PLWHA raising the goats. Many PLWHAs might be ill or dead before realizing a profit.

The KISA revolving fund scheme was a failure because the loans were too thinly spread among many members. However, the fund in STOGA was a success story which provided important lessons for other CBOs. Members of STOGA agreed not to spread the loan too thin by adopting a formula of just a few initial grants. These few members, all women, were able to return the loan instalments in time for the other members to get their turn. In addition, the group has a drama outreach programme which earns some money, which is shared. If a member completely fails to pay, she gets less during the share out as the rest is retained to recover the defaulted amount (UNAIDS, 1999).

In their findings Asingwire and Muhangi (1998) found that group projects tend to have problems as no one was specifically responsible for projects. Group projects should nevertheless be encouraged among PLWHAs because of the satisfaction they derive from the projects and the benefit they receive from meeting together and sharing their experiences. Asingwire and Muhangi (1998) recommend that individual IGPs should be encouraged among people who are not PLWHAs. Individuals are in a position to monitor themselves and are more likely to offer total commitment to their own projects rather than that of a group. Experiences of IGPs in Malawi are similar, as shown in **Example 3**.

In Uganda, one scheme, the “Zero Grazing Heifer Project”, provided families with an expectant cow, so that they could benefit from the milk production. The family fully own the cow after it has given birth to a female calf which is taken away to continue the cycle. While the project was a success under loan circumstances, an indivisible item such as a cow may actually increase the vulnerability if the recipients are forced to make a distress sale when faced with calamity (Kezaala and Bataringaya, 1998).

Example 3: Action Aid’s experience with income-generating projects in Malawi
In 1996 Action Aid Malawi established a pilot project targeted at orphans, the chronically ill and people living with AIDS. With funding from UNICEF, Action Aid provided capacity building to CBOs to facilitate the formation of functional revolving savings and credit schemes (Khonyongwa,1998).

Achievements of the project objectives included reaching 3000 orphans in 756 households, benefiting 62 people living with HIV/AIDS who have received funds to run IGPs, and management and IGP training for the volunteers managing the support groups. The major problems experienced included complaints that the loans were too small for the type of business that some of the beneficiaries wanted to venture into, and some of the beneficiaries did not have enough skills to run IGPs but have now gained some knowledge and skills (Khonyongwa,1998).

In rural areas of Zambia, coping strategies are related to farming activities and brewing beer. Because of poor markets there is less buying and selling of commodities. Community small-scale agricultural schemes are managed with the

profits going to those most in need, as identified by the project committee (Webb, 1995).

In their Mpongwe field study in Zambia, FAO found that livestock loans are an important intervention that strengthen household and community coping responses, especially for women. Microcredit is deliberately packaged to attract female clients, because they have shown better repayment rates worldwide (Hunter and Williamson, 1997b). Experience has also shown that women are more likely to use their income to help meet children's immediate needs.

There were no documented costs and effectiveness of income-generating projects in the literature reviewed. Evaluation of income-generating projects by Asingwire and Muhangi (1998) in Uganda in 1998 did not document any costs and effectiveness of the IGPs. According to Sabatier (1997), AIDS NGOs have poor economies of scale and administrative and overhead costs take up the biggest part of their budgets, sometimes resulting in less than 20% of the budget actually reaching the intended beneficiaries. This has been found to be true for highly personalized support such as home care (considered in the next section), counselling and crisis support. Having the programmes more community focused makes the projects much cheaper and more effective. A similar lack of data has been found in the literature with NGOs involved in mitigation work. Some particularly group-oriented types of income-generation projects have been reported to offer more psychological benefits than material ones. IGP schemes were shown to improve self esteem as members were too busy to indulge in self-pity (Julian et al., 1996).

Some studies emphasise the need to evaluate carefully the relevance of any income generating projects before they are introduced to the community to see whether they are relevant to community skills and resources. Evaluation of a vanilla agricultural project in Mukono district, Uganda, revealed that the project was not viable owing to the lack of a market (Kezaala and Bataringaya, 1998). Lack of relevant skills and knowledge was identified in several studies to be the major reason for failure. .Good intentions, a small injection of capital and a few quick lessons cannot turn out successful tailors, poultry farmers and bakers (Jackson and Civic, 1994).

2.12 Treatment and home-based care programmes

According to UNAIDS (1999) home-based care programmes for people with HIV/AIDS or integrated with other health needs are rapidly expanding in sub-Saharan Africa as a response to HIV/AIDS. This is because of the inability of hospitals and other formal health institutions to cope with the increased demand at the same time as their real budgets are in decline because of economic structural adjustment measures. At its worst, home care equates to home neglect, but at its best, it helps patients live through their illness and die in some dignity and comfort in familiar surroundings with their family around them. They and others (e.g. Woelk et al., 1997) note that the key difficulties facing home care concern costs and long-term sustainability, quality of services, and coverage. Foster and Makufa (1998) estimate that in the best schemes, under 10% coverage is likely to be achieved, and it is often less. The first home-care programmes in Uganda, Zambia and Zimbabwe were developed by hospitals but it was found that 75% of the hospital staff time was spent travelling to patient's homes in the rural areas which were very costly for the hospitals.

The WHO-sponsored study of 1993 (WHO, 1994) in Zambia found out that the average cost of a home visit by a three-person team was US$ 26, and concluded that home care was a costly, capital-intensive service but that it could become more efficient if communities were allowed to play a major role. In a different study Gilks et al., (1998) also concluded that hospital-run home-based care units were not cost-effective since they were expensive and could not cover all the those in need. In the early 1990s, hospital-based home-care programmes began to work more closely with community based volunteers from churches and other social groups. The community home-based programmes, which involve local volunteers in home visits, are more cost-effective and the community-based teams are able to spend more time with patients than hospital based teams.

The home-based care study in Zimbabwe by Woelk et al., (1997), albeit based on a small and not necessarily representative sample, found the cost of community home-based care to be substantially higher in rural areas than urban areas, mainly because of increased transport costs (US$ 42 per visit in rural areas compared to US$ 16 per visit in urban areas). Salaries and transport costs accounted for the greatest part of the costs (ranging from 78% to 90%). The authors concluded that it is essential to increase the involvement of communities and to develop the sense of community ownership of programmes so as to minimize costs.

UNAIDS (1999) points out that many community home-based care programmes take the form of medical and nursing care, material assistance, as well as emotional, spiritual and social support. However, there is a basic assumption that resources will be available to meet the drugs and material requirements. This might not be the case

in resource-poor rural areas and might be a major obstacle for the functioning of the community home-based care programmes. Another major obstacle is when the number of people requiring home-based care rises to levels that outstrip the capacity of the community home-based care service.

Gilks et al., (1998) indicate that costs for the Chikankata home-based care programme in the rural area of Zambia were about US$ 1000 per client served. The largest costs were transport costs. Chikankata hospital is a Salvation Army supported hospital, serving a rural population of about 100 000 people. In comparison, the costs of the Catholic Diocese Copper belt home-based care programmes in Zambia are modest in relation to the number of beneficiaries. An analysis of programme costs (excluding orphan support) in the township of Ipusukilo over a 24-month period in 1996.98 found that the average expenditure per month was US$ 2216 for 400 patients, or 3600 people including household members. The largest single item was welfare support (food, clothing, blankets, bed sheets) for families which accounted for 39% of money spent, followed by drugs and equipment which accounted for 21% (Blinkhoff et al. 1999).

2.13 Changes in cultural norms and values

In the African context, as more and more people die of AIDS, communities have to forgo traditional mourning practices. Many communities today do not have the human and material resources to continue culturally prescribed rituals and rapid adjustments have had to be made. African funeral rituals usually involve bringing the body into the home for at least one night, washing it, a public viewing, a graveside service, a big meal for the mourners and a week-long period of mourning in which

friends and relatives sleep in and around the house of the deceased (McNeil, 1999). Several studies indicate that periods of mourning have been reduced from seven to two or three days for an adult and from three to two days for a child (Lwihula, 1998; SAfAIDS, 1996; Kilonzo and Hogan, 1996). In Uganda, the custom of showing respect when a neighbour dies by not working in one's garden for four days has been dropped. "You cannot afford to do that now or else you will have no food"-Dr D Kabatesi, head of the Theta AIDS-education Project (McNeil, 1999).

In a study undertaken in Zambia by SAfAIDS (1998), ritual cleansing involving sexual intercourse after a woman is widowed is now on the decrease, more so if her late husband's cause of death is suspected to be AIDS. Instead ritual cleansing now involves putting a beaded ring around the waist of the widow, and smearing her with mealie meal. The widow should not get married or have sex, lest she dies or goes mad, until the ring drops off on its own. Some communities have made efforts to protect the property and inheritance of widows and children from being appropriated by the family of the deceased spouse by working together with community leaders.

2.14 Policy implications on community coping responses

According to UNAIDS (1999) rural communities that are coping with increasing losses due to HIV/AIDS draw on the existing family and community for support. They are sharing their experiences of how to cope with HIV/AIDS losses with other communities. Service organizations and NGO support help bring in resources that are required particularly for treatment and home-based programmes. The literature has shown how people are mobilizing themselves using traditional and modern

systems of care in order to provide support to the sick and the disadvantaged in their communities. People living with HIV are playing an increasing role in the community.

The report indicates that the outstanding strengths of traditional grassroots community responses are that they cost less, are based on local needs and available resources and the mutual understanding of community members. The main limitation of these grassroots initiatives is that they do not generate enough resources to buy drugs and other treatment and care requirements, so their support in this aspect is rather limited. In addition they may place a heavy work load on women who already work long hours.

According to UNAIDS (1999) the literature has shown that, as the numbers of AIDS-related deaths increase, the existing community strategies are increasingly under pressure. This observation underscores the importance of closely monitoring the coping capacity of communities so that policies and programmes can be designed that provide support in strategic ways to maximize the effectiveness of local initiatives and help them to continue. External support by health planners, policy makers, donors and NGOs should support community-rooted initiatives and not replace them. The need for sustainable approaches that can reach the growing number requiring support and ensure a basic quality of service makes it essential that effective community mobilization and development form the cornerstone of strategies for care. HIV prevention efforts should be an integral element of these strategies if the emphasis is on openness and community recognition and ownership of the problem. This also requires the creation of a non-discriminatory legal and

human rights framework in which people with HIV/AIDS feel secure in disclosing their situation.

The community-based programmes that are dependent on external support have been very responsive to the needs of those affected by AIDS. The responses supported by such programmes were much wider and more holistic than others and included support to orphans, improved life skills such as training youths, home-based care (nursing care and drugs), income-generating projects and counselling. However, such programmes also have limitations which include poor organizational management skills; lack of adequate funding and technical support to sustain the project when the donor pulls out; poor targeting of support; founder's problems; and, sometimes when the programme is church-funded, discrimination against non-members. Some policy options arise out of the literature review that can be taken up to strengthen the capacity of communities to cope with HIV/AIDS. This section presents a range of possible policy options that can be adopted (UNAIDS,1999).

2.14.1 Enhancing and mobilizing community capacities

As indicated in an earlier section, families depend on the extended family, neighbours and informal community groups for much of their support. It is important that programmes and policy aim to enhance and mobilize capacities that exist within communities. The pandemic is placing enormous strain on the traditional coping mechanisms of the extended family, steadily eroding the extended family's capacity to care for those suffering from or bereaved by HIV/AIDS. According to a 1997 study by McKerrow in Zimbabwe on the willingness of communities to absorb orphaned children, families are more willing to care for orphans if some form of support is

offered, for example free education, free health care and food supplements. It is therefore important that programmes and policy are aimed at enhancing and strengthening the traditional coping responses of extended families and their communities (UNAIDS, 1999).

According to UNAIDS (1999) NGOs and CBOs can greatly increase the effects of their resources by facilitating and strengthening the autonomous AIDS responses of communities, rather than attempting direct provision of services. This can be achieved by supporting activities that are owned by communities such as child care, non-formal education and labour sharing, providing programme ideas and seed funding to community groups, by supporting informal societies so that they can expand to bring in new members and by building community capacity to undertake these responses through the provision of training and technical assistance to community volunteers. Churches and women's groups are willing to help but lack the resources and skills to make orphan visiting programmes work (Foster and Makufa, 1998). However, before making any intervention an external change agent (whether it be government or NGO), should conduct a thorough situation assessment to determine community needs and survey the existing responses. The change agent should build on existing responses to the crisis, seeking to strengthen and not to replace or eliminate initiatives already underway.

2.15 Strengthening community responses

Community responses to AIDS can be strengthened in a number of ways. These include:

- the democratization and localization of resource allocation;
- reinforcement of the management skills of CBOs;
- training on project design, planning, management, monitoring and evaluation;
- the establishment of a forum for NGOs and CBOs to exchange their views and experiences;
- building links between donors, NGOs, CBOs, and the government.

Again, sound community mobilization and development strategies including participatory rural appraisal (PRA) are essential (UNAIDS, 1999).

2.16 Mitigation support

In a survey of 75 NGOs in six selected countries in sub-Saharan Africa (Cameroon, Côte D'Ivoire, Kenya, Tanzania, Zambia and Zimbabwe), the United States National Research Council found that, while on average 65% of the selected NGOs indicated AIDS prevention as one of their goals or objectives, only 32% mentioned mitigation of the impact of AIDS as their goal. Of the NGOs who did, the breakdown of the mitigation interventions provided for all countries was: counselling 50%, community awareness 11%, economic assistance and self-help projects 34%, and training 5%. These results suggest that mitigation is not receiving the support and attention that it deserves. Particularly in some hard-hit countries, increasing numbers of households require mitigation support (UNAIDS, 1999).

According to UNAIDS (1999) the literature review revealed that there is a need to have a combination of relief and mitigation activities. Even in a community with very low HIV/AIDS prevalence, there is a need to set up mechanisms to respond to locally

identified determinants that may increase vulnerability to HIV/AIDS and to work towards strengthening community responses to reduce that vulnerability. Of major importance is the issue of timing of support to strengthen household and community responses. Affected households which are failing to cope because of the youth of the head of household or the lack of land or other basic assets need relief support to help them from entering permanent destitution. Once signs of recovery appear, relief support can be gradually replaced with mitigation support for longer-term needs. The emphasis should be on helping families avoid jeopardizing long-term survival to meet short-term needs, the most obvious examples being withdrawal of children from school and sale of remunerative assets.

According to Donahue (1998) communities are best placed to identify needy families, vulnerable children and orphans. There is need, therefore, to involve communities in developing systems to enumerate and assess the needs of families and children, to determine the extent of problems, to raise awareness, and to promote informed decision-making. Communities are also best placed to monitor and maintain contact with children, supervise their activities, and prevent child labour abuses. Support is more effective when channelled to the poorest families and orphans to prevent them from falling into permanent destitution. Given the large and growing numbers of orphaned children where the epidemic is mature and severe- and the poverty prevailing in many countries-it is important that countries develop an orphan policy that seeks to integrate orphans in national development. Orphan policy will help collaborating organizations identify and target resources to affected children, monitor their progress and protect their rights.

2.17 Conclusion

The literature reveals how household members cope with HIV/AIDS family members. There are many coping strategies used in study including income generating projects, treatment and home-based care programmes, formal community- based organizations and community response to HIV/AIDS. The literature also reveals that HIV/AIDS has negative impact on household members. The following chapter sets out the methodology used in the study, data collection and data analysis that will be used in the study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

The research design and methodology will be discussed in this chapter. The unit of analysis, methods of data collection and management are included. This chapter also deals with the issues of focus group discussions and the researcher.

The aim of the research is to investigate the economic impact of HIV/AIDS in KwaDlangezwa area. Attention will be focused on how HIV/AIDS affect the household members with regard to size of the household, income level, savings, assets, expenditure and borrowing. In this chapter therefore, the issue of research design, unit of analysis, methods of data collection, procedure of the research will be discussed.

3.2 The Research Design

This research uses the combination of both the qualitative and quantitative approach. Sarantakos (1998) and Scrimshaw (1990) are in agreement that the combination of the two methods above will give a good result. According to Naraman (1995) the qualitative research method directs one towards gaining an understanding of the meaning of people's everyday lives from their own point of view. Qualitative research therefore provides detailed descriptions of the particular social settings under investigation and also an explanation of the behaviour that occurs therein.

Open-ended questionnaires have been used to collect data from KwaDlangezwa community. There were structured and informal sets of interviews that were used to

cover the household structure, income, savings, assets, expenditure and borrowing, and household coping strategies. The combination of the two methods was used to gather information and data on households. The key informants were interviewed and focus group discussions were used to collect the qualitative data.

3.3 Research Hypotheses

The study tests the following hypotheses:

Aids has massive economic impact on families infected and affected by HIV/AIDS. At the level of the household, AIDS results in the loss of income, assets, savings and an increase in spending on health care by the households.

3.4 Unit Analysis

The unit analysis in this study is the household. According to Lipton and Ellis (1996) household is made up of both resident and migrant components consisting of the members that do things together as a unit. Household in this study is viewed as the set of people who do and have things in common. According to Rudie (1995) household is family members who live together with many things in common. The households are closely related to one another. Some of them might even be migrant members who contribute to the welfare of the household.

3.5 Method of Data Collection

The data collection method includes interviews with some key informants in the area of KwaDlangezwa. Open-ended questionnaires will be given to the persons concerned and form the major source of collecting information from the community. Data was collected from a focus group by constructing a semi-structured interview

schedule based on data gained in the literature review. A focus group is a form of qualitative research in which a group of people is asked about their attitude towards a product, service, concept, idea, or packaging. Questions are asked in an interactive group setting where participants are free to talk with other group members (Weston, 2006).

The results of the focus group interview will be analyzed and interpreted. They will then used to develop additional questions for the questionnaire. The focus group was seen as a useful addition to the study in that it generated themes and ideas for additional questions used in the survey. Participants completed informed consent forms indicating their willingness to be part of the focus group.

3.6 Research Participants for the Focus Group (Sample)

The researcher selects the sample based on his or her judgment. This is usually an extension of convenience sampling. KwaDlangezwa household members were asked to participate in the focus group discussion. This non-probability method is often used for research as it is a practical, cheap and convenient method of acquiring a sample. It was alleged that KwaDlangezwa households would have a suitable frame of reference in terms of HIV/AIDS knowledge and also the participants form part of HIV/AIDS volunteers in this community to be able to add value in helping generate relevant qualitative questions for the survey. Only females participated in the focus group. Their aged varied between twenty five and thirty three years of age.

3.7 Survey Research Participants

Three hundred survey questionnaires were handed out to KwaDlangezwa households. Only 299 were collected from the participants. KwaDlangezwa falls under uMhlathuze Municipality. The study shows that the City of uMhlathuze had an estimated 75 000 households and a total population of about 332 156 in 2007. This makes the average household size 4.4 persons per household. More than 40% of the residents in the municipal area reside in the non-urban (rural and tribal authority) areas outside Empangeni and Richards Bay, which is indicative of a densely populated rural area (City of uMhlathuze draft report, 2007).

3.8 Data Collection Methods (Survey)

Questionnaires were drawn up with a cover letter emphasizing the fact that involvement in the survey was voluntary and anonymity and confidentiality were ensured. An initial pilot questionnaire was used to assess the validity of the questionnaire. This questionnaire did not change after being piloted. After the questionnaire was piloted permission was asked from KwaDlangezwa local community leaders for questionnaires to be distributed and answered if possible or collected the following day. In total two hundred and ninety nine questionnaires were returned which was the final sample.

3.9 Data Analysis from the Survey (Quantitative)

The household questionnaires were administered as planned and analyzed based on the notes and information gathered during the interviews and focus group discussions. The assistance of a statistician was required to analyse the data. Both the qualitative and

quantitative data collection will be analyzed. Next chapter provides an analysis of the results obtained.

CHAPTER 4

RESULTS AND ANALYSIS

4.1 Introduction

This chapter focuses on the results and analysis produced by the study. The research aimed to investigate the economic impact of HIV/IDS on the KwaDlangezwa households. It focuses on impact on the size of the household, income, expenditure, assets and borrowing patterns of the KwaDlangezwa households.

Three hundred questionnaires were handed out and two hundred and ninety nine were returned which constituted the final sample. The focus group results are presented first. The thoughts and themes that emerged during the focus group discussion are summarized according to themes.

4.2 Qualitative Questions and Results from the Focus group

4.2.1 Knowledge of AIDS and causes of AIDS from the focus group

All the participants have the same knowledge about AIDS. They all believe that it is a human destroyer and it leads to death. They also believe that there are many causes of AIDS, the participants had different views on the causes of AIDS. About 57% of the participants believe that sleeping around without using a condom causes AIDS. Whereas only 42% believe that having multiple sexual partners causes AIDS and 29% believe that unfaithfulness among married couples and between lovers are the main causes of AIDS. All the participants agreed that it is not easy to see that someone has the virus that causes AIDS.

4.2.2 Risky behavior

About 29% of participants believe that the causes of people to engage in sexual intercourse without using a condom is because these people have sex when they are drunk and forget to use a condom. About 29% do not believe in using a condom at all, and the other 29% believe it is because of carelessness.

4.2.3 How AIDS affects people

About 86% of the participants believe that AIDS will have a negative impact on the size of the community and family, meaning the size of the community will be reduced. About 71% to believe that AIDS has a negative impact on income, it reduces the level of income, whereas 57% of the participants believe that AIDS has negative impact on assets, people end up selling their assets and 29% believe AIDS results in reduced expenditure.

About 57% of the participants believe that people in KwaDlangezwa would feel that people infected with HIV/AIDS have a bad character, they are sleeping around. About 29% say they would feel sorry for the family member/s and give support where needed.

4.2.4 Copying Strategies

There are many things that can be done in order to help people and families of people who are already HIV infected or have AIDS. About 86% of participants believe that these people and their families need the support. It could be financial, spiritual or emotional support.

The copying strategies for families who have HIV/AIDS infected members are selling of their assets, borrowing money from other family members, receive grants from the government, reduce monthly expenditure, or take up loan. About 29% of participants believe that they get money from family members who are well of, whereas 43% believe that they sell their assets.

4.2.5 Government Action

Participants believe that government is not addressing the HIV/AIDS pandemic sufficiently. About 71% of participants believe the government can do more. Whereas only 29% believe the government is doing its level best in addressing the issue of HIV/AIDS.

4.2.6 Future Generation

The future of the children whose parents die of AIDS does not look promising. Participants believe that we are going to have parentless generation, uneducated generation, no sense of belonging, street kids, child-headed families, increasing in the level of crime in South Africa and increasing level of poverty. About 43% of participants believe that there will be a parentless generation, whereas 57% believe that we will have an uneducated generation. These results reveal the serious negative economic impact HIV/AIDS has and will have in our families and communities. More should be done to reduce the negative economic impact of HIV/AIDS.

4.3 Quantitative results

It can safely be stated that the most severe economic impact of HIV/AIDS occur at the household level. It is furthermore apparent that poor households carry the greatest burden whilst having the least resources to cope with the disease. The results are as follows and they have been rounded off to the nearest decimal number:

Table 4:1

Classification of households into Age Group

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18-21	34	11.4	11.4	11.4
	22-25	34	11.4	11.4	22.8
	26-30	28	9.4	9.4	32.2
	31-40	60	20.1	20.1	52.3
	40+	142	47.5	47.7	100.0
	Total	298	99.7	100.0	
Missing	0	1	.3		
Total		299	100.0		

Source: Own calculations based on the survey data

The age group of people who participated in the study are between the age of 18 and 40 years and above. However, forty eight percent (48%) of the respondents were above the age of 40. The lowest was between the age of 26 and 30 which was nine percent (9%).

Table 4.2

Gender of the household in the study area

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	93	31.1	31.2	31.2
	Female	205	68.6	68.8	100.0
	Total	298	99.7	100.0	
Missing	0	1	.3		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.2 above indicates that there were more females who participated in the study than males. There were about sixty nine percent (69%) of female respondents. There were approximately thirty one (31%) of male respondents. In most studies on HIV/AIDS the findings show that most of the respondents are females. This study is no exception.

Table 4.3

Marital status of household in the study area

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Married	66	22.1	22.3	22.3
	Divorced	1	.3	.3	22.6
	Engaged	3	1.0	1.0	23.6
	Widowed	16	5.4	5.4	29.1
	Single	210	70.2	70.9	100.0
	Total	296	99.0	100.0	
Missing	0	3	1.0		
Total		299	100.0		

Source: Own calculations based on the survey data

KwaDlangezwa population is dominated by single people. There were about seventy one percent (71%) single people and only twenty two percent (22%) were married, one percent (1%) engaged, and about five percent (5%) widowed. From these results one can draw several conclusions including the fact that the majority of these single people might be sexually active. They might be having more than one sexual partner which means they might be at risk of being infected with HIV virus.

Table 4.4

Number of people living in this household including children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	More than 10	50	16.7	16.8	16.8
	5-9	145	48.5	48.8	65.7
	Less than 5	102	34.1	34.3	100.0
	Total	297	99.3	100.0	
Missing	0	2	.7		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.4 indicates that the highest size of the household in KwaDlangezwa is between 5 and 9 which is about forty nine percent (49%) of the households. Approximately thirty four percent (34%) are less that 5 and seventeen percent (17%) of them are more than ten percent (10%) of the households.

Table 4.5

Number of males living in your household

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	41	13.7	14.5	14.5
	2	58	19.4	20.6	35.1
	3	72	24.1	25.5	60.6
	4	35	11.7	12.4	73.0
	5	32	10.7	11.3	84.4
	6	13	4.3	4.6	89.0
	7	19	6.4	6.7	95.7
	8	4	1.3	1.4	97.2
	9	4	1.3	1.4	98.6
	10	2	.7	.7	99.3
	11	2	.7	.7	100.0
	Total	282	94.3	100.0	
Missing	0	17	5.7		
Total		299	100.0		

Source: Own calculations based on the survey data

The results reveal that there are very few males residing in KwaDlangezwa rural area as compared to females. The results show that twenty six percent (26%) of households have 3 males, twenty one percent (21%) of households have 2 males, fifteen percent (15%) of households have only 1 male, twelve percent (12%) of households have 4 males, eleven percent (11%) of households have 5 males. The results further show that less than ten percent (10%) of households have between 6 and 11 males. These results are emphasising the fact the most households are dominated by females.

Table 4.6

Number of females living in your household

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	28	9.4	10.0	10.0
	2	57	19.1	20.4	30.5
	3	54	18.1	19.4	49.8
	4	51	17.1	18.3	68.1
	5	33	11.0	11.8	79.9
	6	17	5.7	6.1	86.0
	7	13	4.3	4.7	90.7
	8	11	3.7	3.9	94.6
	9	4	1.3	1.4	96.1
	10	3	1.0	1.1	97.1
	11	3	1.0	1.1	98.2
	12	2	.7	.7	98.9
	16	1	.3	.4	99.3
	18	1	.3	.4	99.6
	21	1	.3	.4	100.0
	Total	279	93.3	100.0	
Missing	0	20	6.7		
Total		299	100.0		

Source: Own calculations based on the survey data

The results reveal that most households in KwaDlangezwa are dominated by females. The results show that twenty percent (20%) of households have 2 females, nineteen percent (19%) of households have 3 females, eighteen percent (18%) of households have 4 females, eleven percent (11%) of households has 5 females and ten percent (10%) of households have only 1 female. The results also reveal that less than ten percent (10%) of households have between 6 and 21 females.

Table 4.7

Highest level of education of household in the study area

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Tertiary	19	6.4	6.5	6.5
	Grade 12/Matric	63	21.1	21.6	28.2
	Below grade 12/Matric	209	69.9	71.8	100.0
	Total	291	97.3	100.0	
Missing	0	8	2.7		
Total		299	100.0		

Source: Own calculations based on the survey data

The results show that approximately seventy two percent (72%) of KwaDlangezwa population do not have grade 12. Only twenty two percent (22%) have passed grade 12 of which seven percent 7% have tertiary education. These results reveal that most of the participants might be unemployed because of their level of education.

Table 4.8

Employment status of households in the study area

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Employed	23	7.7	7.8	7.8
	Self employed	15	5.0	5.1	12.9
	Unemployed	256	85.6	87.1	100.0
	Total	294	98.3	100.0	
Missing	0	5	1.7		
Total		299	100.0		

Source: Own calculations based on the survey data

These results are very shocking. The results reveal that approximately eighty seven percent (87%) of KwaDlangezwa households are unemployed. Only thirteen percent (13%) are employed of which five percent (5%) is self employed. This is a very

serious indication of how households in KwaDlangezwa are suffering and there is no doubt that most of these families are living in poverty.

Table 4.9

How long have you been working for the current employer

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	More than five years	8	2.7	29.6	29.6
	Less than five years	19	6.4	70.4	100.0
	Total	27	9.0	100.0	
Missing	0	272	91.0		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.9 reveals that there are about thirty percent (30%) of the respondents who have been working for the current employer for more than five years. The results also reveal that about seventy percent (70%) of the respondents have been working for the current employer for less than five years.

Table 4.10

Monthly household income

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	R5 000-R9 000	2	.7	1.1	1.1
	R2 000-R4 000	9	3.0	5.0	6.1
	R1 000 and below	170	56.9	93.9	100.0
	Total	181	60.5	100.0	
Missing	0	118	39.5		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.10 reveals that ninety four percent (94%) of households earn a monthly income of R1000 and below, five percent (5%) earn between R2000 and R4000 and only one percent (1%) earns between R5000 and R9000. Results from Table 4.9 show that eighty seven percent (87%) of the respondents are unemployed, if eighty seven percent (87%) of the respondents are unemployed that has a negative impact on their monthly income, it is very low.

Table 4.11

Knowledge of saving in monetary terms

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	96	32.1	33.8	33.8
	No	188	62.9	66.2	100.0
	Total	284	95.0	100.0	
Missing	0	15	5.0		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.11 reveals that approximately sixty six percent (66%) of the respondents do not have any knowledge of savings in monetary terms. These results are expected given the fact that eighty seven percent (87%) of the respondents do not have grade 12. Table 4.11 also reveals that only thirty four percent (34%) have knowledge of savings in monetary terms.

Table 4:12

Household savings by type

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Banks	65	21.7	33.0	33.0
	Stokvels	87	29.1	44.2	77.2
	Investment firms	1	.3	.5	77.7
	Other	44	14.7	22.3	100.0
	Total	197	65.9	100.0	
Missing	0	102	34.1		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.12 reveals that respondents save money in many different ways. The results in this study show that forty four percent (44%) of the respondents save money through stokvels and thirty three percent (33%) use banks. The other twenty two percent (22%) use other forms of savings not mentioned and half a percent (0.5%) use investment firms in order to save.

Table 4.13

Monthly total expenditure of household in the study

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	R12000 and above	5	1.7	2.0	2.0
	R5000-R10000	6	2.0	2.4	4.4
	R3000-R8000	61	20.4	24.3	28.7
	Below R2000	179	59.9	71.3	100.0
	Total	251	83.9	100.0	
Missing	0	48	16.1		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.13 shows that approximately seventy one percent (71%) spend below R2000 on monthly expenditure. Approximately twenty four percent (24%) spend between R3000 and R8000 whereas only four percent (4%) spend above R5000. Despite the higher unemployment rate in KwaDlangezwa, households spend approximately R2000 or below on expenditure.

Table 4.14

Ownership of assets by households in the study area

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	133	44.5	49.3	49.3
	No	137	45.8	50.7	100.0
	Total	270	90.3	100.0	
Missing	0	29	9.7		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.14 reveals that only forty nine percent (49%) of the respondents own assets and fifty one (51%) do not own any assets.

Table 4.15

Ownership of any of the following assets: land, house, live stock, car, money in the bank by households in the study area

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	131	43.8	50.0	50.0
	No	131	43.8	50.0	100.0
	Total	262	87.6	100.0	
Missing	0	36	12.0		
	System	1	.3		
	Total	37	12.4		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.15 reveals that fifty percent (50%) of the participants own land, houses, live stock, cars and money in the bank. The other fifty percent (50%) of the respondents do not own any land, house, live stock, car and they do not have any money in the bank.

Table 4.16

The sources used for borrowing money by households in the study area

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Banks	27	9.0	11.6	11.6
	Friends	48	16.1	20.7	32.3
	Family	40	13.4	17.2	49.6
	Co-operatives (stokvels)	98	32.8	42.2	91.8
	Other	19	6.4	8.2	100.0
	Total	232	77.6	100.0	
Missing	0	67	22.4		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.16 reveals different sources respondents use for borrowing money. Approximately forty two percent (42%) use co-operatives (stokvels), twenty one percent (21%) use friends, seventeen percent (17%) use family members and twelve percent (12%) use banks.

Table 4.17

Alcohol intake by household in the study area

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	40	13.4	13.5	13.5
	No	256	85.6	86.5	100.0
	Total	296	99.0	100.0	
Missing	0	3	1.0		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.17 shows that eighty six and a half percent (86.5%) of the respondents do not drink at all and only thirteen and a half percent (13.5%) drink alcohol.

Table 4.18

Drugs intake by households in the study area

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	8	2.7	2.7	2.7
	No	287	96.0	97.3	100.0
	Total	295	98.7	100.0	
Missing	0	4	1.3		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.18 shows that ninety seven percent (97%) of the respondents do not take drugs and only three percent (3%) are taking drugs.

Table 4.19

Are you sexually active

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	182	60.9	66.7	66.7
	No	91	30.4	33.3	100.0
	Total	273	91.3	100.0	
Missing	0	26	8.7		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.19 reveals that approximately sixty seven percent (67%) of the respondents are sexually active and thirty three percent (33%) are not sexually active.

Table 4.20

Practicing of safe sex by households in the study area

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	175	58.5	90.2	90.2
	No	19	6.4	9.8	100.0
	Total	194	64.9	100.0	
Missing	0	105	35.1		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.20 reveals that approximately ninety percent (90%) of the respondents who are sexually practice safe sex and ten percent (10%) do not practice safe sex.

Table 4.21

Knowledge of the consequences of unsafe sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	224	74.9	95.7	95.7
	No	10	3.3	4.3	100.0
	Total	234	78.3	100.0	
Missing	0	65	21.7		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.21 reveals that out of ninety seven percent (96%) of the respondents have knowledge of consequences of unsafe sex and only four percent do not have any knowledge of the consequences of unsafe sex.

Table 4.22

Knowledge of HIV status by households in the study area

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	228	76.3	77.8	77.8
	No	65	21.7	22.2	100.0
	Total	293	98.0	100.0	
Missing	0	6	2.0		
Total		299	100.0		

Source: Authors own calculations based on the survey data

Table 4.22 reveals that seventy eight percent (78%) of the respondents have knowledge of their HIV status. The results also show that twenty two percent (22%) do not have knowledge of their HIV status.

Table 4.23

Number of people households know with HIV/AIDS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	131	43.8	44.9	44.9
	1-5 people	100	33.4	34.2	79.1
	5-10 people	43	14.4	14.7	93.8
	More than 10 people	18	6.0	6.2	100.0
	Total	292	97.7	100.0	
Missing	0	7	2.3		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.23 indicates that forty five percent (45%) of the respondents do not know anybody who is HIV positive. Approximately thirty four percent (34%) know between 1 and 5 people who are HIV positive. Fifteen percent (15%) of the respondents know between 5 and 10 people who are HIV positive and only six percent (6%) of the respondents know more than 10 people who are HIV positive.

Table 4.24

Fear of stigma result in people not admitting to having HIV/AIDS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	103	34.4	34.9	34.9
	Agree	144	48.2	48.8	83.7
	Neutral	36	12.0	12.2	95.9
	Disagree	8	2.7	2.7	98.6
	Strongly disagree	4	1.3	1.4	100.0
	Total	295	98.7	100.0	
Missing	0	4	1.3		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.24 reveals that forty nine percent (49%) of the respondents agree that fear of stigma results in people not admitting to having HIV/AIDS whereas thirty five percent (35%) of the respondents strongly agree that fear of stigma results in people not admitting to having HIV/AIDS. Table 4.24 also shows that only twelve percent (12%) of the respondents are neutral about the fear that stigma results in people not admitting to having HIV/AIDS and only three percent (3%) of the respondents disagree that fear of stigma result in people not admitting to having HIV/AIDS while only one percent (1%) of the respondents strongly agree that the fear of stigma result in people not admitting to having HIV/AIDS.

Table 4.25

HIV/ AIDS can be avoided

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	106	35.5	36.2	36.2
	Agree	149	49.8	50.9	87.0
	Neutral	25	8.4	8.5	95.6
	Disagree	9	3.0	3.1	98.6
	Strongly disagree	4	1.3	1.4	100.0
	Total	293	98.0	100.0	
Missing	0	6	2.0		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.25 indicates that fifty one percent (51%) of the respondents agree that HIV/AIDS can be avoided and also thirty six percent (36%) of the respondents strongly agree that HIV/AIDS can be avoided. The results reveal that three percent

(3%) of the respondents disagree that HIV/AIDS can be avoided and only one percent (1%) strongly disagrees that HIV/AIDS can be avoided.

Table 4.26

Some of the family members have died because of HIV/AIDS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly agree	77	25.8	26.4	26.4
	Agree	77	25.8	26.4	52.7
	Neutral	64	21.4	21.9	74.7
	Disagree	60	20.1	20.5	95.2
	Strongly disagree	14	4.7	4.8	100.0
	Total	292	97.7	100.0	
Missing	0	6	2.0		
	System	1	.3		
	Total	7	2.3		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.26 indicates that twenty six percent (26%) of the respondents strongly agree that some of their family members have died because of HIV/AIDS and also twenty six percent (26%) of the respondents agree that some of their family members have died because of HIV/AIDS. Twenty two percent (22%) of the respondents were neutral about some of their family members having died because of HIV/AIDS. The other twenty one percent (21%) of the respondents disagree that some of their family members have died because of HIV/AIDS and only five percent (5%) of the respondents strongly disagree that some of their family members have died because of HIV/AIDS.

Table 4.27

HIV/AIDS has resulted in the death of the breadwinner in this family

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	117	39.1	44.7	44.7
	No	145	48.5	55.3	100.0
	Total	262	87.6	100.0	
Missing	0	36	12.0		
	System	1	.3		
	Total	37	12.4		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.27 indicates that fifty five percent (55%) of the respondents believe that HIV/AIDS has not resulted in the death of the breadwinner in their families whereas only forty five percent (45%) of the respondents believe that HIV/AIDS has resulted in the death of the breadwinner in their families.

Table 4.28

The death of the breadwinner had a negative impact on savings, assets, borrowings and expenditure

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	96	32.1	38.7	38.7
	No	152	50.8	61.3	100.0
	Total	248	82.9	100.0	
Missing	0	50	16.7		
	System	1	.3		
	Total	51	17.1		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.28 indicates that sixty one percent (61%) of the respondents do not believe that the death of the breadwinner had negative impact on savings, assets, borrowing, and expenditure. Approximately thirty nine percent (39%) of the respondents believe that the death of the breadwinner had a negative impact on savings, assets, borrowing and expenditure.

Table 4.29

There is(are) a member(s) of this household who is/are HIV positive

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	101	33.8	34.0	34.0
	No	56	18.7	18.9	52.9
	Not sure	140	46.8	47.1	100.0
	Total	297	99.3	100.0	
Missing	System	2	.7		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.29 indicates that forty seven percent (47%) of the respondents are not sure if there is/are member/s of the family who is/are HIV positive whereas thirty four percent (34%) of the respondents believe that there is/are member/s of the family who is/are HIV positive. The other nineteen percent (19%) do not believe that there is/are member/s of their family who is/are HIV positive.

Table 4.30

If your answer above is yes, are members in your household who are HIV positive receiving assistance?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	32	10.7	26.4	26.4
	No	89	29.8	73.6	100.0
	Total	121	40.5	100.0	
Missing	0	128	42.8		
	System	50	16.7		
	Total	178	59.5		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.30 indicates that seventy four percent (74%) of the respondents say their household members who are HIV positive or who have AIDS are not receiving assistance, whereas only twenty six percent (26%) of the respondents agree that their household members who are HIV positive or who have AIDS are receiving assistance.

Table 4.31

The status of a family member who is HIV positive has an impact on income, savings, assets, borrowings and expenditure

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	63	21.1	26.0	26.0
	No	50	16.7	20.7	46.7
	Not sure	129	43.1	53.3	100.0
	Total	242	80.9	100.0	
Missing	System	57	19.1		
Total		299	100.0		

Source: Own calculations based on the survey data

Table 4.31 indicates that approximately fifty three percent (53%) of the respondents are not sure that the status of a family member who is HIV positive has an impact on

income, savings, assets, borrowing and expenditure. The other twenty six percent (26%) of the respondents agree that the status of a family member who is HIV positive has an impact on income, savings, assets, borrowing and expenditure. The results also indicate that twenty one percent (21%) of the respondents do not know as to whether the status of a family member who is HIV positive has an impact on income, savings, assets, borrowing and expenditure.

Conclusion

The focus group results show that participants have a clear knowledge of AIDS and the causes of AIDS. Results show that eighty six percent (86%) of the participants believe that AIDS will have a negative impact on the size of the population and family. Aproximately sixty six percent (66%) of the respondents do not have any knowledge of savings in monetary terms, and only thirty four percent (34%) have knowledge of savings in monetary terms. Only forty nine percent (49%) of the respondents own assets and fifty one (51%) do not own any assets and ninety four percent (94%) of households earn a monthly income of R1000 and below.

The quantitative results of the survey on the other hand show very interesting results. The results reveal that HIV/AIDS has a negative impact on the size of the family, community, income, assets and expenditure in KwaDlangezwa. However, the main problem that was identified was that of unemployment. KwaDlangezwa has a very high level of unemployment. The unemployment rate according to the results is about eighty seven percent (87%). Only thirteen (13%) are employed of which five percent (5%) is self employed. Next chapter is about the role of the government in mitigating the impact of HIV/AIDS.

CHAPTER 5

THE ROLE OF THE GOVERNMENT IN MITIGATING THE IMPACT OF HIV/AIDS

5.1 The role of the National Government

The South African government response to the epidemic has followed a similar pattern to many other countries. (Hickey, 2002) It begins with a health-centered response, and then as the disease spreads and prevalence rates rise, a national plan is drawn up which pulls in non-health sectors for the purposes of prevention and education. In 2000 the National Integrated Plan formalised a multi-sectoral approach and set up an accompanying financing strategy. A 2002 study by the Centre for Health Systems Research and Development gives the best review of the evolution of South Africa's response to HIV/AIDS towards a more entrenched multi-sectoral approach.

According to the report by USAID (2002) the challenge involves convincing and encouraging ministries outside health to incorporate the fight against HIV/AIDS into their core activities. Structures and systems are needed to coordinate the activities of the Ministry of Health, other ministries, and NGOs in fighting the disease. The primary tool for this is a multi-sectoral body set up within or on a tangent to the Ministry of Health, or in the office of the Presidency.

Thus there appears to be general consensus that a national government response to HIV/AIDS must include concentrated efforts to build general planning and implementation capacity, for three reasons:

- the unique multi-sectoral response required has its own difficulties;

- sharp increases in funding for HIV/AIDS require government to absorb and spend
- large allocations, and rapidly roll out programmes nationally (UNDP 2001); and
- HIV/AIDS itself will negatively impact on regular government capacity (USAID, 2002).

5.2 The role of the Provincial government

In South Africa the National Integrated Plan (NIP) for HIV/AIDS is the joint strategy by the departments of Health, Education and Social Development, which sees the national departments supporting provinces in running voluntary counselling and testing programmes, life-skills education, and home and community-based care and support interventions. Provincial health, education, and social development departments implement the three NIP programmes, with support and financing from national departments (USAID, 2002).

The multi-level nature of the NIP has implications for: departmental budgeting, strategic management, financial control and accountability, training and hiring, reporting, provincial budgeting, and intergovernmental transfers. Given that provinces are primarily responsible for the delivery of social services but remain largely reliant on national government for their budgets, national government must ensure that provinces effectively budget for and spend on this priority. Idasa studied how government budgets for its HIV/AIDS programmes and now it channels funds to the department responsible for implementation. While the conditional grant funding mechanism ensured nationally allocated funds were spent to fight the

epidemic, problems common to all conditional grants (such as slow transfer of funds, lengthy business plan approval processes) saw low actual spending rates by provinces. According to Hickey (2002) this has prompted National Treasury and the Department of Health to explore new funding mechanisms which transfer HIV/AIDS funds to the provinces with less limitations and close oversight, thus allowing provinces more freedom in how the funds are spent (USAID, 2002).

In addition to the NIP, provinces are also involved in additional HIV/AIDS programmes to varying extent. In some areas, provincial departments implemented expanded programmes on their own initiative – with or without political and/or direct targeted financial support from national government. The prime example is in the area of drug treatment where some provinces have instituted MTCT prevention programmes outside of the 18 designated national pilot sites. Provinces might finance such programmes (outside of NIP programmes) via allocations from their own provincial budgets. Idasa has analysed provincial financing sources for HIV/AIDS programmes in the health, education and social development sectors. However, the research is limited to the policy, attached budgets and financing mechanisms, and does not cover the political and management issues related to non-NIP provincial HIV/AIDS programmes.

5.3 The role of the Local government

Below the national level, there is less material for sub-national governments, particularly regions and municipalities, on how one actually goes about factoring the impact of HIV/AIDS into planning. Whiteside et al produced a study for KwaZulu-

Natal which lays out the expected impact of HIV/AIDS in that province. (Whiteside and FitzSimons, 1995) Conducted for the Town and Regional Planning Commission, the report is an excellent template for similar studies in other provinces, regions and municipalities, as it puts forward projections for the province and then translates these figures into practical changes to regional planning standards used to calculate demand for services and facilities (USAID, 2002).

The 1995 study is also useful in that it shows how municipal and regional planning bodies ought to be concerned with HIV/AIDS, how it directly impacts on their activities, structures and obligations, and entry points for the involvement of these local bodies in fighting the disease (Whiteside and FitzSimons, 1995). Similar updated studies for other provinces and regions are needed to first persuade and encourage municipal structures to address HIV/AIDS issues in their area, and second, give them practical steps and numbers to begin to go about it (USAID, 2002).

Clearly much more work is needed on the obligations and potential role of municipal and regional bodies in confronting the disease. Smart and Whiteside have made the strongest contribution in a 2000 study which discusses the constitutional objectives of local government in development, the predominant reasons for their nonparticipation in HIV/AIDS thus far, and the impact HIV/AIDS can have on local government services and institutions (Smart, 2000 and Whiteside, 2000). The pillars of a local government response must include: leadership by councillors and in the workplace; coordination with other government bodies and planning in consultation with other sectors and the community. The role of local government needs to be

explored and identified more carefully, and more practical strategic planning material needs to be developed for the local level.

The role of the government is clear it is to act at the best interest of the society. This study has shed more light on the responsibility and the operation of the government. The challenge lies in the operation within the local government, whereby there is lack of service delivery even though the funds have been made available, or misuse of funds and misallocation of the resources. Evidently much more work is needed on the obligations and potential role of municipal and regional bodies in confronting the disease.

CHAPTER 6

FINDINGS AND POLICY RECOMMENDATIONS

6.1 Findings

The study on Economic Impact of HIV/AIDS in KwaDlangezwa revealed that there are households members who find it difficult to cope with HIV infected family members. The problem of unemployment contributes to a high level of poverty in KwaDlangezwa. There are policy options that can be adopted to strengthen the coping capacity of households with the impact of HIV/AIDS including:

- Convalescing the access of households to limited resources such as labour, land, capital, draught power, and management skills;
- Promotion of optimal use of available resources through improved technologies; economic support to improve incomes of affected households through income generating activities;
- Provision of self-support (empowerment) to affected groups such as child-headed households, widows, grandparents, youths, orphans, sex workers, etc., with the aim of reducing further vulnerability and strengthening their coping capacity (UNAIDS, 1999).

6.2 Policy Recommendations

According to USAID (2002) the policy recommendations generally involve approaches to alleviate the burden of HIV/AIDS on the woman, child, household or community (a relatively passive approach) or the economic empowerment of the woman, child, household or community (a more pro-active approach).

Programmes aimed at alleviating the strain involve a wide range of initiatives. Credit programmes to maintain household expenditure and schooling (Kongsin et al., 2000) or benefit packages including food, schooling and clothing (Hunter & Williamson, 2007b) can provide immediate relief. More sustainable are women's lending and saving groups (Hunter & Williamson 2007b).

The recommendations regarding care arrangements include formal and informal sector approaches. Increased funding for medical care, counselling and community education (Caldwell et al., 1993) is required for a range of community-based projects, for example home-based care at minimal cost to households, (Smart 1999) and community-based self-help groups. According to Aggleton & Bertozzi (1997) there are stronger links between community health workers to formal health services and informal health-care providers are seen as a logical extension of the intensified support for community-based projects. (Makan & Bachmann 1997) For CBOs to be effective community participation by people with HIV/AIDS needs to be promoted (Aggleton & Bertozzi 1997).

Goudge & Govender (2000) and Hunter & Williamson (2007b) stress the importance of development of the social and economic infrastructure for alleviating the impact on the most vulnerable households, including water infrastructure, electricity, housing etc. In addition, the importance of labour-saving interventions such as community-based health care, water infrastructure, fuel-efficient stoves etc is stressed. (Hunter & Williamson 2007b) It is further recommended that HIV/AIDS prevention strategies are incorporated in development policies, including macroeconomic, health and fiscal policies (Du Guerny & Hsu 2000).

The recommended programmes aimed at economic empowerment range from income-generating schemes to enhanced legal protection for widows. Micro-credit or finance programmes aimed at investing in self-employment include credit, savings and capacity-building programmes (Donahue 1998; UNICEF 1997). They are particularly beneficial to marginalised groups, for example women and children and those without collateral. Although their role in poverty reduction is duly discussed in the literature and the synergetic links with social services is explored (micro-credit schemes tend to reduce poverty faster when they are combined with increased access to basic social services), no thorough analysis is included of the impact of these schemes on economic growth.

An interesting development is the call for income-generating resources for youngsters (10-18 year olds). The increasing number of AIDS orphans and the emergence of child-headed households requires either improved resources of caregivers (for example pensions) or providing these orphans with the resources to look after themselves (Halkett, 1998).

A central theme in the literature on NGO and CBO interventions is that they would benefit from networking and coordination mechanisms (Smart 1999; Hunter & Williamson 2007b) enabling them to respond both rapidly and appropriately to households or communities in need. Moreover, collaboration with government, community leaders and donors is seen as essential to improving the effectiveness and sustainability of community-based responses to HIV/AIDS (Hunter & Williamson 2007b; World Bank 2000).

Ultimately, the literature points towards the limits of coping mechanisms of the household and of community-based organisations. When these are exhausted due to the community-wide impact of HIV/AIDS, the state has a role in providing safety nets, such as insurance, health care provision and enabling income generation. As the World Bank finds: ‘many solutions will involve partnerships among poor communities, the private sector and the state’ (World Bank 2000).

The main recommendations arising from the study include the following needs:

- the importance of looking into strengthening the capacity of rural households to cope with HIV/AIDS by improving their access to limited resources; labour, land, capital, draught power, and management skills. This can be achieved by extension services promoting technologies that make optimal use of available resources, research systems developing technologies that can improve productivity given the labour and capital constraints, improving the incomes of affected households through income generating activities, and better targeting of support to households that are highly vulnerable.
- for social assistance programmes to target a wider group of households based on both poverty and AIDS indicators. This can be achieved best by working through KwaDlangezwa community in identifying the most needy.
- for policy makers and development agencies to help mitigate the impact of HIV/AIDS by working through existing indigenous traditional community mechanisms instead of displacing them. Programmes and policy should aim at strengthening indigenous responses such as savings clubs and labour and draught power clubs.
- to promote the effectiveness of community-based organizations and NGOs.

Community-based coping strategies can be strengthened through the reinforcement of the management skills of CBOs and training on project design, planning, management, monitoring and evaluation.

- for meaningful partnership between the communities, governments, donor agencies, international NGOs, local NGOs, private sector and others in mitigating the impacts of HIV/AIDS.
- to intensify mitigation programmes. Multinational donors need to be more flexible in support of local initiatives with their funding, preferably by making many small grants rather than one large project grant. The present emphasis on large-scale grants and projects undermines local initiatives that may be far more effective and appropriate, as well as sustainable. Donors are, however, reluctant to have to manage numerous small projects. A mechanism is needed to resolve this problem, with perhaps an intermediate body to manage small-scale funds and report to the donors.
- for long-term government strategies to address the underlying problems which make rural households vulnerable to the impact of HIV/AIDS. Strategies should be aimed at eliminating poverty through rehabilitation and expansion of essential services such as primary education, preventive health care, clean water, sanitation, and improved access to land, credit, markets and protection against droughts through introduction of irrigation, and at creating more wage employment for the poor and landless.
- to develop a more encompassing approach to the evaluation of mitigation of programmes and to ensure appropriate planning, measures of impact and outcome (in the short and long term), as well as the costs of the initiatives are needed for community-based organizations and NGOs not to duplicate work

that is already in existent in communities but should strive for integration by supplementing or complementing community responses. External support should build on existing community structures such as churches, women's groups, schools and foster families.

- for governments to be prepared to play a more active leadership role and review their commitment to rural development. They need to undertake this with a clear analysis of the impact of AIDS on development, and of the impact of development on the AIDS epidemic itself (UNAIDS, 1999).

The above policy recommendations are an indication that HIV/AIDS has a negative impact on the household's income, size of the family, expenditure, savings, assets and expenditure. More needs to be done in order to assist communities and families affected by HIV/AIDS. The abovementioned are policy recommendations for this study.

6.3 Limitations of the study

The study was conducted in three areas Nkonjane, Ongoye, and Ezinsimbini. The sample size was 300 and only 299 was suitable for analysis, it is too small to represent the entire population of KwaDlangezwa.

CHAPTER 7

CONCLUSION

Studies that have been conducted on HIV/AIDS reveal more or less the same results. They reveal that HIV/AIDS has a negative impact on household's income, size of the family, assets, savings and expenditure. HIV/AIDS does not only affect rural communities but also urban communities. However, urban communities have access to health facilities, job opportunities and information regarding financial support, for example, grants given by the government to HIV/AIDS infected patients.

The study has discovered a variety of coping responses that have been deployed by households to mitigate the impact of the pandemic. In general terms, some of the coping responses adopted by households have been found to render households insecure and vulnerable. Sale of assets, withdrawal of children from school, reduced food consumption and use of savings and investment, all have a negative impact on the future well-being of the family.

According to UNAIDS (1999), some household coping responses have positive impacts on the long term well-being of the household, such as income diversification, share-cropping, adoption of labour saving technology such as inter-cropping and diversification of crop production. It is therefore important that policy and programmes are designed in such a way that the positive household responses are reinforced while at the same time households are discouraged from adopting coping responses that can compromise their future well- being.

The results in the study reveal that there is a negative economic impact of HIV/AIDS in KwaDlangezwa. The focus group results reveal that about eighty six percent (86%) of the respondents believe that AIDS will have a negative impact on the size of the community and family. Whereas seventy one percent (71%) believe that AIDS has a negative impact on income it reduces the level of income, fifty seven percent (57%) of the respondents believe that AIDS has negative impact on assets, people end up selling their own assets and twenty nine percent (29%) believe AIDS results in reduced expenditure.

The respondents also believe that the government is not addressing the HIV/AIDS pandemic sufficiently. There are still people who do not have access to health services and financial support. The results also reveal that KwaDlangezwa community is going to have parentless generation, uneducated generation with no sense of belonging, street kids, child-headed families, increase in the level of crime and increasing level of poverty.

The quantitative results are in consensus with focus group results. However, the quantitative results have identified the problem of unemployment in the study area. There is a very high level of unemployment in KwaDlangezwa area which is eighty seven percent (87%). The results also show that seven two percent (72%) of the population do not have grade 12. There is a saying that “Education is the key to success”, education in this community will open doors of opportunities.

Without investment in human development, there is no long-term progress in national development, stability and the skills base to overcome development

obstacles. Government alone cannot achieve the basic well-being of the entire national population. This calls for meaningful partnership between the communities, governments, donor agencies, international NGOs, local NGOs, private sector and others in order to address the problems of HIV/AIDS successfully. But governments should be prepared to play a more active leadership role and review their commitment to rural development. They need to undertake this with a clear analysis of the impact of AIDS on development, and of the impact of development on the AIDS epidemic itself (USAID, 2002).

Sub-Saharan Africa remains the region most heavily affected by HIV. In 2010, about 68% of all people living with HIV resided in sub-Saharan Africa, a region with only 12% of the global population. Sub-Saharan Africa also accounted for 70% of new HIV infections in 2010, although there was a notable decline in the regional rate of new infections. The epidemic continues to be most severe in southern Africa, with South Africa having more people living with HIV (an estimated 5.6 million) than any other country in the world (UNAIDS, 2011).

Almost half of the deaths from AIDS-related illnesses in 2010 occurred in southern Africa. AIDS has claimed at least one million lives annually in sub- Saharan Africa since 1998. Since then, however, AIDS-related deaths have steadily decreased, as free antiretroviral therapy has become more widely available in the region (UNAIDS, 2011).

The total number of new HIV infections in sub-Saharan Africa has dropped by more than 26%, down to 1.9 million (1.7 million–2.1 million) from the estimated 2.6 million

(2.4 million–2.8 million) at the height of the epidemic in 1997. In 22 sub-Saharan countries, research shows HIV incidence declined by more than 25% between 2001 and 2009. This includes some of the world's largest epidemics in Ethiopia, Nigeria, South Africa, Zambia and Zimbabwe. The annual HIV incidence in South Africa, though still high, dropped by a third between 2001 and 2009 from 2.4% (2.1%–2.6%) to 1.5% (1.3%–1.8%). Similarly, the epidemics in Botswana, Namibia and Zambia appear to be declining. The epidemics in Lesotho, Mozambique and Swaziland seem to be levelling off, albeit at unacceptably high levels. Globally new HIV infections peaked in 1997(UNAIDS, 2011).

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Appendix A

Interview Schedule of Questions

1. Knowledge of AIDS

1.1 What do you know about this disease called AIDS?

2. Causes of AIDS

2.1 What do you think causes AIDS?

2.2 How do you know if someone has the virus that causes AIDS?

3. Risky Behavior

3.1 What causes people to engage in sexual intercourse without using a condom?

4. How AIDS affects people

4.1 In your opinion, how might AIDS affect people in your community, now and in the future?

4.2 How would people in this area feel if someone in their family or community were infected with HIV?

5. Copying strategies

5.1 In your opinion, what can be done to help people and families of people who are already HIV infected or have AIDS?

5.1 How do you think families cope with HIV/AIDS infected family members?

6. Government Action

6.1 Do you feel the government is addressing the HIV/AIDS pandemic sufficiently?

7. Future generation

7.1 In your opinion, what do you think is going to happen to the future of the children whose parents die of AIDS?

Appendix B

Transcription of KwaDlangezwa focus group

Name (Pseudonyms)	Abbreviation	Responsibility	Age
Gugu	Gu	(group facilitator)	30
Sindisiwe	Si	Participant	26
Nonhlanhla	No	Participant	32
Phindile	Phi	Participant	27
Mandisa	Ma	Participant	27
Smangele	Sma	Participant	25
Thabile	Tha	Participant	30
Nomsa	N	Participant	33

Colour coding key

For the transcribed focus group it was possible to generate the following themes:

Themes	Colour
Knowledge of AIDS	Red
Causes of AIDS	Blue
Risky behavior	Yellow
How AIDS affect people	Light Blue

Copying Strategies	Purple
The Role of the Government	Green
Future Generation	Orange

1. Knowledge of AIDS

Gu: What do you know about this disease called AIDS?

Si: It is an incurable disease that leads to death of our family members, community members, colleagues and friends.

No: It is acquired immune deficiency syndrome, a very high terminology but defining a human destroyer.

Phi: Well it is a well known killer disease it is just that people are ignorant of its existence. It is a unique kind of disease because you cannot see it on the forehead of a person, it is a disease that operates underground and results in sickness and death.

Ma: I don't know much about it, I have heard about it that it kills people, though you can't see someone who has it.

Sma: It is a sexually transmitted disease, if for instance you engage in sexual activity with someone who has this disease without using a condom causes AIDS.

Tha: If it was a person I would say that it is serial killer, it destroys lives.

N: It is a killer disease and it has killed some of my family members.

2. Causes of AIDS

Gu: What do you think causes AIDS?

Si: Sleeping around without using a condom

No: Having more than one sexual partner

Phi: Unfaithfulness between lovers, married couples and sleeping around without a condom

Ma: Having multiple sexual partners

Sma: Sleeping with someone who has AIDS without using a condom

Tha: By sleeping around and having multiple sexual partners

N: Unfaithfulness among married couples and single people

Gu: How do you know if someone has the virus that causes AIDS?

Si: Its not easy to tell

No: Its not easy to tell

Phi: Its impossible to see that a person has a virus

Ma: You can't tell

Sma: Ya, you can't tell

Tha: Its not easy to see that a person has an HIV virus

N: Its not easy to tell until you get tested

3. Risky Behavior

Gu: What causes people to engage in sexual intercourse without using a condom?

Si: I think it is because some people have sex when they are drunk and they end up forgetting to use a condom

No: Some people do not believe in using a condom

Phi: Carelessness

Ma: I think people who take drugs have not time to remember to use a condom because of the state they are in before engaging in sexual activity

Sma: I think, drunk people don't have time to think about protection during sexual activity

Tha: Carelessness and ignorance

N: Some people do not even want to hear about using of a condom, just imagine a drunk person, who is out of control I don't think they have time for a condom

4. How AIDS affects people

Gu: In your opinion, how might AIDS affect people in your community, now and in the future?

Si: It will reduce the size of the family, community, loss of income and assets

No: Sickly members of the community, reduced income when a bread winner falls ill and cannot work anymore.

Phi: There will be a negative economic impact e.g reduced income, selling of assets, reduced expenditure

Ma: I think it will have negative impact on the size of the community, assets people own, income as well as expenditure

Sma: Negative impact on the community, also uneducated community

Tha: Definitely negative impact on income, size of the community, assets and expenditure

N: Negative impact, loss of community members, child headed community and poverty

Gu: How would people in this area feel if someone in their family or community were infected with HIV?

Si: I think they will probably feel that you have a bad character (meaning you are sleeping around)

No: They might feel that you don't love yourself because you did not use a condom

Phi: They might feel that you don't have respect for your body, you sleeping around

Ma: They would feel ashamed that a family member has AIDS

Sma: They will think that you don't have a good character, you are sleeping around

Tha: I think they would feel sorry for that person and give support because they is nothing they can do

N: I also think they would feel sorry it will hurt them to know that your family member has AIDS

5. Copying strategies

Gu: In your opinion, what can be done to help people and families of people who are already HIV infected or have AIDS?

Si: I think we should support them and be there for them and assure them of our support and love

No: I think helping them and supporting them will do

Phi: Help them financially and involve social workers because there are child-headed families

Ma: Support them emotionally and spiritually, speaking hope in their lives so that they can live positively, encourage them to take medication as indicated and eat fruit and vegetables, in other words change diet.

Sma: Give them all kind of support they might need, making sure that resources are available for an example money, food and medication, also encourage them to take their medication.

Tha: We must give them special attention and support, guidance and information of where they can get help

N: We should give them financial support through projects that bring in income

Gu: How do you think families cope with HIV/AIDS infected family members?

Si: I think it must be difficult for the families and maybe they borrow money from other family members or friends

No: I think some of them receive help from other family members who are well-off

Phi: I think some of them end up selling their assets for example land, live stock in order to get money

Ma: I think some of them depend on the grant they receive from the Government on monthly basis, just to assist them financially

Sma: I think they end up selling some of their assets if they have and they also reduce their monthly expenditure

Tha: I think its difficult if the person who is sick is a breadwinner, family members end up selling their assets or take up loan if they can't get help from other family members

N: It depends who is sick, if a child is sick I don't think its that bad because there is a flow of income as usual from family members who are working, I think what happens is that part of income is diverted to taking care of the sick child.

6. Government Action

Gu: Do you feel the government is addressing the HIV/AIDS pandemic sufficiently?

Si: I don't think government is addressing this issue sufficiently, I believe the government can do more to assist AIDS victims

No: I think the government can do more for these people and their families

Phi: I think the government is doing its best it is just that there are many people who are infected and there are limited resources to assist these people

Ma: I think the government is not addressing the issue of HIV/AIDS pandemic sufficiently, they can do more

Sma: I think the government can do more to help these people with available resources

Tha: I think they are not doing enough, I think they can do better than what they are doing currently

No: I think the government is doing its level best in addressing the HIV/AIDS pandemic at a national level, I think the responsibility lies with the local government in addressing the needs of its local communities

7. Future generation

Gu: In your opinion, what do you think is going to happen to the future of the children who's parents die of AIDS?

Si: We are going to have a parentless generation and uneducated generation

No: Parentless generation with no values and sense of belonging, uneducated generation

Phi: We are going to see an increase in child-headed families without proper leadership abilities

Ma: Increase in the number of street kids, increase in the level of crime in South Africa

Sma: We will have child-headed families, loveless, hurt and parentless generation and disorder in the families

Tha: Lost generation, disrespectful generation and uneducated generation

N: Uneducated generation resulting in increasing level of poverty

Appendix C

Faculty of Commerce
and Administration

Department of Economics

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Dear participant

Ucwaningo luchazwe' kithina njenge **Economic Impact of HIV/AIDS on Rural Household in KwaDlangezwa.**

The study has been explained to us as **The Economic Impact of HIV/AIDS on Rural Household in KwaDlangezwa.**

The participation of the household member is voluntary and we can withdraw at anytime without penalty. Ukuzimbandakanya komndeni kulolucwaningo sikwenza ngokukhululeka siyaqonda ukuthi sinelungelo lokuyeka noma ngasiphi isikhathi ngaphandle kokwesabela isijeziso.

Although our identifying details have been disclosed to the investigator, we understand that such information would be kept confidential. Nakuba umcwaningi eyazi imininingwana yethu njengomndeni, siyaqonda ukuthi ulwazi alunjalo luzogcinwa luyimfihlo.

I consent to participation in the study. Ngiyavuma ukuthi ngibe yingxenye yalolucwaningo.

Signature/Ukusayina kombhali.....

Date/ Usuku: .....

Appendix D

Research Questions

Tick only one answer below:

1. Age

18-21	
22-25	
26-30	
31-40	
40+	

2. Gender

Male	
Female	

3. Marital status

Married	
Divorced	
Engaged	
Widow	
Single	

4. How many people live in this house including children?

More than 10	
5 - 9	
Less than 5	

5. How many males live in this house?

Males	

6. How many females live in this house?

Females	

7. What is your highest level of education?

Tertiary	
Grade 12 / Matric	
Below Grade 12/Matric	

8. Are you currently employed, self employed or unemployed?

Employed	
Self employed	
Unemployed	

9. How long have you been working for the current employer?

More than five years	
Less than five years	

10. What is your current monthly income?

R10 000 +	
R5 000 – R9000	
R2000 – R4000	
Below R1000	

11. Do you know anything about savings in monetary terms?

YES	
NO	

12. How do you save your money?

Banks	
Stokvels	
Investment Companies	
Other: Please specify	

13. What is your total monthly expenditure?

R12 000 +	
R5 000 – R10 000	
R3 000 – R8 000	
Below R2 000	

14. Do you own any assets?(Money in the bank, live stock, property, possessions or worldly material).

YES	
NO	

15. Do you own any of the following assets: land, house, live stock, car, money in the bank?

YES	
NO	

16. Which of the following sources do you use for borrowing money?

Banks	
Friends	
Family	
Co-operatives (stokvels)	
Other:	

17. Do you drink alcohol?

YES	
NO	

18. Do you take drugs?

YES	
NO	

19. Are you sexually active? If the answer is no please proceed to Question 21

YES	
NO	

20. Do you practice safe sex with your partner?

YES	
NO	

21. Do you know the possible consequences of practicing unsafe sex?

YES	
NO	

22. Do you know your HIV status?

YES	
NO	

23. How many people do you know with HIV/AIDS?

None	
1-5 people	
5–10 people	
More than 10 people	

24. Fear of stigma results in people not admitting to having an HIV/Aids positive status

Strongly Agree	
Agree	
Neutral	
Disagree	
Strongly Disagree	

25. HIV/AIDS can be avoided

Strongly Agree	
Agree	
Neutral	
Disagree	
Strongly Disagree	

26. Some of your family members have died because of HIV/AIDS?

Strongly Agree	
Agree	
Neutral	
Disagree	
Strongly Disagree	

27. HIV/AIDS has resulted in the death of the breadwinner in this household

YES	
NO	

28. The death of the breadwinner had a negative impact on Savings, assets, income, expenditure and borrowing.

YES	
NO	

29. There are members of this household who are HIV positive

YES	
NO	
NOT SURE	

30. If your answer above is YES, are you receiving any assistance?

YES	
NO	

31. The status of a family member who is HIV positive has an impact on income, savings, assets, borrowing and expenditure.

YES	
NO	
NOT SURE	