THE SOCIO-ECONOMIC IMPACT OF HIV AND AIDS ON COMMUNITY DEVELOPMENT AT FETAKGOMO MUNICIPALITY, LIMPOPO PROVINCE

By

MANCHE HARRY PHAKOAGO ([redacted]

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PROF. D.G. KIROV

Declaration

I, Manche Harry Phakoago, hereby declare that this dissertation, submitted to the University of Limpopo for the degree of Masters of Development, in the Turfloop Graduate School of Leadership, Faculty of Management and Law, has not previously been submitted by me for a degree at this or other university. I further declare that this is my work and all materials therein have been duly acknowledged.

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Manche Harry Phakoago Date

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Dedication

I dedicate this dissertation to the Limpopo University, which has opened its doors for us, students, to study further in order to improve our academic standing in life.

List of Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immune Deficiency Virus
UNICEF	United Nation Children's Fund
MRC	Medical Research Council

ABSTRACT

HIV and AIDS pandemic poses a threat to both poor and rich communities alike. Communities face a developmental challenge as HIV and AIDS kills the lives of people who should improve their socio-economic position. It destroys both the Constitutional rights to life and human dignity. This is seen when people get sick and lose their potential to contribute to the development of their communities. The Fetakgomo communities, in the Limpopo Province, face the same challenge of fighting the pandemic for their social and economic development without sufficient resources.

This study focuses on the socio-economic impact of HIV and AIDS on community development in Fetakgomo Municipality, Limpopo Province. Fetakgomo communities are situated about ± 90 km, South of Burgersfort. These communities are mostly poor and rural.

The researcher used non-probability purposive sampling for this study. Three communities were selected and their leaders were chosen to participate in the study. Through qualitative research, the qualitative data were obtained through person to-person interviews and focus group interviews.

The results of the study indicate that the social lives of community members are disrupted through death from the pandemic. In the two communities – Ga-Nchabeleng and Mohlaletse – there are orphans who are created by the pandemic. There is also a problem of lack of social cohesion created by prejudice around the disease, which raises a challenge in fighting the pandemic in the three villages. The issue of confidentiality compounds the situation in fighting the pandemic among members of the three communities as people are not open to talk freely about the impact of the pandemic on their lives. Economically, the pandemic is impacting on a few families that lose their incomes and are unable to buy electric services.

The final results indicate that the impact of the pandemic is arguably very low. The communities are shown not to be doing enough to fight the impact of the pandemic. Even if the three communities are economically poor, the pandemic does not have serious impact on their material possessions. There is no real economic impact as members of the three communities are poor and at the same time a few families are affected in terms of losing their

incomes. The impact of the pandemic is only experienced on the social lives where it breeds prejudice and secrecy among the people.

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CHAPTER ONE: GENERAL ORIENTATION TO THE STUDY

This chapter presents an overview of the research plan to investigate the socio-economic impact of HIV and AIDS on community development at Fetakgomo Municipality. It is organized as follows: introduction to the study, problem statement, aim and objectives of the study, research questions, significance of the study, definition of the concepts, and structure of the study.

1.1. Introduction to the study

AIDS is arguably the greatest challenge facing the country. It is the largest single cause of death in South Africa. Between 1990 and 2000, there was a 73 per cent increase in the number of adult deaths. There were about 2 60 000 AIDS related deaths in 2002 alone. The number of deaths has increased, and the pattern of mortality has also changed. The burden of the disease on South Africa is enormous. The fact that it is predominantly the young who die of AIDS means that the economic and child-rearing backbone of South Africa will be seriously compromised (Gritzman, 2005:150).

The HIV and AIDS pandemic in the sub-Saharan Africa has been threatening the lives of especially poor people since the middle of the 20th centaury (Kruger, 2005:110). This is because the HIV and AIDS pandemic has presented itself increasingly in the heterosexual population starting as a disease of marginalized groups of homosexuals and drug users (Swanepoel, Erasmus, Schaenk, and Van Wyk, 2003:565). It is argued that the disease had infected more than 14 000 people in 2000 and assumed that 68 million people will die over the disease in the worst affected countries over the next 20 years (Swanepoel *et al.*, 2003:365).

HIV and AIDS will limit the number of community members in relation to attending school and getting educated. Erasmus and van Dyk (2003:15) argue that HIV and AIDS could lead to households losing the breadwinner which will mean a loss of income. The working members of those affected households will have to care for their fellow AIDS sick members. Orphaned children will have lower level of social and human capital development.

It is known that AIDS has had a devastating effect on individuals, families, and communities where the disease has spread. The situation in developing countries including the sub-Saharan Africa is shown to be worrying, and the AIDS epidemic will have a major impact on their already severe problems. It is also indicated that the sub-Saharan Africa has the highest levels of HIV and AIDS and the impact of HIV and AIDS will be greatest (Hubley, 2002:10). It is in the context of HIV and AIDS that people living with HIV and AIDS are at risk of stigmatization from

their communities (Holt, Hough and Romano, 1999:162). There is an indication that a vicious circle is emerging whereby poverty and social upheaval are underlying factors in the spread of HIV; the resulting AIDS causes further social and economic distress at all levels of society. Reviews by UNAIDS provide grim examples of the impact that AIDS has on education. Hubley (2002:11) indicates that the cost of inaction or doing nothing against AIDS by developing countries including South Africa will be great.

Communities experience problems such as caring for destitute children, households are being headed by a child and the neighbours in the community trying to assist with clothes and food to those victims of HIV and AIDS (UNAIDS report, 2006). AIDS impacts the economic progress of developing countries as it claims teachers, doctors and other human resources (Hubley, 2002:11). He also shows that families lose their loved ones adding a burden of financial ruin. AIDS is shown to be causing orphans to drop out of school (Hubley, 2002:11).

In many countries around the world HIV and AIDS forced governments, communities and institutions to be mobilized against it (Hubley, 2002:12). This was born out of the realization that the pandemic needs people to work together in order to reduce its wide spread.

1.2. Problem Statement

Considering that communities are the nucleus of building a prosperous society (Reddy, 2005), it is important to focus on how they engage in the fight against the impact of HIV and AIDS on their development.

The economic and cultural situation in communities under Fetakgomo Municipality is such that could encourage ignorance of the presence of HIV and AIDS among its members. The issue of being poor, rural and rooted in the same culture would contribute to these communities not opening up to the health issues that could also contribute to the wide spread of HIV and AIDS. The same cultural experience would encourage stigma and secrecy around HIV and AIDS issues. At the same time the communities under Fetakgomo Municipality are expected to be effectively engaging in the current issue of fighting HIV and AIDS. It is necessary to study how the pandemic impacts on the Fetakgomo communities and how they fight the pandemic in the context of development process.

1.3. Aim of the study

The aim of the study is to investigate the multiple social and economic effects of HIV and AIDS on community development at Fetakgomo Municipality, Limpopo Province.

1.4. Objectives of the study

The study will attempt to achieve the following objectives:

- To examine the extent to which the communities are experiencing the negative social and economic effects of HIV and AIDS on their people's development;
- To investigate whether the communities discriminate against people with HIV and AIDS;
- To determine whether the communities are ready to use their resources to fight HIV and AIDS; and
- To investigate how HIV and AIDS affect the education of children in the communities.

1.5. Research questions

The researcher will look for answers to the following main questions:

- What is the understanding of the communities about the effects of HIV and AIDS on the well being of their members?
- How does HIV and AIDS affect the basic needs satisfaction of the people from Fetakgomo communities?
- To what extent do the communities get involved in support programmes to AIDS sufferers?
- Is there any stigmatization attached to those perceived to be suffering from HIV and AIDS by the community members?
- Is there any leadership in the community mobilized against AIDS?
- To what extent are the community members ready to share information about HIV and AIDS?
- What indicates that the education of the community members is at risk from HIV and AIDS?
- To what extent do children from the community drop out of school due to HIV and AIDS related problems?

1.6. Significance of the study

The study will contribute to the understanding of how HIV and AIDS affect people's development at community level. It will widen knowledge about the way in which rural communities engage in matters related to this issue. The finding will contribute to further empowerment of policy-makers in South Africa to identity the complex socio-economic issues related to HIV and AIDS that affect people's development in a rural community.

1.7. Definition of concepts

AIDS: "AIDS is an acronym made up of the letters that mean Acquired Immune Deficiency Syndrome. AIDS is a disease that breaks down part of the

body's immune system, leaving the person defenseless against a variety of illnesses that are normally not life threatening to people without AIDS. AIDS is caused by the human immunodeficiency virus" (Department of Health, 1999:101; Venter, 2000: 135; and van Dyk, 2001:4; and Department of Education, 2003:1).

HIV "HIV is an acronym for Human Immune Deficiency Virus. A person infected with HIV may display no physical symptoms, mild physical symptoms or severe symptoms. People can be infected with HIV many years before they develop signs or symptoms of any illness" (Department of Health, 1999:101; Venter, 2000: 135; and Department of Education, 2003:1).

The difference between HIV and AIDS is that an AIDS diagnosis can be made long after the person has been infected with HIV and shows symptoms of severe weakling of the immune system while a person that is infected with HIV does not show any signs of illness (Department of Health, 1999:101; Department of Education, 2003:1, and Euvrard, Findlay, Normand and Nduna, 2005:100).

Community is defined as "people living together in one place

"(Auerbach, Divittis, and Mantell, 1997:10; and Human, Govender, Liewellyn and van Aard, 2003:50).

Development is conceived as "a multidimensional process involving major chances in social structures, popular attitudes, and national institutions, as well as the acceleration of economic growth , the reduction in inequality, and the eradication of poverty" (Smith and Todaro, 2003:17).

1.8. Structure of the study

The study is compiled according to the requirements to mini-dissertation and consists of the following five chapters:

Chapter One

This chapter includes background to the study, problem statement, aims of the study, objectives of the study, research questions, significance of the study, and definition of concepts.

Chapter Two

Chapter two gives an overview of the literature discussing the socio-economic effects of HIV and AIDS on individuals, households, and communities.

Chapter Three

This chapter presents the methods used in the study. It involves methodology, research design, area of study, population, sampling, choice of instruments, pilot study and data collection procedures.

Chapter Four

This chapter deals mainly with data presentation, data analysis and interpretation of findings.

Chapter Five

This chapter comprises summary of major findings, conclusions, recommendations, ethical considerations, limitation of the study and expectations for the future study.

CHAPTER TWO: LITERATURE REVIEW ON THE SOCIO-ECONOMIC IMPACT OF HIV AND AIDS ON INDIVIDUALS, HOUSEHOLDS AND COMMUNITIES

2.1. Introduction

The purpose of this chapter is to reflect the literature on the socio-economic impact of HIV and AIDS on communities passing through individuals and households.

According to Veenstra (2004:2), the socio-economic impact of AIDS may concern with how individuals behave, what determines the decisions they make and how these decisions interact in the context of AIDS. Hert and Lindenbaum (1992:1) define social reality as how people live and organize society. According to Frank and Bernake (2007:4), economic impact is the study of how people make choices under conditions of scarcity and the results of those choices for society. They indicate that there is not enough time, money or energy to everything we want to do or have everything we would like to have. By their definition the socio-economic impact of HIV and AIDS is how HIV and AIDS affect the way people behave, live and organize their society as well as how they make choices under conditions of scarcity and the results of those choices for society.

2.2. The social impact of HIV and AIDS

2.2.1. Major characteristics of the four stages of HIV and AIDS

In the context of social lives of individuals, there are those who are infected and affected by HIV and AIDS. Once individuals are infected there is going to be a number of issues indicating that their social lives are affected negatively.

According to Schoub (1999:32), individuals who are infected with HIV and AIDS may go through four stages of the disease. The **first stage** is called the **silent phase** where individuals may not be aware of being infected during this stage. Fan, Conner and Villarreal (1996:195) show that many individuals who first learn about their seropositive status find it a vital challenge to deal with the new information concerning HIV infection. This is shown to be putting a major pressure on individuals to self concept. In this instance a HIV positive individual may take the news as a threat to his self-concept and his first reaction would be denial. It is further shown that at this stage individuals may reject information from the test that show that they are HIV-positive (Fan, Conner and Villarreal, 1996:196). By rejecting the test they preserve their self concept of being healthy, strong or being HIV-negative. It is in this stage a HIV-positive individual has a possibility of engaging in risky behaviour to prove that he or she is still healthy and strong.

During the **second stage** which is called **progressive generalized Lymphadenopathy** (Schoub: 1999:33) and the stage of anger (Fan, Conner and Villarreal, 1996: 200), individuals become aware of the swollen lymph glands which are said to have the possibility of decreasing or increasing in size. It is shown that individuals may be angry at having a life-threatening condition. It is indicated that this anger is sometimes nonspecific and more diffuse, general and unintentional as the patient hurts others.
According to Schoub (1999:33), **the third stage** is the **AIDS related complex stage** which show signs of infection via weight loss, fever, diarrhea and recurrent through infections of the oral and genital mucous membranes. Fan et al. (1996:200) indicates that this stage is called the stage of bargaining where the infected individual's anger is adjusted. Here an individual moderates his anger. When the futility of bargaining becomes clear, the individual becomes depressed.

The **last stage** is called **AIDS stage** (Schoub, 1999:35) while Fan et al (1996:200) call it the stage of acceptance. It is difficult to deal with opportunistic infections and tumors during this stage of the disease. The infected individuals show both direct and indirect consequences of damage from the components of AIDS. The direct effects involve various organs such as the central nervous system, the gut, the blood forming elements, the kidneys, joints and skin. Other direct general effects are premature graying of hair and wrinkling of skin and ageing of the patient's appearance. Wasting and skeletal picture are characteristics of AIDS patients. Fan et al. (1996:201) indicate that it is at this stage that individuals tend to accept the reality of both good and bad aspects of the disease.

It is generally difficult to accept a disease that may lead any person to death. Evian (2003:293) shows that individuals who are infected with HIV and AIDS suffer from pains. It is difficult to know that one is sick of AIDS and one may die at any time. Bernett and Whiteside (2002:182) show that in the absence of treatment infected individuals can expect to experience periods of illness that increase in frequency, severity, and duration. It makes one's life hard to undergo such a process of illness that inflicts pain into one's body and mind. Van Dyk (2001:216) shows a number of psychosocial experiences that individuals with HIV and AIDS live with. These AIDS patients suffer from fear, loss, grief, guilt, denial, anger, anxiety, low self-esteem, depression and some sort of suicidal thinking. Fear is a factor that troubles individuals who do not know their status after an incident of unsafe sex (Schoub, 1993:33). Bernett and Whiteside (2002:182) show that a few individuals may not fall ill due to a combination of appropriate lifestyle, good nutrition and good luck. Those who do not have that combination get their CD4 cell decline as their state of health does so. It is painful to experience a deteriorating state of health.

Niang and Van Ufford (2002:21) is quoting van Dyk (2001:216) that there are important psychosocial effects that HIV and AIDS has on infected people. These range from frequently feeling uncomfortable, have a melancholic mood, staying in bed for hours, stopping to have children, stopped entertaining oneself, being abandoned by husband or wife, being divorced to avoiding to meet relatives or friends. This is an indication that HIV and AIDS individuals are faced with problems that distress them socially. To be divorced due to HIV and AIDS may indicate that the person is morally disapproved by both his fellow partner in marriage and God who is the founder of marriages. Some of the infected individuals may stop to be involved in social activities they used to do. This has an implication of feelings of failure and guilt that may ruin the so-called self-esteem (Niang and Van Ufford, 2002:21).

In this instance HIV and AIDS threatens the constitutional rights from Chapter 2 of Bill of Rights, articles 10 and 11 that indicate that everyone has inherent dignity and the right to have their dignity respected and protected and that everyone has the right to life. Individuals who are sick of AIDS may feel they are worthless and bound to die due to the pandemic.

2.2.2. Social isolation and stigmatization and discrimination of individuals living with HIV and AIDS

According to the Constitution of the Republic of South Africa 1996, Chapter 2 of the Bill of Rights article 9 (4) no person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). States do not allow any person to be discriminated against on the basis that he or she is HIV-positive or an AIDS patient. However, Gibson and Rohleder (2006:26) show that anecdotal reports indicate that the experience of stigma may be a far more significant part of the experience of those living with HIV and AIDS. HIV infection has been used as a rationale for exclusions from a range of critical social activities. America has read all too frequently about children with HIV being turned away from schools, of employees dismissed from their jobs and losing their life or health insurance, and of AIDS patients not receiving appropriate treatment, or of being forced by circumstance to stay in hospitals because they have no home to go. Discrimination based upon an infectious condition can be as inequitable as discrimination based on other morally irrelevant grounds such as race, gender, or handicap. Gibson and Rohlerder (2006:26) believe that discrimination against the HIV-infected is morally wrong, it can also be counterproductive from a public health perspective as shown in the literature.

According to Schurink and Schurink (1990:40), people with AIDS are probably the most stigmatized persons in the Western society today. Those infected people hide their status not to be known to any other person. Those who tried to share their position with others have lost their friends and jobs overnight. They indicated that hiding one’s status about being HIV positive is fundamentally

wrong in prevention (Schurink and Schurink, 1990:41). People, who get discriminated against on the basis of being HIV positive, are ultimately going to feel humiliated and eventually isolate themselves from others. Discrimination has a way to destroying HIV-positive individual's self esteem since they get labeled negatively from others. They are seen as the other of the human race. In this way discrimination gets individuals who are HIV positive making their self concept confused as they view themselves positively in life despite the fact they are HIV positive or AIDS sick (Schurink and Schurink, 1990:41).

In South Africa it is indicated that insurance industry applied certain clauses as the underwriting rules which were excluding those individuals who were HIV positive from getting life and disability policies (City Press, 2007:5). The exclusion of HIV positive individuals was categorically based on the so called 'fair' discrimination. The underwriting rules show that those who take certain policies have to undergo a blood test as a condition to qualify for the full cover following the results that an individual is not HIV positive. Those who are positive have to pay expensive premiums in order to come to the full amount or cover as compared to lesser premiums paid by those who are HIV negative. The image of the industry is shown to have been despised by the public for its discrimination against individuals who are HIV-positive (City Press, 2007:5). According to van Dyk (2001:335), people with HIV infection or AIDS should be protected from arbitrary discrimination. However, the insurance industry has the right to make underwriting clauses that fairly discriminate against those who are HIV positive in their operations. This is a way to protect their business from conditions that could destroy it (van Dyk, 2001:335).

According to Swanepoel, Erasmus, van Wyk and Schaenk (2003:138), the Employment Equity Act No. 55 of 1998 was introduced to protect HIV positive employees in the workplaces against unfair discrimination. However, this Act provides conditions under which an employee may be dismissed from work if he or she becomes very sick and she or he is unable to perform any duty assigned to him or her. In this instance the welfare of an individual person becomes to be at risk. Individuals still happen to lose their jobs under the umbrella of the very Employment Equity Act No. 55 of 1998, which was designed to protect employees. Although the Bill of Rights in the Constitution, the Employment Equity Act No. 55 of 1998 and the Charter of Rights on HIV and AIDS launched in 1992 try to protect HIV positive individuals from victimization, isolation, and discrimination by the public, Qakisa (2003:47) indicates that media's response to AIDS has stigmatized people with HIV and distinguished between innocent and guilty victims. He further indicates that journalists allocated blame to women and focused on them and portrayed them as individuals, who were destitute, comatose, cachetic, and desperate despite what these women were reporting as facts about their condition.

It is indicated that media contributed to the victimization and sideling of people living with AIDS. The public expect HIV-positive individuals to be skeletal,

emaciated, and fading in picture. The individuals living with HIV and AIDS have been seen as sexually available, deserving of the disease, helpless victims, and unable to make sound decisions. Therefore individuals with AIDS have been living with humiliation and isolation from their fellow citizens. HIV positive individuals have been wrongly portrayed as victims of sexually immoral activities despite the way in which they were infected might not be sexual. This culminates into victimization and humiliation of their image. It may even be a bitter experience when a HIV positive person is discriminated against and isolated by members of his or her family (Qakisa, 2003:47).

2.2.3. How HIV and AIDS affect the lives of old people

One study for Kwa-Zulu Natal projects indicates that there will be increase in burials of people due to HIV and AIDS where there will be increase in terms of cemetery plots, increase in burial costs, and transport from burials and increase in time taken off from work in order to attend funerals (Bollinger and Stover, 1999:5). This will impact on communities by draining their finances and disturbing their daily work operations when taking off their valuable time. It is also clear that deaths of community members disturb development as they bring changes in terms of service delivery and the demand for those services. In another case study by the Joint Oxfam HIV and AIDS Program in South Africa grandmothers` plight of chronic poverty, diminished physical and emotional health, loss of support from family and barriers to access to social assistance and health care are addressed to those grandmothers of Limpopo and KwaZulu-Natal. The grandmothers who experience these social problems created by AIDS are given new strategies to cope. They are given a community-based service for prevention and care (The Joint Oxfam HIV and AIDS Programme, 2006)). The problems of these grandmothers are addressed in a way of community–based service. They are also taught as to how to get help in relation to other departments that can aid them in terms of dealing with their social problems.

According to May (2003:18), older people are vulnerable to HIV and AIDS. They shoulder roles and responsibilities in HIV and AIDS-related care. It is shown that

in their old ages, where they might expect and require support, they are instead taking on the role of caregivers of their adult children. Despite their frailty of old age, they have to tolerate the physical and emotional strains of providing care which further put their health at risk (May, 2003:19). The issue of caring for the sick may get them isolated from their peers due to stigma related to the disease. Barnett and Whiteside (2002:216) indicated that the main problem confronting the elderly in society affected by HIV and AIDS is poverty. Poverty and frailty are made worse by the loss of their adult children who financially aid them and give them support they want. These elderly people are increasingly dependent both physically and financially. It is in the context of these poor communities that the elderly people become vulnerable to hunger, lack of support, and overburdening

responsibility of caring for their adult children, who are sick of AIDS, and their grandchildren. These elderly people need to be helped by their communities with resources for them to cope. They cannot contribute successfully to the development of their communities due to old age. This has a stressful impact as they have to care for the orphans by providing clothes, food, and school fees. This leads to the deterioration of those caring elderly people. It consumes their time and leads to lack of participation in communities hence they are emotionally stressed and old. It is indicated that there will be changes in living arrangements, well being and opportunities for a secure future of children (Poku, 2005:95).

2.2.4. The social impact of HIV and AIDS on households

According to Foster, Levine and Williamson (2005:6), the impact of HIV and AIDS on families beset a lot of social problems. It is highlighted that problems start with a parent's HIV infection, and then to more serious illness and ultimately death. Children remain with lost educational opportunities and psychosocial distress. Barnett and Whiteside (2002:184) indicate that the impact of HIV and AIDS may be experienced on household by reducing the demographic composition of household via death. Households with adult female infections experience lower birth rates and higher infant and child mortality rates. Households where a parent or both parents have AIDS, fewer children will be born and will die in infancy or childhood. The impact is seen when some of the life ways and traditions of these households are not carried forward. Foster et ai. (2005:6), citing Barnett and Whiteside (2002:184) show that in Thailand and Uganda there was a decrease in terms of people per household due to HIV and AIDS.

According to Barnett and Blaikie (1992:58), afflicted household take a lot of time in prayer for an ill member. The household members may travel long distances being in search of a curative drug, visiting the patient temporarily and living in fear of AIDS. Some families may be haunted spiritually by the death of a member who died in anger from AIDS. AIDS may impact negatively on family relationships if the patient has caused tensions between himself and his care-givers (Barnett and Blaikie, 1992:59). They further show that this tension leads to unhappiness of the household members as they do not need their patient to die angry and dissatisfied.

It is at this household level that affected children are forced to bear trauma and hardship from the epidemic. The disease is shown to be causing children to lose their parents or guardian, but sometimes they die as well (Avert, 2006). These children also experience a problem of carrying more responsibility, having no adequate access to nutrition, basic health care, housing and clothing. The AIDS pandemic creates a problem of many orphans who have to be brought up by their grandparents. This creates a social problem for the grandparents since

they are not competent in upbringing their grandchildren any more. These orphans become truant or do not perform well at school since they lack parental support. Barnett and Whiteside (2002:201) show that children in these affected household are usually less well-nourished and have a greater chance of being stunted or wasted. These orphaned children are socially, physically, educationally and emotionally lacking parent's support. De Guzman (2001:665) argues that lack of parental support to children increases their social vulnerability to abuse and hardships due to their social position. They depend on other people to care for them and respect their rights for their well-being. These orphans suffer disadvantages even when relatives care for them (De Guzman, 2001:665).

In terms of social life, AIDS has impact causing divorce in households, making women to leave their sick husbands and go back to their natal homes as these women demand unconditional assistance for their children (Barnett and Blaikie, 1992:60; Barnett and Whiteside, 2002:184; and Niang and Van Ufford, 2002:12.www, Unicef-icdc.org). Women whose husbands died of AIDS engage in either celibacy or migration. It is shown that celibacy, widowhood and divorce can condiderably affect children. Precarious situations as a result of HIV and AIDS infection cause considerate instability in the lives of children. It makes children feel marginal, not valued and confronted to new and difficult challenges.

According to Campbell (1999:142), behavioral and emotional disturbances can occur in children from affected household. Niang and Van Ufford (2002:15) show that children from these affected families can experience stress. These children have to take certain responsibilities if one of the parents is sick. The HIV and AIDS pandemic is extremely isolating as mothers are afraid to share the knowledge about the disease with their children (Campbell, 1999:145 and Niang and Van Ufford, 2002:10). Some of the parents may hide their status from each other and their children because of the stigma HIV and AIDS carries. These households which are affected are depicted to be living in fear of disclosure or of loss of support of friends and other people. Children who lose their parents to AIDS may also lose their neighbours, friends, and schools-their sense of community (Campell, 1999:142).

AIDS is also creating problems to parents who have to leave their children when they die (Faden and Kass, 1996:84). These affected households are experiencing a sense of loss – loss of a shared future for their children. Faden and Kass (1996:84) indicate that parents who are HIV positive may have problems in rearing children. They indicate that the problems of being depressed, demented, and delirious may cause loss of memory, decreased attention, and changes in personality. It is indicated that childrearing becomes difficult in families whose parents are infected of HIV and AIDS due to them being punitive to their children. It is also indicated that these parents become paranoid from the discrimination and hostile attitudes from community. It is

because of the disease that childbearing and childrearing would be difficult in infected families.

2.2.5. The social impact of HIV and AIDS on communities

2.2.5.1. How Isolation, stigmatization and discrimination of people living with HIV and AIDS affect communities

According to Barnett and Whiteside (2002:195), communities may develop or divide around specific issues. They further argue that the level of social cohesion of a community determines susceptibility to HIV. They do give examples of cohesive Ugandan community that responded to the threat of HIV and AIDS in their communities and reduced its spread while, on the other hand, they show that neighbours of Gugu Dlamini in KwaZulu-Natal in South Africa killed the woman after revealing her HIV positive status, because they believed that she brought shame on their community.

Van der Vliet (1996:53) argues that AIDS is unique in those who were actually afflicted, were already victims of prejudice and discrimination. She further indicates that the coincidence of a new disease, in marginalized communities, in troubled and insecure times has been a recipe for a new wave of prejudice. People who are infected may be prejudiced as risky groups. It is difficult to raise AIDS awareness to communities that have adopted negative stances on AIDS. She makes an analogy with the Biblical communities in the book of Leviticus where the lepers were taken as social outcasts. It is thus important to note that communities have to open up communication channels in becoming part of the campaign against the disease.

According to De Guzman (2001:664), HIV and AIDS is not a democratic disease, but is concentrated in population groups that were already marginalized, stigmatized, and discriminated against within society. He argues that some prevention efforts have focused only on reduction of risky behaviours of some individuals who are targeted as risky groups. They are at risk of HIV and AIDS due to their social position in community. This is to indicate that these individuals have reduced access and ability to utilize information and services, and they are powerless in sexual and economic relationships.

De Guzman (2001:665) argues that some individuals in community are less empowered to obtain information necessary for informed decisions and thus cannot act on decisions. It is in the context of social vulnerability within communities that De Guzman (2001) argues certain groups such as women, sex workers and gays may be thought as groups of people who cause the disease. This may increase stigma and discrimination and increase their

position to be socially vulnerable to HIV and AIDS as they do not have the power to protect themselves. At community level, it is important to strengthen the community in order to change the social structure of the situation of those vulnerable (De Guzman, 2001:666). Changing the attitude by reducing the stigmatization and isolation of people living with HIV and AIDS is important to community. If community leaders are involved in reducing the stigma and isolation of people living with AIDS, their social position will improve and the spread of AIDS will ultimately decline.

Van der Vliet (1996:53) shows the problem with stigmatization, blame, and discrimination of people living with AIDS, even though within gay community, where those who are victims get afflicted and further marginalized. De Guzman (2001:665) indicates that stigmatization of those perceived as carriers of the disease or the cause of a local epidemic can reduce access of those stigmatized people to health care and lead to discrimination in other areas of life. This leads to secrecy and may increase social vulnerability to HIV and AIDS. It is in this context of blame, stigmatization, and discrimination that those who are infected in community would prefer to hide their HIV-positive status. Discrimination and stigmatization of people living with HIV and AIDS increase their isolation from community.

According to Van Niekerk and Kopelman (2005:58), one of the cruel effects of AIDS is that it often afflicts people who are already victims of prejudice and discrimination: homosexuals, drug users or addicts, the poor and the wretched. It is also indicated that the results of AIDS are brutalization of intimacy itself.

According to De Guzman (2001:671), community mobilization via testing and counseling increases community awareness and discussion of HIV and AIDS, which can lead to a change in social norms to decrease stigma and more social support for people living with HIV and AIDS. He argues against a disease-centered approach in prevention efforts that it increases stigma and discrimination of people thought as carrier of the disease rather than approach that favours or looks at social vulnerability of individuals in communities. It is in this context of social vulnerability of individual within communities that issues such as unequal gender relations, earning power and low social status and poverty are considered. This approach may lead to better understanding of what could stop the spread of AIDS among members of the community rather than focusing on behaviour change of individuals alone.

It is in the context of community involvement and respectful care of people living with AIDS that a number of issues like community health care, sustained prevention, and the possibility of antiretroviral therapy are going to be possible. According to Barnett and Whiteside (2002:195), although communities cannot be perceived as the answer to the problems imposed by

HIV and AIDS, they are indicated to have a role to play. De Guzman (2001:669) shows the importance of community participation or involvement in matters such as Community Volunteers that are needed for a lot of issues in support and care of people and families afflicted by HIV and AIDS.

According to van Niekerk and Kopelman (2005:57), lack of leadership and the politicization of HIV and AIDS create a problem in curbing the pandemic. If community leaders are not mobilized towards fighting the pandemic in the context of their communities, the situation will not change. Senegal and Uganda have shown leadership and mobilization of communities in succeeding to reduce the spread of AIDS. Hewitt (1997:159) indicates a number of ways through which the disease can spread: social exposure relating to everyday habits and weaknesses, lack of protection, rights and information, and public indifference or stigmatizing. Van Niekerk and Kopelman (2005:57) give an example of South Africa where the spread of HIV and AIDS has been strife that is caused by lack of political leadership and denial.

According to Dejong (2003:108), one of the greatest obstacles or stumbling blocks to HIV and AIDS prevention is the extent of stigma surrounding the disease, with its attendant association with 'illicit' or 'immoral' sex, fatal disease, and deat h. She argues that stigma itself creates resistance to people in the general population recognizing their own high personal levels of risk behaviour. They feel not belonging to a stigmatized 'high-risk group' makes them safe. It tends to motivate fear, which in turn prompts denial and failure to accept vulnerability or the reality of infection. She argues further that this has been the reason why political leaders have been reluctant to accept to take responsibility for HIV. Due to sensitivity and stigma surrounding HIV and AIDS, it is not simple to do literacy campaigns in a short time (Dejong, 2003:109).

Hewitt (1997:162) shows examples of the danger of lack of involvement of community leaders in sub-Saharan African and South Asia where women were defenseless and vulnerable to the disease from their husbands. Women were forced to leave their homes because their husbands were dead of AIDS.

Webb (1997:168) indicates the way in which communities in Natal in the area of Mpolweni had shown a high level of stigmatization towards people living with AIDS. It is indicated that over 70 percent of respondents in the study would want to see people living with AIDS either killed or isolated away from the community. He indicates that AIDS raises fear which is only partly linked to misconception regarding the disease. The reasons for wanting to isolate are shown to be related to fear and resultant stigmatization. President Arab Daniel Moi, the former president of Kenya, is given as an example that during his tenure he wanted to isolate people

living with AIDS for the reason that some wanted to deliberately infect others. However, Webb (1997:168) indicates clearly that fear of AIDS is due to misconceptions and lack of knowledge about people living with AIDS.

Given this stigma, it is thus important to mobilize communities and their leadership so as to defeat stigma in dealing with issues related to AIDS.

According to Campbell, Foulis, Maimane and Sibiya (2005:471), the health-enhancing processes of solidarity, critical consciousness, and empowerment are likely to take place in communities characterized by the existence of trusting and supportive relationships within a local community, which form the context within which people can work collectively to achieve goals of mutual interest. They indicate that bonding social capital is important because people who live in trusting and cohesive communities, where their voices are heard, and they are able to articulate their views, are more likely to take ownership of the problem of HIV and AIDS than to passively regard it as the responsibility of professionals or distant government officials. In such communities, people are most likely to challenge stigmatization of people with HIV and AIDS and tend to treat them and their families with respect and dignity. In such humane conditions, HIV-vulnerable people are less likely to respond to the epidemic with fear and denial, and are more likely to feel confident to seek out information about prevention or testing, for example.

According to Rohleder and Gibson (2006:27), women in some communities in South Africa tend to be regarded as dirty and diseased and are seen as the source and infectors of HIV and sexually transmitted diseases. They show that these

women do not disclose their status to others, resulting in them as patients of AIDS being unable to find social and family support, thereby aggravating their sense of helplessness and loneliness. Quakisa (2003:48) shows that these women are blamed for deserving to have AIDS even if the way they were infected was not through sex. Rohleder and Gibson (2006:26) show that by stigmatizing those who are infected with HIV and AIDS the community tries to exercise power to reinforce socially constructed norms for what is acceptable and desirable, by defining what is deviant and excluding those who are found to be deviant. This practice, however, makes the prevention of HIV and AIDS very difficult to deal with in the communities. It is shown in the literature that it becomes easier to prevent and care for HIV and AIDS patients if AIDS is taken or considered to be ordinary like any other disease (Rohleder and Gibson, 2006:26).

2.2.5.2. How dialogue can bring about change in dealing with the social impact of HIV and AIDS

According to Barnett and Whiteside (2002:194), communities are important in mitigating the impact of HIV and AIDS due to their socio-economic environment that is supportive. The factor which helps communities to be seen as the vehicle of a successful prevention is their openness and willingness to talk about the disease and to give support for those infected. Ideologically there is a trend that perceives the community as the nexus for implementation of currently popular beliefs in empowerment etcetera, which need people to solve problems of poverty and exclusion (Bernett and Whiteside, 2002:194).

Reddy (2005:12), observes that it is important to understand how open communication about sex and sexuality is advocated among adults and young people and how it is interpreted by the young people and whether intergenerational talk facilitate or inhibit making responsible sexual decision within the context of the HIV and AIDS pandemic. It is in the context of communities' way of conducting themselves that may either promote the prevention of the spread of HIV and AIDS or condone its spread among their members. Reddy (2002:8) argues that for any effective communication between generations, the dividing lines between what is considered as public and private, legitimate and taboo, proper and shameful, adult and child, have to be challenged directly. This is necessary because some of the traditionally and culturally upheld notions about sexuality and AIDS from the incumbent communities may prohibit dialogue and communication among its members and prevent them from becoming part of the campaign against the dangerous disease that may curb their development. It is clear that if dialogue is created in the context of culture and tradition, that dialogue will be made to be amicable with that culture so that it can be accepted by the incumbent communities.

Quakisa (2003:47) shows the danger of trying to create a dialogue about HIV and AIDS that is contrary to the culture and traditions the message is intended to reach. Messages that are intended to raise AIDS awareness to the community which are not culturally acceptable would create an atmosphere of disrespect and rejection by the incumbent community. Communities accept messages which are culturally respectful to them. It is against this background that the Department of Health in South Africa has opted to have a programme called Khomanani that focuses on engaging community-based teams in order to spread HIV and AIDS messages through campaigns. It is from this practice of involving community organizations where the target members of communities are not going to receive HIV and AIDS messages that are alienating and culturally irrelevant to them.

According to the Human Sciences Research Council (2005:3), some of the African societies practice circumcision and scarification on infants and children as their cultural practices by using shared instruments and non-

sterile equipment. It is traditional healers who do group circumcision and scarification which expose both the traditional healer and his clients to blood transmission. This has the possibility of transmitting HIV and AIDS to them. It is in the context of these cultural practices which seem to be the possible sources of transmitting HIV and AIDS. Any message which is intended to caution the incumbent communities need to be sensitive and amicable to their cultures.

Reddy (2005:16) argues that what young people indicated as a problem in adult communication on safe sex is that it does not address issues of love and romance, but is subsumed by discourses on danger and disease. She shows the importance of situating sexuality education within relationships and not use an approach that discourages relationships. According to Reddy (2005:18), failure of current HIV and AIDS interventions in communities do not relate only to access to sexual education but also to how and what is taught. What is taught by adult people about HIV and AIDS should not be seen as trying to control young people. It has to be seen as trying to maintain the respect between generations.

According to Campbell *et al.* (2005:475), people are most likely to feel they can take control of their sexual health if they have experiences of being effective in other areas of their lives, and if they have a sense of self-respect and respectful recognition from others. Contrary to this view, they argue that adults frequently describe young people as mad, bad or deviant, a nuisance to be controlled through harsh discipline, corporal punishment and firm rules. In their study on the effectiveness of HIV-prevention programmes in Ekutheleni they show that most adults struggled to see youth as having anything of value to offer the community. And thus youth was locked out of community development structures, and virtually played no role in community decision making. And thus the intergeneration talk about HIV and AIDS is not going to be possible in that community. Again, HIV-prevention programmes that would be carried out in this type of community where young people are distrusted and marginalized are not going to be successful.

According to Auerbach, Divittis and Mantell (1997:14), when evaluating any HIV-prevention programme, it is important to involve communities. However, they indicate that evaluators need to recognize the diversity in communities and not to homogenize them into a group. Again, they indicate to be culturally sensitive to one group in a community may result in insensitivity to other groups. For example, promoting condom use as the primary means of sexual risk reduction may be acceptable to adolescents but unacceptable to parents and religious groups that endorse abstinence. Auerbach *et al.* (1997:14) argue in favour of participation of community members and leaders in any HIV prevention or evaluation programme for its success. They also argue that any evaluation team of a HIV prevention programme must have the understanding of community member and leader

in any HIV prevention or evaluation programme for its success. They also argue that any evaluation team of a HIV prevention programme must have the understanding of community members' cultural background.

2.2.5.3. The impact of HIV and AIDS on the education of orphaned children in community

According to van der Merve and Gouws (2005:53), the phenomenom of child-headed households where both parents have passed away and the eldest child take over the responsibility of caring for the other children is growing rapidly. This is shown to be causing an increase in school drop-outs.

Poku (2005:113) indicates that children in Botswana communities who are affected by HIV and AIDS have their access to education compromised. In Zimbabwean communities HIV and AIDS affect the primary education sector by reducing the number of children into smaller percentages (Policy project for bereau for Africa office of sustainable development, US agency for international development, 2001:34). According to UNICEF (2004:3), AIDS reduces parental care and protection of parents on the orphaned children due to increased economic hardships, and these orphans may fail to receive education. The absence of these orphaned children from school prevents them from learning about HIV and AIDS and how to avoid infection. These orphans are susceptible to abuse and exploitation, which further increases their risk of contracting the disease (UNICEF, 2004:3).

Ahwireng-Obeng and Akussah (2003:17) show that AIDS may impact negatively on attempts to reduce poverty through attacking the building blocks of human capital-that is improved education and health. Since orphaned children are out of school and would be deprived of quality education and lack information and skills which they need to reduce the risk of infection, and this is against the Declaration of Commitment adopted by 189 governments during UN General Assembly Special Session on HIV and AIDS in 2001 set to reverse the pandemic by 2015 (UNICEF, 2004:3). These orphaned children would not have a future as they will be without education and the necessary life skills to get employment and work for their lives. It is indeed difficult for these children to have education under the care of families which have adopted them, as Ahwireng-Obeng and Akussah (2003:16) indicate the disadvantages that these orphaned children have not eaten as well as other children and not being given the opportunities to improve their education. Lack of parental care and guidance is what gets their education disrupted. Poku (2005:113) indicates that communities are subdued by the growing number of orphans; these orphans' educational opportunities disappear due to the lack of support. Barnett and Whiteside (2002:197) show that AIDS orphans run greater risks of getting socially excluded, abused and exploited. Stigma and discrimination associated with AIDS deprive orphans of basic social services and education.

The standard of education that a child receives may be low due to the under-resourcing of public schools or as a result of AIDS pandemic (Barnett and Whiteside, 2002:202). In communities that are stricken by HIV and AIDS, the social roles, rights and obligations of people are disrupted. Younger children get abused by some of the members of communities, depending on the circumstances. It is shown on the disadvantages that these orphans have not eaten as well as other children and not being given the opportunities to improve their education (Ahwireng-Obeng and Akussah, 2003:16). They also indicated that the act of adopting an orphan cannot stop the problem since the country (Zimbabwe) has a high number of orphans estimated at 600 000 in 2000. Schooling for the orphans is disturbed and parents take their monies to bury their loved ones because of AIDS. Time for community members is consumed in caring for the sick, attending burials and comforting or helping those who feel helpless because of AIDS. It is indicated that older people in Zimbabwe are those who care for the orphans.

2.2.5.4. How disease and death due to HIV and AIDS affect communities

In communities, AIDS has the potential to kill parents, children and important professionals like teachers and nurses (Policy project for bureau for Africa office of sustainable development, US agency for international development, 2001:33; Hubbley, 2002:11; and Ahwireng-Obeng and Akussah, 2003:9). The accumulation of deaths in community is shown to be the cause of a number of orphans in community. It is shown that in the first 10 months of 1998 Zambia lost 1300 teachers in communities that were affected-equivalent to two-thirds of their annual output from teacher training colleges (Hubbley, 2002:11). He further indicates that It is not easy to replace a skilled or experienced teacher. When infected teachers die, children go to school without being attended to in terms of subjects (Hubbley, 2002:11). Teaching and learning get disrupted in such affected communities.

The same thing happens when teachers get sick of AIDS and are absent from school. Chifunyise, Benoy and Mukiibi (2002:382) indicate the importance of parents in teaching their children about and getting involved in matters of sexuality. If parents are dead, children and schools would have no parents to get involved and help in AIDS education at large. This leaves a big vacuum as their roles would be played by any other person in the development of communities. Poku (2005:95) indicates that death forces changes in the arrangement of things in the lives of those affected in the community. Thus, children's well being and opportunities are being missed due to deaths of parents cased by AIDS.

It is in the context of HIV and AIDS that the infected members face a problem of decay in their health. This would mean that those who are physically weak and sick would need care and support from the community. De Guzman (2001:668) shows that community involvement is important to intervene in the impact of the disease on members of the community. The responsibility that community members can take is to ensure respectful care and support of people living with HIV and AIDS.

The presence of AIDS in any community disturbs social development of its members (Van Dyk, 2001:177). Social development includes not only the formation of friendships; it includes the development of prejudices and negative attitudes towards other people. Death due to AIDS is shown to be contributing to demographic changes in communities (Family Health International, 2001:12
and Ahwireng-Obeng and Akussah, 2003:17). The reduction in life expectancy has

shown to be the contributing factor to the number of deaths in communities in some of the countries. This problem of death creates a problem in some of the communities as members are predominantly elderly people and children. Indeed this demographic composition disturbs progress of communities. Children and elderly people cannot contribute positively toward improving communities, as Barnett and Whiteside (2002:218) show that the elderly people are dependent and need support. Thus they cannot be expected to contribute fully to community development. Literature indicates that the death of young people in community creates a crisis as they are at the prime of their lives and affects population growth rates (Van der Merwe and Gouws, 2005:53 & Avert, 2006).

AIDS as a disease that kills people has a potential to destroy what the Constitution has set as the basis for human development from Chapter 2 of the Bill of Rights, article 10 and 11, everyone has inherent dignity and the right to have his or her dignity respected and protected and everyone has the right to life. When AIDS is rampant in the community, most of the above-mentioned rights get eliminated. And thus community members get desperate for help. It is in the context of AIDS that infected members of community will basically have no self-esteem, freedom to choose and the ability to meet the basic needs as the three objectives of development (Smith and Todaro, 2000:23).

The disease seems to be turning back objectives of the 1995 World Summit for Social Development article 36(b) which indicates that by 2000, life expectancy of not less than 60 years in a country (World Summit for Social Development, Copenhagen, 1995). AIDS is still contributing towards lack of social development in South Africa as people still have life expectancy of less than sixty. Communities cannot succeed in their quest for social development if they do not fight AIDS as one of the diseases that constitute human health problems.

Barnett and Whiteside (2002:159) argue that the epidemic terminates some lives, incapacitate others and stunt the capabilities of those who have to divert energy and time into care in the end. Sufficient number of deaths and illnesses make

society to take a path other than that it would previously have followed. The epidemic increases morbidity and mortality in populations at precisely those ages where their normal levels are low. The impact may be as an immediate and severe shock or they may be more complex, gradual and long-term changes. It becomes very serious when young people die. This is indicated to be threatening or overwhelming, the issue of AIDS deaths and illnesses, in communities which are poor (Barnett and Whiteside, 2002:160).

The high mortality rate of teachers in the community is affecting the quality of education (Hubbley, 2002:11). Children of families that experience AIDS-related death of its adult members are taken away from school in order to reduce expenditure. There is also some damage done on the education and future skills base due to the problem of HIV and AIDS. In Swaziland communities boys and girls are taken out of school by their elders in order to cope with the expenditures related to AIDS (Arrehag, 2006). There is dependence upon weakening extended
family structure incurring for the orphaned children. This also raises a problem for those extended families hence they cannot afford to give enough care for those orphans. In Swaziland communities' mortality has increased the costs for burial, which are expensive for members of communities. It adds to the suffering of people as they struggle to cope with the expenses emanating from AIDS deaths. It would mean communities would resort to selling their livestock and other productive assets in order that they may cope.

2.2.3.5. How HIV and AIDS affect water services in community

Lack of clean water and sanitation complicates the condition of HIV and AIDS sufferers since they need enough water delivery. Dr David Hemson(Water Services Sector and AIDS Bulletin, 2006) indicated that various studies of home based treatment report that the homes of HIV and AIDS victims are inadequately provided with water and sanitation. He indicated that people living with HIV and AIDS need access to water and sanitation in sufficient qualities to enable adequate health care possible as well as reliable quality of water from multiple uses like growing vegetables.

Lack of adequate water supply and sanitation affect the lives of people living with HIV and AIDS as they have to walk long distances to get them (Water Services Sector HIV and AIDS Bulletin, 2006). A 100 litre per patient per day is recommended. Lack of adequate water supply and sanitation increases chronic diarrhea.

Professor Larry Obi of Unisa presented findings from a case study commissioned by the water research commission which looked at diarrhea pathogens in households of HIV/AIDS patients drinking water from wells. The Study which was conducted in Limpopo focused on Vhembe, Waterberg and Capricorn district municipalities that there were pathogens

assisted from drinking water of households of HIV infected patients. These pathogens were similar to those isolated in stools of the patients themselves (Water Services Sector HIV and AIDS Bulletin, 2006). It was shown that water and sanitation play a key role in mitigating the impact of HIV and AIDS such that opportunities infections like diarrhea can be reduced. The implication is that if people fetch water from wells as some of the people are too weak to collect water from such distant areas, HIV infected households get burdened to fetch water from communal standpipes and the like. Again, lack of water supply increases the possibility for further infection by HIV and AIDS households.

According to Water Information Network (2006:7), many South Africans living in rural areas and informal settlements in urban areas do not have access to clean, running water and quality toilets. Everyone needs protection against contaminated water-related diseases, such as typhoid or cholera, especially people living with HIV, as well as access to hygienic and healthy environment. This has enormous implications as South Africa has one of the fastest growing HIV epidemics in the world. Lack of water services in HIV affected areas or communities will increase
the risk of people getting enormously affected by water-related illness that would worsen their health conditions. This would violate people's rights to basic services and quality of life.

According to Ngwenya and Kgathi (2006:670), for those living with HIV and AIDS, access to safe drinking water is a critical factor due to their vulnerability to infections as their immune systems are impaired. Safe water is an absolute necessity for people living with AIDS as it is needed for drinking, washing their laundry, taking medicines, and keeping their home environment in hygienic conditions. Lack of access to safe drinking water will make the AIDS affected persons, particularly those under home care, more vulnerable to HIV and AIDS as opportunistic infections are likely to thrive in poor hygienic conditions.

In the study done in Ngamiland on the impact of HIV and AIDS on access of water in home based care situations, it was found that water is extremely important to cope with stress due to reciprocity networks (Ngwenya and Kgathi, 2006:679). Lack of access to water is increasing problems in care giving situations of home based care. Water is important for the physical needs of the patient, the total living environment, institutional and social relations in which care giving takes place. The pandemic is also shown to be disturbing to the community. This is causing problems for care giving as opportunistic diseases attack people living with AIDS in the area.

2.3. The economic impact of HIV and AIDS

2.3.1. The economic impact of HIV and AIDS on individuals

According to Alcamo (1997:253), there are direct and indirect economic costs arising from the HIV and AIDS infected individuals. He indicates that a lot of money that is used for caring AIDS patients is a direct cost. The money used indirectly for hospital equipments, mandating blood screening, employing infection control procedures and establishing educational campaigns are indirect costs. Other indirect costs are the "worried well" patients caused by way of counseling expenses, testing procedures, loss of time at work, and infections that may occur while the person is stressed. According to Erasmus and van Dyk (2003:15), an individual who dies due to illness may be a breadwinner. In this instance a lot of income and labour may be lost. Whenever an individual losses his or her income and labour to the company he or she works for, this will render him or her dependent upon others in terms of getting money to sustain his or her life.

According to Brookes et al. (2000:167), AIDS is responsible for the death of many people in this country. Treating AIDS and losing trained people are expensive for the economy of a country that is developing like South Africa. It is clear that individuals who are sick at their workplaces will have to be treated to be productive. It is also important to know that it is very expensive to buy drugs that would successfully sustain the health of an individual worker. The company will lose a lot of money if it will treat an employee who is sick of AIDS. Similarly it will be a great loss to that company if that sick employee dies with the skills and education that the company needs. This is due to the number of years it takes for a person to acquire experience
and the necessary skills from the trainings that companies provide to certain individual employees.

According to Bernett and Biaikie (1992:60), individuals differ in terms of being dependent and not being dependent for their survival from AIDS. Those who have resources and money continue to be integrated as a member of community. Those who have got no resources and money will be desperate from AIDS and would not involve themselves into community. It is shown here that individuals who have enough money and are not dependent upon each other would not be seriously affected by AIDS like those who are poor and dependent upon others.

2.3.2. The economic impact of HIV and AIDS on households

According to Foster, Levine and Williamson (2005:41), household surveys in Cote d'Voire, Tanzania, and Thailand have shown that HIV and AIDS can reduce income by 40 to 60 percent. The findings from the study showed that effects of the disease and the demands of care giving evolve within a household and there are district peaks of financial pressure. This has five phases through

which the family experiences some financial problem of assisting a member of the family whose health is declining and is no longer economically active. As the family visits its AIDS sick member at the hospital, it experiences expenses through liquidating assets and spending time to provide care, leaving less time for their own economic activities. Once the sick member is bedridden, this would exert pressure on the household resources as the business would be closed in order to be with the patient. The family will have to care for the other children of the sick person and there is a lapse of income at this stage. Once the sick member is death it is indicated that burial calls for enormous expenses. Lastly, orphaned children will have to be taken care of. The care giving household will experience a growing pressure as school fees has to be provided for the surviving children who are incorporated into the family.

Veenstra (2004:6) indicates that affected households from several studies show the impact of AIDS on the following:

- medical and funeral expenses consuming household resources,
- less money is spent on food in the household,
- and less resources are given to education.

In other studies by Boosen, Rensburg, Bachman, Engelbrecht and Sten (2002), Nkurunziza and Rakodi (2005:14), Barnett and Whiteside (2002:189) and Bollinger and Stoner (1995:5) indicate a number of economic impact of AIDS on households. They show affected households experiencing higher funeral costs and loss of income due to illness and death. Financial burdens are engendered by the death of an economically active individual, leaving the households existing savings depleted which leads to borrowing in order to ease the financial burden. The affected households remain poor due to using all of their savings and selling some of their natural capital assets like land in order to cope with AIDS. Treatment of HIV and AIDS induced illness levies a heavy financial burden on households' already diminished resources.

HIV and AIDS cause costs in terms of finance and time (Avert, 2006). According to Barnett and Whiteside (2002:193) other households are experiencing the burden via
helping with food, clothes and cash to the affected households. The physical capital which is needed for the well-being of households may be neglected due to diminished labour arising out of caring for the sick member of the households (Nkurunziza and Rakodi, 2005:14). HIV and AIDS affect the physical capital such as basic infrastructure, production equipment and tools that maintain the households' well-being by diminishing the labour resources that have to make use of them. Some of the physical assets are sold out by the affected households so as to cope with the pandemic.

According to Foster et al, (2005:39); Ahwireng-Obeng and Akussah (2003:15); Barnett and Whiteside (2002:193); http://www.avert.org/aidimpat.htm.; and Bollinger and Stoner (1995:5), in terms of economic impact of AIDS on households the following are shown to be experienced:

- Loss of income of patient (who is frequently the main bread-winner); household expenditures for medical expenses may increase substantially; other members of the household, usually daughters and wives, may make school or work less in order to care for the sick person;
- Death results in a permanent loss of income, less labour on the farm and less remittances; funeral costs and the removing of children from school in order to save on education expenses and in household labour, resulting in a severe loss of future earning potential; loss of assets by way of selling in order to cope with the medical expenses and the loss of savings and the creation of housing backlogs that had to be provided to needy and desperate households.

A study in South Africa found that already poor households coping with members who are sick from HIV or AIDS were reducing spending on necessities such as clothing, electricity, food and other services even further (Avert, 2006). It is also reflected in the literature that the AIDS pandemic adds to food insecurity in many areas as agricultural work gets neglected due to household illness. According to Mutangadura, Jackson and Mukurazita (1999), once households' members are sick, less time is dedicated to agriculture. It is again shown that once there is a patient in the household, there is going to be a lost labour from the patient and the care givers also transfer labour time from productive activities into care provision. This shows to be happening especially if a husband or wife is sick. Mutangadura, Jackson and Mukurazita (1999:43) argue that children from afflicted households substitute their fathers and mothers in some domestic tasks and agricultural activities. They also indicate that children are sent to harvest crops and sometimes to prepare food for the household. Harnessing of child labour would mean these children are withdrawn from school. These children would not attend school and have less education which could make them unemployable when they grow up as adults.

The affected household experiences a loss in terms of income which is supposed to improve its members economically (Avert, 2006). Those members of the affected households experience some kind of reduction in terms of spending money on necessities such as electricity, clothes, food and other services such as water supply should not be undersupplied in areas where people need them most. This is that because AIDS patients need clean water to stay washed and drinking in order to avoid further infections. These affected households can no longer afford paying for electricity; they would stay with no electric supply where patients would suffer from lack of proper care since electricity is not there for lights and other domestic chores.

The quality of life of the members of these affected members is devaluating from disease that kills economically active members of the households, leading to inevitable expenses from the survivors (Avert, 2006). Children from these AIDS-stricken households would remain not well-fed and their lives would be limited due to lack of money to attend school (Avert, 2006).

Smith and Todaro (2003:404) argue that a healthy population is a perquisite for successful development. Showing further that health and nutrition do affect empowerment, productivity and wages and very substantially so among the poorest of the poor. Death of members of affected household, ill-health and lack of income contribute to poverty and suffering. The affected households would experience a problem of poverty as there is not time to plough the fields. In this way it is shown that households' assets such as bicycles, livestock and even land are sold (Avert, 2006).

In terms of economic life AIDS has the potential to impoverish households (Barnett and Whiteside, 2002:188; and Niang and Van Ufford, 2002:60). The problem that AIDS causes is to make widows experience a decline in their standard of living because women in general have less entitlement than men to other people`s labour (Niang and Van Ufford, 2002:60). These widows experience a problem of their properties being sold and some of the land taken away from them.

In terms of economic impact of AIDS on households it is indicated that AIDS increases the chances for absolute poverty (Smith and Todaro, 2003: 398 and Hubley, 2002: 11). Basic health is an effective means to achieve goals of poverty reduction (Smith and Todaro, 2003: 405). They argue that if parents are unhealthy and weak to work, their children will be subjected to child labour. Of course, child labour is indicated as one of human rights abuses in the Constitution of South Africa and the African Charter of Human Rights. These children cannot get the education they want. This further means that the children of their children would be subjected to child labour. Child labour may be extended across generation, and a family will be locked into a vicious cycle of poverty (Smith and Todaro, 2003: 405). The issue of children not getting education and families getting locked into poverty would be against the New Millennium goals of reducing illiteracy and poverty by half in 2015. HIV and AIDS create a development crisis for families and their children. The issue of lack of education on the part of children whose families are infected poses a problem to their development as they would not get employment in future.

2.3.3. The economic impact of HIV and AIDS on communities

2.3.3.1. The negative impact of HIV and AIDS on agricultural farming

According to Poku (2005:9), heads of households who were chronically ill reduce the area of cultivated land and thus reducing crop production in farming communities. In cattle farming communities, animals are sold to meet cost

caused by AIDS; death of an adult causes labour loss and reduces income and lower production. It is also indicated that income is reduced by 30 to 50 percent annually. Poku (2005:102) shows that the death of males in crop producing communities affects them greatly. This is for the reason that available labour is entirely dedicated to food crops. And thus males form a good labour for crop production.

According to Policy project for bureau for Africa office of sustainable development, US agency for international development (2001:34), in a study sponsored by the Zimbabwe farmers Union it is shown that production of various crops dropped due to HIV and AIDS deaths of adults in some families. AIDS is cutting the marketed production of maize in small scale farming and communal area by 61 percent due to the death of an adult worker. The death and illness of adults have a devastating impact on agricultural production in communitie. The resulting impact of the pandemic on subsidence farming communities is that food consumption is being reduced and nutritious crops are being replaced by less labour intensive, starchy root crops. It is feared that falling supplies and shifts to lower quality foods may lead to chronic food insecurity and higher levels of malnutrition in some of the communities (Policy project for bereau for Africa office of sustainable development, US agency for international development (2001:34).

It is reported that in Swaziland communities mortality has increased the cost for burial, which are expensive for members of communities (Arrehag, 2006). These communities are shown to be selling their livestock and other productive assets in order that they may cope. People change cropping patterns in order to cope with AIDS death. It is shown that HIV and AIDS morbidity and mortality reduced labour and income. Labour gets reduced on farming moving to crops that require less labour and farm inputs and less livestock. There is reduction of growth domestic product due to loss of labour and less crop output on farms (Muwanga, 2004). HIV and AIDS deaths of adults reduce labour that results in the loss of skills in communities. Factors such as loss of productive members of communities, income change and reduction of crop output affect community negatively (Muwanga, 2004).

AIDS reduces crop production which will reduce the standard of living of members of the incumbent communities (Poku, 2005:102). The problems of malnutrition and loss of labour contribute to food insecurity and lower standard of living. Changing of cropping patterns to less intensive labour crop production where intensive labour crop production is needed shows decline in terms of economic growth. Poku (2005:102) indicates that the agricultural base of rural societies is affected as are livehoods of rural people. She further shows that people who are already impoverished face more desperate situations as HIV and AIDS destroys their limited labour supplies and assets.

Rural communities are shown to be experiencing a loss of labour for food and income productions (Poku, 2005:102). These people are too weak to work or are caring for family members who are ill. What is shown to be lost in community when adults die is the acquired knowledge of farming practices. What is left is the responsibility for farming to those who are new and without an adequate understanding of livestock care, soil and plant type, or land preparation methods. The farming practices are disappearing with the adults who die of HIV and AIDS. And thus the traditional farming knowledge gets lost to communities as adults die of AIDS (Poku, 2005:102).

2.3.3.2. The negative impact of HIV and AIDS on the potential of people who form labour force in community

Tam (1998:85) argues that work is important since it makes communities meet the requirement for converting resources into goods and services sought after by the
citizens themselves, contributes to the generation of income which provides citizens with greater degrees of autonomy so that they take part in collective deliberations without being dependent on others. He further shows that work helps the citizens to achieve the value of fulfillment because without work or any kind of meaningful work, people lose their self-esteem and sense of purpose in life. Communities who suffer severely from the spread of HIV and AIDS thus lose their self-esteem and sense of purpose in life. Loss of labour creates a problem of poverty to community and the loss of skills for companies the labourers belong to (Erasmus and Van Dyk, 2003:15 and Brookes, Conje, Shongwe and Ziervogel, 2000:167). It is in the context of AIDS that people lose their health and become unproductive for their dependence on others: this would mean the community members would live without income or wages. Smith and Todaro (2003:404) put it clearly that a healthy population is a prerequisite for successful development. Without labour communities would grow poor economically.

If parents are sick and without work in their communities, children would have no financial support in order to go to school. Nutrition is what their children would lack due to them being without income. Smith and Todaro (2005:404) indicate that health and nutrition affect empowerment, productivity and wages. Basically if communities lack income and health, they lack the basis for their development and fulfillment in life. By attacking the labour force AIDS plays a role in the reversal of human development. This is done when AIDS is seen damaging the economy (Avert, 2006). It is in the context of AIDS that productivity of those who are infected would decline. Of course, nobody would be effectively productive when he or she feels seriously sick. Once members of communities remain without work due to problems of AIDS they become dependent upon others; they cannot make choice in life and they remain unfulfilled in life. This problem of community members remaining without work would create a problem of poverty as many people are dependent

economically. Smith and Todaro (2003: 404) argue that it will create a cycle of poverty. Rural communities are shown to be experiencing a loss of labour for food and income productions (Poku, 2005:102). These people are too weak to work or are caring for family members who are sick, then work becomes neglected as a means for survival. And thus poverty and disease will settle in those communities.

2.3.3.3. Stress that is put on available community resources due to HIV and AIDS

In Malawi 43% of their time is spent caring for sick members of households. HIV and AIDS has negative impact on development of communities by way of demanding the education of orphans and impacts on future skills base (Arrehag, 2006). There is an increase of strain on available community resources like labour and capital. Again, there is increased food insecurity on communities. Illness and death give a biggest financial setback on communities.

There is a high loss of capital due to illness and death in communities that create a biggest financial setback (Arrehag, 2006). A negative impact appears on land and farming – that is accountable to 54, 2 % reduction in maize production in communities with an AIDS death in Swaziland. In Swaziland one–third of the population could not meet food requirements. There is an increasing number of orphans that impacts on the social fabric and communities. These have an impaction
that people cannot fully help each other when they are hungry and very poor (Arrrehag, 2006).

HIV and AIDS morbidity and mortality reduced labour and income. labour gets reduced on farming moving to crops that require less labour and farm inputs and less livestock. There is reduction of growth domestic product due to the loss of labour and less crop output on farms (Muwanga, 2004). The impact of HIV and AIDS is shown by reducing labour that results in the loss of skills to communities, households and organizations to the socio-economic development of communities. Factors such as loss of productive members of communities, income change and reduction of crop output of communities, income change and reduction of crop output affect communities negatively (Avert, 2006).

CHAPTER THREE: RESEARCH METHODOLOGY

This chapter deals with research design, area of study, specifically with methodology used to conduct the empirical part of the study. It comprises the population, sampling, choice of instrument, pilot survey, data collection procedures, and methods of data analysis.

3.1. RESEARCH DESIGN

According to De Vos, Delport, Fouche, and Strydom (2002:271), research design is explained as all those decisions a researcher makes in planning the study. The researcher used the phenomenological design to study the problem. According to Creswell (1998:51), a phenomenological study describes the meaning of lived experiences for several individuals to adopt a concept or the phenomenon. Phenomenologists explore the structures of consciousness in human experiences (Creswell, 1998:51). De Vos *et al*. (2002:273) define the phenomenological study design as the one that aims to understand and interpret the meaning that experiences of a phenomenon, topic or concept have for various individuals. They further state that the researcher using this study design reduces the experiences to a central meaning or the essence of the experience being studied. The researcher thus found this design suitable to the study, as it reflected on the experience of the respondents about the effect of HIV and AIDS on communities in the Fetakgomo Municipality. In the study the researcher wanted to investigate the devastating effect that HIV and AIDS had for development in the communities.

The study used a qualitative approach. According to Denzen and Lincoln (1998:3) qualitative research is multimethod in focus, involving an interpretive, naturalistic approach to its subject. This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of meaning people attach to them. Qualitative research involves studies that use and collect a variety of empirical materials- case study, personal experience, introspective, life, story, interview, observation, historical, international, and visual texts that describe outline and problematic moments and meaning in individuals` lives.

According to De Vos *et al.* (2002:364), in qualitative approach the researcher tries to gain a first hand holistic understanding of phenomena and data collection gets shaped as the investigation proceeds. The qualitative approach is based on the assumption that valid understanding can be gained through accumulated knowledge acquired at first hand by a single researcher (De Vos *et al*., 2002:364). The researcher thus found the qualitative approach suitable to the study, in reaching the findings and conclusion through the understanding of the HIV and AIDS phenomena in the selected research sites.

Since the researcher wanted to gain understanding of the socio-economic impact of HIV and AIDS on community development at Fetakgomo Municipality, and listen to those involved in telling their experiences from their own perspectives, a qualitative approach was chosen. It helped the researcher to gain a holistic picture and detailed view of the informants in their natural settings as shown by Creswell (1998:14). The researcher had to go into the field of study using the qualitative approach to have access and gather information. This was done with enough caution throughout the research process in order to gain insight. The researcher came into contact with the participants who co-operated and helped him to gather information from the questions under the study.

3.2. AREA OF STUDY

The study took place at communities falling under Fetakgomo Municipality. This municipality is under Greater Sekhukhune District Municipality. Fetakgomo Municipality comprises 15 villages that had been merged as wards: Mphanama, Phaahlamanoge, Radingoana, Mashilabela, Seroka, Phooko Ratsoma, Strydkraal, Apel, Mohlaletse, Nchabeleng, Maesela, Nkwana, Atok, Rostock, and Shubushubung.

The people from these villages have the same culture and are mostly sepedi speakers, except a few of Tsongas and other ethnic groups from other cultures who come to settle in those communities with the approval of the chief. The villages from Fetakgomo Municipality have been ruled by chiefs, or by the so called traditional leaders. The area where the villages are found is South of Burgersfort. Some of the people in those communities work as civil servants – teachers, nurses, policemen and social workers. Most of the old people are illiterate. Some of the people, mostly males, are employed labourers in the mines around. The area has churches, clinics and police stations. The most predominant religion is Christianity even though the people belong to various dominations. There is a high level of poverty and unemployment in the area. (See appendix four: Locality Map)

3.3. POPULATION

According to De Vos *et al*. (2002:198) population is defined as a set of entities in which all the measurement of interest to the practitioners or researcher is represented. The population of the study is determined by the members of those communities, who are aware of HIV and AIDS. In a first approximation, the researcher assumed that traditional leaders and the leadership of established community institutions such as schools, clinics, local government authorities, churches police stations, traditional healers and community-based projects were considered as the target population for the study.

3.4. SAMPLING

The sampling process consisted of convenient and purposive sampling. Convenient sampling was used to select the three villages from which the respondents would be selected. Purposive sampling was used to select the respondents from the three villages. The three villages were selected on the basis of certain factors, which are accessibility, costs, lack of time and lack of resources. The selected villages are as follows: Nchabeleng, Mohlaletse, and Strydkraal.

In purposive sampling, the units are selected according to the researchers' own knowledge of and opinion about which ones they think will be appropriate to the topic area. According to David and Sutton (2004:152), individuals are judged by the researcher to have specific knowledge of the issue. The sample selection was based entirely on their opinion of who would be the most appropriate respondents to select. The researcher was convinced that non-probability purposive sampling would be suitable for the study due to the sensitivity of issues related to the topic. The researcher felt those who were involved in community leadership, mature and more informed would be the most appropriate respondents to select. Traditional leaders and authorities of established institutions such as churches, police stations, clinics and community – based projects would form the sample. About 8 such community representatives from each of the three villages were selected for participating in individual person-to-person interviews. About 24 participants took part in individual person-to-person interviews from the three villages.

The same eight participants from individual interviews were selected for a focus group in each village. There were 24 participants in the focus groups from the three villages. The same eight participants in the village focus groups were selected to make a combined focus group of 24 participants from the three villages. According to Creswell (1998:122), interviewing ten of the people who have experienced the phenomenon is enough. A total of 72 participants from individual interviews, focus group interviews and the combined group interviews were selected to participate in the study. They were different from village to village. At Ga-Nchabeleng, for individual interviews, they were:

One representative of the traditional leader`s office
One representative of a school
One representative of a clinic
One representative of a church
One representative of traditional healers
One representative of a home-based care group
One representative of police
One representative of community development workers

At Mohlaletse, for individual interview, they were:

One representative of the traditional leader`s office
One representative of a school
One representative of a church
One representative of traditional healers
One representative of a home-based care group
One representative of a ward committee
One representative of local government councilor
One representative of community development workers

At Strydkraal, for individual interview, they were as follows:

One representative of the traditional leader`s office
One representative of a school
One representative of a church
One representative of old people care group
One representative of a project
One representative of home-based care group
One representative of a clinic
One representative of a ward committee

The main aim of involving different leaders of established institutions in communities was to get their different views with regard to the socio-economic impact of HIV and AIDS on community development at Fetakgomo Municipality. Their views were important in relation to how those communities of Fetakgomo were affected and how they coped with the pandemic. Some of the institutions like welfare department and police stations were not available in some of the villages. Those who were readily available like schools and clinics,were approached and their leaders participated in the study.

3.5. Choice of instruments

The methods of data collection that are available in qualitative research are participant observation, documentary study and interviewing. Since this was an interpretative study, the researcher found it suitable to use both interviews and participatory observation. According to De Vos *et al*. (2002:273), it is suitable for a researcher who uses the phenomenological design to utilize participant observation and interviews as methods of data collection. It was useful to make use of interviewing techniques to gather information. Field notes were taken during interviews.

The researcher found people or places to study as to gain access and establish rapport so that participants would provide the data. Individuals who had experienced the issue under the investigation were asked for permission to be interviewed.

In terms of interviews, the researcher got participants who had experienced the issue to be interviewed on its impact on the community. In that the researcher happened to gather information on how the pandemic had an impact on their communities. The researcher obtained people who were more informed about the issue under investigation. Both person-to-person interviews and focus group interviews gave information on how the pandemic impacted differently on the three communities under investigation.

During interviews the researcher followed the following steps (Creswell 1998:125):

- Select the site;
- At the site the person to interview, the issue and time to take were determined;
- A protocol as a method for recording notes in the field was held;
- Aspects such as portraits of the information, the physical sting, particular events and activities, and the researcher's reactions were recorded;
- The researcher was introduced where he was an outsider; and
- Before going on with interviews, the researcher gave thanks to the participants and informed them of the use of the data and their accessibility to the study. The researcher made that all of the steps were followed during the interviews to ensure control.

In terms of interviews a semi-structure one – to – one type of interview was used. The semi-structured one-to-one interview helped the researcher to ask questions, which were open – ended via an interview protocol that helped to write the answer to the respondents' comments. Field notes were written down immediately after an interview. In some instances the researcher made use of a tape recorder. The place for an interview was prepared and the setting was also assessed for audio taping. The consent of the interviewee was obtained while the time for that interview was also determined. During the interview the researcher made sure to focus on questions and completed the interview within a specified time. The researcher thanked the participant and gave a few advice wherever necessary.

Four focus groups were formed after careful planning, or recruiting and conducting the group. A combined focus group of leaders from the three villages was done. One group meeting in that combined focus group was conducted. Information was issued to the participants and then four group meetings were conducted with each group of the three village focus groups.

The assistant facilitator, the one who was assisting in facilitating the focus sessions, took the notes as the discussions went on. It was the researcher who found a place for those focus group meetings. The time and place to convene the meetings were communicated to the participants.

3.6. Pilot Survey

A pilot survey was used in this study to test the instruments for data collection. It helped the researcher to improve them with focus on questions which were vague and had to be reshaped.

3.7. Data Collection Procedures

Permission was sought from the community leaders and the municipality before conducting research. Once the authorities granted permission, the researcher sought further permission from time to time so as to avoid intrusion into the public domain.

In terms of recording procedures the researcher made use of data collections forms in all of the interviews. Protocols and predetermined sheets on which one wrote information learned during the interview were used. In terms of tape recorded information the very data was transcribed immediately after each interview. Protocol helped to enable the researcher to organize his thoughts on items as to how to start the interview, give concluding ideas, and give information on ending that interview.

Before the researcher could interview the respondents he developed questions to be used to gather information. The researcher used a schedule to which all of the respondents had to adhere to. The researcher asked set of questions of research but still had the freedom to go beyond them.

It had happened that with regard to individual person-to-person interviews the researcher got a 100 percent response from the community leaders. This was about 24 of them. From the village focus groups the researcher also got a 100 percent respond from the community leaders. This was also about 24 of them. It happened that only one of the eight community leaders from each of Mohlaletse and Ga-Nchabeleng came to attend a combined focus group for the three villages. All of the eight community leaders at Strydkraal were present. The researcher did not get a 100 percent attendance with regard to the combined focus group from the community leaders of the three villages. The combined focus group was held at Strydkraal. In terms of a combined focus group all of the participants were invited and only 10 of 24 presented themselves. The purpose of doing this combined focus group interview was to get questions answered from a different angle. Lastly, the other reason was that people could provoke each other and be able to give deep information.

The questions for both the village focus groups and the combined focus group were answered through the consensus of the participants.

The researcher went to Ga-Nchabeleng, Mohlaletse and Strydkraal to secure an appointment with all of the eight leaders for an interview. This started on the 23 of June and ended on the 15 of July in all of the three villages. The researcher started first with person to person interviews and ended up with focus group interviews in the three villages. A combined focus group was done at Strydkraal with participants from the three villages on the 13 of July**.** The interviews carried on with individual leaders on average took 25 minutes. They were conducted during school holidays and during the general public strike. The researcher went to those leaders' homes and asked them of their permission to be interviewed and scheduled for appointments. The researcher was able to also ask their feelings, views and perceptions on some of the questions regarding the socio-economic impact of HIV and AIDS on the development of community. This helped to unearth the meaning they attach to the issue. According to De Vos *et al*. (2002:298) the interviews meaning is necessarily negotiated between a number of selves. Thus the researcher was after the issue of meaning rather than sentences when translating from English to Sepedi during interviews.

At Ga-Nchabeleng some of the leaders were not found at home. The researcher would go to their houses several times not finding them and with him persisting on making several appointments until the researcher got them. At Mohlaletse the researcher also used one community leader, the chief's spokesperson, to get access to other community leaders, especially in terms of focus groups. The researcher went to Mohlaletse for three days interviewing individual leaders. Focus groups were done at the place of home-based group members and at the church.

The researcher had access of the leaders for interviews. He mostly visited them in their homes and interviewed them. After explaining the purpose of his visit he would give letters of consent to be signed and the interviews would take place on the same day. The researcher had minor problems in accessing the leaders. Some of the leaders were not accessible due to their commitments and the researcher would go for those who were accessible. Some were not willing to take part in the study and the researcher would switch on to those who were readily available.

3.8. METHODS OF DATA ANALYSIS

In this study construction and deconstruction as parts of analytical mechanism were employed. According to Sarantakos (2005:352), construction and deconstruction are parts of an analytical mechanism that is closely associated with interpretivism and the notion that the world is constructed. Because this is an interpretative study about the lived experience on the socio-economic impact of

HIV and AIDS on Fetakgomo communities, construction and deconstruction were chosen as a theory. According to Miles and Huberman (1994:8), phenomenologists need 'deep understanding' of a phenomenon by dwelling on the subject of one's inquiry. They work with interview transcripts but being careful about condensing the material to achieve that. In that manner, continued readings of the source material is made but being careful about their presumptions in order to reach the deep understanding of the informant or capturing the essence of meanings and actions. Researchers have to reflect their convictions or conceptual orientations as they are not detached from the objects of study. The researcher used common features that are used across most analytical methods as are shown in Miles and Huberman (1994:9) as follows:

- Managing data from field sources such as interviews;
- Noting reflections;
- Sorting and sifting throng material to identify similar phrases, relationships between variables, patterns, themes, differences between subgroups and common sequences;
- Elaborating a small set of generalizations that cover the inconsistencies discerned in the database.

The researcher started managing data by creating and organizing files for the data. The files were converted into appropriate text units, for example, a sentence for analysis using a computer or writing. The researcher read through the text to get the sense of the whole database. The data were classified according to themes or categories of information. Statements were grouped into units of meaning. Statements of meaning for individuals were enlisted. The data got interpreted by making sense of it. The researcher developed
what actually happened about the issue in the context and also developed the manner in which it was experienced. The construction of the overall description of the meaning and the essence of the experience was made.

CHAPTER FOUR: DATA PRESENTATION, DATA ANALYSIS AND INTERPRETATIONS

4.1. **Introduction**

This chapter reports on data analysis. This includes analysis of person-to-person interviews, village focus group interviews and analysis of a combined focus group. Person to person interview of community leaders took place in the three villages, involving individual community leaders. Focus groups involved a group of community leaders who participated together in the study as a group to respond to the interview. The focus groups answered the questions through consensus. Each village had its focus group to respond to the interview questions. A combined group of community leaders from each of the three villages formed a combined focus group interview. Again their responses were to answer the questions related to their communities. The tables that reflect the responses of community leaders are as follows: tables 4.1., 4.2., and 4.3. deal with individual community leaders' responses; table 4.4. deals with responses from focus groups while table 4.5. reflects on the responses of a combined focus group.

Before the interviews were conducted, the researcher held the idea that due to poverty these Fetakgomo communities would be less active to fight against HIV and AIDS and its socio-economic impact would be severe on their development.

4.2. **Interviews**

The information gathered from the interviews provided an understanding as to the how HIV and AIDS impact on the development of the three communities. The collected data were grouped into various themes.
The following is an example of categories used:

4.2.1. **Individual responses from community leaders**

- Discrimination against people living with HIV and AIDS in communities
- HIV and Aids orphans and disruptions caused by HIV and AIDS in their lives
- Community members helping HIV and AIDS affected individuals
- Losing jobs due to HIV and AIDS and coping with medical costs by patients of AIDS in the community
- Community members being unable to pay for electric and water services
- Worsening death rates from HIV and AIDS
- Being unemployed due to HIV and AIDS
- Patients of HIV and AIDS walking long distances to fetch water and wood

- Children dropping out of school due to HIV and AIDS
- Community members selling their assets to cope with medical costs from HIV and AIDS
- Community leadership involvement and knowledge of HIV and AIDS by community members

4.2.2. **Focus group interviews**

- Loss of lives due to HIV and AIDS in community
- Dissolution of families due to HIV and AIDS
- Double burden of old people caused by HIV and AIDS
- Death of experienced teachers or engineers caused by HIV and AIDS in the community
- Mobilization of the entire community members
- Change in the spending of incomes from food to medical costs

4.2.3. **Combined focus group**

- Couples in families stopping to bear children due to HIV and AIDS infection
- Extended family system
- Government support to communities in matters related HIV and AIDS and the losses in terms of valuable time in caring for the sick at home and productivity of community members.

The categories of themes were made as they were done after comparing the units of meaning and were grouped according to how each item seemed to be similar to each other. Creswell (1998:145) maintains that during the analysis researchers step back and form larger meanings of what is going on in the sites. The recurring themes and patterns which pulled together many separate pieces of data were grouped together. These themes were categorised in order to reduce data to a manageable and adjustable level. Information was analysed in accordance with responses from leaders of communities at Ga-Nchabeleng, Mohlaletse, and Strydkraal. Data from person to person interviews have been outlined in tables 4.1., 4.2. and 4.3. Table 4.4. presents data from focus groups while table 4.5. reflects a combined focus group interview from leaders of the three villages.

Tables 4.1., 4.2. and 4.3. show the responses of community leaders; pastor, teacher, nurse, representative of traditional leader`s office, home-based care representative, traditional healer, community development worker, police representative, project manager, ward councillor and ward committee representative

Table 4.1. Individual community leaders' responses at Ga-Nchabeleng

	Pastor	Teacher	Community Dev. Worker	Traditional healer	Home-based care group rep	Traditional Leader`s office rep	nurse	Police rep
1. Do your community members accept and know that there are HIV and AIDS?	YES	YES	YES	YES	YES	YES	YES	YES
2. Does your community discriminate against people living with HIV and AIDS?	YES	NO	YES	YES	YES	NO	YES	YES
3. Do you know of any children in your community who are orphaned by HIV and AIDS?	YES	NO	YES	YES	NO	NO	YES	YES
4. Do you think there are any disruptions that HIV and AIDS cause in the lives of orphans?	YES	NO	YES	YES	YES	NO	YES	YES
5. Does your community get involved in helping those who are affected by HIV and AIDS?	NO	YES	YES	NO	YES	YES	YES	YES
6. Do you know of any people who have been employed and have left their jobs for being AIDS sick in your community?	YES	NO	NO	YES	NO	NO	NO	NO
7. Are community members who have lost their jobs due to HIV and AIDS being able to cope with health costs?	NO	NO	NO	NO	NO	NO	NO	NO
8. Are there families that are unable to pay for their electric and water services due to the death of adult members who had HIV/AIDS?	NO	NO	YES	YES	NO	NO	NO	YES
9. Does your community experience worsening death rates from HIV and AIDS?	NO	NO	NO	NO	NO	NO	NO	NO
10. Are there any people who remain unemployed due to the problem of HIV and AIDS?	NO	NO	NO	NO	YES	NO	NO	NO
11. Do you have patients who walk long distances to fetch water, wood, and food?	NO	NO	NO	NO	NO	NO	NO	YES
12. Do you think lack of enough water supply, fuel and food affect the conditions of AIDS patients in your community?	YES	YES	YES	YES	YES	YES	YES	YES
13. Is there any school that experiences increasing teacher mortality and morbidity related to AIDS in your community?	NO	NO	NO	NO	NO	NO	NO	NO
14. Do you know of any children who leave schooling due to AIDS related problems?	NO	NO	NO	NO	NO	NO	NO	NO
15. Do you know of any families that are selling their assets in order to cope with medical costs emanating from HIV and AIDS?	NO	NO	NO	NO	NO	YES	NO	NO
16. Is there involvement of community leadership in community campaigns against HIV and AIDS?	NO	NO	YES	YES	YES	YES	YES	YES
17. Are there any people who are affected by HIV and AIDS in your community?	YES	YES	YES	YES	YES	YES	YES	YES

(Field research Phakoago M.H. July 2007)

Table 4.2. Individual community leaders' responses at Mohlaletse

	Pastor	Teacher	Community Dev. Worker	Traditional healer	Home-based care rep	Traditional leader`s office rep	Ward Committee rep	Local councillor
1. Do your community members accept and know that there are HIV and AIDS?	YES	YES	YES	YES	YES	YES	YES	YES
2. Does your community discriminate against people living with HIV and AIDS?	YES	YES	YES	NO	YES	YES	YES	YES
3. Do you know of any children in your community who are orphaned by HIV and AIDS?	YES	YES	YES	NO	YES	YES	YES	YES
4. Do you think there are any disruptions that HIV and AIDS cause in the lives of orphans?	YES	YES	YES	YES	YES	YES	YES	YES
5. Does your community get involved in helping those who are affected by HIV and AIDS?	YES	NO	YES	NO	YES	YES	YES	YES
6. Do you know of any people who have been employed and have left their jobs for being AIDS sick in your community?	NO	YES	NO	NO	YES	NO	NO	NO
7. Are community members who have lost their jobs due to HIV/AIDS being able to cope with health costs?	NO	NO	NO	NO	NO	NO	NO	NO
8. Are there any families that are unable to pay for electric and water services due to the death of adult members who had HIV/AIDS?	NO	NO	YES	NO	NO	YES	NO	NO
9. Does your community experience worsening death rates from HIV and AIDS?	NO	NO	NO	NO	NO	NO	NO	NO
10. Are there any people who remain unemployed due to the problem of HIV and AIDS?	NO	NO	NO	NO	NO	NO	no	yes
11. Do you have patients who walk long distances to fetch water, wood and food?	NO	NO	NO	NO	YES	YES	YES	YES
12. Do you think lack of enough water supply, fuel, and food affect the conditions of AIDS patients in your community?	YES	YES	YES	YES	YES	YES	YES	YES
13. Is there any school that experience increasing teacher mortality and morbidity related to AIDS in your community?	NO	NO	NO	NO	NO	NO	NO	NO
14. Do you know of any children who leave schooling due to AIDS related problems?	NO	NO	NO	NO	NO	NO	NO	NO
15. Do you know of families that are selling their assets in order to cope with medical costs emanating from HIV/AIDS?	NO	NO	NO	NO	NO	NO	NO	NO
16. Is there involvement of community leadership in community campaigns against AIDS?	YES	YES	YES	NO	YES	YES	YES	YES
17. Are there any people who are affected by HIV and AIDS in your community?	YES	YES	YES	YES	YES	YES	YES	YES

(Field research Phakoago M.H. July 2007)

Table 4.3. Individual community leaders' responses at Strydkraal

	Pastor	Teacher	Ward Committee rep	Old age care rep	Home-based care rep	Traditional leader`s office rep	nurse	Project manager
1. Do your community members accept and know that there are HIV and AIDS?	YES	YES	YES	YES	YES	YES	YES	YES
2. Does your community discriminate against people living with HIV and AIDS?	YES	YES	YES	YES	YES	YES	YES	YES
3. Do you know of any children in your community who are orphaned by HIV and AIDS?	NO	NO	NO	NO	NO	NO	NO	NO
4. Do you think there are any disruptions that HIV and AIDS cause in the lives of orphans?	NO	NO	NO	NO	NO	NO	NO	NO
5. Does your community get involved in helping those who are affected by HIV/AIDS?	YES	YES	YES	YES	YES	YES	YES	YES
6. Do you know of people who have been employed and have left their jobs for being AIDS sick in your community?	NO	NO	NO	NO	NO	NO	NO	NO
7. Are community members who have lost their jobs due to HIV/AIDS being able to cope with health costs?	NO	NO	NO	NO	NO	NO	NO	NO
8. Are there families that are unable to pay for their electric and water services due to death of adult members who had HIV/AIDS?	NO	NO	NO	NO	NO	NO	NO	NO
9. Does your community experience worsening death rates from HIV/AIDS?	NO	NO	NO	NO	NO	NO	NO	NO
10. Are there any people who remain unemployed due to the problem of HIV and AIDS?	NO	NO	NO	NO	NO	NO	NO	NO
11. Do you have AIDS patients who walk long distances to fetch water, wood, and food?	YES	YES	YES	YES	YES	YES	YES	YES
12. Do you think lack of enough water supply, food, and fuel affect the condition of patients of AIDS in your community?	YES	YES	YES	YES	YES	YES	YES	YES
13. Is there any school that experiences increasing teacher mortality and morbidity related to AIDS in your community?	NO	NO	NO	NO	NO	NO	NO	NO
14. Do you know any children who leave schooling due to AIDS related problems?	NO	NO	NO	NO	NO	NO	NO	NO
15. Do you know of any families that are selling their assets in order to cope with medical costs emanating from HIV and AIDS?	NO	NO	NO	NO	NO	NO	NO	NO
16. Is there involvement of community leadership in community campaigns against HIV and AIDS?	YES	YES	YES	YES	YES	YES	YES	YES
17. Are there any people who are affected by HIV and AIDS in your community?	YES	YES	YES	YES	YES	YES	YES	YES

(Field research Phakoago M.H. July 2007)

Table 4.4. Focus groups' responses

	Ga-Nchabeleng	Mohlaletse	Strydkraal
1. Are there any losses of lives to HIV and AIDS in your community?	yes	yes	yes
2. Are there any families that disintegrate due to AIDS deaths of their members in your community?	no	no	no
3. Do old people experience the double burden of taking care of their grand children and lack of support in their old age due to HIV and AIDS?	yes	yes	no
4. Do you find the death of the experienced teacher or engineer at water service of the community replaceable?	no	no	no
5. Do you think there is mobilization of the entire community in HIV and AIDS campaigns?	no	yes	no
6. Do you have families that experience a loss of income due to problems emanating from HIV and AIDS?	yes	yes	no
7. Do you have families that experience material losses due to HIV and AIDS?	no	no	no
8. Is there any loss of subsistence agricultural knowledge and skills in food supply due to adult death from HIV and AIDS in your community?	no	no	no
9. Do you know of any families that have changed spending their incomes on important necessities like food in order to cope with medical costs related to HIV and AIDS?	yes	yes	no
10. Does your community resource such as labour and finances get reduced by the presence of HIV and AIDS?	no	no	no

(Field research Phakoago M.H. July 2007)

Table 4.5. Combined focus group`s responses

Questions	Responses of community leaders
1. Do you know of any families that have stopped bearing children due to the problems emanating from HIV and AIDS?	No
2. Do you have a strong extended family system that cope with accommodating AIDS orphans in your community?	No
3. Does your community receive any support from government in order to cope with HIV and AIDS?	Yes
4. Is there any loss of agricultural production or land due to HIV and AIDS in your communities?	No
5. Do you know of any employed members of families whose time is taken by caring sick members who suffer from HIV and AIDS?	No
6. Do you think that HIV and AIDS contribute to lack of productivity of certain people in your community?	No

(Field research Phakoago M.H. July 2007)

4.3. **Analysis and interpretation of responses**

4.3.1. **Analysis of individual community leaders' responses**

(a) Discrimination against people living with HIV and Aids in community

From tables 4.1., 4.2. and 4.3. on the question whether community members discriminate against people who live with HIV and AIDS it is indicated from the three villages, Ga-Nchabeleng, Mohlaletse and Strydkraal that there is such discrimination against them. The idea that AIDS has to be viewed like any other disease in order that communities could fight it more easily does not exist or happen in these villages. This still instills fear about the disease. It would mean that this discrimination is conceived by the perception that those who have it are promiscuous. This would probably cultivate secrecy about the disease which will lead to further infections in the three communities. Of course, discriminating against people who live with HIV and AIDS further increases their condition of distress and lack of care. Discrimination of HIV and AIDS patients by communities is created by the issue of stigma and prejudice around the disease. De Guzman (2001:665) indicates the impact of discrimination of those living with HIV and AIDS that it can lead to secrecy about the disease. The infected people in community may be denied access to health care and other areas of life due to discrimination. Again prevention strategies can work successfully if HIV and AIDS is treated like any disease as indicated in Van Dyk (2001:95).

This is what the pastor at Ga-Nchabelng said to show discrimination of people living with AIDS from the villagers in excerpt 1:

‘’The people living with HIV and AIDS are discriminated in many ways. Sometimes people talk ill about them. They also avoid them, especially if they know their HIV status.’’

From excerpt 1 the report indicates that the villagers discriminate against people living with HIV and AIDS. The fact that the villagers avoid them indicates that they cannot involve them in community matters. This shows that AIDS is not treated like any disease in this village. The issue of discriminating against those who suffer from the pandemic means that their condition cannot be improved. They cannot cope with the disease since the villagers are not ready to accept them. Stigma increases their distress and isolates them even further from the community. It means that secrecy about the disease is there at Ga-Nchabeleng since this excerpt reports about discrimination of people living with AIDS.

This is what the teacher said about discriminaton of people living with HIV and AIDS at Mohlaletse in excerpt 2:

‘’Yes, people discriminate against them by talking bad about them. They also avoid them at gatherings of the village.’’

At Mohlaletse avoidance and talking ill of people living with HIV and AIDS are there. From excerpt 2 it is clear that HIV and AIDS victims cannot easily get helped by the villagers. This shows that these victims of HIV and AIDS are isolated from the villagers. This means that HIV and AIDS cannot easily be prevented if there is still discrimination of those living with HIV and AIDS.

The representative of the office of traditional chief at Strydkraal said about discrimination of people living with HIV and AIDS in this way in excerpt 3:

“Yes, there is still that discrimination of people living with AIDS. People avoid them. If they may somehow know that someone has died of AIDS, they will talk bad about that dead person in groups even at his or her funeral. The issue of discrimination is still persisting.”

(b) HIV and AIDS orphans and the disruptions caused by the pandemic in their lives

The two villages, Ga-Nchabeleng and Mohlaletse, acknowledge having HIV and AIDS orphans while the community leaders of Strydkraal show that they do not have them. The leaders at Ga-Nchabeleng and Mohlaletse observe that although these orphans are looked after by their extended family members with the government department helping with food parcels, these children are emotionally traumatized even if they are taken care of. However, their presence in the two communities forces the extended family members to extend their hands towards helping them cope with lack of parents in their lives. This creates a burden of caring and raring them up. As De Guzman (2001:665) states that lack of parental support to children increases their social vulnerability to abuse and hardships due to their social position. They depend on other people to care for them and respect their rights for their well-being. As found in the study these HIV and AIDS orphans lack parental support socially, physically, educationally and emotionally. Some of them might be not well-nourished due to the absence of the mother who died. Whiteside (2002:201) shows the importance of the mother for the children to grow up very well. It is clear that due to the death of these orphans’ parents some would not be getting enough care. Even if the leaders indicate that these orphans do not show to be seriously affected, the seriousness of having no parents will be experienced when they grow up in future. Those orphans whose dead parents were working would not enjoy life the same way they did when their parents lived. This is about the question as to whether there are orphans and the disruptions that HIV and AIDS cause in their lives from the table.

The issue that Van Der Merve and Gouws (2005:53) call as the phenomenon of 'child-headed households' is experienced at Mohlaletse village, but not reported at Ga-Nchabeleng.

The ward committee representative at Mohlaletse said about the disruptions that AIDS causes in the lives of orphaned children in excerpt 4:

"Sometimes these orphans live without parents. This I think is the most painful experience in the lives of the AIDS orphans."

The report from this excerpt shows the experience of these orphans living without parents. The orphans of AIDS face the conditions of looking for other people to care
for them. The kind of care they will get is not going to be the same as that which their parents would give them. This means that the rights of these orphaned children are at risk of being violated by other people.

The community development worker at Ga-Nchabeleng said this in excerpt 5:

"These orphans are not properly taken care of like when their parents were still alive. Those children really lack support and care as their parents have died. The other thing that they need is sufficient care in many respects of life."

From excerpt 5 the report shows that these orphans do not get proper care in the same way as their parents gave it when they were still alive. The absence of their parents has left a huge gap that cannot easily be filled by those who offer themselves to care for these orphans.

(c) Helping HIV and AIDS affected individuals by the community

According to the individual responses of the community leaders of Ga-Nchabeleng, Mohlaletse and Strydkraal, the three villages are involved in helping those who are affected. The community leaders showed that the only help that community members do to help those who are affected is in the form of home based care group. These home-based care groups have been established by the government to care for those who are sick in different homes. Communities themselves have no other means to help those who are affected. This is an indication that the affected community members receive no material help or any other help from the members of the three communities except the home based care groups. The leaders themselves point out that the help that these home based care groups give is not effective and enough. This is one indication that members of the three villages are not doing enough to be united in helping those affected. Perhaps poverty is the one that makes the members of the three villages not to be involved in helping the affected members of their communities. It is clear that these communities do not yet take the ownership of the problem of HIV and AIDS as indicated by Campell *et*

al. (2005:471). It would mean that the very villages are not yet cohesive in helping those who are affected as a sign of showing solidarity and empowerment to them. Home–based care groups are regarded as the only viable groups to mitigate the impact of HIV and AIDS in these three villages. This view is illustrated as follows:

The pastor from Ga-Nchabeleng said to answer the question as to whether the community help those who are living with HIV and AIDS in excerpt 6:

"No, there is no help that the community gives to people living with HIV and AIDS except being aided by home-based care group. Our church is still thinking of doing something to help."

The report shows from excerpt 6 that the only group that gives support to the affected people in the community is a home-based care group. This shows that other structures of the community have not yet taken the responsibility of helping those who are affected by the pandemic in their midst.

At Mohlaletse the representative of the traditional leader had this to say in excerpt 7:

"No, the community has nothing to help except those from home-based care group."

The responsibility to help those affected by HIV and AIDS at Mohlaletse is upon a group called home-based care group. The other groups or individuals do not see it as their responsibility to help those affected by the pandemic.

This is what the pastor at Strydkraal said in excerpt 8:

"We do not help them in any way. The community thinks it is not its responsibility to help them. The help they get from home-based care group is not sufficient."

According to the report of the pastor from excerpt 8, the kind of help that the home-based care group gives to the people affected by HIV and AIDS is not enough. The community is reflected to be rejecting the responsibility of helping those who are affected by the pandemic.

d) Losing jobs due to HIV and AIDS and coping with medical costs by community members

From the community leaders' responses, it is indicated in questions 5 and 6 that they do not know of any people who have lost their jobs due to HIV and AIDS, except a few of them who indicate that they knew of at least two to three individuals who have experienced the problem. Due to lack of job opportunities with a few people working as civil servants in the three villages, the problem of

community members losing their jobs and being AIDS sick is not yet experienced. Those very few members who had lost their jobs are not known whether they were coping with their medical costs emanating from HIV and AIDS due to the problem of secrecy and confidentiality around the disease. It is indicative that the three villages do not experience people who have been working and have lost their jobs due to HIV and AIDS problems. This might tally with the issue that unemployment is very high in the three villages.

(e) Community members being unable to pay for water and electric services

The responses show in the two villages, Ga-Nchabeleng, and Mohlaletse, that very few families experience the problem of paying for electric services due to the death of an adult member arising from HIV and AIDS. In the very two villages water service is free of charge. At Strydkraal, the leaders indicated that there is no water supply, and they have never seen any family being unable to pay for electric services due to the death of its adult member emanating from HIV and AIDS. The problem of HIV and AIDS affecting services has not yet being serious to the leaders of these communities.

This is what the community development said in excerpt 9 at Mohlaletse:

"Yes, some of the families are unable to pay for electric services due to that problem."

From excerpt 9 there is an indication that as some of the adults from the affected households die, there is that problem of those families experiencing the problem of being unable to pay for electric services.

The community development worker at Ga-Nchabeleng said this in excerpt 10:

"Yes, even if there are very few of them."

The issue of other families being unable to pay for electric services due to the death of an adult member is experienced by the community of Ga-Nchabeleng. However, it is reported to be happening to a few families.

(f) Worsening death rates from HIV and AIDS

From tables 4.1., 4.2. and 4.3., the responses show that death rates from HIV and AIDS from the three villages are not worsening. Although there are death rates from the pandemic, it is not that prevalent that there are worsening death rates. Again, this comes to the question as to whether there are increasing teacher death rates. The answer to this question is in the negative from the three villages. Thus the three villages experience average death rates from the pandemic. Community leaders also responded to the question that the impact of the pandemic in the three villages is visibly very low. It is also indicated that those who come into the villages just to die are some of their daughters and sons who had once

migrated to seek for jobs in other provinces, especially in Gauteng. They come home being very sick and die of AIDS. Those who live in the villages do not experience the worsening death rates of either professionals such as teachers or ordinary people. Lack of orphans at Strydkraal and a few orphans at Ga-Nchabeleng and Mohlaletse villages show that there are no worsening death rates from the pandemic. This is that because the pandemic is calculated to be causing children to lose their parents or guardians and that they die as well (Avert, 2006).

It is clear that worsening death rates from the pandemic would account to the increasing number of orphans and teacher death rates. This would also account to the deaths of other professionals who are involved in the development of these communities. It is clear that from the leaders' responses there is no worsening of death rate that leads to mass burials in the three communities.

This is what the teacher said about the worsening death rates from HIV and AIDS at Ga-Nchabeleng in excerpt 11:

"We do not have worsening death rates in the village where we sometimes experience mass burials*."*

From excerpt 11 the community at Ga-Nchabeleng does not have the experience of worsening death rates that even affect the development of community by killing important people such as teachers and other professionals.

At Strydkraal the pastor said this about worsening death rates in the village in excerpt 12:

"We experience average death rates from AIDS in the village."

The experience at Strydkraal is that the death rates are not worsening but average.

The pastor at Mohlaletse responded in this way to the question of worsening death rates in excerpt 13:

"No, we do not have worsening death rates from AIDS in our village."

From the report in excerpt 13, the issue of worsening death rates that could affect the development of community is not happening at Mohlaletse.

(g) Unemployment due to HIV and AIDS

Community leaders' responses from tables 4.1., 4.2. and 4.3. show that unemployment due to HIV and AIDS does not exist in the three villages. It is indicated that there are no employment opportunities in the area. Most of the people are said not to be working in the area. AIDS is indicated not to be the

cause of unemployment here. The people in the three villages-Ga-Nchabeleng, Mohlaletse, and Strydkraal do not have employment opportunities in their villages. Lack of job opportunities makes people to be unemployed regardless of HIV and AIDS prevalence in the villages. Lack of job opportunities make people to have no interest in health issues as Smith and Todaro (2003:446) put it.

(h) **Patients of HIV and AIDS walking long distances to fetch water, wood or food and impact of lack of water on HIV and AIDS patients**

The community leaders' responses from the three villages indicate that in two villages, Mohlaletse and Strydkraal, there is a problem of water. At Strydkraal the problem of lack of water forces patients of AIDS to walk long distances in order to fetch water from the river. The whole village is indicated to have no water that forces all of the people, those infected by AIDS and those without it, to walk long distances to fetch it. At Mohlaletse some sections of the village are indicated to be having no water. These sections of the village force those who have AIDS to walk long distances in order to fetch water. It is indicated that having no water in the presence of HIV and AIDS worsens their conditions. At Ga-Nchabeleng the responses are that the community as a whole has water taps.

All of the community leaders indicate that lack of clean water complicates the condition of people living with HIV and AIDS. This is in line with what water service sector HIV and AIDS bulletin (2006: 3) which shows that vulnerable groups need access to 25 litres per person per day. It is clear that health for people living with AIDS in Mohlaletse and Strydkraal is made difficult by lack of water. Without enough clean water per day patients of AIDS experience complications.

This is what the representative of community volunteer from home-based care group at Strydkraal said in excerpt 14:

"We are all affected by the problem of lack of water in this village. Both patients of AIDS and those who are not have to walk long distances in order to fetch water."

The whole community at Strydkraal suffers from fetching water from a distant river. This is indicated as a problem because those patience of AIDS have to walk long distances. This worsens the condition of patients of AIDS.

At Mohlaletse a community volunteer from home-based group representative said this in excerpt 15:

"Some of the sections of this village have water from the taps while other of the sections of this village have no water. Some of the patients from those sections that are without water have to walk long distances just to fetch water from the river. The people living with AIDS are not strong enough to fetch water from the river. They are forced by the conditions to walk long distances."

This experience of lack of water is indicated in excerpt 15 to be a problem since the people living with AIDS do not have the strength to carry water. Yet they are forced by lack of nearby water to fetch it from a distant river.

(i) School children dropping out of school due to HIV and AIDS

According to the community leaders is clear that Ga-Nchabeleng, Mohlaletse and Strydkraal do not experience the problems of school children dropping out of school due to HIV and AIDS. This is an indication that education of he children of these communities is not disturbed. It goes to the point that although HIV and AIDS is there in these communities, it is not interfering with the creation of human capital through education. This would mean that children in these three villages would grow up with skills that they acquire through education despite the presence of HIV and AIDS in their area.

(j) Loss of assets to cope with medical costs emanating from HIV and AIDS

The community leaders` responses indicate that Ga-Nchabeleng, Mohlaletse, and Strydkraal do not experience the issue of community members selling their assets in order to cope with medical costs from HIV and AIDS. It may be inferred that the three villages have never seen the impact of the pandemic on their material possessions. Although the three communities are rural and poor, the experience of their members selling their assets in order to cope with medical costs from HIV and AIDS has never happened.

(k) Community leadership involvement in HIV and AIDS campaigns and acknowledgement of HIV and AIDS

The community leaders` responses indicate that at Ga-Nchabeleng, Mohlaletse and Strydkraal village's community leaders are involved in the HIV and AIDS campaigns of their villages. At Ga-Nchabeleng it was indicated that leaders have a forum at which issues around HIV and AIDS are discussed at the nearby municipal offices. The forum involves traditional healers. It is indicated that the traditional leadership of the three villages welcomes government officials who come to inform villagers about HIV and AIDS pandemic. However, it is indicated that the most active campaigns that involve community leaders from Ga-Nchabeleng, Mohlaletse and Strydkraal villages are being initiated by municipal officials or other government officials. The community leadership is indicated not to be having its own initiated campaigns. They do not have any ownership of initiatives in terms of programmes related to HIV and AIDS campaigns in the villages. However, they get involved when they are invited to be part of any HIV and AIDS campaign by the municipal officers.

This is what a representative of the office traditional leader at Ga-Nchabeleng said this in excerpt 16:

"We are indirectly involved. Because we allow government officials to inform our people about the pandemic in the village."

The representative of the office of traditional leader at Ga-Nchabeleng shows their indirect involvement by allowing government officials to inform the villagers about HIV and AIDS. By giving permission to the government officials to inform the villagers about AIDS, there is that feeling that the leadership is involved.

This is what was said by the representative of the office of traditional leader at Strydkraal in excerpt 17:

"Yes, we are involved as leadership in AIDS matters. We go to the meetings that are about HIV and AIDS. The problem is that we do not report back to the people in the village."

From excerpt 17 the report shows that the leadership is directly involved at Strydkraal. The only problem that faces the leadership is that it does not give feedback to the community members.

The ward committee representative at Mohlaletse said this in excerpt 18:

"We are involved as leadership in AIDS issues. There are times where we as leadership highlight each other about AIDS issues at our meetings in the village."

The community leadership at Mohlaletse is directly involved in matters related to HIV and AIDS. The leadership goes to that extend of cautioning each other about the results of the pandemic at some of their meetings.

It is at schools in the three villages that teacher teach curriculum involving issues around HIV and AIDS. School children get information about HIV and AIDS mostly at school.

It is clear from the data that community leaders take a passive role in the campaigns against HIV and AIDS in their communities in the three villages. They do not take the responsibility of initiating active campaigns against the pandemic. The respondents do not see themselves as people who can bring the solution to the pandemic. They take a passive role in the campaigns against HIV and ADS in their communities. This is in answering the question as to whether community leadership is involved in community campaigns against HIV and AIDS.

From tables 4.1., 4.2. and 4.3. community leaders responses show that the three communities (Ga-Nchabebeng, Mohlaletse and Strydkraal) accept and know that there are HIV and AIDS. Again participation of the three communities leadership shows that acknowledgement and acceptance of the existence of the pandemic by the community. This answers the question as to whether community members know and accept that there are HIV and AIDS.

4.3.2. **Analysis of village focus groups` responses**

(a) **Loss of lives and dissolution of families due to deaths from HIV and AIDS**

Form table 4.4. community leaders' responses indicate that lives are lost at Ga-Nchabeleng, Mohlaletse and Strydkraal due to HIV and AIDS and show that there is no dissolution of families due to the issue of HIV and AIDS in the three villages. The loss of lives in these communities is the impact that HIV and AIDS have on them. Loss of lives creates a vacuum that nobody can fill in those affected families. Those families, whose adult members have died, especially parents, do continue to exist with children being taken care by some of the extended family adult members or children themselves looking after each other. This culminates to the issue of creating what Van Der Merve and Gouws (2005:53) call it as 'child-headed families'. It is indicated that although HIV and AIDS cause death in all of the three villages, the issue of dissolution of families has never been experienced. This was to answer questions 1 and 2 from the focus group responses.

The focus group at Ga-Nchabeleng indicated this way in excerpt 19:

"Though some families experience death of both parents due to HIV and AIDS, some members from the extended family come to help the children. And thus there is no dissolution of families due to death emanating from HIV and AIDS."

The experience from excerpt 19 shows that though some of the families experience the deaths of both parents, the extended family members come to help the very affected from disintegrating.

(b) **Double burden of old people caused by HIV and AIDS**

The responses of focus group of leaders of communities indicate that Ga-Nchabeleng and Mohlaletse villages have the experience of old people having a burden of raring their grand children while they have no support in their old age. The problem is being created by the presents of HIV and AIDS that kill adults and young people. These old people are said to be bringing up their grandchildren whose parents have died due to HIV and AIDS. This issue of HIV and AIDS puts them under pressure to tolerate the physical and emotional strain of providing care as May (2003:19) shows that care for their grandchildren puts their health at strain. These old people care their grandchildren with their last money and their lack of strength. At Strydkraal this is not the case as old people do not experience the issue from the responses of focus groups.

(c) **Replaceability of the death of professionals such as teachers and engineers**

In community

From the responses it is shown that in all of the three villages, Ga-Nchabeleng, Mohlaletse and Strydkraal, the death of an experienced teacher or engineer is not replaceable. This is based on the time it takes to train them, the expenses involved and the experience itself. However, the three communities do not experience the increasing deaths of these professionals in their communities.

(d) Mobilization of the entire community members

The responses of focus groups in the two villages, Ga-Nchabeleng, and Strydkraal, indicate that mobilization of the entire members of the two communities is not there. It is indicated that only young people are mobilized while old people are not showing interest in matters related to HIV and AIDS. The other issue that is shown to be a barrier to mobilization of all members of the two villages is that information, given to community leaders, relating to HIV and AIDS does not get further given to the entire community members. Thus their community leaders attend forums or workshops related to HIV and AIDS and the information remains with them and does not reach the larger community members. However, at Mohlaletse it was indicated in some sections of the village both old and young people are mobilized while in other sections of the village that is not happening.

Lack of mobilization of the entire community members is a problem that makes community members to be ignorant and stay away from intervening in the matters on the impact of HIV and AIDS on community members as shown in De Guzman (2001: 668). When communities are not entirely mobilized they think matters related to HIV and AIDS in their communities do not concern them. This is also the case in the three villages, Ga-Nchabeleng, Mohlaletse and Strydkraal. Mostly young people and home-based workers are the people who are mobilized against HIV and AIDS in these villages.

(e) **Multiple losses of resources such as income, material possessions, agricultural, knowledge and skills, labour and finances of communities due to HIV and AIDS**

The responses indicate that there are families that experience loss of income due to the problem of HIV and AIDS at both Ga-Nchabeleng and Mohlaletse villages. However, it is indicated that families that experience the problem of losing their incomes due to HIV and AIDS deaths are very few. Income loss creates a problem of poverty in families. This is because income enables family members to meet the demands they have. Losing income by any family creates a problem of dependency of its members either on government or other people for

their survival. This answers the question that asks whether families experience a loss of income due to HIV and AIDS.

In terms of losses related to material possessions by families, community labour, finances and community subsistence agricultural knowledge and skills the responses show that Ga-Nchabeleng, Mohlaletse and Strydkraal villages do not experience such losses either at family levels or community levels. The issue is that the impact of the pandemic has not yet reached a position where families experience a problem of selling

their material possessions in order to cope with the pandemic. The three villages showed that they do no longer practice subsistence agriculture any more. There is no need for agricultural knowledge and skills for their survival. It is indicated from the responses that the pandemic does not impact on labour in the community as there are many adults who are still strong and are in need of employment. The responses show that although the three communities are financially poor as many people do not work, there is no indication that the finances of the community are declining from the pandemic.

(f) **Change in families' income spending from food to medical cost related to HIV and AIDS**

From the responses of focus groups, it is shown that at Ga-Nchabeleng and Mohlaletse some of the families that experience a problem of one of its members being sick of AIDS the incomes spending tend to change to medical costs. This disturbs the affected families as they do no longer enjoy getting important necessities they used to get. The pandemic disarrays these families as their incomes do no longer manage to cover most of their needs such as food. It is clear that the pandemic suppresses the very affected families in enjoying life in terms of using their incomes to get the important necessities of life. This in a way affects their well-being as far as enjoying the important necessities that make life easier and enjoyable. However, at Strykraal village, this does not happen from the responses on table 4.2.. The issue of shifting the expenditure from food to medical costs may affect children to be less well-nourished as Barnett and Whiteside (2002:201) put it that those children in affected families experience being wasted.

4.4. **Analysis of a combined focus group`s responses**

(a) **Couples stopping to bear children due to HIV and AIDS.**

From the responses it is indicated that in the three villages-Ga-Nchabeleng, Mohlaletse and Strydkraal – this issue of couples stopping to have children due to HIV and AIDS infections is not known or has never been experienced. It is indicated that if it is happening no leader could know of it due to the issue of confidentiality around HIV and AIDS.

(b) Extended family system and accommodating AIDS orphans

The responses show that in the three villages the issue of extended family system helping each other is gradually growing weak. It is indicated to be weak as some of the orphans prefer to stay in their homes alone or sometimes with their extended family members who do not have to take them away to their home. This is indicated to be declining as these children do no longer prefer to stay with relatives but any person who can take good care of them. Although it is indicated to be weak, it is reported to be existing at Ga-Nchabeleng, Mohlaletse and Strydkraal. This extended family system helps in terms of caring the orphans of HIV and AIDS in the community. Its weakening increases lack of parental care and protection on orphaned children and it increases economic hardships on these children as well (UNICEF, 2004:3). Children who stay alone are not protected as this increases a lot of risks.

(c) Government support to communities in matters related to HIV and AIDS

The responses indicate that all of the communities get the necessary support from government. The major player in terms of providing workshops and HIV and AIDS campaigns is the local municipality. The Department of Health and Social Development closely works with communities to see that they get support in terms of aiding those affected families. This is done in the form of instituting home-based group carers in each of the three communities. Those who are actively involved in matters related to HIV and AIDS are getting remuneration from government as a compensation for the work they do
to their communities. The government's support in the three villages is the only motivation that is encouraging community members to engage in matters related to HIV and AIDS. Young people who are not working get involved in home-based care support groups that they can help sick people in their communities but on the other hand looking for the little remuneration the government gives them. Indeed the government's support to these communities in relation to HIV and AIDS issues is reported to be the only hope that gets some members of communities involved in HIV and AIDS issues. Food parcels are also given to poor families from government.

d) Losses in terms of valuable time by working family members and productivity of community members

From the responses the information shows that there is no valuable time lost in terms of caring for the sick by those family members who are employed. This is referred to the issue of very few people who are employed in these villages. In terms of families that are attacked by the pandemic, it is clear those family members who are not employed elsewhere would care for the sick. Due to lack of economic activities in the villages, it is hard to know who is disturbed in terms of

using one's valuable time due to the caring of the patients of AIDS in the villages. The issue of loss of productivity of some of the community members is also not experienced by the three villages: Ga-Nchabeleng, Mohlaletse and Strydkraal. This is also referred to the lack of economic activities in the three villages. Confidentiality around the pandemic makes it difficult to know who is suffering from the pandemic that takes away his or her productive powers.

CHAPTER FIVE: MAJOR FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1. **Major findings**

According to the researcher's findings, the issue of lack of social cohesion on the part of members of the three communities stands out in this research in mitigating the socio-economic impact of HIV and AIDS in community development. This is shown in two ways, namely; discrimination against people living with HIV and AIDS and lack of mobilization of the entire community members against HIV and AIDS. The pandemic impacts negatively on people's lives as they get sick and finally die. Some families lose their income from the impact of the pandemic.

- **Discrimination against people living with HIV and AIDS**

The three communities, Ga-Nchabeleng, Mohlaletse, and Strydkraal, reflect that they all have a common problem: members of these communities are still discriminating against those affected by HIV and AIDS. Indeed prejudice against those infected in communities shows that people are not yet free to accept and respect the rights of those living with HIV and AIDS. It is clear that lack of acceptance of issues around HIV and AIDS would prevent community members from helping each other in mitigating the impact of HIV and AIDS. There is still an issue of confidentiality and lack of openness about the disease that breeds discrimination and fear among community members.

- **Lack of mobilization of the entire community members against HIV and AIDS**

In Ga-Nchabeleng and Strydkaal, only young people seemed to be mobilized against the disease. Community leaders are shown to be passively involved in community campaigns against HIV and AIDS. Information given to the community leaders is shown to remain with them and not being able to be shared with members of their communities. It was indicated that young people who seemed to be actively involved in matters against HIV and AIDS in these communities are those who are unemployed and desperate to get a job. At Mohlaletse, it is indicated that in some sections of the village both old and young people are mobilized while in other sections old people are not. This shows that mobilizing all members of the three communities against HIV and AIDS is still a problem. There are other factors that impede the communities from mitigating the socio-economic impact of HIV and AIDS in their development. These include the following:

- **Lack of will by community members to help HIV and AIDS affected individuals**
  The question of community members to help HIV and AIDS affected individuals seems to be a problem in fighting the impact of HIV and AIDS. Only the so-called home-based care groups are pointed out as those who help people who are affected by the disease. There is no real material or social groups formed by community members themselves to mitigate the socio-economic impact of HIV and AIDS on their development. The government is seen as the only source of aid in this regard.

- **Weakening extended family system**

  The extended family system seems to be no longer strong in accommodating HIV and AIDS orphans at Mohlaletse and Ga-Nchabeleng. This creates families in which orphans live alone or are taken care of by one of their extended family members who sometimes stays with them in their home or visits them. However, this extended family system seems to be weakening according to the responses. Lack of adoption of orphans of HIV and AIDS is also a problem.

- **Lack of employment and income**

  The lack of employment and income which constitute poverty makes it difficult for these communities to be involved in the campaigns against HIV and AIDS. Community members only get involved in community campaigns against HIV and AIDS when they see an opportunity to get employment or get remuneration from them.

- **Children dropping out of school due to HIV and AIDS**

  Even if the two villages of Ga-Nchabeleng and Mohlaletse's leadership acknowledge having orphans of HIV and AIDS, there is no indication of them being unable to pay the school fees and finally dropping out of school. This contributes to the two communities not realising the potential damage the pandemic is doing on the development of these orphans. Their lives are viewed as normal for the fact that they are not leaving school.

- **Lack of increasing death rates of professionals**

  The question whether there is an increase of death rates of teachers or other professionals shows to have no impact on the education or delivery of services in the three communities. This indicates that there are no HIV and AIDS impact on either the educational development or service delivery of these communities.

- **Lack of resources such as finances in the communities**

  Lack of finances in the communities makes it difficult for community members to see how HIV and AIDS affect them. This also makes it difficult for the three communities to work out means to help those affected. These communities depend upon outside donors to aid them so as to mitigate the impact of HIV and AIDS on their development in establishing and implementing HIV and AIDS campaigns.

5.2. Conclusions

The main purpose of this study was to investigate the socio-economic impact of HIV and AIDS on community development at Fetakgomo Municipality and to see how these communities fight against the pandemic. The study found that even if these communities are not doing enough to fight the pandemic, its socio-economic impact is not severe on their development. The pandemic is found to be having an impact on social lives of these communities due to deaths of community members and creation of orphans in two communities: Ga-Nchabeleng and Mohlaletse. The problem of lack of social cohesion created by prejudice around the disease is raising an inevitable challenge in fighting the pandemic in the three communities. This is also compounded by the issue of confidentiality around the disease that makes community members not to be open in talking about the impact of the pandemic on their socio-economic development. The economic impact that is evident is on a few families that lose their incomes and fail to buy electric services. Few as these families are, it is clear that it makes it difficult to identify the other economic impact the pandemic has on these communities because only a few people are working in these communities.

Because members of these communities are still closed up in responding to the issues of HIV and AIDS, it is difficult to know the economic losses created by the pandemic in the lives of economically active people. The lack of openness creates difficulties in these communities to know clearly people whose lives have been destroyed by the pandemic. Even though the people still remain confidential about the pandemic in most instances, the impact of the pandemic is arguably very low on the three communities. The respondents indicated that it was difficult to relate to some incidents of illness and death to HIV and AIDS pandemic due to the way in which members of those communities treat the issue related to the pandemic with confidentiality. The respondents themselves were closed up with regard to some of the issues related to the impact of the pandemic on their members. Perhaps they will be open once the situation is rife with the pandemic and the consequences will be very obvious for the members of these communities.

5.3. Recommendations

The challenges that face the three villages in relation to the socio-economic impact of HIV and AIDS could be dealt with in many ways. The researcher makes the following recommendations.

- **Disclosure of HIV and AIDS status**

  It can be of use to encourage all of the members of the three communities – Ga-Nchabeleng, Mohlaletse and Strydkraal – to freely disclose their status whether they are positive or not. This would reduce fear and prejudice around the disease by the communities.

- **Creation of jobs in the communities**
  Creation of jobs would reduce the high unemployment rate in the area and people would start to value their lives, participate in HIV and AIDS community campains and start to abstain from unsafe sexual practices.

- **Intensive and sustainable HIV and AIDS campaigns by community members**

  Intensive HIV and AIDS campaigns initiated and steered by the leaders of these communities should be done. This would create awareness of the disease to most members of their communities and would reduce secrecy and confidentiality and lack of will to participate in the discourses around the disease by the community members.

- **Creation of nearby Intensive HIV and AIDS testing centres and supply of antiretroviral**

  Members of these communities do not have nearby testing centres for HIV and AIDS and supply of antiretrovirals. Talking about HIV and AIDS testing seems to be fearsome and exclusive to most of the members of these communities. Creation of such centres would be helpful to encourage testing and supply of antiretrovirals.

- **Water supply to be freely made available**

  If free water supply could be done at both Strydkraal and some parts of Mohlaletse could help to ease the burden of lack of water to families that have patients of HIV and AIDS. This can improve the living conditions of those affected by the pandemic. This could be done by installing taps of free clean water in the two villages.

- **Improving home-based care situation**

  Improving the home-based care situation by way of integrating them into the health system after the carers gain experience in three years and accept them as assistant nurses at clinics or hospitals by the Department of Health would be good for the situation. In these communities home-based carers are viewed as the people who deal with real problems of HIV and AIDS. The condition of work for home-based carers should be improved via integrating them into the Health Department.

- **Encourage moral building in the communities**

  Motivational speakers who are involved in moral building movements should come into these communities and encourage the issue of morality. They may create the spirit of involvement in issues of community regarding HIV and AIDS campaigns. Young people will be motivated to abstain from unsafe sexual practices and begin to volunteer to help those who are affected by the pandemic without looking for remuneration from government.

5.4. Limitation of the study

The study had the following limitation:

Since the study has used small sample it cannot represent the views of the entire communities and the views of the leaders might be doubted due to the idea that perhaps they wanted to satisfy the needs of the study in pleasing the researcher.

For the fact that the study has used purposive sampling cannot be generalized to other communities.

5.5. **Ethical Considerations**

The study has taken the following ethical aspects during the research as stated in Devos *et al.* (2002:63):

- **Informed Consent**

  The participants responded to the study on the basis of personal consent. They were all requested by way of giving them letters and the intentions of the study were clarified to them.

- **Anonymity**

  The researcher clarified every respondent that their names would not be divulged and their views would be kept anonymous.

- **Respect to respondents' culture**

  The researcher made it a point that he showed respect to the cultures of those communities he studied. The researcher made sure that no disrespect was done to the cultures of the respondents.

- **Deception to respondents**

  The researcher made it a point that the purpose of the study was fully clarified to every respondent before he or she could partake in it.

- **Harm to the respondents**
  The researcher made it a point that no harm was done on the emotions of every participant.

5.6. **Expectations for future study**

Research may further be done on other aspects of HIV and AIDS that impact on the socio-economic development of communities.

The study may be carried out in other provinces in South Africa among different communities (perhaps in urban communities). This would give a broader understanding as to how HIV and AIDS impact on the development of communities.

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APPENDIX 1

UNIVERSITY OF LIMPOPO
Turfloop Graduate School of Leadership
Interview questions for community leaders on the socio-economic impact of HIV and AIDS on community development

1. Do your community members accept and know that there are HIV and AIDS?
2. Does your community discriminate against people who live with HIV and AIDS?
3. Do you know of any children in your community who are orphaned by HIV and AIDS?
4. Do you think there are any disruptions that HIV and AIDS cause in the lives of these orphans?
5. Does your community get involved in helping those who are affected by HIV and AIDS?
6. Do you know of any people who have been employed and have left their jobs for being AIDS sick your community?
7. Do community members who have lost their jobs due to HIV and AIDS being able to cope with health costs?
8. Are there families that are unable to pay for their electric and water services due to the death of adult member who had HIV and AIDS?
9. Does your community experience worsening death rates from HIV and AIDS?
10. Are there any people who remain unemployed due to the problems of HIV and AIDS?
11. Do you have AIDS patients who walk long distances to fetch water, wood, and food?
12. Do you think lack of enough water supply, fuel and food supply affect the conditions of AIDS patients in your community?
13. Is there any school that experiences increasing teacher mortality and morbidity related to AIDS?
14. Do you know of any children who leave schooling due to AIDS related problems?
15. Do you know of any families that are selling their assets in order to cope with medical costs emanating from HIV and AIDS?

16. Is there involvement of community leadership in community campaigns against AIDS?

17. Are there people who are affected by HIV and AIDS in your community?

APPENDIX 2

UNIVERSITY OF LIMPOPO
Turfloop Graduate School of Leadership
Focus group interview questions for community leadership on the socio-economic impact of HIV and AIDS on community development

1. Is there any loss of lives of HIV and AIDS in your community?
2. Are there any families that disintegrate due to AIDS deaths of their members in the community?
3. Do old people experience the double burden of taking care of their grandchildren and that of lack of support in their old age due to HIV and AIDS?
4. Do you find the death of a highly experienced teacher or engineers at water services of the community replaceable? And why?
5. Do you think there is any mobilization of the entire community in HIV and AIDS campaigns? And how?
6. Do you have families that experience a loss of income due to problems emanating from HIV and AIDS?
7. Do you know of any families that experience material losses due to HIV and AIDS?
8. Is there any loss of subsistence agricultural knowledge and skills in food supply due to adult deaths from HIV and AIDS in your community?
9. Do you know of any families that have changed spending their incomes on important necessities like food in order to cope with medical costs related to HIV and AIDS?
10. Do the community resources such as labour and finances get reduced by the presence of HIV and AIDS in the community?

APPENDIX 3

UNIVERSITY OF LIMPOPO
Turfloop Graduate School Of Leadership
Combined focus group interview questions for community leaders on the socio-economic impact of HIV and AIDS on community development

1. Do you know of any families that have stopped bearing children due to problems emanating from HIV and AIDS?
2. Do you have a strong extended family system that cope with accommodating AIDS orphans in your community?
3. Does your community receive any support from government in order to cope with AIDS?
4. Is there any loss of agricultural production or land due to HIV and AIDS in community?
5. Do you know of any employed members of families whose time is taken by caring sick family members who suffer from HIV and AIDS?
6. Do you think that HIV and AIDS contribute to lack of productivity of certain people in your village?

APPENDIX 4: Locality Map