Coping Strategies of low-income households in relation to HIV/AIDS and food security

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ABSTRACT

The purpose of this study was to investigate coping strategies employed by low-income households of Sweetwaters KwaZulu-Natal, who have members who are infected with HIV in ensuring food security when dealing with HIV/AIDS. This study was based on households who have members living openly with HIV/AIDS and who were members of a support group of HIV positive people.

This study was conducted between July 2003 and June 2004. Focus group meetings were conducted with a support group of 26 members (Philani Support Group). Questionnaires, group discussions and observations were used to collect data from households. In order for the study to investigate coping strategies, the following sub-problems were investigated to measure changes before and after illness or death in household: changes in finances, changes in food habits, social aspect of studied household which included infrastructure (housing, roads, water, sanitation and energy); external and internal support.

There were no major differences in coping strategies, but the structure, resources and size of households informed their coping strategies. Food was the centre of all activities of households. As the ability of the household to produce food or earn income decreased, the need for food increased. Government social grants have been shown to be the main resource for coping (they enabled households to cope or survive).

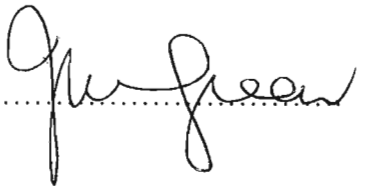
It is recommended that low-income households affected by HIV/AIDS and totally dependent on grants should be helped not to develop a dependency syndrome by implementing strategies that will encourage active participation and deal with passiveness that exists within low-income households of Sweetwaters affected by HIV/AIDS. As this study indicates that there are no resources on which concerned households depend, it suggests a greater need for capital to boost the household and strategies for households to be able to sustain themselves.

Declaration of Originality

I, Vusi Lushaba, hereby declare that the research reported in this thesis is the result of my own investigations, except where acknowledged, and has not in its entirety or in part been previously submitted to any University or Institution for degree purposes.

Signed:  .....

I, Maryann Green, chairperson of the Supervisory Committee, approve release of this thesis for examination

Signed:  .....

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CHAPTER 1

1. 1 Introduction

The HIV and AIDS epidemic is unique among other life-threatening diseases regarding its impacts on affected households. From 1981 when the disease was first reported to 2002, UNAIDS estimated the number of people who have died because of AIDS to be more than 20 million in the whole world. AIDS death in 2004 is estimated to be 3.1 million (AIDS Epidemic Update 2002). This suggests a huge challenge facing humanity.

Sub-Saharan African is the worst infected and affected region in the world (UNAIDS 2002). Studies conducted in the region indicate that this region has about 28.5 million people living with HIV and AIDS, and the estimated number of orphans is about 11 million (UNAIDS, 2002).

South Africa is one of those countries with a very high HIV prevalence rate. According to South African National Health Department in 2001, HIV prevalence among women attending antenatal clinics was 24.8% and it was estimated that about 5 million people were living with HIV and AIDS in this country (Department of Health, 2001)

The impact of HIV and AIDS on people living in rural and semi rural areas of KwaZulu is now clearer as many people are becoming very ill and die of AIDS-associated diseases. The question needing to be asked is what happens at household level when dealing with HIV and AIDS, in ensuring food security when bread winners die and those they depend on become very sick? This study used qualitative data to investigate the coping strategies of households living with the dilemma of HIV and AIDS as they attempt to ensure food security.

This study focused on a few aspects of HIV and AIDS in households directly affected by HIV and AIDS. It investigated the conditions of HIV and AIDS in relation to food security and general social support. It did not include the prevention and spread of HIV/AIDS.

The main focus of the study was on the coping strategies in cases where the crisis has contributed towards food insecurity. Some of the factors that were considered in this study included the type or structure of the family, sources of income, eating patterns, infrastructure and the spirituality of household. These factors were included in a study in order to find out the responses of both the people in charge of the households and also the household itself. It helped in identifying the strategies that were employed for coping and the constraints they faced in coping. It also included a variety of support mechanisms that had been used and the support they needed which they did not receive.

This descriptive study set out to examine various dimensions and characteristics of low-income households affected by HIV/AIDS with special focus on food security.

1.2 Research problem

An investigation into the coping strategies of low-income households in ensuring food security when dealing with HIV and AIDS in their households?

1.3 Sub-problems

In order to identify the coping strategies utilised and how these impacted on the households, the following sub-problems were investigated:

1. In a group that described themselves as poor, what were the changes in finances for before and after illness or death?

What were the economic/financial implications and households' relationship to poverty regarding time, money, and assets? How were they affected financially? What were their sources of income? How did the presence of the pandemic change the earning or income amounts, patterns and subsequently the impact of HIV/AIDS on food security? This included the issues of assets, and the exchange of assets or self (prostitution) for food or employment (Cross 2001).

2. What services were available, accessible for this particular group.
    - Tangible/Physical support (financial; economic basis, money, time, energy, assets, infrastructure and government services)

What support did the households have? The study examined aspects like food parcels, gifts of money and kind. What support was available, was accessible and used? What infrastructure was present? Changes in coping strategies were identified in patterns or trends of behaviour that were followed by households affected by HIV and AIDS.

- Informational support

Did households affected by HIV and AIDS know where to go to for information? The aim was to find out the utilisation and effectiveness of available government services, the NGO's and churches that claim to provide health information for households affected by HIV and AIDS. The main focus was on information relating to food access, income and grants, lowering expenditure and food prices, healthy eating, gardening, HIV/AIDS progress and care.

- Companion support (community support) that offer care

Did households affected by HIV and AIDS find support from the community members? Who were the key people in the community available for helping and moral support? Which organisation/s do they think of when they have nothing to eat? The effectiveness of the available NGOs was determined in this category.

- Intra-household support and care resources

What happens within a household? Were there support structures within households directly affected by HIV and AIDS; and to what extent did household members support each other? Were family size and extended family structures important?

3. What changes in food habits occurred?

What were the changes in food access (types and amounts of food, eating patterns and gardening) and their relationship to available resources?

Data that was collected included: eating patterns, gardening activities, buying responsibilities, quantity of food and levels of food shortages in households. The changes in these factors were investigated in relation to before and after the crisis of HIV/AIDS

4. What changes in spirituality occurred as they attempted to secure food?

What kind of emotional support (family, church key people, support group, care group) was there? What were the spiritual implications? How did the presence of the disease/s in a household affect their spiritual life? Was it driving them away or closer to whoever or whatever they believed in? How did this disease change their spiritual activities? Have they found support for their spiritual needs from their churches, and or traditional sources of spiritual strength e.g. *izangoma*, ancestral worship and prophets? Lastly, how did all of this affect the way they coped with shortages of food.

1.4 Hypothesis of the study

HIV/AIDS has a major impact on food security, specifically access to food, and the coping strategies employed in all households.

There are common constraints to coping effectively, and similar support systems are needed regardless of a variety of environmental support systems and irrespective of the stage of HIV/AIDS illness in the family.

1.5 Assumptions of the study

Assumptions in this study were that:

- Compensation of interviewees' time did not influence the answering of the questions (donations of epap were given)
- There was no interference from political structures during the times of interviews; even though it was an election year.
- The extreme conditions of poverty and suffering did not influence the study by making participation difficult.
- The information provided by respondents was correct.
- Confidentiality and stigma around HIV and AIDS did not affect the data collection.

1.6 Limitations of the study

The main limitation of the study was that it was confined to those who were living or lived openly with HIV/AIDS who were members of Philani support group and that it was conducted in a semi-rural area. Therefore, results that were obtained from the study could not be generalised for urban and other informal settings. Those who were critically ill were not interviewed because of their health and privacy when an individual or family was preparing for death. Financial constraints prevented the study from being carried out in neighbouring semi-rural areas.

The fact that this sample was based on those people who were living openly with the virus suggests its limitation. Due to stigma associated with HIV/AIDS, it was impossible to increase this sample. Researchers could not move from house to house asking if there was any person living with HIV/AIDS in those houses. Therefore this was an in-depth descriptive study of one group of households and results cannot be generalised to other areas. There were no comparative groups in the design of the study, because it was difficult to find a group of comparative households where HIV/AIDS had not been experienced in that area.

1.7 Importance of the study

The study provides baseline information about coping strategies of households in securing food when they deal with HIV/AIDS. It also provides baseline information to analyse community resources that are available; find out to what extent the resources are accessible to households in a semi-rural area. As the study analyses government resources, it also identifies gaps on the side of government and suggests roles that non-governmental organisation (NGOs) such as Youth for Christ (YfC) can play in the fight against HIV and AIDS.

This study takes all this into consideration in recommending strategies that will provide material and non-material support to households directly affected by HIV and AIDS. It also provides recommendations for interventions based on the needs expressed by members of households directly affected by HIV and AIDS.

1.8 Description of the study

The research focus area was Sweetwaters, a semi-rural area (area that belongs to a tribal authority with a poor infrastructure) in KwaMpumuza, 17 kilometres north of Pietermaritzburg in the KwaZulu- Natal, Midlands.

The households interviewed were those that were represented in a support group of twenty six HIV positive people (Philani Support Group) refer to appendix A for functioning of support group. Philani support group was initiated by YfC (NGO) and was still supported by YfC. After explanation of the study, all members were invited to participate in focus group discussions. All members of the support group were patients of the Communicable Diseases Centre (CDC) programme at Edendale and Northdale hospitals, Greys hospital (the provincial hospitals), or Imbalenhle clinic, which was based at Imbali Township, and their HIV status was known.

The group classified themselves as wealthy, being adequately resourced, poor and very poor. The poor group was selected to participate in household discussions (in-depth interviews) refer to chapter four for the reasons of their selection.

These included parents, single parents, and young people in school and out of school. The people who participated in the discussions were above the age of 10. All members of the households who were available during the time of interviews were part of discussion.

It was a comparative study in that it compared their current experiences with what they used to be as perceived by those in the study.

1.9 Structure and organisation of the study

The study is divided into six chapters: It begins by an overview of the study, introduction to the problem, the main problem, sub-problems, hypothesis, and description of the study, importance of the study and assumptions and limitation of the study.

The second chapter explores a review of literature of the subject. In this chapter special attention was given on: the trends of HIV/AIDS, stress on affected households, analysis of food security, the gender dimension, normal coping, and coping strategies employed by HIV/AIDS affected households, intra-household and external support and access to and the use of available services. Chapter three describes the methodology of the study. Chapter four contains the description of the sample and the following chapter describes the results. The last chapter provides conclusion and recommendations.

CHAPTER 2: REVIEW OF LITERATURE

2.1 Introduction

According to UNAIDS (2004) over 39.4 million people are currently living with HIV/AIDS, (64%) of all people living with HIV are in sub-Saharan Africa. This suggests there is a higher prevalence of infection in developing countries. The infected individual affects the lives of other people who might not have the virus. AIDS has been reported to be a leading cause of adult morbidity and mortality in Sub-Saharan Africa (Whiteside 2003).

The aim of this chapter is to identify some of the stages of HIV/AIDS, and to discuss household responses and coping strategies for ensuring food security when dealing with HIV/AIDS in their households. Gillespie *et al* (2001) says that HIV/AIDS is different from many other diseases or shocks because of its nature and the fact that it is incurable and fatal. It kills the most productive members of society, thus increasing household dependency ratios, reducing household productivity and earning capacity, and impairing the inter-generational transfer of local knowledge and skills. This is what this chapter sets out to examine, revealing the experience of people infected and affected by HIV/AIDS as reflected in the literature.

The chapter begins by looking at the current trends of the HIV/AIDS pandemic; it describes the advancement (statistics) at both micro and macro levels. It focuses on the individual household; it highlights some of the stresses experienced by affected HIV/AIDS households by looking at issues like key stresses, the role of poverty, the issues of gender and burdens, impact on household food security, and coping strategies when ensuring food security. After this, it highlights the usual coping strategies in resource poor households, which in this study are sustainable livelihoods. It then, in light of usual coping explores coping strategies employed by affected households. It includes available and accessible external support that a household needs. Careful attention is given to types of household and the availability and accessibility of services.

It goes on to investigate to intra-household support, which includes impact of HIV/AIDS on intra-household care and intra-household constraints. It ends in a summary diagram, which captures the relationships between factors mentioned in this chapter.

2.2 HIV/AIDS description and stages

HIVAIDS has been considered to be a major threat to development particularly economic growth and poverty alleviation (Whiteside 2002). This section focuses on the description of HIV/AIDS and its stages in the affected person. HIV and AIDS are different: HIV is Human Immunodeficiency Virus and AIDS is Acquired Immunodeficiency Syndrome. The virus infects a person when it enters his/her body and causes a weakening of the immune system. After the infection a person progresses to AIDS. AIDS is when symptoms become apparent.

Acquired Immunodeficiency Syndrome (AIDS) leads to the destruction of CD4+ T cells where the individual becomes vulnerable to a wide range of opportunistic infections that lead to death (Chamberlain 2004).

The stages of HIV/AIDS are as follows:

Stage I: Acute viral infection

The infection has an incubation period of 1-3 weeks, with no symptoms or serious illness. During this stage the virus is in the body and the body tries to form HIV antibodies. According Chamberlain (2004) this stage ends with the production of high titers of anti-HIV antibodies at 2-3 months.

Stage II: Asymptomatic stage (no symptoms), symbolized with frequent illnesses. Studies conducted show that this stage can last for 6 or more years in 65-85 percent of cases, but depending on individual, environment, economic status and support the infected person receives (Chamberlain 2004, Whiteside 2000,) During this stage patients produce large amounts of anti-HIV antibodies. It is in this stage that CD4+ T cells

decrease in the blood stream of the infected person. When the peripheral CD4+ T cell number decreases to about 200 or less, a patient is considered to have moved to the following stage.

Stage III: Symptomatic period

In this stage a patient is considered to have a full-blown AIDS. This is related to a sharp decline of CD4+ cells and it is when more opportunistic infections occur and eventually a person dies. According to Whiteside (2000) a person can live for more than ten years with HIV and AIDS.

2.3 HIV/AIDS trends

The HIV and AIDS epidemic is unique among other life-threatening diseases regarding its impacts on affected households. From 1981 when the disease was first reported, UNAIDS (2002) estimated the number of people who have since died because of AIDS to be more than 20 million in the whole world. This suggests a huge challenge facing humanity.

According to Naidu and Robert (2004) HIV/AIDS is now the leading cause of death in the continental region of Sub-Saharan Africa. The region is the worst infected and affected in the world (UNAIDS 2002). Studies conducted in the region indicate that about 28.5 million people are living with HIV and AIDS, and the estimated number of orphans is about 11 million (UNAIDS 2002).

South Africa is one of those countries with a very high HIV prevalence rate. According to South African National Health Department in 2001, HIV prevalence among women attending antenatal clinics was 24.8% and it was estimated that about 5 million people were living with HIV and AIDS in this country (Department of Health 2001, Steinberg *et al* 2002)

The impact of HIV and AIDS on people living in rural and semi rural areas of KwaZulu-Natal is now clearer as many people are becoming very ill and die of AIDS-associated diseases. The province of KwaZulu-Natal was reported to have the highest infection rates in the country and the infection rates was high among women when compared to men (National Department of Health 2003) The question to be asked is what really happens at household level when dealing with HIV and AIDS, to ensure food security when bread winners die or those they depend on become very sick? This review of literature analyses coping strategies employed by households living in a dilemma of HIV and AIDS as they attempt to ensure food security.

2.4 Sustainable Livelihoods

"A livelihood comprises the capabilities, assets and activities required for the means of living. A livelihood is sustainable when it can cope with and recover from stresses and shocks and maintain or enhance its capabilities and assets both now and in the future, while not undermining the natural resource base" (DFID 2003).

A livelihood is the interaction among assets and the environment of household, which produce means of living (Carney: 1998).

Figure 2.1 presents the picture of sustainable livelihood. The inner circle represents the household and the circles around it represent different assets material and non-material and their relationships. Sustainability of household is only possible when these assets are available and function fully. These assets are: human, financial, natural, social and physical. The effect of HIV/AIDS in relation to food security of livelihood asset in household level is as follows

Human assets: This includes aspects such as education, health, childcare, ability to be active, skills and knowledge. How can good or poor education enable them or prevent them from having access to available information resources? Human assets are also

related to change in the size and the composition of household, dependency ratio, change of roles.

Natural assets: This includes aspects such as land productivity, sale of land and climate. Do they have access to land, water, natural building materials and firewood? How are households relating to natural assets; does it enable them to cope better or not?

Physical assets: It includes aspects such as infrastructure: buildings; transport; water supply and sanitation, garden equipment. Do physical asset allow them to cope better or hinder them from coping? This is related to selling of household goods and equipment.

Social assets: This includes aspects such as community, organisations, extended family, religious and political groups and access to those with power. What resources are available to households? What are resources that enable them to cope? What support do they have, and from where? It pays attention to disruption of relationships with extended family members, and weakened social networks with larger community and organisations.

Financial assets: This includes aspects such as income, savings, access to credit, money from relatives, grants, pensions what is it that they do to earn money and gain income? What is it that is preventing them from earning money and gaining income? It includes therefore reduction in income, borrowing, change in income generation activities (Clover 2003).

In simple terms, sustainable livelihoods are ways of living that enable people to sustain their lives. A livelihood is said to be sustainable when it can cope with stresses and shocks, and still maintain a balance in such a way that the future generations are not threatened and at the same time the present generation meets its daily needs (DFID 2003). This implies that a livelihood is a combination of what individuals or households have and what they can do in order to be able to live independently from assistance from other people.

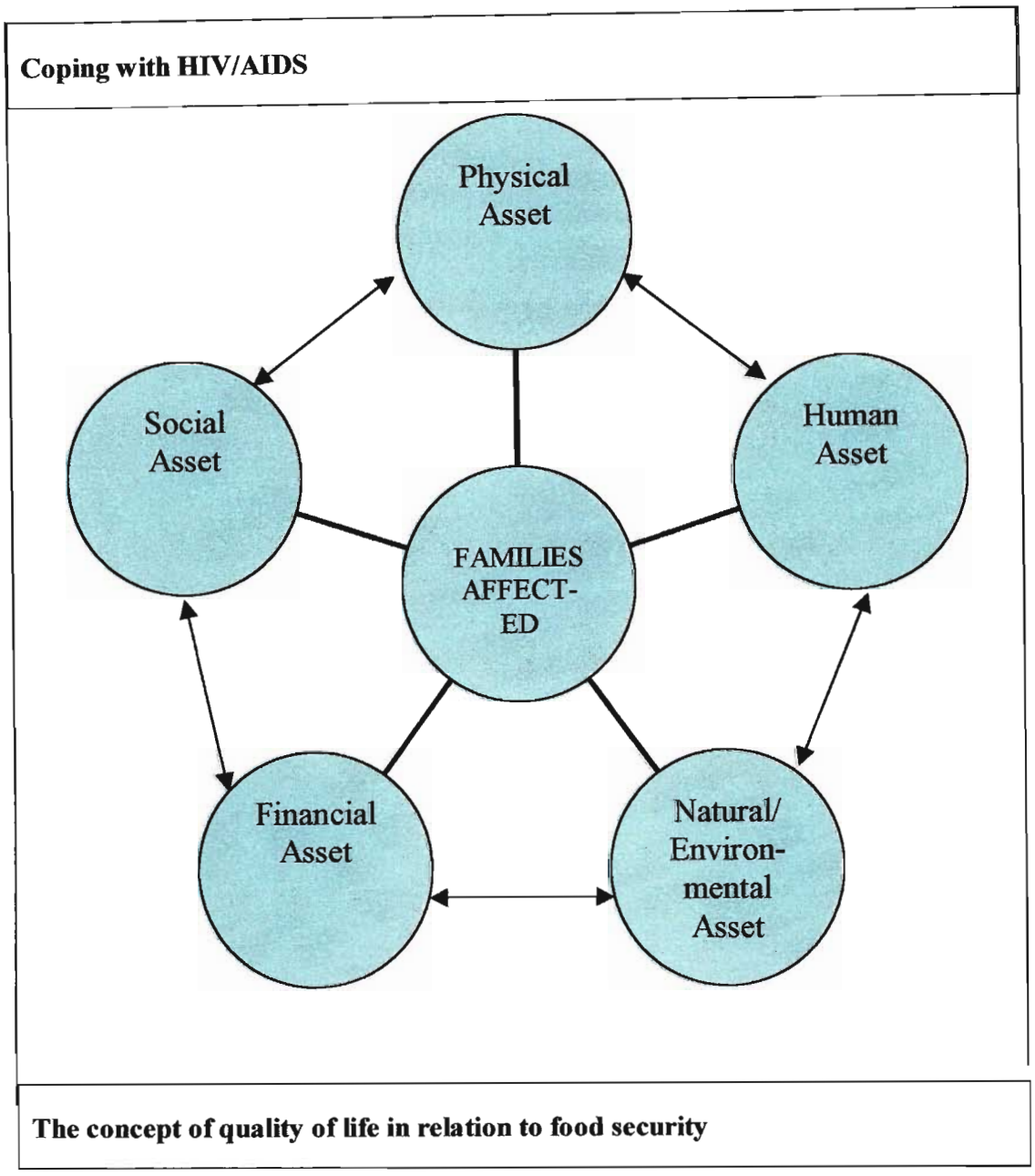

Figure 2.1: Framework of sustainable livelihoods (after Sustainable Livelihoods 2001)

Assets are interrelated, where one is lacking, others need to be accessed. How does interrelationship of assets function in low-income households that are dealing with HIV/AIDS? It includes contact with their extended families, community and organisations.

It is therefore important that there is interrelationship within the assets, for example financial asset which is the financial resources that people use to achieve their livelihood objectives. These resources include: financial savings, cash, bank deposits or assets such as livestock which could be sold. Should there be a decrease in these particular assets, other assets are disturbed. For instance, Human Assets which represents the skills, knowledge, capacity to work, and good health that together enable people to pursue different livelihood strategies can suffer for there will be no money to be used to acquire skills, knowledge and good health. This reduction in financial assets can lead to a compromise in Natural assets, such as trees can chopped for fire wood because of lack of financial resources to purchase alternative fuels. Disturbance of Physical assets can also occur where there will be a compromise in the basic infrastructure and physical goods that support livelihoods. For example, affordable transport systems, water supply and sanitation (of adequate quantity and quality), energy (that is both clean and affordable), good communications and access to information will impact on the Human assets by limiting opportunities for people to obtain work. When the above scenario takes place it also affects the way people and organisations relate to each other, reflecting changes in Social assets, the formal and informal social relationships (or social resources) from which various opportunities and benefits can be drawn by people in their pursuit of livelihoods (DIFD 2001)

HIV/AIDS is one of the shocks that can destroy the assets of the household directly. It can also force people to abandon their homes and dispose of assets (such as land) prematurely as part of coping strategies (DFID 2003).

It is important to note that HIV/AIDS poses a serious problem because households progressively experience the pandemic of HIV and AIDS. But the people's capital or assets indicated in figure 2.1 supports their quality of life. The literature identifies household assets used to cope, and some of constraints to coping. It also reflects factors that enable them to cope with HIV and AIDS when ensuring food security (Sustainable livelihoods 2001a).

2.5 Normal coping

This section explores normal coping strategies when people are confronted with poverty or shocks generally. According to Cobb-Turner (2002), coping strategies indicate that people who are faced with crises or difficulties in a given time have freedom of choice, and always have it within their social, economic and political contexts. Household choices can lead to alternative results for households to survive in crises. They define coping strategies as strategically selected acts that individuals and households in poor socio-economic conditions apply in order to survive in their given conditions. The concept is therefore related to responses, survival, and recovery. White and Robinson (2000) show that there are similarities of behaviour or responses to food insecurity for rural households.

According to Stokes (2002) households find their livelihoods in both the micro and macro contexts. He stresses the importance of the five assets of livelihoods that are essential for sustainability as discussed in section 2.4. The combination or linking of these assets enables the individual or household to activate their coping mechanism. Household responses to a shock or crisis are based on these assets (Coveney: 2000).

This implies that a poor functioning or coordination of these assets results in poor responses in dealing with crises or shocks.

Normal coping is usually seen as reduction in consumption, shifts of expenditure and income generation activities (SADC FANR VAC: 2003). These main factors embrace all smaller elements of individuals or households when coping. The following section looks at stresses on the affected households it explores difficulties and suffering experienced by households concern.

2.6 Impact on the HIV/AIDS affected households

The purpose of this section is to identify and analyse stresses experienced by households directly affected by HIV/AIDS. There are many stresses that households directly affected by HIV/AIDS face, especially women when they have to cope with HIV/AIDS. Du Plessis (1997) looked at the challenges facing women, of being both a patient and primary caregiver. According to this author there are a few themes that one may need to consider investigating when dealing with stresses on coping with HIV/AIDS. Five themes that are of great concern, are as follows:

1. Stigma:
2. Child concerns and care taking roles
3. Social support needs
4. Death, dying and despair and
5. HIV/AIDS information needs

The themes that are presented here show how deeply households or individuals can be affected by HIV/AIDS. It also highlights areas of concern when households are dealing with HIV/AIDS.

In an attempt to identify stresses of HIV/AIDS, these concerns by Du Plessis (1997) shall be investigated in depth. The identified concerns include those mentioned above and also those based on five assets or capitals (Natural, Physical, Financial, Social, and Human) that ensure a sustainable livelihood (DFID 2003). Gillespie *et al* (2001:5) confirm this, *"A livelihood represents the interaction between assets and transforming processes and structures that generate a means for living"*. It has been said shocks like HIV/AIDS strip individuals, households, networks, and communities of different forms of capital, that is human, social, financial, physical and natural (DFID 2003). What happens when there is no interaction between the assets or when assets are replaced by others? According to FAO (2003), HIV/AIDS is one of the shocks that cause disintegration between the assets and leads to a disturbance of assets, which causes lack of sustainability. The FAO shows that "HIV/AIDS undermines the ability of individuals and households to feed and care

for themselves while eroding the capacity of communities and institutions to provide basic services and support for the people in need" (FAO 2003:3). This may result from some of the assets being destroyed, replaced or not functioning to their full capacity. When this takes place in the life of a household, it produces different kinds of stress and despair. HIV/AIDS is regarded as one of the shocks, which affect a household's ability to get ahead and improve lives (FAO 2003). An example would be lack of education: if children of concerned households fail to obtain education and skills, it is unlikely that they can overcome poverty and be able to meet their needs of food and of their households

The impact of HIV/AIDS creates a vicious cycle of poverty and disease. The poorest are the most vulnerable to HIV/AIDS in that the consequences are most severe. Affected households give up their jobs, lose income and they are forced to adjust to changes as they spend more on health care leaving gaps for other basic necessities such us food, clothing and electricity. Studies conducted show that income of the affected households halves the average household income due to illness and diverting personal energy from income generating activities. Food production is affected as households reduce their agricultural work and abandoned their farms because of HIV/AIDS. Illness adds major stress besides loss of income, because of additional care related needs and health care expenses (AVERT 2004; Booysen 2004)

2.6.1 Key stresses

What are some of the key stresses that have been experienced by affected households? Beginning with the question of what happens when an adult household member or breadwinner dies? FAO (2003) suggests that there are at least four kinds of people who are likely to respond quickly to the situation. Those people are surviving parents, grandparents, relatives and children. In meeting household food requirements, income and child care needs, these people present themselves or are approached to help. It must be noted that this task is often too much for them to handle (FAO 2003). The most affected people in households are women and children. Many orphans and vulnerable

children are unable to attend school, even when chances to attend exist. HIV/AIDS plays a major role in reducing human resource capital and ability to implement future activities (Gillespie *et al* 2001).

Some of the stresses that affect households include factors such as altered relationship with partners, dependants and networks within extended family, illness, dying, funeral and life after a funeral.

A very important aspect of food security is nutrition. What are some of the impacts on nutrition? According to Gillespie *et al* (2001) HIV/AIDS has a major impact on nutrition from individual level to the community level. They state that infected individuals have higher nutritional requirements than normal. This suggests that households affected by HIV/AIDS especially when someone is ill, need to ensure that those nutrition requirements are provided to enhance the immune system.

HIV/AIDS causes unbearable demands on affected households. Households go through many stresses. According to FAO (2003) greater difficulty is seen when an adult becomes sick especially if this person is a breadwinner. There will be a shift in spending, the household will spend more on medication for an ill household member, there will also be other related health care expenses (medication and transport) that will occur in a household. The household continuously feels the impact of the disease as the sick member deteriorates and increases the care requirement. Children drop out of school to care for the sick. If a member dies, funeral costs become unbearable and this increases household debt. Those who are left behind (individuals and household) suffer exclusion due to the stigma that goes with HIV/AIDS.

2.6.2 The poverty dimension

HIV/AIDS is likely to increase poverty in Southern Africa Developing Community (SADC), because it reduces household incomes through lowering the productivity of

those who fall ill (Naidu & Roberts 2004; Steyn and Walker 2000). Naidu and Roberts add that households even divert scarce resources to cater for medicine, care and funerals.

Studies conducted in many countries have shown that there is a relationship between poverty and HIV/AIDS (Whiteside 2002). This suggests that HIV/AIDS is more likely to be found in poorer households because of their economic position. According to Whiteside (2002) the greatest impact is at the level of individuals and households, because they are directly affected. According to DFID (2003) poverty can be understood with the following components; a dependency syndrome, lack of psychological well being, powerlessness, lack of voice, food insecurity, lack of employment and insecure sources of income, lack of asset security, including physical insecurity and helplessness.

HIV/AIDS decreases the capacity to act and a large part of poverty presents itself in the form of food insecurity (Gillespie *et al* 2001). This says that poverty does not only increase exposure to contracting AIDS, but it also increases the exposure to the impact of AIDS. Poor people are often illiterate and their learning capacity can be low. This results in less information about avoiding infective virus and minimizing the impact HIV/AIDS.

2.6.3 The gender dimension

This section covers the issues of gender in a family setting and pays more attention to the coping constraints faced by women in ensuring food security when dealing with HIV/AIDS. It also highlights the role of culture and tradition within households, which results in what is called the gender burden especially when food is insufficient for the household (Okoli 2001)

The burden that women carry extends to the medical treatment, nursing and providing for the needs of a household. Okoli (2001: 33) says:

"Women in developing countries play a vital role in meeting the food and nutritional needs of their families through food production, economic access to food and ensuring nutrition security of family members. Despite these contributions, women are constrained

by poverty, illiteracy, and lack of access to credit and extension services as well as well as by inherent difficulties of discrimination that perpetuate gender inequalities".

She continues to say that due to the position of women especially in Africa, HIV/AIDS places them at the higher risk in several respects because of important social, economic, and political inequalities existing between women and men. These aspects include economic security, food security, health security, personal or political security, emotional and material differences. This suggests the heavy load that women have to carry when ensuring food security because they are the ones that stay with children at home when men are away. It must be noted that their task of ensuring food security exists despite their limited resources and they are oppressed by cultural norms and traditions. HIV/AIDS in the life of women, who live at very low economic levels, adds to the suffering and hardship.

2.7 Coping strategies employed by HIV/AIDS affected households

This section deals with coping strategies employed by families affected by HIV/AIDS. Coping strategies in this paper are household responses during and after the shock/s, in this case the shock is HIV/AIDS that has caused changes in household life, because of ill or deceased member/s. According to FAO (2003), the impacts of AIDS are often revealed by the responses or coping strategies shown by affected households or communities.

According to Stokes (2002) HIV/AIDS affects the ability of a household to cope. This simply says that their ability to cope normally is taxed beyond their power to respond effectively to the shock or any other event that seems to be a threat to the normal life of household. It is important to note that coping strategies of a household depend on many cases or factors that vary from one household to another. Those factors or cases include household experiences, characteristics of deceased individuals, family composition, assets, community support and availability of resources (Whiteside 2002). In addition to these, the impact of the epidemic is basically related to households' ability to cope (FAO 2003).

Bishop-Sambrook (2003) elaborates on the arguments of Stokes, FAO and Whiteside by saying that the most important determinants of vulnerability of households directly affected by HIV/AIDS are derived from the context of household itself and how it survives. This implies that the nature of household is a foundation on which responses to the crisis or shock are formed. Bishop-Sambrook (2003) refers to key determinants of vulnerability as 'drivers of vulnerability', which include the following:

- Household composition (age and sex of household head, demographic data of other household members)
- The status of the person with HIV/AIDS in the household. For example, if head of household is ill
- Dependency ratio. For example, the increased number of orphans, and those who need care because of illness due to HIV/AIDS
- Strength of household asset base, where losing assets leaving households vulnerable
- Cultural norms that define individual use and ownership of assets
- Diversity of livelihood strategies and
- Robustness of livelihood outcomes

The drivers are linked to each other. As households attempt to cope they use these drivers. The drivers should enable and not hinder households' attempts to cope. They therefore explain why some people or households affected by HIV/AIDS are able to cope and others struggle to cope, yet have similar levels of assets. They also suggest that there are different types of households, and it explains why some households cope better than others.

HIV/AIDS leads to unbearable demands that affect the normal functioning of household and in normalizing the situation, households respond in different ways and forms. The following strategies are employed to cope with the demands (FAO 2003, Maxwell 2003):

- Denial, concealment of health status, isolation from others and crying
- Household members are driven to exchange sex for money, food, goods or services or to leave home in search of work
- Most AIDS orphans are cared for through extended family networks. As a household contends with increasing expenditures e.g (health care, funerals, fostering orphans) while earning less income, it becomes more and more difficult to mobilize local resources for communal or group-based activities
- Households depend on informal credit at high interest rates
- Survivors migrate to seek work in cities
- Households send children back to rural families to be cared for.

Resources are drained from individuals and households infected and affected by HIV/AIDS, because having few resources reduce people's ability to cope with vulnerability and it limits their activities and options available.

It is important to discuss some factors that enable some households to withstand the impact of HIV/AIDS. Carletto (2001) sees the following factors as enablers for coping better with demands caused by HIV/AIDS in lives of affected households directly.

- Care practices and support for People Living with HIV/AIDS (PWHA)
- Access to, quality of, and use of health care medication and
- Access to, quality of, and use of other services (for example, extension, education, legal, social)

Carletto (2001) argue that these factors support and enable those affected to be able to cope with their difficulties or suffering. It therefore adds to households' resources and it lays the foundation on which households can rely.

In addition, studies conducted show that women who do not have enough resources on which to live they engage themselves in sexual practices as a means to secure food. This practice is viewed as an economic factor that leads individuals to engage in sexual act in order to secure food (Moore and Williamson 2003). This suggests that people who have

limited resources are more likely to engage in sexual relationships in order to increase their resources.

2.8 Impact on household food security

According to Roberts and Naidu (2004), the food security problem is not caused by one factor only but many factors: climatic conditions, livelihoods failure, inappropriate policies in some countries, as well as the devastating impact of the HIV/AIDS pandemic.

Food security means access to enough food at all times by all people (USAID, 1992). This section deals with availability of food. Carletto (2001) associate the availability of food with the capability of households to acquire food. This suggests that the most important factor is local availability of food, and ability of households to acquire food.

It is important to note that there is no single criterion for measuring food security, but a series of closely related constructs (Carletto 2001:74). Because of this complexity this review associates availability of food with non-food indicators such as wealth and food access, assets and livestock. For the fact that there is no single criterion that can be used to measure food security, the literature highlights some of the impacts of HIV/AIDS on food security. It also shows household responses in ensuring food security Food secure individuals and households are capable of sustaining an adequate supply of food without resorting to emergency food supplies or begging, stealing or scavenging to obtain food (Holben, 2003). When households afford food without any assistance, that is considered to be food secure.

According to Gillespie (2001:2) inadequate access to food is an important first sign that indicates distress in any household. One of the main factors that lead to food insecurity is being unable to work, which is often caused by illness and death of key member/s of the household. Stokes (2002) defines it as a decline in human capital with implication of individuals or households being unable to mobilise their resources to secure food.

Inadequate access can be caused by various factors, but HIV/AIDS related illness and death are major contributors to household food insecurity (FAO 2003).

According to the World Food Programme (WFP: 2003), fifteen million people across Southern Africa have exhausted their coping strategies and are now facing serious and potentially life threatening shortages of food. The question that Whiteside (2002) tries to address is: is HIV/AIDS the cause or the consequence of such condition? According to James Morris cited by Steward (2003), the UN secretary general for Humanitarian Needs in Southern Africa, good nutrition helps to slow the progression from HIV to AIDS, and for the stability of family and social structures.

There are various constraints that are faced by affected households when trying to ensure food security. According to Okoli (2001), the major constraint is education. She says that illiteracy rate among women is higher compared to men and this implies their inability to secure food easily. Carletto (2001) discusses two classes of food security, which are relevant to this study.

- Food insecure households

These households are described as families that lack sufficient income that can enable them to produce and buy enough food. They are characterized by large family size, low-levels of education, unemployment and dependency (Carletto 2001).

- Food-secure households

These households are described as capable of having access to income through different kinds of sources. Carletto (2001) mentions sources like remittances, employment and income-generating activities. These food secure households are also said to create opportunities for households mentioned in the first category, through house labour or field activities in exchange for food. They are characterised by having smaller families, higher levels of education, and resources (Carletto 2001).

Women and children play an important role in the life of a family especially in Africa. This includes the role they play in providing food. It has been shown (Okoli 2001) that they work mostly in the informal sector. By doing so they supplement family income, and the income that they generate is spent in providing food and cooking fuel for the household (Okoli 2001). This shows that they play a vital role in providing food to meet the nutritional needs of their family. In reality this highlights the difficulties that women face when they are sick and at the same time need to provide food for their households.

2.9 Coping to ensure food security in low-income households

To prevent food insecurity or food insufficiency many coping strategies are employed. The aim of this sub-section is to investigate coping strategies that are employed by households with low-incomes. Different strategies employed will be outlined and examined in order to see if there is a common pattern followed. This paper refers to practices used by households to obtain food and maintain their food supply as coping strategies.

There are two main dimensions of HIV/AIDS in human food security. One is a threat to socio-economic development and the other is a threat to human survival (Okoli 2001). In 2002/03 HIV/AIDS severely increased the vulnerability of affected households to harsh food insecurity in by eroding traditional strategies used to cope with food insecurity, by reducing the capacity to produce and purchase food, by depleting household assets, and by exhausting social safety nets. Recognizing that the impact of HIV/AIDS is complex and is going to require urgent and innovative responses in forthcoming years, SADC has called for new approaches to food security in the region (SADC FANR 2003). More specifically, a 'three-pronged attack', which is understood to be humanitarian assistance programme and government policy, focusing on consumption-side support, productivity enhancement and household and community safety nets is advocated to help prevent a downward spiralling livelihood trajectory for HIV/AIDS affected households:

Studies conducted show that households are likely to cope using the strategies that are discussed below: SADC FANR (2003), Whiteside (2003), Kempson (2003), Carletto (2001).

The studies conducted by Kempson (2003) revealed some of the coping strategies that are employed in ensuring food security. It shows that households are likely to strategize for food preparation and preservation, which is then followed by reducing the amount of food per meal or skipping meals. Buying low- cost food and use of credit has been reported to be a normal practice for households with low-incomes. Depending on food parcels and getting food from the work place was also a way of securing food. It is also shown that obtaining help from others (neighbours, extended family, friends, bartering, begging) and trusting in God was the way of making it through the hard times. Lastly, home and community gardening and sale of assets was a general practice for most of the low-income communities.

Carletto (2001:85) says, "Food insecure families or individuals, on the other hand have limited resources and the ability to acquire food; therefore they may resort to socially unacceptable ways to acquire food". Unacceptable ways of acquiring food include committing crime in order to get food (Carletto 2001). This shows the negative side of failing to secure food and the damage it can cause in the life of a household and also of the entire community.

2.10 External support

This section investigates the availability and accessibility of external support received or needed by affected households. The focus will be on food security and women as they are the most vulnerable and affected by the pandemic.

External support, is support provided from outside, which include services that are available for household from government, NGOs, private sector, and community structures. According to the FAO (2003) organizations should support affected households and communities by growing food and caring for the poor. The studies they

have conducted show that HIV/AIDS affected households depend largely upon community-based organizations for care and support (Devereux 2001). They include the following types of responses to HIV/AIDS: counselling, home based care, grants, and telephone support and prevention information. These services become available in communities, but services like telephone support are not accessible because many do not have telephone facilities or do not use telephone at all or cannot afford to pay to pay for the telephone.

There are many factors that affect women's access to and use of services. Those factors might be cultural, economic and physical. Hudspeth (2003) sees economic factors as a major constraint to women, which prevent them from accessing services. Her argument is based on the fact that someone has to pay for services and if not paying for services, they have to pay for transport in order to access services. This was considered a barrier to people for making use of services, especially to women (Holben 2003).

According to Okoli (2001) women and young adults carry a heavy load in terms of running of the household or housework. Their tasks include producing food for the household, preparing food, collecting water, firewood and caring for children. The responsibilities they have in households limit them from accessing available services (Hudspeth 2003). This confirms what was discussed earlier in this paper that women's burden in household situations is larger than that of men.

Other factors contributing to the inaccessibility of services are the fact that services are often found mainly in urban areas (Hudspeth 2003). For instance, in most cases welfare offices are located in cities or towns and it becomes difficult for poor rural women to register for grants and obtain important documents for themselves, their children or grandchildren. The same thing applies to health facilities. Hospitals and clinics with the latest technology and advanced facilities are also located in cities or centres. In the end such situations cause an exodus of knowledgeable people from the periphery to the centre ('brain drain'), and people in rural areas become even more vulnerable in terms of access to and information flow.

It is important to note that there is stigma attached to HIV/AIDS. In some cases revealing of HIV status can be the only way to access some of the services.
This makes the situation difficult for those people who are not ready to reveal their status and the services become inaccessible to them (Gillespie *et al* 2001).

A careful analysis of the above situation clearly shows that households, women in particular, are not only prevented by economic factors from accessing available services, but also the burden upon women of running and making provision for their households prevents them spending time needed to access services. It also shows that it is the women's responsibility in many households to ensure that the household is able to meet its basic needs. Women's responsibilities and tasks take a lot of their time and they end up having no time to access available services such as health services (Hudspeth 2003).

Bloom and Canning (2003) argue that illness in a household reduces the economic potential of the household to earn income. They further by indicate that knowledge is more essential in improving health and therefore knowledge is critical for individuals and households because it raises awareness of health. They therefore suggest that households with low-income should be empowered through information.

2.11 Intra-household support

Intra-household support is a very important aspect to consider in order to encourage coping strategies employed to ensure food security. The impact of HIV/AIDS taxes the household and they are the ones that are the primary victims of the pandemic. The external support aims at strengthening of intra-household activities.

In a household there are those who are sick and those who are healthy. Gillespie *et al* (2001) shows that the labour of healthy household member/s is channelled towards someone who is sick in the household and it becomes an important activity in the life of

the household. Attention is not only given to caring for the infected member/s, but they are also expected to attend the funerals of relatives and neighbours who have died.
Thus issues of illness, caring and death of a relative or family member are considered to be high priority to other members of households, relatives and extended family (Devereux 2001).

What happens when key members of a household become sick and die? This is very important to consider as reflected by household responses to HIV/AIDS shocks. Gillespie *et al* (2001) indicates that the most affected groups when an adult becomes ill and dies because of HIV/AIDS are women and children. He says

"The ability to acquire and use information is also impaired by HIV/AIDS as young generations are pulled out of school to bolster the family's ability to provide care and maintain its current livelihood, or develop new ones" (Gillespie et al 2001:8).

This indicates how the pandemic affects the current and future life of children and it simply says that the effects or damages of HIV/AIDS range from individual level to household and communal levels. It also suggests that some of the coping strategies are not as good as others; there are those that are destructive and other are constructive; for example, taking a child out school to take care of sick person. This issue indicates that HIV/AIDS can compel households and younger generations to sacrifice their future livelihoods in order to be able to survive their current situations or crisis (Gillespie *et al* 2001).

Young women, who are more susceptible to infection and suffer higher levels of infection rates, increasingly drop out of school to assume additional household responsibilities in caring for HIV/AIDS sick and orphaned, and in generating additional income. It is also increasingly being recognised that household food insecurity in southern Africa cannot be properly understood if HIV/AIDS is not taken into consideration. There is mounting evidence to suggest that households affected by adult morbidity and mortality, and with a

high demographic load are significantly more vulnerable to food security shocks than are other households (SADC FANR VAC: 2003).

2.11.1 Impact of HIV/AIDS on intra-household care

Public hospitals and clinics fail to cope with the large numbers of patients with HIV/AIDS that need to be cared for. According to Hudspeth (2003) people infected by the virus require additional care, support and nutrition. This crisis in the health public sector forces HIV/AIDS patients to be cared for in their households. Hudspeth (2003) highlights some of the caring capacity that exists in households as they take care of children and adults affected by HIV/AIDS. He discusses care responses or care practices in the following ways:

- People who provide care once there is an ill family member are relatives, neighbours and friends.
- Due to an increased number of people needing care in a household with few people caring, care and household resources are reduced. The caring capacity becomes exhausted.
- "When the main care provider is ill or dies, the care will have to be provided by other family members (e.g. fathers or grandmothers). These new care providers do not always have up-to-date caring knowledge and skills. This result in a deterioration of the quality of care"
- Children are worst affected, because when there is no one to care for an adult, they sacrifice their schooling to provide care to ill parents and siblings.

According to Hudspeth (2003) people who provide care to people living with HIV/AIDS should have a good knowledge of nutrition needed by HIV/AIDS patients. He also raised the issue of gender roles in caring practices. He stressed that both genders should be caregivers because of the fact that they are care receivers. In conclusion he believes that care providers are available because people sacrifice their jobs, homes, children

schooling to be with their ill family member or relative. He sees lack of resources as a major hindrance to people wanting to improve care to their love ones.

However the quality of their service can be challenged in terms of knowledge and attitudes need for training for all caregivers is suggested.

2.11.2 Intra-household constraints

This sub section highlights some of the major constraints that exist in household situations when the household tries to support itself or survive a shock. The constraints that are highlighted here pay more attention to food security. Hudspeth (2003) discuses the constraints as follows:

- Reduction of household productivity due to increased episodes of illness, deaths and the need to care for ill household members. If household are no longer able to produce their chances of securing food decreases.
- Household financial resources are drained by health care, e.g. hospital, medical expenses and cost of funerals and result in a lack of income for purchasing food.
- Household members are moved amongst relatives and the number of orphans and those that need to be cared for increase. Thus household resources fail to cope with the greater demand caused by the pandemic.
- Lack of nutritionally adequate diet to infected members. Nutrition to households that are struggling to get food is not even considered because what becomes important to them is food itself not nutritional ingredients of food.

2.12 Summary

Figure 2.2 below summarizes the impact of HIV/AIDS on affected households. It indicates household's experiences when they struggle with HIV/AIDS. It explains the changes that HIV/AIDS can cause in the life of an individual and that of the household.

The crises or problems start when there is an infected member/s in the household, which leads to illness, and eventually death in a household. If one of these factors occurs it brings changes in the life of the household.

The changes include reduction in commitment because of sickness or death and opens gaps that demand more roles and responsibilities. It also reduces the capacity of affected individuals to acquire information and therefore that particular individual or household becomes passive. This leads to reduced household food security due to decreased production, increased use of household resources for care, increase in the number of people needing care, and then reduction in quality and quantity of food occurs.

As reduction in food occurs, reduction of care also occurs through the following steps: when care giver become ill, the rate of dependency increases, care quality is reduced and community and social networks become weak. Quality or access to health services is also reduced through greater demand for health services, and reduced household resources for health.

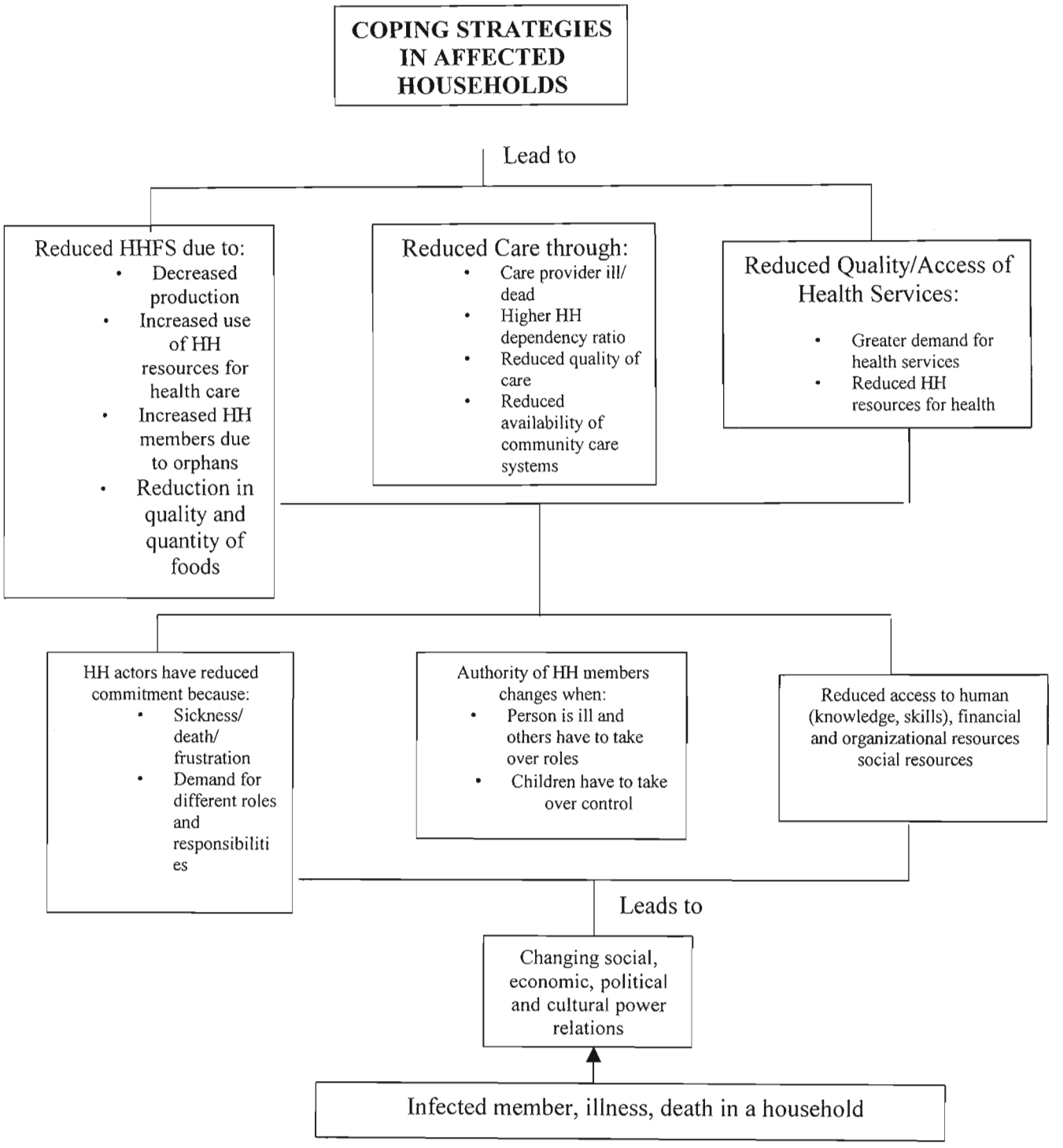

Figure 2.1 Framework summary adapeted from Stokes 2002

CHAPTER 3: METHODOLOGY

The first challenge for investigating the impacts of HIV/AIDS on food security and coping strategies of households directly affected by HIV/AIDS was to develop a methodology for in-depth study of households directly affected by HIV/AIDS living in a semi rural area. The study involved people living openly with HIV/AIDS who were members of a support group for infected people in Sweetwaters area and their immediate nuclear and extended families and friends. A support group which was formed and mentored by Youth for Christ through the researcher, who was later granted finances and permission by the same organisation to conduct the study in the community where the support group was. After the study was explained to members, they gave their verbal informed consent for the focus group activities and a verbal consent was also obtained for each household that was interviewed including taking of pictures. See appendix A for purpose statement of a support group.

It was originally proposed that a comparative group be selected who had not had to cope with HIV/AIDS in their households, but who had similar incomes and living environments. However, it was difficult to approach such unknown households when the HIV/AIDS stigma (secrecy surrounding the epidemic) was strong and so many had to cope with death within their families.

The researcher personally obtained the data, using the common home language of isiZulu. There was additional assistant, who assisted with taking of notes and changing cassettes on a tape recorder as is recommended by Blanche and Durrheim (2002). Two structured open-ended focus group activities were devised which guided the process relating to wealth ranking (after Simanowitz 1999) and HIV/AIDS experiences. A structured open-ended interview schedule was designed for the qualifying families. The researcher recorded the interviews and completed the schedules using audio recordings with the help of the assistant. Figure 3.1 illustrates the methodology for the support group activities to find out who qualified for the following stage and to collect some HIV/AIDS and socio-economic data.

The rapid assessment methodologies were applied to two focus group discussions. The in-depth interview was subsequently conducted with individual households. Focus group discussions, in-depth interviews and using of audio-tape was used in this study as a relevant approach because of its nature (qualitative) as is recommended by De Vos and Fouche (1998) for qualitative approaches. See appendix C for focus group questionnaires

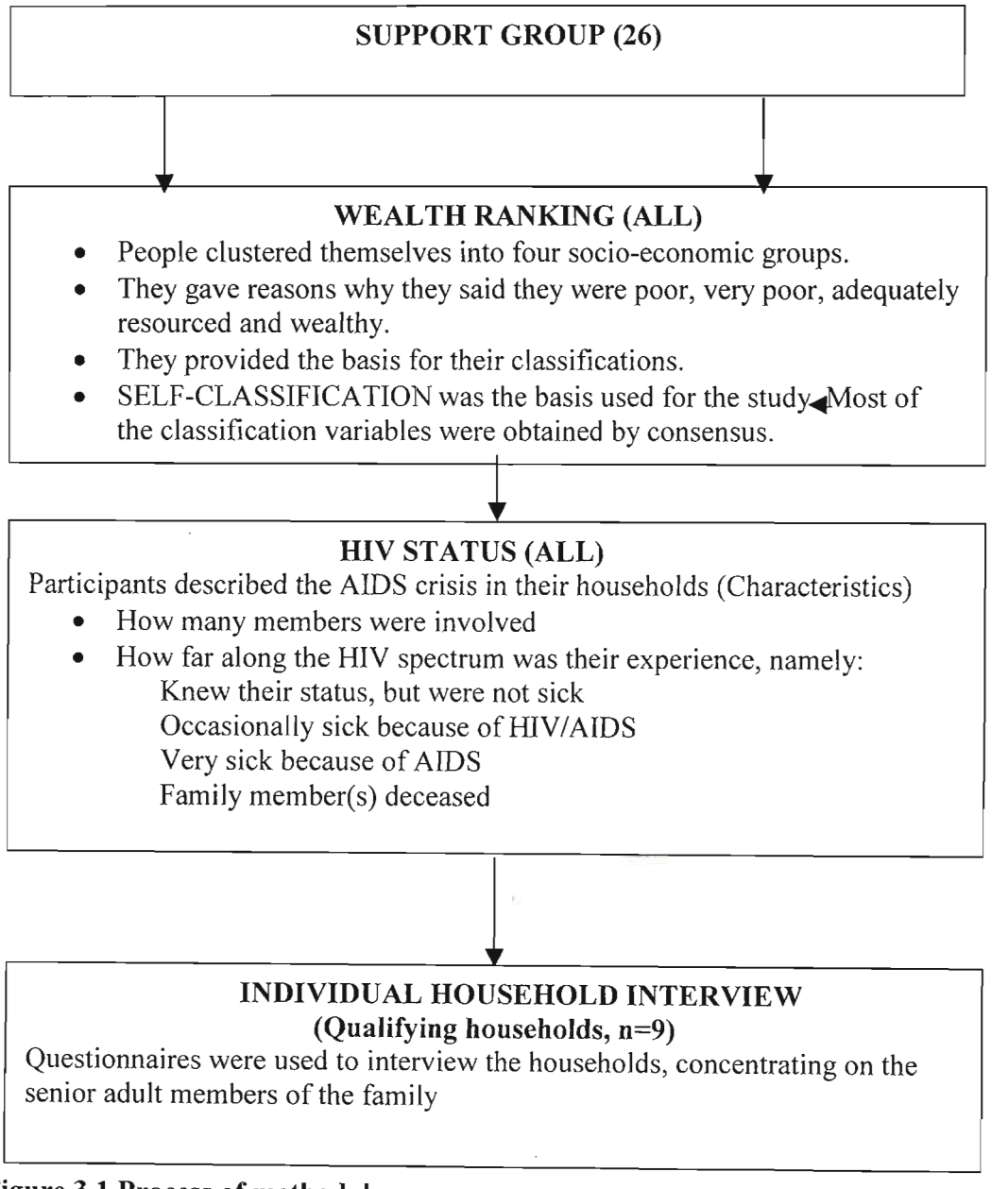

Figure 3.1 Process of methodology

Focus group discussions

All support group members were requested to participate in a wealth ranking exercise. The purpose was for the members of the group to do a "self classification", and to enable the researcher to identify people with similar lifestyles, and who were at similar levels in terms of standard of living. Standard of living was selected because of its pervasive influence on people's coping strategies (Kempson 2003, SADC FANR 2003, Whiteside 2003)

The exercise was conducted in a room where support group members met weekly. Four circles were drawn on the floor in order for group members to stand stating whether a person was poor, very poor, adequately resourced and wealthy. The purpose of the exercise was explained to the group and how the exercise would be conducted. According to their own standards they needed to group themselves in circles that were drawn on the floor.

It was perceived that members knew each other as some had been together in the group for more than two years and came from the same geographic area. Therefore the whole group was allowed to challenge anyone who they thought was not in the correct circle, and people themselves were allowed to change should they have thought that they were in a wrong place.

During one focus group discussion all members of the support group were invited to participate in a wealth ranking game in order to classify themselves according to their standards as opposed to be classified (Simanowitz, 1999). This game was used to identify people with similarities, those who were at similar levels in terms of the standard of living and the impact of HIV and AIDS in their households.

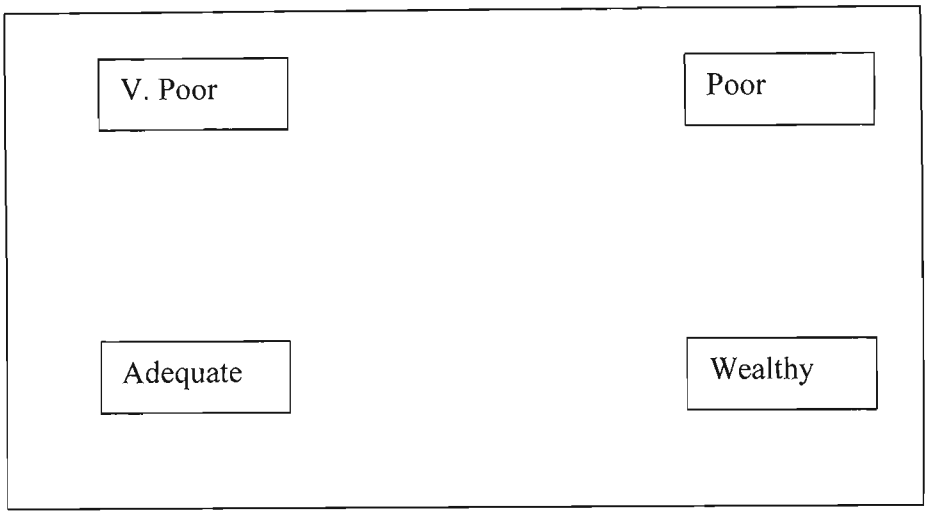

Figure 3.2 Wealth ranking and classification

Figure 3.2 is the example of wealth ranking. Similarly, the members of the support group were later asked to identify where they felt they fitted onto a spectrum of AIDS experiences. See Appendix C for the focus group discussion guide.

Both games identified who qualified to be interviewed in that they occasionally had or often had sick people to care for. The interview methodology was selected because some of the information was too personal to be asked of an individual in a group setting and therefore could not be obtained through focus groups. The semi-structured interview schedule included many open ended questions because this is best suited to elicit a wealth of in-depth information as opposed to structured questions (Terre Blanche and Durrheim 2003). The interview schedule was developed in accordance with the sub-problems and piloted in a household from the same area but not included in the study. Subsequently, minor alterations were effected.

As suggested by the literature, the following additional information was collected (after Okoli 2001, Whiteside 2000, Gillespie et al 2001):

Family structure because the structure of the households is more likely to inform household coping strategies. Below are the examples of how heads of the households and household composition may look like.

- Male headed family
- Child headed family
- Female headed family
- Married couples
- Unmarried couples

General information of heads of households also predicts and informs coping strategies applied by that particular household.

- Age and gender of the person in charge of a household
- Education level of person in charge and people who are working
- Incomes/what do they do and number of people who get an income in a household
- Number of key people they have lost in the family (if any).

Food & assets, which would explain resources which the households had and the food used in the household. It also indicated who was responsible and also informed coping strategies.

- Type of assets available
- Infrastructure
- Gardening activities
- Number of meals a day
- Where they buy food
- Who obtains the groceries?
- How often do they buy food?

Incomes and earnings to support their classifications

- How many are receiving grants?
- Types of grants
- How many people are working, where?
- Do they work for money, food or shelter?

Community and intra-household support, which would show the nature of support within a household and how the household copes with increased demands caused by HIV/AIDS. Information about the assistance they received from government services was included and also the nature of the support they received from families, communities, NGOs, CBOs, churches and key people in the community. The information also reflected whether this support was satisfactory or not.

The resulting information was analysed through a systematic manual inspection of the qualitative information in order to build a case study about each household. Descriptive summarising tables were also compiled. Observations of household environments were rated for comparisons.

3.1 Summary

The methodology of small group discussions for a wealth ranking exercise and HIV/AIDS classification, was followed by selecting qualifying households for in-depth interviews using questionnaires and observations.

CHAPTER 4: DESCRIPTION OF THE SAMPLE

4.1 Outcome of the focus group exercise

All 26 support group members participated in the wealth ranking exercise. The purpose was for the members of the group to do "self classification", and to enable a researcher to identify people with similar lifestyles, and who were at similar levels in terms of standard of living. All participants were female and they all agreed to participate in the exercise.

The chart below indicates how many people were in each of the categories. Of the 26 group members, none considered themselves wealthy, 10 were adequately resourced, 12 were poor and 4 very poor.

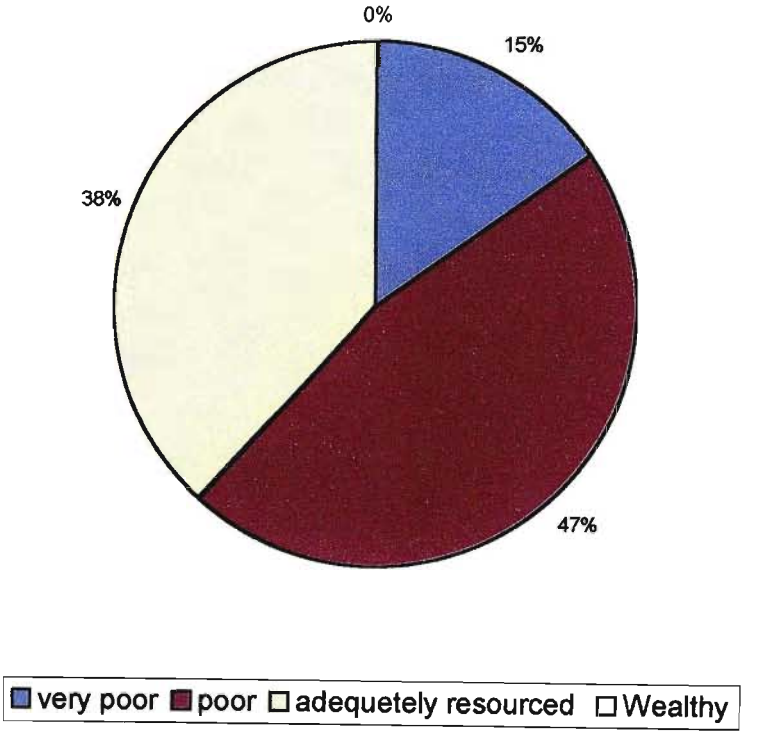

Figure 4.1 Self-classification according to wealth status

The responses to the question 'why do you say you are poor, very poor, adequately resourced or wealthy?' are described below. Both the opinions of the others, as well as those in the particular group are reported.

4.1.1 Being wealthy

As indicated in figure 4.1 none of the participants considered themselves to be wealthy. This was used as a starting point for the whole discussion. Participants in all groups or circles (poor, very poor, and adequately resourced) were asked to give the meaning of being wealthy.

These are some of the answers they gave: *Umuntu ongasweli lutho* is someone who lacks nothing; *Isigwili* a rich person; *Usuke edla izambane likapondo* a person who eats expensive food (generally rich).

The understanding of the entire group of what a rich person was, was in agreement. It must be noted that when they described a rich person, they only described a rich person in terms of material possessions. This was slightly different from the other categories as the latter included some social aspects.

4.1.2 Having adequate resources

The next discussion that followed was that of "having adequate resources". Of the 26 participants, ten classified themselves as having adequate resources. People who were not in this group first gave their understanding of what having adequate resources meant.

One of the respondents from the poor and very poor groups said "*abantu abanokwenele abakwaziyo ukuhlangabezana nezidingo zabo zonke ngesikhathi abasuke bedinga ngazo*". She said that people who classified themselves as having adequate resources should be people who are able to meet their needs as they arose. The whole group of people who classified themselves as poor agreed that such people lack nothing because according to them (the very poor group) whatever and whenever a person needs

something, they can always get it without *ukukhathazeka nokuhlupheka* being worried, suffering and with ease.

This is what the poor and very poor said about the adequately resourced:

"What ever you need, you get it at the same time"
"You don't need to suffer and become worried before you can get whatever you want"
"You lack nothing"
"You have everything"
"All your needs are met with ease"
* "You have people who take care of all your needs"
* "You have all the support you need"
* "You live a life that you want to live"

* Social reason

It is worth noting that as the two groups (very poor and poor) were sharing their understanding of being adequately resourced, the better off group were annoyed by what was said because they felt that the statements were not true for them. They even interrupted by saying *Cha! Cha! Asichazi lokho futhi lokhu enikushoyo ukushibhuqa.* "No! No! We are not saying that and what you are saying is being sarcastic" or unkind.

People who classified themselves as having adequate resources described the meaning of being adequately resourced: accepting who and what you are. They said that being who they are is a gift from God, which they need to accept. This was the main reason for them classifying themselves as having adequate resources. It is not that they can afford anything at any time.

In addition this is what they said about themselves as having adequate resources:

* "I am accepting the life I am living and I am able to overcome"
* "It is not about money. I am not sick. I have a mind and information. I am just like other people having soap, clothes, shelter, and blankets. I am therefore not poor nor

very poor"
* "You cannot change *isabelo sakho* your gift"
"I have food, clothes and my children are schooling"
"I am better off than poor people who have no food, shelter and not knowing where to go"

* social reasons

4.1.3 Being poor

All groups continued by giving meaning to their understanding of what being poor meant. Twelve participants considered themselves to be poor; this was the biggest group. Firstly, the remaining groups discussed their understanding of being poor.

One of the respondents said *kusho ukuhlupheka noma ukweswela,* she said that it means suffering and having nothing. The groups agreed that they are poor because they have nothing and whatever they get, they need to work hard for. Another respondent said, "looking after oneself and people who depend on you, make life to be very tough and it causes people to be poor, because you have your own needs and the needs of those who depend on you including your spouse".

The group that classified itself as being poor had to share why they were saying they are poor. One respondent from the group said "*njengoba sithi siyahlupheka nje sisho ukuthi asinazo izinto ezimqoka abanye abantu abanazo, izinto ezifana namaTV,ifridge, nendlu eyamukelekayo nokunye nokunye. Ngenxa yalokoke siyahlupheka".* As we are saying that we are poor, we mean that we don't have basic things that other people have. Things like TV, fridges, acceptable houses, etc. We are therefore poor.

These are some of the aspects that they based their own classification on:

"We are not eating as we want"
"Our children are watching TV at our neighbours"
"We have children and siblings to support"

* "Our parents left us people to look after"
*"Our houses are falling down" no-one to fix them
* "We have no one to lean on"
"Wishing for things that I can afford"
"I have no TV, fridge, and I'm living in a two room mud house that my parents left me which has no furniture"
"I am not working and I am short of many things"
"I am living on credit and still my needs aren't met. My house is falling apart. We have no food, our clothes are not in good condition and my children are not getting what they want"

*Social reasons

4.1.4 Being very poor

The next point that was discussed was being very poor and as indicated in figure 4.1, only four participants classified themselves in this group. They were the first to share why they were saying that they were very poor. Their classification was based on three elements, as follows.

1. Asinamakhaya noma izindlu abazali abasishiya nazo sihlala ezihlotsheni noma siqashe
We don't have homes or houses that our parents left us with. We stay with extended families or we rent rooms.

2. *Izinsuku ezintathu ziyaphela singazi ukuthi sizodlani, ngaphandle kwethu ibhodwe aliyi eziko.*
We can go up to three days without anything to eat, and also without us bringing food nothing can be cooked or eaten. [We are responsible for getting food]

3. *Singobaba nomama nomkhulu nogogo yithina esondla nesisaphotha imindeni yethu.*
We are fathers, mothers, grandmothers and grandmothers. We are the ones feeding and supporting our families.

In addition to this, they also stated the following, which was similar to those of other groups:

"We have no food"
"We are not working"
* "We have no parents"
"We have no homes"
* "We are suffering"

* Social reasons

As this group was sharing their situation and conditions, the atmosphere changed. One participant from the adequate resources group said "*kuyiqiniso ukuthi laba bahlupheka kakhulu kunathi ngoba abanabazali, akukho bantu ababasaphothayo futhi izingane emakhayha zikhalela bona*". It's true that these people are very poor and they are poorer than us because they don't have parents. No one is supporting them and children in their homes look up to them for everything.

When the two groups (adequately resourced and poor) were asked to explain how they understand being very poor, they responded by saying *umuntu ophila ngomgadlo* someone who lives by bartering; *umuntu ophila ngokucela ngisho nakubantu abangahlobene naye* is a person who lives by begging even from people who are not related.

When the group of participants who classified themselves as being very poor were asked whether there were people who were poorer than they. They responded by saying that yes there were people who were very poor compared to them. They said that some of those people had to beg on the streets and go from house to house to ask for food or feed themselves from rubbish bins.

For this group being wealthy was to have everything you needed by when you need it. It was also associated with big brick houses and cars and having no debt.

4.2 Housing situation and family size of participants

It was important for this study to investigate the housing situation of the participants in order to contribute to the criteria used for selection of in –depth interviews with households. The table below indicates housing situations where members of participating households were staying in as discussed in the focus group.

Table 4.1 Housing situations of participants in the HIV/AIDS support group

Adequately resourced	**All groups**	**All groups**	**Very poor**	**All groups**
Own house or home	Staying with parents who are pensioners and/or not working	Staying in houses or homes left by parents or whoever was in charge	Staying with extended family member(s)	Renting room(s)
1	6	10	3	6
Av. Family size 5	Av. Family size 7	Av. Family size 7	Av. Family size 9	Av. Family size 5

One participant said they owned their home (widow). The largest group (10) reported staying in a house left by parents or whoever was in charge. Others (6) reported to be renting room/s. There was no trend relating housing to wealth status, possibly because housing was inherited or belonged to the previous generation and had no reflection on current (post HIV/AIDS) living standards.

Family size gave an indication of both the degree of caring help potentially available and also of people needing to be supported. The average household size was 7.8 members with the mode of 7 members. The minimum was 5 and the maximum 12.

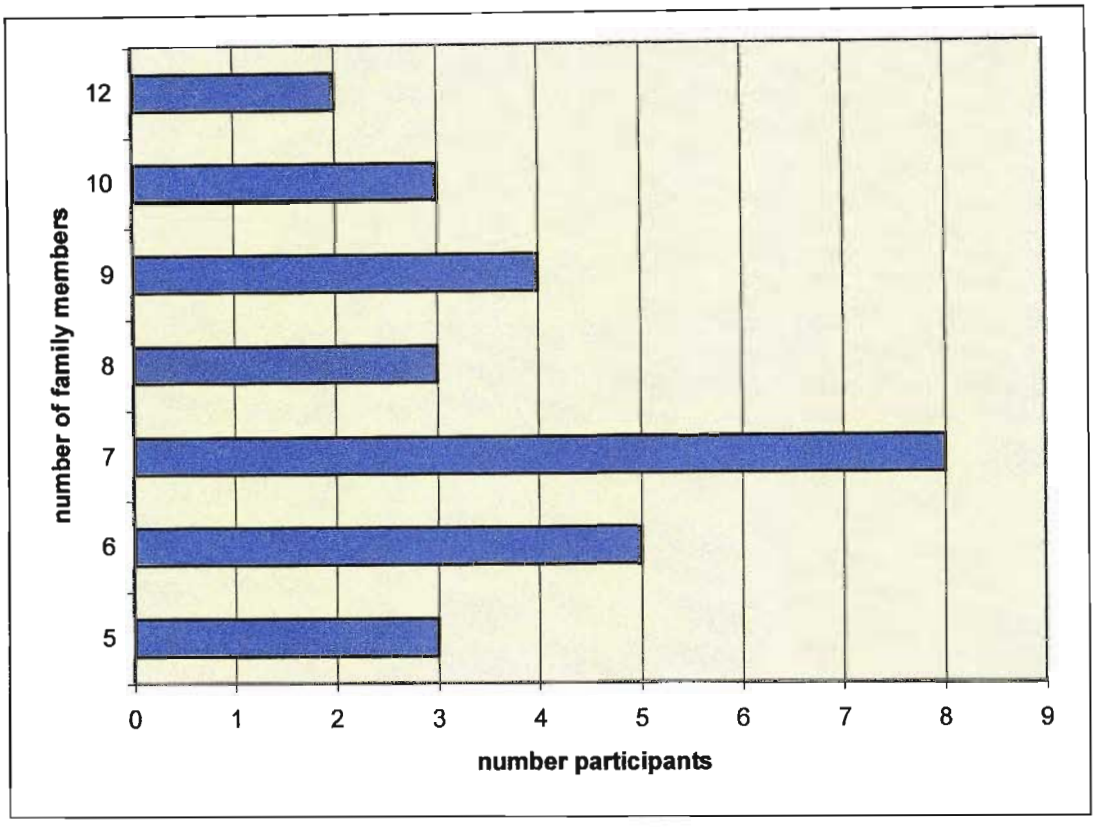

Figure 4.2 Family sizes

4.3 HIV status and the spectrum of disease

A focus group discussion was conducted with all members of the support group. The aim of the discussion was to investigate the spectrum and characteristics of disease experienced in households. They had to describe the crisis in their households (characteristics). The following issues were investigated:

- How many members are involved or ill
- How far along the HIV spectrum is their experience
  - Often sick because of HIV
  - Very sick because of AIDS
  - Family member deceased

What were the common symptoms (diseases) with which they had to cope?

This was over a period of three to four years.

Of 26 participants (suffering from HIV or AIDS themselves), only six reported being very sick. This was evidenced by symptoms they had. Four reported not being sick, and the rest of the group reported being often sick. They said *umeqo siyahambanawo:* we are walking with the virus. *Umeqo* is a Zulu word, referring to have been bewitched. They all said that they were all patients of CDC centre in Edendale hospital. Because the majority were often sick, they go to CDC centres for prophylactics. The chart indicates how many participants were very sick, often sick and not sick though they are HIV positive.

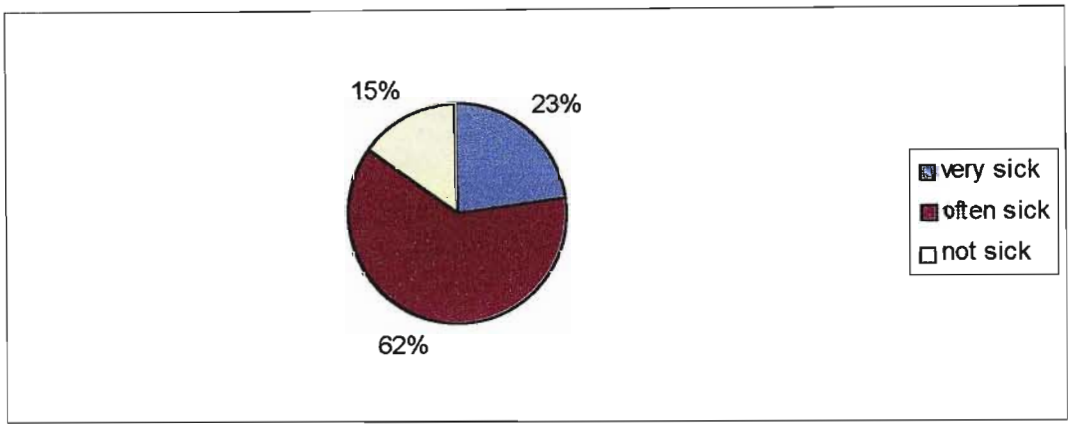

Figure 4.3 Degree of sickness of the support group members

As mentioned in the above paragraph of the 26 participants, only 6 considered themselves to be very sick, but they were able to attend the support group meetings because were feeling better on that day. The majority (16) of participants considered themselves to be often sick. When they were asked why, they said that different kinds of fever often attacked them. One respondent said *siyagula siphile sigule siphile:* we are sick, well and then sick again. They said that although they were often sick, they still had to do everything for themselves. As indicated in Figure 4.4, only four out of 26 participants considered themselves not to be sick. One of them said, "we are not sick, it just happened that we knew our status and we decided to join the support group".

Diseases that were common to the participants are indicated in figure 4.5 below. This gives an indication of the types of medication and care that was needed.

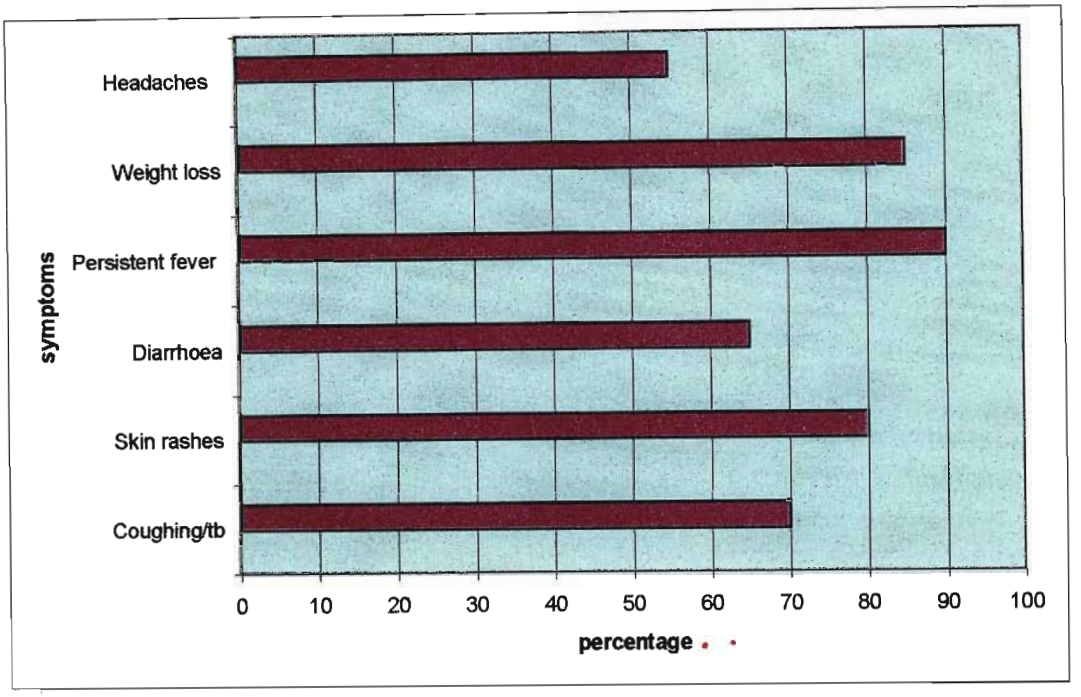

Figure 4.4 common diseases

Figure 4.5 below indicates how far along HIV spectrum their own experience has been. The results must be seen in the light of 3-6 years being the most common period of change reported.

As indicated in Figure 4.5 only one participant had lived with the virus for nine years and two for eight years. The majority of participants were between three and six years.

The group was asked how many members in their households were deceased because of HIV/AIDS. One respondent said that in her household she had lost four people and she was left with her grandmother and children of her sisters and brothers who died because of HIV/AIDS. This was the highest number of deaths; Others had three and less. But all of them reported having had someone who had died of HIV/AIDS. They also raised the fact that they have lost many more people in their households but could not say it was AIDS because they did not know enough about HIV/AIDS.

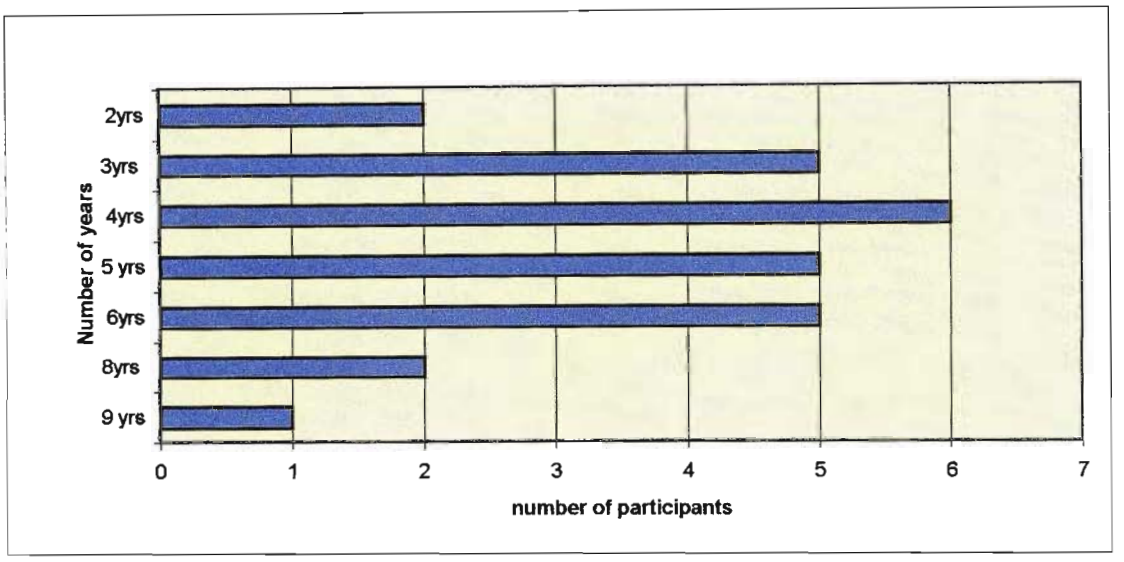

Figure 4.5 HIV/AIDS spectrum as experienced by the support group members

Even though the illnesses were similar, the symptoms indicated that they might have suffered from HIV/AIDS related issues. The group indicated that in the past three to four years, the stigma about HIV/AIDS was very high; therefore households were hiding everything that would associate them with HIV/AIDS.

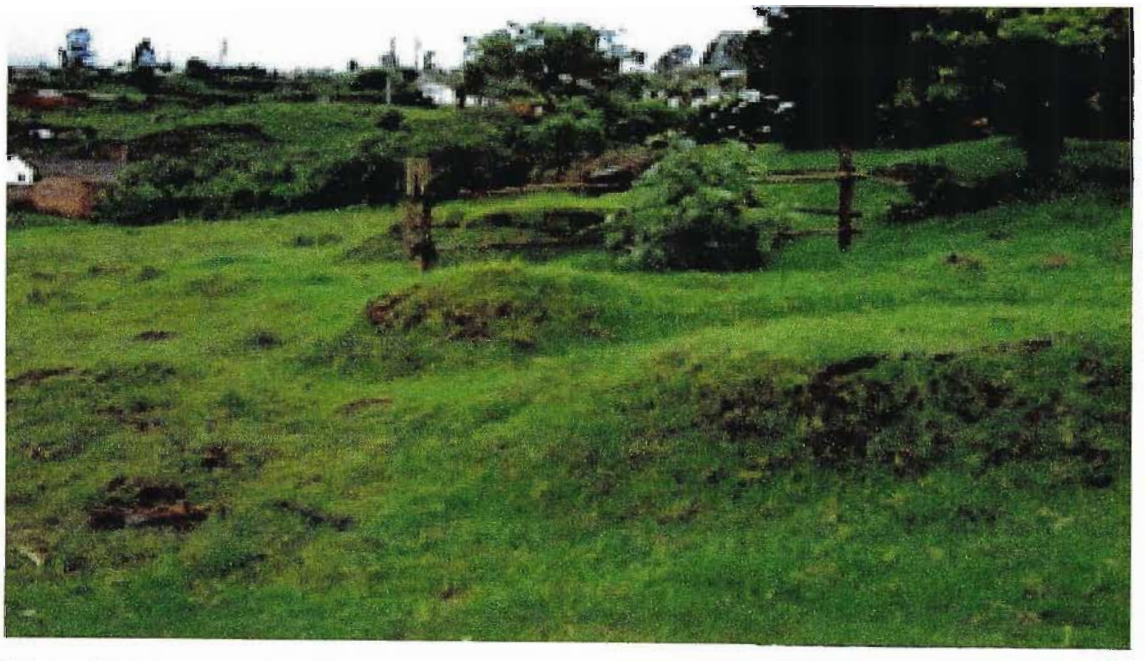

Plate 4.1 Four tombs of one household, of family members buried over a period of two years

Figure 4.6 indicates how participants experienced death in their households. This graph represents the death of people who died below the age of 40, but does not include children below the age of six. The time period was 3-4 years

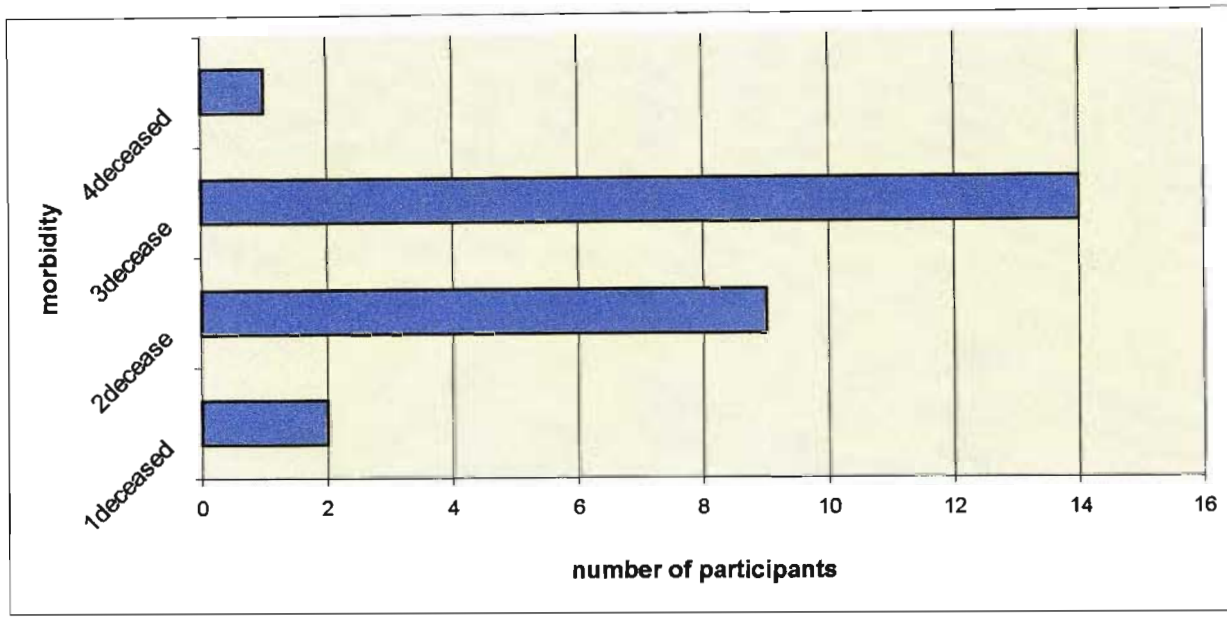

Figure 4.6 Morbidity graph

When they were asked what their experience had been especially within the community after they knew their status. One of the respondents said *impilo yami ikeyabanzima kusukela ekhaya kuye komakhelwane kuze kufike emphakathini…… mina ngangingazi ngestatus sami abantu umabezongibona ngigula babethi ngi neAIDS kodwa ngingakathesti. Ekhaya bangiphoqa ukuthi ngiyothesta amarisalts ami abapositive. Bonke ekhaya batshelwa umama ngoba bangigula ngifa, bonke abantu endaweni bazi ukuthi ngipositive. Ekhaya banginika iplate lami ngedwa, nespoon, ngacwaswa ekhaya nomakhalwane nophakathi. Impilo yami yabanzima kakhulu. Ngiyakwazi ukulahlwa yibo bonke abantu. Kodwa-ke uNkulinkulu wami wangi philisa nakhu ngiya phila namuhla.* "My life has been very difficult from home to neighbours and to the rest of the community..... I was not aware of my status. When people were visiting me while I was very sick, they were saying I had AIDS. This was before my HIV test. I was compelled by my parents to go for HIV testing and my results were positive. My mother

told everyone at home that I was dying because of AIDS. Almost everyone in my area knew about that. At home I was given my own plate, spoon and so on. I was discriminated at home by my family and by neighbours and in the community. I have experienced rejection from all people who were close to me, even my family. But my God kept me and here I am today, healthy"

The group feeling was that discrimination against people with HIV/AIDS exists amongst people who have less knowledge about HIV and AIDS. This was even within their own families and the broader communities including some of church members and a few ministers in their churches.

4.4 Selection criteria for in-depth interviews

Twelve households were selected from the 26 participants who had participated in wealth ranking and HIV/AIDS focus group discussions. From wealth ranking activity, those people who classified themselves as being poor and adequately resourced qualified for in-depth interviews.

It was felt that they had similar assets and were at similar levels in terms of standards of living but exhibited a difference in attitude towards life (shown through their self-classifications). The very poor group was not followed up because they were too few in number (4 households) to provide an accurate picture, when taking the very ill into consideration. In addition, three out of twelve poor households could not be interviewed since `some were very ill and others were in a grieving period. The adequately resourced group was not interviewed because of circumstances operating at the time.

The next criterion for selection was the HIV status and the spectrum of disease, the stage of HIV/IDS of participants. Three people who qualified for in-depth household interviews did not participate further because they were either very sick and would not be in a position to take long interviews or they were still grieving because of the loss of member in the previous week.

The study then continued with nine in-depth interviews with the remaining people from the poor within the HIV/AIDS support group. Out of the nine households that were interviewed, only two households had males who were responsible for providing for their households. The rest of the breadwinners were women and female pensioners

Table 4.2 Participants selected from the poor category

Participant	Wealth status	Housing	Family Size	Stage of disease	Experienced deaths, below 40 yrs over a period of three to four years
1.	Poor	Renting room/s	10	Not sick	3
2.	Poor	Staying with extended family	10	Not sick	4
3.	Poor	Staying with extended family	9	Often sick	3
4.	Poor	Renting room/s	8	Often sick	3
5.	Poor	Staying with parents who are pensioners and not working	7	Often sick	2
6.	Poor	Staying in houses left by parents or whoever was in charge	7	Often sick	2
7.	Poor	Staying in houses left by parents or whoever was in charge	7	Often sick	2
8.	Poor	Staying in houses left by parents or whoever was in charge	7	Often sick	2
9.	Poor	Staying in houses left by parents or whoever was in charge	7	Often sick	3

CHAPTER 5: RESULTS

The aim of this study was to investigate how low-income (or poor) households of Sweetwaters coped in ensuring food security when dealing with HIV/AIDS in their households? This chapter discusses the findings from the in-depth interviews through the following sub-problems, which were investigated to address the main question. The first sub-problem was changes in finance, followed by changes in food habits. Social aspects of households were also studied as the aim of this sub-problem was to gather information about informal support, companion support and intra-household support. The last sub-problem that was investigated was changes in spirituality. Findings relating to economic status were considered a major influence on coping strategies and food security of the households interviewed. The results also report on infrastructure, community and social services.

Table 5.1 Demographic data

Households	**1**	**2**	**4**	**4**	**5**	**6**	**7**	**8**	**9**	**Total**
Age group(yrs)	21-30	21-30	41-50	31-40	31-40	31-40	61-70	61-70	41-50	2@21+ 3@31+ 2@41+ 2@61+
Female	F	F		F	F	F		F	F	7
Male			M				M			2

The majority of households were female headed. Ages of heads of households were evenly spread from 21 to 70 years of age. The men were in the older age categories.

5.1 Changes in finances (economic capital)

Economic status of the community or household can enable or disenable the household from functioning successfully in their attempt to meet daily needs. Finances then become the basis for functioning of each household and without proper financial support,

households would always struggle to overcome crisis, and households with sufficient resources cope better with crisis Whiteside (2003).

5.1.1 Sources of income

Household coping strategies are influenced by the income earned by each household. Figure 5.1 below indicates the main sources of income of households that participated in the study.

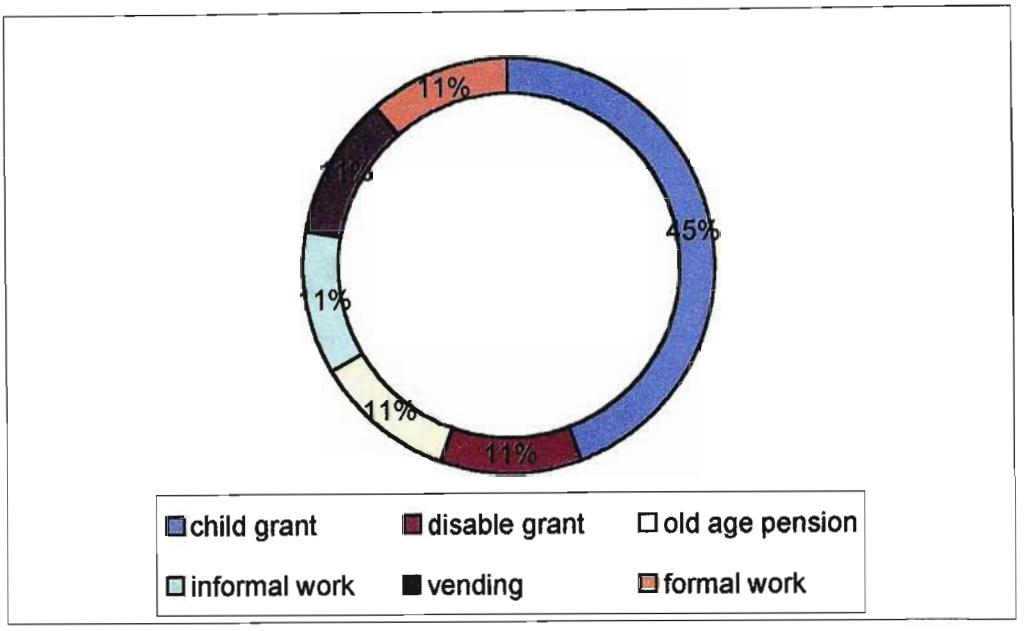

Figure 5.1 Major sources of income per household.

Out of nine households, four (45%) were totally dependent on child grants. The maximum number of children receiving grants per household was four (household number five) and the child grant was R140 per month (R140x 4 = R560 as the total regular income).

Other sources of income identified were an old age pension grant of R700, a disability grant of R700, vending, informal work and formal work, in one household each. Four households had multiple sources of income, but the grants were still the major sources of income in those households. Formal work is defined as when member/s of household

work 5 days (48 hours) a week or more (full time). Casual is working casually for fewer than five days a week. Four households each had one member who was working on a casual basis. Two members were working two days a week doing washing and cleaning as domestic workers; one was employed by the Department of Transport on the Zibambele program (poverty alleviation program); another person was working for a contractor building a bridge in Sweetwaters (Thatheni women contractors).

According to figure 5.2, the maximum income was R1100 and the minimum income is R300 per month, all below the poverty datum line of R1300. The table (Table 5.1) below reflects the changes in the regular income before the HIV/AIDS or death and since illness or death. The average monthly income is R569 after illness - a drop of R733 from the pre-illness average of R1300.

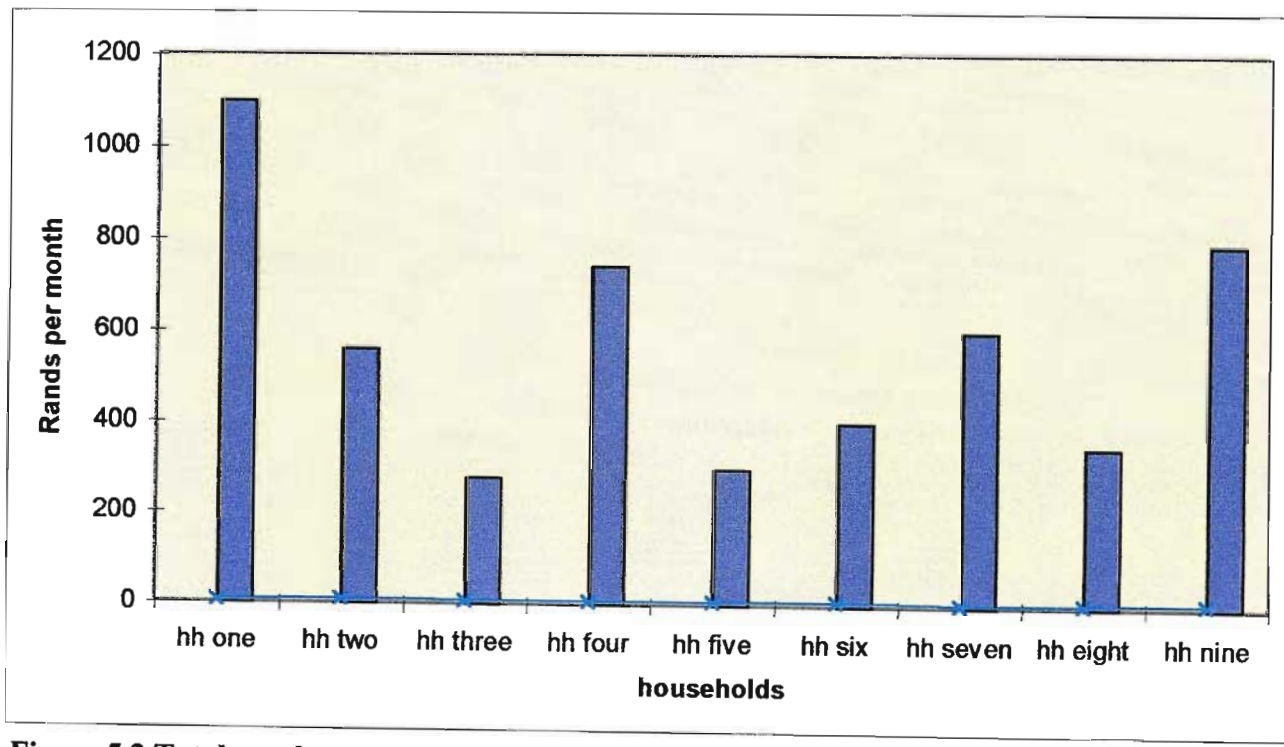

Figure 5.2 Total regular monthly incomes per household after HIV/AIDS

Table 5.1 indicates that household five had increased their income from R200 (before) to 560 (after). The reason was that they had four children receiving child grants since the illness. Before the illness none was working and they were depending on piece jobs, which generated the income of R200 for three members.
According to the participants, a piece job is when you are called to do one specific job and are paid once you finish that job.

Eight respondents said that before illness income was better. One of the respondents said *"Ngangisebenza sasingekho isidingo sokuthi ngicele imali, ngangikwazi ukondla ngigqokise abantwabami ngibakhokhele nasesikoleni ngaphandle kwezinkinga." I was working and there was no need to beg money and I was able to feed, buy clothes for my children and pay school fees without problems.* There were two major factors, which were highlighted by respondents that brought big changes in their incomes. One was that a member/s of household can no longer work because they are sick. Secondly, bread winner/s have died and survivors are unemployed or can't work because they might be too young or too old.

A specific change that was pointed out was the amount of money. As shown in table 5.1 some households lost more than 70% of their income due to sickness or death. Average loss of income was R733 per month from an average income of this "poor" group of R1300 before. This is less than half of pervious earnings.

Table 5.1 Changes in monthly income per household, before and after illness

Household	**Regular income before**	**Regular income after**	**Difference**	**Highest standard passed by head of household**	**Gender of head of household**
1	3500	1100	-2400	Grade 9	Male
2	1700	790	-910	Grade 7	Female
3	1100	740	-360	Grade 12	Female

4	1000	600	-400	Grade 6	Female
5	200	560	+340	Grade 10	Female
6	800	400	-400	Grade 8	Female
7	1500	350	-1150	Grade 7	Female
8	1300	300	-1000	Grade 5	Male
9	600	280	-320	Grade 8	Female
Average	**1300**	**569**	**-733**	**Grade 7**	**Female**

Table 5.1 shows that there is no relationship between educational level and income. This is to be expected varying in that the previous head of household many have died.

5.1.2 Savings and Credit

Savings and credit are considered to be part of a household's financial security and for this study it was crucial to find out whether participating households were saving money or not, and their reasons. When the participants were asked whether they saved money through banks or any other form of saving, one of nine said that he tried to save money but he failed due to needs that were far above the money he earned. He said *"angekengisho ukuthi kukhona imali engiyibekayo ngoba izinyanga azifani. Kwenye inyanga uyakwazi ukushiya u R100 kodwa kwenye wehluleka uze uthathe lo owawuwubekile ngakhoke angeke ngisho ukuthi ukubeka imali lokho. Izidingo zami zinkulu kakhulu kunalemali." I cannot say that there is money that I am saving because the months are not the same. In some months I can leave R100 in my account, but in other months I cannot; you end up taking the R100 you left so I cannot say that is saving. My needs are more than my money.*

Funeral clubs and stokvels were considered by participants as form of saving. All participants indicated that due to illness and the shortage of food, they are unable even to pay money to their funeral clubs. One of the pensioners said *"mina sengesulwe kabili kumasingcwabisane ngenxa yakho ukeswela imali, bonke abantu balaphekhaya abasebenzi balindele ukondliwa yimi ngempesheni." I have been cancelled twice in my funeral club because of lack of money. All people in my home are waiting to be fed from*

my pension. Five said that when their fathers or mothers were still alive, they were playing stokfels for food. She said that they saved money together. Then at the end of each year, they were able to buy food in bulk. But now since they have little money, they are not able to participate in stokfels. Households (4) with better income had more resources that those earned less income and therefore they coped better than others.

When they were asked whether they had any form of credit, all participants indicated they had credit.

One respondent who was in her middle age said "*mtakababa izikweletu siphila ngazo.*" *My brother, we live by credit.* When they were asked whom they owed their money to, eight households said extended family members; friends and neighbours were next on the list. Among other people that they owe were *omashonisa* (informal money lenders).

Seven said that when they have nowhere to go, they end up knocking on doors of moneylenders. Church members and stokfels were also the places that they owe money to.

One of the questions asked was; who loans you money when you run short of cash? Someone that respondents can rely on. The majority of respondents struggled to answer this question. Most of them said that it is very difficult to answer this because they have worried a lot of people and people were even reluctant to speak to them because they feared that they might borrow some money. One of the respondents said *"kunzima mtanami abantu balandula imali ungakayiceli abanezimoto bathi angeke sikwazi ukukuhambisela umntwanakho esibhedlela ngoba imoto ifile noma ungezele lokho." It is very difficult my child. People will tell you that they don't have money even before you ask or borrow the money. Those who are having cars will tell you that they won't be able to take your child to the hospital because their cars are broken, even if you haven't come for that.*

People that all households considered to be most helpful when they were in greatest need of money were relatives or extended family members. All also said that if you have good

neighbours, they sometimes help you. All participants emphasized that borrowing money is not an easy process and one gets it by luck.

All households reported that no changes had occurred in their savings since they were not saving before and they were still not saving. Except one household (number one in Table 5.1) who said he tried very hard to save, but in the long term he cannot do it. Those who have deceased household members were asked whether the deceased had been saving, those that replied said not. Three also indicated that although some of their loved ones had not been saving, they received money from their companies at their death.
All households that reported to have had deaths in their families said that they have used a minimum of R3000 and maximum of R8500 money in funerals. Their money was spent on the coffin, food, tents and other ritual practices. When their were asked where did they get the money five household said that they borrow some of the money and the rest of the money came from funeral clubs, the other four said that they extended family and the community assisted them when they were confronted with funeral.

They all said that they had more debt than before; the situation forced them to borrow money. One respondents said "*angeke uqinisele umuntu egula efa uzohamba uyoboleka imali ukuze umuyise kadokotele mona esibhedlela.*" *You cannot be keep quiet when someone is dying, you will go and borrow money to take that person to a doctor or hospital.* This indicates that some household resources are directed to those who are sick in a household.

Other financial changes

Respondents were asked about how HIV/AIDS or illness affected their financial resources. To respond to this question they were guided by key words as how they view that aspect before and after illness and they had to explain specific change that has occurred. The aspects and their responses included changes in expenditure patterns, school fees, barter, time spent in caring, and assets owned.

Expenditure:

Ninety percent of respondents felt that their spending had changed drastically due to their current income situation. One of the respondents said *"uma ngiyithola nje imali ivele iphele ngaleso sikhathi." If it happens that I get money, it is gone immediately.*

They said that if they received money, they found themselves spending almost all they received on food. If it happens that they had something left from buying food, that money went either to repay credit and for those who had sick members, it was kept for transport fees to the clinic or hospital or when there was an urgent need, to the doctor. They said they usually took sick people to the clinic.

They did not call an ambulance to take a sick person to the hospital because crime was very high in the area so it took an ambulance a long time to come, and in some cases it did not come at all, especially at night. This forced them to hire or take a taxi to the hospital, which was very expensive.

One household said that there was not a big difference from what the situation was before and now, because the money they had been getting before was even smaller than they were getting now. These people were those who depended upon child grants for their survival. This suggests that through child grants, households may cope better financially.

For the majority of respondents the specific change was that they now get less money. The main thing that they were buying was food; details of types of food and eating patterns will be discussed later. They said that in their buying list, food came first, then electricity recharge card. This reflected their changed buying habits. Six of the nine households said that before they had no problem with buying clothes for themselves and their children, but now they could not afford to buy things like clothes or furniture. They said that they depended on handouts (gifts) for clothes and that the money they received was spent on food.

Out of nine households, six reported to be spending a little on medication, though they mentioned that they used the clinic more often than hospital and private doctors. The reason was that clinics offer free services.

Seven households identified two changed areas that they thought caused them to spend more money and or lead them to borrow money. These areas were transport costs for medical care and funerals. In addition to changes in expenditure, one old man said "*Imali yami yaphela yonke ngingcwaba abantwabana, ngaze ngadayisa nezinkomo zami.*" *My money was finished by the funeral of my children. I even sold my cattle.*

School fees

All respondents said that they did not have problem about the school fees. The only problems that they are facing are uniform and food. One of the participants said *"kubuhlungu kabi ukubona ingane iphuma ekhaya iqonde esikole engadle lutho." It is very painful to see a child a leaving home for school having not eaten a thing.* In relation to school fees, they said that there is always someone who is willing to pay school fees for their children, because it is done once a year. They mentioned people like teachers themselves, neighbours, extended family, church members and community leaders. There were no major changes because if household members were unable to pay school fees, there would be someone who would still offer to pay school fees for a child. Children going to school having not eaten and when coming back from school, not getting anything to eat was a more important change.

Economic Activities (barter)

When they were asked about economic activities, one respondent said *"indlala yenza ukuthi kube khona okwenzayo umgadlo noma ukuwasha noma yini nje ezokwenza ukuthi ugcine uthole ukudla uyayenza." Hunger makes you to do something umgadlo (asking neighbours for you to do something in order to get food or small amount of money), doing washing or doing anything that will make you get something to eat, you will do it.*

If there is no one to lean on, you are compelled to do something in order to be able to get something to eat, was the thought of all respondents. They even said that older people and youth, even if in school, would need to leave school and make sure that those who are very little get something to eat. They said that if there were no food in a household, a person in charge and other members would exchange labour for food. In cases where the person in charge is in school, he or she would give up schooling to provide for those who were younger than them and look after those who were sick.

Time

When they were asked how they spend time now compared to before the illness, there were two distinct answers. One group of three said that because they are now sick, they are just sitting at home doing nothing; whereas the other group of six said that they need to do something to ensure that there is food at home. In addition to this they said that they spend more of their time looking after those who are not well in their households.

A specific change that was recorded was that fifteen people who were working are no longer working from all nine households. Others, who were just at home, now had to do something to ensure food and they have to look after their loved ones who are sick. They spent their time in their home or searching for peace jobs that would help them to get food

Assets

The households were asked what had changed in terms of their assets. Some literally cried because of the pain they were feeling. One respondent said *"kunzima kakhulu ukukhuluma ngezinto ezikulahlekele, ngikhuluma nawe abantwana bami babe ne T.V kodwa manje iTV bayibuka emzini wabantu. Ngiyakwesaba okwangithathela ubaba wabantwabani." It is very difficult to speak about assets you have lost. As I am talking to you, my children once had a TV but now they are watching it at our neighbours. I am very afraid of what took away the father of my children.*

There were at least three issues that were raised when talking about assets:

There were at least three issues that were raised when talking about assets:

1. Assets were stolen because there was no male figure at home. Those households without a father or grown up boys were easy targets for gangs. They would steal as much as they wanted to
2. Young people especially boys without the knowledge of older persons in a household were selling the assets, some to buy household food, drugs or clothes for themselves
3. Because there was no one to look after the assets, they were not working (broken) or were taken by relatives, friends, and neighbours. Others were taken to be repaired but because they could not afford to pay, the repairers kept the assets.

Table 5.2 below reflects the number of assets they used to own compared to what they owned now. Assets that were not working were not considered or included in the current assets. Figure 5.3 shows a fridge that cannot be repaired.

Figure 5.1 Assets that were not working like this fridge

Table 5.2 Changes in asset ownership influenced by HIV/AIDS

	Asset	**Assets before HIV**	**Assets since HIV**	**Difference**
Hh 1	Electrical	4	2	-2
	Furniture	5	5	0
	Livestock	-	-	-
	Machinery	Car and s/machine	-	-2
	Phone LL/mobile	LL	2 X mobile	+2
Hh 2	Asset	Assets before	Assets since	Difference
	Electrical	6	3	-3
	Furniture	4	3	-1
	Livestock	-	-	-
	Machinery	Lawnmower	-	-1
	Phone LL/mobile	Mobile	mobile	0
Hh 3	Asset	Assets before	Assets since	Difference
	Electrical	3	3	0
	Furniture	3	3	0
	Livestock	-	-	-
	Machinery	-	-	-
	Phone LL/mobile	-	-	-
Hh 4	Asset	Assets before	Assets since	Difference
	Electrical	5	2	-3
	Furniture	3	3	-
	Livestock	Goats (17)	-	0 (17)
	Machinery	-	-	-
	Phone LL/mobile	mobile	-	-1
Hh 5	Asset	Assets before	Assets since	Difference
	Electrical	4	2	-2
	Furniture	4	3	-1
	Livestock	-	-	-
	Machinery	-	-	-
	Phone LL/mobile	mobile	mobile	0
Hh 6	Asset	Assets before	Assets since	Difference
	Electrical	5	2	-3
	Furniture	4	2	-2
	Livestock	8 cattle	2	-6
	Machinery	1 tractor	-	-1
	Phone LL/mobile	LL	mobile	Change from LL to mobile
Hh 7	Asset	Assets before	Assets since	Difference
	Electrical	3	1	-1
	Furniture	2	2	0
	Livestock	-	-	-

	Machinery	-	-	-
	Phone LL/mobile	-	-	-
Hh 8	Asset	Assets before	Assets since	Difference
	Electrical	1	1	-2
	Furniture	2	2	0
	Livestock	-	-	-
	Machinery	-	-	-
	Phone LL/mobile	-	-	-
Hh 9	Asset	Assets before	Assets since	Difference
	Electrical	2	4	+2
	Furniture	3	3	0
	Livestock	-	-	-
	Machinery	-	-	-
	Phone LL/mobile	-	Mobile	+1
Average	(Electric & Furniture)	9.7	5.1	-4.6

0= no change, LL=Landline

There was a relationship between source of income before illness and after illness, as well as financial resources (living conditions) before and after illness. For most, the source of income before illness was formal work, which reflected better living conditions before illness. On the other hand, the source of income after illness became something other than work, something that was unstable and left households worse off, for having been sold or/and accompanied by poor living conditions.

In table 3.2 electrical assets refers to equipment like TV, Hi fi /Stereo, video machine, DVD and appliances like microwave, electric kettle, and so on. Furniture refers to things like fridges, stoves, beds, sofas (main items in the house). Livestock includes cattle, goats, pigs, and sheep as specified in the table. The most change occurred with reduction in furniture and electrical assets (about 20% less).

5.2 Changes in food habits

In order to be able to identify specific food related coping strategies employed by households directly affected by HIV/AIDS, it was important to trace what had changed, firstly in eating patterns, secondly in types and quantities of food eaten for breakfast, lunch and supper (dinner). The final aspect looked at the changes in terms of food

purchasing and the places where they were obtaining food before the illness or death and place since the illness. Okoli (2001) argues that the issue of food security in a household setting is the very important task which is often left to women or it becomes more a responsibility of women that man in rural areas.

5.2.1 Meals per day

Respondents were asked how many meals they enjoyed before and after the illness or death. Table 5.3 below reflects the changes that have occurred.

All respondents reported having three meals a day before illness irrespective of whether they were at home, school or at work. There was one exception; they said that before the illness or death, their eating pattern was not fixed. They said that they would only eat when food was available. In addition, one household said that relatives took those that were very young (three) to live with them after the crisis.

Table 5.3 Changes in eating pattern influenced by HIV/AIDS.

Household	Meals per day before illness	Meals per day since illness	Difference
Eight households	3 meals	2-3	Less
One household	When food is available	2-3	Less

It was very difficult for the households to state how many meals per day they were having since the illness, because of the illness itself. One of the respondents said *"kunzima kakhulu ukusho ukuthi udla kangakhi ngosuku uma unakekela umuntu ogulayo ehluleka ukudla ngenxa yokugula, nakuwe kugcina kungadleki kubenzima." It is very difficult to say how many times you eat if you are looking after a sick person who fails to eat because of sickness. You end up not eating yourself. It becomes difficult.* All households ended up saying that they eat two or three times a day depending on the availability of food and the condition of a sick person. Five added that when the situation is worse, they end up having one meal a day. As they said this, they indicated that it became very difficult for school children. One respondent who was a parent said that she

once received a letter from schoolteacher saying that her child was not performing well at school and she was not healthy because of hunger. The letter said she must make sure that her child eats first before coming to school.

5.2.2 Main foods for breakfast

When respondents were asked to compare their main foods for breakfast, before and after the illness, there were two main foods that most households ate for breakfast.

The list was as follows in a descending order of importance:

1. Leftovers
2. Soft porridge without or with sugar
3. Bread and tea
4. Bread with margarine (rama), butter and eggs
5. Tea with or without bread

According to all the respondents, food for breakfast did not change. For example, if in a household soft porridge was their meal for breakfast that did not change. They only changed when they were running short of maize meal. Those that used to eat bread as their main meal in break, said that they if they did not have money to buy bread, they ate leftovers. When they were asked what they ate more, bread or leftovers, they said that they ate more leftovers than bread and tea. All respondents reported that the amount of food consumed by households had lessened. They said that they were sometimes eating very little food because they were saving (wanting bought food to last them for the whole month), so portions were smaller.

The main breakfast changes were that they sometimes ran short of things like sugar, teabags, bread and even money to buy maize meal for soft porridge as many people relied on it for breakfast and supper, served as *uphuthu*.

5.2.3 Main foods for lunch

Before HIV/AIDS, *uphuthu* was the main food for lunch for all households, even those who were working. They carred a lunch box with *uphuthu* and vegetables. In another household they said that if they had money, they had bread for lunch. The main reason they preferred to eat *uphuthu* was that their families were too big and they could afford to buy much bread because of its expense compared to a bag of maize meal, which lasted them longer than bread. Respondents stated that the most commonly missed meal was lunch. They said it was possible to get food for lunch when you are out.

Four households said that for Sunday, they used to eat a different meal. They said that their main food for Sundays was chicken or beef curry with rice. One of the respondents said *"uma isimo singcono sike sithenge inkukhu ne rice encane sidle uma kuyisonto." When the situation is better, we sometimes, buy chicken and small packet of rice for Sunday.* Six of the households said that they could no longer afford this.

They also said that if some members of their extended family come to visit someone who is sick, they brought something for them like a bag of potatoes, chicken or beef, a bag of maize meal, bread and so on. And this helped household concerned to save in buying food. There were few changes in terms of the food itself, but food was now scarce and so portions were smaller. They did not have money to buy bread as they used to.

5.2.4 Main food for supper (dinner)

The main foods for supper were pap, *uphuthu*, vegetables, soup and bread for some families who were small in numbers. They said that they very seldom ate meat. According to the respondents there was not that much change from foods they were eating before. They saw the change more in terms of the amount of food. Most of the respondents said that they had always had food before, but since the illness or death, food was sometimes not enough. They also did not think it wise to cook when others were not around, because they preferred to eat together as a family, no matter how little the food was.

Another issue that was raised was that when some of the youngsters, both girls and boys, have money, they ate in shops rather than buy food for a whole household.

Table 5.4 Eating pattern before and after HIV/AIDS

Eating pattern	**Main foods**
Breakfast	Leftovers, soft porridge, bread, pap
Lunch	Pap, bread, vegetables, (curry and rice on Sundays)
Supper	Vegetables, pap, dry porridge, soup, curry and dumpling

Table 5.4 shows the poor variety of food households ate for their meals. It is important to note that the main foods stated here were their regular foods in their meals both before and after HIV/AIDS.

Obtaining food

In six households, people in charge were the ones who did the grocery shopping. In the remaining cases where the person in-charge was sick, he/she delegated this job to someone else, in most cases, the one who looked after them. In cases where the person in charge (two households) had an income, they were the ones who did the buying. In cases where both parents had died, a guardian did the shopping or an older child in that household (one household).

When respondents were asked where they bought food and what had changed, there was a clear shift in all households. One of the respondents said *"thina lapha ekhaya sasithenga ka shoprite nako spar kodwa kwathi kungashona ubaba wayekhaya sesithenga emadiyeni ezansi nedolobha." In this home we were buying from Shoprite and Spar in town, but since the death of my husband, we are now buying from Indian stores downtown.* According to respondents these Indian stores were selling cheap food, but they all indicated that the quality of food was lower compared to stores where they used to buy before illness or death. In addition to this, some said that there are cheap stores selling cheap food so they were buying food from those stores. Nothing was mentioned

about local spaza shops. None of the participants did gardening for food, because there was no one to take up that responsibility, and others reported that they were willing to plant vegetables in their gardens but with no fencing, chickens from the neighbours would eat what they had planted.

5.3 Physical aspects

Social aspects include infrastructure, social support system (human), education, environment, community structures, facilities, and community values and norms.

Infrastructure

The infrastructure available to be households was considered to be among their coping strategies, because it provides an environment for coping or not. A few important infrastructural aspects were identified, as key for allowing households to cope better or making it difficult.

Water availability

The first key aspect was the accessibility of water. Table 5.5 shows how households were accessing water. Most households (6) had their own taps in their yards. Two households were fetching water from a common tap. Because they had never had taps in their yards, there were no pipes going to their houses. One household was fetching water from neighbours, because the owner of the property did not want to fix their broken tap, so they were paying their neighbours for water. All respondents believed they were using clean water. They said that the water is only dirty when there was no water in the taps.

Table 5.5 Water accessibility

Households	Type
6	Tap in yard
2	Common tap
1	Neighbour's tap

Most households said illness or death did not affect their access to water. Only those who were sick (three households) and had no taps in their yards, said that when they want water, they need to beg someone to fetch water for them (anyone who is available). According to participants they were supposed to for water in their yards, but they were not paying. This was and added expenses for households.

Sanitation

All households were using the same kind of toilet, which was a pit toilet outside. When they were asked whether there were any changes in the type of toilet they used because of HIV/AIDS, they said all is still the same. Seven households reported not to be cleaning the toilets; others said that anyone can clean it.

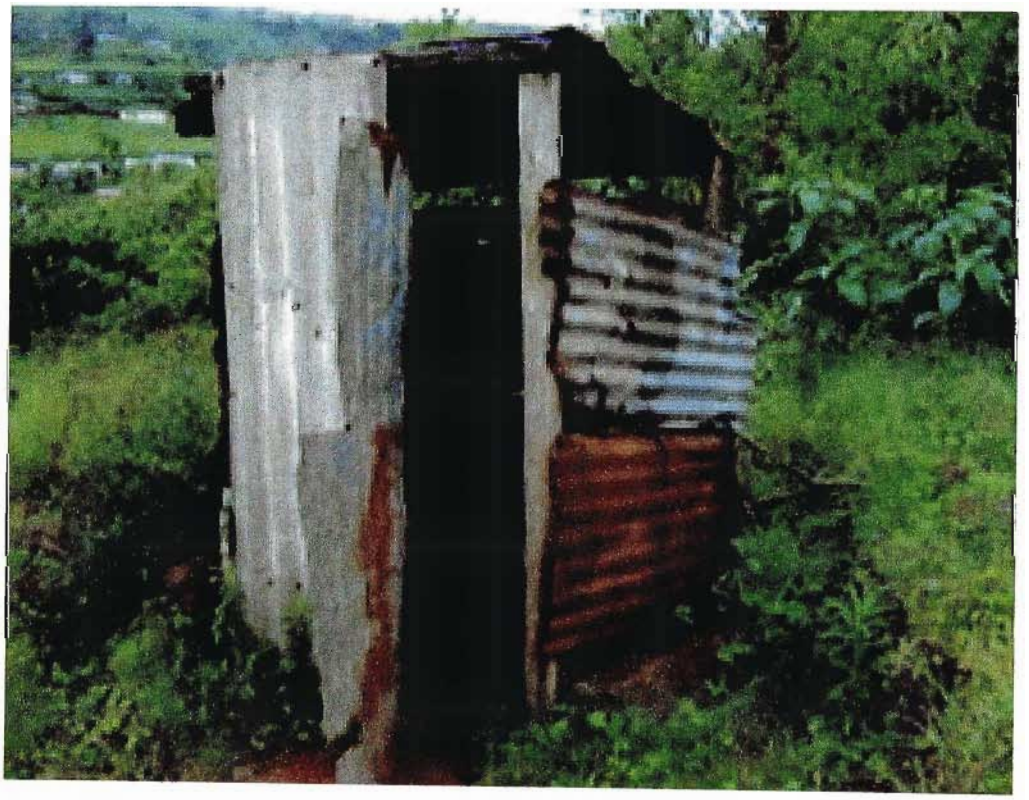

Plate 5.2 Toilet for one of the households

Condition of their roads

All households had a road that went to their area, three had roads in good condition that also lead to their homes, which they said allowed a car to reach their houses even if it was raining. Four respondents said that roads that lead to their houses were in too poor a condition for cars to reach their houses when it was raining. The last two households had no roads leading to their houses. Poor conditions of roads resulted in households not being able to get help within in a short time and it made their households not to be easily accessed (reached) when using vehicles.

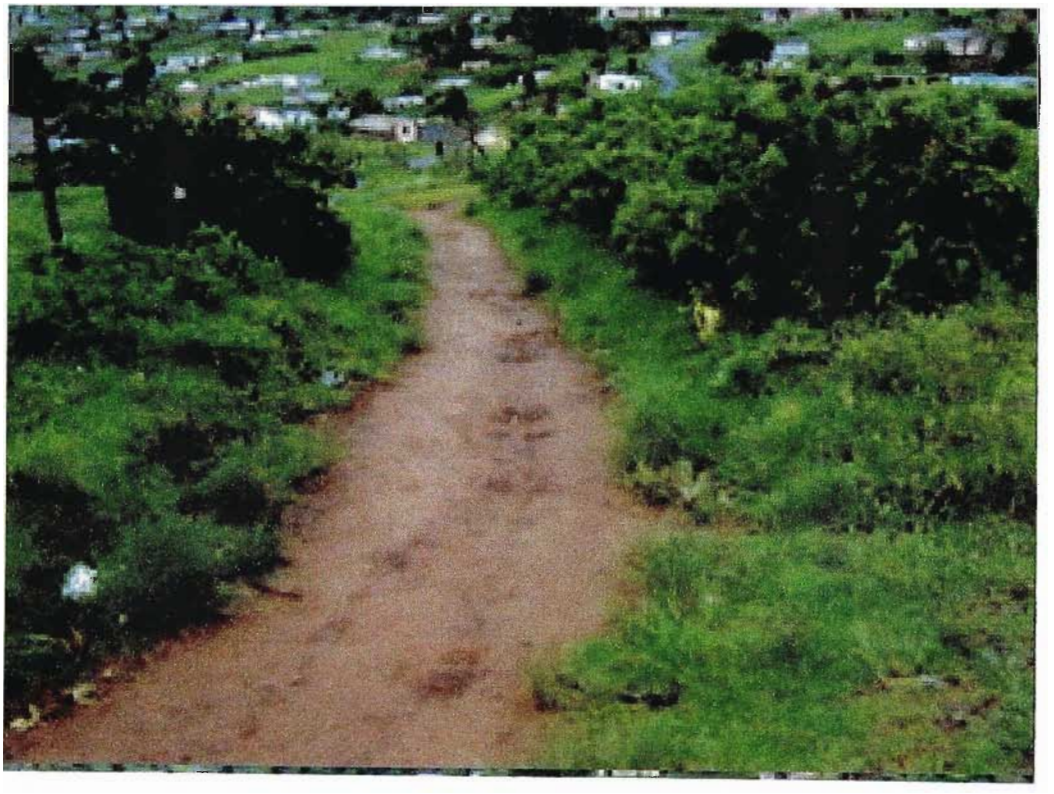

Plate 5.3 Conditions of roads that lead to households

All households had access to electricity, using pre-paid meters. As shown in Table 5.6, the households were using multiple energy sources for cooking, but only two households used electricity. They said that the choice depended on the available money. They said that when there is money, they use better energy but if there is no money, they use whatever is available to them.

This was also similar for energy for lighting reflected in table 5.7. It shows that all households were using more than one energy source for lighting. Electricity was most commonly used for lighting. Then if they did not have electricity, they would use candles or paraffin.

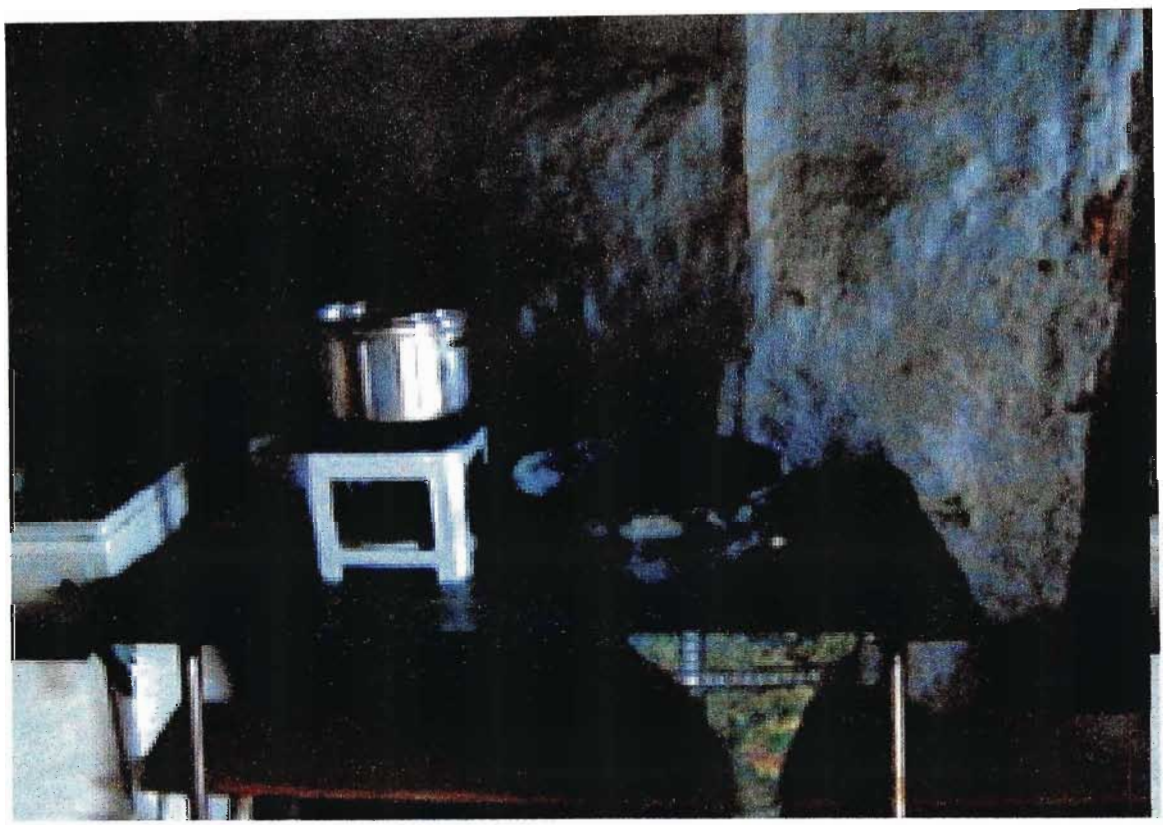

Plate 5.4 Cooking facilities

Energy

Table 5.6 Energy used for cooking, lighting

Number of households	**Energy type for cooking**
3	Fire wood & paraffin
4	Sekeni (paraffin), fire wood & electricity
2	Electricity & fire wood
Number of households	Energy type for lighting
5	Electricity and candles
4	Electricity and paraffin

Although households put electricity first, they also said that usually the electricity they bought when they received their money does not last them for a month and that is the reason they end up using other energy sources like paraffin and candles. This is a change that was reported because previously, they could use electricity for lighting for the whole month

Material used in houses

All houses were self-built houses; no-one was living in a Reconstruction and Development Program (RDP) house.

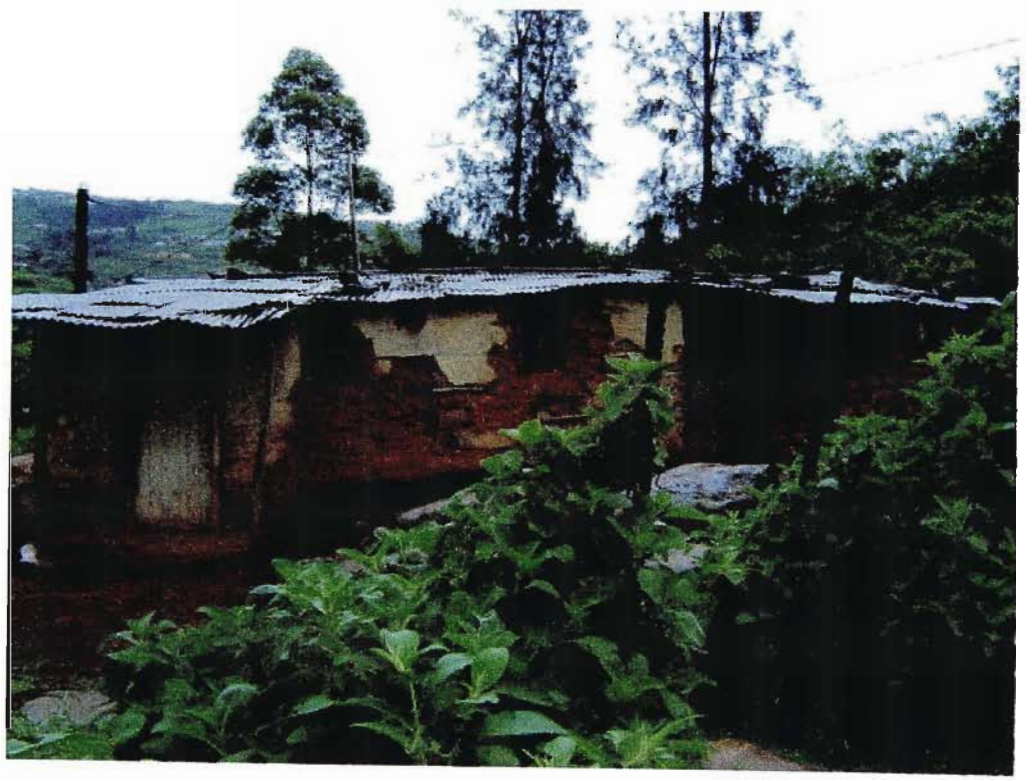

Figure 5.5 House built with mud (hh size =6)

General observations

Hygiene

Hygiene was seen to be a clean yard, no litter and a rubbish bin present

Rating households in terms of hygiene (1 as very poor and 5 as excellent), the following was observed.

5 households would be rated as 2
3 households were 3, and
1 household rated a 4

This reflected the amount of environmental care provided, while coping with HIV/AIDS. Looking at the assets and the buildings it was easy to tell that there had been a change in many of the households. The size of the building would indicate that a household was once successful but now is not cared for. This would apply to assets; in some of the households there was a big wood stove, which was no longer used and was dirty, and other easily noticed aspect was that there was no one looking after the assets.

Table 5.3 Material used in building houses

Number of households	Material used for house walls
6	Mud
3	Cement blocks

The most used building material in the area was wattle and mud. Six houses were built with mud, only three were built with blocks. When asked what had changed, those who had blocks said that they no longer have money to paint their houses as they use to before the illness. Those who were living in mud houses and who had become sick said that since they became sick. no one repairs their houses and they were falling apart. One of the older women pointed out that young people are not willing to touch mud. So there is no one doing *obhandayo* (plastering). This indicates less house maintenance now

5.4 Social Aspects

When they were asked what community services were available to them and what help they had received from those services, they listed the following in order of utility:

Table 5.4 Available services for HIV/AIDS sufferers and families

Department, NGO, CBO	Available (service)	Households helped	Access (helped)
HEALTH	Clinic, Hospital Community health workers	9 9 9 4 When very sick	Get prophylaxis, treating opportunistic diseases, referral letters to hospital, getting condoms, go for family planning, HIV test, obtaining letters for grants Bathing, Adherence to treatments, Cleaning
HOME AFFAIRS and WELFARE	Child grants, Disability pension, Old age pension, Birth certificates	4 1 1 1	Grant processing Grant processing Grant processing Obtained certificates
EDUCATION	Schools	3	Teaching children in schools (HIV/AIDS Programmes)
TRANSPORT	Zibambele (maintaining small road)	1	Employed in a programme: poverty alleviation
NGOs			
Youth for Christ	AIDS information, helping support groups	9 9	AIDS information, helping support groups
Anglican church	Care givers – food parcels, Cooked food provision	9 9	Brought to homes Provided at the church
Edepho	Teaching home based care, birth certificates, teaching about AIDS, helping orphans, preaching	9 9 9	Caregivers, food parcels, home based care, providing home-based kit, information about aids, sermons
Tabitha ministry	Providing home based care kit,	9	Home based care kit
YFC Support groups	Care givers, food, AIDS information	9	Care givers, food, AIDS information
Churches	Prayers, foods, clothes	9	Prayers, foods, clothes

Four government departments were mentioned but the well-known departments were the Departments of Health and Welfare. Out of nine households, only three mentioned the

Departments of Welfare, Education, Transport and Health. Regarding NGOs and CBOs, respondents were unable to make a distinction between NGO and CBO. When they were asked about NGOs all responded that they knew about Youth for Christ, Tabitha ministries, Edepho and Anglican church. Youth for Christ was known for its formation of support groups and teaching about HIV/AIDS in taxi ranks and stops and teaching home based care; Tabitha ministries was known as being supplier of home based care material and their trainings in home based care and counselling; Edepho was a bus depot that was used as a multi purpose centre (respondents did not know the name of organizations that operated from the depot, only the available services), where one could get birth certificates, food parcels, meet support groups, receive AIDS information and trainings and join the sewing women. The Anglican Church was known for food parcels that they supplied to the community, hot meals available from the church and the assistance they offered to orphans. All households have accessed help from the above-mentioned organisations. They indicated that although they were getting help, the help was not enough, especially for those who did not qualify for disability grants because their CD4 count was above 200. They were happy about the information they received about HIV/AIDS from these organizations. The support group YfC conducted workshops, seminars and training for all support group members. The information that they received included mother to child transmission (MTCT): the dangers of a child being infected, preventative aspects, antiretrovirals (ARVs), balanced diet and living positively and basic information about HIV. According to respondent they needed more money, employment, ARVs, RDP houses and free vitamin supplements, which they did not receive.

Intra-household support

When respondents were asked about the activities in their households that supported a sick member or when someone had died, there were different patterns of intra household support.

In six households, the adult women were responsible for bathing a sick person who could no longer help herself. If that person was working, she would ask someone from their neighbours' households or a relative would come to stay with them so that she would

look after the sick person. Three households said that they depended upon community health workers for bathing because their children were very young and were not able to do everything. When there was no one to look after a sick person, her child would drop-out of school to look after her mother. The same thing applied to giving medicine and tablets, and accompanying a sick person to a clinic, hospital, doctor and *enyangeni* (traditional healer). This also included other responsibilities like washing clothes and linen; cleaning house and washing dishes; cooking and feeding. The person who was in charge of the household was responsible for paying medical fees, bills and related costs. If that person did not receive any income, anyone who earned an income in the household would be responsible. If there was no income in a household at that particular time, relatives would be asked to pay. The last alternative would be to borrow the money.

5.5 Changes in spirituality

Seven participants reported that they were not committed to their churches before the illness, and the rest said that they were committed. Participants were asked about changes occurring in their spirituality. Various dimensions of beliefs or spirituality developed very strongly. Of the nine households, three believed that their current situation was God's way of bringing them close to Him as they said that they were now saved, which they were not before the sickness. Four households believed that ancestral worship as well as going to church might help them overcome their situation. Three households said that they would borrow money so that they would be able to slaughter animals for ancestors, pleading for forgiveness and help and they also went to church to pray to God and asked other believers to pray for them.

One of the respondents said *"sikwenza konke ngoba asazi ukuthi usizo luyovelaphi." We are doing it all because we don't know where help will come from.* Since the illness they said that they had put more effort into everything that they thought might help. Others believed that going from one traditional healer to another and going from one church to another or slaughtering for ancestors would help or cure the diseases. Their degrees of belief made some more dependent and others less dependent. The remaining two households were going both to church and consulting traditional healers or believing in

ancestors. These were households where older people had died; they were living by themselves as young people, although others said that their parents had been Christians. These young people were below the age of twenty five years. An issue of stigma was not reported in the church.

When participants were asked about how the church feels about and treats people who were living and affected by HIV/AIDS. The feeling was that there was no discrimination in the church.

6. Summary of findings

Changes in finances

It came out very strongly that all households were depending on loans for their survival therefore borrowing was essential for them. Economic exchange was reported and getting piece job employment. Selling of assets to secure food was also a general practice to some households. The major source of income was government grants.

Changes in food habits

In coping with food shortages, households reported sometimes reducing the number of meals per day especially towards the end of the month. The quantity of food consumed was also reduced. Buying cheap food for households was reported to be a way of ensuring that they had something to eat. Where possible, members of households would exchange work for food. Spending was shifted from other items to food.

Households reported that when the above failed, they moved young children to live with relatives. In addition, relatives often provided food when visiting. When all failed, they opted to obtain food parcels from a local depot which was supplied by Anglican church.

Social aspects

Church groups were providing help in kind e.g. food and clothes. CBOs and NGOs enabled households to cope better by providing care, resources and information. Neighbours were also assisting with care, finances and emotional support. Roads were

also enabling, dwelling conditions were not really enabling because of the backlog in maintenance. The total number of NGOs mentioned was five; these NGOs have assisted the members of all households in one way or another.

Changes in Spirituality

People become more spiritual and consultation of traditional healers and attending church activities increased. Four held onto both traditional and Christian beliefs. They also reported moving from one church to another for healing. Belief of slaughtering for ancestors also increased.

CHAPTER 6: DISCUSSION

The goal of this study was to find out how households cope with ensuring food security when dealing with HIV/AIDS. In order to investigate the problem the following sub-problems were investigated. The first sub-problem was what were the changes in finance? The second one was what were changes in food habits? What social aspects enabled or caused difficulty for households to cope? Factors studied included information support, companion support (external support) and intra-household support. The last sub-problem that was investigated was changes in spirituality. A comparison between wealth groups did not provide large enough samples for effective results. Refer chapter 3.

In this study it was hypothesized that there are common coping strategies employed, regardless of income or education status within the "poor" group. HIV/AIDS has a major impact on food security, specifically access to food, in all households. There are common constraints to coping effectively, regardless of variety of environmental support systems. Similar support systems are needed by all households, irrespective of the stage of HIV/AIDS illness in the household, because of overlapping stages within each household.

This study showed that those food-insecure low-income households affected by HIV/AIDS use a number of coping strategies to delay hunger or secure food. Food became the major financial demand as search for food became paramount.

Low-income households in this study (self defined as poor) affected by HIV/AIDS truly depend on a variety of coping mechanisms to secure food. Household initiatives appeared to place food security at the centre of their own activities and the rest followed. This allowed them to satisfy their short-term goals only. The consequences of such activities endanger their survival in the long-term because their activities were centred on daily food requirements.

Households facing food shortages make decisions about how to meet their needs. This study has indicated that low-income households affected by HIV/AIDS have limited options from informal networks with close relatives on whom they draw for support when they are trying to cope with shortages of food. Their coping strategies included eating less and cheaper food, depending on loans to buy food for their survival; therefore borrowing was essential for them, economic activities in exchange for food was also reported and getting piece job employment. Selling of assets to secure food was also a general practice to some households. These strategies suggest the lack of capacity for household independence and reflect that households were poorly prepared to respond to such crises or shocks and their options were extremely limited. This is consistent with literature studied for this paper, refer to section 2.9 (Carletto 2001, Kempson 2003, Okoli 2001,). It also suggests that they were not able to go beyond their given situation, because their resources were not enabling them to do so. Reduction in consumption and shift of expenditure were main aspects that are usually adjusted when coping with shortages of food. This is consistent with the literature (SADC FANR VAC: 2003)

Based on findings from this study, it was shown that households become poorer as a result of the illness and death of members who were breadwinners. It can therefore be concluded that the effect of illness and death increased poverty in households by diminishing the household's income resources at least by fifty percent (See table 5.1 and 2). There are many contributing factors, namely lack of employment, reduced resources, lack of higher education, sound development and informational support, lack of infrastructure to both poverty and disease at household level as they struggle to secure food. These factors include household's composition and size, assets, relatives and community attitudes towards helping or being available for households, stage of disease and availability of resources. Infrastructure also contributed toward or increased poverty in low-income households affected by HIV/AIDS.

A households' state of economy is affected by illness; it affects household resources and income. For instance, when there is illness, often followed by a funeral of not just one household member but of many (average of three people), this becomes a further drain on

the households' resources and from this point food insecurity begins to be a long-term burden on survivors. In addition to this, when member/s become sick household labour for other activities is reduced. It becomes an additional burden to the household because nursing care was required and extra labour to assume the responsibilities that the sick person used to carry out. For this reason, young people dropped out of school (setting of a downward educational spiral) to look after their loved ones who were sick, and it was also a reason why the 80 percent of households were not cultivating their gardens.

This study found that household spending on food during the period of illness was less when compared to what was spent on food before the illness struck. It also indicated that spending shifted from buying non-food items to food items. This study found that the main practice of securing food was through selling of assets, obtaining social grants and working for neighbours to cope with illness and shortages of food. This was one way in which households were trying to cope with shocks and respond to the disease. In this study AIDS has been viewed as the major factor that deepened poverty in those households with already low-incomes. HIV/AIDS undermined all government programmes of poverty alleviation and empowerment of the poor, because people became too physically weak and were not able to participate in order to obtain food or wages.

Survival of the households studied was based on short-term goals in a sense that ninety percent of participants were in debt and were struggling to repay their debts; this was draining their resources even more as these sources of loans were drying up. Borrowing is one root problem that prevents households from overcoming the cycle of poverty and food insecurity. The study shows that dependency ratio increases because of HIV/AIDS which is caused by powerlessness that leads to food insecurity, lack of employment, insecure sources of income and helplessness. It is consistent with review of literature (DFID 2003).

There is very close relationship between access to food and the treatment of HIV/AIDS. Participants from the studied households reported difficulty in taking treatment when

there is nothing to eat. For these participants, adherence was impossible as they said that they could only take treatment with food. This will be a challenge for the South African governments' plan to roll out Antiretroviral (ARVs) treatment because of this perception regarding medication.

There were two major elements of food security that this study raised, access and affordability of food. According to Whiteside (2002) these elements are linked to economic, social and political factors. As forty-five percent of participants were highly dependent on grants (child support and pension grants) their lives would have been even more difficult without the grants. This leads to very important questions that were associated with these three factors, economic, social and political. The question is, are the grants creating a dependency syndrome for low-income households affected by HIV/AIDS? Do they support household initiatives in their attempts to secure food for themselves? As a result of this research, both aspects were evident. However, use of the grants varied in that the more resourceful group used them for a greater variety of activities.

In this study the researcher suggests that instead of child support grants, government should come up with a strategy, where the money (grant) will come in the form of community development programmes for mothers to participate and earn income. This will mean providing of skills and empowering, it should also create a sense of responsibility for the people's own actions and deal with a dependency syndrome. If a concerned mother is physically weak, they can send someone to represent a household. Grants should be granted on conditions, like if there is no one to send e.g. in child-headed households where the children go to school.

Responses of such households should not only be based or dependent on grants and handouts, but households need to be supported to assume responsibility to explore other avenues for providing food, such as vegetable gardens, saving together, playing stokfels as shown in this study. However, with such low levels of resources, even time becomes scarce.

Low-income households especially with large households, use multiple strategies to cope with shortages of food. The coping strategies used include using cheaper stores, finding sources of free meals (food parcels), cooked meals served or soup kitchen, moving children to live with extended family members, extended families bringing food gifts, reducing number of meals per day and the quantity of food served. They also reduced the quality of food they ate, exchanged work for food and spent more on food than on anything else if they earned an income or received donations. This suggests that households use cheap, possibly unsuitable and/or unsafe food (keeping food for very long period e.g. sprouting potato in order to extend their eating life).

Although the majority of households struggled to obtain sufficient amounts of food, they were accessing food in acceptable ways. This study indicates a lack of choice as households coping strategies were very focussed on alleviating food scarcity. Food insecurity pushed households to look for less typical sources of food such as food parcels, and moving children. Eating less than they felt they should and irregular eating patterns suggest lack of proper nutrition and this contributes to the deterioration of health and energy levels as some of them became infected often and tended to be apathetic. This simply says that it was very difficult to consider nutrition when hungry due to the fact that the variety of foods was limited. Participants barely changed the kind of food they normally had due to loss of income. Although domestic food production activities were critical for providing food (gardening), in this study none of the participants cultivated their gardens. The reasons were that there was no one to take up that responsibility, and others reported that they were willing to plant vegetables in their gardens but with no fencing, chickens from the neighbours would eat what they had planted. Therefore in this study the households did not consider gardening as a coping strategy.

This study shows that activities of ensuring food security in households were not diverse irrespective of their educational level and income (see table 5.1). But those households with better income reported to be coping better than those with low-income. It was clear that issues of food insecurity are complex and beyond the reach of individuals. Despite participants' best efforts they still ran short of food.

This study agrees with perceptions that with adequate support available, concerned households coped better with their situations and this reduced stress. As indicated above, affected households reached a point where the community could no longer help, leaving only community health workers and close relatives. Support from close friends was reported to become less available because as the situation worsened. They were no longer able to offer any help because of many deaths in their own families and in the community. More of the following type of supports such as giving medication, bathing, moral support, cleaning and washing (as given by community health workers and relatives) was needed.

Social support systems that do exist may serve to increase support for households with low incomes, rather than disabling their support system. It is important to note that the lack of positive social support or "negative" support was associated with coping capabilities and also with health status. Perceptions of personal conditions have been shown to play a major role in the link between disease stage and emotional distress, and this affects the way households cope with shortages of food and the disease itself. This is consistent with literature (Hudspeth 2003) as discussed in section 2.10. This is consistent with the coping literature as well as a growing body of HIV literature which suggests that coping styles within the context of stressful life situations are related to an individual's adjustment to the stressful experience (refer to section 2.7). The information gathered from participants indicated that they thought that having NGOs and CBOs, providing them with information was not enough to change their attitudes (toward living positively) and accept their current status. No nutritional information had been given. In the focus group discussion, they had a very good understanding of how to contract the virus, ARVs, mother to child transmission (MTCT)

The infrastructure, which is considered to be enabling or supportive, was found not to be helping the households concerned to cope better with their crisis. This was seen in the condition of the houses, toilets, poor road conditions. It reduced their chances of coping and even survival because of transport difficulties and the additional duties in the household.

Social support was insufficient for these low-income households affected by HIV/AIDS. Lack of positive social support to this population that was affected by HIV, poverty, and unemployment, seemed to be strongly associated with psychological and physical health which resulted in their coping strategies.

Greater satisfaction with social support, more secure networks with relatives and with others especially support groups, were found to be important in the life of an individual and of a household, and need to be encouraged. Links with better-resourced communities are essential for building a wider support base.

The ability of households to explore alternatives to coping with stresses and shortages of food has also been shaped by their spiritualities. Findings from this study indicate that households affected by HIV/AIDS keep on searching for comfort, healing and physical help wherever it might be available, irrespective of its source and nature. They also stuck to what had worked in that particular time and if no longer working, they moved on to search for what might work best for them. They coped by continually searching for help and support. They felt that there was nothing that they could do themselves and for themselves. Healthy household members should be encouraged to participate in training on income generation.

People in the sample felt that going more frequently to church was believed to help pull people out of poverty. They believed that God would help solve the problems for their households and individuals especially for those who are poor. Discrimination against those living with HIV/AIDS in the church was not mentioned. Some churches offered food parcels which fed the physical body. The church also brought assurance about new life in new bodies, which will not feel hunger, so this kept them going. In this way they coped better with improved attitudes. This helped some to be less dependent while others where this was less effective, were more dependent. In more than seventy percent of sample the Zulu idiom which says *uNkulunkulu usiza abazisizayo* meaning God helps those who help themselves was true because of their continued search to cope better and their hope of better lives.

Limitations of the study

- The results of our study are limited by the nature of disease and small size of the sample, which does not represent the entire population affected by HIV/AIDS.
- Study design did not permit a clear distinction between changes before and after illness, because of multiple deaths and multiple changes that households underwent, for example income replaced by grants.
- This study should have compared coping strategies of households of similar income and circumstances but with and without AIDS.
- A comparison between different income groups to see whether number of resources influenced coping strategies.

Recommendations for further research

- Future research should examine the impact of a positive attitude of households or individuals in relation to coping and social support associated with various stages of HIV and AIDS. Much of such research would be useful in determining how to improve the quality of life for households with low-incomes, big household sizes, and dependent on grants for survival.

  -How do low-incomes make people more exposed to higher risk of HIV/AIDS as they search for food and wanting to secure resources?
- A longitudinal study of the same households to investigate the long term ability impact or sustenance of strategies reflected in this study, so that weaknesses and strengths can be identified and also to be able to identify the real needs of low-income households as they cope with limited resources.
- This study illustrates the problem that is faced by low-income households, which are believed to develop when those who are household heads become ill or die because of HIV/AIDS. Difficulties were experienced by those households are passed on to future generations since some drop out of school to look after their loved ones. Future research can also be conducted in this area to find out how those who are left behind survive in the long term (a comparative study).

Recommendations for resolving some issues

- This study also shows that the poor in poor communities have few external resources to drawn on and few internal resources. This simply says that they cannot move on their own because their situation is beyond their capacity. It therefore suggests a greater need of resources that aim not only at providing food, but also empowers and developed those concerned.

- Households should be assisted to be able to meet their present food needs without compromising the ability of future generations to meet theirs. The idea of food security if present in some households should be sustainable from household level and then to the entire community.

- For YfC, as a youth development organisation, there is a need to develop a strategy that will enable support group members to go beyond the attitude of waiting for help. Develop a sense of responsibility for self, taking initiative and sustaining the programs that exist so that when help is withdrawn they would be able to continue without assistance from YfC and other organisations. This suggests a greater need for empowerment on the side of support groups with information in relation to health and food programs, and skills.

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APPENDIX A
PURPOSE STATEMENT OF SUPPORT GROUP

Purpose statement of Philani Support Group: to support and encourage one another, and prevent the spread of HIV/AIDS in order to live healthily and participate in a variety of income generating activities to support our families (Philani Support Group constitution of 2001).

APPENDIX B

SURVEY QUESTIONNAIRES

Household Questionnaire

1. General information about the responsible person in household

a) Gender: Male ☐

Female ☐

b) Age group 10- 20 yrs ☐

21- 30 yrs ☐

31-40 yrs ☐

41-50 yrs ☐

51-60 yrs ☐

61-70 yrs ☐

71yrs/over ☐

c) How many years have you spent at school? ……..

d) How many people stay in this house or home at least four nights a week? ……..

e) Who are they or how are they related to you?

Who	How many
Grandfather	
Grandmother	
Father	
Mother	
Aunt	
Uncle	
Sister (s)	
Brother (s)	
Cousin (s)	
Niece (s)	
Nephew (s)	
Other	

f) What assets do you have at home?

Assets	Working Y/N?	How many?
Car		
Telephone (cell or landline)		
TV		
Hi fi / stereo		
Video machine		
Fridge		
Sink		
Stove		
Microwave oven		
Cattle	Not Applicable	
Sheep		
Goats		
Chickens		
Pigs		
Other		
Number of rooms in the house:		

g) Are you?
Married .....
Divorced...
Widowed...
Single parent.....
Single.....

h) Were you or are you raised by your biological mother?
Yes.....
No.....
Other.....

i) Educational level of guardian or biological parent
Never completed matric.....
Completed matric.....
Post matric schooling .....

2. Changes in finances

a) Please list your sources of income before illness or death in the household (crisis)

Source (What do you do?)	Number of household members involved	Amount (if known) or kind of reward

b) Please list your current sources of income since illness or death in the household

Source (What do you do?)	Number of household members involved	Amount (if known) or kind of reward

Prompts: to ensure answers to the questions in tables

d) Are you working now?
e) Is your father working?
f) Is your mother working?
g) Is your spouse working?
h) If you get a piece job do you work for
   Money……..
   Food……..
   Clothing of family…….
   School fees of your child……
   Place to sleep……
   Other (specify) ……
i) What is your family income condition?
   Very good ……
   Good ……..
   Not good ……
   Very poor ……

Savings and Credit

i) Who loans you money when you are running short of cash?
   Neighbours……..
   Relatives……
   Community leaders……..
   Church members/ministers……..

Local business people.....
Omashonisa/ cash loaners.....
Other.....

j) Do you have any form of credit from:
Village stores.....
Neighbours.....
Community members.....
Church members.....
Omashonisa.....
Bank.....
Other

k) Do you save money through banking?
Yes.....
No.....

l) Do you save money for your children's education?
Yes.....
No.....

m) How did the illness in your family change financial resources?

Resource	Before illness	After illness	Specific changes
1. Income			
2. Expenditure			
3. Savings			
4. Credit			
5. Sales			
6. School fees			
7. Financial activities (barter)			
8. Time			
9. Assets			
10. Sex			

Any specific details of main changes
.....
.....
.....

.....
.....
.....

3. Food habits

Who does these?	Before illness	After illness	What has changed?
Shopping			
Where is main shopping done?			
Vegetable garden			
Who works at the garden			
Meals per day			
Main breakfast food			
Lunch foods			
Main supper foods			
Other			

4. Changes in spirituality

Activity	Before	After	What has changed?
How was spiritual life			
Church attendance			
Is any one in the family a church member or goer ?			

Family prayers			
Special prayers by other church members			
Consulting traditional healers			
Slaughtering to ancestors			
Any church help?			

5. What social aspects are employed and why?

Infrastructure

a) How do you access water?

Type	**Before**	**After**	**What has changed**
Tap in yard			
Tap in a house			
Common tap			
From the river			
From neighbour			
Water tank			
Other			

b) Do you consider the water you are using to be

- Clean
- Polluted
- Dirty

c) Which kind of toilet do you use at home?

Type	**Before**	**After**	**What has changed**
Flushing toilet			
Hole (pit) toilet			

Using neighbour's toilet			
Go to the bush			
VIP/septic tank			
Other (specify)			

d) Do you have a motor road that leads to your home or house?

- Yes
- No

e) If yes, what is the condition of this road?

- Excellent
- Good
- Fair
- Better
- Bad
- Very bad

g) What energy do you use for cooking?

Type	**Before**	**After**	**What has changed?**
Electricity (grid)			
Fire wood			
Gas			
Paraffin			
Other			

h) What energy do you use for lighting?

Type	**Before**	**After**	**What has changed?**
Electricity			
Solar (PV) system			
Gas			
Paraffin			
Candles			
Other			

i) Is your house built mostly with

	Has this changed?
Face brick	
Blocks	
Mud	
Planks	
Cardboard	
Corrugated iron	
Other	

j) General observation of hygienic environment (scores 1-5): 1 very poor, 2 poor, 3 average, 4 good, 5 very good

1. Inside
2. Outside

k) How far is clinic from your home?

1. Walk: how long?
2. Travel: how long and how much

Do you use: Taxi .....
Bus .....
Car (Whose car?) .....
Other .....

6. Community Services

l) What government services do you have access to or that have helped you deal with illness?

Department, NGO or CBO	**Available (service)**	**Access (helped)**	**How have you ben helped?**
HEALTH			
WELFARE			
EDUCATION			
TRANSPORT			
OTHER GOVT DEPTS			

NGO's			
CBO's			
OTHER ORGANISATIONS			

Prompts: to ensure answers to questions in the table:
o) What government services or facilities have helped you?
p) How were you helped?
q) Which other organisations helped you?
r) How are they helping you?
n) How members of both nuclear and extended family have helped with illness?

ACTIVITY	WHO	HOW
Bathing		
Help with taking of medicine and tablets		
Accompanying to clinic hospital, doctor and *enyangeni* (traditional healer)?		
Washing clothes, linen		
Cleaning house, dishes		
Cooking, feeding		
Paying medically related expenses		

Prompts: to ensure answers to questions in the table:
s) How are members of family helping with illness (nuclear)?
t) How do members of the extended family support you?
u) Who in the community helps you with this illness?
v) In what way/are they supporting your family?

7. **General Questions**

1 What do you need in order to help you at this time? (Which you are not getting)

.....
.....
.....
.....
.....

2 What would you like to know more about in dealing with these illnesses?

.....
.....
.....
.....
.....

3 Who do you think should provide this information?

.....
.....
.....

4 How do you think that this illness will affect your family in the future?

.....
.....

THANK YOU FOR GIVING UP YOUR TIME TO HELP THE COMMUNITY.

APPENDIX C
FOCUS GROUP DISCUSSION GUIDE

Focus group discussion one

1. Cluster yourself in one of the circles that are drawn in the floor
    - If you think you are poor go to a circle marked poor
    - If you think you are very poor go to a circle marked very poor
    - If you think you are adequate resourced to a circle marked adequately resourced
    - If you think you are wealthy go to a circle marked wealthy
2. You have a right to ask the person who you think is in the wrong circle to change
3. Can you tell us why are you saying you very poor, poor, adequately resourced or wealthy
4. Explain according to your understanding or rating why a person is very poor, poor adequately resourced or wealthy? On what are you basing your argument?

Focus group discussion two

1. How many people live in your household? Discuss what this means.
2. How many people are directly involved with living with HIV/AIDS? Discuss what this means.
3. How long you have been affected by HIV/AIDS (Illness, death or anything that might have been caused by HIV/AIDS such as TB, diarrhoea, ongoing fever, skin sores)? Discuss
4. How many members do you think you have lost due to HIV/AIDS related diseases? How do you know?
5. Is anyone in your family sick now because of HIV/AIDS? (Often sick, very sick or not sick). Discuss the extent of the situations.
6. Over the previous four years, what are the sicknesses that have attacked you so far?
7. Tell us about your housing situation? What is it built of, who are you staying with and how satisfactory is your home environment?