

**THE EFFECTS OF HIV AND AIDS ON THE SOCIO-ECONOMIC STATUS OF HIV
AND AIDS INFECTED PEOPLE IN THE CAPRICORN DISTRICT OF THE
LIMPOPO PROVINCE, SOUTH AFRICA**

by

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DECLARATION

I declare that the mini-dissertation hereby submitted to the University of Limpopo for the degree of Master of Curationis (M. CUR) has not previously been submitted by me for a degree at this or any University that it is my own work in design and in execution, and all material contained has been duly acknowledged.

Surname, Initials (title)

Date

DEDICATION

This study is dedicated to my one and only daughter, Mahlogonolo Sekgoka, and to both my mother, Grace Sekgoka, and my father, Robert Sekgoka.

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ABSTRACT

Previous research about people living with HIV and AIDS has highlighted social support as an important determinant of health outcomes; i.e. perceived support to be associated with adjustment and coping in relation to HIV diagnosis, as well as its potentially chronic and disability course .

The purpose of the study is to determine the effects of HIV and AIDS on the socio-economic status of people infected with HIV and AIDS at the village of Ga-Mathabatha in the Capricorn District of the Limpopo Province, South Africa. In this study, a qualitative, descriptive, exploratory and contextual design is used.

A non-probability purposive sampling technique was used to carefully select the sample based on the knowledge that the participants had about the phenomena studied.

Semi-structured, one-on-one, in-depth interview with a schedule guide were conducted until saturation of data was reached. To initiate each interview, a central question was asked: "Describe the effects that HIV and AIDS have on your socio-economic status". Participants were given an opportunity to describe their experiences with regard to the effects of HIV and AIDS on their socio-economic status. Field notes of semi-structured, one-to-one, in-depth interview session were recorded. A voice recorder was used to capture all the semi-structured, one-to-one, in-depth interviews. The recorded interviews were transcribed verbatim, using Tesch's qualitative data analysis method.

Trustworthiness was ensured by using Guba's model criteria; i.e. credibility, transferability, confirmability, and dependability. The results indicate that HIV and AIDS have an effect on the socio-economic status of HIV-positive people.

Ethical standards for nurse researchers were adhered to, namely permission to conduct the study was obtained from the Medunsa Research and Ethics Committee. Permission to conduct the research project was granted by the Limpopo Turfloop Campus, Limpopo Provincial Department of Health and Social Development, and the ART clinic management at the Ga-mathabatha Relebogile Wellness and ART Clinic. To ensure confidentiality and anonymity, written informed consent was obtained from

each participant before he/she could participate in the study. The quality of the research was also insured.

Five themes and their sub-themes, and the literature control are presented in the discussion of the research findings.

The findings of this study have a central story line which reveals that participants are sharing similar experiences in terms of socio-economic factors after they have tested HIV-positive which are related to several factors; including the involvement of family and friends in their care, changes encountered which affect their social life, household income, and their living conditions.

The following five themes and their sub-themes have emerged during data analysis:

- Theme 1: Different sources of income of HIV-positive people;
- Theme 2: Living conditions of HIV-positive people;
- Theme 3: Consequences related to HIV and AIDS disease progression;
- Theme 4: Support and care to HIV-positive people; and
- Theme 5: Disclosure versus non-disclosure of HIV-positive status.

The results of this study are limited to the Relebogile Wellness and ART Clinic in the Ga-Mathabatha area of the Capricorn District in the Limpopo Province, South Africa. The study findings cannot be generalised to all clinics that are issuing ARVs in the Capricorn District.

Study conclusions emphasise the fact that there is a need for HIV and AIDS positive patients to receive continuous support from family, friends, and the community with the purpose of enabling them to cope emotionally, socially, and economically. It also reveals the importance of participants to take their treatment as prescribed with the aim of improving their immune systems.

The recommendations emphasise the fact that there is a need for HIV and AIDS patients to receive continuous support from family, friends, and the community with the purpose of enabling them to cope emotionally, socially, and economically.

TERMINOLOGY

Human Immunodeficiency Virus (HIV)

HIV is a virus which has a known and distinct capacity to cause Acquired Immune Deficiency Syndrome once it has entered the body. It attacks a person's immune system (Kaushik, Pandey & Pande, 2006:43)

Acquired Immunodeficiency Syndrome (AIDS)

It is the fourth stage of HIV infection and it is usually characterised by a CD4 count of less than 200. It is not a specific illness but rather a collection of illnesses that affect the body to such an extent that the weakened immune system struggles to respond effectively (Kaushik et al., 2006:43)

Effects

Effects are consequences that are brought about by a cause (Kaushik, Pandey & Pande, 2006:56). Examples of effects are changes in the health status, and standard of living of a population as a result of a programme, project or activity.

In this study, effects refer to changes in the socio-economic status of a population that have occurred as a result of the breadwinner in a family who has become unable to go to work due to a weakened immune system that results from HIV and AIDS.

Epidemic

It is the occurrence of cases of an illness (or an outbreak) in a specific population with a frequency clearly in excess of the normal probability (Giesecke, 2007:19).

In this study, an epidemic refers to the effect HIV and AIDS has on the population.

Socio-economic status

Socio-economic status refers to the standardised way of grouping a population in terms of parental occupation, income, power, prestige, and education (Kirsh, 2006:287).

In this study, socio-economic status defines a person's monthly income, education, and occupation.

Family

A group of people living together in a permanent arrangement, separated from the rest of the world by the walls of the family dwelling and by societal guarantees of family privacy (Bachmann & Booyens, 2006:4).

In this study, a family denotes those people who are living under the same roof with a breadwinner who is HIV-positive.

LIST OF ABBREVIATIONS

HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
MREC	Medunsa Research Ethics Committee
ART	Antiretroviral Therapy

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

The socio-economic impact of the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) creates a vicious cycle of poverty and it affects an increasing number of households. Adult members in a household who are infected with HIV and AIDS become ill and are forced to quit their jobs. Consequently, it results in a decrease in the household income. To cope with the change in income and the need to spend more on health care, children are often taken out from school. People cannot afford to buy food and malnutrition often results, while access to other basic needs; such as health care, housing, and sanitation become threatened. Consequently, children's physical and mental development is impaired due to these inevitable results to further reduce the resistance of household members and children (particularly the ones who may also be infected) to opportunistic infections, given lower levels of immunity. In turn, it leads to increased mortality (Bonnell, 2006).

AIDS robs families of their assets and income earners which results in impoverishing the poor even more. Other countries in the South African Development Community (SADC) region are experiencing the same problem, since individuals who would normally provide a household with an income are prevented from working due to HIV and AIDS, either because they are ill or because they are caring for another sick family member. Such a situation is likely to have repercussions for every member of the family. Children may be forced to abandon their education and, in some cases, women may be forced to turn to sex work (prostitution) in order to alleviate the burden of their lowered economic status (Fredrickson & Kanabus, 2008).

Orphaned children, including children in households with ill parents suffering from HIV and AIDS or a related illness, may find their education destroyed and future economic opportunities compromised because families cannot afford to provide for their basic needs (Nana, 2006).

Considerable HIV and AIDS differences among nations have been attributed to poverty inequality and economic instability (nation's wealth), migration (rural to urban

and foreign), education (literacy), access to health services, drug use, and sexually transmitted diseases. In order to control HIV and AIDS, countries need not only to promote changes in individual behaviour but also need to address social issues; such as unemployment, rapid urbanisation, migration, and the status of women (Zanakis, Alvarez & Li, 2006).

1.2 STATEMENT OF THE PROBLEM

HIV and AIDS have enormous implications for world health and global economic development, particularly in regions such as Southern Africa. As a result of the socio-economic burden caused by HIV and AIDS, few governments worldwide are able to provide treatment to those citizens who are affected by HIV and AIDS. Employees infected with the virus are less productive and have to take more time off from work due to their ill health that is caused by the virus. In most cases, employees and their families struggle to cope economically because they are not paid during absenteeism (Wojcicki, 2005). HIV and AIDS at Ga-mathabatha village seem to affect the socio-economic status of working adults, who are expected to take care of their families' basic needs. As a result, poverty increases, since breadwinners receive less remuneration, and scarce savings are utilised during the period of ill health.

1.3 PURPOSE

The purpose of this study is to:

- Determine the effects of HIV and AIDS on the socio-economic status of people infected with HIV/AIDS in the village of Ga-Mathabatha in the Capricorn District of the Limpopo Province, South Africa.

1.4 RESEARCH QUESTION

The following research question is used to guide the study:

- What are the experiences of HIV and AIDS infected people with regard to the effects of HIV and AIDS on the socio-economic status of the residents in the Ga-Mathabatha village?

1.5 OBJECTIVES

The objective of this study is to:

- Explore and describe the lived experiences of HIV and AIDS infected people with regard to the effects of HIV and AIDS on the socio-economic status of residents in the Ga-Mathabatha village of the Capricorn District in the Limpopo Province, South Africa.

1.6 SCOPE OF THE STUDY

The greater emphasis of this research is placed on describing and exploring the effects of HIV and AIDS on the socio-economic status of individuals (men and women) who are attending the support group at the Relebogile Wellness and Antiretroviral Therapy Clinic in the village of Ga-Mathabatha.

1.7 LITERATURE REVIEW

The economic and social impact of the HIV and AIDS epidemic in Sub-Saharan Africa has attracted much attention. Households that are affected by HIV and AIDS may reduce non-health-related expenditure, and children's nutritional status and educational attainment may suffer. Household members may also reallocate their efforts away from income-earning activity to care-giving. When a large portion of the household expenditure goes towards treatment and funerals, care-giving responsibilities increase and income is lost as a result of premature mortality and morbidity among younger adult wage earners. Inevitably, households may be unable to cope with these financial shocks (Mahal, Canning, Odumosu & Okonkwo, 2008).

HIV and AIDS change the structure of the population; it is distinct from other diseases because it strikes prime-aged adults, the most productive segment of the economy. Consequently, the breadwinners are falling ill and dying, destroying much needed skills and depriving children of their parents. Since it is a slowly evolving virus, Barnett and Clement (2005) in Casale and Whiteside (2006) point out that the key to the social and economic impact of HIV and AIDS is the affect it has on at least three human generations. The principal economic impact that is experienced by affected households is the loss of available income, since working adults are either falling ill, dying, or having to stop work to look after children and/or the ill. The

additional expenditure on health care and funerals also impacts the available income negatively. Other effects include the depletion of household assets (due to increased health expenditure, consumption needs and labour losses), lower productivity of subsistence labour, and reduced availability of food. School enrolment may also decrease, since children are forced to dedicate time to labour and care-giving (UNAIDS, 2004 in Casale & Whiteside 2006).

The HIV and AIDS epidemic that is gripping the world is just as serious in South Africa than in many other countries in Africa. Countries like Uganda seem to have the incidence of HIV and AIDS under control whilst the South African statistics are showing that there are increasing numbers of people who are infected with HIV and many are in advanced stages of AIDS and are dying. The majority of these people are in their thirties which is the age at which they should be making their greatest socio-economic contribution to their households and to the national economy (King, Justus, Erasmus & Kinsman, 2008).

HIV and AIDS can aggravate poverty by making it difficult for the poor to mitigate its impact. The study involving 728 households conducted in Gauteng, Mpumalanga, the Free State and KwaZulu-Natal reveal that family members who are suffering from HIV and AIDS or who have recently experienced HIV and AIDS related death are affected economically and socially. Almost half (44%) of these households have an income of less than R1 000 and could, therefore, be classified as being poor. Approximately two-thirds of these households report having lost income due to AIDS: Firstly, due to increasing expenditure on medical treatment (53%); secondly, as a result of absenteeism for care giving purposes; and lastly, as owing to the high funeral expenses. In more than 40% of the households, the primary caregiver is taking time off from work or school to take care of ailing members of the household. The households report that the sick person has usually been chronically ill for a year before passing on. Considering the number of paid leave days that employees are entitled to, such continuous ailment is guaranteed to result in a loss of income. Consequently, it is reducing the disposable income of the household (Tladi, 2006).

The loss of schooling leads to lack of skills that are necessary for gaining employment. Therefore, the chances of alleviating household poverty are also slimmer. HIV and AIDS increase the likelihood of households that are suffering from

chronic poverty, as a result of the increasing orphan status. Death of parents due to HIV and AIDS further increases the number of orphans who will be without a disposable income. The study establishes that approximately 22% of all children aged 15 and below have lost one or both parents to HIV and AIDS (Tladi, 2006).

A survey of 771 AIDS-affected households throughout South Africa, has documented the impoverishment and burden of care for family members. The researchers have found that poor people in South Africa are the most adversely affected by HIV and AIDS, and that those households worst hit by the epidemic are also the ones that are underserved by basic public services, such as sanitation and piped water (Casale & Whiteside, 2006).

Furthermore, the epidemic deepens poverty among the already poor due to loss of income and medical care costs, which absorb up to one-third of household income. Children's schooling is also disrupted, especially among girls. Increasing early childhood malnutrition is also observed. This study also reveals a growing burden on extended family networks: more than 12% of households have sent their children to live elsewhere, most often with relatives (Casale & Whiteside, 2006).

Another survey carried out in South Africa in the Limpopo Province Capricorn district provides further evidence of how HIV and AIDS aggravate poverty among households that are already living below the poverty line. One empirical result indicates that income received by affected households during the year 2000 has been approximately 35 per cent lower than the income received by unaffected households. The per capita monthly income of the average affected household has been about 31% lower than the income of unaffected households. The study brings to light changes in household expenditure patterns: Health and medical care, transportation, and funeral expenditure increases among affected households interviewed, while spending on education, housing and remittances is reduced. For example, affected households are increasing their transportation costs by 4.7% and reducing expenditure on education by 7.3% and housing by 11.5% (Casale & Whiteside, 2006).

1.8 METHODOLOGICAL APPROACH

In this study; a qualitative, descriptive, exploratory; and contextual design is used.

A qualitative design is used in this study in order for the researcher to explore and describe the effects of HIV and AIDS on the socio-economic status of the people infected with HIV and AIDS in the village of Ga-Mathabatha, Capricorn District of the Limpopo Province. A qualitative, descriptive, explorative, and contextual research design has assisted the researcher to allow the participants to continuously interpret, create, give meaning, define, and rationalise their experiences with regard to the phenomenon studied (Babbie & Mouton, 2009). The contextual interest of the researcher is aimed at understanding events of the phenomenon studied; within the concrete, natural context in which it occurs (Brink, 2006; Babbie & Mouton, 2009).

1.9 POPULATION AND SAMPLING

In this study, the target population were individuals (men and women) who were attending a support group at the Relebogile Wellness and ART Clinic in the Ga-Mathabatha village, in the Capricorn District of the Limpopo Province, South Africa. A non-probability purposive sampling technique was used in this study because it allowed the researcher to carefully select the sample based on knowledge the participant had about the phenomena to be studied (Brink, 2006).

1.10 RECRUITMENT OF PARTICIPANTS

Participants who participated in the study were the ones who were already infected with HIV and AIDS and/or attending a support group at the Relebogile Wellness and ART Clinic. The researcher, in conjunction with the clinic manager, checked patient's files to choose the ones who had met the selection criteria of the study. Invitation letters were sent to all participants that included the following information:

- Research topic;
- Purpose of the study;
- Criteria needed to participate in the study;
- Contact person's name and number; and
- Institution where the interview would take place.

1.11 INCLUSION CRITERIA

The participants who were included in this study were the ones who were infected with HIV and AIDS, working, retrenched due to ill health, early retirement due to ill health, living with their own families, 25 years and older, and who were attending a support group at the Relebogile Wellness and ART Clinic in the Ga-Mathabatha village.

1.12 DATA COLLECTION METHOD

Semi-structured, one-on-one interviews with a schedule guide were conducted during the research project that assisted the researcher to understand the lived experiences of the participants with regard to the effects HIV and AIDS on their socio-economic status. De Vos, Strydom, Fouché and Delport (2005); Babbie & Mouton, (2009) describe the semi-structured, one-on-one interviews that enable the researcher to understand the experiences of the participants and the meaning they make of those experiences. Data were collected by interviewing participants in the consulting rooms away from possible distractions. The central question that was posed to each participant in the same manner was:

“Describe the effects HIV and AIDS have on your socio-economic status?”

- Field notes of semi-structured one-on-one interviews were recorded verbatim.
- A voice recorder was utilised to capture all the interviews.

1.13 DATA ANALYSIS

Data were analysed and themes were systematically identified based on Tesch’s method of qualitative data analysis (De Vos et al., 2005). Data collected from the semi-structured, one-on-one interviews with a schedule guide using a voice recorder were listened to and transcribed verbatim. In this study, the aim of data analysis was to produce a detailed and systematic record of issues that were addressed during semi-structured, one-on-one interviews (Brink, 2006).

A literature control was conducted after the data were analysed with the purpose of supporting the findings of this study (Creswell, 2004).

1.14 TRUSTWORTHINESS OF THE STUDY

Trustworthiness was maintained by using Guba's (De Vos, 2005; Babbie & Mouton, 2009) model criteria that are credibility, transferability, confirmability and dependability. Trustworthiness is discussed in detail in Chapter 2.

Credibility was ensured by prolonged engagement by conducting semi-structured, one-on-one interviews with a schedule guide during which participants were allowed to describe their experiences with regard to the phenomenon studied over a period of two months until data saturation occurred (Babbie & Mouton, 2009). A comprehensive thick description of the research methodology is provided in Chapter 2 of this study (Babbie & Mouton, 2009). The findings of this research project are the product of inquiry and not of the researcher's bias. Dependability in this study was ensured by providing a thick description of the research methods (Chapter 2) that enhances the possibility of repeating the study by another researcher (Babbie & Mouton, 2009).

1.15 ETHICAL CONSIDERATIONS

The following ethical standards for nurse researchers as outlined by Burns and Grove (2007) were adhered to throughout the research project. Ethical principles will be discussed in detail in Chapter 2.

Ethical clearance to conduct the study was obtained from Medunsa Research Ethics Committee (MREC). Permission was granted by the Limpopo Provincial Department of Health and Social Development, and the ART clinic management.

Informed consent was obtained from each participant before they could participate in the study. The purpose of the study was explained to every participant before commencing with semi-structured one-to-one interview sessions with schedule guide.

The participants were told that they can terminate their participation in the research study if they feel that they will not continue. They were also informed that the information they have given will be only used for the purpose of the study.

The participants were informed that field notes will be written during the semi-structured one-to-one interview sessions and that a tape recorder will be used to record interviews. Confidentiality and anonymity were also ensured.

1.16 SIGNIFICANCE OF THE STUDY

The study extends the knowledge base that currently exists in the health field by exploring the experiences of participants. The study aims at assisting the health care practitioners, who are caring for HIV and AIDS patients, to gain more knowledge about the way in which HIV and AIDS affect the socio-economic status of their patients. The study also benefits the family members of HIV and AIDS infected people, since they are going to acquire more knowledge and understanding about the importance of supporting HIV and AIDS infected people socially and economically.

1.17 DIVISION OF CHAPTERS

The chapters of this study are arranged as follows:

Chapter 1: Orientation of the study

Chapter 2: Research methodology

Chapter 3: Discussion of results and literature control

Chapter 4: Conclusion, limitations, and recommendations

CHAPTER 2

RESEARCH METHOD AND DESIGN

2.1 INTRODUCTION

This chapter focuses on the research method and design that have been used to conduct this research study. A qualitative, descriptive, exploratory and contextual design has been used in this study. The semi-structured, one-on-one interviews with a schedule guide have been conducted to assist the researcher with understanding the lived experiences of the participants with regard to the effects that HIV and AIDS have on their socio-economic status.

2.2 QUALITATIVE RESEARCH METHOD

In this study qualitative research method is used in order for the researcher to explore and describe the effects of HIV and AIDS on the socio-economic status of the people in the Ga-Mathabatha area of the Limpopo Province. De Vos et al. (2005) explain that a qualitative research design is holistic in nature and aims at understanding social life and the meaning that people attach to everyday experiences. This design has been chosen because it attempts to gain a first-hand, holistic understanding of the phenomena of interest by means of a flexible strategy that involves problem formulation and data collection (De Vos et al., 2005).

In the context of this study, the research method is used to obtain full information about the effects of HIV and AIDS on socio-economic status. The researcher allows participants to describe their lived experiences with regard to the effects of HIV and AIDS on their socio-economic status.

2.2.1 Research design

According to Moule and Goodman (2009), a research design is a map of the way in which the researcher will engage with the research subjects in order to achieve the outcomes that are needed to address the research aims and objectives. It also provides a representation of the researcher's beliefs about how knowledge is generated. The purpose of a research design is to ensure that the evidence that gets collected answers the research question satisfactorily. Creswell in De Vos et al.

(2005) defines design in the qualitative context as “the entire process of research from conceptualizing a problem, to writing the narrative”. De Vos et al. (2005) state that in qualitative research the researchers develop their own design while they are conducting research, using one or more of the available strategies or tools as an aid or guideline. In this study, the researcher uses a qualitative, descriptive, exploratory and contextual design as a methodological approach.

2.2.2 Descriptive research design

A descriptive design was used in order to assist the researcher with obtaining complete and accurate information about the effects of HIV and AIDS on the socio-economic status of individuals (men and women) who were attending a support group at the Relebogile Wellness and ART Clinic (Denzin & Lincoln, 2008). In order to achieve the descriptive part of the study, participants were given an opportunity to describe their own experiences with regard to the problem studied.

2.2.3 Exploratory research design

The exploratory design was used in this study to gain insight and an understanding of the problem under study. The aim of the exploratory research was to establish the facts, to gather new data, to establish patterns in the collected data, and to gain new insights in the problem studied (Mouton, 1996; De Vos, et al., 2005). The researcher conducted semi-structured, one-on-one interviews with a schedule guide and used probing questions to afford participants the opportunity to explain issues which needed clarity with the purpose of assisting with a better understanding about the problem studied.

2.2.4 Contextual research design

Burns and Grove (2007) define a contextual research design as a study that is conducted in a specific area and the results of the study would only be valid for the situation in which the study has been conducted. A contextual design is used in order for the researcher to understand the problem studied. The study is contextual in nature because the researcher aims at understanding the effects of HIV and AIDS on the socio-economic status of individuals (men and women) who are attending a

support group at the Relebogile Wellness and ART Clinic, in the context of the concrete, natural environment where it occurs (Brink, 2006; Babbie & Mouton, 2009).

The study was conducted in the environment where participants were collecting treatment and attending a support group due to the following reasons :

- The researcher felt that cooperation with participants could easily be achieved by being calm, free, and having a good relationship with the participants with the purpose of obtaining required information from them in an environment that was familiar; and
- Participants were displaying that they were comfortable during the interviews, since they were familiar with the environment and, therefore, the required information seemed to be easily obtained.

2.2.5 Study site

The study was conducted at the Relebogile Wellness and ART Clinic which is situated in the village of Ga-Mathabatha, Lepelle-Nkumpi Local Municipality of the Capricorn District, Limpopo Province.

2.2.6 Population

Population is defined by Brink (2006) as a complete set of persons who possess some common characteristics that are of interest to the researcher. According to Moule and Goodman (2009), the target population is a particular population whose composition meets specific criteria that the researcher is interested in collecting data from. In this study, the target population were individuals (men and women) who were attending a support group at the Relebogile Wellness and ART Clinic in the Ga-Mathabatha area of the Capricorn District in the Limpopo Province, South Africa. The target population were selected because they had met the criteria of this study.

2.2.7 Sampling

Non-probability purposive sampling is used in this study because it allows the researcher to carefully select the participants based on the knowledge they have about the phenomena studied (Brink, 2006). De Vos et al. (2005) define sampling as elements of the population that are considered for actual inclusion in the study, or it

can be viewed as a subset of measurement gets drawn from a population in which the researcher is interested. De Vos (1998) explains that purposive sampling is based on the judgment of the researcher who chooses a sample that has elements that are of interest and represent the whole population that needs to be studied. Participants are chosen based on the judgment of the researcher, since the participants have the characteristics that are relevant to the research project (De Vos et al., 2005). The researcher in conjunction with the nurse in-charge check patient's files to select the ones who they believe have experienced or have a set of knowledge that relates to addressing the research question.

The sample size is determined by data saturation. Data saturation is the point at which new data no longer emerge during the data collection process (Brink, 2006). The sample size for the study are ten participants.

2.3 INCLUSION CRITERIA

Inclusion criteria are sets of conditions that need to be met in order to participate in a research study (Polit & Beck, 2012). These criteria are the standards that are applied to determine whether a person may be allowed to participate in a study. Participants who are HIV positive, are on ART, and are breadwinners have been included in the study. The participants have to meet the following criteria:

- They are at least 25 years old, since these HIV-positive participants are on ART and most likely are earning a living.
- They are attending a support group at the Relebogile Wellness and ART Clinic in Ga-Mathabatha.

2.4 PREPARATION FOR DATA COLLECTION

According to Van der Burgh (1988) in De Vos (2005), it is very important to obtain permission before entering the identified field to conduct the research study.

The interviews were conducted in a well ventilated, quiet consulting room, far away from noise and disturbance. The environment provided privacy, it was comfortable, and it encouraged involvement and interaction with the participants. Participants were prepared for semi-structured one-on-one interviews by the nurse in-charge and the researcher. Arrangement of date, time and place was conducted and it was

followed up in writing closer to the date to confirm the particulars of scheduled data collection interview.

2.5 DATA COLLECTION

Semi-structured, one-on-one interviews with a schedule guide were conducted in order for the researcher to understand the problem studied. The participants were given an opportunity to describe the effects HIV and AIDS had on their socio-economic status. De Vos et al. (2005) describe the semi-structured one-on-one interview as interaction that is organised according to topics of particular interest, while still allowing considerable flexibility in opportunity. In this study, client who were attending a support group at the Relebogile Wellness and ART Clinic in Ga-Mathabatha were interviewed during semi-structured, one-on-one interviews with a schedule guide and interviews were conducted until saturation of data was reached.

According to Moule and Goodman (2009), triangulation of data is thought to improve the validity of a study by drawing on multiple reference points to address research questions. Triangulation in data collection is used with the purpose of overcoming potential biases of using a single data collection method, source or an individual researcher. In this study, triangulation of data collection tools was achieved by using field notes and a voice recorder for capturing all interview proceedings.

The central question was expressed in the same manner to each participant: "Describe the effects HIV and AIDS has on your socio-economic status?" Field notes of semi-structured, one-on-one interviews were recorded in a note book which was securely kept. A voice recorder was used to capture all semi-structured, one-on-one interviews to enable the researcher to listen to the captured information during a verbatim transcribing session in preparation for data analysis.

2.5.1 Semi-structured, one-on-one interviews

Semi-structured, one-on-one interviews with a schedule guide were used in this study to collect data from participants who satisfied the inclusion criteria. Semi-structured, one-on-one interviews are open-ended interviews during which the researcher is guided by a list of specific topics to address (Polit & Beck, 2010). It involves the use of topics or open-ended questions, since it is not as controlled or

fixed as a structured interview. During the interview, there is an opportunity for dialogue and for participants to offer responses that are not predetermined (Watson, McKenna, Cowman & Keady, 2008). The main question is followed by probing questions which focus according to the schedule guide to allow the participants to clarify and to provide sufficient information about the phenomenon studied.

2.5.2 Field notes

Field notes are broader, more analytical, and more interpretive than a simple tabulation of occurrences. Field notes represent the observer's efforts to record information and also to synthesise and understand the data that are provided by participants (Polit & Beck, 2012). The researcher writes down information collected during the semi-structured, one-one-one interviews and non-verbal cues which the participants display during the interviews.

2.5.3 Voice recorder

The voice recording of the semi-structured, one-by-one interviews is conducted to afford the researcher an opportunity to concentrate on the conversation and to focus on certain topics that arise during the interview. Voice recording of a semi-structured, one-on-one interview is conducted to support the subsequent analysis. It is followed by transcribing the recordings verbatim (Moule & Goodman, 2009). Before commencing with the interviews, permission is obtained from the participants to record the interviews by using a voice recorder.

2.5.4 Bracketing

Bracketing is a technique that gets used in qualitative research that enables the researcher to suspend (or bracket) their pre-conceived ideas with the view of approaching the phenomena to be studied without any biases. The researcher uses bracketing to avoid the misinterpretation of the issue as the individual experiences it (Burns & Grove, 2009). In this study, the researcher suspended all her pre-conceived ideas about the effect of HIV and AIDS on the socio-economic status of individuals who were attending a support group at the Relebogile Wellness and ART Clinic by recording these ideas before starting with a research project. The following pre-conceived ideas were recorded:

- The socio-economic status of most of the HIV-positive people deteriorates after their status had become known.
- HIV-positive people find it difficult to cope with their status, especially when they are not receiving support from their families.

2.6 COMMUNICATION TECHNIQUES

The following communication techniques as outlined by (De Vos et al., 2005; Benner & Ketefian, 2008) were used during the semi-structured interviews.

- **Listening:** The researcher nodded her head during the interview to indicate that she was listening to what the participant was saying.
- **Probing:** Probing was done to supply the participants with cues about the level of response that was desired and to obtain more information about the effects of HIV and AIDS on the socio-economic status. The following methods of probing were followed:
 - **Encouraging:** participants were given compliments to encourage them to continue.
 - **Showing understanding and allowing time for elaboration:** participants were given enough time for further comment and the interviewer informed them that their comments were understood and treasured.
 - **Acknowledging:** the researcher repeated some of the participants' answers to demonstrate that she was paying attention.
 - **Direct questions:** the researcher asked direct questions to get more information.
 - **Procuring details:** the researcher asked further questions to establish whether more information could be obtained.
 - **Reflective summary:** the researcher was summarising some of the participants' ideas, thoughts and feelings verbalised to confirm that she understood what the participants were saying and to encourage the participants to provide more information.
 - **Minimal verbal response:** the researcher was responding verbally, i.e. "mm-mm, I see," to demonstrate to the participant that she was listening.

- **Clarification:** during the interview, the researcher asked for the clarification of vague statements.
- **Reflection:** the researcher was reflecting on something important that the participants had said in order to encourage them to elaborate.
- **Paraphrasing:** the researcher was stating some of the participants' words in another form with the same meaning to verify whether she understood what the participants had said.
- **Language:** the researcher facilitated the flow of information by using appropriate language and she also avoided the use of jargon or terminology that might have hampered a clear understanding.
- **Silence:** the researcher and the participants were comfortable with the silence and it gave the participants more time to reflect, gather their thoughts, and construct a significant response.

2.7 DATA ANALYSIS

Data that were collected from the semi-structured, one-on-one interviews by using a voice recorder was listened to and transcribed verbatim. The aim of data analysis was to produce a detailed and systematic recording of issues that were addressed (Burnard, 2003). The data were systematically identified and grouped in themes according to Tesch's open coding technique (in Creswell, 2009) by using these steps:

1. The researcher got a sense of the comprehensive topic by reading all transcripts carefully, while recording all ideas that came to mind.
2. The researcher selected one of the shortest, interesting interview transcripts and went through it while asking: "What is this about?" with the purpose of establishing what the underlying meaning of the information was. Once again, any thoughts that came to mind were noted in the margin.
3. After the researcher had completed this task for several participants, a list of all the topics was compiled. Similar topics were clustered together and formed into columns that were arranged into major topics, unique topics and exceptions.
4. The list was compared with the data. The topics were abbreviated as codes and the codes were written next to the appropriate segments of the text. This

preliminary organising scheme was inspected to establish whether new categories and codes were emerging.

5. The most descriptive wording for the topics was turned into categories. The deduction of the total list of categories was achieved by grouping topics that related to each other. Lines were drawn between categories to show interrelationships.
6. The final decision about the abbreviations for each category was made and the codes were tabulated alphabetically.
7. The data of each category were assembled in one place and a preliminary analysis was performed.
8. Existing data were inspected according to the final themes and sub-themes.

2.8 ETHICAL CONSIDERATIONS

The following ethical standards were adhered to during the research study: permission to conduct the study, confidentiality and anonymity, and signing a written informed consent form (Burns & Grove, 2007).

2.8.1 Permission to conduct the study

Ethical clearance to conduct the study was obtained from the Medunsa Research and Ethics Committee (Annexure E). Permission to conduct the interview sessions at a health facility was granted by the Limpopo Provincial Department of Health and Social Development (Annexure F), and the ART clinic management at the GamaMathabatha Relebogile Wellness and ART Clinic.

2.8.2 Confidentiality and anonymity

The participants were informed that they would be allocated numbers since their real names were not going to be recorded anywhere. Participants were ensured that the information provided would be only available to people involved in this study and it would not be divulged to anyone who was not part of the research project, except when the participants had given permission to do so.

2.8.3 Informed consent

Written informed consent was obtained from each participant before they could participate in the study. The participants were informed that they had the right to withdraw from the study at any time but information already provided before termination would still be used for the purpose of the study. The consent form included the research topic, purpose, and objectives of the study.

2.8.4 Quality research

Participants were treated with integrity by being honest with them, especially in relation to the importance and the outcome of the study.

2.9 TRUSTWORTHINESS OF THE STUDY

Trustworthiness in qualitative research is a concept that has been coined by Lincoln and Guba in 1989 as an alternative to the criteria of reliability and validity in quantitative studies. It refers to the truth value, as well as the methodological steadiness and adequacy of the research which are judged by the criteria of credibility, conformability, dependability and transferability (Holloway & Wheeler, 2002).

Credibility

Credibility was insured in this study by investing more time in the field and also by extended engagement with participants to support the development of trust. The researcher conducted the interviews for a period of a month. Triangulation of data collection tools was achieved during the interviews session by writing field notes and recording all the interview sessions with the assistance of a voice recorder. Paraphrasing, clarification, reflection, minimal verbal response, probing, listening, and reflective summary were used during the semi-structured, one-on-one interviews to elicit more information and to confirm that data collected reflected the information of the participants and not the biases of the researcher.

Transferability

Transferability refers to what extent the findings of the study can be transferred to another context or with other participants (De Vos et al., 2005). During this study, the researcher insured transferability by thick description of the research method. Purposive sampling was used to select participants for the semi-structured, one-on-one interview with a schedule guide.

Confirmability

In this study, confirmability was ensured by the use of an independent coder. Written field notes and a voice recorder were used to capture the data during the interview sessions.

Dependability

De Vos et al. (2005) state that dependability is an alternative to reliability, since the researcher has to account for changing conditions in the research phenomena. In this study, dependability was ensured by describing the methodology of the study extensively in this chapter. A dependability audit was carried out with the guidance of the supervisor who is an experienced qualitative researcher and the co-supervisor who holds a PhD.

2.10 CONCLUSION

The qualitative, descriptive, exploratory research design and its contextual in nature is described in this chapter. Participants were interviewed during semi-structured, one-on-one interviews with a schedule guide until data saturation was reached. Each participant was given an opportunity to describe the effect of HIV and AIDS on the socio-economic status. Data were collected by using field notes and a voice recorder. Data were analysed according to Tesch's open coding method for analysing qualitative data.

CHAPTER 3

DISCUSSION OF RESEARCH RESULTS

3.1 INTRODUCTION

Chapter 3 presents the results of the data that were collected during semi-structured, one-on-one in-depth interviews with HIV-positive patients who were taking treatment and attending a support group at the Relebogile Wellness and ART Clinic in the Ga-Mathabatha village. Themes and sub-themes emerged during data analysis as a result of using Tesch's open coding method. The themes and sub-themes are supported by a literature control that reinforces the study results and participants' direct verbatim statements that are presented in italics.

3.2 PARTICIPANTS OF THE STUDY

Of the participants, one (1) was from the 20-30 years age group, four (4) were 30-40 years, four (4) 40-50 years, and one (1) was from the 50-60 years age group; they were HIV-positive, taking ART, attending a support group at the Relebogile Wellness and ART Clinic in Ga-mathabatha, and working for a living.

3.3 DISCUSSION OF THE RESULTS

The discussion of findings is based on Table 3.1 which represents the themes and sub-themes that have emerged during the data analysis of this study.

Table 3.1: Themes and sub-themes

These themes reflect the effects of HIV and AIDS on the socio-economic status of HIV and AIDS infected people in the Ga-mathabatha village of the Capricorn District of the Limpopo Province, South Africa.

Central storyline: Participants shared the different experiences in terms of their socio-economic circumstances after they had tested HIV-positive. These circumstances were described in relation to several matters that included the involvement of the family and friends in their care, changes encountered that affected their social life, household income, and lastly their living conditions. On the one hand, experiences emerged that reflected a dominant story of perceived

constraints in relation to financial burden experiences which resulted in a lack of nutritious food and appropriate housing. On the other hand, participants shared the positive aspects about their family members and friends who were providing care and support while reminding them to take their ARVs and providing food when the need arose.

Main themes	Sub-themes
<p>1. Different sources of income for HIV-positive people.</p>	<p>1.1 Government Child Support Grant serves as a source of income.</p> <p>1.2 Working children provide financial support to infected parents.</p> <p>1.3 Responsibilities versus rights of HIV- positive people in relation to financial support of their families.</p>
<p>2. Living conditions of HIV-positive people.</p>	<p>2.1 Appropriate versus inappropriate residential areas.</p> <p>2.2 Financial constraints lead to unavailability of well-balanced food.</p> <p>2.3 HIV-positive people reside with family members.</p>
<p>3. Consequences of HIV and AIDS disease progression.</p>	<p>3.1 Inability to work due to disease progression.</p> <p>3.2 Retrenchment from employment due to decreased ability to perform daily duties.</p> <p>3.3 Self-discrimination and stigmatisation.</p> <p>3.4 Rejection by family, friends, and community members.</p> <p>3.5 Fear of rejection by family, friends</p>

	and, community members. 3.6 Life style changes.
4. Support and care to HIV-positive people.	4.1 Support versus lack of support for HIV-positive people. 4.2 Reliability of treatment by supporters.
5. Disclosure versus non-disclosure of HIV-positive status.	5.1 Lack of disclosure leads to emotional burdens. 5.2 Fear of disclosure. 5.3 Acceptance of HIV-positive status is determined by time.

3.3.1 THEME 1: DIFFERENT SOURCES OF INCOME FOR HIV-POSITIVE PEOPLE

The study findings indicate that HIV-positive people experience financial constraints as a result of a shortage of income. They depend mostly on the child support and disability grants from government. These grants play a critical role in supporting people who are living with HIV by ensuring economic stability.

3.3.1.1 Sub-theme 1.1: Government Child Support Grant serves as a source of income

The Government Child Support Grant is an initiative by government for children from birth to the age of eighteen years and it is received by the primary caregiver of the child. The child support grant forms part of the general poverty relief efforts by government (Kanyane, Kola, Braehmer, Morake & Kimmie, 2006).

This effort was acknowledged by a participant who said: *“I only receive [a] child support grant”*. Another participant said: *“I only receive [a] child support grant for my four children as I left my work due to illness and this assist us in the family”*.

According to a social impact study by the community agency for social enquiry, the Child Support Grant is reaching very poor households and, therefore, it is making a

significant contribution to household income. The study also indicates that most households use the grant for the survival of the entire household, rather than to meet the specific needs of the child. Social grants are assisting many families with providing food and clothing for children (Kanyane, Kola, Braehmer, Morake & Kimmie, 2006).

3.3.1.2 Sub-theme 1.2: Working children provide financial support to infected parents

Financial support refers to the provision of everything necessary, especially money, with the purpose of enabling someone to afford buying anything that they can use for their survival. The study findings reveal that in some of the households parents are depending on their children for financial support, since they do not receive a stable monthly salary. This concept was reinforced by a participant who said: *“My first born child is disabled and he is receiving disability grant, two are at Gauteng working piece jobs and three are getting child support grant (R750). I am working as a home based carer and receive R800 when there is money in the account because sometimes we do not get paid as the money will be finished.”* Another participant indicated: *“Two grand children are getting child support grant (R500), one is doing internship and the other one is working piece jobs. I also work as a maid and get paid R700.”*

Some children are encouraged by parents or foster parents to work in order to supplement household incomes and some work out of economic necessity (Amoako, 2010).

3.3.1.3 Sub-theme 1.3: Responsibilities versus rights of HIV-positive people in relation to financial support of their families

Responsibility is a duty to deal with or take care of something. Rights are moral principles that are defining and sanctioning a human being's freedom of action in a social context (Hornby, 2006). Issues of rights and responsibilities were described by the following participants who said: *“HIV has affected my life so much because I am unable to provide for my family like I used to. I was working well till I discovered that am sick with HIV and because of many sick leaves I used to take at work, I was retrenched. I was working in the mine and because the work demanded too much*

power and energy I was unable to perform my work anymore. I feel like am a burden to my family these days because they always have to make sure someone is at home with me”.

Another participant reinforced this concept: *“I work as a maid but I can see that the work is becoming too much for me. I am always tired at work and sometimes I feel like quitting my work but I always ask myself what will happen to my children.”*

A third participant concurred: *“I left my work at the kitchens because I was always sick and I could see that I am unable to work the way I used to. My boss was so supportive but at the end I could see I was a burden to her as she was the one taking care of me and not me taking care of the house. I am unable to work as hard as I used to and it is difficult for me to find an easy job”.*

According to May (2003), one of the most critical effects is that HIV robs the family of their only “social security” system. Productive members are taken out of the equation when they become ill and die, forcing children and the elderly to satisfy their own needs. The perceptions of their responsibilities to their families by people who are living with HIV encourage them to live a life that appears normal. They feel a need to save money or to earn money for children and other family members (Xianhong, Wang, He, Fennie & Williams, 2012). The refusal to hire or the dismissal of a person because s/he is HIV-positive violates their rights and compromises their ability not only to support themselves but also their families (Gruskin, Ferguson & O’Malley, 2007).

3.3.2 THEME 2: LIVING CONDITIONS OF HIV-POSITIVE PEOPLE

The study findings indicate that most of the HIV-positive people are residing with their family members for the purpose of the family members to care for them when they are ill. The findings also indicate that they are unable to eat a well-balanced diet and or stay in an appropriate house due to the financial constraints they are experiencing.

3.3.2.1 Sub-theme 2.1: Appropriate versus inappropriate residential areas

Something is appropriate when it is suitable or proper. Inappropriate means when something is not suitable (Hornby, 2009). An appropriate residential area is a

suitable place where people reside and an inappropriate residential area is not suitable for people to reside in. In this study, most people indicated that they reside in inappropriate areas while some were living in appropriate areas.

It was confirmed by a participant who said: *“I live in a tin house which has one room and I use the room as a bedroom and kitchen”*.

Another participant indicated: *“I live in a three roomed RDP house and two room brick house and the space is enough, but sometimes it becomes a problem when I am having visitors”*.

With over two million inhabitants, Soweto is the most populated black urban residential area in South Africa and most people are of the working class, but they live in small houses, shacks or rented rooms. (Kirchheff, 2005). In South Africa, the highest number of HIV/AIDS cases (28,4%) are in informal urban settlements, followed by 15,8% in the formal urban settlements, and the rural areas have the lowest figure of 12,4% (Vhumani, 2005).

3.3.2.2 Sub-theme 2.2: Financial constraints lead to unavailability of well-balanced food

Financial constraints occur when there is a lack of money in the family that results in the unavailability of food in the household. In most of the households, they are able to buy and eat fruit when they receive their salary or when they receive their social grant. It also means that during the month they are unable to continue buying fruit due to financial constraints.

It is supported by the participants who said respectively *“I am able to buy fruits when I receive social grant money during and most of the times I eat pap and bread”*, and *“I eat pap and meat but am only able to buy fruits and vegetables once a month when I get paid”*. Another participant said *“I can only manage to eat fruits when I receive social grant money but mostly I eat pap and fish, chicken feets [sic] and Mopani worms”*.

Spending money on food and education may be reduced significantly. A study conducted in Côte d'Ivoire that explores the spending on basic consumption items (food and accommodation) reveal that all these expenses drop by 40 per cent when

a family member dies due to AIDS. These cuts in basic necessities further contribute to general household poverty that results in malnutrition, affects the health of children and women, and future work opportunities are also compromised (Aggleton, 2000).

Gillespie and Kadiyala (2005) affirm that food insecurity and malnutrition may accelerate the spread of HIV, both by increasing people's exposure to the virus and by increasing the risk of infections following exposure. Therefore, the people living with HIV need to be supported financially in order to satisfy basic needs.

In combination with unemployment, the loss of a grant may increase food insecurity, which could have serious consequences for individuals on ARVs, given the need for proper nutrition to ensure treatment efficacy (De Paoli, Mills & Groonings, 2012).

3.3.2.3 Sub-theme 2.3: HIV-positive people reside with family members

The study findings reveal that HIV-positive people reside with their family members or next of kin because these people can provide care when they are unable to take care for themselves. They reside with relatives who remind them to take treatment when they forget. This observation was supported by a participant who indicated: *“They [family members] are always so protective about me and they always make sure that I take the treatment to avoid myself from getting sick. When am sick they are able to cook for me and bring me water to bath”*. Another participant indicated: *“My girlfriend is the one taking care of me because she knows how things can be when I am sick? She is my buddy and always makes sure that I take my treatment as expected. She is always the one to accompany me to the clinic to collect treatment”*.

Family caregivers must not only provide people living with HIV and AIDS with emotional support but the caregivers need to also provide them with their activities of daily living. In addition, they have to live in the same household with people with HIV and AIDS in order to remind them of their treatment and scheduled appointments (Prachakul & Grant, 2003).

3.3.3 THEME 3: CONSEQUENCES OF HIV AND AIDS DISEASE PROGRESSION

The study findings indicate that HIV has negative consequences, since the infection progresses to AIDS. While the disease is progressing, the immune system deteriorates and the body becomes weak and an individual is unable to work as expected.

3.3.3.1 Sub-theme 3.1: Inability to work due to disease progression

HIV destroy the body's immune system and the body is becoming increasingly susceptible to opportunistic infections. Once the immune system starts deteriorating, the person will experience a loss of energy and power and he or she will no longer be able to work the way he/she used to (Department of Health, 2001). The study findings point out that HIV-positive people are unable to work when the disease starts progressing to stage three. This observation was supported by a participant who said *"I work as a maid but I can see that the work is becoming too much for me. I am always tired at work and sometimes I fell like quitting my work but I always ask myself what will happen to my children"*.

Another participant added: *"I am unable to work because of different illness I experience sometimes due to this HIV status. My life has changed because I am always weak and I do not do anything that I want at anytime because am always sick. I am always at home resting because if I do something hard after sometime I will feel body weakness. I am no longer able to visit my relatives because I am not feeling well most of the times"*.

According to Beegle and De Weerd (2008), a large effect on HIV infected people is evident, since their individual productivity decreases due to disease progression and most of them stop working and it results in a loss of income. Subsequently, it affects the proper running of the household.

Once someone has HIV, however, faster disease progression and poorer access to care are clearly associated with poverty because these people cannot work any longer (Gruskin, Ferguson & O'Malley, 2007).

3.3.3.2 Sub-theme 3.2: Retrenchment from employment due to decreased ability to perform daily duties

Retrenchment from work was one of the problems identified in this study because the participants were unable to perform their daily duties. Therefore, their employers retrenched them. Some of the participants in this study were retrenched from work due to the decreased ability to perform daily duties. This reason was supported by the participant who said: *“I was working as a taxi driver and my boss fired me because he was always worried whether I will return safe with his taxi or not. I was no longer enjoying life the way I used to, as I was always quite and losing weight and my colleagues were also suspecting that am infected”*.

Another participant said: *“I was working as a taxi driver and my boss fired me because he was always worried whether I will return safe with his taxi or not. I was no longer enjoying life the way I used to, as I was always quit and losing weight and my colleagues were also suspecting that am infected”*.

While HIV is not readily transmitted in the majority of workplace settings, the perceived risk of transmission has been used as an excuse by numerous employers to terminate or refuse employment to HIV-positive people. It is also evident that people living with HIV and AIDS who are not concealing their serostatus at work are likely to experience stigmatisation and ostracism by other people while it is predisposing them to retrenchment (Aggleton, 2000).

3.3.3.3 Sub-theme 3.3: Self-discrimination and stigmatisation

Discrimination is the recognition and understanding of the difference between one thing and another (Hornby, 2006) and stigmatisation is the severe disapproval of, or discontent with, a person on the grounds of characteristics that distinguish them from other members of a society (Hornby, 2006). Self-discrimination and stigmatisation, in this study, occurred when an individual perceived himself/herself as being different from other people in terms of the HIV-positive status.

It was confirmed by the statements, such as: *“HIV changed my life because since I started knowing my status I stopped visiting people like I used to, I believed they can see that am HIV- positive and start looking at me somehow”*.

Another statement by another participant reflected: *“I always suspected that it might be HIV doing this to me. People always see a person with HIV so different and I was afraid to go to the clinic to find out”*.

HIV-related stigma and discrimination have restricted the success of HIV prevention, care and treatment programmes and reduce the willingness of people with HIV to disclose their status. The fear of stigma and discrimination that can lead to non-disclosure impacts not only on the life of the persons with HIV but also their partners, children and other family members (Gruskin et al., 2007).

3.3.3.4 Sub-theme 3.4: Rejection by family, friends and community members

Rejection happens when someone refuses to accept something (Hornby, 2006). In this study, it occurred since family members, friends, and community members were refusing to accept individuals due to their HIV-positive status.

A participant confirmed this sub-theme: *“My life changed because people were looking at me somehow and even my own mother treated me in a bad way. She chased me out of her home because she thought people will look at her and think maybe she is also infected”*. Another participant with the same experience said: *“My social life has changed a lot because am unable to meet with my friends the way I used to and some of them they no longer talk to me because of my status”*.

Across the world, the global pandemic of HIV and AIDS has shown itself capable of triggering responses of compassion, solidarity, and support; bringing out the best in people, their families, and communities. But the disease is also associated with stigma, ostracism, repression and discrimination, since individuals who are affected (or believed to be affected) by HIV have been rejected by their families, their loved ones and their communities (Aggleton, 2000).

3.3.3.5 Sub-theme 3.5: Fear of rejection from family, friends, and community members

Fear is an unpleasant emotion caused by the belief that someone or something is dangerous, likely to cause pain, or a threat (Collins, 2009). In this study, fear of rejection occurred when HIV-positive individuals were afraid that their family, friends, and community members would reject them due to their HIV-positive status. It was

expressed by the participant who said. *“I am afraid to go and socialize with my friends and relatives the way I used to because I am afraid that people will see how my body has changed and they will know that I am HIV infected and start calling me names”*.

Decisions about HIV disclosure are dependent on perceived AIDS-related stigma. Stigma is closely related to disclosure. Due to the persistent nature of AIDS-related stigma, people living with HIV fear to disclose their status, since it is believed that it might lead to rejection by their families or partners, or losing their jobs (Aggleton, 2000).

3.3.3.6 Sub-theme 3.6: Life style changes

Life style changes are permanent changes that are experienced after finding out about something or wanting to change something (Hornby, 2006). In this study, lifestyle changes occurred due to the HIV-positive status of participants.

A participant supported this concept: *“I experience changes in my social life because I used to be able to go and attend society meetings but this days am able to go sometimes when am not sick. Sometimes is hard for me to go to community gathering because am afraid of how the community members will look at me as am suspecting that they know about my status”*.

In the eyes of HIV infected people, once they become aware of their HIV-positive status, they immediately start internalising the concept that contracting HIV is abnormal. They begin thinking of themselves as abnormal and subsequently they withdraw from a communal social life (Xianhong et al., 2012).

3.3.4 THEME 4: SUPPORT AND CARE TO HIV-POSITIVE PEOPLE

The study findings indicate that people living with HIV receive support from family members and community when they disclose their status. Treatment supporters also play an important role in the lives of HIV-positive people.

3.3.4.1 Sub-theme 4.1: Support versus lack of support for HIV-positive people

Support means to help someone with something (Hornby, 2006). In this study, support and a lack of support occurred when HIV-positive patients were either being

helped by family members or not being helped. This observation was supported by participant who said: *“I disclosed my status to my sister and her child and they are able to support me every time I need them. When I am sick they are able to hire a car to take me to the clinic and they also come to cook for me and my children. My sister is the one who is always making sure that I take my medication and she always call to check on whether I took the medication or not”*.

Another participant indicated support by the following statement: *“My family also supports me by buying fruits and vegetables for me and coming to cook for me when I am not feeling well. Some of my siblings always call to check if there is something I need so that they can be able to do it for me. My family always makes sure that I visit the clinic when I am not feeling well”*.

The rapid spread of HIV/AIDS in Thailand has placed a great burden on the health care system, as well as on the people living with HIV and AIDS and their families. In an attempt to address this issue, support groups for people living with HIV and AIDS have been established as an alternative health care approach for the ones who are not receiving any support (Liamputtong, Haritavorn & Kiatying-Angsulee, 2009).

3.3.4.2 Sub-theme 4.2: Reliability of treatment by supporters

Reliability means trusting someone or depending on someone for something (Hornby, 2006). In the context of this study, reliability occurred when participants depended on their family members as treatment supporters, since they were able to remind them to take treatment. It was confirmed by participant who said: *“When I ask them to bring pills for me they do it and even when am not around, I will find my pills ready for me to take them”*.

Furthermore, another participant added: *“They treat me well by reminding me on when to take treatment and they sometimes ask me if I have taken treatment or not. They always make sure that I take my treatment as required”*.

Disclosure is also a fundamental requirement for the management of HIV infection; it has become an entry criterion for many treatment programmes in resource-constrained settings and it is a crucial prerequisite for adherence to complex

treatment regimens when treatment “buddies” and support can be accessed (Burgoyne & Saunders, 2001).

3.3.5 THEME 5: DISCLOSURE VERSUS NON-DISCLOSURE OF HIV-POSITIVE STATUS

The study findings indicate that people living with HIV experience emotional burdens due to a lack of disclosure. Participants who have disclosed their status to their family members are receiving support and care from them.

At the individual level, disclosure of HIV infection can stimulate family or community support networks while reducing morbidity by means of better psychosocial management of the illness (Burgoyne & Saunders, 2001).

3.3.5.1 Sub-theme 5.1: Lack of disclosure lead to emotional burdens

Disclosure is the action of making something new, or secret information known (Hornby, 2006). In this study, a lack of disclosure occurred when HIV-positive patients did not disclose their status which led to emotional burdens. It was confirmed by a participant who said: *“My relatives and friends were acting somehow towards me but after I disclosed my status they started treating me in a good way. This thing was burning inside of me then I decided to disclose my status in the church and now all my community members and church mates are aware of my status”*.

Another participant said in support of the previous one: *“It was difficult for me because I was unable to disclose my status to my children. It came a time where I told myself I have to accept my status then I will be able to disclose my status and be able to socialise with community members like I used to”*.

Disclosure of an HIV-positive status often amounts to a disclosure of stigmatised behaviour that is associated with the modes of transmission. The feelings of shame that are experienced by parents/caregivers and their fear of inadvertent disclosure and stigma tend to discourage people who are HIV-positive from revealing their own status. Concealing one’s HIV status, however, may lead to or exacerbate

depression, worries, and other negative mental health outcomes. Potentially, these issues are going to interfere with treatment and affect family life, including parenting ability (Krauss, Letteney, De Baets, Murugi & Okero, 2011)

3.3.5.2 Sub-theme 5.2: Fear of disclosure

Fear of disclosure occurs when someone is scared to tell her/his secret due to being afraid of the manner in which people may react, as confirmed by the participant who said: *“No one of my friends is taking care of me because they are afraid that am HIV infected. I did not disclose my status to any of my friends because I do not want them to be feeling shame for me. After I visited the clinic, I started feeling well but to disclose my status to my parents was hard for me”*.

Another participant indicated: *“None of my friends are supporting me, but sometimes I think maybe is because I did not tell them about my status”*.

HIV-related stigma leads to fear of HIV disclosure, social rejection and inadequate social support. It also may be a factor in determining a lack of support to individuals who are infected with HIV and AIDS (Prachakul, Grant & Keltner, 2007)

Who to tell, how, and when can be a potential source of fear and anxiety among many people living with HIV and AIDS and may prevent individuals from accessing treatment and care. Reluctance and anxiety to disclose an HIV-positive status, and fears of being rejected and discriminated against are evidence of the persistent nature of AIDS-related stigma and discrimination in communities and households (Aggleton, 2000)

3.3.5.3 Sub-theme 5.3: Acceptance of HIV-positive status determined is by time

Acceptance is a person's assent to the reality of a situation, by recognising a process or condition without attempting to change it. The study findings revealed that the participants' acceptance of their HIV-status was determined by the duration of knowing their status after they had been diagnosed. It was indicated by a participant who said: *“At first, I was afraid that I am infected but as time goes on I got used to it and not be afraid to go anywhere I want to”*.

Another participant supported that point of view by saying: *“It was difficult for me because I was unable to disclose my status to my children. It came a time where I told myself I have to accept my status then I will be able to disclose my status and be able to socialize with community members like I used to”*.

The diagnosis of an HIV-positive status usually an immediate reaction of denial, since HIV infection is perceived to be fatal. After receiving positive HIV test results, some patients go into a denial stage. Such a denial stage functions as a buffer, and it gives people the opportunity to compose themselves before they become accepting of their status (Department of Health, 2001). Immediate emotional reactions dissipate with time while individuals are responding to programme interventions (Krauss, Letteney, De Baets, Murugi & Okere, 2011).

3.4 CONCLUSION

Chapter 3 provides themes and sub-themes that have emerged during Tesch’s open coding method of qualitative analysis. The themes and sub-themes are discussed and supported by the participants’ responses and a literature control is presented to re-contextualise the research results in recent, existing literature. The results show that HIV and AIDS have an effect on the socio-economic status of HIV-positive people, since they are experiencing financial constraints due to unemployment and a lack of support after disclosure of their status.

CHAPTER 4

SUMMARY, CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

The results in Chapter 3 show that HIV and AIDS have an effect on the socio-economic status of the HIV infected people in the Capricorn District, Limpopo Province, South Africa. In this chapter, recommendations for the theme and sub-themes that have emerged in Chapter 3 are formulated. The recommendations are aimed at enabling the health care professionals to assist the patients with understanding and accepting their HIV-positive status. The recommendations also aim at helping the family and community members with understanding people who are living with HIV whilst minimising stigma and discrimination, since people will be knowledgeable about the condition. The recommendations will also assist people living with HIV to be well-informed about the importance of disclosing their status to family and friends with the aim of receiving their support.

4.2 SUMMARY

The purpose of the study sought to determine the effects of HIV and AIDS on the socio-economic status of people infected with HIV and AIDS in the village of Ga-Mathabatha.

The objective of this study was to:

Explore and describe the lived experiences of HIV positive people with regard to the effects of HIV and AIDS on the socio-economic status of the Ga-Mathabatha village in the Capricorn District of the Limpopo Province, South Africa.

4.2.1 Research design and method

In this study a qualitative, descriptive, exploratory and contextual design was conducted to explore and describe the effects of HIV and AIDS on the socio-economic status of the people infected with HIV and AIDS in the Ga-Mathabatha village of the Capricorn District in the Limpopo Province (Polit & Beck, 2010). Participants were given an opportunity to explain their experiences with regard to the phenomenon. The target population in this study were individuals who were

attending a support group at the Relebogile Wellness and ART Clinic. Semi-structured, one-on-one interviews were conducted in the consulting rooms for participants to explain the phenomenon that was being studied.

Tesch's open-coding method of qualitative analysis was used to analyse the collected data. An independent coder analysed verbatim transcripts of the data. The criteria of Lincoln and Guba's model of trustworthiness were ensured with the purpose of maintaining the quality of the research study by adhering to the following criteria: credibility, transferability, conformability, and dependability (Moule & Goodman, 2009).

4.2.2 Findings of the study

The study revealed that participants shared the same experiences with regard to the effects of HIV and AIDS on the socio-economic status of HIV infected people. Participants shared the same view that when they did not disclose their status it led to emotional burdens for them and a lack of support from family and community members. They also agreed that their life-style changed after they found out about their HIV status. On the other hand, participants shared the same view about the inability to continue working due to the disease progression that led to financial constraints and the consequential unavailability of food. The participants further agreed that they were relying on treatment supporters to remind them when to take treatment and that was the reason why most of them stayed with their family members. Five themes and their sub-themes emerged during Tesch' open coding method of qualitative data analysis.

Theme 1 had three sub-themes that indicated financial constraints. The following sub-themes emerged:

- Government Child Support Grant served as a source of income;
- Working children provided financial support to infected parents; and
- Responsibilities versus rights of HIV-positive people in relation to financial support to their families.

Theme 2 had three sub-themes which indicated that HIV-positive people lived with their family members and due to of financial constraints food was unavailable. The following sub-themes emerged:

- Appropriate versus inappropriate residential areas;
- Financial constraints led to unavailability of well-balanced food; and
- HIV-positive people resided with family members.

The findings of Theme 3 showed that there were consequences related to HIV and AIDS disease progression. The following six sub-themes had emerged:

- Inability to work due to disease progression;
- Retrenchment from employment due to decreased ability to perform daily duties;
- Self-discrimination and stigmatisation;
- Rejection by family, friends and community members;
- Fear of rejection from family, friends and community members; and
- Life style changes.

Theme 4 had two sub-themes that emerged that indicated a lack of support for HIV-positive people due to not disclosing their status. The following sub-themes emerged:

- Support versus lack of support for HIV positive people; and
- Reliability of treatment by supporters.

The findings of Theme 5 showed that non-disclosure led to emotional burdens and that people with HIV feared to disclose their HIV status due to a fear of being rejected by the family and community members. Three sub-themes emerged:

- Lack of disclosure led to emotional burdens;
- Fear of disclosure; and
- Acceptance of HIV-positive status was determined by time.

4.3 RECOMMENDATIONS

4.3.1 Theme 1: Different sources of income for HIV-positive people

Health care providers should provide information to the people living with HIV about the importance of doing gardens, selling fruit and vegetables to gain income and not to depend on child support grants only. People living with HIV should take their treatment as prescribed with the purpose of improving their immune system and enabling them to work without getting tired often or taking too much sick leave.

4.3.2 Theme 2: Living conditions of HIV-positive people

Health care providers should advise family members to stay with people living with HIV in order for them to care for these family members when they are ill. Family members who are living with HIV-positive people should also be taught about infection control measures that they must adhere to in order to avoid the spread of opportunistic infections, such as Tuberculosis.

4.3.3 Theme 3: Consequences of HIV and AIDS disease progression

Health care providers should emphasise the importance of taking treatment because it boosts the immune system and the infected people need to understand that it is still possible to work like before. Employers should also be taught about the importance of supporting people who are living with HIV. It will enable them to recognise when these employees are ill, and the employers should also act as treatment supporters to make sure that they take treatment to avoid recurrent sickness due to a low immune system. People living with HIV should be taught to avoid self-discrimination and stigmatisation that will enable them to participate in the community gatherings. Family members should be taught that people living with HIV need their support and they should not reject them, since rejection will lead to emotional burdens for people living with HIV.

4.3.4 Theme 4: Support and care to HIV-positive people

Health care providers should inform people living with HIV about the importance of attending a support group that will enable them to understand that they are not the only people with the disease. People living with HIV should be advised that to make

support from their family possible, they should disclose their status to the family members.

4.3.5 Theme 5: Disclosure versus non-disclosure of HIV-positive status

Health care providers should provide sufficient information to HIV-positive people about the importance of disclosing their status to family and community members to avoid emotional burdens which might be caused by stigma and discrimination. Health care providers should also give information and teach the community about HIV and AIDS and the importance of supporting their family members when they disclose their status. Community members should also be taught not to discriminate and stigmatise people who are living with HIV. People who are living with HIV should be taught about the importance of accepting their status and taking it in a positive way with the purpose of disclosing their status to family members through effective counselling.

4.4 LIMITATIONS OF THE STUDY

The study was limited to the Relebogile Wellness and ART Clinic in the Ga-Mathabatha area of the Capricorn District, Limpopo Province, South Africa. Therefore, the study findings cannot be generalised to all clinics in the Capricorn District that are issuing ARVs.

4.5 CONCLUSION

This study was qualitative, descriptive, exploratory and contextual in nature. The researcher collected data by means of semi-structured, one-on-one interviews in order to meet the objectives of the study. Participants were given an opportunity to describe the effects of HIV and AIDS on their socio-economic status and the researcher was probing to encourage the participants to provide more information. Tesch's open coding method of qualitative data analysis was used to analyse the data collected. Recommendations and limitations of the study were outlined.

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ANNEXURE A: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

BOX 313

TRICHARDSTAL

0890

RELEBOGILE WELLNESS CLINIC AND ART

P O BOX 01

MATHABATHA

0736

APPLICATION FOR CONDUCTING RESEARCH

DEAR SIR/MADAM

I hereby apply to conduct an HIV/AIDS research in relation to the socio-economic status of the population who are attending a support group at your organisation. I am currently a registered student with the University of Limpopo, Turfloop Campus, studying to obtain a Master's degree in Nursing Science.

The objective of the study is:

- to explore and describe the effects of HIV and AIDS on the socio-economic status in the Ga-Mathabatha village.

I hope my application will be successful.

Yours sincerely

SEKGOKA B. M.

ANNEXURE B: CONSENT FORM

UNIVERSITY OF LIMPOPO (Medunsa Campus) ENGLISH CONSENT FORM

Statement about the participation in a research study

Topic of the study:

THE EFFECTS OF HIV AND AIDS ON THE SOCIO-ECONOMIC STATUS OF HIV AND AIDS INFECTED PEOPLE IN THE CAPRICORN DISTRICT OF THE LIMPOPO PROVINCE, SOUTH AFRICA

I have read the information about the aims and objectives of the proposed study and have had the opportunity to ask questions and adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressured to participate in any way. I know that sound recordings will be made of me during the research interview.

I understand that participation in this study is completely voluntary and that I may withdraw from it at any time and without supplying any reasons. It will have no influence on the regular treatment that holds for my condition neither will it influence the care that I receive from my regular doctor.

I know that this study has been approved by the research team, Ethics and Publications Committee of the Faculty of Health Sciences, University of Limpopo (Turfloop Campus). I am fully aware that the results of this study will be published and confidentiality of my information will be maintained.

I hereby consent to participate in this study.

Name of patient/volunteer

Signature of patient or guardian.

Place

Date

Witness

Statement by the researcher:

I provided verbal and/or written information regarding this study

I agree to answer any future questions about the study to the best of my ability.

I will adhere to the approved protocols.

Name of Researcher

Signature

Date

Place

ANNEXURE C: INTERVIEW SCHEDULE GUIDE

QUESTIONS THAT WILL BE ASKED DURING THE SEMI-STRUCTURED INTERVIEW.

1. Central Question

Describe the effects HIV/AIDS has on your socio-economic status?

2. Probing questions

- Can you please describe the involvement of your family and friends in your care and well-being?
- Can you describe the changes you are encountering with your social life?
- Explain the total income of your household.
- Describe the living conditions of your household which include the following:
 - The type of a house you reside in and the space availability in terms of rooms.
 - How many people are you living with in the house, their ages and your relationship with them?
 - Describe the type of food that you eat.

ANNEXURE D: INTERVIEW TRANSCRIPT

Age: 47 years
Gender: Male
Marital status: Single
Number of children: Three
Education: Grade 12
Employment history: Employed
Household income: R1200
Living conditions: Average
House size: Four rooms

CENTRAL QUESTION

- Describe the effect HIV/AIDS has on your socio-economic status?

It was difficult for me because I was unable to disclose my status to my children. It came a time where I told myself I have to accept my status then I will be able to disclose my status and be able to socialize with community members like I used to. I was unable to work like I used to and I could see that my children suspect that am infected then I disclosed to them and they accepted me as their mother. As for working I am unable to work as I used to because I am always tired.

PROBING QUESTIONS

R-Researcher

P-Participant

R- Can you please describe the involvement of your family and friends in your care and well-being?

P- My family is so much involved

R- How?

P- By helping when am sick they are able to take care of me by cooking for me and always making sure that I eat something.

R- “mmm”

P-They also help by reminding me to take treatment at the right time. When I am seriously sick they are able to come and take me to the hospital or clinic for help. None of my friends is involved because they afraid of being infected.

R- Can you describe the changes you are encountering with your social life?

P- I am a known osteoarthritis patient on treatment so I just told myself that they will assume that am going to the clinic to collect my monthly treatment.

R- “I see”

P- I did not experience any social changes in my life.

R- Explain the total monthly income of your household

P- Two grand children are getting child support grant (R500), one is doing internship and the other one is working piece jobs. I also work as a maid and get paid R700.

R- Describe the living conditions of your household which includes the following:

R-The type of a house you reside in and the space availability in terms of rooms

P-I live in RDP house which have four rooms, two bedrooms, one dining room and one kitchen.

R-How many people are you living with in the house, their ages and your relationship with them?

P-Am staying with my three grand-children

Grandson-7years

Granddaughter-3years

Granddaughter-2years

R-Describe the type of food that you eat

P-Most of the times I eat pap and fish, meat or eggs and am able to buy fruits and vegetables at least once a month when I get paid.

ANNEXURE E: CODING REPORT

FOR: SEKGOKA B. M.

DATE: 2012-06-14

STUDY: THE EFFECTS OF HIV AND AIDS ON THE SOCIO-ECONOMIC STATUS OF HIV AND AIDS INFECTED PEOPLE IN THE CAPRICORN DISTRICT OF THE LIMPOPO PROVINCE, SOUTH AFRICA

BY: Prof S. M. Maputle

Method: Tesch's open coding technique (in Creswell, 1994:155-156) was used by following the steps below:

- The researcher got a sense of the whole by reading all transcripts carefully, and jotting down all ideas that came to mind.
- Picked up one interview; the shortest, interesting one and went through it while asking: "What is this about?" thinking about the underlying meaning in the information. Again, any thoughts which came to mind were jotted down in the margin.
- When the researcher had completed this task for several participants, a list was made of all the topics. Similar topics were clustered together and formed into columns that were arranged into major topics, unique topics and exceptions.
- The list was compared with the data. The topics were abbreviated as codes and the codes were written next to the appropriate segments of the text. It was verified against a preliminary organising scheme to see whether new categories and codes emerged.
- The most descriptive wording for the topics was turned into categories. Reduction of the total list of categories by grouping together topics that related to each other was done. Lines were drawn between categories to show interrelationships.
- The final decision about the abbreviations for each category was made and the codes were listed alphabetically.

- The data belonging to each category were assembled in one place and a preliminary analysis was performed.
- Existing data were recorded and the final themes and sub-themes were recorded.

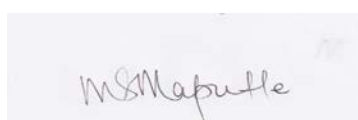
Themes and sub-themes reflecting the effects of HIV and AIDS on the socio-economic status of HIV and AIDS infected people in the Capricorn District of the Limpopo Province, South Africa

Central storyline: Participants shared the different experiences in terms of their socio-economic circumstances after they had tested HIV-positive. These circumstance were described in relation to several matters that included the involvement of the family and friends in their care, changes encountered that affected their social life, household income, and lastly their living conditions. On the one hand, experiences emerged that reflected a dominant story of perceived constraints in relation to financial burden experiences which resulted in a lack of nutritious food and appropriate housing. On the other hand, participants shared the positive aspects about their family members and friends who were providing care and support while reminding them to take their ARVs and providing food when the need arose.

Main themes	Sub-themes
1. Different sources of income for HIV-positive people.	1.1 Government Child Support Grant serves as a source of income. 1.2 Working children provide financial support to infected parents. 1.3 Responsibilities versus rights of HIV- positive people in relation to financial support of their families.
2. Living conditions of HIV-positive people.	2.1 Appropriate versus inappropriate residential areas. 2.2 Financial constraints lead to unavailability of well-balanced food.

	2.3 HIV-positive people reside with family members.
3. Consequences of HIV and AIDS disease progression.	<p>3.1 Inability to work due to disease progression.</p> <p>3.2 Retrenchment from employment due to decreased ability to perform daily duties.</p> <p>3.3 Self-discrimination and stigmatisation.</p> <p>3.4 Rejection by family, friends, and community members.</p> <p>3.5 Fear of rejection by family, friends and, community members.</p> <p>3.6 Life style changes.</p>
4. Support and care to HIV-positive people.	<p>4.1 Support versus lack of support for HIV-positive people.</p> <p>4.2 Reliability of treatment by supporters.</p>
5. Disclosure versus non-disclosure of HIV-positive status.	<p>5.1 Lack of disclosure leads to emotional burdens.</p> <p>5.2 Fear of disclosure.</p> <p>5.3 Acceptance of HIV-positive status is determined by time.</p>

Saturation of data was achieved related to the major themes and most sub-themes.



Prof S. M. Maputle

ANNEXURE F: CERTIFICATE FROM INDEPENDENT CODER

Qualitative data analysis

Master of Curationis degree (Nursing Science)

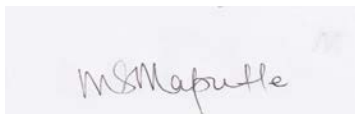
B. M. SEKGOKA

THIS CONFIRMATION CERTIFIES THAT:

Prof Maria Sonto Maputle has co-coded the following qualitative data:

10 Individual interviews and field notes for the study: "The effects of HIV and AIDS on the socio-economic status of HIV and AIDS infected people in the Capricorn District of the Limpopo Province, South Africa".

I declare that the candidate and I have reached consensus about the major themes reflected by the data during a consensus discussion. I further declare that adequate data saturation was achieved as evidenced by repeating themes.



Prof Maria Sonto Maputle

ANNEXURE G: CLEARANCE CERTIFICATE

UNIVERSITY OF LIMPOPO Medunsa Campus



MEDUNSA RESEARCH & ETHICS COMMITTEE

CLEARANCE CERTIFICATE

MEETING: 07/2010

PROJECT NUMBER: MREC/H/184/2010: PG

PROJECT :

Title: The effects of HIV and AIDS on the socio-economic status on HIV and AIDS infected people in the Capricorn District Limpopo Province, South Africa

Researcher: Ms BM Segoka
Supervisor: Mrs TM Mothiba
Co-supervisor: Dr RN Malema
Other Involved HOD: ME Lekhuleni
Department: Nursing Sciences – Turfloop Campus
School: Health Sciences
Degree: MCur

DECISION OF THE COMMITTEE:

MREC approved the project.

DATE: 09 September 2010


PROF GA OGUNBANJO
CHAIRPERSON MREC



Note:

- i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
- ii) The budget for the research will be considered separately from the protocol. PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

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ANNEXURE H: PERMISSION TO CONDUCT RESEARCH



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH & SOCIAL DEVELOPMENT

Enquiries: Selamolela Donald

Ref: 4/2/2

26 October 2010
Sekgoka B.M
Box 313
Trichardstal
0890

Dear Madam

Re: Permission to conduct the study titled: The effects of HIV and AIDS on the socio-economic status on HIV and AIDS infected people in the Capricorn District Limpopo Province, South Africa

1. The above matter refers.
2. The permission to conduct the above mentioned is hereby granted.
3. Kindly be informed that:-
 - Further arrangement should be made with the targeted institutions.
 - In the course of your study there should not be any action that will disrupt the services.
 - After completion of the study, a copy should be submitted to the Department to serve as a resource.
 - The researcher should be prepared to assist in the interpretation and implementation of study recommendations where possible.

Your cooperation will be highly appreciated.



Head of Department
Health and Social Development
Limpopo Province

Private Bag x 9302 Polokwane.
18 College Str. Polokwane 0700. Tel.: (015) 293 6000 Fax: (015) 293 6211 Website: <http://www.limpopo.gov.za>

The heartland of Southern Africa - development is about people!

ANNEXURE I: EDITING CONFIRMATION



* The stars that tell the spade when to dig and the seeds when to grow*
* Isilimela – iinkwenkwezi ezixelela umhlakulo ukuba mawembe nembewu ukuba mayikhule*

P O Box 65251

Erasmusrand

0165

05 February 2013

Dear Ms Sekgoka

CONFIRMATION OF EDITING YOUR DISSERTATION WITH THE TITLE THE EFFECTS OF HIV AND AIDS ON THE SOCIO-ECONOMIC STATUS OF HIV AND AIDS INFECTED PEOPLE IN THE CAPRICORN DISTRICT OF THE LIMPOPO PROVINCE, SOUTH AFRICA

I hereby confirm that I have edited the abovementioned dissertation as requested.

Please pay particular attention to the editing notes AH01 to AH15 for your revision.

The tracks copy of the document contains all the changes I have effected while the edited copy is a clean copy with the changes removed. Kindly make any further changes to the edited copy since I have effected minor editing changes after removing the changes from the tracks copy. The tracks copy should only be used for reference purposes.

Please note that it remains your responsibility to supply references according to the convention that is used at your institution of learning.

You are more than welcome to send me the document again to perform final editing should it be necessary.

Kind regards



André Hills

083 501 4124