LIMPOPO

PROVINCIAL GOVERNMENT

REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF

HEALTH AND SOCIAL DEVELOPMENT

Socio-economic Impact of HIV and AIDS on Population and Development in Limpopo Province

2006

The Heartland of southern Africa - development is about people

FOREWORD BY THE MEC

Since 1994, the Government of South Africa has made tremendous progress towards the emancipation of poor people. This bears testimony through various initiatives by Government to improve people's access to basic services particularly public health care. While we have a lot to show as points of success in this regard, the positive strides we have made stand to be eroded by the scourge of HIV and AIDS. It is in recognition of the possible reversal of the achieved success that the Department of Health and Social Development undertook a study to explore the Socio-economic Impacts of HIV and AIDS in Limpopo Province.

The study report reflects the improvements in communities' access to basic services. What is particularly disturbing is the high degree of stigma associated with HIV and AIDS among communities in Limpopo province. In spite of the numerous initiatives through public – private partnerships to educate communities on issues around HIV and AIDS, stigmatization of people infected and affected by HIV and AIDS is reportedly still high. Close to 90% of the people in Limpopo province rely on public hospitals and clinics for their health needs. Stigmatization of people infected by HIV and AIDS worsens the burden on health care services as people fail to make use of existing services which would prolong their lives as healthy people. They end up in hospitals as terminally ill patients which defeats the efforts put in place through public – private partnerships.

Publication of this report provides an opportunity for government and the private sector to revisit the implementation of existing programs, particularly the intensification of efforts around information, education and communication on HIV and AIDS issues.

I sincerely hope that the public–private partnerships will heed the report's recommendations in their programme appraisal. I therefore urge all stakeholders to make use of this report to improve service delivery for the improvement of quality of life in Limpopo Province.

MR SEAPARO SEKOATI
MEMBER OF EXECUTIVE COUNCIL

FOREWORD BY THE HOD

The research report on the "Socio-economic Impacts of HIV and AIDS in Limpopo Province" has been produced. The main objective of conducting this research was to update available information on the demographic and socio-economic impacts of AIDS on households and communities. Available baseline demographic and socio-economic context of AIDS and its impacts in the province has been unfolded. To get a clear understanding of the reciprocal nature of the impact of HIV and AIDS, and emphasis was put on identifying the impacts of AIDS and AIDS interventions from the perspectives of those who experience those impacts, namely, households and communities. Attention was also paid to public sector institutions which are the main channel for delivery of official anti-AIDS interventions to households and communities.

The study provides a wealth of empirical data which can be further explored for academic research and, policy review on part of the provincial Government of Limpopo. The study finds amongst others, a high degree of stigma associated with HIV and AIDS among communities in the province. This needs to be acted upon if existing policies and programs around HIV and AIDS are to be successful.

Publication of this report provides an opportunity for government and relevant stakeholders to review existing programs and to take the necessary steps to address the issues recommended by the study.

We therefore urge all stakeholders within and outside government to make good use of the report.

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DR. J. DLAMINI
HEAD OF DEPARTMENT

Date: 12/02/2007

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EXECUTIVE SUMMARY

1. INTRODUCTION

This study investigated the socioeconomic impacts of AIDS on population and development in Limpopo province. Its main objective was to update available information on the demographic and socio-economic impacts of AIDS on households and communities.

It was implemented in two interrelated parts. In the first part, the study focused on producing and updating available baseline data for understanding the demographic and socioeconomic context of AIDS and its impacts in the province. This component of the study highlighted areas of human and social development being impacted by HIV and AIDS in the province.

The second part of the study placed an emphasis on identifying the impacts of AIDS and AIDS interventions from the perspectives of those who experience those impacts, namely, households and communities. Attention was also paid to public sector institutions which are the main channel for delivery of official anti-AIDS interventions to households and communities.

A combination of various research methods was used to achieve the study objectives. These include (i) a household survey involving collection of quantitative information from a representative sample of 3400 households from all districts in the province, (ii) focused group discussion sessions with different sub-groups of the provincial population, (iii) collection and analysis of sectoral input from various provincial Departments, and, (iv) collection and analysis of secondary data from the wider research and policy community on the subject of socioeconomic impacts of AIDS. Field work for the study was conducted between November 2005 and May 2006.

As a baseline study, the scope of this project was limited to the production and descriptive presentation of data. As much as possible the neutrality that is defined by this scope is adhered to in the presentation of this report. This makes it possible for planners and researchers to use the data to address as many questions as possible on AIDS impacts without encountering interpretative biases in the baseline report.

2. GENERAL STUDY FINDINGS

The general findings in relation to the issues that were focused upon in the study are as follows:

2.1 Baseline data produced

As was indicated earlier, this study set out to update available information about the demographic and socio-economic impacts of HIV and AIDS in Limpopo province. This objective was achieved in the form of a database containing a wealth of fresh empirical data at the household and community levels. With these data, policy makers and planners are in a better position to understand and handle challenges about the context and impacts of AIDS. The quantitative data have been packaged in an electronic format that is suitable for distribution and use by all analytical software systems.

2.2 The context of AIDS impacts in Limpopo Province

This study found that most affected individuals, households and communities experience AIDS's impact in a context of poverty and general socioeconomic vulnerability. Their reactions to the epidemic are severely constrained by the existing burden of poverty.

The survival strategies devised by or for affected people pass through the grids of harsh realities of the interplay of AIDS and poverty. Thus, the situation in Limpopo province is a good example of conflation of the dynamics of poverty and the impacts of AIDS. This is what makes the AIDS epidemic one of the most dangerous threats to human and socioeconomic development for Limpopo Province.

2.3 AIDS impacts and interventions

AIDS continues to exert serious impacts which contribute negatively to human and social development in the province. AIDS attacks the demographic stock for human development in the province. A high proportion of AIDS deaths occur to people in economically active age groups. Furthermore, its demographic impacts are seen across all segments of the population including the following:

(i) an increase in the number of orphans and vulnerable children,

(ii) an increase in the number of households headed by substitute heads who are economically insecure,

(iii) an increase in the burden of household economic support on women, and,

(iv) a reduction in household based economic support for the elderly population as a result of the death of an income-earning head.

At the same time, the AIDS epidemic fights the ability of the provincial government to mount sustained and effective AIDS intervention programmes for the benefit of affected individuals, households and communities. Data collected in this study highlight various constraints faced by Departments as a result of AIDS.

2.4 AIDS related stigma

2.4.1 One of the most disturbing findings of this study is the high degree of stigma that remains associated with HIV and AIDS in the province. This is one of the central intervening problems in understanding the impacts of AIDS on individuals, communities and public sector institutions.

2.4.2 Individuals and households affected by AIDS lose almost all their existing personal and community support networks because of the high level of stigma associated with the epidemic.

3. DEMOGRAPHIC AND SOCIOECONOMIC CONTEXT OF AIDS

The results presented in this section were produced for two reasons. Firstly, following the aim of the study, these results contain data that update or compliment existing demographic, health and social development indicators for the province. Secondly, they are produced as an empirical description of the context of AIDS and its impacts in Limpopo Province. Although the database that resulted from the study contains many variables, only selected indicators that easily relate to the impacts of AIDS on the provincial population are highlighted here.

3.1 Demographic profile

Official demographic estimates show that Limpopo province has a total population of 5.4 million. The population profile shows that there are more females than males in rural and

urban areas, and in all districts of the province. A significant reduction is observable in the proportion of both males and females in the youngest age group. Another significant demographic feature of the population is the relatively large proportion of adults, particularly males, who have never been married.

3.2 Childbearing patterns

In comparison to other provinces, the average number of children for women in their child bearing ages remains high. The estimated total fertility rate for Limpopo Province is 3.12, with the peak of child bearing occurring in the 30-34 age groups. The data confirm a continuing downward trend in fertility in the province despite an unfavorable socioeconomic environment.

3.3 Mortality and longevity

Infant mortality rate is one of the most sensitive indicators of health and socioeconomic development. The rate of infant mortality estimated from this study is 41.7 per thousand. This is higher than the level of 37.2 and 34.7 which were estimated for 1998 and 2004 respectively. The official estimate of life expectation at birth is just above fifty years.

3.4 Educational status

About 15% of the population has never attended a formal school. Most people with more than matric education are found in urban areas.

3.5 Work status

Overall, 46% of the adult population is not currently working. Sub groups with relatively high proportions of non-working population include females and people living in rural areas.

3.6 Household size and relationships

The average number of people per household in 2006 is 4.3. Heads of households are 46% female. Less than half of them (49%) are currently married. Only 29.7% of household heads have matric or higher level of education; 35.7% of households' heads are currently working.

3.7 Type of dwelling

Stand-alone houses and traditional houses are the main types of dwellings for most households in the province. Most houses have cement floors and plastered walls.

3.8 Ownership of facilities

Most households own a radio (79.1%). Many own television (65.3 %), any type of phone (72.8%), and refrigerators (56.5%). Cars and computers are not widely owned by households in the province.

3.9 Sources of energy

Electricity is the principal source of energy for lighting in the province. It is used by more than eighty percent of the households for this purpose; 40% of the households use electricity for cooking and another 40% use firewood for cooking. Wood and straw are the main sources of energy for heating, followed by electricity.

3.10 Economic status

More than half of all households in the province consider themselves poor or very poor. Just over half of all households reported that they receive government grants. The reported income groups for many households cluster around very low levels, and in some cases are lower than reported household expenditure.

In summary, the demographic and socioeconomic profile of the province continues to exhibit a society with a high level of poverty. The demographic and socioeconomic profile reinforces the poverty context for understanding the impacts of AIDS on the population. There is a large population in the working age group who are not steadily and gainfully employed. Consequently, sufficient wealth is not generated at the household level in order to put members on an upward path to human and social development.

Demographically, there are indicators of change in reproductive behaviour. However, the province remains among the high fertility provinces in the country. The infant mortality rate appears to have increased in the past five years. Although some indicators of social development show important improvements vis-a-vis millennium development goals, the general socioeconomic picture remains that of a society in which development challenges are being complicated by the impacts of AIDS.

4. DEMOGRAPHIC AND HEALTH IMPACTS

The study examined key indicators that are commonly used to determine the demographic and socioeconomic impacts of AIDS. It was found that AIDS distorts the age and sex structure of the provincial population; obviously the epidemic contributes to increases in mortality and morbidity in the population. Overall, AIDS impacts appear responsible for the observed inconsistency in the trend in infant mortality.

4.1. An increase in household morbidity and mortality

It was found that HIV and AIDS related morbidity and mortality tend to cluster in households. This is particularly true in poorer households. If due to poverty, a household is unable to afford external medical care; household members are forced to play a role of care giver for which they are not properly trained. In the process, they are likely to be exposed to opportunistic infections, which lead to increased morbidity and mortality in the household.

4.2 AIDS related sickness in the household

Despite the problems associated with reporting sensitive and rare events in sample surveys, 11.4% of households reported that they had sick people, and 6.4% reported that they had very sick people, in the past year.

4.3 Reported deaths due specifically to AIDS

It was found that people are generally reluctant to talk about deaths in their households especially if such deaths are related to AIDS. In such a situation, it is not surprising that only one percent of households reported a death that was specifically due to AIDS during the past 12 months.

5. SOCIOECONOMIC IMPACTS ON HOUSEHOLD

The study found that HIV and AIDS have several direct and indirect impacts which threaten the stability and functionality of the household as a basic unit for human and socioeconomic development.

5.1 A reduction in household economic status

Death of economically active people in the household due to AIDS leads to a disruption in the income generating activities of household members. Usually, following an AIDS-related death of a principal breadwinner in the household, major changes occur in household economic status. The replacement 'breadwinner' may not have sufficient levels of skills and training to maintain stable and gainful sources of employment for the household. Some members of the household stop working, while others experience serious disruptions in their regular income-generating activities. The problem is more acute in households with self-employed individuals.

5.2 An increase in household expenditure

An obvious direct economic impact of HIV and AIDS is an appreciable increase in general household expenditure as the household tries to adjust to nutritional and general changes in day to day living patterns of both the persons who are HIV positive and those living with AIDS. In particular, progression of AIDS-related illnesses leads to an increase in household medical expenditure.5.3 Educational disadvantage for young people

In many affected households, HIV and AIDS lead to educational disadvantage for young people whether or not they themselves live with AIDS. As the economic and psychological burden of AIDS related illnesses increase on household members, issues such as schooling for young people take a low priority. Younger members of the households start missing regular schooling, and are more likely to drop out of school altogether temporarily or permanently. Depending on whether or not the illness or death occurred to the head of the household, younger members are sent to live with other related or non-related households. In some cases, these young people are forced to undertake economic activities that they would not ordinarily be required to perform in order to support the family.

6. SOCIO-ECONOMIC IMPACTS IN THE COMMUNITY

Generally, the results of the study show that the HIV and AIDS epidemic introduces deep strains in social relations and communal solidarity which are not conducive for human and socioeconomic development. In economically fragile communities of Limpopo province, AIDS subverts the development potential and aspirations of the people. Specific areas of socioeconomic impacts identified in the course of the study area as follows:

6.1 AIDS threatens the medium term and long term supply of local human resources for the development of Province.

6.2 AIDS is resulting in a restructuring of the provincial socio-demographic profile by producing a substantial increase in economically dependent population in the province, including,

(a) Orphans, who if they survive, experience hazardous transition into adulthood with little or no economic security as orphans and vulnerable children.

(b) Widows, who already bear a disproportionate burden of poverty and gender discrimination in allocation of economic burdens and privileges in the household and community, and,

(c) The elderly, whose social and health conditions make them more vulnerable than others in the community.

6.3 AIDS impacts seriously on the public sector in Limpopo Province. Government departments raised and emphasized the point that AIDS impacts negatively on their ability to provide services to individuals, households and communities in the Province.

7. COMMUNITY PREVENTION, CARE AND SUPPORT ACTIVITIES

7.1 Community AIDS prevention activities

Many community respondents indicated that their communities have done something to prevent AIDS. Specific AIDS preventive actions undertaken by communities include school-based and community-based educational programmes, condom distribution and provision of voluntary counseling and testing facilities.

7.2 Illness-related care and assistance

The study found that many communities have care and support networks for individuals and households affected by AIDS. Community hospitals, friends, relatives and churches are particularly involved as agents of care and support for people who are affected by AIDS. Community members who become ill with AIDS turn overwhelmingly to hospitals or clinics for care (84.5%). Other places that offer some assistance include traditional healers (18.8%), churches (17.7%), non-governmental organizations, especially AIDS organizations (14.7%) and family members (10.8%).

7.3 Types of assistance to AIDS affected households

The most common forms of assistance given to AIDS-affected households in communities within the province include counseling, monetary assistance, food; help with child care, free medicine and home-based care. Some community members perceive and quantify the assistance to AIDS-affected households in monetary terms.

7.4 Value of assistance offered by different organizations

The various sources of care and support received by affected individuals are not equally valued. Assistance from family members remains most highly valued, followed by assistance from government health facility staff, friends and neighbours.

8. RECOMMENDATIONS

Since the early 1990s, there has been many studies, recommendations and declarations on AIDS at the national and provincial levels. Several consultations have been undertaken in order to mainstream HIV and AIDS in the provincial growth and development strategy.

It is not the intention here to simply repeat any of the recommendations that have already been made or are already at different stages of implementation in the province. In line with the study approach, only three recommendations are put forward.

8.1. Recommendation 1

In the light of the findings of this survey which show among other things that households and communities expect particular models of AIDS intervention at the household and community levels, it is recommended that the Department of Health and Social Development implements realignment reviews of existing projects in the province, starting with those directly implemented by the Department of Health and Social Development.

8.2. Recommendation 2

It is recommended that the Department of Health and Social Development should undertake a new wave of public education campaign against stigma and discrimination. This new wave of public education campaign should directly target communities. It should be culturally and socially grounded, and should focus on day to day issues and practical experiences of people affected by HIV and AIDS in Limpopo communities.

8.3. Recommendation 3

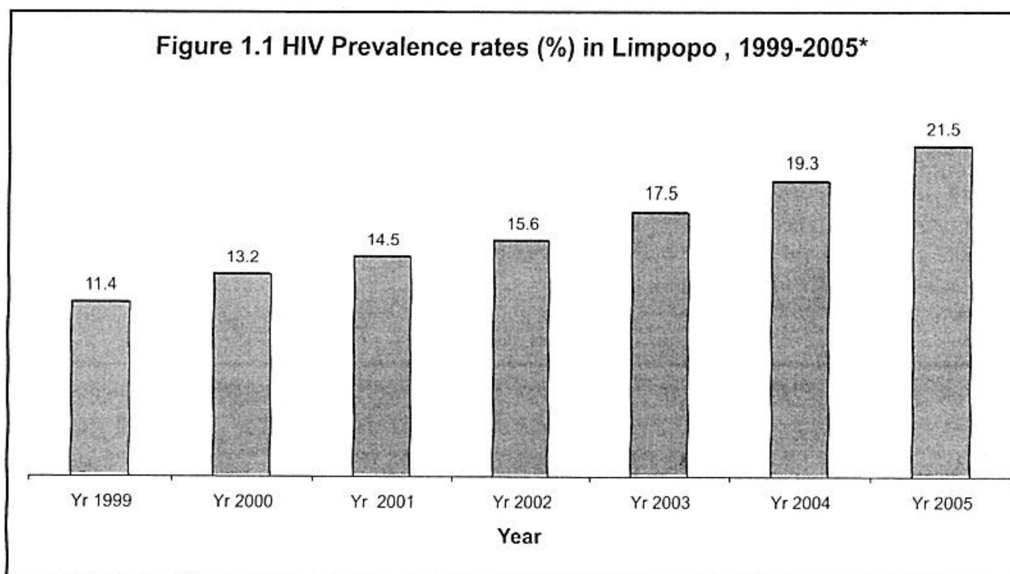
The Department of Health and Social Development should investigate the possibility of establishing a new and direct HIV and AIDS assistance grant.

INTRODUCTION

1.1. BACKGROUND

This study was designed to update information on the demographic and socio-economic impacts of HIV and AIDS in the province. The problems of HIV and AIDS in the province have been far-reaching. Despite determined efforts by the provincial government and several other development partners, there remain challenges of population, development and poverty which are exacerbated by the AIDS epidemic. Existing information on the prevalence of HIV (compiled from several annual sero-prevalence surveys conducted by the National Department of Health; see Figure 1.1) suggests that AIDS will remain one of the major development challenges in the province in the foreseeable future. Up-to-date baseline population data are lacking. As a result, planners are faced with problems of trying to understand AIDS impacts with scanty and in most cases indirect statistics.

Relative to most other provinces, the population profile of Limpopo province still to a large extent reflects several demographic features that tend to negate the best of efforts in development interventions. Whereas some of the critical demographic variables that affect development may be showing favourable rates in a number of other provinces and nationally, these remain major problems in Limpopo province.



The Provincial Growth and Development Strategy (PGDS) has provided a unified vision and comprehensive sets of strategies for development in the years to come. However, the success of the various interventions envisioned in the Provincial GDS will, to a very large extent, depend on how well the impacts of AIDS are understood and mitigated. This study was aimed to produce baseline data to guide and facilitate successful implementation of interventions against HIV and AIDS in the province.

THE STUDY

The objective of this study was to provide baseline data on the current socioeconomic and demographic situation which will unearth the socioeconomic impacts of the HIV/AIDS epidemic. The study was implemented in two interrelated parts. The first part focused on producing and understanding the demographic and socioeconomic profile that defines the context in which the problems of AIDS impacts are discussed. A baseline survey was conducted with an aim to provide and update available information in critical areas of socioeconomic and health status in the province. The survey involved collection of quantitative information from a representative

sample of 3400 households from all districts in the province.

Secondly, original and secondary qualitative data were collected. Focus Group Discussion (FGD) sessions were conducted with different segments of the population in different districts. The subgroups included formal rural dwellers, formal urban dwellers, informal urban dwellers, dwellers in farms and immigrant populations. Lastly, information was collected from government departments in the province about their perceptions, challenges and intervention activities against HIV and AIDS.

THE SAMPLE

The survey was designed to use a two-stage probability sample drawn from the most recently available STATSSA complete census data for the province as the sample frame. The sample was self-weighting with respect to rural and urban, and district compositions of the provincial population. In the first stage of selection, 160 enumeration areas were selected. An initial planned sample size of 3000 was increased by just over 17% in order to achieve sufficient number of cases for sub-group analysis on certain key variables. The total target sample was 3520 households.

A summary of the sample distribution is presented in Figure 1.2 and Table 1.1

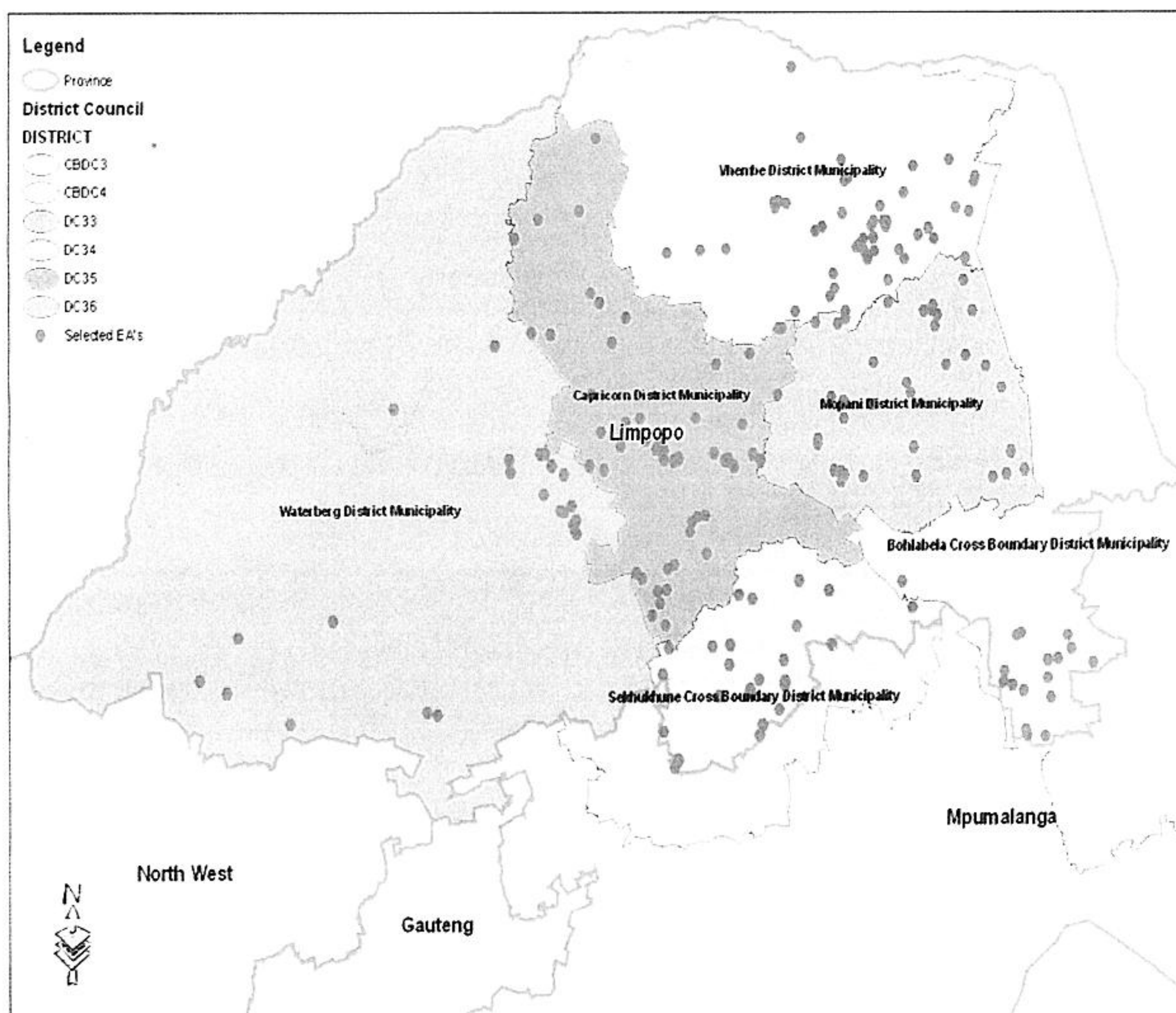
- A total of 10 465 Enumeration Areas (EAs) were identified in the Limpopo province.
- Type of EAs excluded were those listed as vacant (660), recreational areas and institutions including hostels and all others not classified.
- After eliminating known EAs listed as empty from the database, a total of 9562 remained.
- In the first stage, 160 enumeration areas were selected.
- In the second stage, 22 dwelling units were selected from each of the 160 EAs in the sample - yielding a target of 3520 dwelling units.
- Information was collected about all individuals and households in the targeted dwelling units throughout the province.

Table 1.1: Target and achieved sample households, Limpopo Province, 2006

Sample characteristics	Target sample size	Achieved sample size	Response Rate (%)
District			
Bohlabela	320	291	90.9
Capricorn	886	848	95.7
Mopani	640	613	95.8
Sekhukhune	515	514	99.8
Vhembe	806	804	99.7
Waterberg	353	330	93.5
Type of place of residence			
Rural	2792	2701	96.7
Urban formal	454	442	97.3
Urban informal	110	102	92.7
Farm areas	164	155	94.5
All Limpopo Province	**3520**	**3400**	**96.5**

IMPLEMENTATION

Fig 1.2. Spatial distribution of the EAs included in the survey sample



Training of Fieldworkers

The main training of field workers took place in the two weeks from 18 September to 30 September 2005. Various training approaches were considered based on previous experiences. Finally a decentralized approach was adopted. Local people were recruited to complement existing staff and associates of Africa Strategic Research Corporation. Together with the newly recruited field workers, dedicated staff members for the project were trained in the specific districts they worked in. This approach ensured that only those who are genuinely local to particular districts, who are familiar with the area and who are experienced, were deployed to each district. The training sessions served to provide detailed explanations and training to field workers and all members of the field team. Areas in which they were trained for field work included the correct expected data, quality checks in the field as well as other field interviewing techniques for sensitive economic, sexual and reproductive health questions, and especially questions concerning different ramifications of HIV and AIDS.

Pilot Study

The study design, questionnaires and implementation procedure were tested in a pilot study in September 2005. The pilot study was conducted in enumeration areas of the following selected three districts (Sekhukhune, Waterberg and Capricorn). Aspects of the survey process piloted included the nature and phrasing of questions, accessibility of households included in the sample, rules for selecting respondents in a household, questionnaire length and duration of

interviews, ability of interviewers to complete the required number of questionnaires in a day, how supervisors maintain quality control, storage and transport of completed questionnaires.

Data Collection

Data collection commenced after training and de-briefing of the field work team after the pilot study. Field workers were provided with sufficient aids to locate the enumeration areas and the households selected for interview. Interviewers and field workers collected data using the specified questionnaires and other qualitative instruments designed for such purposes. Interviews of eligible women in the sample were conducted by female field workers. Interviews of eligible men in the sample were conducted by male field workers. Interviews were conducted in the language preferred by the respondent. The enumeration areas included in the sample design were easily identified during field work. Field supervisors were provided with new maps. There were instances where maps were not clear. In a few cases, enumeration areas were difficult to access due to bad roads or rain. Field work for the different components of the study was conducted between November 2005 and May 2006.

Post Survey Checks

Field monitors involved in quality control made call back visits to 2% of the households included in the sample in order to ascertain the conduct and quality of household interviews.

Response Rates

A response rate of 96.5% was achieved in this survey. The response rates were higher in Sekhukhune and Vhembe districts and slightly lower in Bohlabela and Waterberg (See Table 1.1). Reasons for not completing the questionnaires included refusal, absent households, postponement of interviews and non-availability of an eligible respondent.

Data Processing and Analysis

Completed questionnaires were processed at the Africa Strategic Research Corporation offices in Johannesburg. Office editors checked questionnaires for completeness and consistency before data entry. Whereas the most important quality check was at the stage of data collection in the field, office editing was carefully done to detect and remove errors at this stage. The data processing and analysis were done using different modules of SPSS and other specialized software. The data sets have been prepared in formats that can be used by all analytical software systems.

Basic Characteristics of the Sample

The resulting sample is shown by district and type of place of residence in Table 1.2 below.

Table 1.2 Basic characteristics of the sample; Limpopo Province, 2006

Sample characteristics	%	N
District		
Bohlabela	8.6	291
Capricorn	24.9	848
Mopani	18	613
Sekhukhune	15.1	514
Vhembe	23.6	804
Waterberg	9.7	330

Table 1.2 (continued) Basic characteristics of the sample; Limpopo Province, 2006

Type of place of residence		
Rural	79.4	2701
Urban formal	13	442
Urban informal	3	102
Farm areas	4.6	155
All Limpopo Province	**100**	**3400**

SCOPE AND STRUCTURE OF THIS REPORT

In this study, emphasis was placed on the experiences and perspectives of households and communities in understanding AIDS impacts and interventions. This emphasis was built into the study design and instruments. In effect, this study attempted to bring to the centre of attention, the very individuals, households and communities who experience these impacts and interventions.

Scope

As a baseline study, the scope of this project was limited to the production and descriptive presentation of the data. As much as possible the neutrality that is defined by this scope is adhered to in the presentation of this report. This makes it possible for planners and researchers to use the data to address as many questions as possible on AIDS impacts without encountering interpretative biases in the baseline report. The empirical results are presented for districts and type of place of residence. No detailed or comparative perspectives were introduced into these data. Advanced level statistical analysis of specific topics does not fall within the scope of this baseline report.

Structure

This report is presented in three parts as follows:

Part I: Demographic and socioeconomic profile

The first task was to examine and update key indicators used to understand the demographic and socioeconomic profile of the province in relation to the AIDS epidemic. These data include original data collected from the household survey and secondary information from other relevant sources.

Part II: AIDS impacts

The second part of the report focused on identifying the impacts of AIDS from the perspectives of those who themselves experience those impacts. These include demographic, social and economic impacts.

Part III: AIDS interventions

Part three presented results about AIDS interventions that were identified in communities. Results were presented on the type, sources and community assessment of these AIDS interventions.

PART I

SOCIO-ECONOMIC CONTEXT OF HIV AND AIDS IN LIMPOPO PROVINCE

2. DEMOGRAPHIC AND SOCIOECONOMIC CONTEXT OF HIV AND AIDS

The results presented in this section were produced for two reasons. First, following the aim of the study, these results contain data that update existing demographic, health and social development indicators for the province. Secondly, they are produced as an empirical description of the context of AIDS and its impacts in Limpopo Province. Although the database that resulted from the study contains many variables, only selected indicators that easily relate to the impacts of AIDS on the provincial population are highlighted here.

2.1 DEMOGRAPHIC CONTEXT

Population size, age and sex structure

Official demographic estimates show that Limpopo province has a total population of 5.4 million. The population pyramid (Figure 2.1) generated from the survey is quite similar to the expected patterns of the age and sex composition of the provincial population.

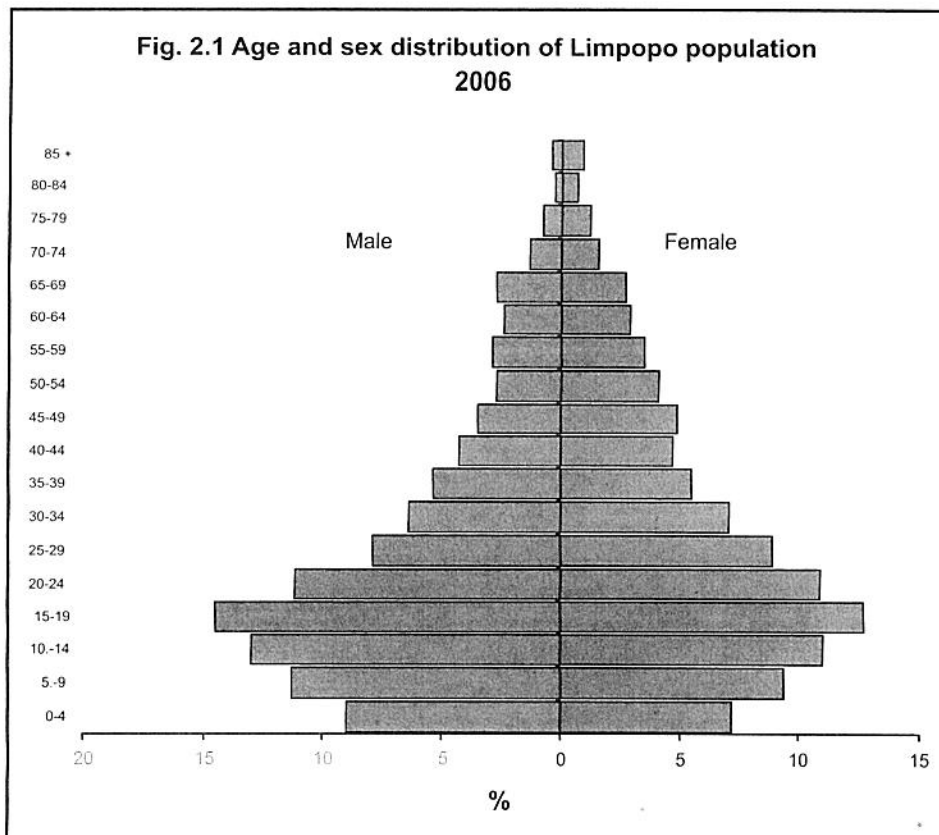
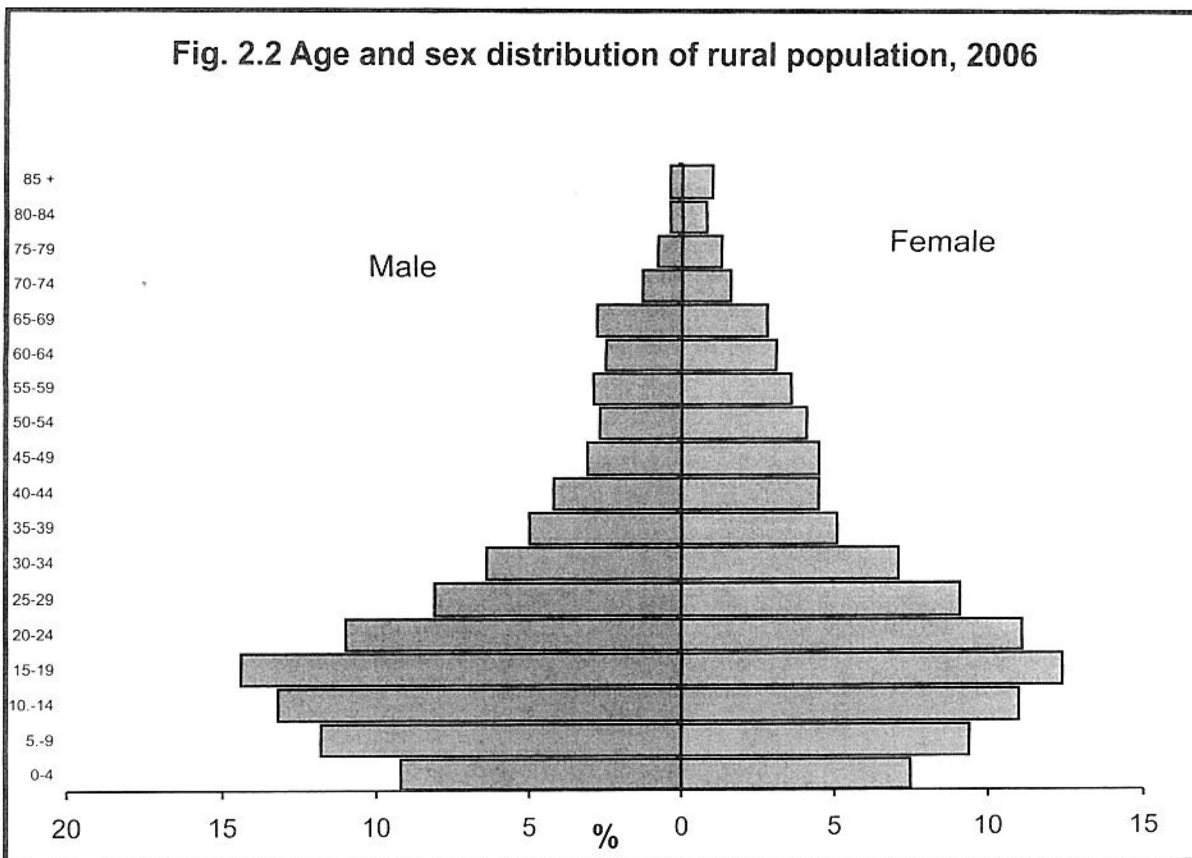
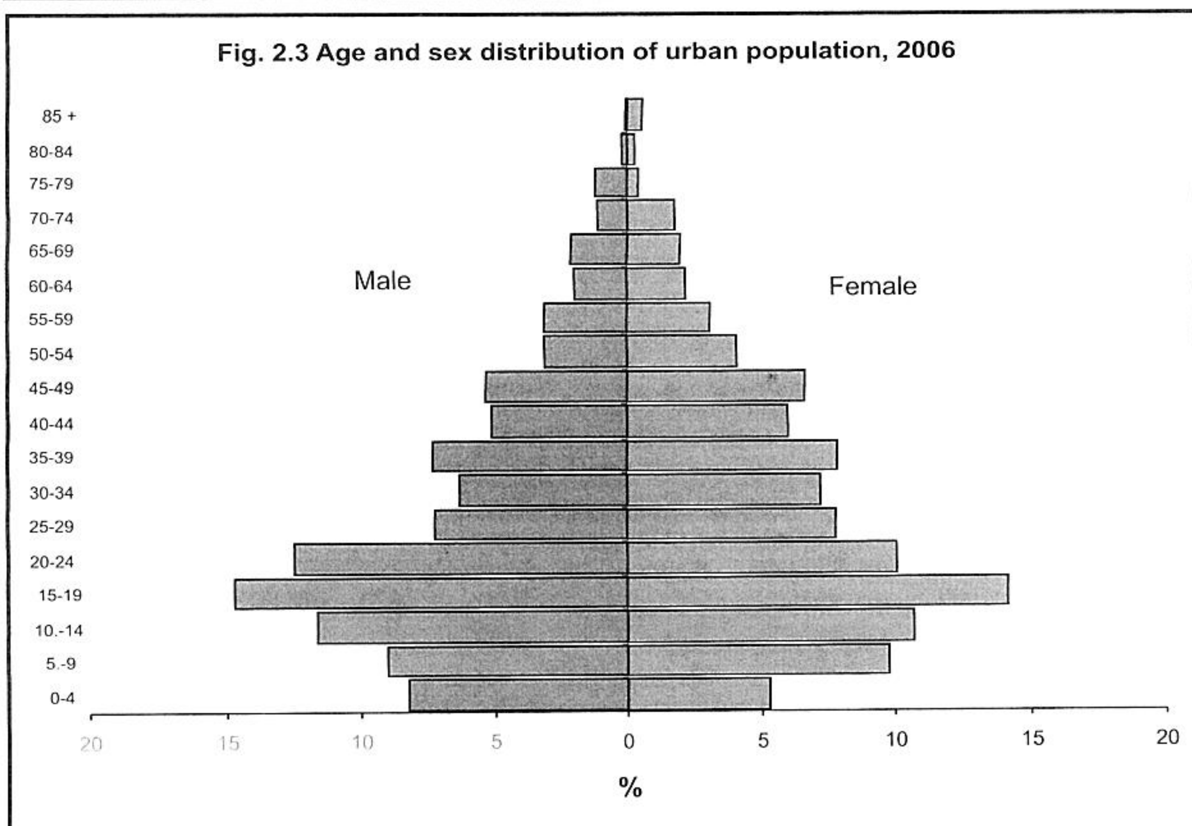


Fig. 2.1 Age and sex distribution of Limpopo population 2006





A significant reduction is observable in the proportion of both males and females in the youngest age group (Fig. 2.1).

There is a clear difference in the age and sex structure of the rural and urban populations. This is a relatively smaller number of children and young people in urban areas, compared to rural areas (Figure. 2.2 and Figure 2.3).

Table 2.1. Percent (%) age-sex distribution of the population: Limpopo province 2006

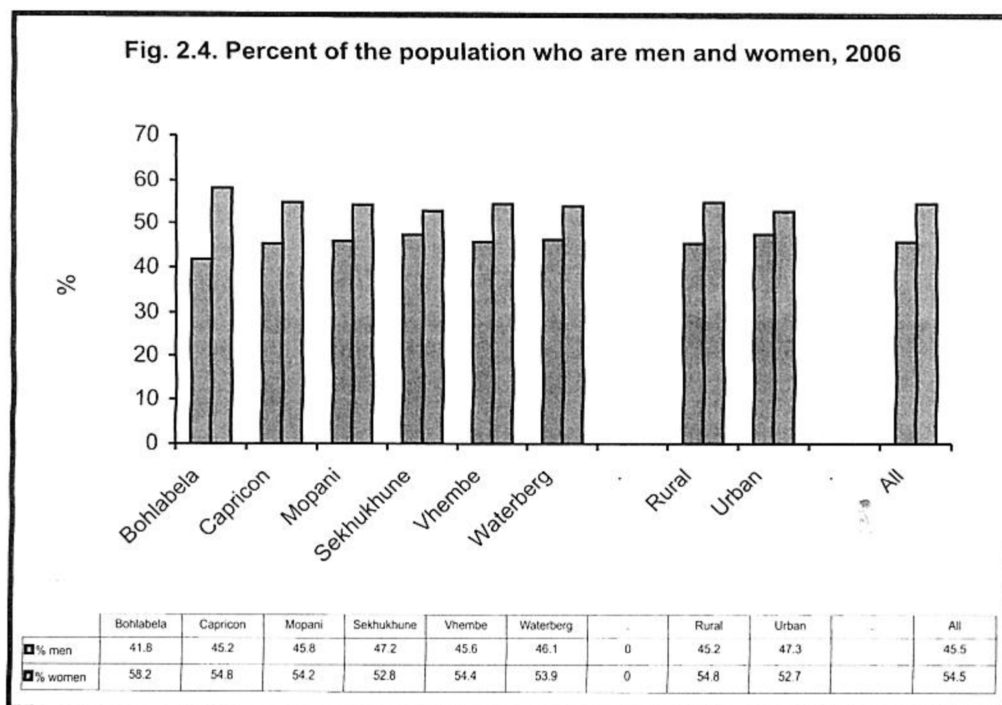
Age group	Place of residence				All		All
	Rural		Urban				
	Sex of person		Sex of person		Sex of person		
	Male	Female	Male	Female	Male	Female	
0 - 4	9.2	7.5	8.2	5.3	9.0	7.2	8.0
5 - 9	11.8	9.4	9.0	9.8	11.3	9.4	10.3
10-14	13.2	11.0	11.6	10.7	13.0	11.0	11.9
15-19	14.4	12.4	14.7	14.2	14.5	12.7	13.5
20-24	11.0	11.1	12.5	10.1	11.2	10.9	11.1
25-29	8.1	9.1	7.2	7.8	7.9	8.9	8.5
30-34	6.4	7.1	6.3	7.2	6.4	7.1	6.8
35-39	5.0	5.1	7.3	7.9	5.4	5.5	5.4
40-44	4.2	4.5	5.1	6.0	4.3	4.7	4.5
45-49	3.1	4.5	5.3	6.7	3.5	4.9	4.2
50-54	2.7	4.1	3.1	4.1	2.7	4.1	3.5
55-59	2.9	3.6	3.1	3.1	2.9	3.5	3.2
60-64	2.5	3.1	2.0	2.2	2.4	2.9	2.7
65-69	2.8	2.8	2.1	2.0	2.7	2.7	2.7
70-74	1.3	1.6	1.1	1.8	1.3	1.6	1.5
75-79	.8	1.3	1.2	.4	.8	1.2	1.0
80 -84	.4	.8	.2	.3	.3	.7	.6
85 +	.4	1.0	.1	.6	.4	.9	.7
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 2.2. Percent (%) distribution of the population by age and district: Limpopo province 2006

Age group	District						All
	Bohlabela	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	
0 - 4	10.6	7.6	9.9	7.6	7.0	6.4	8.0
5 - 9	12.5	9.2	10.9	10.4	10.7	8.9	10.3
10-14	11.7	11.8	12.8	14.1	10.0	11.4	11.9
15-19	11.7	13.2	11.9	16.4	13.4	14.3	13.5
20-24	10.5	11.0	11.0	12.4	11.0	9.6	11.1
25-29	10.5	8.0	9.2	7.3	8.3	8.7	8.5
30-34	8.0	5.9	7.4	4.5	7.9	7.9	6.8
35-39	4.4	6.5	6.0	3.6	4.8	7.0	5.4
40-44	3.5	5.3	4.0	4.2	4.6	5.1	4.5
45-49	3.5	5.0	4.8	2.7	3.8	5.4	4.2
50-54	3.6	3.9	2.7	3.1	3.8	3.5	3.5
55-59	3.4	3.3	2.6	2.6	3.9	3.6	3.2
60-64	1.7	3.0	2.1	3.0	3.0	2.8	2.7
65-69	1.7	2.4	2.2	4.5	2.7	2.2	2.7
70-74	1.3	1.4	.9	1.7	1.9	1.3	1.5
75-79	.6	1.2	.6	1.1	1.2	1.2	1.0
80 -84	.3	.6	.5	.3	.8	.4	.6
85 +	.6	.7	.6	.4	1.1	.2	.7
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Sex composition

The differences in the proportions of males and females in the provincial population are shown in Fig. 2.4. The population profile shows that women are more in number than men in the province. This is true in every district and in both rural and urban areas.



	Bohlabela	Capricon	Mopani	Sekhukhune	Vhembe	Waterberg		Rural	Urban		All
% men	41.8	45.2	45.8	47.2	45.6	46.1	0	45.2	47.3		45.5
% women	58.2	54.8	54.2	52.8	54.4	53.9	0	54.8	52.7		54.5

Age groups

In the young age group of 0-14, there are more males than females. In contrast, women outnumber men in the active working ages of 15-64, and slightly so in the very old ages (Figure 2.5).

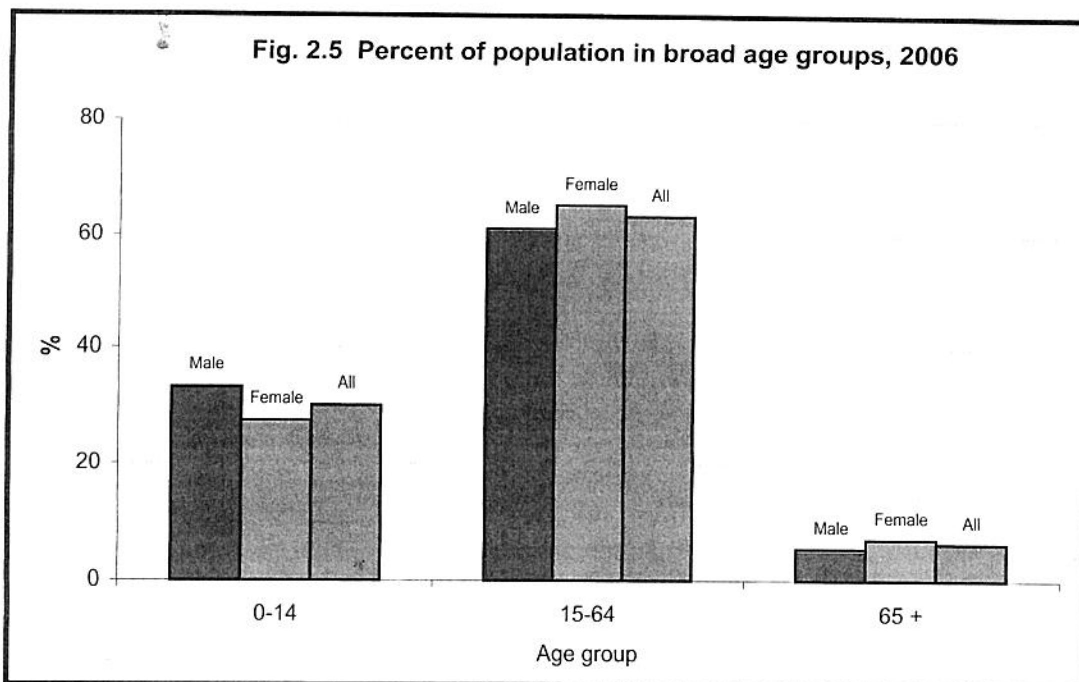


Table 2.3. Percent (%) of the district population by age and sex distribution: Limpopo province 2006

District		Age group			Total
		0 -15	15-64	65 +	
Bohlabela	Male	39.9	55.9	4.1	100
	Female	31.2	64.2	4.6	100
Capricorn	Male	30.9	64.0	5.0	100
	Female	26.6	65.9	7.5	100
Mopani	Male	37.5	58.8	3.7	100
	Female	30.1	64.2	5.6	100
Sekhukhune	Male	36.3	56.2	7.5	100
	Female	28.4	63.2	8.5	100
Vhembe	Male	30.6	62.5	6.8	100
	Female	25.3	66.2	8.5	100
Waterberg	Male	27.5	67.9	4.6	100
	Female	26.1	67.8	6.1	100
All	Male	33.3	61.2	5.5	100
	Female	27.6	65.3	7.1	100
All		**30.2**	**63.4**	**6.4**	**100**

Marital status

Less than half of the provincial population aged 15 years or older (41.1%) have ever been married (Fig. 2.6 and Table 2.4). The figures range from 35% in Bohlabela district to 48.2% in Vhembe district. Fewer men have ever been married (36.9%) compared to women (44.2%). The difference in the current marital status of people in rural and urban areas is small. Considering those who have never been married as shown in Table 2.4, the prevalence of marriage appears to be particularly low in Sekhukhune (60.9% single) and Bohlabela districts (60.3% single).

About 60% of the population aged 15 years or older have never been in a formal marriage. Table 2.5 shows that the prevalence of marriage rises with age. For people aged 15-19, 99.4% of them are single while 9.4% of those aged 50 years or older are single. Considering the data in Table 2.4, and Figure 2.7, the major difference in current marital status appears to result from the reporting of widowhood. A significant number of women reported widowhood more than men. Although cohabitation is evident in the province, its prevalence is reportedly low (4.5% as seen in Table 2.5).

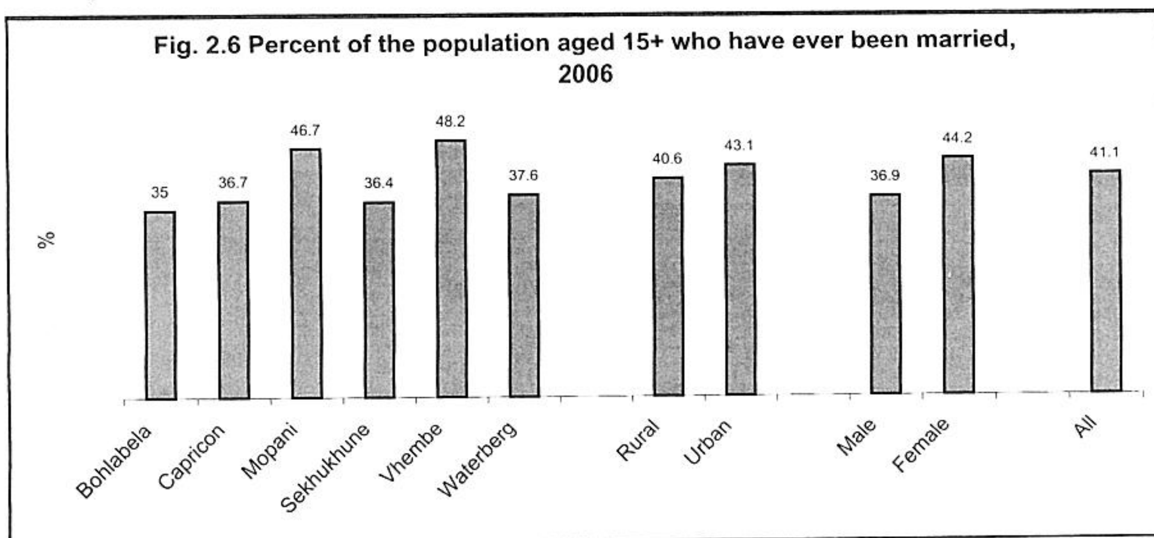


Table 2.4. Percent (%) distribution of district population aged 15+ by marital status: Limpopo province 2006

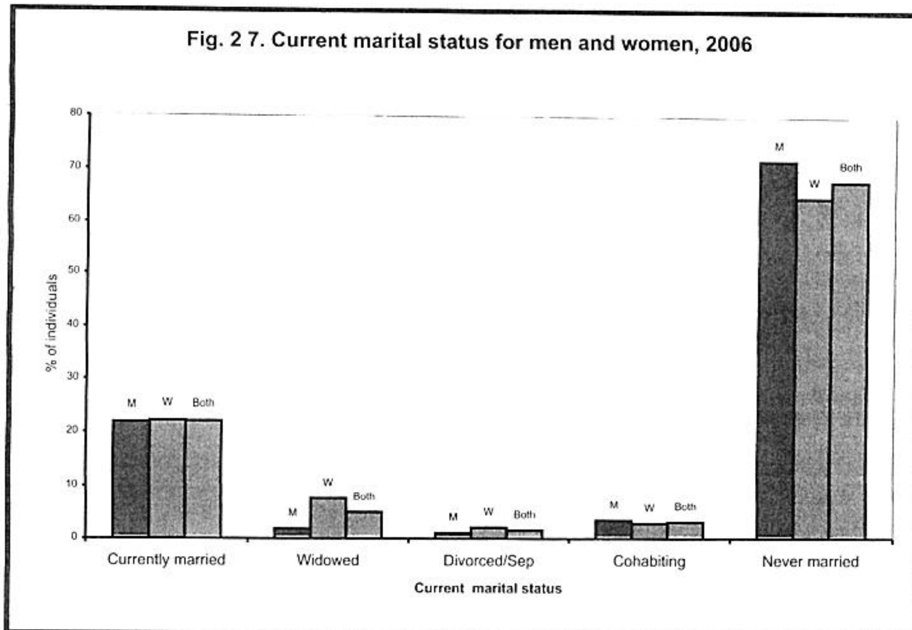
Current marital status	District						All
	Bohlabela	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	
Currently married lives with husband/wife	20.4	25.2	30.4	21.9	29.6	25.6	26.3
Currently married husband/wife lives away	5.1	2.9	3.7	4.8	10.2	3.0	5.3
Divorced	1.5	.7	2.4	.9	.7	1.7	1.2
Separated	1.7	1.2	1.7	.1	1.1	1.6	1.2
Widowed	6.3	6.7	8.5	8.7	6.6	5.7	7.1
Cohabiting	4.7	4.0	6.9	2.8	2.8	8.0	4.5
Single, never married, not cohabiting	60.3	59.3	46.3	60.9	49.1	54.5	54.4
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 2.5. Marital status of people aged 15+ by age groups: Limpopo province 2006

Current marital status	Age group						All
	15-24	25-29	30-34	35-39	40-49	50 +	
Currently married lives with husband/wife	2.7	13.0	28.6	43.0	48.7	50.8	26.3
Currently married husband/wife lives away	1.1	3.7	7.8	7.0	9.7	8.4	5.3
Divorced	.0	.6	.9	2.8	3.5	1.6	1.2
Separated		.5	1.2	2.0	2.7	2.2	1.2
Widowed	.0	.3	1.0	2.4	6.8	26.3	7.1
Cohabiting	1.7	10.5	8.6	10.1	5.8	1.3	4.5
Single, never married, not cohabiting	94.4	71.4	51.8	32.6	22.9	9.4	54.4
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 2.6. Marital status of people aged 15+ by current age group and sex: Limpopo province 2006

Current marital status	Age group												All	
	below 25		25-29		30-34		35-39		40-44		50 +			
	Sex of person		Sex of person		Sex of person		Sex of person		Sex of person		Sex of person		Sex of person	
	Male	Fem	Male	Fem	Male	Fem	Male	Fem	Male	Fem	Male	Fem	Male	Fem
Currently married lives with husband/wife	1.7	3.7	8.9	16.0	28.4	28.8	46.7	39.9	60.7	40.6	72.6	36.9	30.0	23.4
Currently married husband/wife lives away	.3	1.8	1.5	5.3	4.8	10.0	3.4	10.0	5.5	12.5	4.7	10.8	2.6	7.3
Divorced		.1		1.0	.2	1.4	2.3	3.2	3.1	3.7	1.2	1.8	.8	1.5
Separated			.4	.6	1.4	1.1	1.1	2.8	2.2	3.1	1.6	2.5	.8	1.4
Widowed		.1	.2	.4	.5	1.4	.9	3.7	2.2	10.0	11.2	35.9	2.7	10.6
Cohabiting	.6	2.6	12.0	9.4	11.1	6.8	12.5	8.1	8.2	4.1	2.6	.5	5.2	4.0
Single, never married, not cohabiting	97.4	91.7	77.0	67.3	53.6	50.5	33.0	32.3	18.2	26.0	6.1	11.5	57.8	51.9
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**



The data in Table 2.5 shows that 22.9% of the population in their 40s have never been married. The comparative figure for those in their 50s or older is 9.4%.

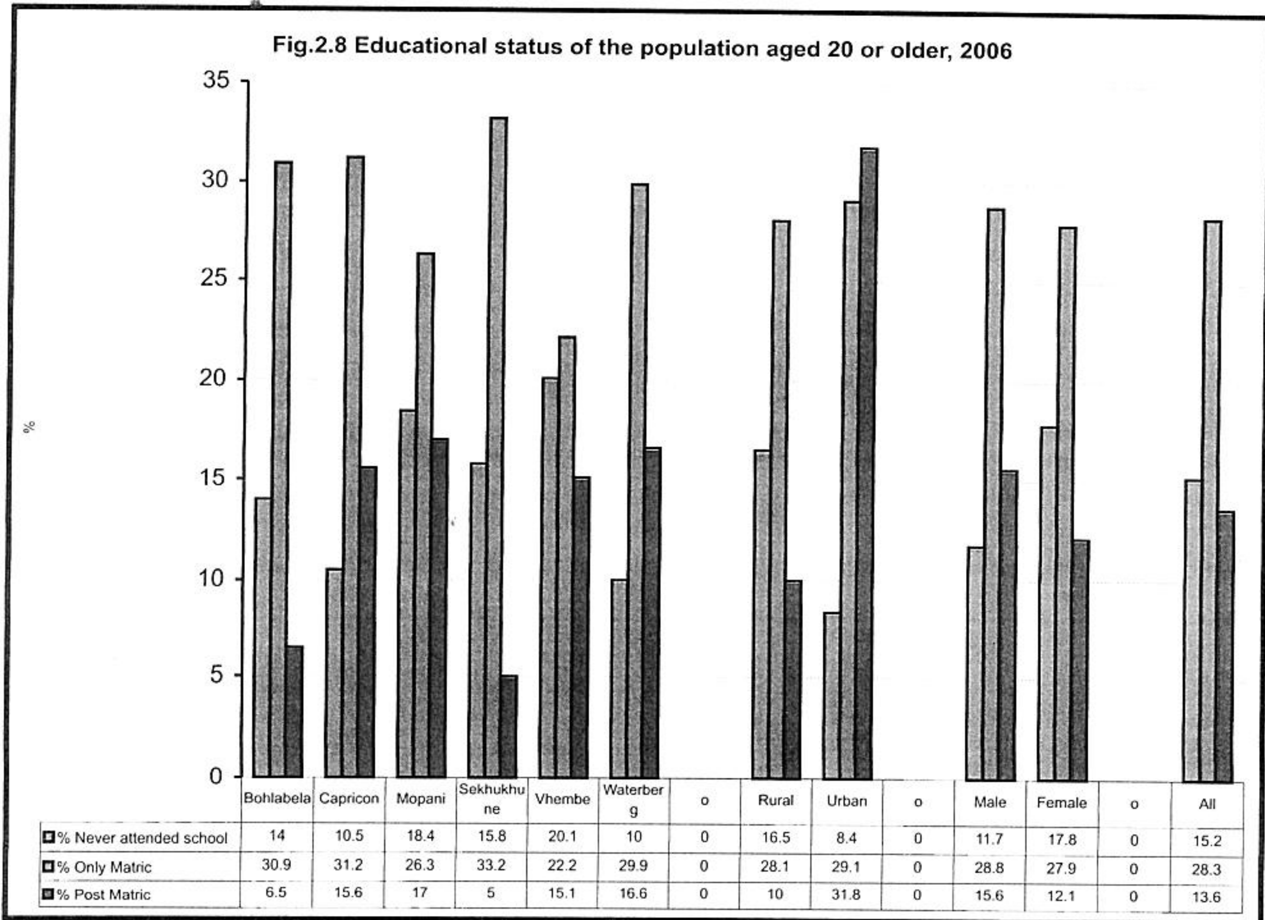
Gender differences in the prevalence of marriage are shown in Table 2.6. Before the age of 40, more men tend to remain single than women. After the age of 40, the pattern appears to reverse, with more women than being reported as single. In both rural and urban areas, a higher percent of men remains single (Table 2.7).

Table 2.7. Marital status of men and women aged 15+ in rural and urban areas: Limpopo province 2006

Current marital status	Place of residence						All
	Rural			Urban			
	Sex of person		All	Sex of person		All	
	Male	Female		Male	Female		
Currently married lives with husband/wife	28.9	22.3	25.1	35.3	29.6	32.2	26.3
Currently married husband/wife lives away	2.7	7.8	5.6	2.5	4.3	3.4	5.3
Divorced	.8	1.5	1.2	1.0	1.3	1.2	1.2
Separated	1.0	1.3	1.2	.3	1.8	1.1	1.2
Widowed	2.9	11.0	7.5	1.8	8.1	5.2	7.1
Cohabiting	5.5	4.2	4.7	3.9	3.0	3.4	4.5
Single, never married, not cohabiting	58.3	51.9	54.6	55.2	51.9	53.4	54.4

Educational status

About 15% of the population has never attended formal school. The percentage of people who have never attended school is relatively high in Vhembe and Mopani and relatively low in Capricorn and Waterberg. On the other hand, the percent of the population with more than matric education is high in Waterberg, Mopani and Capricorn.



	Bohlabela	Capricon	Mopani	Sekhukhune	Vhembe	Waterberg	o	Rural	Urban	o	Male	Female	o	All
% Never attended school	14	10.5	18.4	15.8	20.1	10	0	16.5	8.4	0	11.7	17.8	0	15.2
% Only Matric	30.9	31.2	26.3	33.2	22.2	29.9	0	28.1	29.1	0	28.8	27.9	0	28.3
% Post Matric	6.5	15.6	17	5	15.1	16.6	0	10	31.8	0	15.6	12.1	0	13.6

Table 2.8. Percent (%) education level for people aged 20+ by district: Limpopo province 2006

Highest education level	District						All
	Bohlabela	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	
Less than 1 year	11.5	6.6	14.5	9.7	16.5	8.4	11.4
Sub A-Grade 1	.2	.3	.6	.4	.8	.3	.5
Sub B -Grade 2	1.1	1.0	.7	.6	1.8	1.9	1.2
Std 1-Grade 3	3.2	1.6	1.5	1.4	2.4	2.5	2.0
Std 2-Grade 4	3.8	2.5	2.1	3.0	3.2	2.7	2.8
Std 3-Grade 5	2.4	2.6	3.0	3.3	2.2	1.8	2.6
Std 4-Grade 6	4.1	3.5	2.5	2.9	3.2	4.2	3.3
Std 5-Grade 7	5.3	4.5	5.2	7.5	5.9	5.2	5.5
Std 6-Grade 8	9.4	8.5	7.5	7.4	6.3	4.6	7.3
Std 7-Grade 9	6.2	3.9	6.3	4.4	5.8	3.8	5.0
Std 8-Grade10	7.8	9.6	8.8	11.4	8.1	9.6	9.2
Std 9-Grade 11	7.8	8.5	10.6	10.0	8.3	8.6	9.0
Std 10-Grade 12	30.9	31.2	30.3	33.2	28.6	29.9	30.0
Any post matric studies	2.7	3.5	3.1	1.4	2.8	3.7	2.9
Post matric diploma-certificate	2.1	5.8	1.5	2.6	2.3	7.6	3.6
University degree-diploma certificate	1.7	6.3	1.5	1.0	1.8	5.3	3.1
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Work status

Overall 45.9% of the population reported that they are not currently working. This group is made up of those who have never worked before (32.3%) and those who worked before but were not working when the survey took place (13.6%). People who are too young to work, pensioners and full-time students are excluded from the 'not currently working' category. Sub-groups with relatively high percent of non-working population include the district of Bohlabela (61.2%), females (52.5%) and people in rural areas (48.2%) (Figure 2.9, Table 2.9 and Table 2.10).

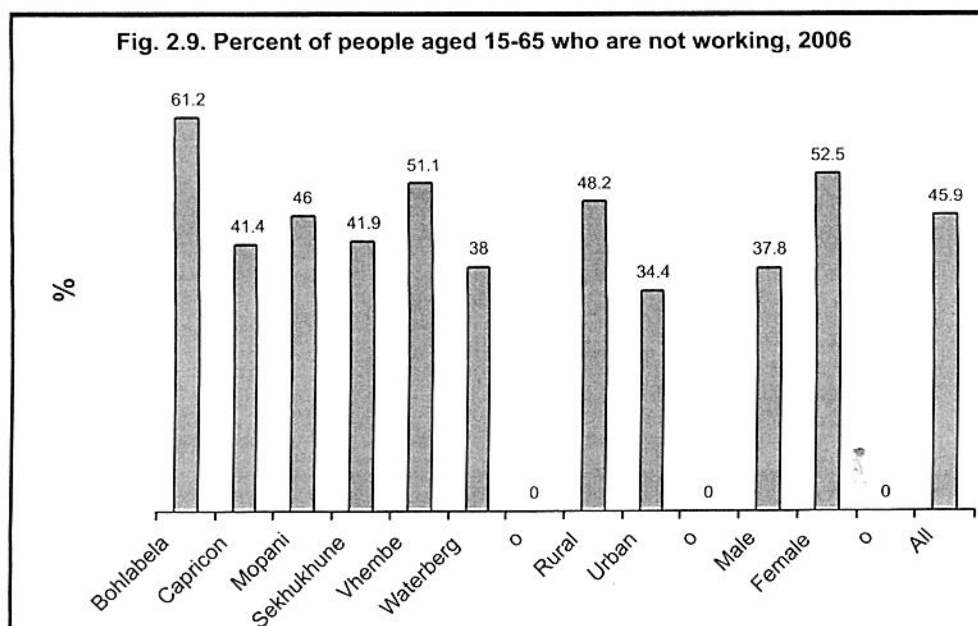


Table 2.9. Percent (%) district population aged 15-65 by current work status: Limpopo province 2006

Current work status	District						All
	Bohlabela	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	
Currently working	17.3	30.7	27.0	16.2	18.4	37.2	24.5
Worked before but not now	19.7	16.1	10.8	10.6	11.9	15.0	13.6
Never worked	4 1.5	25.3	35.2	31.3	39.2	23.0	32.3
Too young to work	1.7	1.1	1.6	1.1	.3	2.4	1.2
Pensioner	1.8	3.0	4.5	7.6	3.7	3.5	4.1
Full-time student	17.9	23.5	20.7	32.7	26.1	18.9	24.0
Not stated		.3	.2	.5	.3		.3
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 2.10. Percent (%) current work status of people aged 15-65 by sex and place of residence: Limpopo province 2006

Current work status	Sex of person		Place of residence		All
	Male	Female	Rural	Urban	
Currently working	31.3	19.2	22.0	36.9	24.5
Worked before but not now	13.4	13.7	14.0	11.4	13.6
Never worked	24.2	38.8	34.2	23.0	32.3
Too young to work	1.4	1.0	1.2	1.4	1.2
Pensioner	2.4	5.3	4.3	3.1	4.1
Full-time student	26.9	21.8	24.0	24.0	24.0
Not stated	.4	.2	.3	.3	.3
Total	**100**	**100**	**100**	**100**	**100**

Characteristics of women in childbearing ages

The age distribution of women in the reproductive ages of 15-49 years is shown in Table 2.11. The percentage of women in childbearing ages who are teenagers is 18.5. Thirty-six percent are in their 20s, 32.3% in their 30s and 18.7% in their 40s.

Table 2.11. Percent (%) distribution of women in reproductive ages: Limpopo Province 2006

Age group	District						Type of place of residence		All
	Bohlabela	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	Rural	Urban	
15-19	15.1	15.6	17.9	27.6	17.4	20.4	18.2	20.3	18.5
20-24	21.1	16.0	20.9	17.8	19.6	17.4	19.2	15.3	18.7
25-29	22.6	17.8	16.3	15.6	17.3	15.8	17.9	13.8	17.3
30-34	18.1	13.3	15.3	10.9	17.2	16.6	15.3	13.6	15.0
35-39	9.8	14.4	10.8	11.8 10.2	12.0	11.6	12.5	11.7	17.3
40-44	7.4	11.1	8.9	11.1	10.5	8.7	9.6	12.1	9.9
45-49	5.9	11.9	9.8	5.1	7.8	9.2	8.2	12.5	8.8
Total	100	100	100	100	100	100	100	100	100

Marital status

Sixty percent of women aged 15-49 have never been married (Table 2.12). Only 21.8% are currently married and live with their husbands. Close to six percent and 3% are cohabiting and widowed respectively.

The proportion of women in childbearing ages who have never been married declines by age, ranging from 97.3% in the 15-19 ages group to 22.7% in the oldest childbearing age group. The percent of single women is highest in Bohlabela (70%) and lowest in Mopani (49.1%). The difference in percentage of women who have never been married in rural and urban area is small.

For women who have ever been married, the average age at first married is 21 years. Women in rural rears marry at younger ages than those in urban areas. Districts with relatively young age at first marriages are Bohlabela, Mopani and Vhembe. The oldest age at first marriage is observed for women in Sekhukhune district (Figure 2.10).

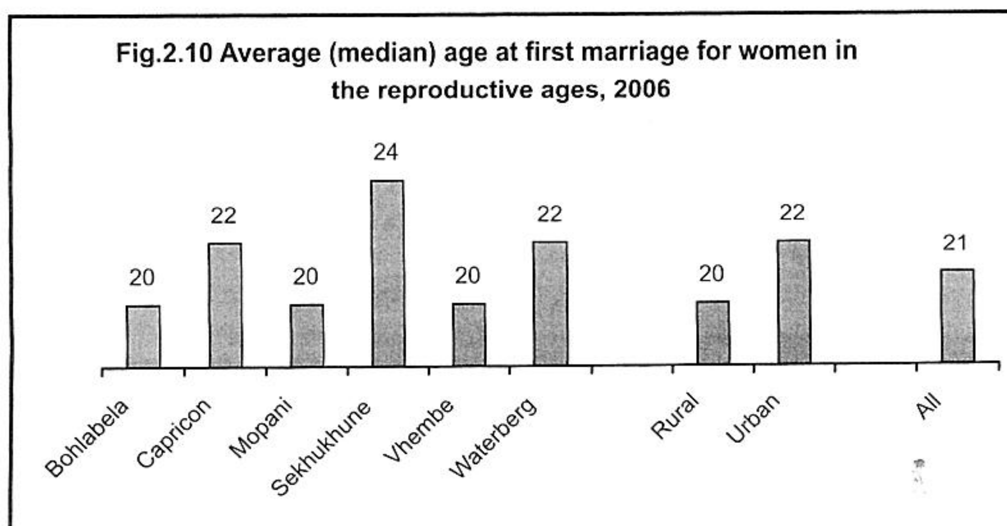
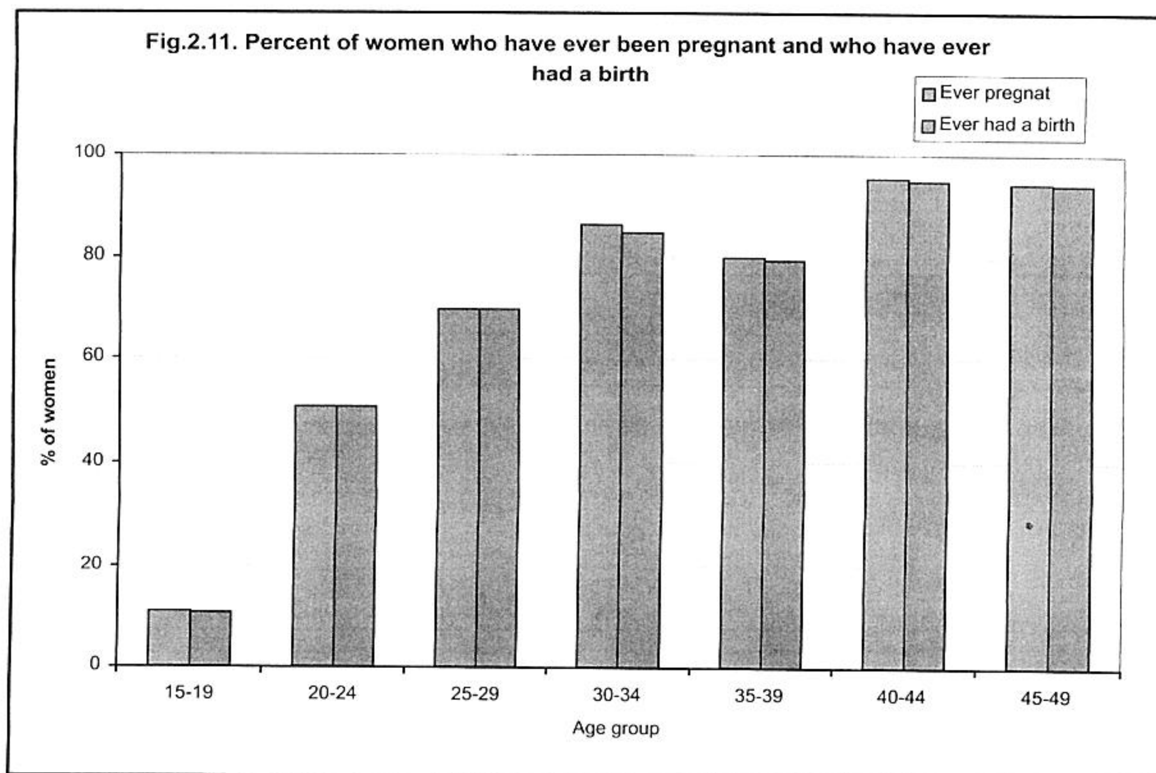


Table 2.12. Current marital status of women aged 15-49 by age group: Limpopo province 2006

		Current marital status							Total
		Currently married lives with husband/ wife	Currently married husband/wife lives away	Divorced	Separated	Widowed	Cohabiting	Single, never married, not cohabiting	
Age group	15-19	1.6	.3			.2	.6	97.3	100
	20-24	8.3	5.0	.2			6.4	80.2	100
	25-29	16.8	5.4	.7	.7	.5	9.4	66.7	100
	30-34	30.3	9.8	1.2	1.2	1.5	7.5	48.5	100
	35-39	40.0	9.9	3.7	2.7	3.2	8.9	31.5	100
	40-44	41.9	14.1	2.9	2.3	8.5	3.8	26.4	100
	45-49	41.4	11.8	3.9	4.3	10.9	4.9	22.7	100
District	Bohlabela	12.8	6.5	2.1	.9	2.7	5.0	70.0	100
	Capricorn	20.9	3.4	.5	1.8	2.8	5.8	64.8	100
	Mopani	27.7	5.6	3.2	2.0	4.2	8.2	49.1	100
	Sekhukhune	17.8	8.0			.4	4.0	69.7	100
	Vhembe	25.0	13.7	1.1	.8	2.8	3.9	52.8	100
	Waterberg	19.3	3.5	1.9	1.1	.5	9.2	64.4	100
Type of place of residence	Rural	20.6	7.5	1.4	1.1	2.7	6.2	60.5	100
	Urban	29.0	4.0	1.3	2.1	1.7	4.2	57.6	100
Total		**21.8**	**7.0**	**1.4**	**1.2**	**2.5**	**5.9**	**60.1**	**100**

Pregnancies and motherhood

Figure 2.11 shows the percent of women in the reproductive ages who have ever been pregnant and those who have experienced a live birth as reported. The reported number of pregnancies is just slightly higher than the reported numbers of life births.



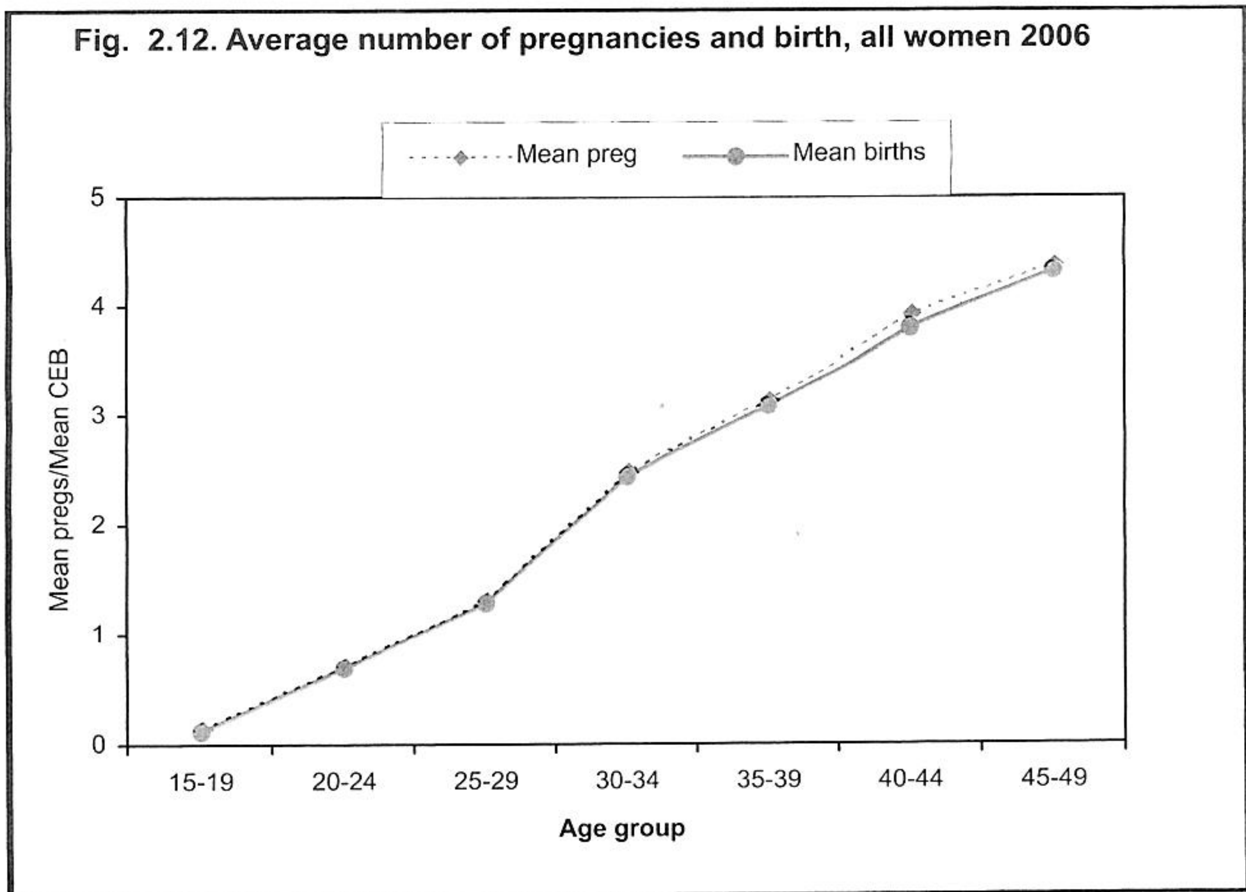
Childbearing

Figure 2.12 is a summary of the results on the average number of pregnancies and children born by women in each reproductive age group. The average number of children remains relatively high compared to other provinces in the country.

The differences in the average number of pregnancies are shown by district and rural and urban areas in Table 2.13. The differences in completed family size in each age group, measured by the mean CEB (children ever born hereafter), are shown by district, type of place of residence and marital status in Table 2.14. Bohlabela and Sekhukhune have higher levels while Capricorn and Waterberg have low levels. Average family size is slightly small in urban areas.

Childbearing is relatively common among women who have never been married in all age groups (Table 2.14). This is a major characteristic of childbearing in Limpopo province and other parts of the country.

The completed family size is inversely related to educational status. Women with low level of education have a larger completed family size than those with a high level of education.



Similarly, the data (Table 2.15) show that non-working women have larger completed family size that those who currently work.

Table 2.13. Average number of pregnancies by district and place of residence: Limpopo province 2006

		All pregnancies ever						
		Age group						
		15-19	20-24	25-29	30-34	35-39	40-44	45-49
District	Bohlabela	.18	.83	1.54	2.75	2.64	3.48	5.60
	Capricorn	.10	.58	1.21	2.42	3.21	3.77	3.90
	Mopani	.19	.81	1.53	2.54	3.81	4.66	4.63
	Sekhukhune	.12	.65	1.39	2.78	3.81	4.08	5.17
	Vhembe	.12	.77	1.20	2.35	2.46	3.67	4.40
	Waterberg	.08	.44	.98	2.20	2.50	3.44	3.76
All		.13	.70	1.31	2.47	3.14	3.90	4.35
Type of place of residence	Rural	.13	.73	1.33	2.51	3.23	3.99	4.49
	Urban	.10	.44	1.11	2.23	2.61	3.46	3.80
All		.13	.70	1.31	2.47	3.14	3.90	4.35

Table 2.14. Average number of children by district, place of residence and marital status: Limpopo province 2006

		Number of children ever born						
		Age group						
		15-19	20-24	25-29	30-34	35-39	40-44	45-49
District	Bohlabela	.18	.82	1.51	2.74	2.61	3.36	5.45
	Capricorn	.10	.56	1.19	2.38	3.15	3.65	3.85
	Mopani	.18	.81	1.50	2.49	3.69	4.45	4.62
	Sekhukhune	.12	.65	1.37	2.76	3.70	3.96	5.09
	Vhembe	.09	.73	1.16	2.34	2.46	3.63	4.31
	Waterberg	.07	.44	.97	2.15	2.45	3.34	3.76
All		.12	.68	1.28	2.44	3.07	3.79	4.30
Type of place of residence	Rural	.12	.71	1.30	2.47	3.16	3.87	4.42
	Urban	.09	.44	1.11	2.23	2.56	3.37	3.78
All		.12	.68	1.28	2.44	3.07	3.79	4.30
Ever been married?	Yes	.89	1.37	2.05	3.20	3.78	4.25	4.65
	No	.11	.58	1.05	1.90	2.12	2.79	3.52
All		.12	.68	1.28	2.44	3.07	3.79	4.30

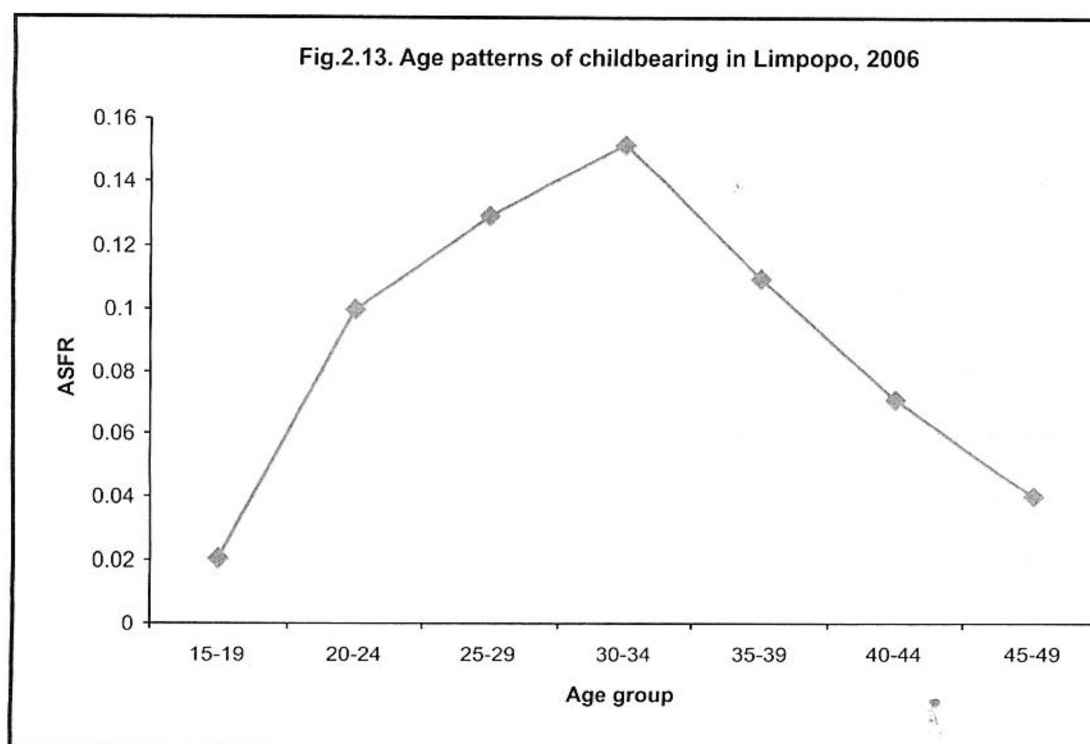
Table 2.15. Average number of children by education and work status: Limpopo province 2006

		Number of children ever born						
		Age group						
		15-19	20-24	25-29	30-34	35-39	40-44	45-49
Education level	< Gr 7	.25	1.00	1.79	3.20	4.77	4.67	4.80
	Gr 7-11	.12	.85	1.62	2.93	3.47	3.83	4.30
	Gr 12+	.08	.52	1.05	2.01	2.38	3.19	3.51
All		.12	.68	1.28	2.44	3.07	3.79	4.30
Work category	Never worked	.37	.82	1.44	2.95	3.41	4.35	4.72
	FT student/too young	.08	.46	.50	2.00	3.00	2.00	.
	Worked before not now	.25	.74	1.22	1.61	3.17	3.92	4.37
	Currently working	.43	.48	.98	2.13	2.69	3.03	3.93
All		.12	.68	1.28	2.44	3.07	3.79	4.30

Age patterns of childbearing

The age specific fertility rates in Fig. 2.13 and Table 2.16 summarize the age patterns of child bearing in Limpopo Province. The main features in Figure 2.13 are that (i) childbearing peaks in the 30-34 age group; and (ii) childbearing is relatively common in the youngest and oldest age groups.

Important variations in age specific fertility rates are observed in Table 2.16. Teenage fertility is relatively high in rural areas, and in the districts of Bohlabela and Mopani.



Total fertility rate

In comparison to other provinces, the average number of children for women in their childbearing ages remains high. The estimated total fertility rate for Limpopo Province is 3.12, with the peak of childbearing occurring in the 30-34 age group.

Figure 2.14 shows that total fertility rate is highest among ever married women (5.25). Sub-groups with comparatively low levels of fertility are urban areas (2.15), Capricorn and Waterberg districts (2.61 and 2.07 respectively).

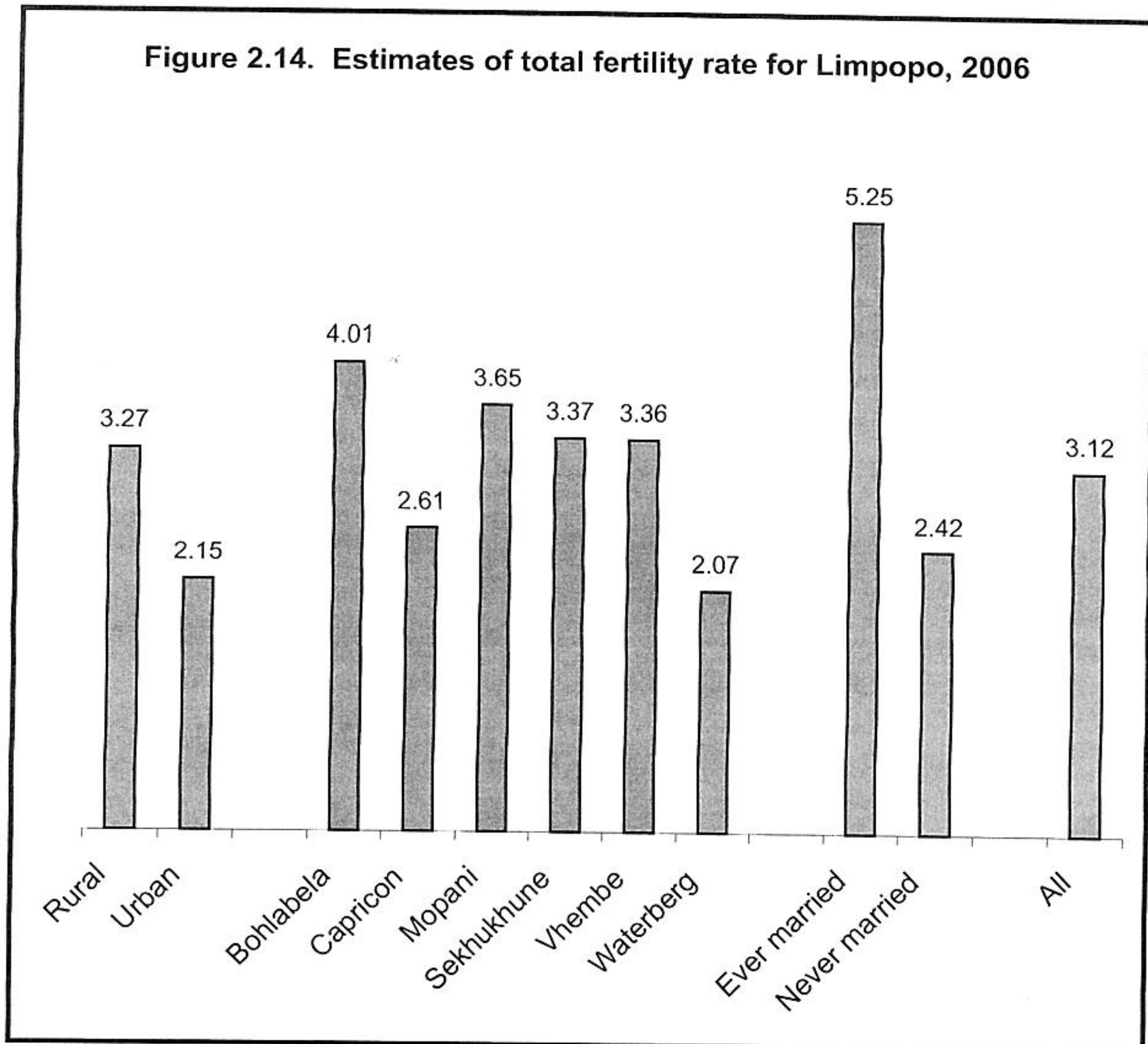


Table 2.16. Age specific fertility rates and total fertility rates in Limpopo, 2006

Characteristic	Age specific fertility rate							Total fertility rate
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	
Rural	.023	.106	.134	.148	.116	.082	.045	**3.27**
Urban	.008	.058	.083	.131	.081	.049	.020	**2.15**
District								
Bohlabela	.035	.130	.153	.184	.163	.056	.080	**4.01**
Capricorn	.016	.072	.118	.129	.106	.059	.022	**2.61**
Mopani	.034	.124	.149	.153	.115	.116	.032	**3.62**
Sekhukhune	.019	.103	.117	.180	.101	.084	.069	**3.37**
Vhembe	.015	.100	.133	.164	.121	.082	.056	**3.36**
Waterberg	.011	.066	.010	.108	.060	..044	.035	**2.07**
Ever married	.155	.212	.214	.214	.121	.088	.046	**5.25**
Never married	.019	.083	.097	.108	.097	.052	.029	**2.42**
All Limpopo	.021	.100	.129	.152	.110	.071	.040	**3.12**

Fertility trend

With fertility data of reasonable quality, P/F ratios can be used as a robust indicator of fertility trend. Ratios that are above one indicate that fertility is declining for that age group. If the ratios are less than one, this could be an indication of a rise in fertility. These ratios are summarized for Limpopo Province in Table 2.17. The data confirm a continuing downward trend in fertility in the province despite an unfavourable socioeconomic environment.

Table 2.17. Estimates of simple P/F ratios for Limpopo province, 2006

Age group	P	F	P/F ratio
15-19	0.119	0.105	1.133
20-24	0.682	0.605	1.127
25-29	1.283	1.250	1.026
30-34	2.442	2.010	1.215
35-39	3.072	2.560	1.200
40-44	3.786	2.915	1.299
45-49	4.299	**3.115**	1.380

Timing of childbearing

The survey results indicate that many children are born outside marriage in Limpopo province. The data in Figure 2.15 show that as many as 58.4% of women have their first birth before entering into a first marriage.

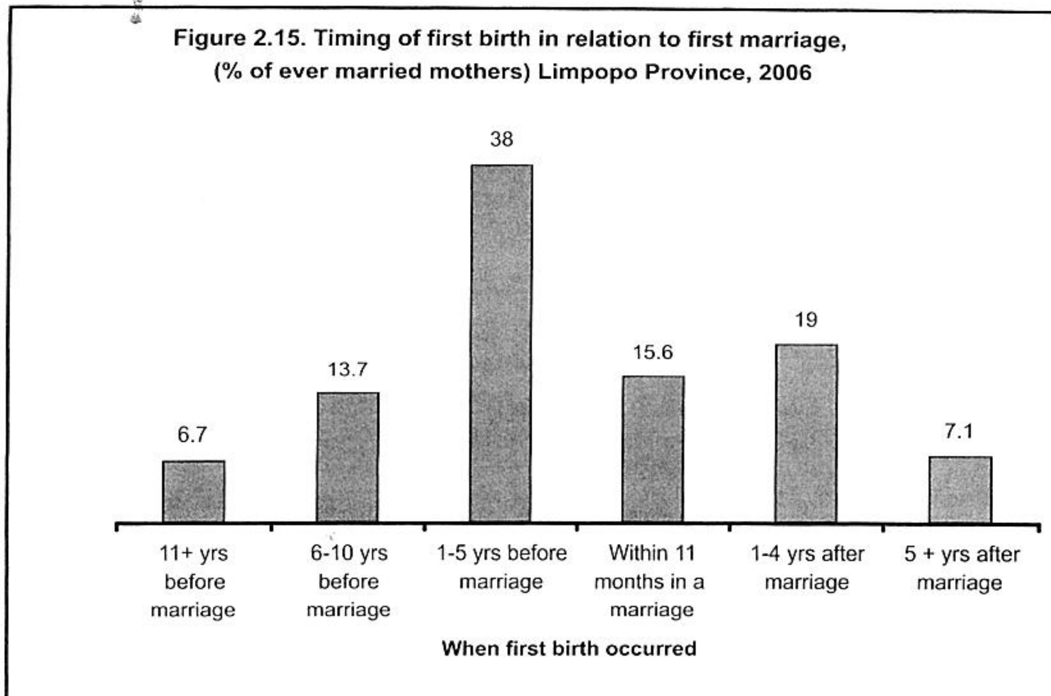


Figure 2.15. Timing of first birth in relation to first marriage, (% of ever married mothers) Limpopo Province, 2006

Teenage Childbearing

Figure 2.16 shows that only 10.5% of current teenagers reported that they have ever had a baby. However, the experience of current teenagers provides only a partial and inadequate picture. This is because of three reasons. First, not all of them have completed their life experience as teenagers. Secondly, they represent only a small portion (18.5%) of all women in their reproductive ages. Thirdly, it is not possible to establish a trend from this cross-sectional statistic.

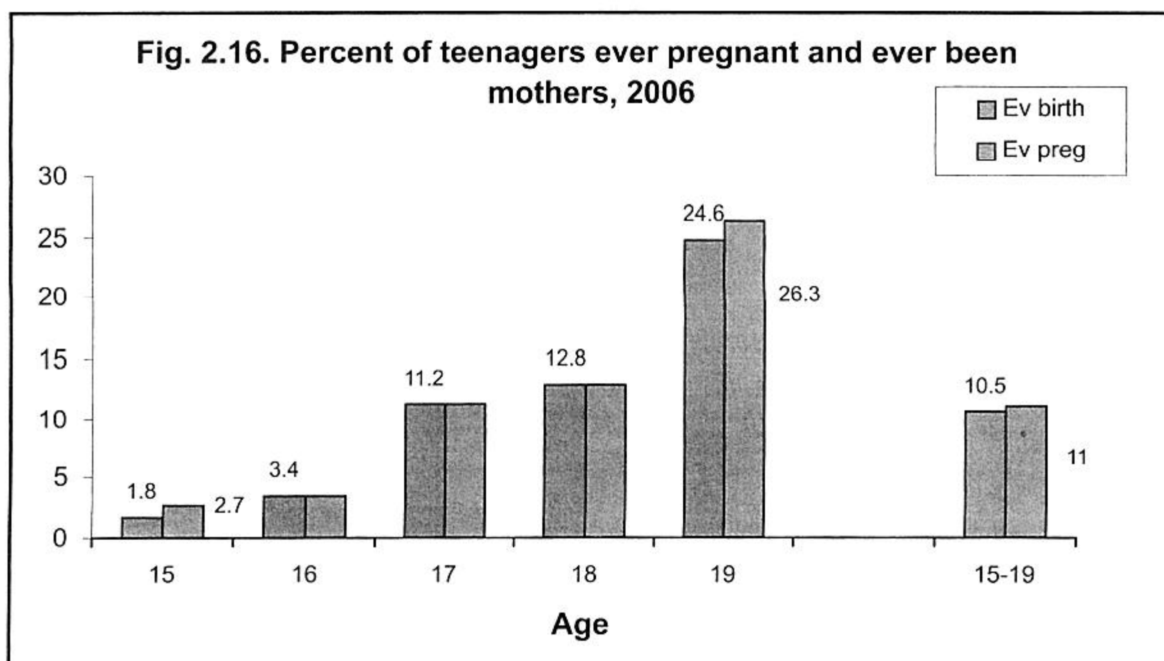


Fig. 2.16. Percent of teenagers ever pregnant and ever been mothers, 2006

The data in Table 2.18 and Figure 2.17 incorporate the childbearing experiences of all women who are currently in the 15-49 age range. Table 2.18 shows that by the age of 17, 28.7% of women in Limpopo province have had their first birth and by the age 19, more than half (51.7%) of women have become mothers. By the age of 17, about 36.3% of women in Bohlabela and 31.5% of those in Mopani have had their first birth. By the age of 19, 62.9% percent of women in Bohlabela and 56% of those in Mopani have had their first birth.

Table 2.18: Percent of women according to the age at which they had their first birth

District	% who have had their first birth by exact age	
	exact age 17	*exact age 19*
Bohlabela	36.3	62.9
Capricorn	25.5	49.8
Mopani	31.5	56.4
Sekhukhune	28.2	50.8
Vhembe	25.1	47.1
Waterberg	30.4	52.4
Rural	29.3	53.1
Urban	24.9	41.9
All Limpopo Province	**28.7**	**51.7**

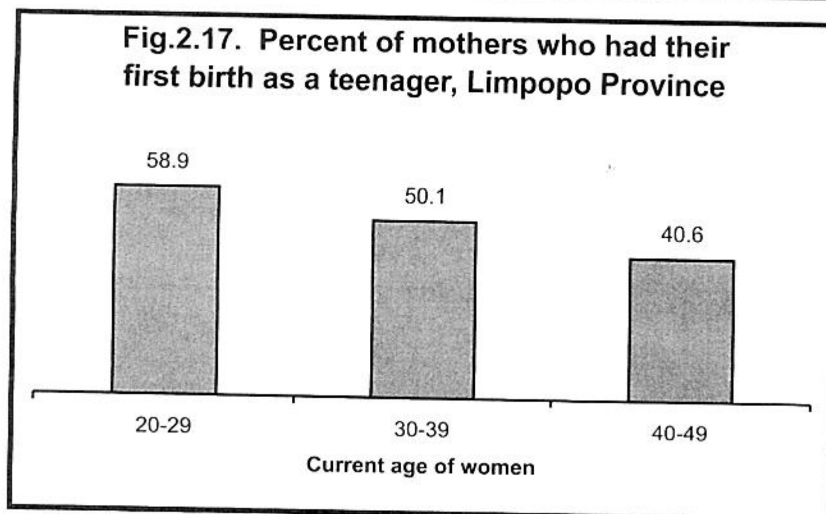


Fig.2.17. Percent of mothers who had their first birth as a teenager, Limpopo Province

Figure 2.17 shows the percentage of mothers (by age group), who had their first babies when they were teenagers. The incidence of teenage childbearing ranges from 40.6% for women currently in their forties to 58.9% for women currently in their twenties. Differences are also shown for districts, place of residence, education and work status in Table 2.19 and Table 2.20.

If these age differences are seen in generational terms, these results show that teenage childbearing is not declining in Limpopo province. The overall trend reflected in the data is that of an increasing trend in the incidence of teenage childbearing among cohorts of women in the province.

Table 2.19. Percent (%) distribution of mothers by age at first birth: Limpopo Province 2006

		Age at first birth						
		10-14	**15-17**	**18-19**	**20-21**	**22-24**	**25-27**	**28 +**
Age group	15-19	13.1	72.1	14.8				
	20-24	5.4	34.3	30.2	21.3	8.9		
	25-29	4.4	26.1	17.3	22.0	21.5	8.0	.7
	30-34	7.1	19.6	25.6	19.1	13.1	11.1	4.4
	35-39	5.6	19.1	23.2	23.2	15.4	8.2	5.3
	40-44	2.2	18.8	26.3	24.1	16.6	6.3	5.9
	45-49	3.5	14.4	16.9	21.1	22.5	10.6	10.9
All		**5.1**	**23.6**	**23.0**	**21.0**	**15.8**	**7.3**	**4.2**
District	Bohlabela	6.6	29.7	26.6	19.7	9.6	5.7	2.2
	Capricorn	6.1	19.4	24.3	18.5	17.2	9.4	5.0
	Mopani	3.6	27.9	24.9	22.0	15.2	3.2	3.2
	Sekhukhune	5.6	22.6	22.6	22.2	17.9	6.0	3.2
	Vhembe	4.0	21.1	22.0	21.8	14.8	11.0	5.2
	Waterberg	5.9	24.5	13.2	24.0	20.1	6.9	5.4
All		**5.1**	**23.6**	**23.0**	**21.0**	**15.8**	**7.3**	**4.2**
Type of place of residence	Rural	4.7	24.6	23.8	20.9	15.1	7.1	3.9
	Urban	7.9	17.0	17.0	22.0	20.9	9.0	6.1
All		**5.1**	**23.6**	**23.0**	**21.0**	**15.8**	**7.3**	**4.2**

Table 2.20. Percent (%) distribution of mother's education and age at first birth: Limpopo Province 2006

		Age at first birth						
		10-14	**15-17**	**18-19**	**20-21**	**22-24**	**25-27**	**28 +**
Education level	< Grade 7	5.9	25.2	25.8	20.2	13.4	5.9	3.7
	Grade 7-11	5.0	27.7	24.7	19.2	12.8	6.5	4.0
	Grade 12 +	4.9	19.4	20.4	23.0	19.4	8.6	4.
	I							
Work category	Never worked	5.0	24.5	24.2	21.6	14.7	6.3	3.7
	FT student/too young	3.9	44.2	30.2	14.0	6.2	1.6	
	Worked before not now	5.1	20.9	24.0	22.6	15.0	8.5	4.0
	Currently working	5.6	19.0	18.3	20.6	20.6	9.9	6.1
Children ever born	1-2	5.5	25.0	21.1	20.3	15.7	8.4	3.9
	3-4	3.5	15.7	22.4	24.1	19.3	8.1	6.9
	5 +	5.8	29.9	29.1	19.2	11.7	3.2	1.2
All		**5.1**	**23.6**	**23.0**	**21.0**	**15.8**	**7.3**	**4.2**

2.2. SOCIOECONOMIC CONTEXT OF HIV AND AIDS

Household size and relationships

The average number of people per household is 4.3. Figure 2.18 shows that the key relationships in the households include the head (24%), husband or wife (10.1%), son (20.4%) or daughter (21%) and grandchildren (15.1%). Data in Table 2.21 show that this pattern is fairly similar for all districts and for rural and urban areas.

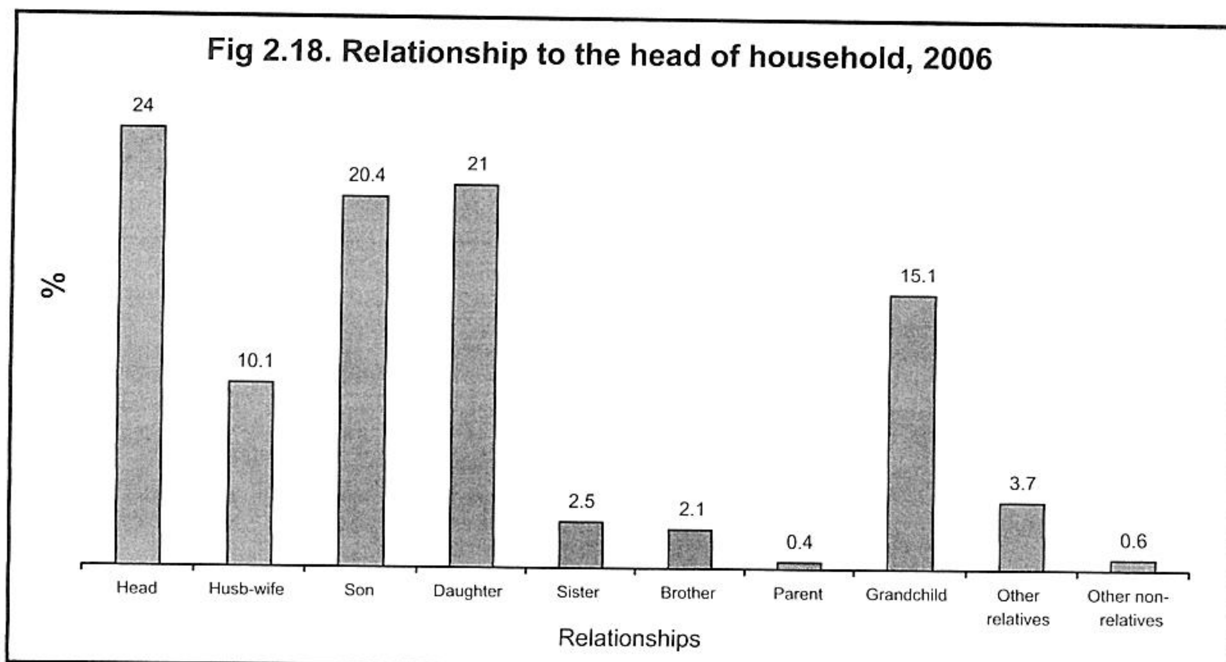


Table 2.21. Relationship of members to the head of household: Limpopo province 2006

Relationship to household head	District						Place of residence		All
	Bohlabela	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	Rural	Urban	
Head	23.2	24.2	23.2	23.1	24.9	24.6	23.9	24.2	24.0
Husband-wife	8.1	10.4	11.0	8.2	10.4	11.7	9.6	13.0	10.1
Son	20.5	20.5	20.9	18.7	21.9	18.5	20.3	20.9	20.4
Daughter	23.4	21.2	21.2	18.9	21.9	19.5	20.9	21.9	21.0
Sister	2.8	2.0	2.4	3.4	2.4	2.6	2.5	2.5	2.5
Brother	1.7	1.7	1.8	3.2	2.1	2.9	2.1	2.6	2.1
Parent	.2	.3	.4	.4	.5	.8	.4	.4	.4
Grandchild	16.0	15.8	13.3	19.9	12.9	13.5	16.1	9.5	15.1
Other relatives	3.6	3.2	5.2	3.9	2.7	4.4	3.7	3.9	3.7
Other non-relatives	.5	.8	.7	.3	.4	1.5	.5	1.2	.6
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Characteristics of household head

Considering the role of household heads in the fight against HIV and AIDS, further examination of heads was carried out. The key socio-economic features of household heads are shown in Figure 2.19. These data are also presented in Table 2.22 and Table 2.23. Heads of household are 46% female: 49% are currently married; 35.7% are currently working. Only 29.7% have matric or higher level of education.

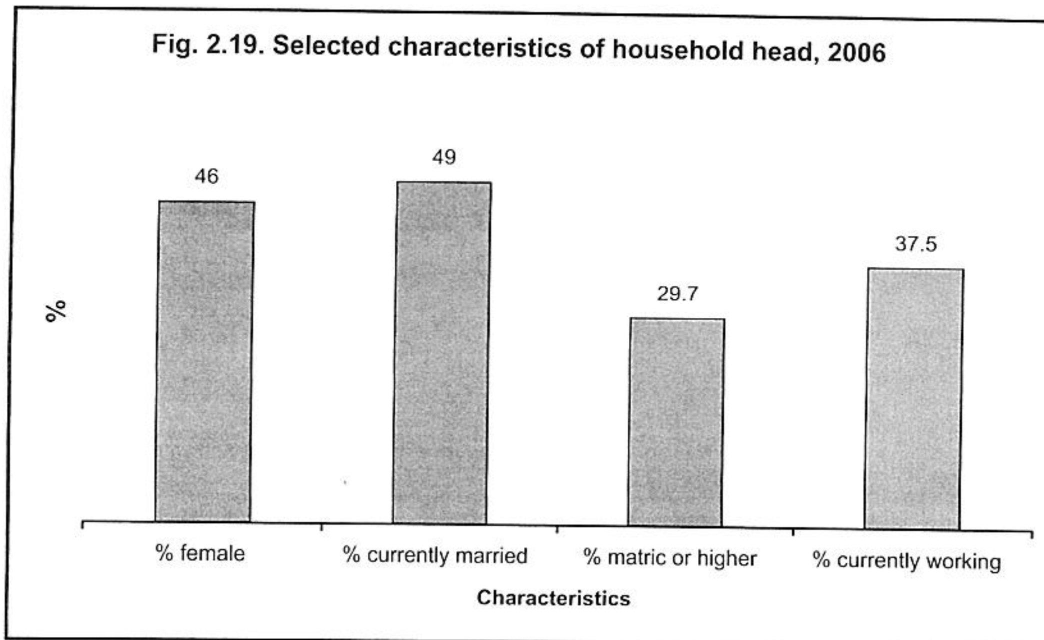


Table 2.22. Percent (%) age distribution of heads of household: Limpopo province 2006

		District						Place of residence		All
		Bohlabela	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	Rural	Urban	
Age group of head	< 20	1.4	.4	1.8	1.4	2.0	1.5	1.4	1.3	1.4
	20-39	39.0	25.6	38.8	28.5	29.9	34.3	30.9	34.2	31.4
	40-64	45.5	53.0	44.3	42.7	45.7	47.9	46.3	50.5	47.0
	65 +	14.0	21.1	15.1	27.4	22.4	16.3	21.4	14.0	20.2
	Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Sex of person	Male	42.8	55.0	59.6	51.8	51.3	60.9	52.1	64.0	54.0
	Female	57.2	45.0	40.4	48.2	48.7	39.1	47.9	36.0	46.0
	Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Current marital status	Curr married lives with hus-wife	30.8	36.6	40.2	32.8	42.2	36.4	35.7	47.1	37.5
	Curr married hus-wife lives away	11.6	6.8	7.3	10.7	22.4	6.8	12.4	7.5	11.6
	Divorced	3.1	2.0	4.7	2.3	1.2	4.1	2.5	3.5	2.6
	Separated	3.1	3.2	3.7	.2	1.7	4.1	2.6	2.5	2.6
	Widowed	16.4	18.3	20.7	24.1	16.1	14.2	19.4	13.8	18.5
	Cohabiting	5.1	5.8	7.8	3.3	3.7	11.8	6.0	4.9	5.8
	Single, never married, not cohabiting	29.8	27.3	15.5	26.6	12.7	22.5	21.4	20.7	21.3
	Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 2.23. Education and work status of household head (%): Limpopo province 2006

Highest education level		District						Place of residence		All
		Bohlabela	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	Rural	Urban	
Less than 1 year		18.2	10.7	21.8	16.6	22.4	14.3	19.0	9.6	17.4
SubA-Grade 1		.4	.6	.5		1.2	.6	.7	.2	.6
Sub B -Grade 2		2.1	1.3	1.4	.9	2.7	2.7	1.9	1.1	1.8
Std 1-Grade 3		5.4	2.9	1.7	2.8	3.5	4.0	3.6	.9	3.1
Std 2-Grade 4		4.6	4.0	1.9	4.5	5.3	3.0	4.4	1.9	4.0
Std 3-Grade 5		3.2	4.1	3.8	5.4	3.3	1.8	4.0	2.4	3.7
Std 4-Grade 6		5.4	5.0	2.8	4.3	4.6	5.5	4.7	3.6	4.5
Std 5-Grade 7		6.1	5.8	8.5	9.9	6.8	6.1	7.7	4.7	7.2
Std 6-Grade 8		11.8	13.4	7.1	9.9	8.7	6.1	10.2	7.3	9.8
Std 7-Grade 9		5.7	4.2	4.2	3.4	4.1	4.3	4.7	1.7	4.2
Std 8-Grade10		5.4	9.8	7.8	9.5	6.8	9.4	8.6	6.8	8.3
Std 9-Grade 11		8.2	3.8	7.0	6.5	5.1	6.4	5.8	5.6	5.7
Std 10-Grade 12		17.1	17.0	17.4	20.9	13.5	18.2	16.1	21.0	16.9
Any post matric studies		2.5	1.7	2.1	1.3	3.3	4.0	2.1	4.1	2.4
Post matric diploma-cert		1.8	7.2	3.8	3.2	2.9	8.2	3.6	9.8	4.6
University degree/diploma/certificate		2.1	8.4	8.0	1.1	5.8	5.5	3.1	19.3	5.8
Total		**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Current work status	Currently working	24.7	46.2	41.9	20.6	25.9	54.1	31.6	57.1	35.7
	Worked before but not now	30.8	23.2	14.3	18.3	13.0	17.2	19.3	14.2	18.5
	Never worked	30.1	9.8	21.8	24.7	37.2	11.2	24.6	12.2	22.6
	Too young to work	.3	.1			.1	.9	.1	.4	.2
	Pensioner	13.4	19.5	19.7	32.6	18.9	16.0	21.7	14.0	20.5
	Full-time student	.7	.9	2.3	3.3	4.3	.6	2.3	2.0	2.3
	Not stated		.2		.6	.5		.3	.2	.3
Total		**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Type of dwelling

Figure 2.20 and Table 2.24 summarize the provincial households by type of dwelling. Essentially, stand-alone houses and traditional houses constitute the main types of dwellings occupied by most households in the province. It should however be noted that how people describe their dwelling vary significantly, despite the standardized categories included in the questions. Most houses have cement floors with plastered walls.

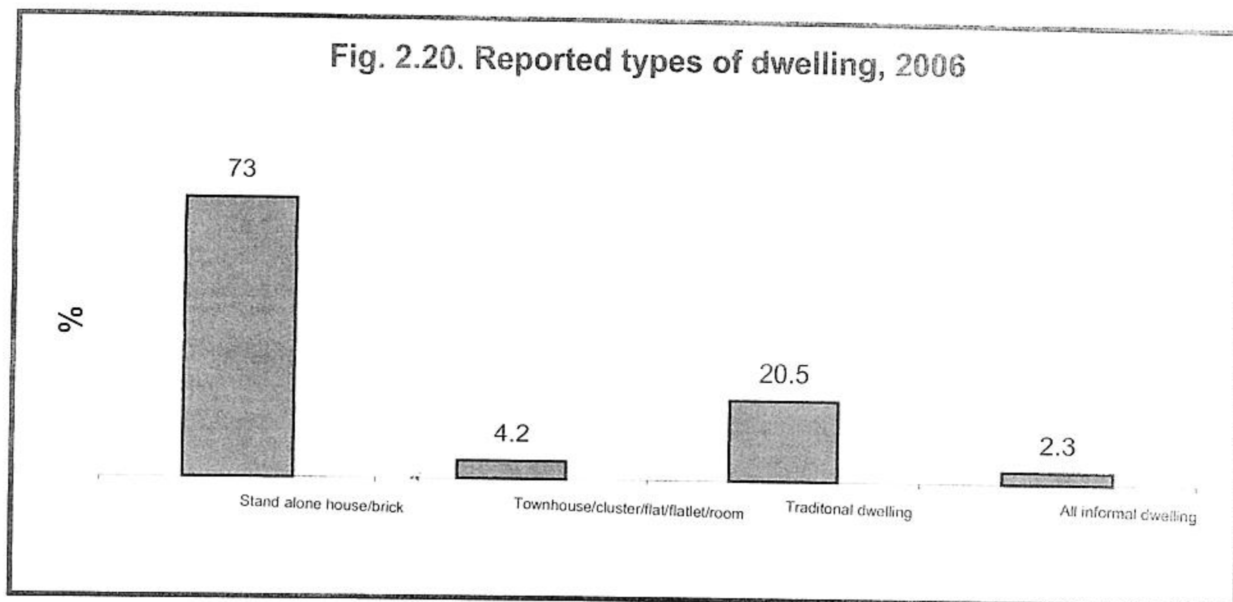


Table 2.24. Percent (%) distribution of households by dwelling type: Limpopo province 2006

Type of dwelling	District						Type of place		All Limpopo
	Bohlabela	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	Rural	Urban	
Stand alone house/brick	64.3	78.9	63.3	76.5	72.9	78.5	72.5	75.7	73.0
Town house/cluster	1.7	4.4	2.1		2.0	2.4	.7	10.8	2.3
Flat in block of flats	.2		.2		.2		1.7	.2	0.3
Traditional dwelling/hut	30.1	8.1	33.8	23.3	22.1	10.6	21.3	7.5	20,5
Backyard flat/house/room	1.4	1.8	.5		.7	.9	.9	.9	.9
Informal dwelling/shack	2.1	2.7	.2	.2	1.6	3.9	1.1	4.8	1.7
Informal dwelling shack not in backyard		2.2			.2		.7		.6
Room/flatlet not in backyard	.3	1.9			.1	3.6	1.1		.9
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 2.25. Percent (%) distribution of households' floor and walls material: Limpopo province 2006

		District						All Limpopo
		Bohlabela	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	
Main material for the floor	Natural floor/sand/dung	9.3	3.7	7.0	13.4	20.8	4.2	10.3
	Bare wood planks	2.1	.1	.2	.2	.5		.4
	Parquest or polished floor	.3	.2		2.1	1.0	1.2	.8
	Vinyl or asphalt strips		.6	.2		.1	.9	.3
	Ceramic tiles	.3	12.1	10.0	2.3	2.0	10.6	6.7
	Cement	87.6	81.6	81.7	81.3	75.4	80.0	80.5
	Carpet	.3	1.7	1.0	.6	.2	3.0	1.1
	Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Main material of the walls	Plastic/cardboard	.7	1.3	.2	.2	1.2		.7
	Mud	2.4	.2	10.3	1.2	11.4		5.0
	Mud and cement	41.2	4.1	26.1	9.3	13.6	2.7	14.1
	Corrugated iron/zinc	1.4	6.7	3.1	5.4	.4	3.3	3.6
	Prefab					.5	.3	.1
	Bare bricks/cement blocks	12.7	36.8	24.0	20.0	16.3	19.1	23.3
	Plastered/finished	40.9	49.1	36.2	63.6	55.8	74.2	52.3
	Other	.7	1.8	.2	.2	.7	.3	.8
	Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Ownership of facilities

The results in Figure 2.21 show ownership of specific items in the province. Most households own a radio (79.1%). Many own a television (65.3%), cellular phones (66.2%), and refrigerators (56.5%). Items like cars and computers are not widely owned by households in the province (Figure 2.21 and Table 2.26).

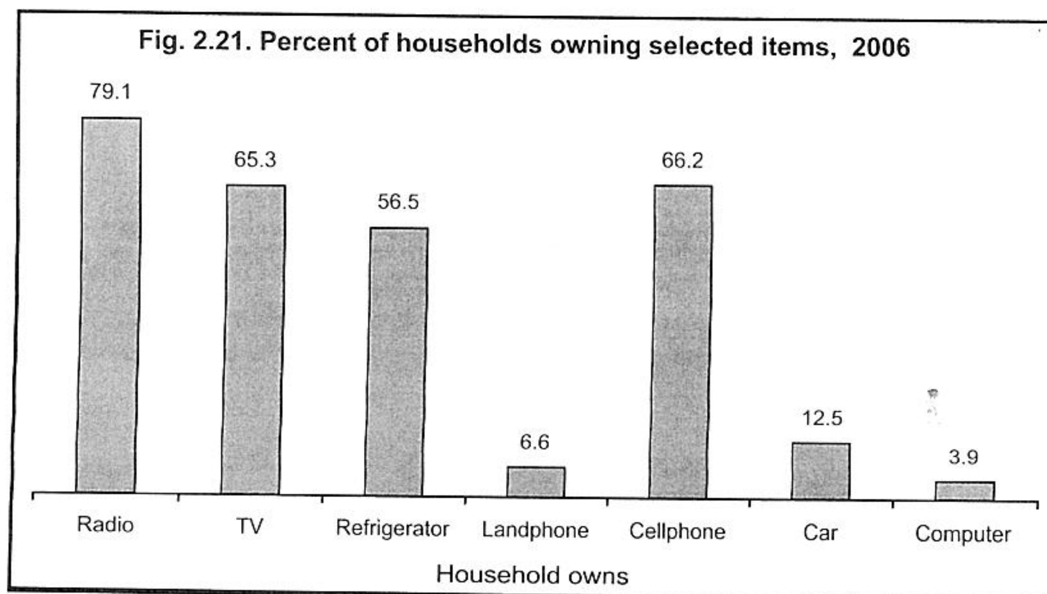


Table 2.26. Percent of household owning selected items for districts and place of residence, 2006

Items	District						Residence		All
	Bohlabela	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	Rural	Urban	
A radio	75.6	84.0	75.5	77.8	77.1	82.7	78.2	83.6	79.1
A television	56.0	71.2	58.6	73.0	58.0	77.0	61.6	84.7	65.3
A computer	3.1	6.4	2.4	2.3	2.5	6.7	2.9	18.2	3.9
A refrigerator	55.3	57.2	56.6	66.0	45.5	67.3	53.2	73.5	56.5
Land telephone	3.4	9.8	8.3	3.9	3.0	11.2	3.2	24.4	6.6
Any type of phone	75.9	76.1	73.6	76.8	63.1	77.6	70.5	84.7	72.8
A bicycle	6.9	16.3	10.0	9.3	12.8	16.4	14.7	22.2	12.5
A motorcycle /scooter	0.3	1.2	0.3	0.2	0.5	1.2	0.4	1.8	0.6
A car	5.5	20.9	8.5	7.4	8.6	23.3	9.7	38.8	12.6
A bakkie or truck	4.5	2.5	2.1	2.9	2.5	6.7	3.2	8.6	4.7
Donkeys or horses	0.7	1.9	1.6	2.7	1.1	0.6	1.8	0.4	1.6
Sheep or goats	5.8	7.5	4.6	16.5	8.0	2.1	9.1	1.1	7.8
Cattle	2.7	7.9	5.1	6.8	4.2	4.5	6.3	2.0	5.6

Sources of energy

Sources of energy for cooking, heating and lighting are shown in Figure 2.22 and in Table 2.27. Electricity is the principal source of energy for lighting in the province. It is used by more than eighty percent of the households for this purpose. 40% of the households use electricity for cooking and 40% use firewood for cooking. Wood or straw constitutes the main source of energy for heating, followed by electricity. Some variations in the use of electricity for various energy uses can be observed in Table 2.27. For instance use of electricity for cooking is higher in Waterberg and Capricorn than in other districts, and far higher in urban areas.

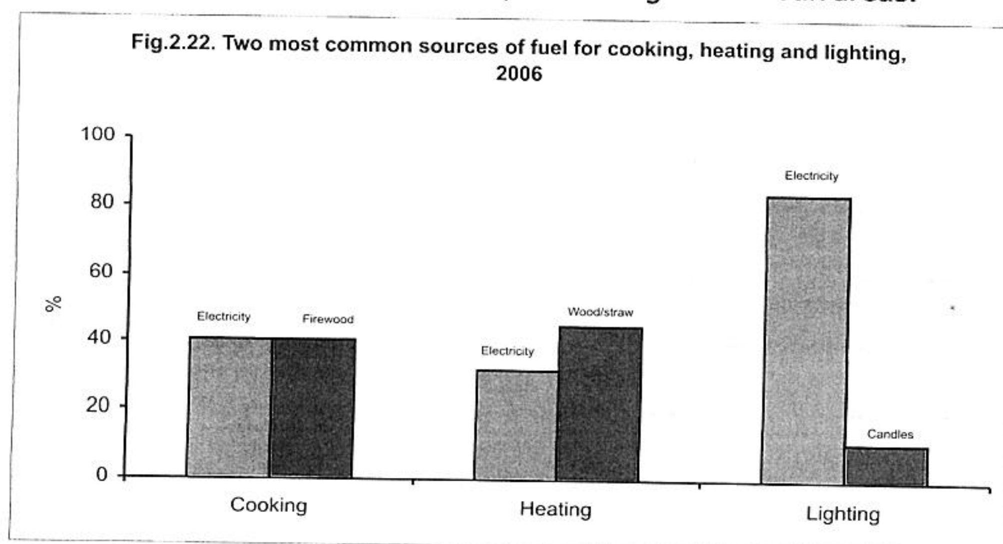


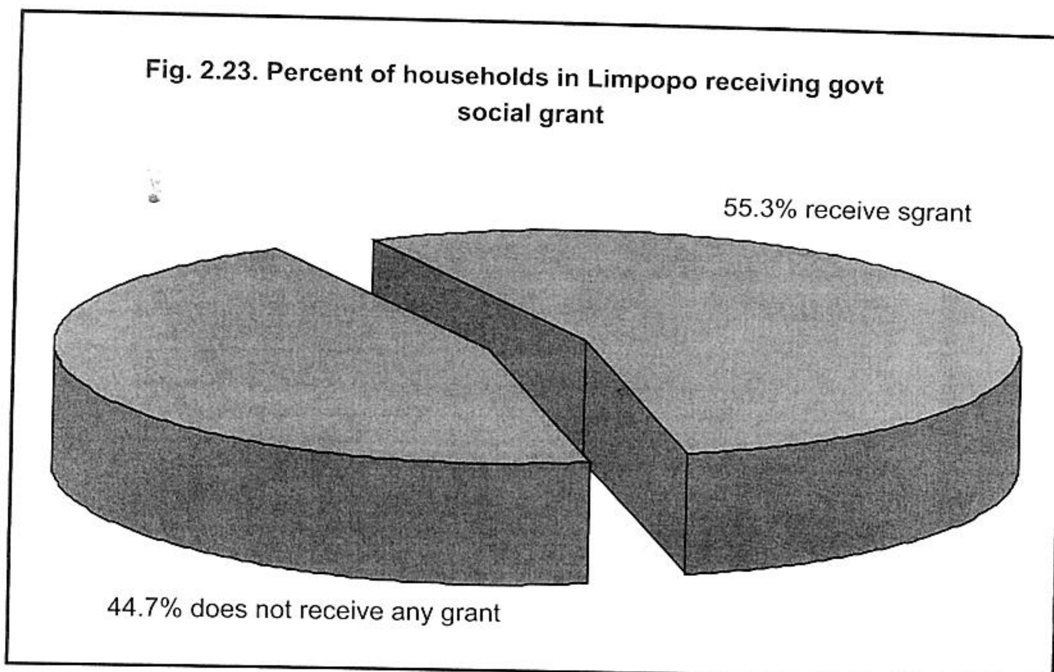
Table 2.27. Percent (%) distribution of households by types of fuel used: Limpopo province 2006

		District						Type of place		All Limpopo
		Bohlabela	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	Rural	Urban	
What you use for cooking	Electricity	37.1	45.6	37.0	30.2	37.9	59.4	34.2	73.5	40.5
	Gas	1.0	2.1	.8	.8	1.4	1.5	1.3	1.8	1.4
	Paraffin	12.0	19.5	5.1	14.4	4.4	12.1	10.7	13.6	11.2
	Coal	.7	2.7	3.1	27.8	2.1	1.8	6.9	2.6	6.2
	Firewood-straw	49.1	30.1	53.8	26.3	53.6	24.8	46.6	8.5	40.5
	Animal dung						.3	.0		.0
	Other			.2	.6	.6		.3		.3
Total		**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
What you use for heating	Electricity	11.7	35.3	32.1	14.4	36.3	54.5	25.6	63.2	31.6
	Gas	.3	1.1	.8	.4	1.6	.9	1.0	.9	1.0
	Paraffin	.7	1.9	1.3	.6	2.2	1.5	1.3	2.9	1.5
	Coal	1.0	6.5	4.7	37.9	3.5	1.8	9.9	6.3	9.3
	Firewood-straw	66.3	39.7	56.6	25.7	51.7	30.9	50.8	13.8	44.9
	Animal dung		.1		.4		.3	.1		.1
	Other	19.9	15.4	4.4	20.6	4.6	10.0	11.3	12.9	11.5
Total		**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
What you use for lighting	Electricity	85.9	80.3	84.2	80.7	84.1	95.2	84.0	83.1	83.9
	Gas	.7	2.0	1.6	.4	2.5	1.5	1.6	2.0	1.6
	Paraffin	2.4	2.7	.7	2.3	2.5		1.8	2.9	1.9
	Coal		.1	.3	.6			.2	.2	.2
	Candles	8.9	14.3	13.2	14.0	10.0	2.7	11.4	11.6	11.4
	Firewood-straw	2.1	.4		.4	.6	.3	.6		.5
	Other		.2		1.6	.4	.3	.5	.2	.4
Total		**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Sources of water supply and refuse removal

Most households use water piped into site/yard or public tap. Together these two sources are used by close to seventy percent of all households in the province (Table 2.28). Most households dump their refuse, burn them or dispose of them in any other way (Table 2.29). Only in some cases (17 .5%) does the local authority perform this task.

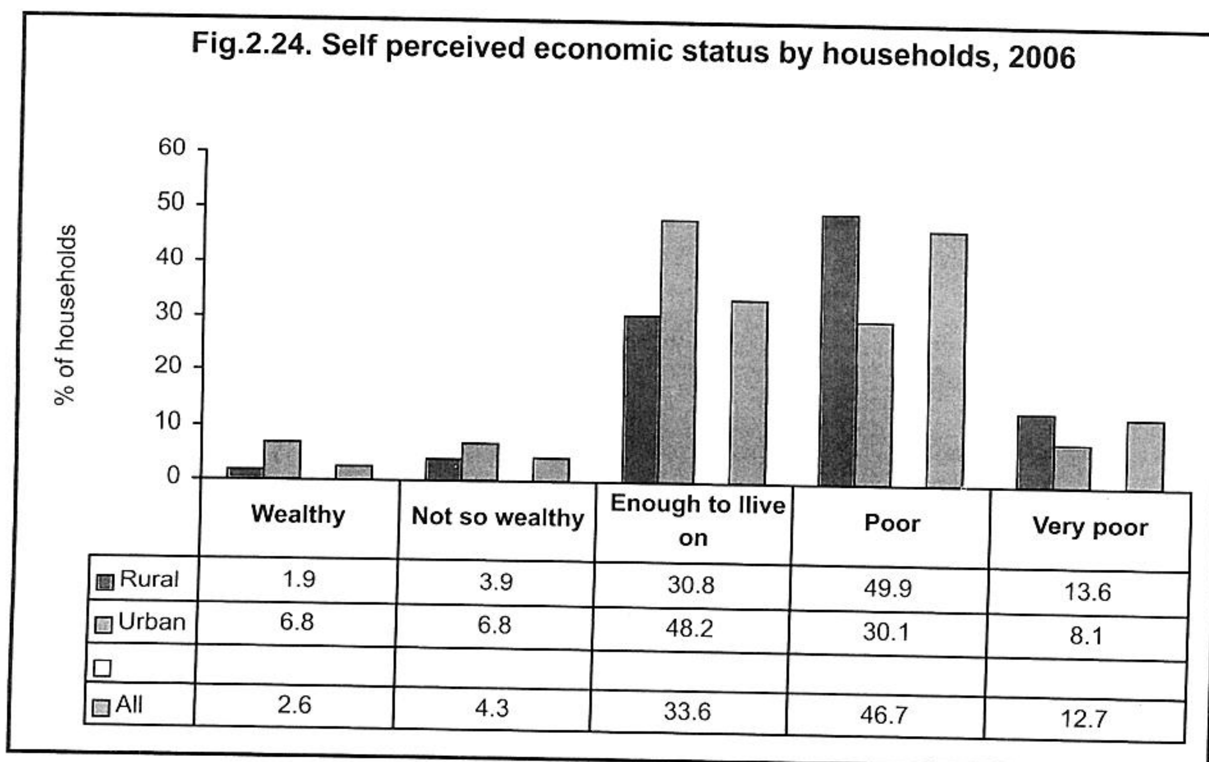
Receipt of government grants



The study found that just more than half of all households receive government grants (Figure 2.23). The data also show that about fourteen percent receive more than one grant from the government (see Table 2.30). Considering the relatively high rate of teenage and non-marital childbearing in the province, child support grant is likely to account for a substantial proportion of grants provided by the provincial government.

Economic status

The difficulty in getting accurate responses about individual and household income in surveys is well-documented. In this study an additional question was included in order to get some information about the subjective perception by households about their economic status. Asked about how they perceive their economic status, more than half of the population see their households as poor or very poor (Figure 2.24).



	Wealthy	Not so wealthy	Enough to llive on	Poor	Very poor
Rural	1.9	3.9	30.8	49.9	13.6
Urban	6.8	6.8	48.2	30.1	8.1
All	2.6	4.3	33.6	46.7	12.7

Table 2.28. Percent (%) distribution of households by source of water supply: Limpopo province 2006

Main source of drinking water	District						Type of place		All Limpopo
	Bohlabela	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	Rural	Urban	
	5.5	16.4	12.9	3.1	10.2	26.7	4.4	54.2	12.4
Piped into site/yard	33.0	40.9	49.3	26.1	28.5	44.8	36.5	39.3	36.9
Public tap	52.2	25.7	28.7	21.8	49.9	16.4	37.9	5.7	32.7
Water from open well	.3	.7			1.0	.3	.5	.2	.5
Water from covered well/borehole	3.4	12.0	4.4	10.5	2.5	10.3	8.6	.2	7.3
Spring				14.4	.9	.6	2.9		2.4
River/stream	.3	.2	1.8	4.3	2.0		1.8		1.5
Pond/Lake	1.0						.1		.1
Pool/stagnant water				4.3			.8		.6
Dam				10.3	1.7		2.3		2.0
Rain water				.2			.0		.0
Water supplier/tanker	3.1	.8	1.6	.2	2.4		1.6		1.4
Water vendor/bottled water	1.0	1.1	.3	1.9	.9	.6	1.2		1.0
Other		2.1	1.0	2.9	.1	.3	1.4	.4	1.2
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 2.29. Percent (%) distribution of households by type of refuse removal facility: Limpopo province 2006

How is household rubbish removed?	District						Type of place		All Limpopo
	Bohlabela	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	Rural	Urban	
By local authority at least once a week	2.4	23.2	19.6	8.6	4.1	37.9	4.7	72.2	15.5
By local authority less than once a week	1.0	.2	5.2		1.2	6.1	.5	9.6	2.0
Communal refuse dump	2.4	1.1	1.0	.2	1.5		1.0	1.1	1.0
Own household refuse dump	76.3	19.7	45.7	64.6	69.8	13.9	54.2	11.0	47.3
Burn household refuse	16.2	38.0	20.2	12.8	15.4	26.7	26.1	4.6	22.7
No refuse disposal	1.7	17.8	8.3	13.8	8.0	15.5	13.5	1.5	11.6
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Table 2.30. Percent (%) distribution of households by perceived economic status and receipt of govt grants: Limpopo 2006

		District						Type of place		All Limpopo
		Bohlabela	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	Rural	Urban	
Perceived economic status of household	Very rich-wealthy	2.4	2.7	1.3	4.7	2.0	3.6	1.9	6.8	2.6
	Not so wealthy	1.7	4.2	2.8	10.5	3.5	2.1	3.9	6.8	4.3
	Enough to live on	28.2	34.9	37.0	39.5	25.0	40.3	30.8	48.2	33.6
	Poor	57.4	47.6	47.1	41.2	44.0	49.1	49.9	30.1	46.7
	Very poor	10.3	10.5	11.7	4.1	25.5	4.8	13.6	8.1	12.7
Any household member receives govt grant	Yes	61.2	50.1	57.4	61.5	56.6	46.7	58.9	36.4	55.3
	No	38.8	49.9	42.6	38.5	43.4	53.3	41.1	63.6	44.7
Total		**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Number of grants received by household	Only 1 grant	89.9	84.2	83.5	88.0	87.7	85.1	85.7	89.9	86.2
	2 or more grants	10.1	15.8	16.5	12.0	12.3	14.9	14.3	10.1	13.8

The reported income and expenditure profile of households in the province are contained in the data presented in Figure 2.25 and Table 2.31. As in this type of information, the expenditure tends to be more than income. But the expected pattern is the clustering of households in the population around the very low income categories.

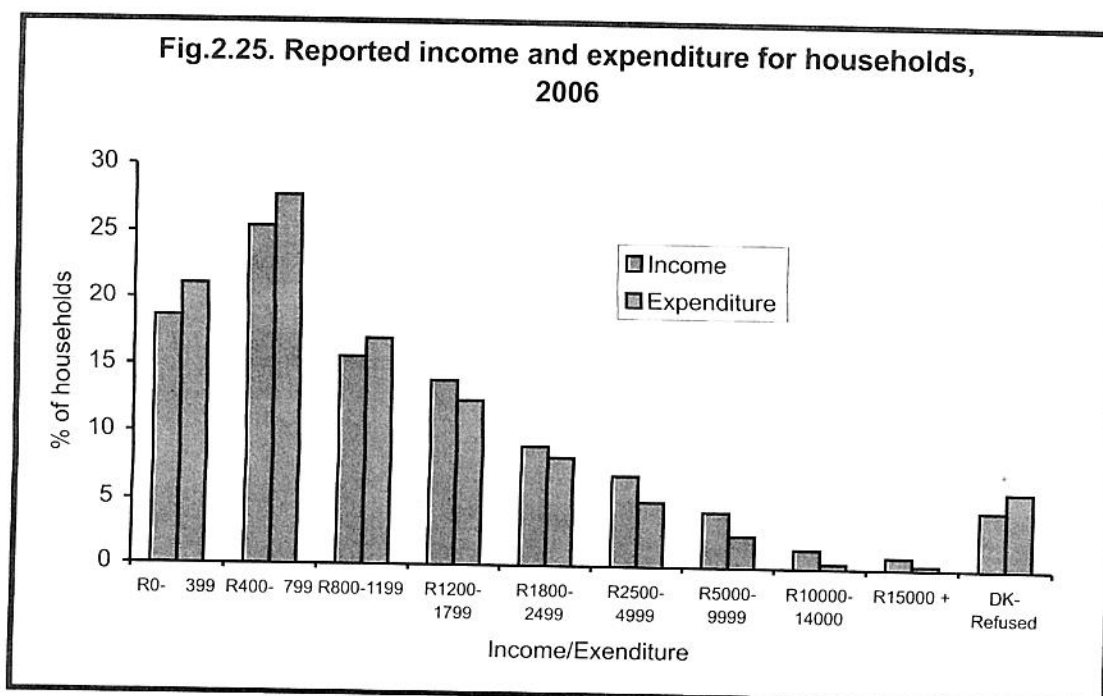


Table 2.31. Percent (%) distribution of households by income and expenditure levels: Limpopo province 2006

		District						Type of place		All Limpopo
		Bohlabela	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	Rural	Urban	
Total household income	**R 0 - R 399**	**30.9**	**9.9**	**17.8**	**12.5**	**33.1**	**6.4**	**20.6**	**8.5**	**18.6**
	R 400 - R 799	32.6	24.3	19.4	29.8	28.7	17.6	27.3	15.1	25.4
	R 800 - R 1 199	12.7	17.6	17.1	16.5	12.7	16.4	16.4	11.9	15.6
	R 1 200 - R 1 799	8.2	15.3	13.1	17.3	12.4	14.8	14.7	9.7	13.9
	R 1 800 - R 2 499	6.2	8.6	10.6	13.8	4.5	11.5	8.5	10.5	8.9
	R 2 500 - R 4 999	3.8	8.5	8.0	4.5	4.4	12.1	5.8	11.9	6.8
	R 5 000 - R 9 999	1.0	4.8	6.2	3.1	2.1	8.5	2.8	11.4	4.2
	R 10 000 - R14 000		2.0	2.0	.2	.4	4.2	.3	7.0	1.4
	R 15 000 +	.7	1.2	1.6		.1	2.1	.2	4.2	.9
	Don't know	2.7	6.3	3.1	1.8	.4	3.6	2.3	7.0	3.1
	Refused to say	1.0	1.5	1.1	.6	1.2	2.7	1.1	2.8	1.3
	Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Total household expenditure	**R 0 - R 399**	**29.6**	**14.5**	**20.2**	**16.5**	**34.0**	**7.6**	**23.2**	**9.7**	**21.1**
	R 400 - R 799	35.1	25.9	22.7	32.1	30.8	20.9	29.7	17.5	27.7
	R 800 - R 1 199	14.4	16.6	19.1	19.3	13.3	20.6	17.6	13.2	16.9
	R 1 200 - R 1 799	7.6	14.4	12.9	15.8	9.2	13.6	12.6	11.6	12.4
	R 1 800 - R 2 499	5.5	9.0	8.2	9.3	4.9	14.2	7.5	11.6	8.1
	R 2 500 - R 4 999	3.1	6.5	7.5	2.1	2.2	8.2	3.7	11.2	4.9
	R 5 000 - R 9 999	.3	3.4	3.9	1.4	.5	5.2	.9	10.1	2.4
	R 10 000 - R14 000	.3	.7	.7	.2	.1	.3	.1	2.0	.4
	R 15 000 - R19 999		.2	.2			.9	.0	.9	.2
	R 20 000 or more		.1	.2			.3	.1	.2	.1
	Don't know	2.4	6.7	3.3	1.8	2.5	5.2	2.8	9.0	3.8
	Refused to say	1.7	1.9	1.3	1.6	2.5	3.0	1.8	2.9	2.0
	Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

PART II

DEMOGRAPHIC AND SOCIOECONOMIC IMPACTS OF HIV AND AIDS

3.1. DEMOGRAPHIC IMPACTS OF AIDS

The epidemiological profile of HIV and AIDS sets the scenario for the demographic impacts of AIDS in the province. The projected data presented in Table 3.1, Table 3.2, Table 3.3 and Table 3.5 were derived from the ASSA2003 model produced by the Actuarial Society of South Africa.

Table 3.1 shows the projected prevalence of HIV in the province from 2006 to 2015. HIV prevalence is projected to increase in the future with accompanying demographic consequences in the next 10 years. The number of all adults who are currently HIV positive in the province is estimated to be 13.7% of the adult population (aged 20-64). This figure is projected to reach 14.5% of adult population, and 8.3% of total Limpopo population by 2015.

Table 3.1. Projected Prevalence rates of HIV in Limpopo Province, 2006-2015

	Women aged 15-49	Men aged 15-49	Men and women aged 15-49	Adult women aged 20-64	Adult men aged 20-64	All adults aged 20-64	Total Population Limpopo
2006	14.9	8.7	12.1	15.2	11.7	13.7	6.9
2007	15.3	8.8	12.3	15.6	11.7	13.9	7.1
2008	15.6	8.9	12.5	15.8	11.8	14	7.3
2009	15.8	9.1	12.7	16.1	11.8	14.2	7.5
2010	16	9.3	12.8	16.2	11.9	14.3	7.7
2011	16.1	9.5	13	16.3	12	14.4	7.9
2012	16.2	9.7	13.1	16.4	12.1	14.4	8
2013	16.3	9.9	13.2	16.4	12.3	14.5	8.1
2014	16.3	10.2	13.4	16.4	12.4	14.5	8.2
2015	16.3	10.4	13.5	16.3	12.5	14.5	8.3

The projected annual new cases of HIV infections in the province also ranges from over 46 thousand in 2006 to more than 49 thousand individuals by 2015 (Table 3.2). These data illustrate the huge burden that will be placed on provincial health and social services directly in the next few years as a result of HIV and AIDS related illnesses.

Table 3.2. Projected incidence rates of HIV in Limpopo Province, 2006-2015

Period/Year	Annual new infections	Incidence rate (%)
2006	46 545	0.9
2007	46 887	0.9
2008	47 275	0.9
2009	47 632	0.9
2010	47 982	0.9
2011	48 354	0.9
2012	48 723	0.9
2013	49 071	0.8
2014	49 386	0.8
2015	49 656	0.8

Sickness and mortality impacts

Short term projections that illustrate the sickness and mortality impacts of HIV and AIDS in Limpopo province are presented in Table 3.3. The number of people currently infected with HIV in the province could be anything plus or minus four hundred thousand (400 000). It is projected that this number will rise to more than half a million by 2015. Close to four percent of all births are likely to be infected prenatally and through mother's birth milk.

There could be about 39 474 people currently sick with AIDS in the province. This figure is projected to rise to more than 64 000 by 2015.

The projections in Table 3.3 show that any hope of improvement in longevity (measured by the expectation of life at birth) could be stifled by the impacts of HIV and AIDS. In the absence of AIDS, expectation of life would be expected to rise gradually. The current expectation of life is 56.2 years and is expected not to improve but rather shorten to 55.5 years by 2015.

Table 3.3. Morbidity impacts of AIDS in Limpopo Province, 2006-2015

Period/ Year	Projected number and percent of people infected by HIV, and total AIDS sick Limpopo province 2006-2015				Longevity/ Expectation of life at birth (Eo)
	Total number of people infected with HIV	Total births infected prenatally & mothers' milk		Total AIDS sick	
	Number	Number	% of total births		
2006	396 873	6 102	3.9	39 474	56.2
2007	415 652	6 231	4	42 559	55.9
2008	433 820	6 376	4.1	45 229	55.8

Period/ Year	Projected number and percent of people infected by HIV, and total AIDS sick Limpopo province 2006-2015				Longevity/ Expectation of life at birth (Eo)
	Total number of people infected with HIV	Total births infected prenatally & mothers' milk		Total AIDS sick	
	Number	Number	% of total births		
2009	451 553	6505	4.2	47 390	55.8
2010	468 659	6615	4.2	50 275	55.7
2011	484 851	6707	4.2	53 305	55.6
2012	500 094	6780	4.2	56 243	55.5
2013	514 430	6834	4.2	59 008	55.5
2014	527 909	6872	4.2	61 601	55.6
2015	540 554	6895	4.2	64 046	55.6

Impacts on infant mortality rate

Infant mortality rate (IMR) is one of the most sensitive indicators of health and socioeconomic development. Table 3.4 shows estimates of infant mortality rate for the province for three 5-year periods since 1994. The most recent estimate is from the current survey. Estimates for 1994-1998 were from the 1998 Demographic and Health Survey. The estimates for 1999-2003 were from the 2003 Demographic and Health Survey. The rate of infant mortality estimated from this study is 41.7 per thousand live births. This is higher than the level of 37.2 and 34.7 which were estimated for 1998 and 2004 respectively. These figures suggest that infant mortality has increased slightly, most probably reflecting an impact of HIV and AIDS.

Table 3.4. Recent trend in infant mortality rate (1994-2006)

Period	Infant mortality rate
2002-2006	41.7
1999-2003	34.7
1994-1998	37.2

Impacts on fertility

Although the province has one of the highest total fertility rate in the country, there is an established trend in fertility decline. Considering key fertility determinants and their directions, the most likely impact of AIDS will be to increase the speed of the existing declining trend in fertility. In this respect, the impacts of AIDS could present different forms of crisis to childbearing in the province. If HIV and AIDS artificially and prematurely push total fertility rate below the replacement level, this could have longer term implications for family structure and human resources supply for the province.

Impacts on orphans and vulnerable children

One of the sub-group most seriously affected in the province are orphans and vulnerable children. The number of this group is projected to rise from 78 569 to as many as 192 150 by 2015. It is also projected that the proportion of young people who become orphans as a result of AIDS will increase from a current level of 57.4% to 81.5% by 2015.

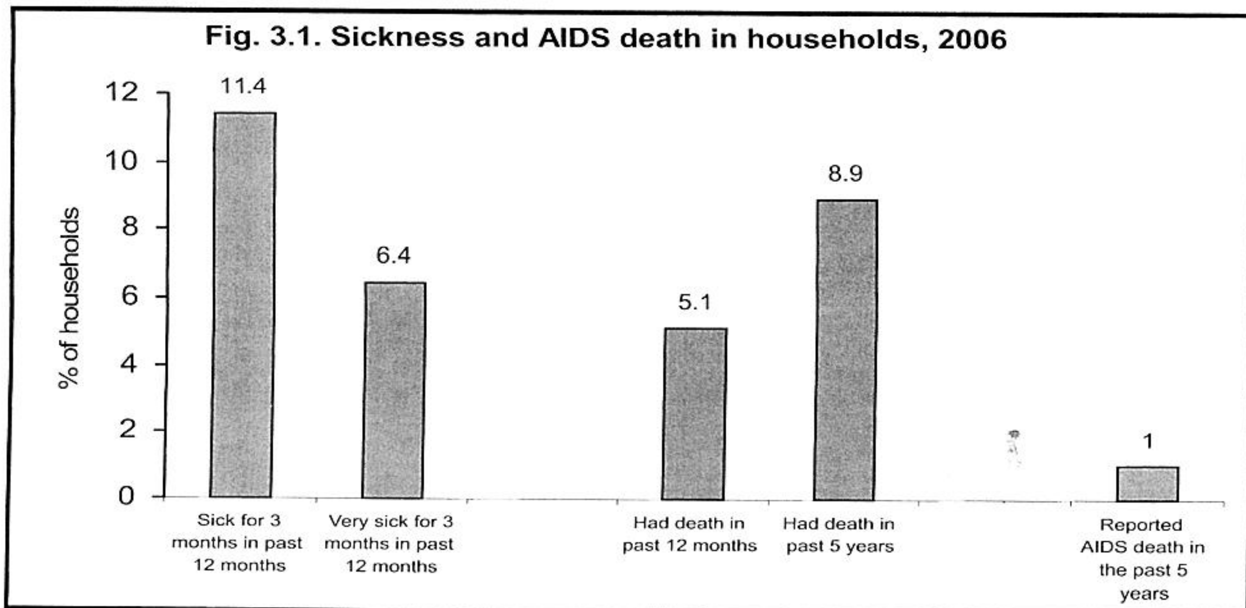
Table 3.5. Projected AIDS orphans in Limpopo Province, 2006-2015

Year	Total AIDS orphans	AIDS orphans as a % of all orphans
2006	78 569	57.4
2007	94 208	62.5
2008	109 481	66.7
2009	123 950	70.1
2010	137 460	72.9
2011	150 143	75.3
2012	161 994	77.3
2013	172 974	78.9
2014	183 081	80.3
2015	192 150	81.5

3.2. AIDS AND HOUSEHOLDS

Sickness in the household

The survey results on recent sickness in the households are reported in Figure 3.1 and Table 3.2, Table 3.3 and Table 3.4. These results are statistically about rare events, such as sickness and death from a sample survey. As a result the findings could be susceptible to fluctuations. Nevertheless, they can and do provide substantive indicators. First, it is observed that 11.4% of households reported that they had sick people and 6.4% reported that they had very sick people in the past year. Comparable figures of sick and very sick people for the past 5 years were smaller.



Main sources of health services for households

For the majority of households, the public health sector is the major source of health care. The private health care sector serves less than ten percent of households in the province (Figure 3.2 and Table 3.6).

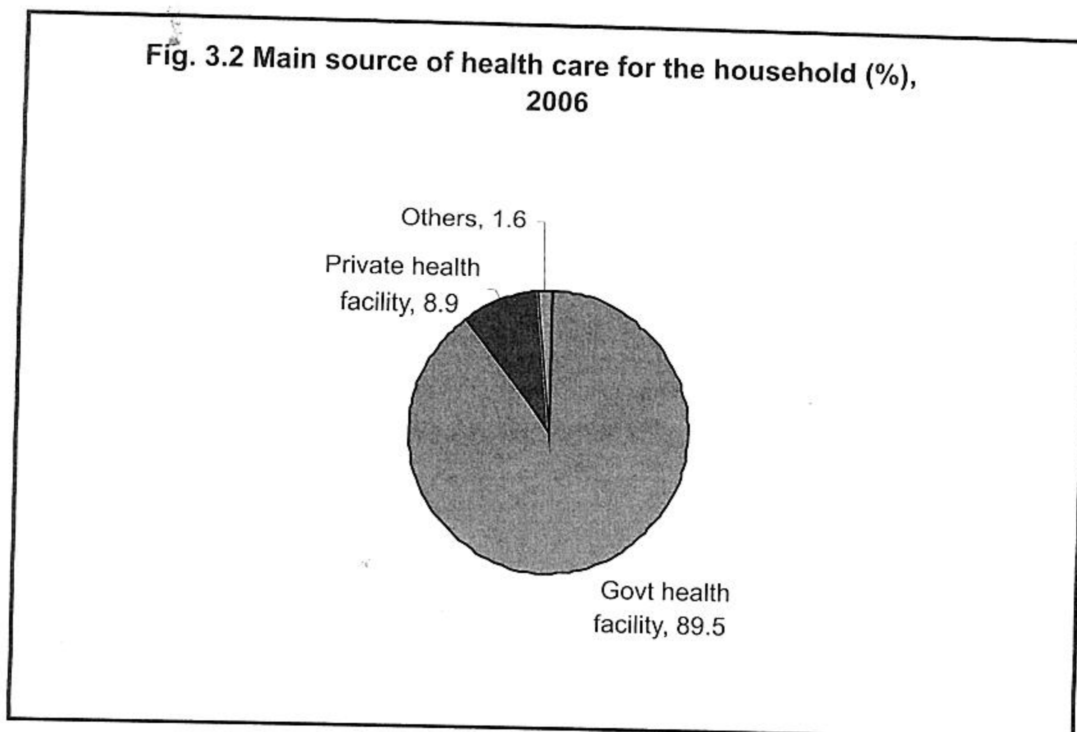


Table 3.6. Percent (%) distribution of households by main source of health services: Limpopo 2006

Which sector provide health services	District						Type of place		All Limpopo
	Bohlabela	Capricorn	Mopani	Sekhukhune	Vhembe	Waterberg	Rural	Urban	
Government hospital	8.9	17.5	9.3	8.9	27.6	9.7	15.2	18.0	15.6
Government health centre-clinic	85.6	58.7	73.9	84.4	65.7	70.9	74.9	47.4	70.5
Mobile health clinic	1.0	5.5	3.4	2.3	2.7	.3	3.0	3.5	3.1
Community health workers			.2		.1		.1		.1
Other government health facility					1.2		.4		.3
Private hospital		1.7	.2		.1		.3	1.3	.5
Private hospital-clinic	.3	1.8	.7	.2	.2	.3	.3	2.9	.7
Pharmacy		.9	.2			.3	.2	.6	.3
Private doctor	2.7	10.5	10.4	2.5	1.7	13.6	3.9	22.4	6.9
Other private medical services		.2	1.0			2.7	.1	2.8	.5
Traditional healers		.2	.3	.2		.3	.1	.4	.2
Others	1.4	2.9	.5	1.4	.5	1.8	1.6	.7	1.4
Total	**291**	**848**	**613**	**514**	**804**	**330**	**2856**	**544**	**3400**
	100.0	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Table 3.7. Percent (%) distribution of households according to number of people who are sick for at least 3 months in the past 12 months: Limpopo 2006

		Number of people who are sick for at least 3mths past 12 months					Number of people who are very sick for at least 3mths past 12 months			Total	
		None	1	2	6	8	None	1	2		
District	Bohlabela	79.7	19.6	.3		.3	90.0	8.2	1.7	**291**	**100**
	Capricorn	92.6	6.7	.6	.1		95.4	3.9	.7	**848**	**100**
	Mopani	90.4	8.8	.8			94.0	5.7	.3	**613**	**100**
	Sekhukhune	88.3	11.7				97.7	1.9	.4	**514**	**100**
	Vhembe	86.1	13.7	.2			90.0	8.7	1.2	**804**	**100**
	Waterberg	90.0	9.7	.3			93.6	5.8	.6	**330**	**100**
Type of place	Rural	88.0	11.4	.5	.0	.0	93.3	5.8	.8	**2856**	**100**
	Urban	91.9	7.9	.2			95.0	4.4	.6	**544**	**100**
All Limpopo		**88.6**	**10.9**	**.4**	**.0**	**.0**	**93.6**	**5.6**	**.8**	**3400**	**100**

Table 3.8. Any member of the household died in the last 12 months & 5 years: Limpopo province 2006

		Any deaths in the last 12 months		Any deaths in the last 5 years			
		Yes	**No**	**Yes**	**No**	**Total (N)**	
District	Bohlabela	4.1	95.9	12.0	88.0	**291**	**100.0**
	Capricorn	3.3	96.7	7.3	92.7	**848**	**100.0**
	Mopani	4.2	95.8	9.0	91.0	**613**	**100.0**
	Sekhukhune	4.1	95.9	6.8	93.2	**514**	**100.0**
	Vhembe	10.0	90.0	11.9	88.1	**804**	**100.0**
	Waterberg	1.8	98.2	6.1	93.9	**330**	**100.0**
Type of place	Rural	5.5	94.5	9.7	90.3	**2856**	**100.0**
	Urban	2.8	97.2	4.8	95.2	**544**	**100.0**
All Limpopo		**5.1**	**94.9**	**8.9**	**91.1**	**3400**	**100.0**

Table 3.9. Deaths in the household in the past 12 months and 5 years

Number of people	**Type of place**			
	Rural		**Urban**	
	How many died in the past 12 months	**How many died in the last 5 yrs?**	**How many died in the past 12 months**	**How many died in the last 5 yrs?**
0	94.0%	90.0%	97.1%	94.9%
1	5.0%	8.4%	2.4%	4.8%
2	.9%	1.3%	.6%	.4%
3	.0%	.2%		
4	.0%	.1%		
5		.0%		
All	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Reported death due to AIDS

Reported death in the household in the past year is appreciably more difficult to estimate with simple percentages. People are reluctant to talk about death in the household, especially in relation to HIV and AIDS. This is true for the household death data in Table 3.7 and Table 3.8. The data in Figure 3.3 shows that the number of deaths reported in the household is far more in the 40's, declines gradually and picks up from the very old ages of 70 or older. The 10-19 age group recorded the smallest reported deaths in the period.

It is difficult to ascertain the number of death due to AIDS from a cross-sectional survey. However, the data indicate that overall, only one percent of households reported a death that was specifically due to AIDS during the past 12 months. Only 1% of all households reported that a death in the past 5 years was AIDS related. This is evidence of under reporting, and is indicative of the secretive attitude of households and communities in general to HIV and AIDS among their members. They are comfortable to talk about AIDS as a general problem. When probed about closer impacts in the household, the population remains secretive and almost in denial about their close experience of the problem.

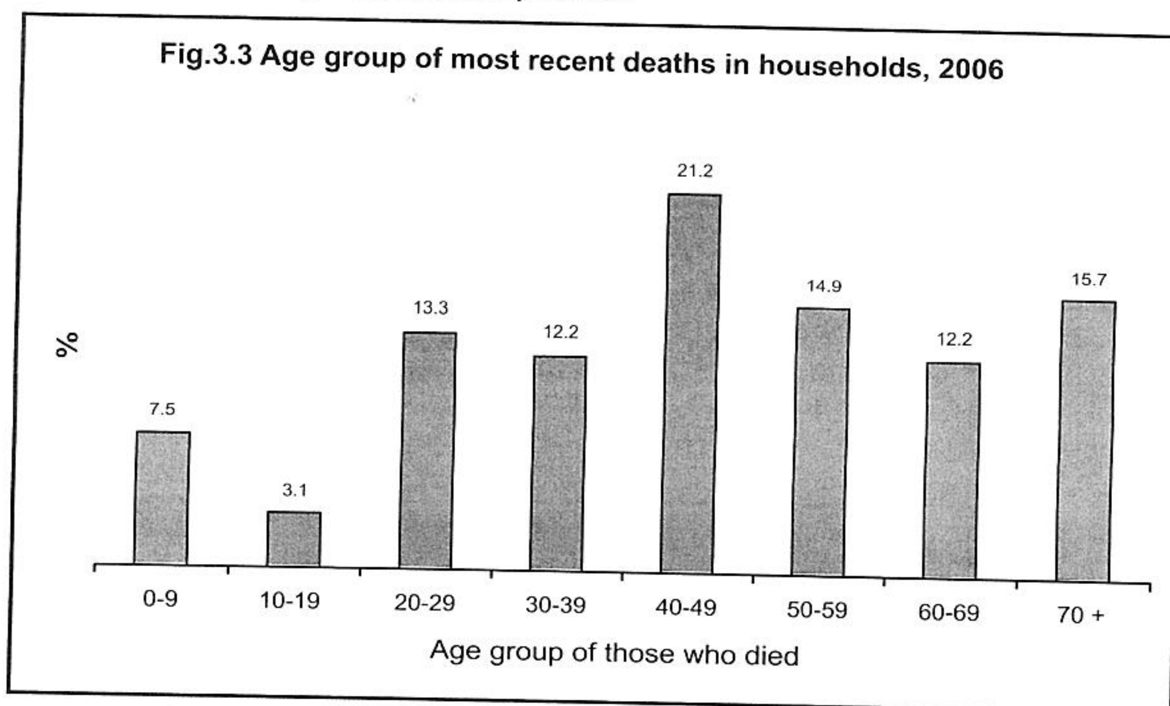


Table 3.10. Number of deaths in the past 5 years due to AIDS: Limpopo province 2006

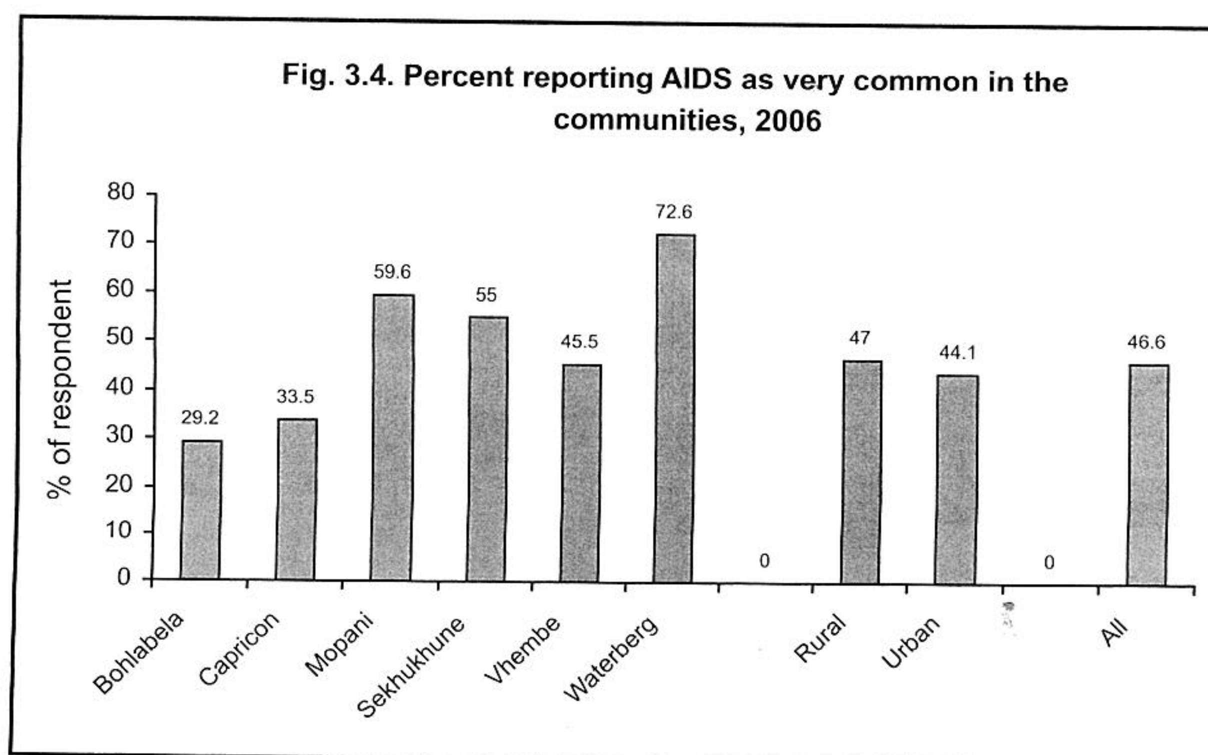
		How many died of HIV/AIDS-related illnesses?					
		0	1	2	4	Total (N)	
District	Bohlabela	97.6	2.1	.3		291	100
	Capricorn	99.5	.5			848	100
	Mopani	99.2	.2	.3	.3	613	100
	Sekhukhune	99.6	.4			514	100
	Vhembe	98.6	1.0	.4		804	100
	Waterberg	98.2	1.2	.6		330	100
Type of place	Rural	98.8	.8	.3	.1	2856	100
	Urban	99.6	.4			544	100
	All Limpopo	**99.0**	**.7**	**.2**	**.1**	**3400**	**100**

3.3 AIDS AND THE COMMUNITY

AIDS reported as a major problem in the community

In the absence of very reliable direct statistical estimates of the true level of AIDS death prevalence at the level of household, information was collected about perceptions around AIDS deaths in the community. The percent of respondents who reported AIDS as very common in their community are shown in Figure 3.4.

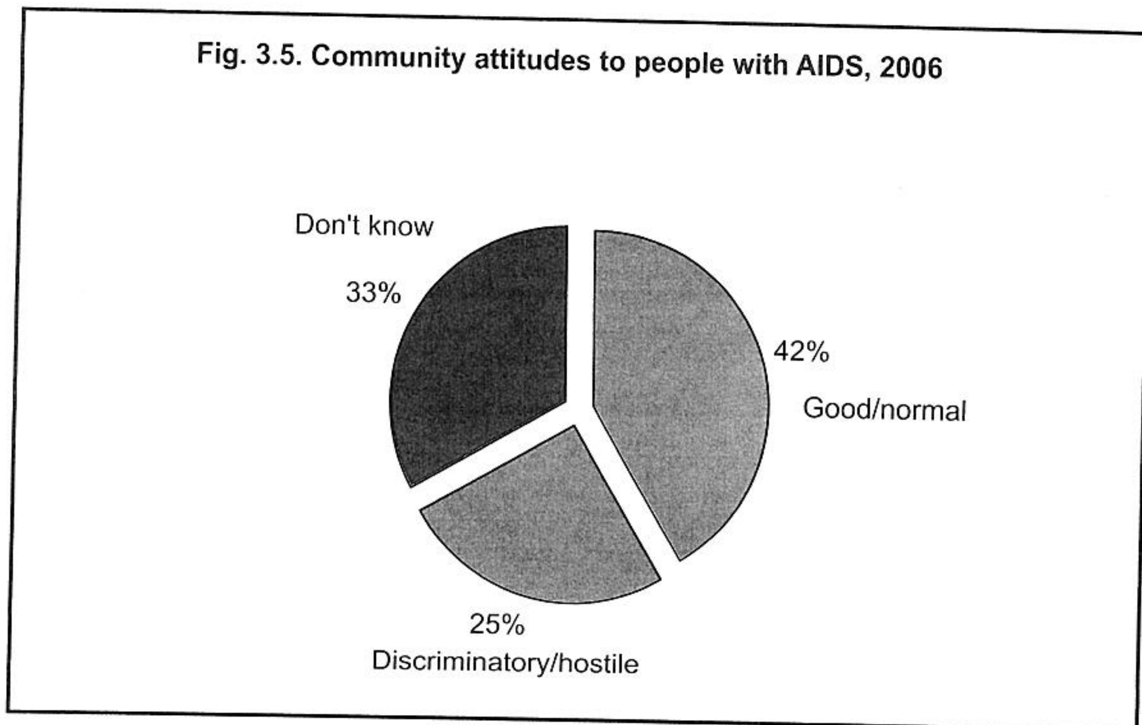
Just under half of the respondents indicated that AIDS was prevalent in their communities. The percentages are not markedly different in rural and urban areas (47% and 44% respectively). The highest percentages are reported in Waterberg (72.6%) and Mopani (59.6%).



Community attitudes

Reports of community attitudes to people with AIDS are shown in Figure 3.5. Less than half of community respondents indicated that community attitude to those with AIDS was good or normal. Only a quarter of respondents indicated that community members discriminated or were hostile to those living with AIDS. However, about 33% indicated that they did not know community attitude to those living with AIDS.

When related to the findings from qualitative study, especially the detailed focus group discussions, a more accurate picture unfolds. The real level of stigma and discrimination is higher, and manifests when a practical HIV and AIDS situation is encountered in the society.



Deaths due to AIDS in the community

Figure 3.6 shows that only 10.1% of community respondents indicated that they did not have deaths due to AIDS in the past 12 months. Around 15.1% reported between 1-5 deaths in the community in the past 12 months.

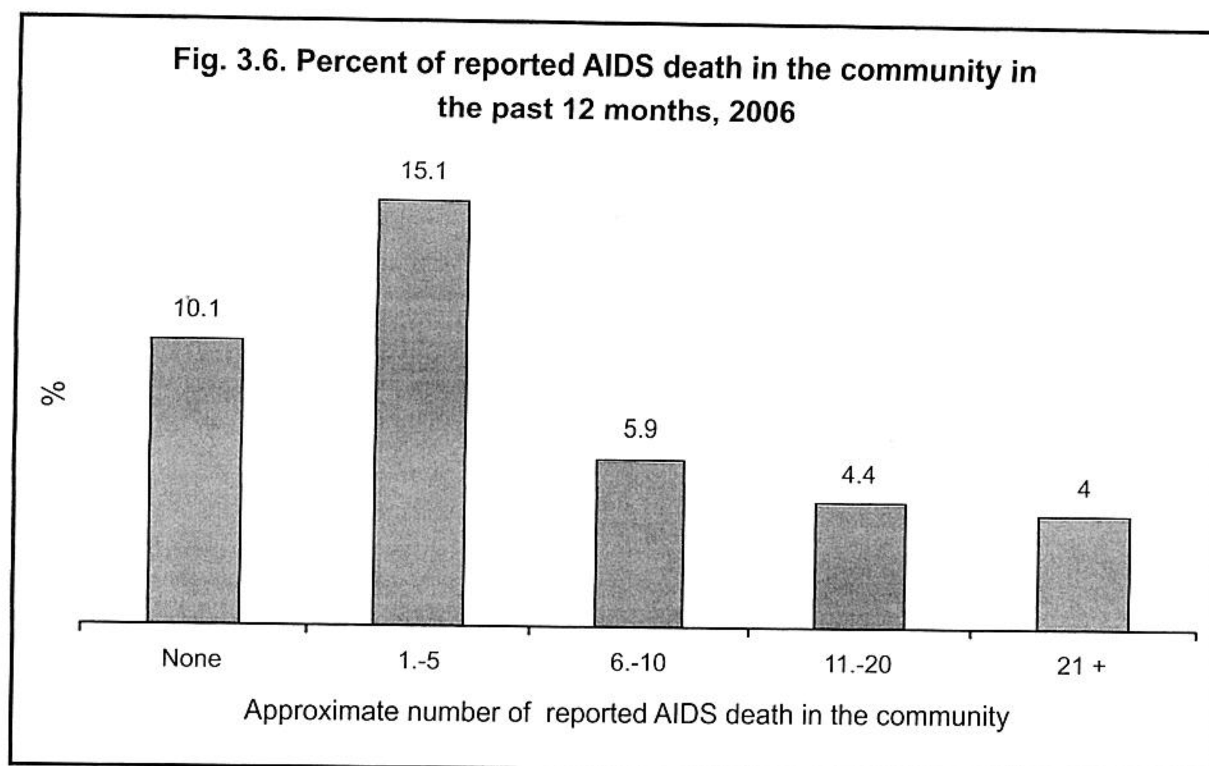


Fig. 3.6. Percent of reported AIDS death in the community in the past 12 months, 2006

Table 3.11. AIDS reported as a common health problems and attitudes in the communities, Limpopo 2006

		AIDS common in this community				Attitude of community to people with AIDS			
		Very common	Some-what common	Not common	Don't know	Good/ Normal	Discrim inatory	Hostile	Don't Know
Communities in	Bohlabela	29.2	28.3	20.8	21.7	59.4	13.2	2.8	24.5
	Capricorn	33.5	6.6	13.2	46.7	29.5	7.9		62.6
	Mopani	59.6	8.3	7.1	25.0	64.7	9.6	3.8	21.8
	Sekhukhune	55.0	8.3	22.9	13.8	56.9	11.9	.9	30.3
	Vhembe	45.5	10.4	8.4	35.8	20.7	37.1	18.4	23.7
	Waterberg	72.6	3.6	4.8	19.0	58.3	13.1		28.6
All communities in Limpopo		**46.6**	**10.3**	**11.9**	**31.2**	**41.2**	**18.6**	**6.6**	**33.6**
Type of area	Rural	47.0	10.2	12.4	30.4	41.3	19.4	6.7	32.5
	Urban	44.1	11.0	8.8	36.0	40.4	13.2	5.9	40.4
All communities in Limpopo		**46.6**	**10.3**	**11.9**	**31.2**	**41.2**	**18.6**	**6.6**	**33.6**

Table 3.12. Approximate number of AIDS reported deaths in the past 12 months in the community, Limpopo 2006

		Number of AIDS deaths in this community						
		None	1 - 5	6 -10	11-20	21 +	Don't know	
Communities in	Bohlabela	6.6	17.9	10.4	5.7	7.5	51.9	**100.0**
	Capricorn	11.9	7.9	3.1	3.1	2.2	71.8	**100.0**
	Mopani	10.9	7.7	5.1	10.3	10.3	55.8	**100.0**
	Sekhukhune	6.4	28.4	9.2	4.6		51.4	**100.0**
	Vhembe	11.0	19.4	4.3	2.0	1.3	61.9	**100.0**
	Waterberg	13.1	11.9	10.7	3.6	7.1	53.6	**100.0**
All communities in Limpopo		**10.4**	**15.1**	**5.9**	**4.4**	**4.0**	**60.2**	**100.0**
Type of area	Rural	10.1	15.3	6.0	4.9	4.0	59.8	**100.0**
	Urban	12.5	14.0	5.1	1.5	3.7	63.2	**100.0**
All communities in Limpopo		**10.4**	**15.1**	**5.9**	**4.4**	**4.0**	**60.2**	**100.0**

PART III

INTERVENTIONS AGAINST HIV AND AIDS IN THE PROVINCE

4.1. COMMUNITY PREVENTION, CARE AND SUPPORT ACTIVITIES

Community AIDS prevention activities

Many community respondents (64.7%) indicated that their community has done something to prevent AIDS. Only 42% reported the existence of AIDS committees in their communities. Not all the community AIDS committee are active according to the reports (Figure 4.1 and Table 4.1).

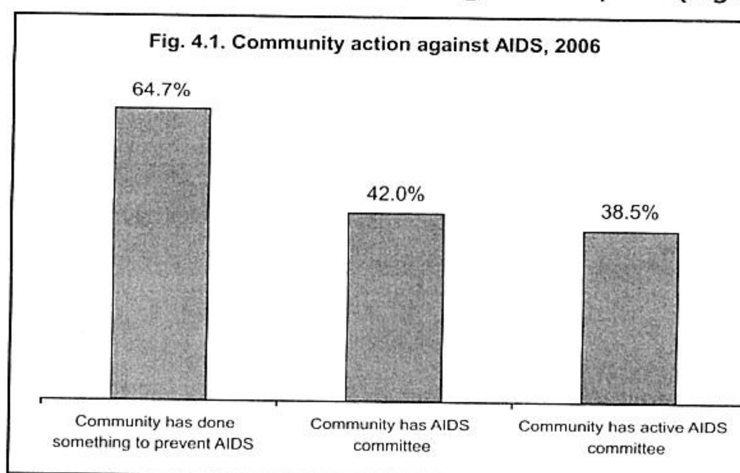


Fig. 4.1. Community action against AIDS, 2006

Details of what communities have done to prevent the spread of HIV and AIDS in the province are presented by districts and rural/urban types of residence in Table 4.2. and Table 4.4. From Table 4.2, it appears that school-based and community-based educational programme and condom distribution are among the more popular prevention activities in the communities. Table 4.3 shows that health workers take the lead in promoting HIV prevention in the communities in all districts and in rural and urban areas.

Table 4.1. Have community members done anything specifically to prevent the spread of HIV/AIDS?

		Has community done anything to prevent AIDS?			Any AIDS committee in the community?		
		Yes	No	Don't know	Yes	No	Don't know
Communities in	Bohlabela	35.8	47.2	17.0	24.5	53.8	21.7
	Capricorn	52.9	21.1	26.0	20.3	44.1	35.7
	Mopani	76.3	19.2	4.5	42.3	28.8	28.8
	Sekhukhune	66.1	23.9	10.1	48.6	42.2	9.2
	Vhembe	74.6	10.4	15.1	62.2	16.4	21.4
	Waterberg	75.0	14.3	10.7	41.7	32.1	26.2
All communities in Limpopo		**64.7**	**20.1**	**15.2**	**42.0**	**33.0**	**25.0**
Type of area	Rural	64.7	20.5	14.8	42.7	33.6	23.7
	Urban	64.7	17.6	17.6	37.5	29.4	33.1
All communities in Limpopo		**64.7**	**20.1**	**15.2**	**42.0**	**33.0**	**25.0**

Table 4.2. What community members are doing to prevent the spread of HIV/AIDS: Limpopo 2006

		Community done educational campaign	Community done education in education in school	Community done youth programs	Community done women's program
Communities in	Bohlabela	18.9	33.0	7.5	7.5
	Capricorn	13.2	47.1	6.2	3.1
	Mopani	35.3	57.7	10.9	7.7
	Sekhukhune	30.3	62.4	11.9	11.0
	Vhembe	25.4	60.9	54.5	51.5
	Waterberg	25.0	69.0	14.3	8.3
All communities in Limpopo		**24.0**	**55.0**	**23.1**	**20.4**
Type of area	Rural	24.1	55.9	24.1	20.9
	Urban	22.8	50.0	16.9	16.9
All communities in Limpopo		**24.0**	**55.0**	**23.1**	**20.4**

Table 4.2 (continued) What community members are doing to prevent the spread of HIV/ADS

		Community done condom distribution	Community done church group programs	Community done counseling programs	Community done other things
Communities in	Bohlabela	29.2	5.7	6.6	
	Capricorn	25.6	3.1	3.5	1.8
	Mopani	32.1	5.8	1.9	1.3
	Sekhukhune	22.0	18.3	15.6	
	Vhembe	52.5	11.4	8.0	
	Waterberg	23.8	13.1	9.5	
All communities in Limpopo		**34.7**	**8.9**	**6.8**	**.6**
Type of area	Rural	34.6	8.6	6.6	.5
	Urban	35.3	10.3	8.1	1.5
All communities in Limpopo		**34.7**	**8.9**	**6.8**	**.6**

Table 4.3. What have community members done to prevent the spread of HIV/AIDS

		Health workers promoting HIV prevention			Are condoms avail in health clinics			Condoms in shops		
		Yes	No	Don't know	Yes	No	Don't know	Yes	No	Don't know
Communities in	Bohlabela	88.7	6.6	4.7	99.1	.9		35.8	52.8	11.3
	Capricorn	97.8	1.8	.4	99.6		.4	57.3	26.9	15.9
	Mopani	92.9	2.6	4.5	98.1	1.9		51.3	42.9	5.8
	Sekhukhune	97.2		2.8	100			29.4	64.2	6.4
	Vhembe	98.0	.3	1.7	97.7	1.3	1.0	66.9	28.4	4.7
	Waterberg	97.6		2.4	95.2	2.4	2.4	78.6	16.7	4.8
All communities in Limpopo		**96.0**	**1.6**	**2.3**	**98.4**	**1.0**	**.6**	**55.7**	**36.0**	**8.4**
Type of area	Rural	96.4	1.5	2.0	98.5	.9	.6	53.5	38.3	8.2
	Urban	93.4	2.2	4.4	97.8	1.5	.7	69.1	21.3	9.6
All communities in Limpopo		**96.0**	**1.6**	**2.3**	**98.4**	**1.0**	**.6**	**55.7**	**36.0**	**8.4**

Table 4.3 (contd) What have community members done to prevent the spread of HIV/AIDS

		Condom in sheebens and bars			Traditional healers active in HIV prevention		
		Yes	No	Don't know	Yes	No	Don't know
Communities in	Bohlabela	17.9	56.6	25.5	10.4	38.7	50.9
	Capricorn	26.0	25.1	48.9	3.1	34.4	62.6
	Mopani	21.8	44.2	34.0	9.0	53.8	37.2
	Sekhukhune	15.6	72.5	11.9	7.3	69.7	22.9
	Vhembe	61.5	28.8	9.7	30.8	46.2	23.1
	Waterberg	31.0	51.2	17.9	2.4	65.5	32.1
All communities in Limpopo		**34.6**	**40.2**	**25.3**	**13.7**	**48.1**	**38.2**
Type of area	Rural	33.1	43.4	23.4	13.3	50.8	36.0
	Urban	43.4	19.9	36.8	16.2	31.6	52.2
All communities in Limpopo		**34.6**	**40.2**	**25.3**	**13.7**	**48.1**	**38.2**

Voluntary counseling and testing in the community

The data on voluntary counseling and testing services in the community are encouraging. According to Table 4.4, if people want to know their HIV status, respondents reported that those who wish to know their HIV status can either do so in health facility (66.3%), in VCT sites (35%). Based on the information collected from community respondents, there appears to be no major shortage of facility for VCT at the community level in the province.

Table 4.4. If people want to know their HIV status, where do they go for that? Limpopo 2006

		Know status in health facility	Know status in VCT centre	Know status - nowhere to go	Other places to know status
Communities in	Bohlabela	81.1	30.2	1.9	.9
	Capricorn	69.2	26.9	.9	10.6
	Mopani	92.3	11.5	.6	
	Sekhukhune	95.4	.9		
	Vhembe	30.1	68.9	.3	
	Waterberg	82.1	29.8		8.3
All communities in Limpopo		**66.3**	**35.0**	**.6**	**3.3**
Type of area	Rural	66.9	33.3	.6	2.8
	Urban	62.5	45.6	.7	5.9
All communities in Limpopo		**66.3**	**35.0**	**.6**	**3.3**

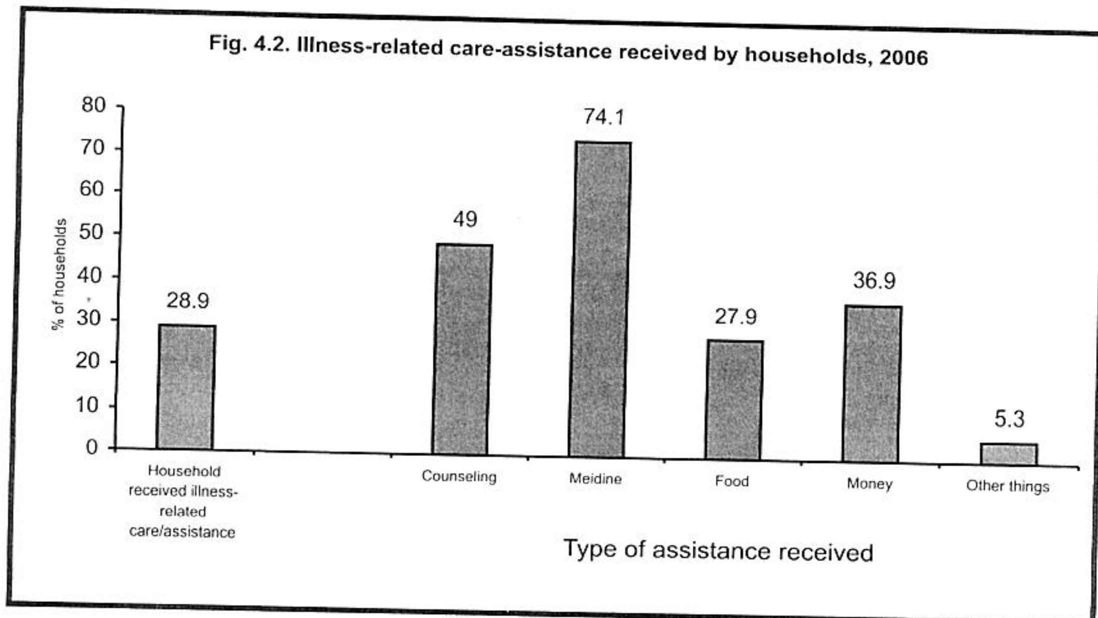
4.2. COMMUNITY AIDS CARE AND SUPPORT

Illness-related care and assistance

At household level, information was collected about the level of material care and assistance received by households which are specifically illness-related. The results in Table 4.5 show that 28.9% of all households received illness-related assistance in the past 12 months. Households in Vhembe and Bohlabela received more illness-related assistance than others (37.4% and 35.3% respectively).

Table 4.5 Households received any illness-related care and assistance: Limpopo province 2006

		Household received care/assistance		All
		Yes	No	
Communities in	Bohlabela	35.3	64.7	100
	Capricorn	26.8	73.2	100
	Mopani	25.6	74.4	100
	Sekhukhune	21.1	78.9	100
	Vhembe	37.4	62.6	100
	Waterberg	25.6	74.4	100
Type of area	Rural	29.5	70.5	100
	Urban	25.2	74.8	100
All communities in Limpopo		**28.9**	**71.1**	**100**



The survey found that assistance received by households is mainly medical (74.1%) and to some extent counseling (49%), money (36.9%) and food (27.9%). These results are shown in Figure 4.2 and Table 4.6.

Table 4.6. Type of illness-related assistance received by households: Limpopo province 2006

		Household received counseling	Household received free medicine	Household received extra food	Household received other assistance
Communities in	Bohlabela	57.5	83.0	11.3	4.7
	Capricorn	36.6	76.7	30.4	7.9
	Mopani	71.2	55.8	54.5	8.3
	Sekhukhune	44.0	93.6	24.8	.9
	Vhembe	36.5	68.2	12.4	3.7
	Waterberg	82.1	85.7	52.4	4.8
All communities in Limpopo		**49.0**	**74.1**	**27.9**	**5.3**
Type of area	Rural	49.1	74.4	28.4	4.6
	Urban	48.5	72.1	25.0	9.6
All communities in Limpopo		**49.0**	**74.1**	**27.9**	**5.3**

Sources of illness-related care and assistance

Information about sources of illness-related care and assistance in general are contained in Table 4.7. According the data, the three most important sources of help are health workers in hospitals/clinics (75.9%), friends and relatives (36.5%) and churches 9.7%.

Table 4.7. Sources of illness-related care and assistance: Limpopo province 2006

		Friends/relatives provided help	Health workers/ hospital clinic provided help	Church provided help	Community organizations provided help	NGO provided help
Communities in	Bohlabela	17.9	80.2	6.6	2.8	
	Capricorn	35.2	86.8	3.5	1.3	.4
	Mopani	62.2	48.1	18.6	19.2	1.9
	Sekhukhune	20.2	90.8	2.8	.9	
	Vhembe	30.1	73.6	15.1	7.7	2.0
	Waterberg	59.5	82.1	3.6	2.4	
All communities in Limpopo		**36.5**	**75.9**	**9.7**	**6.3**	**1.0**
Type of area	Rural	36.9	75.7	9.8	6.6	.9
	Urban	33.8	77.2	8.8	4.4	1.5
All communities in Limpopo		**36.5**	**75.9**	**9.7**	**6.3**	**1.0**

Table 4.7 (contd). Sources of illness-related care and assistance: Limpopo province 2006

		Traditional healers provided help	Women's group provided help	Government social services	Other sources of help
Communities in	Bohlabela	2.8	1.9	5.7	2.8
	Capricorn	.4	4.8	4.0	1.3
	Mopani	1.3	2.6	5.1	1.9
	Sekhukhune		.9	1.8	
	Vhembe	.7	2.0	24.7	5.4
	Waterberg	1.2	6.0	3.6	1.2
All communities in Limpopo		**.9**	**3.0**	**10.4**	**2.7**
Type of area	Rural	.8	2.6	10.5	3.1
	Urban	1.5	5.1	9.6	
All communities in Limpopo		**.9**	**3.0**	**10.4**	**2.7**

Organizations known to offer AIDS-related care and assistance

When focus is specifically on AIDS related illnesses and assistance in the community, patterns of care and assistance changes somewhat. Community members who become ill with AIDS turn overwhelmingly to hospitals or clinic for care (84.5%). Other places include traditional healers (18.8%), churches (17.7), non-governmental, especially AIDS organizations (14.7) and family members (10.6) [Figure 4.3]. This pattern appears to be true for both rural and urban areas (Table 4.8) but varies significantly by district.

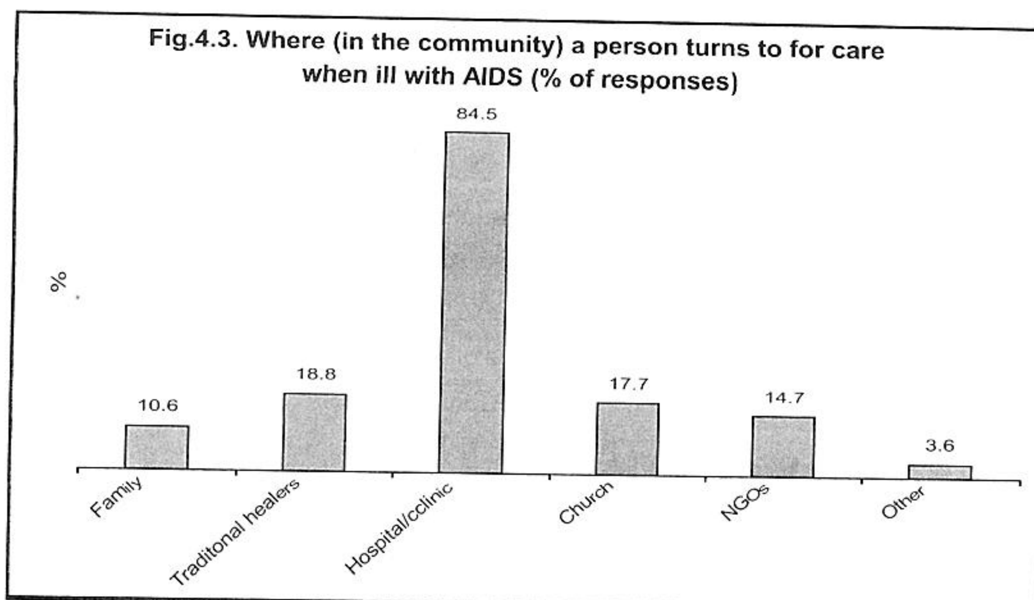


Fig.4.3. Where (in the community) a person turns to for care when ill with AIDS (% of responses)

Table 4.8. Where a person goes for help when ill with AIDS, Limpopo 2006

		AIDS ill person turns to family	AIDS ill person go to traditional healers	AIDS ill person go to clinic for help	AIDS ill person go to church for help
Communities in	Bohlabela	11.3	22.6	84.0	11.3
	Capricorn	4.8	3.1	74.9	4.0
	Mopani	8.3	10.3	87.2	3.8
	Sekhukhune	28.4	22.0	87.2	25.7
	Vhembe	7.7	33.1	88.6	35.8
	Waterberg	16.7	16.7	88.1	14.3
All communities in Limpopo		**10.6**	**18.8**	**84.5**	**17.7**
Type of area	Rural	10.7	19.8	85.6	18.6
	Urban	10.3	12.5	77.9	12.5
All communities in Limpopo		**10.6**	**18.8**	**84.5**	**17.7**

Table 4.8 (continued). Where a person goes for help when ill with AIDS, Limpopo 2006

		AIDS ill person go AIDS organizations for help	AIDS ill person to NGOs for help	AIDS ill persons go to other places for help
Communities in	Bohlabela	7.5	1.9	4.7
	Capricorn	1.8	.9	8.8
	Mopani	5.1		
	Sekhukhune	5.5	2.8	.9
	Vhembe	31.4	3.3	.7
	Waterberg	2.4	7.1	8.3
All communities in Limpopo		**12.4**	**2.3**	**3.6**
Type of area	Rural	13.1	2.0	3.2
	Urban	8.1	4.4	5.9
All communities in Limpopo		**12.4**	**2.3**	**3.6**

Types of assistance to AIDS affected households

Figure 4.4 shows six most common forms of assistance given to AIDS-affected households in the communities within the province. These include counseling (60%), monetary assistance (46.9%), food (36.9), help with child care (22.8%), free medicine (18.5%) and home-based care (14%). These and more information on what is done by different community members for households who lose their heads to AIDS are shown in Table 4.9 and Table 4.10.

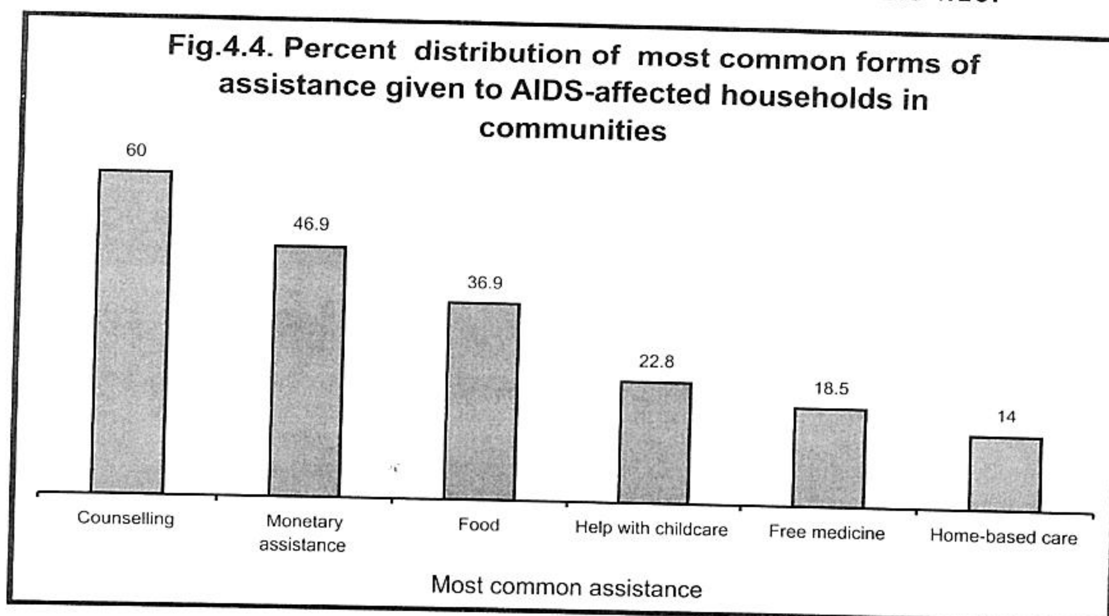


Table 4.9. Assistance given to households affected by AIDS, Limpopo 2006

		Counseling	Money	Extra food	Free medicine
Communities in	Bohlabela	36.8	35.8	23.6	6.6
	Capricorn	30.8	55.5	32.2	8.8
	Mopani	59.0	57.1	47.4	13.5
	Sekhukhune	77.1	60.6	72.5	59.6
	Vhembe	77.6	24.4	26.1	16.4
	Waterberg	85.7	81.0	39.3	22.6
All communities in Limpopo		**60.0**	**46.9**	**36.9**	**18.5**
Type of area	Rural	61.4	46.5	37.9	19.2
	Urban	51.5	49.3	30.9	14.0
All communities in Limpopo		**60.0**	**46.9**	**36.9**	**18.5**

Table 4.9 (continued). Assistance given to households affected by AIDS- Limpopo 2006

		Home based care for ill persons	Help with child care	School fees	Income generating projects	Micro credit schemes
Communities in	Bohlabela	14.2	7.5	12.3	1.9	
	Capricorn	4.0	6.2	8.4	.4	.4
	Mopani	8.3	11.5	9.6	.6	.6
	Sekhukhune	43.1	37.6	28.4	7.3	2.8
	Vhembe	13.4	43.8	6.0	1.3	2.7
	Waterberg	15.5	14.3	10.7		
All communities in Limpopo		**14.0**	**22.8**	**10.7**	**1.6**	**1.3**
Type of area	Rural	14.7	23.2	11.1	1.9	1.5
	Urban	9.6	20.6	8.1		
All communities in Limpopo		**14.0**	**22.8**	**10.7**	**1.6**	**1.3**

Table 4.9 (continued). Assistance given to households affected by AIDS, Limpopo 2006

		Help with house work	Help with food preparation	Spiritual/religious support	Support group	Hospice
Communities in	Bohlabela	3.8	4.7	13.2	11.3	3.8
	Capricorn	2.2	2.6	3.1	14.5	21.1
	Mopani	3.8	4.5	9.0	5.1	.6
	Sekhukhune	36.7	38.5	38.5	22.9	
	Vhembe	20.1	19.4	18.1	13.0	1.7
	Waterberg	11.9	10.7	13.1	28.6	
All communities in Limpopo		**12.7**	**12.9**	**14.5**	**14.4**	**5.9**
Type of area	Rural	13.1	13.6	15.0	14.1	5.0
	Urban	10.3	8.8	11.0	16.2	11.8
All communities in Limpopo		**12.7**	**12.9**	**14.5**	**14.4**	**5.9**

Table 4.10. What is done by different community members to take care of households that lose heads due to AIDS

		Sick people are sent to hospitals	Care provided by traditional healers	Community hospice care	They are provided with financial assist
Communities in	Bohlabela	47.2	3.8	3.8	3.8
	Capricorn	56.8	2.2	2.2	4.0
	Mopani	74.4	1.9	1.3	5.8
	Sekhukhune	86.2	1.8		24.8
	Vhembe	81.6	37.8	20.4	8.4
	Waterberg	82.1		2.4	14.3
All communities in Limpopo		**71.6**	**12.9**	**7.5**	**8.8**
Type of area	Rural	72.4	14.0	7.8	8.9
	Urban	66.2	6.6	5.9	8.1
All communities in Limpopo		**71.6**	**12.9**	**7.5**	**8.8**

Table 4.10 (continued). What is done by different community members to take care of households that lose heads due to AIDS

		Health workers provide HBC	Sick are provided with medicine	Community support groups
Communities in	Bohlabela	9.4	9.4	7.5
	Capricorn	8.8	14.1	1.8
	Mopani	7.7	3.2	
	Sekhukhune	18.3	36.7	7.3
	Vhembe	10.4	9.4	4.3
	Waterberg	17.9	28.6	11.9
All communities in Limpopo		**11.0**	**14.2**	**4.4**
Type of area	Rural	11.0	13.6	4.3
	Urban	11.0	17.6	5.1
All communities in Limpopo		**11.0**	**14.2**	**4.4**

Table 4.10 **(continued). What is done by different community members to take care of households that lose heads due to AIDS**

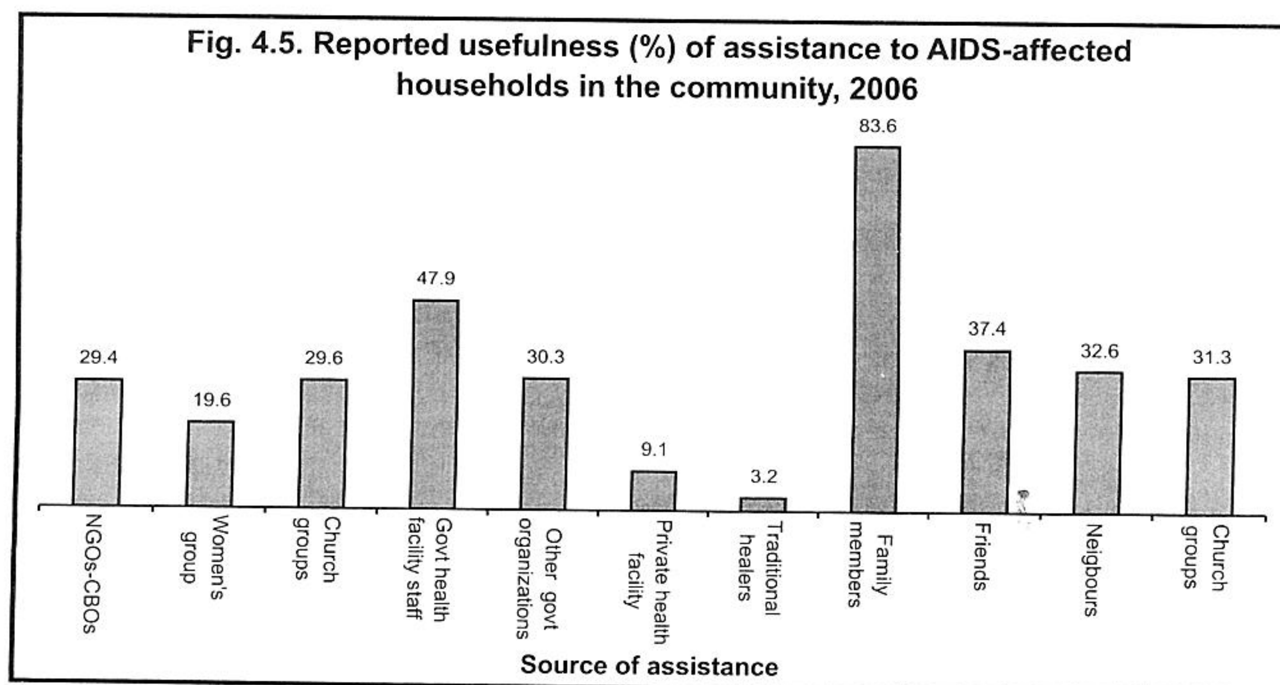
		Free schooling for children	Church groups	Diff community members do other things
Communities in	Bohlabela	.9		3.8
	Capricorn	1.3	1.8	.4
	Mopani	.6	.6	.6
	Sekhukhune	10.1	24.8	
	Vhembe	2.0	4.3	.3
	Waterberg	1.2	10.7	
All communities in Limpopo		**2.3**	**5.5**	.7
Type of area	Rural	2.5	5.7	.8
	Urban	1.5	4.4	
All communities in Limpopo		**2.3**	**5.5**	.7

Value of assistance offered by different organizations

This section presents the results on the type and value of assistance offered by different organizations to family affected by HIV and AIDS in the community.

A summary of the responses on how community members see the usefulness of assistance from various organizations is presented in Figure 4.5. Assistance from family members remains most useful (83.6%) from the perspective of community members, followed by assistance from government health facility staff (47.9%), assistance from friends (37.4%), neighbours (32.6%) and other government agencies (30.3%).

Details of what each organization does for households affected by HIV and how useful their assistance is ranked are presented in Table 4.11 to Table 4.18.



Assistance by NGOs-CBOs

Table 4.11. NGOs-CBOs assistance to people living with HIV/AIDS and AIDS-affected households

		NGOs provide counseling	NGO provide education	NGO provide free medicine	NGO provide extra food
Communities in	Bohlabela	24.5	25.5	6.6	5.7
	Capricorn	22.9	23.8	7.9	6.6
	Mopani	62.2	58.3	19.9	9.6
	Sekhukhune	56.9	49.5	40.4	25.7
	Vhembe	35.5	75.3	18.7	10.0
	Waterberg	60.7	56.0	1.2	2.4
All communities in Limpopo		**40.2**	**50.8**	**16.0**	**9.8**
Type of area	Rural	40.8	52.1	16.6	9.8
	Urban	36.0	42.6	12.5	9.6
All communities in Limpopo		**40.2**	**50.8**	**16.0**	**9.8**

Table 4.11 (continued). NGOs-CBOs assistance to people living with HIV/AIDS and AIDS-affected households

		NGO provide income generating projects	NGO provide micro credit scheme	NGO provide home based care
Communities in	Bohlabela			7.5
	Capricorn	2.6	.9	4.8
	Mopani	2.6	1.3	14.1
	Sekhukhune	.9		10.1
	Vhembe	.7	1.3	11.4
	Waterberg			7.1
All communities in Limpopo		**1.3**	**.8**	**9.4**
Type of area	Rural	1.2	.7	8.8
	Urban	2.2	1.5	13.2
All communities in Limpopo		**1.3**	**.8**	**9.4**

Table 4.11 (continued). NGOs-CBOs assistance to people living with HIV/AIDS and AIDS-affected households

		NGO provide support group	NGO provide other forms of assistance	How useful all assistance provided by NGO			
				A lot	A little	Not at all	Don't know
Communities in	Bohlabela	10.4	.9	13.2	16.0	26.4	44.3
	Capricorn	14.5	.9	8.4	18.5	3.5	69.6
	Mopani	9.6		20.5	46.2	16.7	16.7
	Sekhukhune	30.3		42.2	17.4	11.9	28.4
	Vhembe	17.7	1.3	56.5	28.8	3.0	11.7
	Waterberg	22.6	1.2	9.5	61.9	3.6	25.0
All communities in Limpopo		**16.7**	**.8**	**29.4**	**29.4**	**8.9**	**32.4**
Type of area	Rural	17.3	.8	31.2	29.0	9.9	29.8
	Urban	13.2	.7	17.6	31.6	2.2	48.5
All communities in Limpopo		**16.7**	**.8**	**29.4**	**29.4**	**8.9**	**32.4**

Assistance by women groups

Table 4.12. Women groups' assistance to people living with HIV/AIDS and AIDS-affected households

		Women group provide counseling	Women group provide education	women group provide free medicine	Women groups provide extra food
Communities in	Bohlabela	16.0	12.3	5.7	8.5
	Capricorn	14.5	26.9	3.5	4.4
	Mopani	40.4	30.8	10.3	5.8
	Sekhukhune	23.9	19.3	23.9	12.8
	Vhembe	59.2	19.1	7.4	2.7
	Waterberg	50.0	32.1	3.6	3.6
All communities in Limpopo		**36.5**	**23.1**	**8.3**	**5.4**
Type of area	Rural	36.7	22.2	8.4	5.1
	Urban	35.3	28.7	7.4	7.4
All communities in Limpopo		**36.5**	**23.1**	**8.3**	**5.4**

Table 4.12 (continued). Women groups assistance to people living with HIV/AIDS and AIDS-affected households

		Women group provide income generating projects	Women group provide micro credit scheme	Women group provide home based care
Communities in	Bohlabela	.9	2.8	14.2
	Capricorn	3.5	.9	9.7
	Mopani	3.8	4.5	32.1
	Sekhukhune	4.6	1.8	43.1
	Vhembe	.3	1.3	14.7
	Waterberg	1.2	1.2	31.0
All communities in Limpopo		2.2	1.9	20.8
Type of area	Rural	2.2	1.8	21.5
	Urban	2.2	2.9	16.2
All communities in Limpopo		2.2	1.9	20.8

Table 4.12 (continued). Women groups assistance to people living with HIV/AIDS and AIDS-affected households

		Women group provide support groups	Women group provide other forms of assistance	How useful all assistance provided by women groups			
				A lot	A little	Not at all	Don't know
Communities in	Bohlabela	18.9	.9	6.6	27.4	33.0	33.0
	Capricorn	27.3	2.6	3.1	30.8	12.8	53.3
	Mopani	9.0		7.1	47.4	28.2	17.3
	Sekhukhune	17.4		14.7	34.9	7.3	43.1
	Vhembe	59.2	1.3	48.2	30.4	9.7	11.7
	Waterberg	44.0	1.2	8.3	44.0	11.9	35.7
All communities in Limpopo		33.5	1.2	19.6	34.6	15.8	30.1
Type of area	Rural	33.4	1.2	21.1	33.7	17.5	27.7
	Urban	34.6	1.5	10.3	39.7	5.1	44.9
All communities in Limpopo		33.5	1.2	19.6	34.6	15.8	30.1

Assistance by church groups

Table 4.13. Church groups assistance to people living with HIV/AIDS and AIDS-affected households

		Church groups provide counseling	Church group provide education	Church group provide free medicine	Church group provide extra food
Communities in	Bohlabela	28.3	24.5	2.8	10.4
	Capricorn	41.0	41.9	3.5	10.1
	Mopani	55.1	34.6	3.8	10.9
	Sekhukhune	39.4	22.0	7.3	13.8
	Vhembe	66.6	18.7	4.0	6.4
	Waterberg	70.2	42.9		3.6
All communities in Limpopo		**52.0**	**29.7**	**3.8**	**9.0**
Type of area	Rural	51.1	26.6	3.4	7.9
	Urban	57.4	48.5	5.9	15.4
All communities in Limpopo		**52.0**	**29.7**	**3.8**	**9.0**

Table 4.13 (continued). Church groups assistance to people living with HIV/AIDS and AIDS-affected households

		Church group provide income generating projects	Church provide micro credit scheme	Church group provide home based care
Communities in	Bohlabela		1.9	7.5
	Capricorn	7.0	1.8	13.7
	Mopani	2.6	1.9	8.3
	Sekhukhune	3.7	1.8	37.6
	Vhembe	.3	.7	7.0
	Waterberg			11.9
All communities in Limpopo		**2.5**	**1.3**	**12.6**
Type of area	Rural	2.0	1.2	12.0
	Urban	5.9	2.2	16.9
All communities in Limpopo		**2.5**	**1.3**	**12.6**

Table 4.13 (continued). Church groups' assistance to people living with HIV/AIDS and AIDS-affected households

		Church provide prayer group	Church group provide support group	Church provide other forms of assistance	How useful assistance provided by church groups			
					A lot	A little	Not at all	Don't know
Communities in	Bohlabela	59.4	43.4	2.8	23.6	44.3	20.8	11.3
	Capricorn	62.6	49.3	4.0	14.5	54.2	2.6	28.6
	Mopani	67.3	30.1	1.3	19.9	55.1	12.8	12.2
	Sekhukhune	78.9	33.0	1.8	37.6	45.9	9.2	7.3
	Vhembe	77.3	50.8	3.0	47.5	36.5	8.0	8.0
	Waterberg	82.1	71.4		21.4	63.1	6.0	9.5
All communities in Limpopo		**70.9**	**46.2**	**2.5**	**29.6**	**47.7**	**8.9**	**13.9**
Type of area	Rural	70.5	45.1	2.2	30.4	46.3	9.7	13.6
	Urban	73.5	52.9	4.4	24.3	56.6	3.7	15.4
All communities in Limpopo		**70.9**	**46.2**	**2.5**	**29.6**	**47.7**	**8.9**	**13.9**

Assistance by government health facility staff

Table 4.14. Government health facility staff assistance to people living with HIV/AIDS and AIDS-affected households

		Government health facilities provide counseling	Government health facilities provide education	Government health facilities provide free medicine	Government health facilities provide extra food
Communities in	Bohlabela	69.8	69.8	66.0	28.3
	Capricorn	90.7	88.5	88.1	68.3
	Mopani	80.8	81.4	75.6	36.5
	Sekhukhune	83.5	79.8	90.8	72.5
	Vhembe	44.1	47.5	85.6	34.4
	Waterberg	95.2	91.7	95.2	22.6
All communities in Limpopo		**72.3**	**72.2**	**83.9**	**45.2**
Type of area	Rural	72.0	72.1	84.0	44.7
	Urban	74.3	72.8	83.1	47.8
All communities in Limpopo		**72.3**	**72.2**	**83.9**	**45.2**

Table 4.14 (continued). Government health facility staff's assistance to people living with HIV/AIDS and AIDS-affected households

		Government health facility staff provide income generating project	Government health facility staff provide micro credit scheme	Government health facility staff provide home based care
Communities in	Bohlabela	2.8	3.8	31.1
	Capricorn	21.1	20.3	33.9
	Mopani	5.8	1.9	24.4
	Sekhukhune	6.4	2.8	42.2
	Vhembe	2.3	1.3	23.4
	Waterberg	1.2	1.2	32.1
All communities in Limpopo		**7.6**	**6.2**	**29.7**
Type of area	Rural	6.7	5.9	29.3
	Urban	13.2	8.1	31.6
All communities in Limpopo		**7.6**	**6.2**	**29.7**

Table 4.14 (continued). Government health facility staff's assistance to people living with HIV/AIDS and AIDS-affected households

		Government health facility staff provide support group	Government health facility staff provide other forms of assistance	How useful assistance by Government health facility			
				A lot	A little	Not at all	Don't know
Communities in	Bohlabela	30.2	2.8	50.0	22.6	7.5	19.8
	Capricorn	69.6	3.5	41.4	52.4	1.3	4.8
	Mopani	11.5		29.5	61.5	5.1	3.8
	Sekhukhune	40.4	4.6	65.1	30.3	.9	3.7
	Vhembe	20.1	2.0	58.5	35.5	1.0	5.0
	Waterberg	40.5	1.2	36.9	60.7	1.2	1.2
All communities in Limpopo		**35.3**	**2.3**	**47.9**	**43.7**	**2.4**	**5.9**
Type of area	Rural	33.4	2.0	49.5	42.2	2.6	5.7
	Urban	47.1	4.4	38.2	52.9	1.5	7.4
All communities in Limpopo		**35.3**	**2.3**	**47.9**	**43.7**	**2.4**	**5.9**

Assistance from family members

Table 4.15. Family members' assistance to people living with HIV/AIDS and AIDS-affected households

		Family members help with extra food	Family members help with child care	Family members help with food preparation	Family members help with house work
Communities in	Bohlabela	88.7	87.7	86.8	85.8
	Capricorn	96.0	97.8	97.4	97.4
	Mopani	87.8	89.7	91.0	91.0
	Sekhukhune	95.4	95.4	93.6	93.6
	Vhembe	79.6	86.0	75.9	79.9
	Waterberg	98.8	98.8	97.6	98.8
All communities in Limpopo		**89.1**	**91.6**	**88.3**	**89.5**
Type of area	Rural	89.8	92.0	88.3	89.8
	Urban	84.6	89.7	88.2	87.5
All communities in Limpopo		**89.1**	**91.6**	**88.3**	**89.5**

Table 4.15 (continued). Family members' assistance to people living with HIV/AIDS and AIDS-affected households

		Family members help with money	Family members help with emotional support	Family members help in other ways	How useful help from family members Something missing here			
					A lot	A little	Not at all	Don't know
Communities in	Bohlabela	81.1	89.6	3.8	82.1	7.5	6.6	3.8
	Capricorn	89.4	96.5	4.8	89.4	9.7		.9
	Mopani	85.3	87.8	1.9	87.2	6.4	4.5	1.9
	Sekhukhune	88.1	95.4	3.7	90.8	7.3		1.8
	Vhembe	72.2	85.6	3.3	71.2	23.1	2.7	3.0
	Waterberg	94.0	97.6	1.2	97.6			2.4
All communities in Limpopo		**82.9**	**91.0**	**3.4**	**83.6**	**11.9**	**2.2**	**2.2**
Type of area	Rural	83.7	91.6	3.2	84.0	12.2	2.2	1.5
	Urban	77.9	87.5	4.4	80.9	10.3	2.2	6.6
All communities in Limpopo		**82.9**	**91.0**	**3.4**	**83.6**	**11.9**	**2.2**	**2.2**

Assistance from friends

Table 4.16. Friends' assistance to people living with HIV/AIDS and AIDS-affected households

		Friends help with extra food	Friends help with child care	Friends help with food preparation	Friends help with house work
Communities in	Bohlabela	65.1	58.5	51.9	58.5
	Capricorn	57.3	46.7	49.3	52.9
	Mopani	49.4	39.7	52.6	41.0
	Sekhukhune	33.9	26.6	22.9	28.4
	Vhembe	48.8	52.8	42.5	43.1
	Waterberg	47.6	15.5	34.5	23.8
All communities in Limpopo		**50.9**	**43.8**	**43.8**	**43.4**
Type of area	Rural	49.6	42.2	43.2	41.9
	Urban	58.8	53.7	47.8	52.9
All communities in Limpopo		**50.9**	**43.8**	**43.8**	**43.4**

Table 4.16 (continued). Friends' assistance to people living with HIV/AIDS and AIDS-affected households

		Friends help with emotional support	Friends help in other ways	How useful help from friends			
				A lot	A little	Not at all	Don't know
Communities in	Bohlabela	68.9	2.8	55.7	14.2	24.5	5.7
	Capricorn	76.2	2.2	33.0	46.7	16.3	4.0
	Mopani	73.1	1.3	27.6	53.8	15.4	3.2
	Sekhukhune	59.6	.9	28.4	34.9	15.6	21.1
	Vhembe	73.9	2.0	46.2	37.1	10.7	6.0
	Waterberg	83.3		25.0	58.3	10.7	6.0
All communities in Limpopo		**73.0**	**1.7**	**37.4**	**41.1**	**14.8**	**6.7**
Type of area	Rural	72.3	1.8	35.9	42.0	15.5	6.6
	Urban	77.2	1.5	47.1	35.3	10.3	7.4
All communities in Limpopo		**73.0**	**1.7**	**37.4**	**41.1**	**14.8**	**6.7**

Assistance from neighbours

Table 4.17. Neighbours' assistance to people living with HIV/AIDS and AIDS-affected households

		Neighbours help with extra food	Neighbours help with child care	Neighbours help with food preparation	Neighbours help with house work
Communities in	Bohlabela	62.3	55.7	54.7	52.8
	Capricorn	30.8	24.2	24.2	23.8
	Mopani	41.7	40.4	48.1	32.7
	Sekhukhune	41.3	30.3	25.7	27.5
	Vhembe	50.5	49.8	44.8	42.5
	Waterberg	19.0	13.1	15.5	14.3
All communities in Limpopo		**42.1**	**37.7**	**37.0**	**33.6**
Type of area	Rural	42.6	38.6	37.2	33.8
	Urban	39.0	32.4	36.0	32.4
All communities in Limpopo		**42.1**	**37.7**	**37.0**	**33.6**

Table 4.17 (continued) Neighbours' assistance to people living with HIV/AIDS and AIDS-affected households

		Neighbours help with emotional support	Neighbours help in other ways	How useful help from neighbours			
				A lot	A little	Not at all	Don't know
Communities in	Bohlabela	67.9	3.8	46.2	31.1	15.1	7.5
	Capricorn	59.9	1.3	24.2	38.3	28.2	9.3
	Mopani	67.9	1.9	20.5	57.7	17.9	3.8
	Sekhukhune	59.6		33.9	31.2	22.9	11.9
	Vhembe	69.9	4.7	44.5	38.1	10.4	7.0
	Waterberg	78.6		16.7	65.5	10.7	7.1
All communities in Limpopo		**66.7**	**2.4**	**32.6**	**42.1**	**17.6**	**7.6**
Type of area	Rural	67.2	2.5	33.0	42.5	17.5	7.0
	Urban	63.2	2.2	30.1	39.7	18.4	11.8
All communities in Limpopo		**66.7**	**2.4**	**32.6**	**42.1**	**17.6**	**7.6**

Assistance from people from the church

Table 4.18. Individuals from church groups' assistance to people living with HIV/AIDS and AIDS-affected households

		Church groups help with extra food	Church groups help with child care	Church groups help with food preparation	Church groups help with house work
Communities in	Bohlabela	15.1	7.5	5.7	5.7
	Capricorn	26.9	21.1	19.4	22.0
	Mopani	22.4	29.5	25.6	27.6
	Sekhukhune	19.3	9.2	10.1	29.4
	Vhembe	38.5	45.2	38.5	40.8
	Waterberg	14.3	11.9	3.6	3.6
All communities in Limpopo		**26.5**	**26.2**	**22.3**	**26.1**
Type of area	Rural	23.8	24.1	20.7	24.4
	Urban	43.4	39.0	32.4	36.8
All communities in Limpopo		**26.5**	**26.2**	**22.3**	**26.1**

Table 4.18 (continued). Individuals from church groups' assistance to people living with HIV/AIDS and AIDS-affected households

		Church groups help with emotional support	Church groups help in other ways	How useful help from church groups			
				A lot	A little	Not at all	Don't know
Communities in	Bohlabela	62.3	1.9	16.0	46.2	17.0	20.8
	Capricorn	62.1	3.1	23.8	41.4	7.5	27.3
	Mopani	59.6	6.4	22.4	48.7	24.4	4.5
	Sekhukhune	63.3	7.3	35.8	33.9	17.4	12.8
	Vhembe	76.3	13.0	49.8	36.5	9.7	4.0
	Waterberg	79.8	2.4	15.5	63.1	13.1	8.3
All communities in Limpopo		**67.7**	**6.9**	**31.3**	**42.6**	**13.5**	**12.6**
Type of area	Rural	66.6	6.7	30.9	41.7	14.8	12.7
	Urban	74.3	8.1	33.8	48.5	5.1	12.5
All communities in Limpopo		**67.7**	**6.9**	**31.3**	**42.6**	**13.5**	**12.6**

CONCLUSION AND RECOMMENDATIONS

CONCLUSION

Objective

The central objective of this study was to improve the empirical basis for understanding and dealing with the socio-economic impacts of HIV and AIDS in Limpopo Province. This was accomplished in the form of a database that contains demographic and socioeconomic information, experiences and perspectives of households and community members on some aspects of AIDS impacts and interventions.

Context

It was found that poverty defines the overall socioeconomic context in which AIDS exerts its influences on populations and communities of the province. This, according to the results of the study, is exactly how most households and segments of the population perceive the problem of HIV and AIDS in the province. Their reactions to the epidemic and survival strategies cannot be properly understood without taking into consideration this hostile context of poverty.

Impacts

In such a context of poverty, HIV and AIDS have serious socioeconomic impacts which are far more pervasive than the experiences of perhaps other provinces with stronger economies. The combinations of the burdens of poverty and problems of HIV and AIDS provide the epidemic with its most potent force against human and socioeconomic development in the province.

Stigma and discrimination

(i) The study found out an intermediate factor in the chain of complex interactions of AIDS impacts and poverty, namely stigma. Community members are, in theory tolerant of people affected by HIV and AIDS from a distance, but if the experience is personalized, people remain highly prejudiced and discriminatory in their perceptions, attitudes and actions toward people and households affected by HIV and AIDS.

(ii) This high degree of stigma and discrimination has resulted in a very low level of disclosure of HIV and AIDS status in the society and also among government officials. In turn, the problem of disclosure presents a stumbling block for effective delivery of HIV and AIDS interventions in the workplace and in communities.

(iii) Addressing the issue of stigma and discrimination will probably be a key to the success or failure of interventions by the Department and other government sectors and stakeholders now and in the years to come.

HIV and AIDS interventions

In this study, an intervention was approached from the perspective of households and communities. The central issue of interest was how households and communities perceive and relate to existing HIV and AIDS interventions at the community level.

It was found that there was no shortage of conventional HIV and AIDS interventions that are implemented by the public sector, the formal private sector and non-governmental organizations

in the province. However, the study found that a number of interventions available are not packaged and delivered in the forms that households and communities would prefer. It would appear that community expectations tend to favour a highly integrated model of intervention, which relate HIV and AIDS support to the bigger problems of poverty that is experienced by many affected and unaffected households. Whether existing intervention programmes are willing and able to meet this expectation at the community level remains a question for government and private sector stakeholders in the province.

The study found that government Departments have a challenging role in the fight against HIV and AIDS. They initiate and implement official programmes to mitigate the impacts of HIV and AIDS specifically through their line functions activities. At the same time, the study showed that the epidemic is having serious impacts that make it difficult for Departments to manage the epidemic within their structural mandates. In fact, given the nature of work in some Departments, staff members are, by the nature of their work among the high risk category for HIV and AIDS. For Departments within the social sector cluster, the two-pronged tasks posed by the AIDS epidemic are quite challenging.

It was found that government departments in all clusters are sufficiently concerned and are making internal and collaborative workplace guidelines and other policies to combat the AIDS epidemic in the province. The Inter-Department HIV and AIDS Committee has been in existence for several years, and has helped to keep the epidemic on the agenda for collaborative efforts among all departments. In addition, Departments in the social sector cluster have several well designed programmes that address many of the critical areas of impacts identified in this study. The Department of Health and Social Development, in particular, has vigorously pursued a range of interventions including direct medical services, home-based care; support for orphans and provision of voluntary counseling and testing services.

RECOMMENDATIONS

With the huge amount of information and policy initiatives already in existence on the AIDS epidemic in the country, this study emphasized only two aspects of the problem. The first was to update the available empirical data on the demographic and socioeconomic context of HIV and AIDS impacts in Limpopo province. Secondly, this study introduced more empirical data and emphasis on the experiences and perspectives of households and communities in understanding AIDS impacts and interventions. This study has attempted to bring to the centre the very individuals and people who experience these impacts and intervention in households and communities.

Within its scope as a baseline survey, this study did not pretend to touch on all of the relevant issues, or go into detailed analysis of the areas highlighted. These second order and in-depth analytical investigations can be more conveniently pursued with the database that has been produced in this study. Indeed such further issue-based analyses are highly recommended.

Since the early 1990s, there has been many studies, recommendations and declarations on HIV and AIDS at the national and provincial levels. It is not the intention here to simply repeat any of the recommendations that have already been made or are already at different stages of implementation in the province. Much thinking and consultation has been undertaken in order to mainstream HIV and AIDS in the provincial growth and development strategy.

General Recommendations

The need remains to intensify and go beyond crisis management to sustained and coordinated responses. There is a need to take adaptive rather than prescriptive policies in the management of policy processes. Policy development should be based on deep articulation of the perspectives and preferences and needs of the households, communities and provincial public sector in the handling of the fallouts of the epidemic. The Department needs to develop policies that carry an emphasis on the needs of communities in Limpopo province. These will be more effective in addressing the issues identified in this study.

Specific Recommendations

These specific recommendations focus on two areas that are consistent with the areas of emphasis in this survey. These two questions are:

(i) Are there areas of impacts identified that are not yet covered by existing intervention programmes?

(ii) In the light of the identified impacts, how can existing interventions and their implementation be improved?

All provincial departments, especially those in the social development cluster should by now be engaged in the development of specific and practicable action plans from the general consensus. It is not the intention here to simply repeat any of the recommendations that have already been made or are already at different stages of implementation in the province. In line with the study approach, only three recommendations are put forward. These recommendations place emphasis on household and community conditions and preferences.

Recommendation 1

The Department of Health and Social Development should undertake a realignment review of all existing community based HIV and AIDS interventions.

In the light of the findings of this survey which show among other things that households and communities expect particular models of AIDS intervention at the household and community levels, it is recommended that the Department of Health and Social Development implements realignment reviews of existing projects in the province, starting with those directly implemented by the Department of Health and Social Development.

The aim of this realignment reviews will be to measure the extent to which the models and delivery approaches of such services are in line with the preferences of recipient households and communities. The investigations should preferably target to collect information at the points of services delivery; they should not be conducted as a desktop research. The results will be used to realign models of services in ways that will be maximally beneficial in mitigating the impacts of HIV and AIDS in the province.

Recommendation 2

The Department of Health and Social Development should undertake a new wave of community level public education campaign against stigma and discrimination in the province.

It has been pointed out that the study found a very high level of stigma and discrimination against individuals and households that are affected by HIV and AIDS. Anti-stigma campaigns currently in place do not appear to have changed deep-seated prejudices in the community.

It was found that community level stigma and discrimination destroys any remaining household and social capital for affected individuals to confront the impacts of HIV and AIDS. In the end, disproportionate burden of care is transferred to the state. Moreover, the high level of non-disclosure makes it extremely difficult for government departments to develop and follow strategic policies within and outside the work place.

It is recommended that the Department of Health and Social Development should undertake a new wave of public education campaign against stigma and discrimination. This new wave of public education campaign should directly target communities. It should be culturally and socially grounded, and should focus on day to day issues and practical experiences of people affected by HIV and AIDS in Limpopo communities.

Recommendation 3

The Department of Health and Social Development should investigate the possibility of establishing a new and direct HIV and AIDS assistance grant.

The immediate benefits of such a grant will be twofold: first, it will serve as a cushion and lifeline for affected individuals and households who usually loose most other sources of material support networks when affected by HIV and AIDS. Secondly, it will encourage people to disclose their HIV and AIDS status, thus making it easer for the Department of Health and Social Development to develop better intervention strategies.

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