

The Effects of Disability Grant Termination on The Livelihoods of Rural Women Aged Between 25-30 Living With HIV. A Case of Wellness Clinic at Vhembe District in Limpopo

Chrisen E Mhangwani*, Kholiswa Malindini

University of South Africa, South Africa.

*Corresponding author: Chrisen E Mhangwani

Abstract

Introduction: The termination of the disability grant is identified as one of the determinants contributing to non-adherence to Anti-Retroviral Treatment (ART) by rural women living with HIV aged between 25-30 attending a Wellness Clinic in Vhembe District. The study has established that once the disability grant is terminated upon improved health outcomes as a result from adhering adequately to ART, the livelihoods of rural women living with HIV are adversely interrupted.

Research purpose: The paper sought to explore and examine the effects of disability grant termination on the livelihoods of rural women living with HIV aged between 25-30 attending a Wellness Clinic in Vhembe District

Research Approach: The paper adopted a qualitative approach and individual in-depth semi-structured interviews as a data collection technique. A purposive sampling technique was utilised to draw a sample of 20 rural women living with HIV attending a Wellness Clinic in Vhembe District who were enrolled on ART and whose disability grant was terminated upon improved health outcomes. The purpose was to elicit the participants' views on their experiences on how the termination of the disability grant interferes with their livelihoods towards adhering effectively to ART.

Main findings: The findings revealed that the termination of the disability grant for rural women living with HIV has adverse implications on their livelihoods towards adhering effectively to ART as access to the disability plays an important role to incentivise the adequate uptake of ART.

Policy implications: Economic incentives for rural women living with HIV with little or no education has proven to contribute to optimal adherence to ART. However, the manner in which these economic incentives are provided for is a cause for concern in areas where poverty trends are prevalent. Therefore, policy makers should consider different modalities of access to the disability grant.

Keywords: disability grant; anti-retroviral treatment; HIV; vhembe district; wellness clinic

Introduction

Globally, since the discovery of HIV over 40 years ago, sub-Saharan African countries have seen a ravaging effects of HIV infections among the general population and this accounts for more than two thirds of the world's HIV infections (World Health Organisation, 2021; Joint United Nations Programme for HIV and AIDS, 2016; Khasarny, 2016). Proportionately, Southern Africa remains the region most severely affected by the HIV infections. In this region, literature highlights that women are severely affected by the HIV epidemic with young

women affected almost ten years earlier compared to their male counterparts (UN Women, 2021; HSRC, 2019; Ramjee and Daniels, 2013).

Evidence from epidemiological studies, suggests that there is a high proportionate of young women between the ages of 25-30 living with HIV (UN, 2021; UN Women, 2020). This is because this age group of young women are at the height of their reproductive age and compounded with little or no education, chances of having unprotected sex with older working men are prevalent (Mabaso, Mlangeni, Makola, Oladimeji, Naidoo, Naidoo, Chibi, Zuma and Simbayi, 2021). Relevantly, it is further argued that

because of multiple factors that increases women's vulnerability to HIV infection such as the structural drivers that include the biological, behavioural, socioeconomic, cultural and structural risks (Psaros, Milford, Smit, Greener, Mosery, Matthews, Harrison, Gordon, Mimiaga, Bangsberg, and Safren, 2019), women are proportionately at risk of acquiring HIV more than men of their age group.

Progressively in the HIV prevention continuum, the biomedical prevention and management of HIV infection have made positive strides globally with the introduction of Anti-Retroviral (ARVs) to people living with HIV over a period of time. ART is scientifically proven to alter the speedy progression of HIV disease to Acquired Immune Deficiency Syndrome (AIDS) which in many respects is fatal (World health Organisation, 2021; Günthard, Saag, Benson, del Rio, Eron, Gallan, Mugavero, Sax, Thompson, Gandhi, Landovitz, Smith, Jacobsen and Volberding, 2016).

However, despite that there has been considerable progress made in the biomedical prevention and management of HIV, gaps in the socioeconomic and behavioural interventions still remains. It is argued that the development of appropriate HIV prevention strategies which encapsulate the socioeconomic and cultural factors can be beneficial as these are seen to be contributing much to predisposing women particularly in rural contexts to HIV infections (Vermund, Tique, Cassell, Pask, Ciampa and Audet, 2013).

Contextually, an abundance of literature report that South Africa is faced with a debilitating health crisis resulting from HIV infections and this remains a major health problem for the country even after two decades since the introduction of ART (HSRC, 2019; Allinder and Fleischman, 2019; Masquillier, Wouters, Campbell, Delpont, Sematlane, Dube and Knight, 2020; Global Health Policy, 2021). Some studies highlight that people living with HIV (PLHIV), inclusive of those enrolled on ARVs, are exposed to a diverse set of disabilities (Myezwa, Hanass-Hancock, Ajidahun and Carpenter, 2018; Khasarny and Karim, 2016; Banks, Zuurmond, Ferrand and Kuper, 2015; Hanass-Hancock, Regondi, Van Egeraat, and Nixon, 2013; Health Canada, 2009; Myezwa, Stewart, Musenge and Nesara, 2009; Myezwa, Buchalla, Jelsma and Stewart, 2011).

Despite that the provision of ARVs have a profound importance to enabling PLHIV to live longer and

productive lives, (De Paoli, 2012) notes that it is important for one to understand the myriad of factors that constrain and shape life beyond the biomedical problem or solution framework. What compounds this is that long-term survival with HIV is associated with new health-related issues and a risk of functional limitation or disability (Myezwa, Hanass-Hancock, Ajidahun & Carpenter, 2018). Amidst these challenges, studies have shown that young women in rural areas remain deeply affected than men of their age group. Disabilities have potential to limit one to contribute effectively to the daily needs especially for people living with HIV and enrolled on ART.

Infection with HIV especially for young women in rural areas remain a threat to their livelihoods and socioeconomic needs. Studies have shown that treatment of PLHIV must be accompanied with other social measures to enhance their physical, mental, and social wellbeing (Ramjee and Daniels, 2013). PLHIV face many developmental challenges such as poverty, affecting particularly women and young people. Weakened family and societal support systems, decreased participation in formal education of young women as a result of AIDS in the family, along with depleted family income due to loss of work, and poor disease management present additional vulnerabilities compounded by HIV induced disabilities (Taraphdar, Guha, Haldar, Chatterjee, Dasgupta, Saha and Mallik, 2011).

Around the world, people living with HIV and enrolled on ART have been seen to be struggling with treatment adherence where the socioeconomic challenges are prevalent (Moomba and van Wyk, 2019). Adherence to ART is identified to be tied to food security, transport to access wellness clinics and other socioeconomic amenities (Weiser, Tuller, Frongillo, Senkungu, Mukiibi and Bangsberg, 2010). Therefore, in the absence of this supplementary needs to treatment adherence due to decreased productivity resulting from inactive participation in the economy due to HIV induced disabilities, risks of not adhering effectively to treatment and lost to follow-ups for clinic reviews may emerge (Tuller, Bangsberg, Senkungu, Ware, Emenyonu and Weiser, 2010). To cushion this financial loss resulting from disabilities and other forms of vulnerabilities, the South African government introduced the social security system which is regarded as one of the world's largest non-contributory social security systems.

The South African social security system provides social grants which are administered by the South

African Social Security Agency (SASSA). Some of the grants awarded by SASSA include the old-age pension, disability, war veterans, care dependency, foster child, child support, grant-in-aid and social relief of distress (SASSA, 2010). It is reported that by 2023, over 18 million South Africans received social grants. The disability grant in South Africa is one of the social relief measures amongst others provided for people living with disabilities including people living with HIV whose functionality is impaired due to the biological determinations of HIV infections. To access this grant, one must satisfy certain criteria as it is means tested (SASSA, 2010). For people living with HIV, the qualifying criteria during the period when this study was conducted was 500 CD4 cell count and below and having some form of disability that constrain one to be productive or be fully disabled.

One of the challenges that rural women living with HIV face today is the continued developmental trajectory of the apartheid years which still concentrates economic development in the provinces of Gauteng and the Western Cape. Rural provinces such as Limpopo in South Africa remain underdeveloped which is a major concern for the developmental trajectory of South Africa as espoused in the National Development Plan Vision 2030 (Stas SA, 2019). Underdevelopment in the rural parts of South Africa as in the Vhembe District has negative ramifications for the young women and girls to find employment opportunities and sound educational outcomes (Wilkinson, Pettifor, Rosenberg, Halpern, Thirumurthy, Collinson and Kahn, 2017). Uneven developmental trajectory between the urban and rural areas has a potential to project people to uneven human developmental outcomes. Literature on the uneven human developmental outcomes in the realm of HIV risk behaviour, has established that this forces people living in rural areas to migratory labour systems (Camlin and Charlebois, 2019).

Literature has found that the migratory labour system has profound effect on family incomes as when men work in the urban areas, send remittances to their families in the rural areas. On the other side, this has shown to have its own challenges when one considers how HIV is spread and also considering the rural women vulnerabilities to HIV infections (Rai, Lambert and Ward, 2017). Poverty often projects women particularly young women living in the rural areas at the receiving end of human developmental initiatives (World Bank, 2014; ILO, 2019; Department of Women, 2015). That said, there has

been a noticeable trend over a period of time that young rural women find themselves in precarious financial conditions that subjects them to have sexual relationships with older working men who might have been infected with HIV (Schaefer, Gregson, Eaton, Mugurungi, Rhead, Takaruzza, Maswera, and Nyamukapa, 2017).

Compounding these challenges, are the high levels of little or no education among these rural young women which exposes them to dire situation to make informed decisions about their sexual preferences resulting from their vulnerability to coercion (Motsa, 2018; The World Bank, 2015, p. 33). The result of these vulnerabilities has been noted in literature to have negative implications for these young rural women to HIV infection and further exacerbate the levels of poverty among them (UN Women, 2020; Pascoe, Langhaug, Mavhu, Hargreaves, Jaffar, Hayes and Cowan, 2015).

Problem Statement

Literature suggests that the nature of the qualifying criteria for the disability grant may incentivise non-adherence to ARVs among the PLHIV that may further subjects them to various vulnerabilities such as AIDS. Studies have shown that PLHIV are vulnerable to disabilities as result of non-adherence to ART. This is compounded by the lack of nutritional support to adhere to ARVs intake as the disability grant is terminated. In this regard, young women living with HIV in the Vhembe District are not spared from this global phenomenon considering their unemployable statuses and the poverty as propelled by the current economic climate and lack of employment opportunities in South Africa specifically in the rural areas (Govender, Fried, Birch, Chimbindi and Cleary, 2015; Knight, Hoosegood and Timaeus, 2013; de Paoli, Mills and Grønningsæter, 2012).

Poverty remain one of the human developmental challenges especially for young women living with HIV between the ages of 25-30 in the District of Vhembe in Limpopo Province. One can attribute these challenges to the developmental quagmire of the district as studies have shown that the district falls under socioeconomic quintile 2 (HST, 2015). In the absence of employment opportunities and deteriorating health status of young women living with HIV in the rural areas such as Vhembe District, the disability grant becomes a modest form of socioeconomic relief measure (Kagee, 2014).

However, when this grant is terminated upon improved health status of these young women living with HIV in the Vhembe District, their livelihoods become interrupted. Also, this has a profound impact on adherence on ART. Against this challenge, the study sought to explore and examine how the termination of the disability grant affects the livelihoods of young women between the ages of 25-30 living in Vhembe District in Limpopo Province.

Study Aims

The aim of our study was to explore and examine the effects of disability grant termination on the livelihoods of rural women living with HIV aged between 25-30 attending a Wellness Clinic in Vhembe District. The study was guided by the following objectives:

- To explore and examine the extent of the disability grant on the livelihoods of young rural women aged between 25-30 living with HIV attending a Wellness Clinic in Vhembe District.
- To explore how the disability grant termination interferes with treatment adherence among young rural women living with HIV attending a Wellness Clinic in Vhembe District.

The study was guided by the following question

- To what extent does the terminations of the disability grant interfere with the livelihoods of the rural women aged 25-30 living with HIV attending a Wellness Clinic in Vhembe District?

Sub-questions

- Why is it that the disability grant is so important for the livelihoods of young rural women aged 25-30 living with HIV attending a Wellness Clinic in Vhembe District?
- How does the termination of the disability grant upon improved health outcomes interferes with the treatment adherence among young rural women aged 25-30 living with HIV attending a Wellness Clinic in Vhembe District?

Literature Review

The Concept of Disability Grant

The concept of the disability grant in the South African context is one of the many social grants which the National Department of Social Department has initiated and disbursed through the South African Social Security Agency (SASSA). The disability grant is awarded to persons owing to their physical inability to perform the daily functions adequately like people whose functionality is not impaired. People living HIV and AIDS are considered to access the grant when their normal functioning is impaired as a result of the biological determinations of HIV and AIDS infections (Govender, Fried, Birch, Chimbindi and Cleary, 2015).

For one to access this grant, should have met a certain criterion which is means-tested by a medical practitioner, and it is given to people living with HIV for six to twelve months depending on the improved health outcomes. For people living with disabilities apart from PLHIV, the grant is given for five years upon which the recipients must be reevaluated for further access. It is used as one of the poverty reduction strategies among the unemployed and an incentive for PLHIV to adhere to treatment.

Theoretical Review-disability grant, treatment adherence

The literature presents inconclusive findings regarding the relationship between the economic incentives to ART adherence by young women living with HIV. This presents a challenge for determining how the disability grant influences the uptake of ART in rural context with limited job opportunities. The disability grant has been identified as a lifeline for young rural women living with HIV with little or no education attainment. Adequate adherence to ART has been identified to have beneficial health outcomes for people living with HIV, while sub-optimal adherence comes with health debilitating challenges. Early optimism concerning the benefits of these medications has been tempered, however, by evidence that even modest or occasional nonadherence can greatly diminish the benefits of treatment and lead to serious personal and public health consequences.

Evidence from studies have demonstrated that suboptimal adherence is usually associated with risks of adverse virologic and clinical health outcomes. In the absence of the disability grant which plays a

greater role for rural women living with HIV to adhere to ART to achieve improved health outcomes, this is scientifically proven to have a contribution to the increased viral replication and the development of drug-resistant HIV strains as well as AIDS which have disabling effects (Hansana, Sanchaisuriya, Durham, Sychareun, Chaleunvong, Boonyaleepun, and Schelp, 2013). In this line, studies have shown how poverty presents plausible challenges for households living with HIV to ART adherence when the disability grant is terminated (Govender, 2015; Kagee, 2013; de Paoli, Mills and Grønningsæter, 2012).

Significantly, studies have shown the value of the use of economic incentives in some countries in the sub-Saharan countries such as Malawi and Kenya to the delayed engagement in early sexual debut by young women and girls from poverty-stricken households as poverty is conceptualised to have triggering incentive to engage in ill-informed health seeking behaviours (Fentie, Kidie, Fetene and Shewarega, 2023) Since the relationship between suboptimal adherence to ART and its related adverse clinical outcomes in PLHIV has been outlined in literature, endeavours to find ways on factors that may help to predict adherence to ART remain sparsely. Therefore, the need to explore ways in which rural young women living with HIV can be influenced to continually adhere to treatment despite the disability grant termination. Studies in this regard have focused on examining the significance of the demographic characteristics such as age, ethnicity, mental health status, social support and cultural beliefs, regimen complexity in predicting ART adherence (Chesney, Morin and Sherr, 2000; Kalichman, Ramachandran and Catz, 1999; Smith, Rapkin, Morrison and Kammerman, 1997). However, since the prediction of young rural women living with HIV adherence to ART is a multidimensional issue that need different angles of interventions, the study employed the psychological theory of Health Belief Model (HBM) to help elicit the ways in which ART adherence can be sustained despite the termination of the disability grant on young women with inferior employable skills and low education attainment.

The HBM is a most widely used theoretical framework for explaining health-related behaviours which was first introduced by Rosenstock (1974). The use of the HBM in health-related behaviours is influenced by the assumptions that it hypothesises that health behaviours depend mainly on the desire to avoid illness and the belief that certain actions will prevent

or alleviate the disease (Jones, Jensen, Scherr, Brown, Christy and Weaver, 2015). The model consists of a number of dimensions, including (a) perceived susceptibility to illness, which is the belief that one is at risk of disease progression if not compliant to treatment, or belief in the validity of the treatment; (b) perceived illness severity, which includes feelings regarding the seriousness of developing resistance to treatment if not taken as prescribed; (c) perceived benefits of treatment, which relates to beliefs in the effectiveness of various actions in reducing the suboptimal health behaviour with adverse health outcomes (Jones, Jensen, Scherr, Brown, Christy and Weaver, 2015).

Thus, this model was adopted in this study to understand how the health behaviour of rural women aged between 25-30 living with HIV attending a Wellness Clinic in Vhembe District can be altered after experiencing termination of the disability grant which may act as a perceived threat to ART adherence thereby their suboptimal health outcomes. ART in general is perceived to have benefits for people living with HIV to improve their health outcomes. Therefore, seeing that poor or complete non-adherence to ART and the associated adverse health outcomes that comes with it (severity), would change the perceptions of rural women living with HIV towards non-adherence to ART, and therefore, the likelihood of individual health behaviour changes towards non-adherence to ART.

Empirical Evidence

Literature agrees that infection with HIV comes with various challenges such as social, economic, psychological challenges and especially for young rural women living with HIV. These factors play a vital role in altering the anticipated health outcomes as espoused in the National Development Plan Vision 2030 (NDP, 2012). Some studies have established that there is correlation between access to the socioeconomic incentives for rural people living with HIV and Antiretroviral therapy (ART) adherence. Adherence to ART plays a crucial role in the maintenance of health of persons living with HIV.

Evidence on the value of adequate ART adherence provides indubitable data that the introduction of ART in South Africa has saved millions of lives when patients maintain high levels of adherence to their medications (Parienti, Das-Douglas, Massari, Guzman, Deeks and Verdon, 2008; Kimmel, Charles, Deschamps, Severe, Edwards, Johnson, 2013;

Nsubuga, Maher and Todd 2013). The possibility that the desire to retain a disability grant may stand in the way of optimal adherence, constituting a perverse incentive to health maintenance, is therefore cause for concern (Kagee, 2013; Nattrass, 2007)

In this regard, (Knight, Hosegood and Timæus, 2013) maintain that there is a perceived trade-offs between adherence to ART and the termination of the disability grant for PLHIV in poverty-stricken environments especially in the rural areas. Evidence from literature points out that PLHIV stand to lose the grant as a result of their improved health (Peltzer, 2012). In combination with high unemployment rates among the youth in South Africa at 46,5 % with Limpopo at 33,6 % overall unemployment rates (Stats SA, 2023), women stand to be the most vulnerable in the labour market. Compared to men, women are more likely to remain unemployed for longer periods, which eventually affects their chances of being employed in the future and infection with HIV further compounds the problem (ILO, 2013)

To put this in context, the (Stats SA, 2023 report) add that during the period of quarter four (4) of 2022, 80,6% of women were in long-term unemployment compared to their male counterparts at 76,1%. The report further claims that the incidence of long-term unemployment among women subjects them to rely on social grants for economic gains. Some studies highlight that sound education attainment plays a vital role in the employability of unemployed persons in the labour market. Therefore, people with little or no education stand on periphery of being in the formal employment (ILO, 2019). Suggestive of these assumptions, evidence from studies reveal that unemployed persons with less than a matric level of education and matric qualification have a higher likelihood of being in long-term unemployment as opposed to tertiary and other tertiary qualifications. Given that the lack of education among young rural women living with HIV in Vhembe District adversely contribute to their unemployability in the scarce labour market, the disability grant may be an incentive to cushion the poverty trends among these households (Govender, Fried, Birch, Chimbindi and Cleary, 2015).

In this situation, the termination of the disability grant may pose a severe threat to the livelihoods of women headed households living with HIV in the rural areas and it may increase food insecurity, which could have serious consequences for individuals on ARVs, given the need for proper nutrition to ensure

treatment efficacy (de Paoli, Mills and Grønningsæter, 2012; ILO, 2013). Since the disability grant is means-tested for one to qualify, a study done by (de Paoli, Mills and Grønningsæter, 2012) found that PLHIV in poverty-stricken households in rural areas deliberately not adhere to the ART treatment daily routines as they are aware that once the health outcomes improve, the disability is terminated.

However, it is argued that while some studies reveal the extent to which the disability grant provides a valuable role in the health, nutrition and income as well as providing incentives for transport to access wellness clinics for monthly health reviews of households affected by HIV, gaps are evident on understanding whether when the grant is accessed and whether a potentially beneficial relationship exists between this grant and adherence to ART (Venkataramani, Maughan-Brown, Nattrass, and Ruger, 2010; Phaswana-Mafuya, Peltzer, and Petros, 2009) .

Method

A qualitative, exploratory, and contextual design using individual semi-structured in-depth interviews method was utilised. The relevance of this data collection technique was useful in this study as it embeds the use of dialogue between the researcher and the participant and is always guided by a flexible interview protocol and supplemented by follow-up questions, probes and comments. This method allowed the researcher to collect open-ended data to explore participants' thoughts, feelings and beliefs on how the termination of the disability grant affects them socially, financially and how this affects their adherence to ART.

Study setting

The study setting was a stable indigent community of approximately 200 000 residents situated on the north-eastern part of the Limpopo Province bordering Zimbabwe in the north, Mozambique in the east and Botswana in the west. The community comprised mainly of economic migrants from a predominantly urban province, Gauteng Province. The community had high HIV prevalence and unemployment rates exacerbated by the low levels of development in the area and scarcity of formal job opportunities. The main sources of income were unskilled labour-intensive work which does not fall under the country's labour legislation.

The disability grant and other types of social relief grants and remittances from the members of the households who work in the Gauteng Province contributed much to the alleviation of poverty in households with young women living with HIV. During the execution of this study, conditions for awarding the disability grant for people living with HIV was increased from CD4 cell count of 200 to 500 and below. Individual semi-structured in-depth interviews were conducted with 20 participants who had agreed voluntarily to participate in the study. The inclusion criteria for participating in the study were that these young women should have been enrolled in ART for a period of one year and beyond, not working because of their functionality challenges and having poor educational background. Also, they should be depending on the disability grant which is terminated or facing termination due to their improved health outcomes.

The exclusion criteria included any person living with HIV and not falling within the age range of 25-30 years of age living in the same circumstances as these young women live in, working and enrolled or not enrolled on ART and those considered to be too ill to participate in the interest of doing no harm. This decision was made on the basis of the patient's history, physical symptoms, and clinical examination. All the participants were Tsonga speakers, and this enabled the researcher to ask interview questions in Xitsonga as it was the dominant language in the area and the researcher was a fluent Xitsonga speaker.

Data Collection

Individual semi-structured interview questions were developed considering the vulnerability of these young women. Questions were pretested with a group of people living with HIV who received their monthly health reviews at a clinic not far from the identified wellness clinic for purposes of this study. Interviews which took approximately 30-40 minutes in duration were conducted in a convenient setting in the church adjacent to the wellness clinic. The individual semi-structured in-depth interviews were audio-recorded and scribed by the researcher as he was fluent Xitsonga speaker. Three general questions dealing with participants' knowledge on how to access and terminate the disability grants, the socioeconomic hardships and the role of the disability grant in promoting the uptake of critical health enhancing measures were posed to each individual participant.

After the completion of each individual in-depth interview, recorded discussions were played back to each participant to provide an opportunity to check the accuracy of their responses.

Data Analysis

Data from the audio-tape and field notes were transcribed into English verbatim, incorporating observational notes, non-verbal cues, and context descriptions from the participants lived experiences. Each participant was given a code to enhance anonymity and privacy (Saunders, Kitzinger and Kitzinger, 2015 p.2). Then a thematic analysis approach was utilised (Maguire and Delahunt, 2017). The researcher read through the transcripts, which were then reread, with related data being classified into patterns. Thereafter, each individual responses were grouped and analysed for related patterns (Saldhana, 2013).

Ethical Considerations

Ethical approval was obtained from the University of South Africa Higher Degrees Committee Faculty of Health Sciences. Permission to gain access to the study population was obtained from the Limpopo Department of Health and the Wellness Clinic. The study adhered to the principles of the Belmont Report as espoused in McMillan (2014). Voluntary informed written consent was obtained in the language of each participant which in the context of this study was Xitsonga without coercion (Gray, Grove and Sutherland, 2017). To ensure confidentiality and anonymity, all participants were given codes to protect their identity and no one who was not part of the study was permitted where interviews were conducted (Surmiak, 2018). The questions that guided this study were developed considering the vulnerability of the study participants and the problem which this study sought to solve in the interest of doing no harm (Bracken-Roche, Bell, Macdonald and Racine, 2017).

Trustworthiness

Maintaining trustworthiness through the tenets of credibility, transferability, dependability, and confirmability facilitated the evaluation of the quality of the study. According to (Bryman, 2012; Lincoln and Guba, 1985; Burns and Grove, 2017), early familiarity and prolonged involvement promote the credibility of qualitative studies. The researcher had

worked in the Wellness clinic for 12 years and had the opportunity to engage with the people living with HIV during working hours. Through this prolonged engagement, the researcher became accustomed with the behavioural dynamics of these young women living with HIV and became accepted, and observed their concerns (Lincoln and Guba, 1985).

Peer debriefing was done with another academic in the field to provide an external check on the research process which increased the credibility of this study, and to examine the referential adequacy to verify the preliminary findings and interpretations against the

raw data (Nowell, Norris, White and Moules, 2017). The researcher ensured that the field notes as well as the audio recordings of the in-depth individual semi-structured interviews were verified for their relevance to the participants narratives and played them back to each participant after every interview so that each one could ascertain that the discussion sufficiently reflected their views and experiences. An audit trail of field notes and verbatim transcriptions of the interviews were kept for future reference by others in the field (Nowell, Norris, White and Moules, 2017).

Demographic Characteristics of the Individual Semi-Structured In-Depth Interviews Participants

Table 1: Participants' Demographic Characteristics

Participant No.	Age	Marital Status		Education level	Employment Status	Income	On ART
No. 1	29	Single	Rural	STD 07	Unemployed	Grant	Yes
No. 2	30	Single	Rural	STD 04	Unemployed	Grant	Yes
No. 3	26	Single	Rural	STD 08	Unemployed	Grant	YES
No. 4	28	Single	Rural	STD 10	Unemployed	Grant	Yes
No. 5	30	Single	Rural	STD 03	Unemployed	Grant	Yes
No. 6	25	Single	Rural	STD 05	Unemployed	Grant	Yes
No. 7	28	Single	Rural	Grade 11	Unemployed	Grant	Yes
No. 8	29	Single	Rural	STD 04	Unemployed	Grant	Yes
No. 9	26	Single	Rural	STD 04	Unemployed	Grant	Yes
No. 10	27	Married	Rural	STD 05	Unemployed	Grant	Yes
No. 11	25	Single	Rural	Grade 10	Unemployed	Grant	Yes
No. 12	28	Single	Rural	Grade 10	Unemployed	Grant	Yes
No. 13	30	Single	Rural	Grade 11	Unemployed	Grant	Yes
No. 14	29	Single	Rural	STD 05	Unemployed	Grant	Yes
No. 15	30	Single	Rural	Grade 10	Unemployed	Grant	Yes
No. 16	27	Single	Rural	STD 05	Unemployed	Grant	Yes

Findings of the study

The researcher used a thematic analysis method to analyse the collected data from the in-depth qualitative interviews. From the transcripts and audio-clips, it was possible to deduce meaningful units or themes, and these became the units for analysing the data collected from the participants. The following themes emerged from the interviews and were categorised as follows:

The knowledge of how to access and terminate the disability grant.

The socioeconomic hardships.

The role of disability grant in promoting uptake of critical health measures.

The knowledge of how to access and terminate the disability grant processes

The study participants highlighted varied responses based on their knowledge and experiences. Even though some participants knew about the eligibility for the disability grant, 13 participants also highlighted the administrative challenges experienced in obtaining the disability grant. Poor knowledge of the disability grant process and the eligibility criteria featured most. In most instances, the theme of knowledge about the disability grant and its ameliorative effects on their daily challenges was highlighted. This is evidenced by the following excerpts from 13 participants' narratives:

"I know that the disability grant is given temporarily for six to twelve months, but when my health improves when I am adhering adequately to treatment, SASSA cuts the grant and this makes me not to adhere adequately to the treatment, so that I can get sick, and the disability grant can be prolonged. We receive R1500.00 per month from the government."

Poor knowledge about the disability grant processes and the eligibility criteria could have implications on how recipients understand the process, leading to confusion and mistrust. In the case of eligibility to disability grant, 13 participants highlighted that they did not know the eligibility period of the disability grant, but what they knew was that it was given by the state. This is evidenced by the following response:

"I do not know the eligibility period of the disability grant, but what I know is that it is given by the state, and this money is helping me a lot, and if it could be terminated, it will have negative impact on my health as I am not working, with two children who are fatherless, and I am a breadwinner."

The socio-economic hardships

In a context of chronic poverty, scarcity of employment opportunities, exacerbated by underdevelopment in the rural areas, and poor educational backgrounds, conversations with rural women aged between 25-30 years living with HIV, highlighted the disability grant as a lifeline for survival in the rural areas. The disability grant is of great importance on the lives of rural women living with HIV in Vhembe District. The situation of underdevelopment in the rural areas, especially in the Vhembe district of Limpopo Province (Health System Trust, 2015), adversely impact on the lives of young rural women to HIV infections. Once these young rural women are found to be living with HIV, the disability grant become a modest form of socioeconomic relief more so that when it is terminated upon the improved health outcomes resulting from treatment compliance, this group of women find it difficult to find domestic jobs in their communities as HIV is highly stigmatised in the rural areas. These sentiments were echoed by seven of the participants:

"When the disability grant IS terminated after six months, I find it difficult to continue adhering effectively to treatment as this treatment needs some nutritional supplements to work effectively. When I take this treatment, I feel hungrier than when not taking treatment. If I was educated, I would

not complain about the disability grant, but my educational situation put me in a dire situation to get employment, and even though I try to look for domestic work, once they know about my HIV status, they fire me immediately for fear of infection."

Sixteen of the participants alluded to the fact that, apart from accessing the disability grant, there are no other means of income that they receive and no other form of social assistance, and so the disability grant remains the sole provider of socio-economic comfort, as shown by the following excerpt from the participant's narratives:

"I stay alone with my two children aged between three and seven. All of us depend on this money for all household items and for education. The father of these children passed on three years back as he was sick from HIV. I tried to apply for the child support grant but to no avail. They told me that they need birth certificates for children, which I don't have. The Social Workers are not helpful in that case."

Ten participants revealed that they used the disability grant money to pay for their funeral schemes to cover for their own funerals and for their immediate family members, and once the disability grant is terminated, their livelihoods are severely affected since they are solely dependent on it.

"I have no other means of social support. I use the disability grant to pay Maeteko Funeral Services for funeral insurance to cover me and my children. My family members do not accept me and my children because we are sick."

Upon probing, 11 participants mentioned that they used the disability grant money to pay for transport on a monthly basis when they go to the clinic for their monthly health and treatment reviews, and when they no longer receive the disability grant, they would find themselves in a difficult economic situation to access the Wellness Clinic. This situation is evidenced by the following narrative:

"This DG helps me a lot. I have children to look after, and sometimes my legs become swollen, and it becomes so difficult for me to access the Clinic and in such adverse conditions, I can be able to access transport to take me to the Clinic, using the disability grant money."

Another eight participants highlighted this upon probing, that if there were rains, they would not mind too much about the termination of the disability grant, because they could plough the fields in order to plant fresh nutritious food, but given the current drought situation which had hit the rural areas so hard in Limpopo, the termination of the disability grant brings about socioeconomic challenges. This

statement is evidenced by responses from 14 participants as espoused in the following excerpt:

"As I am living in the rural area where the drought has severely affected us, the disability grant is of utmost importance. If there could be rains, I would not mind about the termination of the disability grant because I would cultivate the land and plant mealies and vegetables."

The third objective aimed at examining the importance that the disability grant has on the lives of the rural women living with HIV. The disability grant is of great importance in the lives of rural women living with HIV in the District of Vhembe in Limpopo. The situation of underdevelopment in the rural areas, especially in the Vhembe district of Limpopo Province (Health System Trust, 2015), forces rural women to be vulnerable to HIV infection. Once these rural women are found to be living with HIV, the disability grant become a modest form of socioeconomic relief. Moreover, once the disability grant is terminated, they find it difficult to find domestic jobs in their vicinities as HIV is highly stigmatised in the rural areas. These sentiments were echoed by 11 of the participants.

The role of the disability grant in promoting the uptake of critical health measures

Participants' narratives highlighted that in the absence of the disability grant, the survival of them and their households was tenuous, and access to treatment became very difficult. Twelve participants in the study highlighted the fact that the termination of the disability grant has debilitating effects on their health, because once the grant is terminated, they incur costs by borrowing money from the neighbours to buy food, which they promise to back when they receive the child support grant (CSG) money, which is less than the disability grant in value. These sentiments were echoed as follows by 12 participants: *"I know that the disability grant which I get on a monthly basis will be terminated when my health improves. This is the only money that helps me to take treatment twice a day as I have been living with this health condition for a long time. Sometimes I have to borrow money from my neighbours promising to pay them back when I receive the child grant in order to buy food."*

The role of the disability grant in promoting participants to attend the Wellness Clinic on monthly basis as it enables them to pay for transport was a recurrent theme and was highlighted by 10 participants' narratives:

"Sometimes I am unable to go to the Clinic to collect my treatment because I have no money for transport during rainy and cold days. I know that this act is detrimental to my health, but I have no other option."

Once the health of an individual improves, the disability grant is terminated, and so, the rural women choose not to adhere effectively to the treatment for fear of losing the grant. The fear of losing the disability grant featured in the conversation, with 14 of the participants echoing these sentiments as follows:

"This treatment (ARVs) is very strong for my body, and when I take them on an empty stomach, I feel dizzy. Sometimes I intentionally stop taking this treatment because I know that it makes me to be strong and no longer suffer from recurrent colds and diarrhoea. If I can take this treatment every day, the doctor will cut my grant."

Discussion

HIV infection has been identified to be having debilitating effects on the health of a person living with the disease and long-time survival with HIV in some cases have disabling effects. In this case, the South African government through the social security system grants monetary assistance in the form of disability grant for people living with HIV which is means tested. The findings of the study present compelling evidence that the structure of the qualification rules of South Africa's social security programme with special emphasis on the disability grant may incentivise the unintended low uptake of ART for people living with HIV especially in rural areas. Also, the findings were consistent with those of studies in similar demographic and socioeconomic areas. This is so because since the advent of democracy in South Africa, the remnants of separate development adopted by the apartheid government have not been erased but promoted to further polarise the people of South Africa in terms of economic development and resource sharing.

Also, this current setting has exacerbated the migratory labour system wherein people from the rural areas which are constantly underdeveloped with no employment opportunities migrate to urban areas for employment opportunities to pay remittances to their families left in the rural areas. This has added to the vicious cycle of HIV infections as older working men find themselves having multiple relationships with young women due to boredom in the urban areas. In this study, some narratives have pointed out

that some of these young women had relationships with older working men working in urban areas of Gauteng province who in turn return to their households in the rural areas with HIV and infect them.

The value of the disability grant for people living with HIV on ART has been cited in many respects. Disability grant despite its disincentive to adequate ART adherence as this study has noted, has an incentive to encourage people living with HIV to continually seek medical attention and attend to their monthly health and treatment reviews. Nonetheless, its termination due to improved health people living with HIV especially in the rural areas, experiences difficulties to continue complying with certain routines such as treatment adherence as food insecurity is noted to be a deterrent to adequate ART adherence. This is so because ARV drugs need food to work effectively to improve the immunity of an individual living with HIV. As with the young rural women between the ages of 25-30 attending a Wellness Clinic in the Vhembe District, indicators of lower socio-economic position, food insecurity, low education attainment were associated with HIV infection and disability with elevated dependency on the disability grant. Food insecurity was associated with lower adherence to ART. Lower levels of education attainment impacted on the HIV knowledge which in turn lessen the feelings of self-esteem around sexual choices and lower self-efficacy to make informed decision about their lives.

Limitations

The researcher experienced delays in obtaining the ethical clearance from the University's Department of Health Studies Research Ethics Committee. Furthermore, due to the high stigmatisation of the HIV disease and the vulnerability of women in Vhembe district, some participants might have had difficulty in participating in this study for fear of victimisation by members of their immediate community members. The linguistical challenges interfered with understanding the interview questions effectively as Vhembe District area has many dialects of the main dominant Tsonga language.

The eligibility criteria for inclusion in the study might have disadvantaged some participants to participate in this study as the focus was on young women between the ages of 25-35 who were experiencing the disabling effects of HIV and depending on the disability grants.

Also, the financial difficulties might have been a disincentive for maximum participation in the study and this may have had an impact on the findings anticipated by this study. Another limitation was that the findings cannot be generalised to the wider population with similar characteristics, but lessons can be drawn from this study for future studies.

Conclusion

The study highlighted the importance of the disability grant on the lives of people living with HIV in the rural areas. The study also accentuated the relationship between ART adherence and disability grant access. Food security has been underscored as predictor to adequate treatment adherence. In this regard, the variation of disability grant access for people living with HIV in urban and rural areas becomes imperative. The relationship between high levels of education and self-worth have been noted to have empowering effects on the lives of young rural women and women in general to make informed choices when engaging in sexual relationships.

Declarations

Ethics approval and consent to participate.

The study was conducted ethically considering that it involved human participants and dealt with vulnerable populations. Also, the study acknowledged that it dealt with a sensitive topic that could raise emotions. To position the study within the ambit of good ethical practices of research, ethical approval to conduct the study was granted by the University of South Africa Higher Degrees Ethics Committee of the Faculty of Health Sciences and the Wellness Clinic in Vhembe District where the study was conducted. Participants were recruited willingly after they were informed about the purpose of the study and the potential benefits that the study could have on their lives. The study declare that no coercion was involved in the recruitment of potential participants, but participants consented to participate in the study out of their own volition considering that the study could have benefits for them.

Consent for publication

The participants were informed that the findings of the study and gave consent to publish the findings of the study for purposes of future studies that might be conducted in the field to broaden the scope of

understanding of the issues that the study investigated.

Availability of data and materials

Data and materials used for the purposes of this study are available on request.

Competing interests

The researcher declares that there are no competing interests in this study.

Funding

The researcher declares that the University of South Africa funded the study for the researcher to collect data and other items related to the study objectives.

Authors contribution

The authors declares that the study is his own work, and no other contributing author was involved in the conceptualisation of the idea that guided this study and the study itself. The study is solely his own contribution.

Acknowledgements

I acknowledge the contribution that the University of South Africa had for this study for approving the study and granting me permission to conduct the study. Also, I acknowledge the value that the Limpopo Department of Health had for giving access to the Wellness Clinic in Vhembe District, the management of the Wellness Clinic and participants for availing themselves for the purposes of this study amid the health challenges they faced.

Authors information

The author of the manuscript is holder of Masters of Arts Degree in Social Behaviour Studies obtained at University of South Africa Department of Sociology. The author also holds a Masters in Management in the Field of Governance with specialisation in Public and Development Sector Monitoring and Evaluation obtained at the University of the Witwatersrand school of governance. The author also holds a Postgraduate Diploma in Management with specialization in Monitoring and Evaluation. Currently, the author is completing a PhD Degree in Sociology at the University of South Africa.

References

1. Allinder, S.M and Fleichsman, J (2019). The World's Largest HIV Epidemic in Crisis: HIV in South Africa. *Center for Strategic and International Studies in Washington, D.C.*
2. Banks, L. M., Zuurmond, M., Ferrand, R., & Kuper, H. (2015). The relationship between HIV and prevalence of disabilities in sub-Saharan Africa: Systematic review (FA). *Tropical Medicine & International Health*, 20(4):411-429.
3. Bracken-Roche, D.; Bell, E.; Macdonald, M.E and Racine, E The concept of 'vulnerability' in research ethics: an in-depth analysis of policies and guidelines, *Health Research Policy and Systems*, 15:8.
4. Bryman, A. (2012). *Social Research Methods*. 4th Edition. Oxford.
5. Camlin, C.S and Charlebois, E.D. (2019). Mobility and its Effects on HIV Acquisition and Treatment Engagement: Recent Theoretical and Empirical Advances. *Curr HIV/AIDS Rep.* 16(4):314-323.
6. Chesney, M.A., Morin, M, and Sherr, L. (2000) Adherence to HIV combination therapy. *Social Science & Medicine*, 50:1599-1605.
7. Gray, J.R.; Grove, S.K. and Sutherland, S. (2017). *The Practice of Nursing Research*. 8th Edition. Appraisal, Synthesis and Generation of Evidence. Elsevier.
8. de Paoli, M.M., Mills, E.A and Grønningsæter, A. A (2012). The ARV roll out and the disability grant: a South African dilemma? *Journal of the International AIDS Society*, 15(6):1-10.
9. Fentie, E.A., Kidie, A.A., Fetene, S.M and Shewarega, E.S. (2023) Socioeconomic inequality in early sexual initiation among female youths in sub-Saharan African countries: a decomposition analysis. *BMC Public Health*, 4:23(1):1283.
10. Global Health Policy (2021). *The Global HIV/AIDS Epidemic*.
11. Govender, V.; Fried, J.; Birch, S.; Chimbindi, N, and Cleary, S. (2015). Disability Grant: a precarious lifeline for HIV/AIDS patients in South Africa *Health Services Research*, 15:227.
12. Günthard, H.F.; Saag, M.S.; Benson, C.A.; del Rio, C.; MD. et al. (2016) Antiretroviral Drugs for Treatment and Prevention of HIV Infection in Adults: Recommendations.
13. The Health System Trust (2015). *The District Health Barometer*.
14. International Antiviral Society-USA, *HHS Public Access*, 316(2):191-210.

15. Hanass-Hancock, J., Regondi, I., Van Egeraat, L., & Nixon, S. (2013). HIV related disability in HIV hyper-endemic countries: A scoping review. *World Journal of AIDS*, 3(03):257-279.
16. Hansana, V., Sanchaisuriya, P., Durham, J. Sychareun, V., Chaleunvong, K., et al. (2013). Adherence to Antiretroviral Therapy (ART) among People Living with HIV (PLHIV): a cross-sectional survey to measure in Lao PDR. *BMC Public Health*, 13:617.
17. Health Canada. (2009). HIV/AIDS and disability: Final report of the 4th international policy dialogue international affairs directorate, Ottawa: Health Canada.
18. Human Sciences Research Council. (2019). South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, TOWARDS ACHIEVING THE UNAIDS 90-90-90 TARGETS, HSRC Press.
19. International Labour Organisation. (2013). The Impact of Employment on HIV Treatment Adherence. ILO Publications. Geneva.
20. International Labour Organisation (2019) Empowering Women in the Rural Economy. Decent Work in the Rural Economy Policy Guidance Notes. ILO. Geneva.
21. Jones, C.L., Jensen, J.D., Scherr, C.L., Brown, N.R., Christy, K. et al. (2015) The Health Belief Model as an explanatory framework in communication research: exploring parallel, serial, and moderated mediation. *Health Commun*, 30(6):566-576.
22. Kalichman, S.C, Ramachandran, B and Catz, S. (1999) Adherence to combination antiretroviral therapies in HIV patients of low health literacy. *Journal of General Internal Medicine*, 14:267-273.
23. Kharsany, A.B.M and Karim, Q (HIV Infection and AIDS in Sub-Saharan Africa: Current Status, Challenges and Opportunities, *The Open AIDS Journal*, (10):34-48.
24. Kimmel, A.D., Charles, M., Deschamps, M.M., Severe, P., Edwards, A.M., Johnson, W.D. (2013) 'Lives saved by expanding HIV treatment availability in resource-limited settings: The example of Haiti', *AIDS Journal of Acquired Immune Deficiency Syndromes*, 63(2):40-48.
25. Knight, L.; Hosegood, V and Timæus, I.M. (2013). The South African disability grant: Influence on HIV treatment outcomes and household well-being in KwaZulu-Natal. *Development Southern Africa*, 30(1):135-147.
26. Lincoln, Y.S, & Guba, E.A. (1985) Naturalistic inquiry. Beverly Hills, CA: Sage.
27. Mabaso, M., Mlangeni, L., Makola, L., Oladimeji, O., Naidoo, I. et al. (2021). Factors associated with age-disparate sexual partnerships among males and females in South Africa: a multinomial analysis of the 2012 national population-based household survey data. *Emerg Themes Epidemiol*, 18:3.
28. Magubane, K (2020). SA grants system on par with the world's best, says dept of social development. *Fin24*.
29. Maguire, M and Delahunt, B. (2017). Doing a Thematic Analysis: A Practical, Step-by-Step Guide for Learning and Teaching Scholars, *AISHE*, 3:1-14.
30. Maloka, V.L., Gahongayire, B and Chiwara, L (2021). gender equality, women's empowerment (gewe) and hiv in africa. un women.
31. Masquillier C, Wouters E, Campbell L, Delport A, Sematlane N. et al. (2020). Households in HIV Care: Designing an Intervention to Stimulate HIV Competency in Households in South Africa, *Front. Public Health* 8:246.
32. Motsa, N. (2018). Vulnerable femininities: Implications for rural girls' schooling experiences in Swaziland. *Educational Research for Social Change (ERSC)*, 7(2):102-116.
33. Moomba K, Van Wyk B. (2019). Social and economic barriers to adherence among patients at Livingstone General Hospital in Zambia. *Afr J Prm Health Care Fam Med*, 11(1):a1740.
34. Myezwa, H., Stewart, A., Musenge, E., & Nesara, P. (2009). Assessment of HIV positive in-patients using the international classification of functioning, disability and health (ICF) at Chris Hani Baragwanath Hospital, Johannesburg. *African Journal of AIDS Research*, 8(1):93-105.
35. Myezwa, H., Buchalla, C., Jelsma, J., & Stewart, A. (2011). HIV/AIDS: Use of the ICF in Brazil and South Africa-comparative data from four cross-sectional studies. *Physiotherapy*, 97(1):17-25.

36. Nattrass, N. (2007) 'Disability and welfare in South Africa's era of unemployment and AIDS', in S. Buhlungu, J. Daniel, R. Southall & J. Luchman (eds.), *State of the Nation 2007*, 179–200, HSRC Press, Cape Town.
37. Nsubuga, R.N., Maher, D and Todd, J.E. (2013). Impact of antiretroviral therapy on adult HIV prevalence in a low-income rural setting in Uganda: A longitudinal population-based study, *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 62(5):562-568.
38. Nowell, L.S.; Norris, J.M.; White, D.E and Moules, N.J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria, *International Journal of Qualitative Methods*, 16:1-13.
39. Parienti, J.J., Das-Douglas, M., Massari, V., Guzman, D., Deeks, S.G., et al. (2008), Not all missed doses are the same: Sustained NNRTI treatment interruptions predict HIV rebound at low-to-moderate adherence levels, *PLOS One*, 3(7):e2783.
40. Pascoe, S.J.S., Langhaug, L.F., Mavhu, W., Hargreaves, J., Jaffar, S., et al. (2015). Poverty, Food Insufficiency and HIV Infection and Sexual Behaviour among Young Rural Zimbabwean Women, *Women. PLoS ONE*, 10(1):e0115290.
41. Peltzer, K. (2012). Social grants for people living with HIV and on antiretroviral therapy in KwaZulu-Natal, South Africa: a longitudinal study. *Journal of Social Aspects of HIV/AIDS*, 9(1):1-9.
42. Psaros, C., Milford., Smit, J.A., Greener, L., Mosery, N., et al. (2018). HIV Prevention Among Young Women in South Africa: Understanding Multiple Layers of Risk, *Arch Sex Behav*, 47(7):1969-1982.
43. Rai, T., Lambert, H.S and Ward, H. (2017). Migration as a risk and a livelihood strategy: HIV across the life course of migrant families in India. *Glob Public Health*, 12(4):381-395.
44. Ramjee, G and Daniel, B. Women and HIV in Sub-Saharan Africa, *AIDS Research and Therapy*, 10(30):1-9.
45. Saldana, J. (2013). *The Coding Manual for Qualitative Researchers* (2nd ed.). London: Sage.
46. South African Social Security Agency: You and your grant.
47. South African Social Security Agency: Statistical Report on Social Grants Report, 31.
48. Pretoria, (2010). Department of Monitoring and Evaluation, South African Social Security Agency.
49. Saunders, B., Kritzing, J and Kritzing C (2015). Anonymising interview data: R challenges and compromise in practice, *Qualitative Research*, 15(5):616-632
50. Schaefer, R., Gregson, S., Eaton, J.W., Mugurungi, O., Rhead, R., et al. (2017). Age-disparate relationships and HIV incidence in adolescent girls and young women: evidence from Zimbabwe. *AIDS*. 19;31(10):1461-1470.
51. Smith, M.Y., Rapkin, B.D., Morrison A, and Kammerman S. (1997) Zidovudine adherence in persons with AIDS: Relation of patient beliefs about medications to self-termination of therapy. *Journal of General Internal Medicine*, 12:216-223.
52. Statistics South Africa (2019) *Sustainable Development Goals*. Country Report, South Africa. Stats SA.
53. Statistics South Africa (2022). Statistical Release. Quarterly Labour Force Survey Quarter 4: 2021. Stats SA.
54. South Africa (Republic). (2012). National Planning Commission *The National Development Plan Vision 2030*. *Government Gazette*.
55. Surmaik, A (2018). Confidentiality in Qualitative Research Involving Vulnerable Participants: Researchers' Perspectives, *Forum Qualitative Social Research* Volume 19(3):1-13.
56. The World Bank. (2015). Voice and Agency Empowering women and girls for shared prosperity. *The World Bank*.
57. The World Bank (2021) South Africa: A New Social Assistance Assessment Aims to Help Strengthen Policies and Programs for the Poor, *Press Release*.
58. Tuller, D.M., Bangsberg, D.R., Senkungu, J., Ware, N.C., Emenyonu, N and Weiser, S.D. (2010). Transportation costs impede sustained adherence and access to HAART in a clinic population in Southwestern Uganda: A qualitative study. *AIDS Behav*. 14:778-784.

59. United Nations (2020). Sustainable Development Goals 2030. Department of Economic and Social Affairs. *Sustainable Development*.
60. UN Women. (2021). UNAIDS. *Global HIV & AIDS statistics – 2020 fact sheet*.
61. Weiser, S.D., Tuller, D.M., Frongillo, E.A., Senkungu, J., Mukiibi, N and Bangsberg, D.R. (2010) Food insecurity as a barrier to sustained antiretroviral therapy adherence in Uganda. *PLoS One*, 5(4):2-8.
62. Vermund, S.H., Tique, J.A., Cassell, H.M., Pask, M.E., Ciampa, P.J and Audet, C.M. (2013) Translation of biomedical prevention strategies for HIV: prospects and pitfalls. *J Acquir Immune Defic Syndr*, 1(1):S12-25.
63. WHO. (2021). *Global tuberculosis report; 2021*. World Health Organisation.
64. Wilkinson, A., Pettifor, A., Rosenberg, M., Halpern, C., Thirumurthy, H., et al. (2017). The employment environment for youth in rural South Africa: A mixed-methods study. *Dev South Afr.*, 34(1):17-32.

Cite this article: Chrisen E Mhangwani, Malindini K. (2023). The Effects of Disability Grant Termination on The Livelihoods of Rural Women Aged Between 25-30 Living With HIV. A Case of Wellness Clinic at Vhembe District in Limpopo, *Journal of BioMed Research and Reports*, BioRes Scientia Publishers. 3(1):1-15. DOI: 10.59657/2837-4681.brs.23.047

Copyright: © 2023 Chrisen E Mhangwani, this is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Article History: Received: October 09, 2023 | Accepted: October 23, 2023 | Published: October 30, 2023