

**AN ANALYSIS OF LIVELIHOOD STRATEGIES OF
HIV/AIDS AFFECTED HOUSEHOLDS RECEIVING
SUPPORT FROM CATHOLIC RELIEF SERVICES
(CRS) IN CHEGUTU, ZIMBABWE**

BY

KUDZAI E. CHADEMANA- MUNODAWAFA

**A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENT FOR THE DEGREE OF MASTERS IN
DEVELOPMENT STUDIES IN THE SCHOOL OF DEVELOPMENT
STUDIES UNIVERSITY OF KWAZULU-NATAL**

MAY 2009

SUPERVISOR: PROFESSOR ELEANOR PRESTON- WHYTE

ABSTRACT

The AIDS epidemic in Sub-Saharan Africa threatens to roll back decades of development progress as the epidemic has contributed to rising child mortality, sharp reductions in life expectancy and has already orphaned a generation of children (Andrews et al 2006). UNAIDS (2007) notes that sub-Saharan Africa is the epicentre of the epidemic with an estimated figure of 22.5 million people having said to be living with HIV at the end of 2007. Approximately 1.7 million people were infected with HIV during the same year. UNAIDS (2007) further notes that one fifth of the adult population in Zimbabwe are living with HIV/AIDS. A total of 135 000 adults are estimated to have died between January 2003 and August 2003 as a result of HIV/AIDS related complications (Kujinga 2004:126).

The HIV epidemic infects mostly the economically active household members and thus has the potential to draw households into poverty and even deeper poverty for those already in a state of deprivation. When hit by HIV/AIDS, like any other shock, households will adopt coping mechanisms; but in Zimbabwe's context of hyperinflation and economic instability, how viable are these livelihood strategies? The objectives of this study were to explore the livelihood strategies that urban households resort to in response to the effects of HIV/AIDS in Zimbabwe; and to assess the feasibility of these strategies in the context of the country's current socio-economic turmoil.

A qualitative methodology making use of ethnographic techniques such as semi-structured individual interviews, focus group discussions and observations was employed to gather this data. Results indicate that households are limited in livelihood options due to underlying structural problems such as hyperinflation, resource and cash shortages as well as market failure. Households engaged in livelihood strategies such as use of savings, the sale of assets and commercial sex work.

DECLARATION OF ORIGINALITY

Submitted in fulfillment / partial fulfillment of the requirements for the degree of Master of Development Studies, in the Graduate Programme in School of Development Studies, University of KwaZulu-Natal, Durban, South Africa.

I declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. It is being submitted for the degree of Master of Development Studies in the Faculty of Humanities, Development and Social Science, University of KwaZulu-Natal, Durban, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.

Student signature

Date

DEDICATION

This thesis is dedicated to my family who have stood by me and supported me all the way. Thank you for your unwavering love and support, most of all I thank you for believing in me, even when I doubted myself. I also dedicate this work to the future of Kudzanai Orphan Support Trust (KOST).

ACKNOWLEDGEMENTS

My sincere appreciation goes to:

- ❖ The Lord Almighty, “This far you have taken me”
- ❖ Professor Eleanor Preston-Whyte, my supervisor, your dedication, guidance and motivation is highly appreciated. I have learnt a lot from you, thank you for your mentorship.
- ❖ The Catholic Relief Services (CRS) and Faith In Community Aiders (FICA), for taking time to accommodate me.
- ❖ My family: Mum, thank you for always believing in me and for your unceasing support and encouragement. Dad your wisdom and intellectual guidance is sincerely appreciated. Taka, you are my pillar of strength, thank you for your patience. Tarisai, I love you little brother, let this be your source of inspiration. My Pretoria family, Sebastian and Arnold thank you so much.
- ❖ Lastly, I would like to acknowledge and thank the Ford Foundation for funding this study.

TABLE OF CONTENTS

PAGES

ABSTRACT	ii
DECLARATION.....	iii
DEDICATION.....	iv
ACKNOWLEDGEMENTS.....	v
TABLE OF CONTENTS.....	vi

CHAPTER ONE: INTRODUCTION AND STATEMENT OF PROBLEM

1.1 Background of the study	1
1.2 Statement of the problem.....	2
1.3 Objectives.....	3
1.4 Research questions.....	3
1.5 Structure of dissertation.....	4

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction.....	5
2.2 Effects of HIV/AIDS on household livelihoods.....	5
2.2.1 Loss of Resources.....	6
2.2.2 High expenditure.....	6
2.2.3 Children dropping out of school	7
2.2.5 Burden on Women.....	8
2.2.6 Poverty	8
2.3 Survival Strategies	
2.3.1 Borrowing.....	9
2.3.2 Sale of Assets	10
2.3.3 Livelihood diversification.....	10
2.3.4 Safety nets.....	11

2.3.5 Child Labour.....	12
2.3.6 Adjustments of funeral practices.....	13
2.3.7 External support.....	13
2.3.8 Other mechanisms.....	13
2.4 NGO Support	
2.4.1 SIMBA Program.....	15
2.4.2 The Catholic Relief Services.....	16
2.5 Conclusion.....	16

CHAPTER THREE: CONTEXT OF STUDY

3.1 Introduction.....	18
3.2 Land Reform.....	18
3.3 Operation Murambatsvina/Restore Order	
3.4 Food Insecurity.....	20
3.4.1 Food Shortages.....	21
3.4.2 Reduction in agricultural outputs.....	22
3.4.3 Operation Maguta.....	22
3.4.4 Basic Commodity Supply Side Intervention (BACOSSI) Facility.....	22
3.5 Economic problems	
3.5.1 Price Control.....	23
3.5.2 Economic Recovery Programs.....	24
3.5.3 Coping Strategies.....	25
3.6 Collapse of the Health System	
3.6.1 Shortages of staff and drugs.....	26
3.6.2 HIV/AIDS.....	27
3.6.3 The Cholera epidemic.....	28
3.7 Conclusion.....	29

CHAPTER FOUR: METHODOLOGY

4.1 Introduction.....	30
-----------------------	----

4.2 Research Design.....	30
4.3 Conceptual Framework.....	30
4.4 Site of study.....	33
4.5 Sample and sampling method.....	33
4.6 Data collection.....	34
4.7 Data analysis.....	35
4.8 Ethical considerations.....	35
4.9 Limitations.....	36
4.10 Conclusion.....	37

CHAPTER FIVE: FINDINGS AND ANALYSIS

5.1 Introduction.....	38
5.2 Case Studies.....	38
5.3 Effects of HIV/AIDS on Households	
5.3.1 Effects of Illness on household finances.....	44
5.4 Unemployment.....	45
5.5 Livelihood Strategies	
5.5.1 Use of Savings.....	47
5.5.2 Sale of Assets.....	48
5.5.3 Barter Trade.....	48
5.5.4 Informal Sector Activities.....	49
5.5.5 Assistance from extended family	53
5.6 The Dual Role.....	55
5.7 External Assistance.....	56
5.8 Catholic Relief Services	
5.8.1 Rationale for Food Aid.....	58
5.9 Conclusion.....	59

CHAPTER SIX: SUMMERY, CONCLUSION AND RECOMMENDATIONS

6.1 Introduction.....	60
6.2 Summery and conclusion.....	60

6.3 Recommendations	
6.3.1 Macro-level Recommendations.....	62
6.3.2 Micro-level Recommendations.....	64
References.....	66
Appendices.....	76

CHAPTER ONE

INTRODUCTION AND PROBLEM STATEMENT

1.1 Introduction

This study explores the livelihood strategies that low income households affected by HIV/AIDS resort to. The research exclusively focuses on households in Chegutu that receive support from the Catholic Relief Services (CRS). The main thrust of the study is the livelihood options available and their feasibility in the context of socio-economic and political instability.

This chapter presents a brief background and the objectives of the study. Chapter two reviews related literature as well as previous studies. A more detailed background and discussion of the context of the research is expounded on in chapter three. The following chapter describes the research design and methods used to investigate the research questions. The last two chapters will present, analyze and develop inference from the data.

1.2 Background to the study

The AIDS epidemic in Sub-Saharan Africa threatens to roll back decades of development progress as the epidemic has contributed to rising child mortality, sharp reductions in life expectancy and has already orphaned a generation of children (Andrews et al 2006). According to the Human Development Report 2004, Zimbabwe's life expectancy has plunged from 55.3 years in 1990 to 33.9 years in 2004. According to UNAIDS (2007) sub-Saharan Africa is viewed as the epicentre of the epidemic with an estimated figure of 22.5 million people having said to be living with HIV at the end of 2007. Approximately 1.7 million people were infected with HIV during the same year. UNAIDS (2007) further notes that one fifth of the adult population in Zimbabwe are living with HIV/AIDS. A total of 135 000 adults are estimated to have died between January 2003 and August 2003 as a result of HIV/AIDS related complications (Kujinga 2004:126).

It is evident that there exists an intersection of HIV/AIDS and poverty. The epidemic has deepened poverty and exacerbated a myriad of deprivations in sub-Saharan Africa (Steinberg et al 2003). Steinberg et al (2002) in a study of South Africa argue that poor people are the most adversely affected by HIV/AIDS and Bicego et al (2003) state that the economic impact of HIV/AIDS is increasingly felt by the poorest households. The prevalence of the pandemic in sub-Saharan Africa has indeed had a deleterious effect on millions of households.

Zimbabwe is currently an impoverished low-income country characterized by an unemployment rate of 85%, inflation pegged at 231 million percent as of October 2008 (Zimbabwe Central Statistic Office, 2008 *in* UNICEF 2009), severe food shortages and a collapse of most basic services. Poverty is rife as millions of Zimbabweans struggle to survive amid a dire economic meltdown instigated by the 2000 fast-track land reform and the more recent Operation Murambatsvina in 2006. Operation Murambatsvina was a major cause of urban poverty and has raised the poverty datum line destroying the informal sector which constituted the main source of income for urban dwellers. The poor performance in the agricultural sector has seen thousands of people losing their jobs both in the agriculture and manufacturing sectors. This has seen many resorting to survival strategies such as commercial and survival sex. There is a high HIV/AIDS prevalence resulting from interplay of these characteristics of poverty and unemployment.

1.3 Statement of the problem

HIV infects mostly economically active household members and thus has the potential to draw households into poverty and even deeper poverty for those already in a state of deprivation. When hit by HIV/AIDS, like any other shock, households will adopt coping mechanisms; but in Zimbabwe's context of hyperinflation and economic instability, how viable are these livelihood strategies?

Using the Sustainable Livelihoods Approach this study seeks to investigate whether these strategies are sustainable. A livelihood is said to be sustainable when it can "cope with and recover from stresses and shocks and maintain or enhance its capabilities and assets" (Chambers and Conway 1998: 4). The study of livelihood strategies is particularly

interesting in the context of Zimbabwe's economic and political turmoil as livelihood diversification has virtually become impossible due to the destruction of the informal sector.

1.4 Objectives

- To explore the livelihood strategies of urban households in response to the effects of HIV/AIDS.
- To assess the feasibility of these strategies in the context of Zimbabwe's current socio-economic turmoil.
- To investigate how the CRS has assisted AIDS-affected households.
- To assess the impact of the CRS assistance, from the household's perspective.
- To explore whether households still engage in other livelihood activities in addition to receiving NGO assistance.

1.5 Research questions

- How has the serostatus/illness of individuals affected the household's livelihoods (means of earning income)?
- What strategies did the households resort to as a way of coping with the effects of HIV/AIDS?
- In light of the current socio-economic situation, are these strategies viable?
- What kind of support does CRS render to these households?
- What is the impact of the assistance provided by CRS?
- In addition to NGO assistance, do households still engage in other livelihood activities?
- What challenges and obstacles did CRS encounter in trying to sustain the livelihoods of the households?

1.6 Structure of dissertation

Chapter one introduces the rationale and objectives for studying the livelihood strategies of low-income households affected by HIV/AIDS and the role and contribution of CRS to household livelihoods. It also describes the research problem and outlines the structure of the dissertation. The Literature Review chapter is divided into three sections; the first section, *Effects of HIV/AIDS on household livelihoods*, reviews factors affecting the livelihoods of households as a result of sero-positivity and HIV/AIDS-related illness. The second section discusses literature on how households have coped as a result of the effects of the epidemic upon their livelihoods. The strategies households have resorted to are also discussed. The last section reviews the role of NGOs within the sustainable livelihoods framework of households affected by HIV/AIDS. Chapter three is the context chapter. This chapter gives an overview of the Zimbabwean socio-economic conditions and a background that has led to the current crisis. The chapter seeks to outline the challenging environment HIV/AIDS affected households and NGOs operating in Zimbabwe are confronted with. Chapter four outlines the research method and design as to how the data was collected, analyzed and interpreted. Ethical concerns and potential biases are examined. The theory informing the study will be presented. The Sustainable Livelihoods Approach and its applicability to AIDS-affected households in the context of Zimbabwe are discussed. Chapter five focuses on the research findings. An analysis and interpretation of the data is presented. A summary, recommendations and suggestions for further research will be outlined in chapter six.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

On reading the literature, a number of aspects significant to this particular study arose. This chapter briefly discusses these points. The chapter is subdivided into three sections. The first section covers the effects of HIV/AIDS on household livelihoods; literature on how households have coped as a result of these effects is reviewed in the second section; the third section looks at the role NGOs play and their contribution to AIDS-affected households.

2.2 Effects of HIV/AIDS on household economics

Although the effects of HIV/AIDS on economic development are recognized the microeconomics of the epidemic is not well understood (Booyesen et al, 2006). Thus there is a need to understand the process through which the experience of HIV/AIDS by households and communities leads to an intensification of poverty (Cohen 1999). These effects are often long term and span from during illness to after the death of the household member as SIDA (2006: 4) notes that “HIV is a slow motion disaster with extensive time lags”. Thus measuring the impacts during illness is difficult as illness ranges from not feeling very well to complete inability to function (Barnett and Whiteside, 2002: 186).

Poku (2005) also warns that when assessing the impact of HIV/AIDS on households some caution is necessary as other factors are at work at the same time. Firstly, the impacts of HIV/AIDS differ between different groups and vary according to each household's capacity to cope with the epidemic (SIDA, 2006: 195). This capacity is directly linked to education, income and access to resources and safety nets. Households with lower income and educational levels are hit hardest by the epidemic. Secondly, HIV/AIDS is exacerbated by prevailing economic conditions; it is not a stand alone

condition, rather it exists within a wider socio-economic context. Thus its effects tend to be more severe and felt harder in strained economic conditions such as the context of this study (Poku, 2005: 86-88).

It is however, difficult to separate the impacts and the coping strategies of the epidemic as the effects give rise to coping mechanisms which in turn have negative effects on the household thus creating a vicious cycle; for example poverty is an effect of coping mechanisms such as the sale of assets which is a coping mechanism to high medical expenses. School drop out can also be termed as both an effect and a coping mechanism.

Loss of Resources

The epidemic has the potential to damage or entirely deplete household resources as the household experiences multiple losses. Poku (2005: 105) highlights that HIV-affected households may experience a rapid transition from relative wealth to poverty. This is evident in a Cote d'Ivoire study where the average income of HIV-affected households dropped by 50% in 1997 (Bechu, 1998). Households may lose both assets and financial resources as they struggle to survive the 'HIV shock'. Unlike other 'shocks' such as drought, famine and war, HIV/AIDS is more severe and long-term as household may not be able to recover. Failing to recover, households may actually disintegrate as social and economic units (Poku, 2005: 89).

High expenditure

The economic costs of HIV/AIDS morbidity and mortality on households can be divided into direct and indirect costs (Bollinger and Stover, 1991: 1). The direct costs encompass the out-of-pocket expenses to the household (UNAIDS, 2000: 37). Medical expenditure makes up a greater portion of the direct expenses as the epidemic is characterized by repeated bouts of illness which require constant medical and clinical attention. These medical costs encompass transport, hospital and medication expenses all which have to be borne by the household. Usually there is more than one case of HIV/AIDS in the household due to 'inter-infection' and the pattern of illness and impoverishment is repeated (Poku, 2005: 89).

A study in Thailand revealed that a family spends approximately US \$1000 (equivalent to an annual income) on an AIDS patient in his/her last year of life (UNAIDS, 2000: 27). Bollinger and Stover (1999:2) point out that, households with an HIV/AIDS patient in Cote d'Ivoire spend twice as much on medical expenditure as other non-affected households. Similarly, Steinberg et al's study in South Africa found that most HIV/AIDS-affected households spend about a third of household monthly income on medical expenses (2002:18). UNAIDS (2001) reports that 83% of families in Rwanda that have HIV positive family members found it difficult to meet their basic needs, including housing and education. Expenditure tends to shift from essentials to health care; Steinberg et al's study found that 21% of households reduced expenditure on clothing, 16% reduced on electricity and 9% on other services (2002: 17).

The indirect costs of HIV/AIDS are associated with the loss of incomes of the sick person and caregiver (Booyesen et al, 2002: 109). The sick individual loses income through reduced productivity and the loss of employment due to illness and death (Mutangadura, 2000:4, SAfAIDS 2000). This loss of a working adult's income could mean no money for food, medication and school fees (SAfAIDS 2000). The death of an economically active family member is a permanent loss; thus the household's total income drops drastically. Some households are unable to recover from this instability and become economically worse off (Poku, 2005: 114).

The death of a family member will result in funeral costs and subsequent rituals and rites which further drain the family's resources (Jackson, 2000: 94). These funeral costs constitute a great portion of the total HIV-related expenditure for low-income households. These costs comprise transportation, food and the funeral ceremony. In a South African survey funeral costs were equivalent to one third of the annual household income (Desmond and Gow *in* Poku, 2005:109).

Children dropping out of school

Research by Booyesen et al (2004) in South Africa indicates that children from affected families were more likely to drop out of school compared to those in non-affected households. UNICEF (2006) notes that as AIDS erodes household and community

earning power, families may agonize over which child to send to school. The International HIV/AIDS Alliance (2008) also indicates that children may drop out of school due to the lack of money for fees and educational materials as funds are diverted to care and support of the ill family member. In many cases children are withdrawn from school in order to perform domestic and income generating activities (Bourdillon, 2000). This affects the children's future ability to earn an income and restricts their capabilities¹, thus intensifying poverty and inequality as their opportunity to move out of poverty is undermined.

The burden on women

As HIV progresses to AIDS the level of care required increases and these care demands fall mostly on women and children. SIDA (2006) clearly points out the impact of HIV/AIDS is highly gendered to the disadvantage of women. Women may have to give up jobs and income earning activities. Girls may also be withdrawn from school to assist in caregiving and household work (Poku, 2005: 99). This adversely impacts on women's participation in the labour market.

Poverty

There is a direct link between HIV/AIDS and the increasing rates of poverty (Seaman and Petty, 2005: 1) commonly referred to as the poverty-HIV nexus (Masanjala, 2007). This nexus is a bi-directional relationship whereby "debilitating HIV or full-blown AIDS undermine livelihoods by eroding affected households' resource base, thereby raising vulnerability to future collapse of livelihoods... and can readily lead to an increase in numbers of impoverished nexus households and intensification of poverty among those that are already deprived" (Masanjala, 2007:1032) thus acts as a forceful vehicle for impoverishment (Van Donk, 2002: 1). Cohen (1999) notes that there exists evidence in urban communities of an emerging class of those recently impoverished by the epidemic, as the family income falls while the costs increase.

¹ The lack of education limits children in their ability to move out of poverty and improving their livelihood.

The pandemic also accentuates existing inequalities as most households become poorer due to the sale of assets and the loss of income. As the breadwinner falls sick and eventually dies, the remaining family members may face eviction from the company or rented premises.

Poverty on the other hand, is a key factor in the spread of HIV as some dimensions of being poor increase risk and vulnerability to HIV. For example, destitution can drive individuals into risky livelihood strategies such as commercial sex work.

2.3 Survival Strategies

Households survive the extra burden of the financial costs of HIV/AIDS through one or a combination of short term strategies (Naidoo, 2004: 35). These are often referred to as ‘coping strategies’, Rugalema however, (2000: 538) contends that the concept of ‘coping’ implies that households are dealing successfully with the situation, yet in fact they are merely surviving. The concept rather, has become a convenient escape route for academics and policy makers (Rugalema, 2000: 537). Sauerborn, Adams and Hien (1996: 293-297) established a hierarchy of household survival strategies which were grouped into four categories. These categories include strategies to alleviate the loss of income; to survive the financial costs; to alleviate the loss of labour; and strategies to utilize safety networks.

Borrowing

Initially, household members may ‘pool’ their incomes to meet the household costs; however this might not be sufficient to meet the increasing expenditures, SIDA (2006: 63) notes that not all households have the necessary cash reserves to meet these expenses. In this circumstance, households will resort to borrowing. In Booysen et al’s (2004) study of the socio-economic impacts of HIV/AIDS on households in South Africa, the most frequent coping mechanism was borrowing followed by the utilization of savings and the sale of assets. Most of the poor have limited access to financial capital services due to lack of collateral, thus family and friends become the only source of money.

Women often acquire credit from community microfinance schemes; however evidence has shown that credit only deepens the household's poverty (Khawari, 2004; Hulme and Mosley, 1996; Dichter, 2006). Microfinance schemes have received considerable criticism and it has been asked whether they raise people out of poverty or bury them in further poverty. Credit acquired is normally spent on basic needs and taking care of sick family members instead of on income generating activities, thus households become more indebted.

Sale of Assets

The selling of assets is a common household coping strategy all over sub-Saharan Africa. These assets are normally the only form of savings that poor households possess. A study in Zimbabwe found that households which experienced HIV/AIDS-related deaths were more likely to sell assets (Mutangadura, 2007:17-20). This mostly occurs when households face economic problems and according to the International Food Policy Research Institute (IFPRI 2002 *cited in* SIDA, 2006:61) HIV/AIDS is the greatest cause of household asset liquidation. This is a short-term measure to mitigate the effects of adult mortality and other shocks; however this has negative consequences as it increases the household's vulnerability to other economic shocks (SIDA, 2006:62). Money generated from the sale is eventually used up leaving the household in search of more survival strategies.

Livelihood diversification

Income diversification through participating in the informal sector is also a common survival strategy aimed at alleviating the loss of income. A study conducted in Burkina Faso (Sauerborn et al 1996: 291) reveals that individuals from low-income households were engaged in a variety of income-generating activities and was able to generate additional revenue.

“When a household suffers HIV/AIDS-related labour loss and illnesses, productive activities may be dropped and the household begins to depend on new sources of livelihoods” (SIDA 2006: 59). A household can have several sources of entitlement

which constitute its livelihoods. The sustainable livelihoods framework defines these entitlements as livelihood assets. Livelihood assets are the resources that people possess, the human capital include people's health, nutrition, education, knowledge and skills; the social capital consists of the networks and informal groups people have in a community and financial capital comprise of the savings, wages, and credit (IFAD, 2006). When facing shocks such as famines and HIV/AIDS a household will draw on these existing assets for a livelihood.

Households often make money by buying and selling small quantities of goods. Food, clothing and other goods are bought from markets far from the settlements and then sold in the settlement for a slightly higher price. Women also sell their own produce such as eggs, vegetables and fruits; they also prepare goods by cooking, sewing, weaving and crocheting. Women often peddle from house to house selling these goods (Katona-Apte, 1988). However, for households in dire poverty this might be difficult as initial capital is required to purchase the food and if acquired chances are it will go to the hungry family.

Safety nets

A household's ability to cope depends on its access to resources, household size and composition, access to resources of extended families and the ability of the community to provide support (Mutangadura 1999: 18). Safety nets play a significant role in household survival strategies; this is where the extended family comes in. The community, family and religious groups all play a large role in helping families deal with the financial burden. In Rwanda, two thirds of the surveyed households received assistance from religious and community groups (Poku, 2005: 111). Booysen et al's (2004) study showed that affected households were more dependent on non-employment sources of income such as remittances and contributions from family.

Traditionally, the extended family and community would assist the family socially, psychologically and financially, however these support structures have been eroded due to lack of resources, poverty, urbanization and the soaring rates of HIV infection. Foster and Makufa (2000) note that the extended family is becoming saturated and may have reached its threshold as a support system due to the high HIV-related orphan prevalence.

Social networks in urban areas are much weaker as there is less social solidarity; unlike the rural setting, urban areas do not have a kinship community residing within the same geographical location. There is more of what Durkheim (1933 *cited in* Giddens, 1972) terms organic solidarity than mechanical solidarity. Urban areas tend to have less social cohesion as there is more dependence on the individual rather than on the society, Durkheim termed this organic solidarity. This means households in the urban context are less dependent on each other and the boundaries of privacy are more pronounced. Thus it is different from the rural setting where a household's problems become the community's problems.

Child Labour

The use of child-labour is a common coping strategy employed to make up for the lost labour due to the epidemic. Children drop out of school to supplement household incomes. According to the UNDP (2000) children have assumed decision making roles and responsibilities that transform roles within the family. Many children drop out of school, and jeopardize their future, health and developmental needs to take on the roles of parent, provider and caregiver. These children resort to working in the informal sector and prostitution, thus exposing themselves to the deadly pandemic. A child's health is compromised when he/she engages in prostitution for the reasons of earning money for food and basic amenities.

As households struggle to deal with the multiple losses, they are pushed into increasingly risky situations. Surviving household members, including children may be forced into low-income work, crime or commercial sex work which in turn perpetuates the epidemic (Pelser et al, 2004). Topouzis (2004) contends that sexual services may be a coping mechanism that people may adopt. Poor women may engage in sexual services either temporarily or on a long-term basis to support their families.

Young girls are usually employed as domestic workers, and since it is possible for very young children to undertake light household tasks, the age of entry is very low in comparison to other sectors in which children work. This form of employment is favored by children because of the advantages it offers, children do not incur transport costs since

it is a live-in occupation. This also means that there are fewer mouths to feed back home and more money for the dependent family including the ill family member. However, Mupedziswa (1997) notes that children's powerlessness within the household renders them especially vulnerable to sexual abuse. Bourdillon (2000) also notes that children as domestic workers are under the exclusive round-the-clock control of the employer thus have little freedom. Work for these children has become a necessity for survival.

Adjustments of funeral practices

Adjustments of funeral practices can be evidenced as a response to the high funeral costs (SIDA, 2006: 63). Traditionally, when a person passes on, burial takes place at the rural home, however due to the financial burden preceding death coupled by the food and fuel shortages in Zimbabwe- funerals now take place in the city with burials in the municipal cemeteries. The ceremonies that normally take about three to six days are concluded within two days. This cuts down on the cost of transportation and food expenses for the week-long ceremony.

External support

Booyesen et al's (2004) research also highlights the important role of external support (NGOs and government) in mitigating the socio-economic impacts of the epidemic. Households that had gained access to social grants-such as the child support, disability and old pension grants-were relatively better off. In Zimbabwe's case, households cannot rely on any financial assistance from the government.

Other coping mechanisms

Usually a household employs several types of survival mechanisms at the same time in order to raise enough for household survival. Coping mechanisms that households employ can be classified into a coping strategies index which has the categories of consumption, expenditure, income and migration strategies. Consumption strategies include reducing the amount and quality of food intake. Senefeld and Polsky (2007) assert that modifying diets to less nutritious alternatives can be harmful strategy for children and for the HIV positive individuals as proper nutrition is of vital importance.

Changing spending patterns is one way that households meet the costs of HIV/AIDS (Poku, 2005: 108).

Change in household composition is a long established survival strategy in Sub-Saharan Africa (Ansell and van Blerk, 2004). Household members may migrate in search of employment and other livelihood opportunities. In Naidoo and Harris's study (2006), movement of household members, particularly children was a common strategy. This is a crucial coping mechanism which chronically affected households tend to employ as this shifts the burden of dependency (of the migrant) from the AIDS-affected household on to the receiving household. Individuals may actually migrate from the urban centers back to rural areas to engage in agricultural activities after a failure to secure a sustainable livelihood in the city. Rural households tend to have a wider asset base (i.e. land, cattle, labour) than the urban low-income households. In shocks, like chronic illness, the urban households will draw on this asset base.

2.4 NGO Support

The non-profit sector has become increasingly important in its efforts to alleviate sectoral problems (Sethna, 2003). Non-governmental organizations make up the subset of the non-profit sector involved in development work (Salamon, 1997). The World Bank defines non-governmental organizations (NGOs) as "private organizations that pursue activities to relieve suffering, promote the interests of the poor, protect the environment or undertake community development" (World Bank, 1988).

Most NGOs follow a household livelihood security framework which stems out of a food security perspective. It recognizes that food is only one important basic need among several others, which include water and health facilities.

Many organizations advocate incorporating food aid into HIV/AIDS intervention programmes. Food aid leads to increased consumption and improved health which can translate in to an increase in the ability to work and overall wellbeing. The Consortium for Southern Africa's food emergency (C-SAFE) provides food assistance to HIV/AIDS affected groups in its targeted food aid (TFA) program. TFA refers to supplemental and

complementary household rations; it is distinct from general food distributions and the food for assets (C-SAFE, 2007). The TFA objectives are to improve and maintain nutritional status and improve community resilience to food security shocks.

2.4.1 Supporting the Income and Basic Needs of HIV/AIDS Affected Households (SIMBA) Program

Supporting the Income and Basic Needs of HIV/AIDS Affected Households (SIMBA²) program is a savings-based program approach that works through other AIDS service organizations (ASOs) by building their capacity to implement economic development initiatives. SIMBA and its partners provide microfinance services that targets HIV/AIDS-affected households and individuals in Zimbabwe, as its name implies; the program was designed to reach groups often left out of economic development programs, including orphans, widows, caregivers, sex workers, and people living with HIV/AIDS (SIMBA, 2002).

“SIMBA draws upon the comparative advantages of both microfinance initiatives and community-based HIV/AIDS initiatives” (SIMBA, 2002: 8). SIMBA has an Internal Savings and Loan (ISAL) system whereby group members are able to draw out loans from their saving funds. Other services provided by the institution include basic business skills’ training as well as HIV/AIDS education and peer support groups.

SIMBA draws on lessons learnt from CARE’s Kupfumu Ishungu³ microfinance program (KI) Kupfuma Ishungu is a Village Savings and Lending (VS&L) scheme that generally targets rural households, SIMBA on the other hand, as mentioned before, specifically targets HIV/AIDS affected households. Many microfinance institutions exclude AIDS-affected households and as a result of this economic vulnerability, individuals and households are pushed into risky behaviour and unsustainable survival strategies such as selling assets (SIMBA, 2002). Disinvestment strips the household’s livelihood assets and

² SIMBA also means power in Shona.

³ Kupfuma Ishungu roughly translates as “for you to get rich you have to be persistent,”

in so doing further undermines the household's capacity for coping or survival. It is upon this realization that SIMBA was formed, as a response to the adverse economic impact of HIV/AIDS on households. The ultimate objective of the program is to improve the stability of HIV/AIDS-affected households.

2.4.2 The Catholic Relief Services

The Catholic Relief Services is an international humanitarian organization that provides emergency relief and development assistance mainly in the areas of agriculture, education, health, HIV and AIDS, microfinance as well as food security. The organization is financially supported by the Catholic community in the United States. CRS' Zimbabwe program started in 1989 with a focus on HIV and AIDS, and later extended its focus to food security; capacity building; livelihood security; as well as justice and peace. CRS' main thrust is poverty eradication through community-based and sustainable development initiatives; projects in Zimbabwe include the food-for-work program whereby household members engage in community development projects in exchange for food parcels for the entire household. Other projects in Zimbabwe include the home-based care program, the nutrition garden project and the water and sanitation program. Due to the prevailing food crisis and socio-economic instability in the country these projects have come to a stand still as the organization is channeling all resources to the humanitarian crisis. Currently (as of 2004) CRS has a food aid program that is providing food handouts in drought stricken areas and in areas experiencing severe food shortages. An HIV/AIDS Opportunistic Infection (OI) and Tuberculosis (TB) program is running throughout the country, this program provides food aid to HIV positive people undergoing TB and OI treatment.

2.5 Conclusion

Literature on the effects of HIV/AIDS on household livelihoods and the coping strategies has been discussed in this chapter. Poor households adopt a wide range of survival strategies when faced with shocks. However, the applicability of these strategies varies according to the vulnerability context. The following chapter presents the context of this study; the challenging environment that these households and NGOs operate in will be

discussed. A brief background to the current economic and political turmoil will be outlined.

CHAPTER THREE

CONTEXT OF STUDY

3.1 Introduction

This chapter gives an overview of the socio-economic environment in which the study has been carried out. The fieldwork was conducted in a time of increasing political turmoil. The background and causes of poverty, unemployment and food insecurity in Zimbabwe are discussed. The chapter highlights how HIV/AIDS is linked to politics, land reform, unemployment and food insecurity in particular, forming a vicious cycle of deprivation. In accordance with the sustainable livelihoods framework which points out that policies and institutions influence access and composition of livelihood resources, this chapter sheds light on household responses to the epidemic.

3.2 Land Reform

In 1998 the Land Reform and Resettlement Programme Phase Two was initiated, having been endorsed by 48 countries and international organizations at a Donor Conference held the same year. At this point the Donor community envisaged that land reform was necessary for poverty alleviation and economic growth. The programme aimed at purchasing 50,000 square kilometers of land over a period of five years. In 2000, groups of government supporters led by the now infamous War Veterans Association started occupying white-owned farms and seized a total of 110 000square kilometers of land (IRIN, 2008). By 2003 the total number of white farmers had fallen from 4000 to about 200. In 2005 all farmlands were declared state property, giving the government the right to expropriate the land (IRIN, 2008).

The irony of this programme is that it aimed to eradicate poverty by empowering poor peasants; instead it intensified poverty. Firstly, by redistributing the land economies of

scale were destroyed; secondly the ‘new farmers’ did not have experience in commercial farming; and thirdly, beneficiaries had no access to capital as they had no collateral required by banks. The result was a devastating drop in total agricultural production and widespread hunger. The fast track land reform crippled the economy leading to chronic shortage of basic commodities and services.

3.3 Operation Murambatsvina/Restore Order

In 2005 the government of Zimbabwe embarked on a slum clearing and ‘urban beautification’ project, the infamous Operation Murambatsvina. The Operation was designed to eradicate illegal housing and informal economic activities. Families were displaced as their homes and possessions were ruthlessly burnt to the ground, in other places bulldozers demolished entire structures (Zimbabwe Action, 2005). The UN estimates that at least 114 000 people were living in the open after the operation (Potts, 2008; UN, 2005). There was no back-up plan to create new and more permanent housing for the displaced. Small to medium enterprises were targeted and the informal structures were condemned as illegal; tailors and hairdressers were raided as well. Riot squads arrested vendors and destroyed their vending sites, including those of licensed vendors.

Potts (2006) emphasizes the injustice of enforcing ‘urban order’ when the symptoms of poverty are evident. The Operation directly affected thousands of poor urban dwellers, according to Zimbabwe Action (2005) as many as 4 million Zimbabweans survived by informal employment and their income was supporting at least another 4 million.

The Operation has intensified the problems of the public health system in a number of ways; firstly the operation zones have become a breeding ground for water-borne diseases. Families have had to live in makeshift plastic shacks which lack proper sanitation such as toilet, water drainage and clean water supply. Thus exposing communities to cholera and other health hazards (Kapp, 2007). Secondly, HIV positive people on antiretroviral therapy were cut off from their supplies due to this displacement. Most ART programmes were localized making it easier for patients to access treatment at

their local clinics closest to home (within a 5 km range); however the Operation resulted in many people relocating with some returning to their rural homes. This interruption of ART led to drug resistance and deterioration of health among many people. Thirdly, Home-based care was also disrupted as patients and volunteers were forced to relocate (Union Aid Abroad, 2006).

The Operation accelerated the progression from HIV to AIDS as it disrupted communities leaving people homeless with no livelihoods, 2,4 million people were displaced (IWPR, 2007). With no livelihoods, total household incomes were reduced which can translate into a reduction in food consumption, lowering of food quality (in terms of nutrition) and cutbacks in medical spending. The displaced population was temporarily resettled in camps lacking basic services (decent shelter, clean water supply, sanitation, electricity) and characterized by poor sanitation thus exposing HIV patients to the risks of opportunistic infections.

3.4 Food Insecurity

Chronic vulnerability to food insecurity exists in many Zimbabwean households (FAO/WFP, 2003). The country's food security has been jeopardized by the economic turmoil coupled with a decline in food production (FAO, 2001). Food production declined after the land reform programme as the new farmers were unable to utilize the land. The Grain Marketing Board (GMB)'s low fixed sale prices have discouraged new farmers from planting staple grain crops leading to a high cereal deficit. As a result, agricultural production has plummeted leading to widespread food shortages and the constant threats of starvation. "Zimbabwe's looming food crisis is the result of another poor harvest exacerbated by the country's unprecedented economic decline; extremely high unemployment and the impact of HIV/AIDS" (Abdulla, World Food Programme Regional Director for Southern Africa, 2007). During my fieldwork there was ample evidence of widespread hunger resulting from these conditions as well as malnutrition; for example many of the interviewed households indicated that they survived entirely on food packages from CRS. This caused HIV to develop into AIDS at an accelerated rate

(Union Aid Abroad, 2006). In 2002, all communal lands, resettlements and urban areas were declared by the government to be in a state of disaster.

3.4.1 Food Shortages

The economic crisis has fuelled food shortages leading to what has been referred to (by donors and international press) as a desperate humanitarian crisis. There is an acute shortage of food supply in urban areas as shops are empty with short supplies of basic commodities such as sugar, bread, cooking oil and meat (IRIN, 2008). A survey conducted by the Combined Harare Residents Association (CHRA) in July 2008 revealed that 4 out of 5 households were surviving on one meal a day consisting of sadza⁴ and boiled vegetables (CHRA, 2008). In 2007, the government had to import over 400,000 tonnes of maize from Malawi (FEWS-NET, 2008).

According to the World Food Programme (2008) more than 5 million Zimbabweans were facing severe food shortages in October 2008. The country experienced widespread shortages of meat, sugar, maize and other basic commodities (Zimdaily, October 2008). Due to this acute shortage of food, wild fruit has become a common source of food in many households. In the rural areas, villagers survive on baobab porridge made from baobab fruit, *mawuyu* as well as cassava pap made from pounded cassava roots. In peri-urban areas children have stopped going to school and spend the day gathering fruit from nearby bushes (Zimbabwe Independent, October 2008).

Amid this humanitarian crisis, NGOs were banned from operating. The government suspended NGO food distribution in June 2008 accusing NGOs of being politically biased and having political motives for their statements and actions. Although the ban was later lifted in September of the same year, many NGOs are still facing serious operational problems as a result of this ban.

⁴ Sadza is Shona for mealie-meal pap.

The country has been importing thousands of tonnes of cereals in an attempt to rescue its starving nation, support has also been rendered by the FAO who provided US\$21.4 million targeted at rural farmers (FAO, 2008).

3.4.2 Reduction in agricultural outputs

Agriculture is the main economic driver; it accounts for a large portion of firstly, foreign exchange earnings, i.e. tobacco and cotton exports and secondly, the bulk of the raw materials for the manufacturing sector (FAO/WFP, 2003). The drought conditions in several areas have resulted in poor harvests. AIDS-related illness and death has caused a labour crisis leading to reduction in agricultural outputs as well. This directly impacts rural households who depend on agriculture for subsistence as well as for household income, thus a reduction in production threatens the household's food security. According to FAO (2001) the food insecurity in the country is largely due to diminishing purchasing power among the poverty-stricken population.

3.4.3 Operation Maguta

In 2005 the Government launched Operation Maguta⁵ under the auspice of the Zimbabwe National Defense Army (ZNDA) in an attempt to increase food production (IRIN, 2008). Soldiers were deployed to former commercial farms where new farmers had been resettled and to provide manpower; these 'new' farmers were instructed to cultivate strictly maize and wheat only. The ultimate goal was to boost food production and improve food security; the rationale was that increase in production would reduce the reliance on imports thereby reducing pressure on foreign currency usage. Operation Maguta was accompanied by the Mechanization program in 2007.

3.4.4 Basic Commodity Supply Side Intervention (BACOSSI) Facility

In response to this crisis, the Central Bank introduced the Basic Commodity Supply Side Intervention (BACOSSI) Facility in September 2008. This is a government subsidized food (GSF) programme. The facility has two intervention levels, the industry level where manufacturers of basic commodities were given loans to boost production and the

⁵ Maguta means people have had their fill, usually referred to after a meal

household distribution level. Under the household level, each household adult qualified for a BACOSI package consisting of 750ml cooking oil; 2kg rice; 2.5kg flour; candles; bath and laundry soap; Vaseline and sanitary pads. The entire package was sold at Z\$100 billion. According to the Reserve Bank the main objective of BACOSI was to ensure the availability and affordability of basic commodities so as to alleviate the current shortages of basic commodities in formal market (Reserve Bank of Zimbabwe, 2008).

Many have questioned BACOSI's inclusiveness and effectiveness as it apparently became a new frontier for politically-motivated food discriminations (Zimbabwe Peace Projects, 2008). It is rumored that political watchdogs have exploited these GSFs to their advantage by making business capital through selling the packages in hard currency as well as for settling political scores in areas where the ruling party lost election votes. In some areas, only those in possession of party cards qualified for food packages. Other requirements included regular attendance of party meetings and being familiar with the latest party slogans (Zimbabwe Peace Projects, 2008).

3.5 Economic problems

The economy of Zimbabwe spiraled from one of Africa's strongest economies to one of the world's most impoverished with the fastest shrinking economy with the GDP contracting by 40% since 2000 (Bird and Prowse, 2008). According to the USAID (2004) economic growth over the past three years has been close to zero. The country is suffering from a rapidly deteriorating economy. There are numerous competing factors explaining this long economic crisis, namely the 2000 land invasions and the 1997 'black Friday' when the currency collapsed by 74% within four hours (Bond, 2007). The US State Department however, attributes the economic crisis to a long term combination of poor fiscal policies and rampant government spending, particularly Zimbabwe's military involvement in the Congo War and the chaotic land reform that disrupted the agricultural sector (Bond, 2007). For many however, the economic crisis dates back to the introduction of the World Bank's Economic Structural Adjustments Programmes (ESAP).

Poverty is now endemic in Zimbabwe, driven by the shrinking economy and hyperinflation. As of July 2008 the official poverty line was at ZWD13 trillion/month with general labourers and cleaners earning below ZWD 200 billion/month (US\$0.60) making day-to-day life for ordinary Zimbabweans increasingly difficult (Bloomberg, 2008). Potts (2006) points out cogently that Zimbabwe's economic crisis has destroyed the livelihoods of a majority of the urban population and has created conditions of extreme poverty. Over 85% of Zimbabweans are categorized as poor (Bird and Prowse, 2008). This high unemployment and high cost of living have exacerbated poverty.

3.5.1 Price Control

In 2005, the government paradoxically enforced price controls as a response to the sky rocketing inflation. Shops and supermarkets were required to lower their prices to the specified figures; this meant selling at a lower price than the purchasing price implying a loss. To avoid these losses shops stopped stocking goods and as a result, basic goods were in short supply and unavailable (The Economist, 2007). In 2007 shops and factories were operating at less than 20% capacity; industries also reduced production due to this price control coupled with the shortage of raw materials. Most raw materials had to be imported which meant a higher price for the end products which were obviously unaffordable to the general public. Reduced production resulted in massive job losses as some international companies relocated altogether (IRIN, 2004).

3.5.2 Economic Recovery Programs

In 2008 the Reserve Bank of Zimbabwe introduced a series of economic recovery programs; these include the Foreign Exchange Licensed Warehouse and Retail Shops Program (FOLIWARS); the Foreign Exchange License Oil Companies (FELOCS) and the Foreign Exchange Licensed Outlets for Petrol and diesel (FELOPADS). Under FOLIWARS manufacturers were able to sell their products in foreign currency to the licensed shops (Zimbabwe Independent, November 2008). FOLIWARS has however been greatly criticized; firstly it poses a threat to cross border trading which is the livelihood of more than 50% of Zimbabweans. This new programme threatens the

business of cross border traders who sell goods in foreign currency. Dollarising the economy would also increase the demand for hard currency thus rates would sky rocket and reduce their (cross border traders) spending power. Secondly, FOLIWARS is said to widen the gap between the rich and the poor as most low-income households have no access to foreign currency. In addition, the foreign currency goods are much more expensive; according to the business digest the prices charged in foreign currency were higher than those prices in neighboring countries (South Africa, Botswana) for the same goods. For example, while conducting fieldwork a 750ml bottle of cooking oil was sold for R40 yet in South Africa it was about R15 in local supermarkets like Checkers and Shoprite.

The Zimbabwe Congress of Trade Unions (ZCTU) and the National Income and Pricing Commission (NIPC) protested against these forex shops arguing that this further impoverishes low-income earners as salaries were still paid in Zimbabwe dollar. The irony of this policy is that salaries are still being paid in Zimbabwe dollar yet people are expected to purchase and spend in US dollars and Rands neither of which are available at local banks. This policy completely excludes people in rural areas with no access to any foreign currency at all.

3.5.3 Coping Strategies

In order to survive Zimbabweans are taking advantage of the system in any way possible. Informal mining (chikorokoza) was one of the cumbersome survival strategies poverty-stricken Zimbabweans engaged in. However, under Operation chikorokoza chapera (No illegal mining) in 2006 over 25,000 illegal gold panners were arrested. The majority of this mining was in Kadoma district which is the gold belt area.

Cross-border trading has become a prevalent and lucrative livelihood activity. Many Zimbabweans are crossing over to South Africa and Botswana to buy bulk quantities of basic goods for family consumption as well as for resale. This activity has become the main livelihood in the country such that traders have turned from flea markets to opening shops. Goods being imported include rice, sugar, flour, cooking oil and toiletries.

One of the latest coping strategies in the black market has been the so called ‘money burning’ whereby one buys foreign currency at cash rate then resells it through real time gross system (RTGS) transaction at a higher price. This has become a very lucrative survival strategy as a day spent ‘burning’ money fetches more than an average monthly salary. Thus many have left their formal sector jobs to join this ‘money burning’ market.

Remittances from the diaspora have become a lifeline for many Zimbabweans (International Crisis Group, 2008). These remittances make the difference between starvation and survival. Many families depend on remittances from a family member in the United Kingdom, according to USA Today (August 2008) 10 000 Zimbabwean nurses are in England.

Zimbabwe can be termed a fragile state as the state has failed to provide basic services and functions to the majority of its population. Torres and Anderson (2004) indicate that fragile states are environments where the state is unable or unwilling to direct national and international resources to alleviate poverty. It has increasingly become difficult for foreign NGOs to operate in Zimbabwe and as a result some NGOs have withdrawn from the country.

3.6 Collapse of the Health System

Zimbabwe’s health system has suffered immensely due to shortage of resources and has failed to provide its much required services to a ‘desperate’ nation. The current political and economic mayhem has had a catastrophic effect on the functioning of the health system; the country’s public health system has virtually collapsed. A glimpse of this effect is presented below.

3.6.1 Shortages of staff and drugs

There has been a large scale exodus of health care workers and professionals (USAID, 2004). As a result, there is serious understaffing with a doctor-patient ratio of 1:13 500 (UN study, 2008; The New York Times, 2008). Understaffing is not the only problem

Zimbabwe's health system faces; there is also a lack of 1) essential drugs including ARVs, antibiotics and painkillers as the government has no foreign currency to import them (Union Aid Abroad, 2006) and 2) a lack of vital equipment such as rubber gloves, syringes and saline drips. Operating rooms in government hospitals have closed down due to lack of adequate functioning equipment. In 2007, half of Harare's kidney dialysis patients died as the government hospitals could not afford to buy catheters for blood-cleansing equipment (The New York Times, 2008). Maternity sections in many government hospitals have ceased operating. Bird and Prowse (2008) point out that in some parts of the country unattended home deliveries total up to 50% of pregnant women.

This drug shortage has made room for a thriving parallel market for drugs, many of which are counterfeit (IWPR, 2007). This illegal drug market is increasingly flourishing due to the high costs and shortages of the drugs. Drugs on the parallel market are usually cheaper than those from a registered pharmacy as they are smuggled in from neighboring countries mainly Botswana and Zambia.

Life expectancy in Zimbabwe has plunged from 63 years in 1998 to 37 for men and 34 for women (WHO, 2007; MSF, 2009) and according to the New York Times (2009) is the lowest in the world. The USAID (2004) contends that this decline in life expectancy is one consequence of the HIV/AIDS epidemic. Medicins Sans Frontieres (2009) attributes the country's lowered life expectancy to a combination of HIV/AIDS, the weakened health system and malnutrition. Infant mortality has doubled since 1990 (The Independent, 2006). Malnutrition is on the rise and according to WFP 28% of children under five years are said to be chronically malnourished (WFP, 2008).

3.6.2 HIV/AIDS

Zimbabwe has one of the highest HIV incidence rates in the world with an estimated number of 4000 deaths per week in 2004 (USAID, 2004; Bird and Prowse, 2008). A quarter of the country's population is estimated to be HIV positive (IWPR, 2007). Being

infected with HIV/AIDS in Zimbabwe is more heightened and harsh than in South Africa or the West; medicines to treat or prevent common opportunistic infections for people with HIV are completely inaccessible. Union Aid Abroad (2006) point out that access to treatment has ceased to become a human right and has become a luxury. Only 42 000 people are receiving antiretroviral therapy as the government does not have resources to roll out ARVs. The epidemic is in danger of being overlooked in the face of more immediate survival concerns.

3.6.3 The Cholera epidemic

In October 2008, a Cholera scourge bedeviled Zimbabwe and claimed 3200 lives as of January 2009 (WHO *cited in* Office of US Foreign Disaster Assistance, 2009). A total of 62 900 cases were recorded with a case fatality rate (CFR) of 5.1%. According to the World Health Organization more than 71% of the deaths were outside health facilities as many health facilities were not in operation. The epidemic has spread to eight other Southern African nations including South Africa, Swaziland, Botswana, Namibia, Zambia and Mozambique.

Initially this health crisis was a result of a water crisis that the Zimbabwe National Water Authority (ZINWA) had been facing since January of the same year. The financially and technically incapacitated ZINWA took over Water and Sewer Management from the City Council. Consequently, ZINWA was unable to import water treatment chemicals which required hard currency, it was also unable to repair burst pipes leading to nationwide water shortages. Electricity cuts also contributed and hindered efforts to pump water throughout cities (BBC Monitoring, October 2008). Residential areas in Harare and Bulawayo would go for as long as four weeks without water (IRIN, 2008). This resulted in people accessing water from unsafe sources and using backyards and nearby bushes as toilets. MSF (2009) point out that this cholera epidemic is only a manifestation of a much broader crisis in Zimbabwe.

It is therefore clear that government policies play a role in shaping household survival strategies, for example the Operation Murambatsvina heightened unemployment and the Land Reform not only affected household incomes but also food security. HIV/AIDS becomes a further challenge on households already struggling in these extreme conditions.

3.7 Summary and Conclusion

This chapter has presented a brief background of Zimbabwe's socio-economic problems. Issues underlying such events as the 1998 Land Reform and Resettlement Programme and the 2005 Operation Murambatsvina were discussed. The chapter discusses how government policies have had unintended consequences on people's lives and livelihoods. The country is faced with numerous socio-economic problems such as widespread poverty, chronic food shortages and a health sector on the verge of collapse due to drug shortages and exodus of professionals. HIV/AIDS has become the last straw for a nation already in crisis. It is therefore evident that poor economic and political policies have had a catastrophic effect on the country and exacerbated the HIV/AIDS crisis.

CHAPTER FOUR

METHODOLOGY

4.1 Introduction

This chapter presents the methodology employed in conducting this study. The research design, theoretical framework, data collection procedures and methods of analysis are presented. Ethical issues and limitations to the study are discussed as well.

4.2 Research Design

This study employed a qualitative design and drew heavily on ethnographic techniques of observations and in-depth interviews. Qualitative research involves an interpretive, naturalistic approach to the world (Creswell, 2007). This type of research studies phenomena in their natural settings attempting to elucidate the meanings people attach to them (Denzin and Lincoln, 2005:3). A qualitative design was selected for this study because it enabled the study to gain an in-depth understanding of the livelihood strategies households affected by HIV/AIDS employ.

4.3 Conceptual Framework

The theoretical framework employed in this study is that of Sustainable Livelihoods; this is the analytical lens through which household livelihoods were analyzed. Firstly, it is essential to begin by defining the concepts behind the framework, which include livelihoods, sustainable livelihoods and the sustainable livelihoods approach. A livelihood comprises of the capabilities, assets and activities required for a means of living (Carney, 1998: 4). The International Institute for Sustainable Development (1999) defines sustainable livelihoods as “people’s capacities to generate and maintain their means of living, enhance their wellbeing and that of future generations”.

The sustainable livelihoods approach has its origins in Robert Chambers' work which aimed at enhancing the efficiency of development cooperation and in 1997 the British Department for International Development (DFID) integrated the approach into its program. The sustainable livelihood approach consists of two components; these are the framework and a set of principles. The first core principle is espousing a holistic view in understanding people's livelihoods as a whole, with all aspects included. "An understanding of the complexity and integrated nature of livelihoods allows for a better understanding of vulnerability to external shocks and stress" (Toner and Franks, 2006). Livelihood approaches offer a holistic way of addressing the HIV/AIDS epidemic which promotes systematic thinking across sectors, they recognize the significance of viewing livelihood systems holistically and that concentrating on specific parts of systems only, will not yield desirable results. This approach therefore, offered an understanding of household livelihoods in the context of the prevailing economic situation in Zimbabwe

As a second principle, the sustainable livelihoods approach recognizes that livelihood strategies are dynamic, as they respond flexibly to changing situations and therefore advocates that the affected parties must be key actors in identifying and addressing livelihood priorities. This is evident in the versatility of livelihood activities of households interviewed. The third core principle is maintaining a focus on people and their strengths and on the options available to them.

At the centre of the sustainable livelihoods approach is the sustainable livelihoods framework which serves to investigate and comprehend people's livelihoods taking into consideration the main factors of influence. The framework consists of livelihood assets, livelihood strategies and livelihood outcomes as indicated in the diagram below (*Fig 2*). The assets are five-dimensional with human, natural, physical, social and financial capitals thus making up a livelihood pentagon (*Fig 1*). Livelihood assets are the resources that people possess, the human capital include people's health, nutrition, education, knowledge and skills; the social capital consists of the networks and informal groups people have in a community and financial capital comprise of the savings, wages, and credit. This therefore informed the questions asked in the interviews.

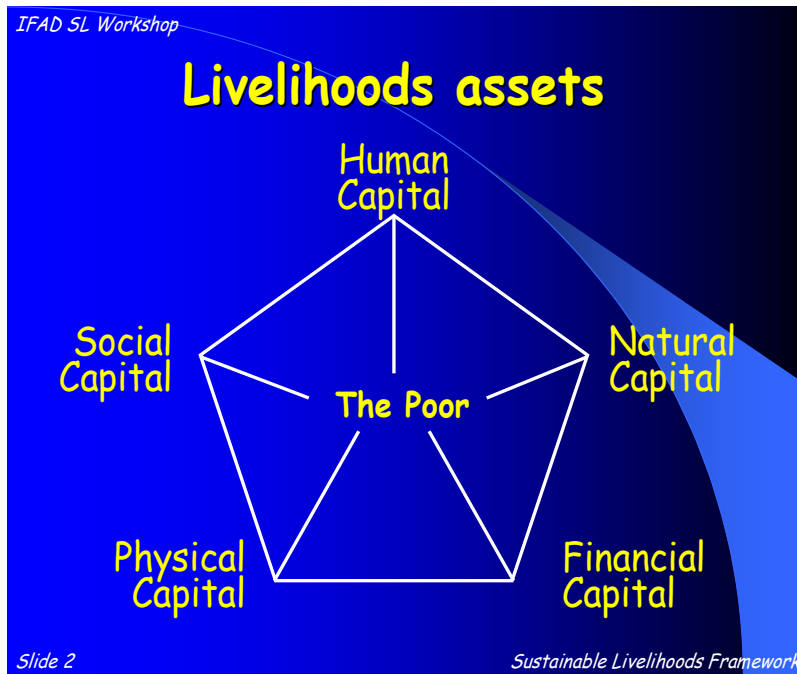


Figure 1 (International Fund for Agricultural Development (IFAD))

In accordance with the framework, successful livelihood strategies can be achieved by combining the already existing assets and taking into account the vulnerability context, supported by policies and institutions. Policies and institutions play a major role in influencing access and composition of livelihood resources. It is with this lens which incorporates the socio-economic context, that household livelihood strategies were analyzed. Livelihood strategies will produce livelihood outcomes, which will be the final product of the framework.

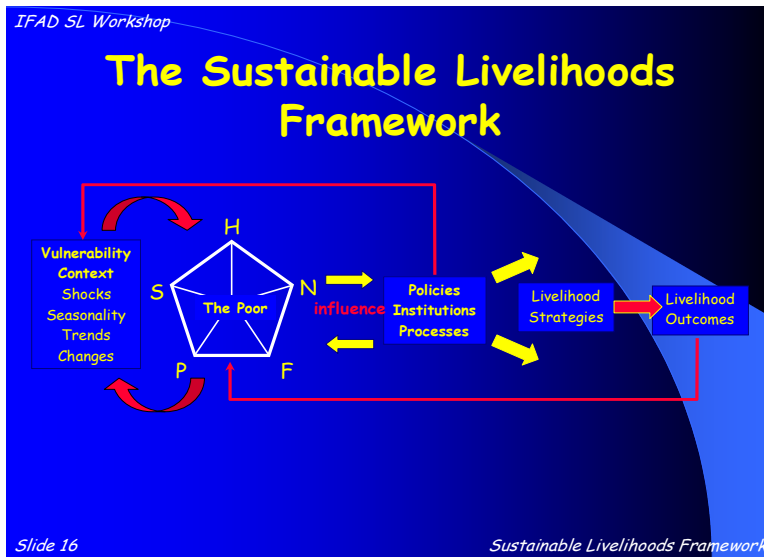


Figure 2 (International Fund for Agricultural Development (IFAD))

4.4 Site of study

Chegutu town which is located 80km from Harare in the Mashonaland West Province in Zimbabwe was the focus of the research. The study focused on Chegutu as it is the researcher's home town, thus presenting many advantages. The researcher is well versed in the town's socio-economic background, and has some knowledge of the interplay of poverty and HIV/AIDS including the factors fueling the epidemic. Furthermore, some considerable time, prior to this study has been spent studying the target population in relation to HIV/AIDS. A study on the effects of HIV/AIDS on children at household level was conducted in the same community prior to this research. Thirdly, the researcher is affiliated to a local faith-based organization, Faith In Community Aiders (FICA) which provides food supplements to AIDS affected households, school fees for children in these households as well as home-based care for the HIV/AIDS patients.

4.5 Sample and sampling method

Purposive sampling was used for selection of the NGO as the Catholic Relief Services (CRS) is the only NGO in the area that works directly with households affected by HIV/AIDS. Purposive sampling is a non-probability sampling technique in which the elements are selected because they possess the information required. Expert sampling, a

subcategory of purposive sampling was employed in the selection of CRS officials for the interviews. The rationale for this type of sampling technique is that persons with known or demonstrable experience and expertise in the area will provide the best information. The people identified are perceived as being well informed; for example the HIV/AIDS officer and a project officer who does the community visits are in this instance very knowledgeable about households' livelihood activities.

A total of eight households were selected randomly from the sample frame (all the HIV-affected households with which CRS works). Thus every household had an equal chance of selection. A simple random sample was chosen for the households as there are no specific categories or strata under research. All low-income households had the same phenomena to be studied, deserved an equal chance of selection.

4.6 Data collection

Semi-structured interviews and observations were conducted between October and December 2008. The semi-structured interviews were used to gather qualitative data from CRS officials and members of beneficiary households. Interview questions were structured in accordance to the sustainable livelihoods framework to explore the assets households possess as well as the role and influence of national policies and institutions.

Interviews are a means of getting direct knowledge personally therefore the information is generally reliable. The major advantage of a semi-focused interview is its flexibility which enables the interviewer to explore the opinions of respondents so as to obtain an in-depth understanding (Dane 1990: 129). Interviews also allow the researcher to note the non-verbal expressions thus sincerity, frankness and truthfulness can be better judged.

Concurrent observation served to complement data collected from the interviews. Human behaviour is significantly influenced by the settings in which it occurs this is why research must be conducted in the setting where all the contextual variables are operating (Glesne and Peshkin, 1992). The same households participating in the semi-structured interviews were observed over a short period of time in order to gain insight of the nature

of their livelihood activities. Observations also capture data that cannot be obtained from interviews, the nature of the knowledge generated from observation is in most cases difficult to acquire verbally from interviews and questionnaires. The greatest strength of observation as a data collection technique is that it is a naturalistic inquiry allowing the investigation of phenomena in their naturally occurring settings (Thomas, 1993).

A focus group discussion was also conducted with the Community Focal Persons⁶. Originally from the District AIDS Awareness Committee (DAAC), these focal persons are HIV positive volunteers who assist the Catholic Relief Services as field workers. This focus group was ad hoc in nature and was a suggestion from the focal persons themselves, (providing rich data and a huge input to the study).

4.7 Data analysis

In ethnography data analysis is an ongoing process (Hammersley and Atkinson, 1995:160), thus in this study analysis commenced on the first day in the field and was ongoing. This enabled the researcher to learn from one visit and to identify themes and patterns for the next visits. Interview transcripts and field notes were analyzed thematically; emerging patterns, similarities and connections were arranged into thematic codes. Thematic analysis is a method for identifying and analyzing patterns within data (Braun and Clarke, 2006). “A theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set” Braun and Clarke (2006).

4.8 Ethical considerations

Ethical clearance for the study was obtained from the necessary authorities, i.e. the Research Ethics Committee of the Faculty of Humanities, Social Sciences and Development Studies, University of KwaZulu-Natal. The study involved people who are HIV positive and their household members, thus it was an issue of ethical concern. Respondents were briefed before the interviews on the nature and intent of the research as

⁶ Focal Persons are the Community home based-care givers, initiated by DAAC.

well as its implications and risks; they were also notified that participation was entirely voluntary, that they were free to refrain from answering any questions that they found too sensitive and they were free to withdraw at any time. Due to the sensitivity of the topic, all steps were taken to ensure anonymity and confidentiality. In the presentation of the data no real names are used rather pseudonyms were employed and households were given numerical codes.

4.9 Limitations

As already mentioned, the fieldwork of this study was conducted in 2008; which was during a period of increasing political tension in Zimbabwe. This was a major obstacle in accessing information as well as for mobility; participants were reluctant to discuss issues relating to the economic situation such as cash shortages in banks, food shortages in supermarkets as well as issues of staff shortages in the health and education sector. Discussing these issues was perceived as accusing the government of failing to do its job and thus identifying with the opposition party. Participants feared that this information would get into the hands of the fearsome ‘green bombers’⁷ who often patrolled the cities to stamp out any potential threat to the ruling party and thus would become targets. CRS officials in particular were very cautious of their statements and evaded any discussion on the economic situation as NGOs are a target and are closely monitored. Observations and daily interactions served to obtain information on food shortages, cash shortages and the collapse of the health system.

Another limitation of this study was that of time as the fieldwork was conducted over a short period of time. A longer study would have served best in analyzing the livelihood strategies of AIDS-affected households; this longer study would have allowed the researcher to capture household adaptations to the changing economic climate in Zimbabwe.

⁷ Green bombers are the trained Zanu PF youth militia

The current economic and political instability in Zimbabwe may have had a negative effect on the results of the study. Due to the economic hardship in the country many households have adopted a wide range of coping mechanisms; thus it was difficult to determine whether livelihood diversification was due to the high costs and financial burden associated with HIV/AIDS or was a coping mechanism to the harsh economic conditions.

4.10 Summary and Conclusion

The methodology of the study, which included the research design, sampling methods and data collection instruments, was outlined. The chapter has also discussed ethical considerations as well as factors limiting the study. The theory informing the study was presented; the sustainable livelihoods approach offers an holistic lens through which to view household coping strategies. Factors influencing livelihood strategies include the vulnerability context and the livelihood resources available to households. In principle, the framework acknowledges that policies play a major role in influencing livelihood strategies as evident in Operation Murambatsvina discussed in chapter three. The next chapter will discuss the theory's applicability to AIDS-affected households in the context of Zimbabwe.

CHAPTER FIVE

FINDINGS AND ANALYSIS

5.1 Introduction

Data collected from the field is presented and analyzed in this chapter, emerging themes and ideas are discussed. Interview and focus group data were used to examine the effects of HIV/AIDS on household livelihoods as well as the livelihood strategies adopted. An analysis of livelihood and survival strategies is vital; it provides insight on what strategies are successful and thus contributes and enables development projects.

5.2 Case Studies

The study gave rise to case studies which will be used as illustrations of the analysis, thus only selected household cases are presented. These case studies illustrate the participants' livelihood strategies and the challenges of the underlying socio-economic environment. A focus group discussion is also presented as it provides insight to new phenomena not explored in the individual household cases. The findings presented below confirm and highlight the literature discussed in the context chapter

Household 1

Ms Dudzai (24) takes care of her young sister, Ms Mary (18) who is HIV positive and bedridden. Ms Mary has been ill for about two years, before falling ill she was a domestic worker in Chegutu. Upon falling ill, Ms Mary left work and went home (rural areas) to receive care from her mother. Within a year, Ms Mary's parents passed away leaving Ms Mary with no option but to return to the city (Chegutu) where her sister Ms Dudzai, could look after her.

Ms Dudzai has two children and is both the breadwinner and the caregiver and survives on market trading, which entails selling seasonal fruits as well as bananas and oranges at the taxi and bus rank. This is the only income activity that supports the household.

Vending and market trading at the bus rank in Chegutu has been declared illegal under the Operation Murambatsvina. Thus for Ms Dudzai half of her day is spent running away from the municipality police. While Ms Dudzai is at work her sister is left unattended as she is both the breadwinner and the caregiver. Ms Dudzai normally goes to work from morning till late in the afternoon, thus has a normal working day.

The household expenditure encompasses rent, electricity and water rates, school fees for one child, medical requirements and food. Ms Mary's condition requires a lot of food intake as well as a nutritious diet as she is on TB treatment. TB treatment course requires large quantities of food. The income earned by Dudzai is expected to meet all these costs. In the current economic crisis Ms Dudzai's income can barely meet the food requirements let alone the medical requirements.

The household does not receive any external assistance from family and friends. The household has recently been put on the CRS food aid program. This has helped to reduce the household costs; however there are still medical costs to be covered by Ms Dudzai's meager income. Ms Mary is on the Government's antiretroviral therapy (ART) program which is rolling out ARVs free of charge. Thus the cost of ART is not incurred by the household.

Household 2

Ms Winnet is looking after her husband Mr Cephas who is currently on TB treatment. Mr Cephas is a mechanic by profession and was employed on a part time basis performing piece jobs. It was after a work-related injury that Mr Cephas discovered he had TB and was diagnosed HIV positive. Mr Cephas' illness has meant a loss in household income leaving Ms Winnet's income to sustain the household as well as medical costs.

Ms Winnet sells fish, groundnuts and boiled eggs at a local bottle store and her working hours range from 20.00 to 03.00. Winnet works 7 days a week irregardless of weather. This has been her livelihood for the past 15 years, as she has never been formally

employed. Ms Winnet also engages in a daily rotating lending scheme with her friends. Despite the economic distress, Ms Winnet's business activities and the rotating schemes have proved to be viable, sufficing for rent and other household costs. Ms Winnet seems quite content with the income generated from her livelihood activities.

Due to the nature of Ms Winnet's livelihood she is unable to provide adequate care for her husband as she will be away for most of the night. It is on this base that Ms Cephas is staying with his elderly mother while Ms Winnet sources a livelihood.

Mr Cephas has recently been put under the CRS program, other than CRS the family does not receive any external assistance from the government nor relatives. Both the CRS program and the government TB program have reduced household costs.

Ms Winnet also supports her brother who is HIV positive and ill. Ms Winnet's brother is a tailor in Kadoma but due to his illness he has not been able to engage in any livelihood activity.

Household 3

Mr Goodwill (32) has been ill for 3 years now and is being cared for by his aged mother, Mrs Zivai (81). Mr Goodwill's wife passed away (HIV/AIDS-related death) leaving behind two children who are now in the care of Mrs Zivai. Mr Goodwill was the breadwinner, like many others in Chegutu he survived by fruit vending. His deteriorating health has impeded him from vending.

Mrs Zivai has other children in South Africa who she was looking to and anticipating for support, however these children have not visited nor provided any assistance to the family. Mrs Zivai is dismayed by her children's attitude as she is too old to work and cannot engage in any income generating activity. Mr Goodwill's savings have managed to cover his medical expenses; it is these savings that the family was able to fall back on and made the difference. The family is currently surviving on food hand-outs from CRS and material contributions from neighbours and well wishers.

The sale of assets has also been a common coping strategy in this household. Mrs Zivai has been selling her household utensils and clothing in order to pay rent as well as school fees for her grandchild.

Mrs Zivai faces the challenge of transporting her son to the hospital and clinic for check ups as she has no vehicle and cannot afford to hire a car. Upon the visit, Mr Goodwill's friends had pledged to contribute and hire a vehicle to transport their friend as well as to purchase Chortrimoxazole, the required medication.

Household 4

Mr Abel was a Church Pastor in Victoria Falls when he fell ill, he was put on an indefinite leave and moved back home in Chegutu. His wife, Mrs Abel is currently taking care of him. Both Mr and Mrs Abel are currently unemployed; they are being supported by their children. The household is also receiving a monthly food hamper from CRS.

Mrs Abel has been unable to access remittance sent through the bank due to the shortage of cash in the country. The maximum withdrawal being Z\$50,000/day while Mr Abel's medication is costing over Z\$200,000. This has meant queuing for about four days while the price of medication will have tripled within those four days.

During winter, Mrs Abel knits jerseys and barter them for maize or mealie-meal (upfu). However, due to the widespread food shortages Mrs Abel has not been able to trade for food.

Mrs Abel has repeatedly applied to the Government's Social Welfare Department for assistance but to no avail. The family has since been told that they will receive some form of government assistance. Mr Abel was recently put on the CRS food distribution programme and is now receiving a monthly food hamper.

Household 5

Mrs Vongai (58) is a caregiver to ten grandchildren and to a chronically ill daughter, Ms Mavis (31). Ms Mavis is HIV positive and bedridden thus she is unable to work or perform any income generating activity, leaving her mother to care for her six children. Other than Ms Mavis' six children Mrs Vongai has four other grandchildren including two from her deceased brother who died from HIV-related TB. These children fall into the range of 0-14 years, with a greater concentration at 6-8 years.

The family is renting a two-roomed house which cannot accommodate all twelve family members thus some of the older boys sleep away from home. These boys sleep in a *tangwena* (shack) on a plot about 8 km from their home

Ms Mavis was the breadwinner supporting her mother and these ten children. Now that she is bedridden the only source of income comes from the small income generating activities that the children engage in, while Mrs Vongai looks after Ms Mavis and the younger children. Ms Mavis has a four month old baby which she cannot look after due to her condition. The children sell oranges and firewood and the income generated is used to pay for rent, medical expenses and feed all twelve family members.

Ms Mavis was recently put on the CRS programme thus receives food packages. The children are under the FICA programme and receive a meal/day. Nonetheless the pressure of looking after ten children and a chronically ill adult is still felt.

Crying: Honestly this child has given me a huge task! She recently gave birth to a sixth child. This little girl you're seeing (about 5 years) carries firewood to sell as small as she is! Her children are too close together (birth spacing). When she delivered this young one then the disease came out. As you see, she cannot even carry or hold her own baby (4months). We have to use a wheel barrow to take her to hospital. She never married any of the children's fathers (This pot you're seeing is not enough I am yet to make another one.)

The family does not receive any support from relatives as Mrs Vongai is the only surviving child in her family as most of her family members have been wiped out by the deadly pandemic. Mrs Vongai lost contact with her husband's family after his death⁸ and thus cannot expect any assistance from them.

Mrs Vongai has taken her daughter to the hospital four times in an effort to see the doctor who visits the hospital once a week and sees a total of 20 patients per visit. Unfortunately for the past four weeks Ms Mavis has not been part of the 20 people.

Household 6

Ms Alice (42) is a caregiver to her sister Ms Natsai (31) who is currently bedridden. Ms Natsai lost her husband in 2007 due to an HIV-related illness. When her husband died, Ms Natsai was evicted from the house they were renting; the husband's family also took all the household utensils and assets⁹. Thus Ms Natsai now resides with Ms Alice in a two roomed house which is owned by Ms Alice.

Ms Alice has two children (*all with different fathers*) and is single; Currently Ms Natsai has no children but had one with her deceased husband, the child was diagnosed HIV positive and died at four months.

Ms Alice is the household's breadwinner, she engages in flea market trading. Ms Alice buys second hand clothes, *mabhero*¹⁰ from Mbare¹¹ in Harare and resells them in Chegutu and in surrounding farms compounds. Ms Alice's busiest days are usually the month-end week when farm workers are paid. During this period Ms Natsai is left in the care of Ms Alice's eldest daughter, this has meant missing out on school for about three days in a row for the young girl.

⁸ In most cases when a husband dies, ties with his family are broken

⁹ It is a Shona cultural practice to distribute the deceased's belongings among the remaining relatives, it is said to be a way of maintaining a link with the deceased.

¹⁰ Mabhero is a Shona word referring to bulk second hand clothing donations that come in from various countries, usually the USA but are sold instead of being handed out freely.

¹¹ Mbare is Zimbabwe's largest informal trading area comprising of markets and settlements; equivalent to Warwick Junction in Durban,

This economic activity has not been viable for the household as people do not buy materials such as clothing as these are regarded as a 'luxury' with food being the main priority in this dire economic condition. Income generated from this activity is supposed to cover the household's costs which include food; transport; school fees and sanitary (soap; cotton wool; antiseptic) requirements for Ms Natsai. These sanitary products are all purchased in foreign currency as they are imported from South Africa and Botswana. Fortunately, Ms Natsai's medical attendances are free of charge at the local Government clinic and hospital.

Ms Natsai is also on the CRS Chronically ill program which has helped to reduce the burden in terms of food provision and costs.

5.3 Effects of HIV/AIDS on Households

5.3.1 Effects of Illness on household finances

The most immediate impact of HIV/AIDS is on human capital; this subsequently translates into an economic effect as individuals lose their productive ability. Masanjala (2006) argues that the epidemic can create 'new' poverty by increasing the risk of income failure. Accordingly, interviews revealed that illness does have a negative effect on household income; firstly, by falling ill the afflicted individual loses his/her productive ability as they are occasionally ill and eventually become bedridden. Consequently, these breadwinners lose their jobs creating a vicious cycle.

Although informally employed, seven of the participants indicated that they had to leave work due to chronic illness. For example Miss Mary who was a domestic worker and Mr Cephas who was a mechanic, both presented above became bedridden and non-economically active. Mr Abel from household number 4 had to leave his pastoral duties after becoming severely ill. Similarly, Ms Mavis mentioned earlier, was the breadwinner supporting her mother and ten children; due to illness she is unable to support her family.

Accordingly, Masanjala notes that ‘HIV/AIDS undermines livelihoods and raises vulnerability to future collapse of livelihoods’ (2006:1032). Before falling ill, Mr Simon from household 8 was engaged in numerous income generating activities which include buying and selling cell phones, forex dealings and selling airtime, mainly black market activities. With these activities, Simon was able to provide for his six children, his mother, his two siblings and his mother-in-law. These activities depended on Mr Simon’s physical fitness and despite having regular customers, once Mr Simon became bedridden this livelihood dissolved. Similarly, Mr Goodwill’s deteriorating health has disrupted his livelihood.

Furthermore, the illness of a household member affects income as time is diverted from productive activity to caregiving. Six households indicated that more time was spent performing caregiving tasks than income generating activities. In household number seven, Mr Thomas (27) is bedridden and is being cared for by his mother Mrs Sarudzai (65). Consequently, Mrs Sarudzai is unable to perform any income generating activity due to this caregiving role

The medical costs linked to HIV/AIDS also place a heavy burden on household finances. Mrs Zivai for example, has to frequently hire a car to take her son to the hospital. Similarly in household number seven, Mrs Sarudzai cannot afford to constantly take her son to the hospital for treatment. This has become quite costly for her as she has to hire a car to ferry her son to the hospital. With petrol going for R30/litre in Zimbabwe, transport has become a very expensive service.

5.4 Unemployment

Unemployment in Zimbabwe has reached an alarming level of 85% (CIA, 2008) and can be attributed to several factors; these include the callous Operation Murambatsvina in 2005 discussed in previous chapters as well as the lack of economic growth and development which translates into a lack of job creation. The pulling out and relocation of the majority of multinational companies and mines nationwide, namely Unilever and Coca-cola has caused a large number of job losses.

Being a mining and farming town, Chegutu has suffered severely from the political instability; land reform saw a vast majority of farm workers being retrenched as the ‘new farmers’ reduced on production thereby downsizing their staff. The shutting down of multinational mining companies has left the town on its knees. Thus unemployment is of great concern as majority of the population in this small and ‘economically dead’ town is unemployed. The focus group also revealed these concerns of unemployment and the lack of opportunity in Chegutu, as the town is hardly economically active:

***M1:** To be honest with you, Chegutu has no economic opportunities there are no industries, no companies with offices. Majority of the population are unemployed and so even if people try to engage in income generating activities business will be low, they are all too poor to spend money.*

Of all the households in the sample, no household had a member with a stable and sustainable economic activity. The focus group discussion also pointed out that for AIDS-affected households it is difficult for members to seek stability and sustainability in income generating activities as the primary target is survival i.e. food and medication for the day, week as well as flexible hours for caregiving:

***F2:** It is difficult to engage in income generating activities as the week is spent scavenging for food and medication so as to stay alive.*

It is difficult to seek stability and sustainability in an economy that is volatile and extremely unstable itself. It is particularly challenging for people in the informal sector for the reasons of lack of start up capital and market due to reduced spending and most importantly the hyperinflationary nature of the currency:

***M1:** We have a lot of great ideas for sustainable projects but we do not have the start up capital,*

F2: The problem is that other projects require lots of capital like the candle making requires machines to make the candles; with these current shortages you are not guaranteed of finding wax.

5.5 Livelihood Strategies

As previously discussed, Chambers and Conway (1992) define livelihood strategies as the different activities that people engage in to generate income. In an effort to reduce the effects of HIV/AIDS households engaged in a variety of livelihood activities. Households also resorted to coping mechanisms common in sub-Saharan Africa in particular, such as the use of savings and selling of assets. However, it was difficult to separate HIV/AIDS coping strategies and those of the prevailing economic crisis.

Masanjala (2006: 1036) indicates that the livelihood strategies that a household adopts are influenced by the household's assets, institutional and policy environment as well as the vulnerability context. Results from the research indicate that livelihood activities were indeed limited due to the hyperinflationary nature of the crumbling economy, widespread poverty and the highly volatile political atmosphere.

5.5.1 Use of Savings

The use of family savings is one of the most common and often the first coping strategy that households resort to in the event of a shock such as illness. Mutangadura (2000) notes that “when faced with the costs associated with increased morbidity, households cope by using up savings”. The majority of the households indicated that they turned to family or the individual's savings to meet food requirements as well as medical costs associated with the illness. In household number three, Mrs Zivai notes that it was her son, Mr Goodwill's savings that made the huge difference:

It is the money that my son saved while he was still fit and working that has made the difference, it is with this money that we took him to the hospital when he first fell ill. If my son hadn't saved I honestly don't know what I would have done or what would have happened to him as I his mother, am penniless.

Booyesen et al (2006) point out that savings serve as a shock absorber and are an important means of coping with the impacts of the epidemic.

5.5.2 Sale of Assets

An interesting phenomenon that is widespread not only in AIDS-affected households but in households affected by various shocks such as drought, throughout sub-Saharan Africa is the sale of assets. There is ample evidence from previous studies that confirm that the disposal of assets is a common response to adverse seasonality and shocks among the poor (Booyesen et al, 2004; Mutangadura, 2007; IFPRI 2002; Sauerborn et al 1996). Mrs Zivai has been selling her household utensils and clothing in order to pay rent as well as school fees for her grandchild. According to the World Bank (1997) selling assets is one of the most common household responses to the impact of HIV/AIDS. Senefeld and Polsky (2007) describe this as an income generating strategy as it aims to increase household income.

5.5.3 Barter trading

Katona-Apte (1988) notes that barter is a long established custom that still occurs in many parts of the world, even where there is a cash economy. Zimbabwe's socio-economic turmoil provides good reason for reviving and extending the barter system. Many people have resorted to barter trade as a response to the multitude socio-economic problems that have faced them. These problems include widespread food shortage; the inaccessibility of the local currency which when it is available is highly inflated; and the 'informal' dollarisation of the economy which was discussed in chapter three.

Bartering was one of the coping strategies that household number four employed. During winter, Mrs Abel would knit jerseys and barter them for maize or mealie-meal (upfu). However, due to the widespread food shortages Mrs Abel was not been able to trade for food. In this harsh condition not many people are willing to trade food for non-consumables.

5.5.4 Informal Sector Activities

Chegutu has traditionally been characterized by a lot of informal economic activities, namely home industries, petty trading and shebeens; however, the prevailing economic situation has resulted in a sharp increase in informal activities as many formal workers are corralled into the informal sector, thus choking the sector. The term informal sector encompasses a wide array of activities ranging from trading, collecting to providing a service and manufacturing as well as different employment relations (Devey, Skinner and Valoida, 2003). Presented below, are some of the informal sector activities that AIDS-affected households interviewed engaged in for subsistence.

Income diversification

A major impact of HIV/AIDS is on the household income thus many households seek to supplement their income through diversifying their sources. Devereux (2001) notes that income diversification can be categorized as a mitigating strategy aimed at reducing income loss due to illness. Households engaged in many income generating activities as a way of making up for the lost income as well as to meet the extra costs incurred as a result of illness. Devereux (2001) describes these as accumulative strategies as they seek to increase income.

Fruit vending/ market trading

Fruit vending is a common livelihood activity and is the main source of income for many households in Chegutu. Of the households interviewed, six out of eight indicated that they engaged in fruit vending as a livelihood activity prior to being affected by HIV/AIDS. As presented in the previous section, Ms Dudzai in household one survives on market trading, which entails selling seasonal fruits as well as bananas and oranges at the taxi and bus rank. This is the only income activity that supports the household; however, this activity has been declared illegal under the Operation Murambatsvina. Thus Ms Dudzai spends half her day running away from the municipality police.

Mrs Winnet's livelihood activity entails long working hours and runs throughout the week irregardless of the weather. This has been her livelihood for the past 15 years and according to her it has stood the test of time in this economic distress as it has proved to be viable, sufficing for rent and other household costs. Similarly, the livelihood of household number five depends on children selling oranges and firewood; the income generated is used to pay for rent, medical expenses and feed all twelve family members.

Flea market trading

The informal economy has become the livelihood of the majority of the population. Household number 6 is involved in flea market trading. Ms Alice buys second hand clothes, *mabhero*¹² from Mbare¹³ in Harare and resells them in Chegutu and in surrounding farms compounds.

Rotating Savings and Credit Associations (ROSCA)

Besides street trading, Mrs Winnet also engages in a daily rotating lending scheme with her friends. "A rotating credit association is an association formed upon a core of participants who agree to make regular contributions to a fund which is given in whole or in part, to each contributor in rotation" (Ardener, 1964 *In* Thomas *in* Preston-Whyte, 1991: 290). These are basically saving clubs commonly referred to as *chimbado*¹⁴ in Zimbabwe. These lending schemes normally alternate on a monthly basis, however due to the hyperinflationary nature of the country's economy members take turns on a weekly and daily basis. Money obtained from the day's work in the market or street vending is contributed when members meet at the end of the working day. This puts pressure on individual members to raise enough money for the ROSCA and thus feel the need to sell their products even if it means lowering the price. Owing to the cash shortages and the hyperinflationary nature of the Zimbabwean dollar, members rotate in foreign currency- South African Rands, US dollars and Botswana Pula. Elhiraika (1999) notes that rotating

¹² Mabhero is a Shona word referring to bulk second hand clothing donations that come in from various countries, usually the USA but are sold instead of being handed out freely.

¹³ Mbare is Zimbabwe's largest informal trading area comprising of markets and settlements; equivalent to Warwick Junction in Durban,

¹⁴ Chimbado is a shona term referring to rotating saving and credit associations.

savings and credit associations (ROSCAs) are an alternative source of saving and credit for individuals who do not have access to credit markets, they are also particularly useful when purchasing assets or costly items such as medication in this case.

This livelihood seems to be ubiquitous, found not only in Africa but in Europe, Asia and the Americas as well. ROSCAs establish friendship and neighborhood ties, which is of great significance in the context of AIDS-affected communities where social support is needed (Thomas *in* Preston-Whyte, 1991).

Commercial sex work

Most of the alternative income earning opportunities open to households in particular locations exhibit high correlation between risks in returns attached to them (Ellis, 1998). Although not evident in the households interviewed, commercial sex work is one of these alternative income earning activities. Preston-Whyte et al (1991) use the term 'survival sex' to describe this type of sex work; it is indeed about surviving the poverty. Sex work is evidently the most frequent and enduring strategy used by the poor for survival (1991: 168). This economic activity has always been rife in Chegutu due to its mining and farming activities.

The focus group discussion revealed that despite not having found a household engaging in sex work as a livelihood activity, there are quite a number of households that survive on commercial sex work. Due to the severe economic meltdown and increasing poverty and hunger in households, survival sex has become the order of the day:

F2: Women are also surviving on prostitution, people used to be afraid but now it's an issue of desperation so that your children have something to eat. This further spreads the virus because you come across someone who will offer you more money for unprotected sex. You see its poverty; this is what poverty has done to us.

Focal persons raised the point that people may not have been willing to disclose and discuss this type of livelihood activity. Society has neither recognized nor approved commercial sex work as a livelihood activity; rather it is considered an immoral activity. There is still a lot of stigma and blame for HIV/AIDS. Commercial sex work is illegal in Zimbabwe thus although it is a livelihood activity for many, participants of this livelihood activity are often at loggerheads with the police. Nonetheless participants/commercial sex workers constantly pursue this livelihood activity as it is one of the few lucrative activities left in the country. Commercial sex workers in Zimbabwe earn more than civil servants; a day's work earns an equivalent of a teacher's monthly salary.

Illegal Activities

With unemployment at 80% and widespread poverty illegal activities have become the order of the day. The black-market has become the source of many livelihoods in Zimbabwe.

Before falling ill Mr Simon was the breadwinner for household number eight, he was engaged in numerous income generating activities which included buying and selling cell phones, forex dealings and selling airtime (mainly black market activities). Now that Mr Simon is bedridden Ms Chiedza has joined the flooded forex and *bacossi*¹⁵ business in order to support the family.

Theft

A livelihood strategy that emerged in the focus group discussion was theft. According to Chambers & Conway (1992) some livelihood activities are introduced as coping strategies in difficult times. According to the focal persons, majority of households in Chegutu survive on stealing. Most fruit vendors obtain their products from the surrounding farms; it is believed that they steal these at night. An inquiry/investigation was carried out to validate/verify this claim. I inquired from community members on the

¹⁵ Bacossi is government subsidized food hampers which are now being sold on the black market.

source of these fruits. During participant observation at the bus terminals/taxi ranks, I managed to get one of the young boys from the households to open up to me,

“My sister to be honest with you, there is no place you will order these oranges there is only one source that is at that white man’s farm. We go to fetch them at night.”

Indeed this was true, there is only one farm in Chegutu area that farms oranges, and this is at the “white man’s” farm. This citrus farm grows oranges on a large scale for export purposes. Mrs Winnet from household number two also mentioned how hordes of people go to steal oranges from the farm once it gets dark,

“You should see it for yourself, its ridiculous! But people are actually surviving on these oranges; households depend on income from the stolen oranges.”

5.5.4 Assistance from extended family

Fieldwork revealed that safety nets and support structures are slowly being eroded due to the economic hardship characterized by poverty and a lack of resources. Traditionally, the extended family and community played a leading role in helping families deal with shocks such as HIV/AIDS, however for Zimbabwe’s case this is slowly shifting. Most households interviewed indicated that they did not receive any external assistance from family and friends. As mentioned earlier, Mrs Vongai from household five has lost many of her relatives to the deadly pandemic. Mrs Vongai lost contact with her husband’s family after his death¹⁶ and thus cannot expect any assistance from them.

Another contributing factor for lack of dependence on the extended family is that many people in Chegutu do not have strong family ties and do not know the whereabouts of their family. Chegutu is more of a migrant town that formed as a result of the mines and

¹⁶ In most cases when a husband dies, all ties with his family are broken.

cotton industry; thus the present generation cannot trace their roots and family line to more than a generation down.

On the other hand, there were households that said they were being supported by friends and relatives. Upon the visit in household number three, Mr Goodwill's friends had pledged to contribute and hire a vehicle to transport their friend as well as to purchase Chortrimoxazole, the required medication. In a situation where HIV/AIDS has ravaged through the community, reciprocity becomes a buffer against vulnerability. In realization that the epidemic has affected every household, community members contribute and assist each other where possible forming what Moser (1996:14) describes as social capital. Goodwill's friends offer assistance knowing that tomorrow it could be them facing illness. Lombardi (1975) notes that reciprocity arises in situations of extreme scarcity, fluctuations and uncertainty of resource availability, which is the case for this community as they are faced with economic uncertainty and resource shortages.

Mrs Zivai, Mr Goodwill's mother has other children in South Africa who she was looking up to and anticipating for support, however these children have not visited nor provided any assistance to the family. Mrs Zivai mentioned how she was dismayed by her children's attitude. The family is currently surviving on material contributions from neighbours and well wishers.

Mrs Sarudzai in household seven is currently being supported by her son-in-law as both mother and son are unable to work. Mr and Mrs Abel are being supported by their children as well.

Change in household composition and size

Change in household size through migration has been an established strategy to cope with stresses such as poverty and famine throughout sub-Saharan Africa (Murray 1980, Spiegel 1987). In this study, sending children away to relatives was a strategy that households employed to cope with the impact of HIV/AIDS. In household number eight, Mr Simon (38) is chronically ill and is being cared for by his wife Ms Chiedza (24) who

is his third wife. The couple has two children together (5 and 3years) who are currently staying with Ms Chiedza's mother. Mr Simon has four other children with two of his former wives. When Mr Simon fell ill and was no longer economically active all six children were put in the care of relatives. This was to reduce the costs of food, school fees and rent as they are now renting only one room instead of two rooms. Ansell and van Blerk (2004: 675) confirm this point and notes that the household's inability to meet the material needs of children is a leading factor to the use of child migration as a household coping strategy.

5.6 The Dual Role

An interesting aspect to look at is the household composition; households in Chegutu generally have a nuclear set up. With the exception of household number six, interviewed households are made up of three or four members. In most of these households, the caregiver is normally the assumed breadwinner as well. Of the eight households interviewed, four caregivers were the wage earners as well. Ms Dudzai in household number one is both the breadwinner and the caregiver to her sister, Ms Mary. Ms Dudzai engages in fruit vending at the bus terminal and normally goes to work from morning till late in the afternoon, thus has a normal working day. While Ms Dudzai is at work her sister is left unattended.

In the second household, Ms Winnet is also the breadwinner and due to the nature of her livelihood she is unable to provide adequate care for her husband as she will be away for most of the night. It is for this reason that Mr Cephas is staying with his elderly mother while Ms Winnet sources a livelihood.

Ms Alice is both a caregiver to her sister Ms Natsai and a clothing trader. Ms Alice sells second-hand clothes in Chegutu and in surrounding farm compounds, peddling from door to door; the nature of her job requires her to be very mobile and thus is not always available to perform her caregiving duties. When Ms Alice is away, her eldest daughter takes care of Ms Natsai; however this has negative implications as the young girl ends up missing out on school for about three days in a row.

Of the households interviewed, it seems household number five has the greatest challenges as there is only one caregiver and eleven care recipients. Mrs Vongai has ten grandchildren to care for as well as her chronically ill daughter, Ms Mavis. The pressure of looking after ten children and a chronically ill adult is immense:

Crying: Honestly this child has given me a huge task! She recently gave birth to a sixth child. This little girl you're seeing (about 5 years) carries firewood to sell as small as she is! Her children are too close together (birth spacing). When she delivered this young one then the disease came out. As you see, she cannot even carry or hold her own baby (4months). We have to use a wheel barrow to take her to hospital. She never any of the children's fathers (This pot you're seeing is not enough I am yet to make another one.)

In two of the households the caregivers were too old and ill themselves to take on the extra role of income earner.

5.7 External Assistance

Due to the insurmountable predicament the country is facing, Government assistance is currently limited. Grants and assistance from the Social Welfare Department have all ceased. Mrs Abel from household number four has repeatedly applied to the Government's Social Welfare Department for assistance but to no avail. The family has since been told that they will receive some form of government assistance.

Of the few activities currently in action is the Government's antiretroviral therapy (ART) program which is rolling out ARVs free of charge in public hospitals. Mary from household number one and the four focal persons are currently beneficiaries of this program. This has reduced pressure on household finances as the cost of ART is not incurred by the household. What was quite striking was that out of eight households only one had a member on this ART program, given the situation one would expect to find more households benefiting from the program. The reasons put forward for not being on

the program were that, firstly ART requires a CD4 count below 200, and thus one has to go for a CD4 count which is a difficult task:

***F1:** Another problem is the CD4 count machine, Chegutu does not have one so you have to get into a bus and go to the nearest city either Kadoma or Kutama. When you get there you are given an appointment date to come back another time but you will have already used up all the money you had for this one trip. The state of our hospitals is depressing, if you are pregnant you have to bring along: 15 pairs of gloves, a peg for the umbilical cord, a candle for night delivery, 20l of water, cotton wool and soap.*

***F2:** Sometimes the local clinic takes blood and sends it to Kadoma for the CD4 count but due to fuel shortages as well as power cuts the blood samples always clot before getting to Kadoma and you do not get your refund, you end up going there three or four times experiencing the same problem.*

When one finally gets a CD4 count and is put under the program, there is the challenge of accessing the treatment. There is a massive shortage of antiretroviral drugs in Zimbabwe; currently there is a generic Stalenev 30, which is the only one available. When treatment is available, there are long queues at the hospitals such that people are not able to replenish their supplies. In household number five, Mrs Vongai has taken her daughter to the hospital four times in an effort to see the doctor who visits the hospital once a week and sees a total of 20 patients per visit. Unfortunately for the past four weeks Mavis has not been part of the 20 people. This shortage and inaccessibility of ART drugs has resulted in many people defaulting from treatment and thus running the risk of resistance.

Some households, like household number five receive assistance from Faith In Community Aiders (FICA). Faith In Community Aiders is a small Community-based organization (CBO) that provides care and support to AIDS affected households. FICA assists orphans and other vulnerable children (OVC) through school fees, food and

clothing handouts as well as school uniforms and stationary. These children receive a meal a day.

5.8 Catholic Relief Services

An interview with a CRS Official was conducted to provide insight on how the organization has assisted HIV/AIDS affected households. The following information is a reflection of the interview.

The Catholic Relief Services has two food aid programs, the Chronically Ill (CI) and the Emergency Relief (ER) program. The Emergency Relief program provides / offers food hand-outs to households in drought stricken areas. However, due to widespread food shortages in Zimbabwe the ER has expanded its coverage to a national scale. The CI program provides food parcels to HIV positive individuals under the TB treatment. This program was the focus of the study.

5.8.1 The Chronically Ill Programme: Rationale for Food Aid

Households with an HIV positive member under TB treatment receive monthly food parcels. Once an individual completes treatment, he/she is automatically off the food aid programme. The justification for providing food aid in contrast to other forms of assistance such as cash, are firstly, food packages are much more practical in this unstable economic environment. Food hampers are not affected by the hyperinflation or economic instability, particularly CRS packages that are imported. Secondly, food hand outs increase the nutrition status of chronically ill individuals as well as of the entire household. This helps the adherence to treatment and prevents people from defaulting from treatment on the basis of lack of food.

In the households interviewed, it is evident that food aid greatly reduces household costs; for example households' number one and seven reported to have a reduced burden on the total household expenditure. This food aid goes a long way in preventing households from starvation as there are households surviving entirely on the food hampers. Household number eight lives on CRS food aid.

5.9 Summary and Conclusion

This chapter presented and discussed the findings of the study; case studies were employed to illustrate livelihood strategies in the contexts of the households. Of importance, the chapter raises two significant issues firstly the inability to diversify livelihoods and secondly the lack of sustainability. Due to the prevailing economic climate in the country households are limited in their livelihood options as evidenced by the fact that many households engaged in the same activities. Using thematic analysis new aspects that were not adequately explored in livelihood literature in relation to HIV/AIDS were identified. Of noteworthy were bartering and illegal activities such as selling foreign currency and theft. The livelihood strategies presented highlighted and substantiated the literature discussed in earlier chapters.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

The objectives of this study were to explore the livelihood strategies that urban households resort to in response to the effects of HIV/AIDS in Zimbabwe; and to assess the feasibility of these strategies in the context of the country's current socio-economic turmoil. The previous chapter presented a discussion of these livelihood activities; this final chapter provides a summary and conclusion to the study. Recommendations and suggestions for further research are noted.

6.2 Summary and conclusion

This study provides insight into how Zimbabwean households are dealing with the effects of HIV/AIDS in an urban hyper-inflated context. Previous studies (Booyesen et al, 2006; Mutangadura et al 1999, 2000; Bechu, 1998) of household livelihood strategies have concentrated on rural areas with an emphasis on agricultural activities, this study however focused on urban households as well as urban economic activities. Data generated from the case studies underline and substantiate the information discussed in the context chapter.

Of great concern is the lack of opportunity and sustainability of income generating activities in Chegutu. Results from the study revealed a lack of diversity in livelihood activities as most people in the area engaged in the same activity, fruit vending. Due to the economic crisis, households have not been able to engage in productive livelihood activities as they lack capital, resources and a lucrative market. Unfavorable national policies have also contributed to and limited their livelihood options, for example the Operation Murambatsvina. A combination of these factors leaves households with limited options.

The town is also plagued by massive unemployment due to the closure of mines and the fast tracked land reform. The Land resettlement and redistribution program resulted in the downsizing of the agricultural service industry and the retrenchment of farm labourers as commercial production was disrupted.

The country's social upheaval plays a contributory role in the plight of AIDS-affected households. Noteworthy are food shortages, drug scarcity and poor public service delivery. Service delivery in public health facilities is of grave concern; observations and interactions in the field helped shed light on this, for example patients having to make numerous and futile trips to see the doctor in addition to the shortage of CD4 count machines, as mentioned in detail in the previous chapter. Owing to these food and drug shortages, people have defaulted from treatment. The data therefore suggests that these factors collectively exacerbate the effects of HIV/AIDS on households.

Similar to other studies (Mutangadura et al, 2007; Naidu, 2004; Booysen et al, 2004; Bechu, 1998), this exploration has also found the use of savings and the sale of assets to be common household survival strategies. The use of informal credit schemes was also evident although unusual, unlike the traditional credit associations in Zimbabwe, which rotate and take turns on a monthly basis, rotations were conducted on a daily basis due to hyper-inflation and the inability to save.

Households and individuals are resorting to 'immoral'¹⁷ activities as they have reached levels of desperation; interview respondents indicated that they stole and participated in black market activities as well as prostitution. Barter trade has become a popular survival strategy not only in AIDS-affected households but throughout the country as the Zimbabwean dollar has become worthless.

An interesting phenomenon is the dual role of breadwinners and its complexity; in most cases the breadwinner is the HIV positive individual leaving other household members to assume this role in addition to being the caregiver. This draws attention to the role of the

¹⁷ The community regarded commercial sex work as immoral.

extended family; as already discussed in the literature review section, extended family systems play a vital role as social safety nets, however this study interestingly discovered that most households did not have relatives nor were they in contact with other family members and thus did not feel this buffering effect of an extended family.

Non-governmental organizations (NGOs) such as the Catholic Relief Services play a very critical role-both economically and socially- in these households. CRS provided monthly food handouts to these households. These handouts helped reduce financial burdens of households, as previously discussed these packages made the difference between survival and starvation for many households as many households noted that they survived on these food hampers. Food aid proved to be a more reasonable intervention strategy as it is not affected by the prevailing socio-economic crisis. Furthermore, food aid increases nutritional levels of chronically ill individuals and helps in treatment adherence. However, the socio-economic and political environment has proved to be challenging for CRS and other NGOs to operate in.

Comparable to other studies and existing literature, this research has revealed that when faced with shocks and stresses households will employ the livelihood assets available to them to survive and cope. Results from the study correspond with Sauerborn, Adams and Hien's (1996: 293-297) hierarchy of household survival strategies. The study has also revealed that these livelihoods are not sustainable as households are not coping to both HIV/AIDS and the economic shock but are 'merely surviving'. Furthermore, the study has shed light on the challenges of HIV/AIDS affected households in an already adverse environment like in Zimbabwe's case.

6.3 Recommendations

6.3.1 Macro-level Recommendations

Tackling the AIDS crisis is a long-term task that requires sustained effort and planning (Avert, 2008). Before any recommendations and policy suggestions can be made, it is vital to address problems at the macro-level, as this level shapes policy outcome. The

country is currently facing what has commonly become known as a ‘triple threat’ namely HIV/AIDS, food insecurity, and the diminishing capacities to deliver basic services to the people. Thus there is need for cooperation among the leaders in order to address the problems bedeviling the country.

Firstly, political differences; instability and feuds need to be resolved. This includes putting an end to politically motivated violence, intimidation as well as harassment. Fighting this pandemic requires a joint effort as well as strong-willed leadership. Political stability is of vital importance in creating an enabling operating environment for civil society, which has a huge role to play in treatment and prevention. The depoliticization of state institutions is a prerequisite in addressing the issue of sustainable livelihoods and livelihood outcomes; as “policies and institutions can play a key role in transforming livelihoods since a livelihood also includes access to, and benefits derived from, social and public services provided by the state” (Masanjala 2007). For example, the role of policies and institutions is captured in the endorsement of Operation Murambatsvina, discussed earlier, which destroyed the informal economy disrupting the livelihoods of more than four million people (Zimbabwe Action, 2005). The role of policies and institutions is also illustrated by the interplay between the state and the market in the provision of antiretroviral drugs. Thus radical political reform is highly recommended.

Following political stability is the need to create a conducive environment for economic revival and the resuscitation of the public service delivery (NANGO, 2008). Issues to be addressed include hyperinflation, cash availability and employment. This will help develop a conducive environment that will help attract foreign investment and thus resuscitate the shrinking economy through employment creation, as well as infrastructural development.

Accompanying formal employment creation is the need to inject resources and create an enabling and conducive environment for the informal economy. Operation Murambatsvina revealed the extent to which Zimbabweans rely on the informal economy for their livelihood. Accordingly, the results from the study indicate that many

households survive on informal employment and activities. Job creation will indirectly boost the informal economy as people are able to buy and spend more thus leading to a larger and lucrative market for the informal traders. For AIDS-affected households it means more income coming in to the households.

Service delivery in Zimbabwe has reached appalling conditions as pointed out in Chapter three. Public services have been seriously affected by the prevailing economic crisis and political conflict. The current conditions render HIV positive people prone to opportunistic infections, for example the water shortages which gave rise to a Cholera outbreak as mentioned earlier. For human development's sake and in order to effectively fight the AIDS pandemic it is necessary to address and resuscitate basic services delivery. Public health needs to be seriously addressed (Medicins San Frontieres, 2009); attention needs to be given to the provision of efficient liquid and solid waste management as well as a clean and constant water supply.

Food insecurity is one of Zimbabwe's predicaments as the country is currently surviving on food imports. Food scarcity was amongst the critical problems that the households interviewed faced; the study revealed that there was a tendency to reduce spending on food purchases. There is an urgent need to revitalize the agricultural sector, which will not only increase food supply but will stimulate service industries and create employment. For example, horticulture will contribute to the nation's food basket, create employment on farms as well as in equipment service industries and revive the market economy through export trading thereby bringing in foreign currency. However, this is a long term plan thus appropriate short term food security interventions need to be put in place; the country is in need of international assistance in the form of food aid.

6.3.2 Micro-level Recommendations

"The AIDS epidemic depletes livelihood assets, undermines normal livelihood strategies, renders households more vulnerable to collapse of livelihoods and thus creates a cycle of poverty and HIV and AIDS" (Masanjala, 2007). There is a need to focus on the economic aspect of the epidemic, attention and resources need to be directed towards the economic

empowerment of households and individuals. The establishment of cooperatives will help prevent and raise households from poverty as they organize themselves into skills training cooperatives and rotating, savings and credit associations (ROSCAs). These groups and organizations need to be accompanied by training in various trades. This will equip individuals with the ability to diversify their livelihood activities thereby preventing them from falling into destitution. The study shows that, individuals who assume the role of breadwinner often lack and have few livelihood skills and options; this is why skills' training is imperative.

Learning from and repeating successful interventions are highly recommended. An ideal model is that of Care's 'Supporting the Income and Basic needs of HIV/AIDS-affected households' (SIMBA) program discussed in Chapter two. There is a need for more programs and interventions following a savings-based approach. Microfinance programs like SIMBA that specifically target poor AIDS-affected households will provide individuals and households with access to credit which can be used to meet basic household needs and expand their income opportunities (SIMBA, 2002). The availability of small, timely and convenient loans can go a long way in helping poor people negotiate their way into the monetized market economy.

However, it could be argued that in the prevailing economic situation microfinance and savings-based schemes are futile and inappropriate. Due to acute cash shortages, absolute poverty and daily escalating inflation rates it is virtually impossible for households to save money. Thus, adopting SIMBA's approach is put forward as a secondary recommendation to macro-economic recovery.

REFERENCES

- Andrew, G., Skinner, D. and Khangelani, Z. (2006) Epidemiology of health and vulnerability among children orphaned and made vulnerable by HIV/ AIDS in sub-Saharan Africa. *AIDS Care* 18 (3): 269-276.
- Ansell, N. and van Blerk, L (2004) Children's Migration as a Household/Family Strategy: Coping with AIDS in Lesotho and Malawi. *Journal of Southern African Studies*. 30(3): 673-690
- Barnett, T. and P. Blaike (1992) *AIDS in Africa- The present and future impact*. Belhaven Press, London
- Barnett, T. and Whiteside, A. (2000). *Guidelines for studies of the social and economic impact of HIV/AIDS*, UNAIDS, Geneva
- Barnett, T and Whiteside, A. (2002) *Aids in the Twenty-First Century: Disease and Globalisation*. Palgrave, New York
- Baylies, C. (2002) 'The impact of AIDS on rural households in Africa: a shock like any other?' *Development & Change*, 33 (4), 611–632.
- Bechu, N. (1998). The impact of AIDS on the economy of families in Cote d'Ivoire: Changes in consumption among AIDS-affected households. In M Ainsworth, L Fransen, and M Over, eds., *Confronting AIDS: Evidence from the developing world: Selected background papers for the World Bank Policy Research Report*. European Commission: United Kingdom; and AIDS Analysis Africa; 8(1): 2-3
- Bicego, G. et al (2003) Dimensions of the emerging orphan crisis in Sub-Saharan Africa. *Social Science Medical Journal*. 56:1235-47

Bird, K. and Prowse, M (2008) *Vulnerability, Poverty and Coping in Zimbabwe*. Research Paper No. 2008/41. The World Institute for Development Economics Research (WIDER)

Bollinger, L. and Stover, J (1999) *The Economic Impact of AIDS*. The Futures Group, Cape Town

Bond, P. (2007) 'Competing Explanations of Zimbabwe's Long Economic Crisis ', *Safundi*, 8:2, 149 - 181

Booyesen, F. Bachmann, M., Matebesi, Z. & Meyer, J. (2006) *The Socio-Economic Impact of HIV/AIDS on Households in Two Communities in the Free State Province*, University of the Free State and Centre for Health Systems Research & Development, Bloemfontein.

Booyesen, F (2004) Social grants as safety net for HIV/AIDS-affected households in South Africa. *Journal of Social Aspects of HIV/AIDS Research Alliance*. 1(1):45-56

Bourdillon, M. (Ed) (2000) *Earning A Life: Working Children in Zimbabwe* Weaver Press: Harare

Brocklesby, M and E. Fisher (2003) Community Development in Sustainable Livelihoods Approaches: An Introduction *Community Development Journal* 38:185-198

Burman, S and Preston-Whyte (eds) 1992 Questionable Issue: Illegitimacy in South Africa. Cape Town, Oxford University Press.

Carney, D. (Ed.) (1998). Sustainable livelihood: What contribution can we make? *Paper Presented at the Department of International Development's Natural Resources Advisers' Conference*. London,

Chambers, R. & Conway, G. (1992). Sustainable rural livelihoods: practical concepts for the 21st century. *IDS Discussion Papers*, No 296. Institute for Development Studies, Brighton.UK

CIA (2008) www.cia.gov/library/publications/the-world-factbook/

Cohen, D. (1998) ***Poverty and HIV/AIDS in sub-Saharan Africa***, UNDP HIV and Development Programme, Issues Paper No. 27,

Cohen, D (1999) 'Sustainable development and the HIV epidemic in Africa', in Mutangadura, G; Jackson, H & Mukurazita, D, (Eds) ***AIDS and African Smallholder Agriculture***, Southern African AIDS Information Dissemination Service (SAFAIDS), Harare

Collins, J. and Rau, B. (2000) ***AIDS in the Context of Development***. UNRISD, Geneva.

Consortium for Southern Africa Food Security Emergency [C-SAFE] (2007) **SOUTHERN AFRICA Food Security Update August 2007**

http://www.fews.net/docs/Publications/South_200707en.pdf Famine Early Warning Systems Network

Creswell, J. (2007) 2nd Ed ***Qualitative Inquiry and Research Design: Choosing among five Approaches***. Sage Publications: New Delhi

Dane, F. (1990) ***Research methods*** Pacific Grove, Brooks/Cole

Denzin, N and Lincoln, Y. (2005). ***The Sage handbook of qualitative research***. Sage Publications, Thousand Oaks

Devey, R. Skinner, C. and I. Valodia (2003) ***Informal Economy Employment Data In South Africa: A Critical Analysis***. Paper presented at the TIPS AND DPRU FORUM 2003, *The Challenge of Growth and Poverty: The South African Economy Since Democracy*, 8 - 10 September 2003,

Devereux, S. (2002). Can social safety nets reduce chronic poverty. ***Development Policy Review***, 20(5), 657-675.

Dichter, T. (2006). *“Hype and Hope: The Worrisome State of the Microcredit Movement”*
www.microfinancegateway.org/content/article/detail/31747

Ellis, F. (1998) Household strategies and rural livelihood diversification. *Journal of Development Studies* 3(1): 1–38.

FAO, (2003) *Food Security and HIV/AIDS: An Update*. Committee on World Food Security. 29th Session, Rome, 12-16 May 2003.

FAO (2006) *Sustainable Livelihoods and Emergencies*. [www.fao-ilo.org/fileadmin/user_upload/fao_ilo/pdf/Sustainable_Livelihoods_and_Emergencies.pdf](http://www.fao.org/fileadmin/user_upload/fao_ilo/pdf/Sustainable_Livelihoods_and_Emergencies.pdf)

Foster G, and Makufa C. (2000) *The capacity of the extended family safety net for orphans in Africa*. International Conference on AIDS 2000 Jul 9-14; 13: abstract no. ThOrD772.

Giddens, A. (1972). *Emile Durkheim: Selected Writings*. Cambridge University Press, London.

Glesne, C and Peshkin, A. (1992) *Becoming Qualitative Researchers: An Introduction*. Longman, New York

Hammersley, M and Atkinson, P. (1995). *Documents in Ethnography: Principles in Practice*. Second edition. Routledge, New York.

Hulme, D. and Mosley, P. (1996) *Finance Against Poverty*. Routledge, London.

The International Institute for Sustainable Development (IISD) (1999) Community Adaptation and Sustainable Livelihoods (CASL) Programme. *Empowering Communities for Sustainable Livelihoods*. <http://www.iisd.org/casl/default.htm>

The International Crisis Group. (2007) *Conflict history: Zimbabwe*
www.crisisgroup.org/home/index.cfm?action=conflict_search&l=1&t=1&c_country=119

International HIV/AIDS Alliance (2008) *Effects of HIV/AIDS on Children's Education* www.ovcsupport.net/sw476.asp

Jackson, H. (1999). *HIV/AIDS in Southern Africa: the threat to development*. SFAIDS, Harare

Jackson, H. (2002) *AIDS Africa: continent in crisis*. SFAIDS, Harare

Kapp, C. (2007) Health crisis worsens in Zimbabwe in *The Lancet*, 369(9578): 1987-1988
[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(09\)60151-3/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60151-3/fulltext)

Katona-Apte, J. (1988) Coping Strategies of Destitute Women in Bangladesh. *Food and Nutrition. Bulletin*, 10(3): 42-7.

Khawari, A. (2004). *"Microfinance: Does It Hold Its Promises?"* Discussion Paper, Hamburg Institute of International Economics

Kujinga, T. (2004) Challenges facing Civil Society in Zimbabwe In *Development Update: From disaster to Development? HIV and AIDS in Southern Africa* by Heywood, M. (Ed) 123-129

Lindsey, D. (2002) *Supporting the income and basic needs of HIV and AIDS affected households: SIMBA*. International Conference on AIDS.

Lombardi, J (1975) Reciprocity and Survival. *Anthropological Quarterly*. 48:4, 245-254

Lovell, V. (2002) *AIDS in Africa: Help the victims or ignore them?* Novinka Books, New York

Marshall, C. and Rossman, G. (1999) *Designing Qualitative Research*. 3rd Ed. Sage Publications, London

Mail & Guardian (1999) *'How AIDS is starving Zimbabwe'*, 16 August 1999.

Masanjala, W. (2007) The poverty-HIV/AIDS nexus in Africa: A livelihood Approach. *Social Science & Medicine* 64(5): 1032-1041

Medecins Sans Frontieres (2009) *Beyond Cholera: Zim's worsening crisis.*

www.msf.org/source/countries/africa/zimbabwe/2009/Zimbabwe_Beyond_Cholera_Feb09.pdf

Meintjes, F (1996) *Informalisation as a Strength: Community Survival Systems and Economic Development in the African City.* Universal-Publishers

Mupedziswa, R. (1997). *Empowerment or repression?: ESAP and Children in Zimbabwe.* Mambo Press, Gweru.

Mupedziswa, R. (1998) AIDS in Africa. *Journal of Social Development in Africa.* 145-152.

Murray, C. (1980). Migrant labour and changing family structure in the rural periphery of Southern Africa. *Journal of Southern African Studies*, 6(2), 139-156.

Mutangadura, G. et al. (1999) *AIDS and African smallholder agriculture*, SAfAIDS, Harare

Mutangadura, G, Mukurazita D. and Jackson H. (1999) *A review of household and community coping responses to the HIV/AIDS epidemic in the rural areas of sub-Saharan Africa*, UNAIDS Best Practice Paper, UNAIDS, Geneva

Mutangadura, G. (2000). *Household welfare impacts of mortality of adult females in Zimbabwe: Implications for policy and programme development.* Paper presented at the AIDS and Economics Symposium organized by the IAEC Network, Durban.

Mutangadura, G. (2007) "Gender, HIV/AIDS and Rural Livelihoods in Southern Africa: Addressing the Challenges," *JENDA: A Journal of Culture and African Women Studies*, Issue 7.

Naidu V. (2004) *A pilot study of the impact of HIV/AIDS on income-earning urban household economics in Soweto, South Africa where women utilize public health care facilities.* Unpublished thesis. University of KwaZulu-Natal.

Naidu, V and Harris, G (2006) 'Survival strategies of HIV/AIDS - affected households in Soweto', *Development Southern Africa*, 23(3): 417- 426

Office of U.S. Foreign Disaster Assistance (OFDA). (2009) *Zimbabwe – Cholera Outbreak*
www.usaid.gov/our_work/humanitarian_assistance/disaster_assistance/countries/zimbabwe/.../fy2009/zimbabwe_ch_fs08_02-10-09

Oni, S., C.L. Obi, A. Okone, D. Thabede and A. Jordaan (2005) The Economic Impact of HIV/AIDS on Rural Households in Limpopo Province. *South African Journal of Economics*. 70(7): 551 - 562

Pelser, J. et al (2004) The HIV/AIDS epidemic in South Africa: Trends, Impacts and Policy Responds in Van Rensburg, H. (Ed) *Health and Health care in South Africa*. Van Schaik Publishers: Pretoria

Poku, N. (2005) *AIDS in Africa: how the poor are dying*. Cambridge: Polity,

Potts, D. (2006). “Restoring Order?” Operation Murambatsvina and the Urban Crisis in Zimbabwe’. *Journal of Southern African Studies*, 32 (2): 273-91.

Preston-Whyte, E.M 1978 Families without marriage. In Argyle and Preston-Whyte (Eds) *Social System and Tradition in Southern Africa*. Oxford University Press. 55-83

Rugalema, G. (2000) Coping or Struggling? A Journey into the Impact of HIV/AIDS in Southern Africa. *Review of African Political Economy*. 86: 537-545

SAfAIDS (2000) *SAfAIDS News*. 8(3) www.safaids.net/files/publications/2000

Salamon, L. and Anheier, H. (1997). *Defining the nonprofit sector: A cross-national analysis*. Manchester University Press, Manchester.

Sauerborn, R., Adams, A. and Hien, M. (1996) Household Strategies to Cope with the Economic Costs of Illness. *Social Science Medicine* 43(1): 291-301.

Seaman, J. and Petty, C. (2005) *Understanding the Impact on Household Economy* www.ifpri.org/events/conferences/2005/Durban/papers/seamanWP.pdf

Seeley, J and Pringle, C. (2001). *Sustainable Livelihoods Approaches and the HIV/AIDS epidemic. A preliminary resource paper*. Department for International Development: Sustainable Livelihoods Support Office.

Senefeld, S. and Polsky, K. (2005) “*Chronically Ill Households, Food Security and Coping Strategies in Rural Zimbabwe*”. Paper presented at the Conference on HIV/AIDS and Food and Nutrition Security, 14-16 April. Durban.
www.ifpri.org/events/conferences/2005/durban/papers/senefeldWP.pdf.

Sethna, H. (2003) *The role of non-governmental organisations (NGOs) in HIV/AIDS prevention and care*. Department of Public Health. Case Western Reserve University, Cleveland,

SIDA (2006). *The impact of HIV/AIDS on livelihoods, poverty and the economy of Malawi*. SIDA, Stockholm.

Spiegel, A. (1987). Dispersing dependents: A response to the exigencies of labour migration in rural Transkei. In J. Eades (Ed.), *Migrants, workers, and the social order* (pp. 113-129). London, England: Tavistock.

Steinberg, M. et al (2002). *A survey of households impacted by HIV/AIDS in South Africa: What are the priority responses?* Health Systems Trust. Durban.

Steinberg, M., Johnson, S., Schierhout, G. and Ndegwa, D., (2002). ‘*Hitting Home – How Households Cope with the Impact of the HIV/AIDS Epidemic.*’ *A Survey of Households Affected by HIV/AIDS in South Africa*. Abt Associates, Johannesburg

Toner, A and Franks, T (2006) Putting Livelihoods into Practice: Implications for Development Management. *Public Administration and Development*. 26 (1): 81-92

Toner, A (2003) Exploring sustainable livelihoods approaches in relation to two interventions in Tanzania. *Journal of International Development*. 15: 771-781.

Topouzis, D. (1999) *The Implications of HIV/AIDS for Household Food Security in Africa*. United Nations Economic Commission for Africa Food Security and Sustainable Development Division. www.uneca.org/POPIA/gateways/Women_Back_doc_4.pdf

UNAIDS (2007) *AIDS epidemic update*
www.unaids.org/en/HIV_data/2007EpiUpdate/default

USAID (2004) *HIV/AIDS Causes Lifespans to Decline in Southern Africa*.
www.usaid.gov/our_work/global_health/aids/News/lifespans.html

UNDP *Human Development Report 2007/2008*. <http://hdrstats.undp.org/en/indicators/2.html>

UN IRIN News (2006) *Zimbabwe: Sick economy fuels growth of fake drug market*
<http://www.irinnews.org/report.aspx?reportid=62413>

Van Donk, M (2002), 'HIV/AIDS and Urban Poverty in South Africa', in '*Urban Poverty in South Africa*' (2002), report prepared for DPLG and SA Cities Network by Palmer Development Group and Isandla Institute

World Bank (2000) *Intensifying Action against HIV/AIDS in Africa: Responding to a Development Crisis*. World Bank: Washington DC

Zimbabwe Civic Action Support Group. (2005) "*Operation Murambatsvina: An Overview and Summary*" www.sokwanele.com/articles/sokwanele/opmuramb_overview_18june2005.html - 36k -

Zimbabwe Independent (2008 October 31). *Villagers Resort To Wild Fruits As Food Shortages Worsen*. www.thezimbabweindependent.com/index.php/opinion?start=100

Zimbabwe Peace Project (2008) *ZPP human rights and food monitoring report*.
www.freedomhouse.org/uploads/zpp_hrviol_report_0809.pdf

ZIMDAILY, 2008 October www.zimdaily.com/news/summit27.6540.html

Websites

BBC Monitoring (2008) www.bbcmonitoringonline.com/

Institute of War and Peace Reporting (IWPR) (2007)
www.iwpr.net/?africa_zimba_photos_100605.html

www.livelihoods.org/cgi-bin/dbtcgi.exe

www.khanya-aicdd.org/photo_root/doc/slnewsletter/june-newsletter.asp

APPENDICES

APPENDIX A: Household Interview Guide

Interviews will be conducted in Shona, the local language.

HIV/AIDS and the household

- Which family member is ill?
- Was he/she working before falling ill?
- Is he/she still working?
- How has this illness affected the household's ability to earn income?
- What additional costs have you (the household) incurred as a result of the illness? [Has there been any additional expenditure?]

Livelihood Activities

- Can you tell what your income-generating (economic) activities and sources of income are?
- In light of the current socio-economic situation, what challenges do you face in your livelihood activities?

CRS Support

- What kind of assistance do you receive from CRS?
- How does this support contribute to household needs and to lessening the burden?
- In addition to CRS assistance do you still engage in other livelihood activities?
- Besides CRS, what other organizations provide financial, medical and/or material support?

APPENDIX B: CRS Official Interview Guide

Interview Guide: CRS Officials

Nature of the Program

- Background of the organization in general (history, goals, mission, funding)
- Nature of the HIV/AIDS project (History; goals; mission; activities; outreach/recruitment; extent to which HIV/AIDS program is integrated into other organization activities; staff)

Target group

- Who is the target group? Who is the program intended to reach?
- Who is actually being reached by this program?
- Heterogeneous/homogenous nature of this target group?
(Demographic characteristics)

HIV/AIDS and households

- How does the illness of a family member impacted on the household economy?
- Taking into consideration the current socio-economic situation, can you attribute changes in livelihoods to HIV/AIDS in the household?
- What are the effects of HIV/AIDS on the low-income households in Chegutu?

- What livelihood activities have family members resorted to as coping mechanisms?
- In light of the current socio-economic situation, are these strategies viable?
- What challenges do households encounter when engaging in these livelihood activities?

CRS Support

- What kind of support does your organization render to these households?
- In your view, how does this contribute to the household economy?
- In addition to CRS assistance do households still engage in livelihood activities?

APPENDIX C: Informed Consent Form



Informed Consent Form

My name is Kudzai Emma Chademana-Munodawafa. I am a student working towards my Masters degree. I am doing a research entitled '*An analysis of livelihood strategies of HIV/AIDS-affected households receiving support from the Catholic Relief Services (CRS) in Chegutu, Zimbabwe.*'. This project is supervised by Professor Eleanor Preston-Whyte at the School of Development Studies, University of KwaZulu-Natal. I am managing the project and should you have any questions my contact details are:

School of Development Studies, University of KwaZulu-Natal, Durban, Cell: 0027737885688 OR Tel: 00263912242986. Email: anodiwanaishe@webmail.co.za or 208518906@ukzn.ac.za.

I would like to emphasize that:

- your participation is entirely voluntary;
- you are free to refuse to answer any question;
- you are at liberty to withdraw from the project at any time, should you wish to do so.

The interview will be kept strictly confidential. Excerpts from the interview may be made part of the final research report. Do you give your consent for: *(please tick one of the options below)*

Your name	
Your position and organization	
None of the above	

to be used in the report?

Please sign this form to show that I have read the contents to you and are willing to participate.

----- (signed) ----- (date)

----- (Print Name)