Livelihoods and HIV/AIDS: A Case Study of Nhamoinesu Village, Zaka District, Zimbabwe

Submitted By

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Abstract

The Human Immune Virus (HIV) and Acquired Immuno Deficiency Syndrome (AIDS) is pandemic that has worsened the plight of vulnerable communities and environments in Africa. It is estimated that 40, 3 million adults and children are living with HIV and AIDS and 3.1 million adults and children died in 2004 in the world (UNAIDS, 2005). Southern Africa is the most affected, region with a very high HIV/AIDS prevalence rate. Zimbabwe is one of the most affected, with a prevalence rate at 18, 1 %(UNAIDS 2006, Ministry of Health and Child Welfare 2006). Within communities and at household level HIV/AIDS results in acute labor shortages giving rise to economic problems that disrupt livelihood activities. Many studies have documented the impact of HIV and AIDS on household livelihoods, (De Waal and Tumushabe, 2003; UNAIDS, 2005). However very little research has sought to find out how households are coping with HIV and AIDS and how various HIV/AIDS mitigatory interventions are performing. The primary objective of the proposed study to examine livelihoods and coping strategies of HIV/AIDS affected households of Zaka district in Zimbabwe. Attention is given to institutional frameworks for HIV/AIDS interventions at district and village level. A second objective of the study is whether interventions are appropriately aligned and responsive to household livelihoods and coping

Findings of the research show that the current practice of targeting people within defined risk groups by age and prioritizing interests of the most common economically active people between aged 15 and 49 years overlooks the fact that the elderly , the very young and women are among the worst affected within communities. The study also shows that the term ‘coping’ strategies is often a misnomer, as most HIV infected and affected

respondents in Nhamoinesu are struggling to survive and in some instances households are dissolving completely.

Declaration

I declare that Livelihoods and HIV/AIDS : A study of Nhamoinesu village in Zaka District ; is my own work and it has not been submitted before for any degree or examination in any other university , and that all the sources I have used or quoted have been indicated and acknowledged as complete reference and Bibliography.

Loveness Makonese May 2007

Signed……..

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
AREX	Agricultural Research and Extension Services
CBO	Community Based Organisations
CHBC	Community Home Based Care
CI	Chronic illness
DAAC	Districts AIDS Action Committee
DFID	Department for International Development
FAO	Food and Agriculture Organization of United Nations
FHI	Family Health International
HBC	Home Based Care
HIV	Human Immuno-deficiency Virus
HRSC	Human Sciences Research Council
MoHCW	Ministry of Health and Child Welfare
NGO	Non-government organization
NGOs	Non-Governmental Organisations
OVC	Orphans and Vulnerable Children
PSI	Population Services International
RDC	Rural District Council
SADC	Southern African Development Community
SAFIRE	Southern Africa Alliance For Indigenous Resources
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Fund
USAID-OFDA	United States Overseas Fund for Disaster and Recovery
VAAC	Village AIDS Action Committee
WAAC	Ward AIDS Action Committee
WHO	World Health Organization
UZ-UCF	University of Zimbabwe-University of California San Francisco
ZAT	Zaka Antiretroviral Therapy Support group
ZHDR	Zimbabwe Human Development Report

CHAPTER ONE INTRODUCTION

1.1 BACKGROUND TO THE STUDY

Human Immune Virus (HIV) and Acquired Deficiency Syndrome (AIDS) is a pandemic that has created a crisis in some of the most vulnerable communities and environments in Africa. Globally 40, 3 million adults and children are living with HIV and AIDS and 3.1 million adults and children died from it in 2004 (UNAIDS, 2005). In sub-Saharan Africa 25.8 million adults and children are living with the condition. Southern Africa remains the epicenter of the epidemic and this has serious implications for development in the region (Cohen, 1995; Gillespie, 2005, Topouzis, 2003; UNAIDS, 2005). Zimbabwe's HIV and AIDS prevalence rate is 18.1% (Ministry of Health and Child Welfare (MOHCW), 2006). This has significant implications for livelihood coping strategies and leads to human capital deprivation.

The most pervasive deprivation originates from: loss of productive lives, natural capital neglect and destruction, psychological trauma and the breakdown of community and institutional networks (Drinkwater, 2003; Tango, 2003; Mazzeo, 2005). The HIV and AIDS problem causes severe labor shortages and economic constraints that disrupt livelihood activities (Tango, 2003). Unlike other major livelihood shocks, HIV and AIDS escalates morbidity and mortality predominantly in the most active and productive segments of the rural society, (Baylies, 2001). Integrated and crosscutting sectoral responses are urgently required in order to arrest the impact of the disease (Tango, 2003).

Many studies have documented the impact of HIV and AIDS on household livelihoods, (De Waal, 2003; UNAIDS, 2005). However very little research has been conducted to find out how households are coping with HIV and AIDS and how various HIV/AIDS mitigatory interventions are performing (Baier, 1997; Drimie and Gandure, 2005; Strand, 2006). This study empirically explores and examines the livelihood dynamics of HIV/AIDS affected households in Zaka District in Zimbabwe. The study also devotes attention to the institutional frameworks for HIV/AIDS interventions at district and

village level, and assesses whether interventions are appropriately aligned and responsive to household livelihoods and coping strategies.

1.2 CHARACTERISTICS OF THE STUDY AREA

Zaka district in which this study was done is located in Masvingo province in the southeastern part of Zimbabwe. The area falls under agro-ecological zone 4 wherein mean rainfall ranges from 450-650 mm with periodic dry spells during the rainy season. The farming system characteristic of this agro-ecological zone is semi-intensive. The study area was randomly selected from four villages in Ward 13 of Zaka district, due to logistical constraints of doing the study over a large geographical area of the district or the whole ward (refer to figure 1.1 below).

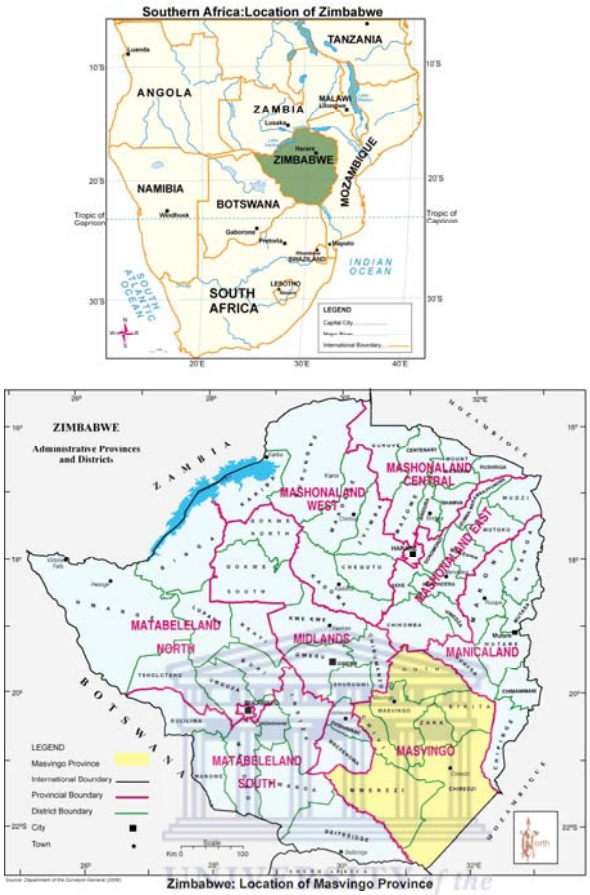


Figure 1.1 Location of Study Area

The total population for ward 13 in which Nhamoinesu village is located is 4 611 (Zimbabwe National Census Report, 2002). The total number of households in the ward is 955 with an average household population size of 4.8 (Zimbabwe National Census Report, 2002). Almost all of the population is of African ethnic origin.

The net migration ratio for Zaka district was -7.5 % (Census: 2002). The 2002 census data reveal that a total of 29 780 were born elsewhere and migrated into the area and of those born in Zaka district 44 995 individuals had migrated outside the area**.** Zaka district

has 86 % of households engaged in agricultural activities and 4 % of its population engaged in other service activities.

1.3. PROBLEM STATEMENT

The livelihood sustainability of households affected by HIV and AIDS is a challenge facing not only Zimbabwe but also most governments and development agencies in the Southern African region (Baier, 1997; Tango, 2003; Topouzis, 2003; UNAIDS, 2005). Although the government and several organizations have been engaging in HIV/AIDS programs, problems posed by the epidemic within affected households are far from being addressed (Baier, 1997; Baylies, 2001; Strand, 2006; Topouzis, 2003; UNAIDS, 2005). In Zaka district a number of non-governmental Organisations (NGOs), government institutions and community based Organisations (CBOs) have implemented an integrated HIV/AIDS program targeted at building resilience (the ability to adapt and recover from outside shocks like drought or HIV/AIDS) and coping strategies amongst the affected households. However, despite significant efforts being invested in the community, affected households have not shown any significant reduction in vulnerability or improved resilience Problems faced by HIV/AIDS affected households, the impact of the disease on livelihoods and the effectiveness of interventions needs to be explored.

1.4 OBJECTIVES OF THE STUDY

The objectives of the study are:

- To examine livelihoods and coping strategies of HIV/AIDS affected households in Nhamoinesu village of Zaka District in Zimbabwe; and

- To assess whether institutional interventions are appropriately aligned and responsive to household livelihoods and coping strategies.

1.5 RESEARCH QUESTIONS

The study is guided by the following research questions:

1. In what livelihood generation activities are HIV/AIDS affected households in Nhamoinesu involved?
2. How are affected households coping with HIV/AIDS?
3. What is the vulnerability context of HIV/AIDS affected households in Nhamoinesu village?
4. What institutions are engaged in interventions in Zaka District and within Nhamoinesu village in particular?
5. What impacts do interventions have in terms of improving the livelihoods and coping strategies of members of HIV/AIDS affected households in Nhamoinesu.

1.6 METHODOLOGY

The research employed both qualitative and quantitative methods of social inquiry.

1.6.1 THE RESEARCH FRAMEWORK

The research framework is based on the following questions: How are households in a community with AIDS coping and surviving? How do the households respond to the initiatives by key stakeholders in the community to deal with HIV/AIDS?

A Key analytical tool within the research framework is the testing of the CARE International Sustainable livelihoods framework against a defined set of critical elements for success derived from literature and other sources. The study acknowledges that although there are several sustainable livelihoods models, this one is the programming

tool that has been adapted to respond to HIV /AIDS problems in the study area. This process provided useful elements for assessing the potential success and effectiveness of the tools used in responding to the HIV /AIDS pandemic.

1.6. 2 DATA COLLECTION METHODS

A cross-sectional survey across the whole village was conducted to find out how households in the community are surviving with HIV/AIDS. A questionnaire was used to gather data on a range of questions dealing with livelihood and coping strategies found in households in the community.

In-depth interviews and focus group discussions were conducted with consenting HIV/AIDS infected and affected community members , as well as with stakeholders such as local leadership such as village headmen, AIDS Action Committees at district, ward and village levels and Non-Governmental Organisations (NGOs) and Community Based Organisations(CBOs).The purpose of the interviews and discussions was to explore the nature and dynamics of the livelihood strategies of HIV/AIDS affected households, to determine levels of vulnerability and to get perceptions on institutional interventions, with emphasis on structures and processes.

The researcher employed participant observation to identify and view events through the HIV/AIDS infected and affected respondents. The researcher and research assistant participated in the HIV/AIDS related activities at district and community level. The participation enabled the researcher and research assistant to break the distance barriers so that they could observe and record information on how the infected and affected were coping with HIV/AIDS.

The initial stage of sampling entailed a pre-feasibility survey to identify and purposively select the study area. Zaka district and Ward 13 of the district were selected on the basis that several projects have and were being implemented in the area. A random selection of wards in the district resulted in ward 13 was chosen. Following this, Nhamoinesu village was selected as the focal point for the case study. A cross sectional survey targeting 35 out of a total of 45 households in the village was done. The researcher designed a coding system to identify the households during the cross- sectional survey. Apart from expediting identification for the study's own purposes, coding protects respondent identities, thereby articulating a principal ethical concern for this study. The next stage was the analysis of the data in order to identify, households and individuals that have experienced death, illness, orphans and vulnerable children that would be defined as HIV infected and AIDS affected. After the data analysis, the researcher identified 15 households on which the study would focus using in-depth interviews and detailed case histories.

1.6.3 RESEARCH DESIGN

According to Ragin and Becker (1992), social science is based on logic and empirical observations. It involves the interaction between ideas and evidence in order to extend, revise and test ideas. This study adopts the 'sustainable livelihoods' framework to explore and describe social patterns and coping strategies of HIV/AIDS affected households and individuals. According to Ulin et al. (2005), 'a research design is the researcher's overall plan for obtaining answers to questions and for testing the research hypotheses. The process adopted for this research is not linear but is an interdependent and overlapping process. Rubin (1995) states that a good study will use both quantitative and qualitative information; quantitative aspects refer to whatever can be expressed in terms of numbers such as amounts and quantities. Not everything that happens in a household is measurable hence it is necessary to adopt qualitative methods as well. Qualitative aspects like advice given or level of self-confidence, beliefs, behaviour and motivation are not easy to measure but may be extremely important in determining whether or not households are coping. It is even more important to know why they are

failing to cope. Quantitative methods are used for measuring what happens and what changes take place; qualitative methods answer questions of how and why things happen. Qualitative methods include observing activity, interviewing and trying to get a more complete understanding of complex changes. Despite major criticism that as qualitative methods are neither representative nor scientific generalisations cannot be drawn for the representative population, combining the two approaches was beneficial to this study and helped to build a more complete picture of the social world of the households affected by HIV/AIDS (Ulin et al., 2005).

1.6.4 DATA ANALYSIS AND PROCESSING

The researcher used the Stastical Package for Social Sciences (SPSS) to capture, edit and analyze data collected through the structured interviews. Qualitative data was broken down into manageable themes, patterns, trends and relationships. Statistical data was analyzed in relationship to the qualitative data. If households were selling livestock, the researcher wanted to know how many and which were being sold, to whom and whether there were signs of livestock concentration in a few individuals in the community? Qualitative data was coded according to themes emerging from the discussions, social patterns and coping trends that could be identified or isolated. A coping strategy index to measure levels of coping in the households was used analyze the coping trends and the vulnerability status of affected individuals and households. This also distinguished methods of coping in relation to age as well as coping on the margins and those who are completely failing to cope. To map out those institutions engaging in HIV/AIDS work, an institutional mapping exercise was carried out to ascertain which institutions were operating in Nhamoinesu village and to find out their roles and responsibilities and what resources they brought to the village. A stakeholder analysis was conducted to map out the interests and level of influence held in the communities in Nhamoinesu village and to map out gaps and strengths of programs.

Table 1 variable operationalization.

Variable	Operationalising the variable	Methods of observation
Vulnerability	-Description of various vulnerabilities related to HIV and AIDS condition -Definition of affected and infected -What are the HIV/AIDS and social, political, economic and natural trends and shocks and cultural practices that affect livelihoods? -Participation and community involvement of infected and affected?	-Secondary and primary literature review -Structured interviews -Semi structured interviews -Survey questionnaire -Case study analysis -Venn Diagrams
Coping Strategies (Resilience)	-What is the level of robustness (recovery degree) of infected and affected? -What are the broad livelihood strategies for those households? -What are the strategies for alleviating loss of labor? -What are the strategies aimed at improving food security? -What are the strategies aimed at raising or supplementing income? -Coping through time(illness, death and post death) -What is the role of original asset base in coping? -Does age matter in coping? -Does gender matter in coping? -When is coping not coping? i.e. coping that has gone bad.	-Case study analysis -Structured interviews -Focus group discussions -Secondary literature -Coping strategy index

	-Coping as influenced by local power structures?	
Outcomes and Feedback loops	-What are the outcomes (positive and negative) for the households? -What are the effects of these outcomes on the capital assets of both the household carrying out the livelihood activities and those of other households or communities? -Which assets disappear and which assets remain in coping? -How do assets determine and influence provision of care for sick, orphans and vulnerable?	-Semi structured interviews with stakeholders -Structured interviews with beneficiaries -Focus group discussions -Flow charts
Institutional Arrangements	-What institutions are dealing with HIV/AIDS on the ground directly or indirectly, what are the activities they are involved in and what are their roles? -What interventions on the ground are responding to HIV? -What are the roles and relationships on the ground? -Who are the stakeholders and what are their interests?	- Institutional mapping - Stakeholder analysis.

1.6.5 UNIT OF ANALYSIS

The household is the unit of analysis for the questionnaire. The researcher realized that it is critical not to assume homogeneity within households themselves, hence individuals were also considered as a unit of analysis. The study considered relevant social divisions relating to class and age that could be defined and agreed upon through an interactive process of participatory inquiry at community and household level.

1.6.6 KEY ETHICAL QUESTIONS

Research on HIV/AIDS is necessary in order to learn how to improve existing strategies, services and public policies in programs to help the infected and affected. However it is essential that such research be done in an ethical manner with careful planning and procedures so that the research participants can be protected. HIV/AIDS infected and affected persons and households are a particularly vulnerable group in communities where stigmatization remains rife. Stigmatization often results in unfair discrimination and the loss to HIV/AIDS infected and affected persons and households of livelihood assets such as land, employment, and access to social networks. Any investigation of HIV/AIDS issues therefore carries significant risks for infected and affected persons and households. For that reason this study gave particular attention to ethical considerations throughout the conduct of the research. An overriding concern in the research design and process was to avoid inadvertently exposing respondents to possible negative ramifications because of the research. Key ethical considerations arising from the research included issues around consent, privacy and sensitivity to real needs and potential problems.

1.6.6.1 Consent

The principle of informed consent was upheld throughout the research process. Respondents were informed about the purpose of the survey, how long it might take and the purposes for which the data was going to be used. In cases where prospective respondents were minors (i.e. below 16 years), consent was sought prior to the interview from the parents or guardians. However, this did not preclude these minors' individual rights to accept or decline the invitation to participate in the research, to ask questions or

to terminate interviews when they so wish. The possible risks and benefits of participating in the research were discussed with prospective respondents. Although the researcher took all necessary precautions to avoid any risks or harm to respondents, and although assurance in this regard was given, respondents were also made aware of their right to accept or decline the invitation to participate in the research project, to ask questions before, during and after each interview, and to terminate an interview at any point they wished. ; Participants were protected from these possible negative results by being assured of their freedom not to answer questions they thought sensitive.

1.6.6.2 No Deception

The researcher used no concealment or deception when she was seeking information that she felt might encroach on respondent's privacy. Respondents were not coerced into participating in the interviews.

1.6.6.3 Confidentiality

Data collected through this research will not be accessible to unauthorized users. Respondents were assured both during and after the research process that the information would be kept confidential and that the researcher would not be professionally negligent.

The AIDS epidemic has prompted difficult ethical issues regarding informed consent for research. Where HIV /AIDS rates are high as in Zaka community consent was sought through involving the community (FHI, 2006).All decisions regarding participation were decisions shared by the researcher, the volunteers and their representatives. Full consultation took place with the community in order to foster a sense of partnership with respect to the research project.

1.6.6.4 Respect and Beneficence

Volunteers and participants in the research were treated as autonomous agents – people who had self rule. Respondents and participants with diminished self rule due to age, marital status, mental or physical impairment, lack of education or financial instability

were entitled to additional precautions. Beneficence; participants were also protected from harm, through extensive enforcements in procedures and study protocols that secured their well being. The researcher maintained a strict obligation to maximize possible benefits and to minimize possible harm to participants. The responsibility of the well being of the participants – physically, mentally and socially was the direct responsibility of the researcher who adhered to the ancient maxim of 'first do no harm'. Protection of the human research participant was more important than the pursuit of new knowledge. The well being of participants took precedence in the research over the personal or professional gain of the researcher.

1.6.6.5 Justice

Justice weighs such questions as who will benefit from the research and who will bear its burdens (FHI, 2006). The study was designed in such a way that the risks and participation in the research would be distributed equally. Recruitment and selection of participants was done in an equitable manner, and the research was not done on the vulnerable in order to benefit the privileged. The researcher presented findings of the study accurately and fully - including results that might argue against the researcher's hypothesis in order to protect both the study participants and people who volunteered for future research on the same topic, as well as the general public whose access to products or services might have been affected by the outcome of this study. It is common for HIV/AIDS affected communities' expectations to be raised when people start to gather data on their problems. The researcher made it known at the outset that this was merely an academic exercise.

The researcher is an accredited member of the International AIDS Society (IAS) and adhered to its international guidelines and principles of conducting HIV and AIDS research. The institutional affiliation helped in guiding and handling in a professional manner those ethical issues that arose as a result of conducting this research. Where matters beside the issues raised in the questionnaire developed, the researcher intervened and made referrals where possible.

1.7 SCOPE OF THE STUDY

Chapter Two presents a review of literature on the problem of livelihoods and HIV/AIDS. This entails a brief overview of HIV/AIDS epidemiology and key scholars who have used the livelihood's framework in order to understand affected households and strategies to achieve sustainability for affected households. Households under shock try to survive by engaging in strategies to cope and deal with the impact. These include income strategies, food and consumption strategies, labor strategies, migration and cultural change strategies.

At a policy level the Southern Africa Development Cooperation (SADC) region and Zimbabwe has designed and adopted a multi-sectoral strategy to deal with the epidemic within the framework of building resilience and coping strategies.

Chapter Three introduces the case study area; Nhamoinesu village. Its brief historical background is given including the number of initiatives that have dealt with HIV and AIDS. The chapter also gives a detailed account of the socio-economic and livelihood activities of the people in the case study. A brief outline of HIV/AIDS in the community is given as well as the structures operating in the area and other forms of social organization.

An analysis of findings is made in Chapter four. The analysis relies of the themes developed in the conceptual framework outlined in Chapter Two.

Chapter Five presents a discussion of findings on the potential and effectiveness of the CARE sustainable framework in dealing with HIV/AIDS vulnerability and susceptibility for affected households.

On the basis of concrete empirical evidence, suggestions and recommendations are made for the Nhamoinesu, Zaka case. While these findings and recommendations are not intended as absolute and rigid guidelines for successfully dealing with HIV/AIDS, it is

hoped that some of the insights gained will be useful for Nhamoinesu and similar initiatives.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter presents review of literature on livelihoods and HIV/AIDS. The review begins with an overview of HIV/AIDS, followed by definition of key concepts related to HIV/AIDS. After this a review of the impacts of HIV/AIDS using the livelihoods approaches is suggested. The chapter describes the impact of HIV/AIDS in all the livelihood 'capital' (human, physical, natural, social and political assets or resources). Attention is given to household's coping strategies, such as income strategies, food and consumption strategies, labor strategies, migration and cultural change strategies and related livelihood outcomes. Finally the review focuses on institutional interventions/strategies within the SADC region and Zimbabwe in particular which has adopted a multi-sectoral strategy to deal with the epidemic. Relevant literature identified on such strategies will be reviewed.

2.2 DEFINITION OF CONCEPTS

2.2.1 COMMUNITY

The term community refers to social divisions, including class, age, education and group power dynamics at the village level. HIV infected individuals and AIDS affected households' livelihoods need to be understood in the context of local community dynamics in which they are contextualized.

2.2.2 HUMAN IMMUNO VIRUS (HIV)

HIV is the name of the virus that causes AIDS. If one is infected with HIV, it does not mean that one has AIDS. HIV is a life-long infection that weakens the body's natural ability to fight off diseases. Generally it takes between two to fifteen years before the HIV infection results in AIDS.

2.2.3 ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

Acquired Immune Deficiency Syndrome (AIDS). AIDS is a syndrome because the disease is comprised of a group of associated symptoms that affect the patient's ability to fight disease resulting in their ability to acquire immunity to germs becoming compromised. A person with a healthy immune system can resist infections. People infected with the HIV virus gradually lose this ability and as a result they can contract many infections, sometimes several can attack a person at the same time. It is only at this late stage that the Human Immuno Virus (HIV) produces what is known as Acquired Immune Deficiency Syndrome (AIDS. As time passes the infections worsens leading to death. The WHO (2005) has categorised the progress of HIV infection to an acute immune deficiency according to an HIV timeline is what is collectively referred as AIDS stage.

2.2.4 HIV and AIDS

Since the possession of HIV does not mean one has AIDS, the correct way of referring to the terms is HIV and AIDS but for purposes of avoiding confusion of terms and unnecessary repetition of terms the author will refer to the terms together as HIV/AIDS thorough the thesis

2.2.5 HIV INFECTED

For the purposes of this study HIV infected refers to the person who is HIV positive and who has gone for an HIV test. In instances where the person has not been tested a screening process using the WHO clinical staging guideline has been used with the consultation of qualified medical personnel.

2.2.6 HIV/AIDS AFFECTED

HIV/AIDS affected refers to individuals whose lives have been affected because they are infected with the HIV virus, have lost a spouse, child or relative because of HIV related conditions and as a result are taking responsibilities like looking after the deceased's children or have adopted orphans whose parents have died as a result of AIDS related deaths.

2.2.7 ORPHAN

For purposes of this research the term orphan refers to a child below the age of 18 who has lost either one or both parents due to an AIDS related conditions (UNICEF, 2005).

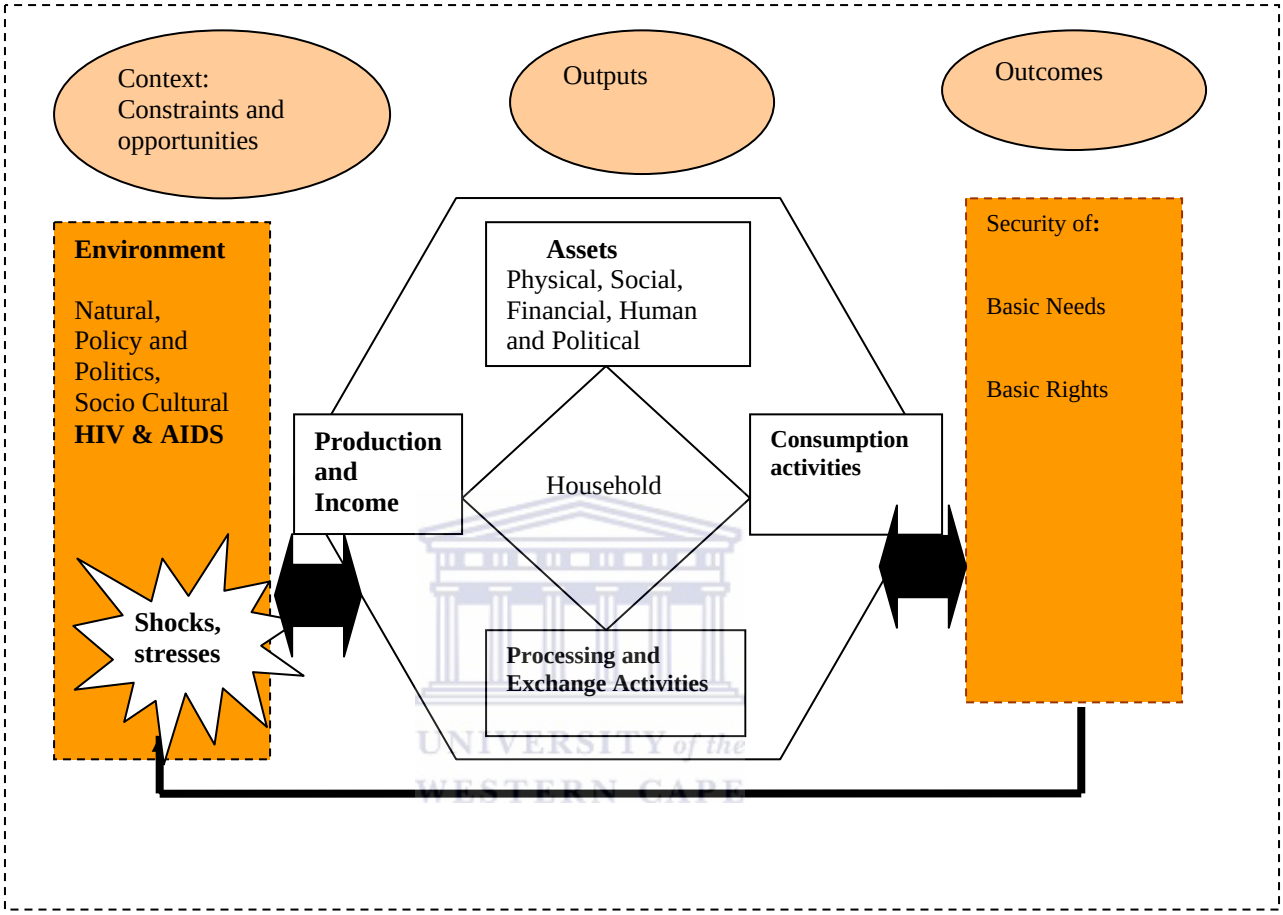
2.2.8 SUSTAINABLE LIVELIHOOD AND HIV AIDS

The 'Sustainable Livelihoods' framework(refer figure 2.1) is a tool 'for understanding the causes of poverty, through analyzing relationships between relevant factors at micro, intermediate, macro-levels and prioritizing interventions', Meinzen-Dick and Adato (2001:2). It takes into context the assets on which different individuals can draw for their own livelihood, and how these interact with existing policies, institutions and processes in shaping the choice of livelihoods' strategies and outcomes. According to Chambers and Conway (1992) livelihoods' security can be defined as adequate and sustainable access to income and resources to meet basic needs and realize basic rights. It includes adequate access to food, potable water, health facilities, educational opportunities, housing and time for community participation and social integration. Secure livelihoods are based upon ownership of, or access to resources which are used in productive activities to offset risks, ease shocks and meet contingencies.

A livelihood comprises of capabilities, education, skills, health, psychological orientation, assets, tangible resources and access to resources and economic activities required for a means of living. A sustainable livelihood can cope with stresses and shocks and recover from shocks, maintain or build its capabilities and assets, provide durable opportunities for the livelihoods of successive generations, and contribute net benefits to other livelihoods at local and global levels in the long and short term (CARE, 2005).

Figure 2.1 Sustainable livelihoods Framework

Adapted from Mullins (2002), Drinkwater: 2003



Various models have been developed to explain the context and causes of HIV and AIDS and to identify the impact of the epidemic together with a range of responses and coping strategies, (Bishop-Sambrook, 2003). The livelihoods approach is one of the models and frameworks that have been adapted to explain the causes and impacts of HIV and AIDS on household coping strategies. In the context of HIV/AIDS, the livelihoods approach identifies the fundamental causes and effects of individual vulnerability and susceptibility to HIV and AIDS, (Bishop-Sambrook, 2003; Seely and Pringle, 2001; Tango, 2002) According to Whiteside and Robinson (2002) the impact of HIV and AIDS at household level is similar to that of other shocks to which poor rural households are vulnerable. The livelihood conceptual framework best explains strategies identified in literature that cover

HIV/AIDS and are similar to those to which poor households have been observed to resort in times of crisis and need.

2.2.9 SUSCEPTIBILITY AND VULNERABILITY

According to Gillespie (2003), the likelihood of becoming infected with HIV is referred to as susceptibility. This is determined by economic and social characteristics of a society, relationships between groups, livelihood strategies, culture and balance of power, particularly with regard to gender as well as to biological factors. The likelihood of suffering adverse consequences as a result of HIV and AIDS is referred as vulnerability. This is mainly determined by poverty, fragmented social and family structure and gender inequality (Gillespie, 2003).Vulnerability to HIV/AIDS impacts is a combination of a number of pre-existing factors in the livelihoods of individuals and families hence different levels of coping and resilience. Insecure livelihoods exacerbate the risk and vulnerability environment for HIV/AIDS, (Tango, 2003; DeWaal and Tumushabe, 2003).Illness and AIDS associated deaths undermine livelihood options forcing affected people to make decisions which involve making tradeoffs among basic needs (Drimie, 2003, Drimie and Gandure: 2005, Gillespie, 2003, Gillespie and Kadiyala, 2003,).

2.2.10 COPING IN RELATION TO HIV/AIDS

HIV/AIDS affected households engage in a suite of behavioural responses to enable them to cope, DeWaal (2003). This has raised the question whether the HIV infected and AIDS affected are coping because the literature identified has shown that some households dissolve completely as a result of failure to cope. Rugalema (1999) argues that HIV and AIDS affected households never fully cope in the sense that they cannot simply return to some semblance of normal following a shock.

2.3 BACKGROUND TO HIV/AIDS EPIDEMIOLOGY

Since the first clinical evidence of HIV/AIDS was reported in 1982, it has become one of the most devastating condition humankind has ever faced. Globally 42 million adults and children are currently estimated to be infected with the virus, (UNAIDS, 2005).Since the epidemic began more than 42 million people have been infected with the virus that causes AIDS. More than 20 million infected people have died since the epidemic was identified, and in sub-Saharan Africa where 70% of global infections are located, 29.4 million people estimated to be infected (UNAIDS, 2004).The disease is now responsible for more annual deaths in Africa than any other cause. In the southern African region the pandemic has already reached critical levels, SADC-FANR (2003:2) and devastation will only worsen in the near future.

The 'impact of HIV/AIDS continues to deepen in the region and it is becoming a threat to human and economic development. All sectors of the population are affected: the young; the elderly; parents; children; men and women', (UNFPA, 2002:1). In Southern Africa it is estimated that the HIV/AIDS pandemic has claimed over 20 million people (UNAIDS, 2006).De Waal and Tumushabe (2003) claim that the Southern African region is facing a challenge at a scale that it has never witnessed in its history.

In Southern Africa, Zimbabwe ranks among the countries with highest infection rates having an estimated infection rate currently at 18.1 %(MOHCW, 2006).HIV/AIDS has reduced life expectancy in Zimbabwe to 39 years (MOHCW, 2004; UNAIDS, 2004). Each year 124 000 Zimbabweans die from AIDS related deaths and about 2 000 new infections occur every day (UNAIDS: 2004). About a third of all adults between 15 and 49 are living with HIV/AIDS. According to UNAIDS (2004) 50% of those infected are between the ages of 15-24.These comprise people in the most reproductive age group and has had a widespread impact on almost every sector of the economy. The problem of orphans is increasingly becoming a problem with the current population of orphans estimated to be about 1.3 million (MOHCW, 2005).In Zimbabwe HIV/AIDS has become

a crisis worsening the livelihood conditions of the majority of population; particularly in regard to rural livelihoods. . The impending severity and duration of the HIV and AIDS pandemic warrants an urgent call to understand HIV and AIDS dynamics better and to plan for the level of intervention the syndrome requires.

2.4 VULNERABILITY OF INFECTED AND AFFECTED

2.4.1 INCREASED MORBIDITY AND MORTALITY

HIV/AIDS attacks those individuals who are at their prime productive age (15-49 years), (Rugalema, 1999 Mazzeo, 2005).The epidemic has magnified the existing social and economic problems of households, (Baylies, 2002; Drinkwater, 2003; Gillespie, 2003; Hammarskjöld, 2003). In countries like Zimbabwe that are hard hit by the pandemic, morbidity and mortality have risen and are expected to continue to rise, (UNAIDS, 2006). Chronic illness(CI) related to HIV infection has also increased(Mazzeo,2005).The implications of rising morbidity and mortality are not only that HIV/AIDS is changing the demographic structure of the household but also that it is taking a heavy toll on household resources and assets. As a result, the social and economic progress of the last few decades is being reversed, with a serious impact on household livelihood systems. The loss of labour, income and managerial skills associated with the HIV/AIDS epidemic threatens the sustainability of rural agricultural production, (Mutangadura et al., 1999: iv). Rugalema (1999) was among the first scholars to refer to HIV/AIDS as a livelihood crisis. Studies by FAO, revealed that 7 million workers in 25 Sub-Saharan African countries have died due to HIV and AIDS, and the figure will rise cumulatively to 16 million in the next decades (Tango, 2002).

2.4.2 REDUCED HOUSEHOLD LABOR

In Malawi, 70% of households faced reduced labor due to HIV/AIDS, and in Tanzania, two thirds of all households faced a 43% labor loss. In Zimbabwe around 38 hours per week is spent in care giving (Tango, 2002). Children are forced to leave school early and there is a loss of indigenous knowledge transfer between generations, 80% of agricultural labor in sub-Saharan Africa is supplied by women, who also provide primary care to affected family members, the majority of women are shifting from agricultural production to provide care to sick family members(SADC-FANR :2003,Shah et al:2001,Tango,2002,UNAIDS:1999).In poor rural households HIV/ AIDS causes severe labor shortages and economic constraints that disrupt agricultural activities, (Mutangadura et al,1999).

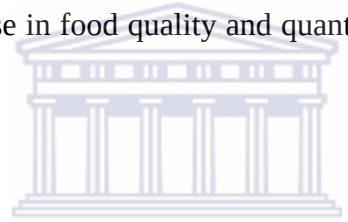
2.4.3 DISRUPTED AGRICULTURAL ACTIVITIES

In labor scarce households, land is increasingly left fallow or abandoned; Drimie (2002). Land has been sold in some affected households to support livelihoods and to pay for medical and funeral expenses (Drimie, 2002).Muchunguzi (1999) also recorded that households were selling banana and coffee plantations to cover medical costs. The productivity of land in AIDS affected households has gone down considerably, crop diversity has decreased and cropping patterns have favored less labor intensive and less nutritious crops, (Gillespie and Kadiyala, 2003). HIV and AIDS decrease the productivity of household labor due to sickness and AIDS related malnutrition and ultimately death. Existing studies reveal that the effect of chronic illness on the ability to provide labor to the household is devastating, with some households reporting figures as high as 60-80%, (Gillespie and Kadiyala, 2003; Rugalema, 1999; Ncube, 1999; Muchunguzi, 1999 and CARE, 2004). In central Malawi productivity of land has gone down by 72% and production of maize and cotton has been reduced by 50% in Zimbabwe, (Shah et al., 2001, Tango, 2002). Timeliness of agricultural operations has also been affected with affected households experiencing delays. Even with access to good land and rainfall,

AIDS affected households cannot maximize production and the use of natural resources effectively, (Mazzeo, 2005). All these aspects contribute to a decline in production in rural communities and to farm degradation in terms of a decrease in the agro-biodiversity.

2.4.4 DECREASED CROP DIVERSITY AND MALNUTRITION

In Uganda crop diversity has decreased by 44% particularly in female-headed households. Cash crop production is often abandoned due to what have become excessive financial and labor requirements. According to Muchunguzi (1999) in studies conducted in Tanzania it was noted that affected households have also shifted to growing low maintenance crops (e.g. tubers and sweet potatoes), reducing the quality of nutritional intake in households, a decrease in food quality and quantity and an abandonment of and disinvestment in land.



2.4.5 REDUCED HOUSEHOLD INCOMES

Some studies have pointed out that in households with chronic illness while the need for more income rose due to a rise in treatment and funeral costs, capacity for income generation within the household decreased, (Kwaramba, 1997; Mazzeo, 2005; Tango, 2003).Faced with HIV and AIDS, farmers often abandoned market-oriented and high external input agricultural practices and shifted over to subsistence farming, (du Gueny, 2004; Kwaramba, 1997; Topouzis, 1998; UNAIDS, 2004).

2.5.6 STIGMA AND DISCRIMINATION AND DISPOSSESION OF ASSETS

Stigma and discrimination affect the participation of affected households in livelihood programs. Furthermore participation of HIV/AIDS affected households **and family** members are constrained due to the burden of illness and lack of time for participation.

AIDS affected households are often deliberately excluded from political meetings and social gatherings in the community due to stigma and discrimination. Lack of time for participation in community activities due to the demands for caring placed on households with chronic illness as well as exclusion due to discrimination, may result in local deliberate processes that produce outcomes that do not reflect the needs and interests of HIV and AIDS affected households and individuals. Even where communities do not purposely discriminate, local ways embedded in the social systems, structures and processes on the ground may not accommodate the specific needs of AIDS affected family members. There is growing evidence in literature that shows dispossession of key assets like land and cattle, particularly for AIDS widows and children in communities with patrilineal inheritance of key livelihood assets (Drimie, 2002; Drimie and Gandure; 2005).

2.5 EMERGING COPING STRATEGIES

2.5.1 STRATEGIES FOR ALLEVIATING LOSS OF LABOR

Labor allocation patterns have changed, the elderly work later in life and children are beginning agricultural work at a younger age. It is generally believed that in affected households labor force is mostly comprised of young children and the elderly. A reduction in the availability of labor due to HIV and AIDS leads to a reduction in areas under cultivation, a reduction in the number of crops for sale and a process of transition to crops that require less labor and storage (Kwaramba, 1997; Shah et al., 2002; Topouzis& du Gueney, 1999). HIV and AIDS leads to difficulties in looking after different types of perennial crops, produce for sale and can have consequences so that production diminishes or comes to a complete standstill. In affected households there has been a shift to labor extensive crops like tubers,(Tango, 2002; Barnett and Whiteside, 2002; Muchunguzi, 1999).However it is important to note that current agricultural policies promoting tubers are influential in shifting to these crops and also the positive

living initiative of encouraging consumption of nutritionally rich natural products that can be found locally to manage consumption and nutritional needs of the HIV infected(Drimie and Gandure,2005).Critical agricultural activities like weeding are now being abandoned and households have decreased consumption patterns and are now resorting to wild foods consumption, (Tango, 2002; Muchunguzi, 1999).Land use changes as agricultural practices change with falling capacity for heavy labor. In Uganda Rakai district 60% of households for example stated that parts of the land they usually cultivated had now been abandoned and the bush had taken over the land, leading to the exacerbation of the problem of bush encroachment (Barnett and Whiteside, 2002; Barnett: 1994). Ncube (1999) stated that in Zimbabwe, Shurugwi district, there was a decline in livestock production, less time spent on tending animals and often less qualified labor was used for the purpose including identifying and treating injuries. Hammarskjöld (2003) noted that there was a transition by households to smaller animals such as goats and poultry which required less tending time and knowledge of raising them.

2.5.2 STRATEGIES AT IMPROVING FOOD SECURITY

As people affected by HIV and AIDS are less able to grow crops due to progression of the disease and the sickness, they increasingly shift to gathering for their daily subsistence needs (Hammarskjöld, 2003; Drimie and Gandure, 2005). Studies have revealed that ‘natural capital’ and common property resources contribute to household resilience as they serve as safety nets during agricultural shortfalls. Affected households have shown a tendency to ‘increasingly rely on woodland activities as a coping strategy’ (Drimie and Gandure, 2005:27). The pandemic has generated a greater need for medicine, and most plant-based medicine is sourced from the forest. Wild foods are free, nutritious and require little labor input and are particularly needed in times of stress. The reliance of affected households on sale of forest products like firewood and thatching grass, has led to concerns of changes in collection strategies and has led to increasing

nutritional dependence on the environment(Barany et al.,2005) quoted by Drimie and Gandure(2005). Institutional arrangements governing resource use and allocation may not function efficiently, to the detriment of HIV/AIDS affected sustainable use and management of resources in general.

2.5.3 STRATEGIES AIMED AT SUPPLEMENTING INCOME

Some households have resorted to selling of productive assets to cope with increasing demand for income, in Malawi 40% of affected households have sold productive assets, Tango (2002). In many sub-Saharan African countries with a heavy HIV and AIDS burden, livestock numbers have been reduced and market prices depressed, as households sell off animals to pay for medical and death costs(Tango,2002).Children are sometimes withdrawn from school to keep the little money the household has for survival of the family

2.6.4 CULTURAL STRATEGIES

Communities and households are changing cultural practices. Cultural practices like ritual cleansing, and marriage of widows by male members of the deceased family (*kugara nhaka)* have decreased. Funeral practices have been shortened and simplified. Cultural taboos around sex and sexuality taboos have now been relaxed since individuals can now talk about HIV and AIDS issues in public. The slaughter of animals for funerals has reduced availability of draft animals and this has been relaxed except where households can afford it.

2.5.5 MIGRATION AS A COPING STRATEGY

Individuals sometimes ask their relatives to look after their children in order to absorb the extra burden of income demands when they are sick. Orphans seek employment locally and in towns if there is no one to look after them. In Zimbabwe incidences of sending children to live with relatives were reported and this has been a common strategy in the

Zimbabwean tradition (Kwaramba, 1997). Urban dwellers have a tendency to migrate to their villages of origin when they become seriously ill, so that the caring and support costs of the wider family are frequently borne by rural communities (UNFPA, 2002). In cases where husbands have died and women have been dispossessed of assets they resort to migrating to the urban areas (Drimie and Gandure, 2005). Migration is a coping strategy which also increases ones' susceptibility to new infections or re-infection.

2.5.6 COPING AS INFLUENCED BY GENDER

As women fall sick or divert time to care for sick family members, their ability to produce food and manage natural resources in a sustainable way is diminished. The gender division of labor in Zimbabwe and Malawi has changed; women have learned to grow tobacco and cotton and women are assuming control over large livestock (Kwaramba, 1997). Traditionally knowledge of management and production of livestock has been a male prerogative and male loss might have implications on the quality of management and production systems of livestock (Kwaramba, 1997).

Women's survival and that of their households and communities specifically depends on access to and control of natural resources. Where women are not entitled to land in the same way as men, documented research has proved that the living conditions of surviving widows and orphans deteriorate (Drimie, 2002). Land inheritance patterns have often disadvantaged widows in patrilineal systems (Seely and Pringle, 2001; Mutangadura and Muchopa, 1999). In Uganda, women cannot keep the land of their deceased husband and in Zimbabwe relatives often claim the land of the deceased husband. This will have implications of increased inequalities in the local community and can pose problems for long term sustainable development (Drimie: 2002).

2.5.7 WHEN IS COPING NOT COPING?

Sustainable livelihood is about sustainable utilization of natural capital (Chambers and Conway, 1992). Demand for timber products increases. More timber is demanded for making coffins and for firewood to provide warmth for the sick. A considerable increase in the consumption of timber for coffins in Kisumu Kenya has led to an increase in felling in a forest reserve in Kakomega, (Hammarskjöld, 2003). Selling off productive assets like livestock leads to a loss of productive animals for traction; and this reduces agricultural productivity (Gillespie and Kadiyala, 2003; Gillespie, 2005). The loss of livestock further reduces agricultural production through the loss of manure and traction.

2.5.8 SOCIAL & POLITICAL DYNAMICS OF COPING.

HIV/AIDS resources are not devoid of local power dynamics. Alliances have been formed at community levels with some households getting the bigger share of the HIV/AIDS cake. The reliance on social networks (*reciprocal arrangements for sharing resources through gifts, loans of cash, food and labor between relatives*) becomes more difficult as demand for resources and assets have been increasing with the progression of the condition. The loss of labor often strains the capacity of a household to mobilize social capital. Topouzis (1998) predicated that HIV/AIDS may "create a crisis of an unprecedented proportion particularly among the extended family and kinship systems, with implications not only for the spread of HIV but also for the viability of rural institutions and of traditional social safety mechanisms (widow inheritance and child fostering). Studies are confirming that the social safety system is overburdened with the demands for care giving, cash and labor needs. Community labor and credit groups are undermined by the number of affected persons. In Zimbabwe, 90% of households stated that network assistance has become more difficult to mobilize and, this is worsened by reports of lower incentives for coordinated group action.

HIV/AIDS has increased the vulnerability of households already strained by poverty. Although the infected and affected may escape complete demise in the face of a food

security shock through various coping strategies, they cannot escape the longer term downward trend of food insecurity (DeWaal and Tumushabe, 2003). Tango (2002) found that in Kenya affected households experienced a major loss of income and increased risk of infection. The loss of quality and quantity of labor for farmers has meant less cash and less livestock and hence less income. As HIV infected individuals' transition along the continuum to the AIDS stage, the demand for care and medical expenses increases in the household until it becomes difficult for the household members to cope with day to day income demands. The impact goes beyond the household to local institutions. Tango (2002) pointed out that HIV/AIDS may lead to the straining of local institutions to the point of collapse.

2.6 RESPONSE TO THE HIV/AIDS EPIDEMIC

Generally the Zimbabwean response to the HIV/AIDS '*has been slow, weak and selective'* (Zimbabwe Human Development Report, 2003). In the 1980s the response was fragmented and targeted certain risk groups like truck drivers and commercial sex workers. There was a denial among the policy makers and the general population (Zimbabwe Human Development Report, 2003).The multi -sectoral approach was operationalised in 1999 whilst the epidemic had already matured since the first HIV cases were identified in the mid 1980s.

Box 2.1 Zimbabwe HIV/AIDS framework key principles

Key Principles of National HIV/AIDS Strategic Framework for Zimbabwe

- HIV/AIDS should be addressed through a multi-sectoral approach which will be co-ordinated by the National AIDS Council. All sectors, organizations, and communities should participate actively in the fight against HIV/AIDS.
- The human rights and dignity of people living with HIV/AIDS should be promoted and protected. Discrimination and stigmatisation should be avoided, while at the same time the rights of society and the uninfected should be respected.
- Reducing HIV transmission should be central to combating the HIV/AIDS epidemic.
- Comprehensive cost effective and affordable care should be made available to people living with HIV/AIDS.
- All HIV, AIDS and STI programs should be gender sensitive and include gender related issues.
- The rights of children and young people with and affected by HIV/AIDS, must be protected and respected.
- Strengthening and Supporting the Local/Grassroots response to HIV/AIDS.

Source, HIV and AIDS Epidemic in Zimbabwe: 2004 and Zimbabwe National HIV/AIDS Policy (1999)

Since this strategy was put in place a number of programs on prevention, care and support have been designed and implemented. Legislation to support the rights of the infected and affected and mandating the collection of an AIDS levy was also operationalised.

Despite the strategy being in place and a number of programs running, the challenges brought about by HIV/AIDS are still endemic in Zimbabwe. This raises a lot of concerns on HIV/AIDS policy and programs relevancy. One would pose the same concerns raised by Topouzis (1998:4) whether 'national and district level rural development policies and plans manage to take into account the unique dynamics and impact of HIV/AIDS'. In

most instances policy makers understood the problems posed by HIV/AIDS but they did not want to take action that would offend their political constituencies. The policy frameworks guiding design and implementation of strategies are failing to match up to the needs and challenges on the ground.

On the other hand some HIV/AIDS researchers are arguing that most HIV/AIDS strategy plans are failing to curb the pandemic because they have failed to study and deal with other embedded cultural systems and institutional obstructions that fuel the epidemic (Strand, 2006). There is a need to consider issues of gender and sex power dynamics if an effective strategy is going to be implemented. 'Repositioning of women in society at a level equal to men is a political struggle that has become even more important in the context of HIV/AIDS' (Strand, 2006 quoting Siplon, 2006).

According to the authors of the Zimbabwe Human Development Report (2003), HIV/AIDS work is dominated by service provision, mode of work where Organizations concerned are 'delivering goods and services (food aid, school fees and HIV/AIDS materials) to communities without proper capacity building'. Such an approach undermines local capacities and does not utilize 'community stock of knowledge' (ZHDR, 2003). HIV/AIDS programs are generally separated from other community development programs (ZHDR, 2003). Apart from adjusting to developmental issues, the interventions should vary by circumstances. Some households are in such distress that they need practical help.

Strand (2006) is of the opinion that in Zimbabwe conflicts such as between NGOs and state are underpinning an otherwise strong and coherent response, hence a need for constructive government cooperation with independent civil society actors. Despite this opinion (Siplon, 2006 quoted by Strand, 2006) also acknowledges that increasing HIV/AIDS vulnerability is also due to the failure of responses to broaden interventions to

the whole populations and that this is the major reason for the failure to curb the HIV/AIDS pandemic.

2.9 CONCLUSION

HIV/AIDS impacts on the households are diverse and complex in nature. The various coping strategies adopted by households have implications on whether the household can survive or become vulnerable. Although a strategy has been developed there is a need for programs and projects to adapt and respond to circumstances on the ground. Chapter 3 introduces Nhamoinesu case study.

CHAPTER 3: CASE STUDY OF NHAMOINESU VILLAGE

3.1 INTRODUCTION.

This chapter gives a descriptive account of Nhamoinesu setting, livelihood activities of the general population, development and infrastructure, household food sources, income sources and land ownership and use. An HIV/AIDS epidemiological history of the village is given and the institutions which are implementing the Multi-sectoral strategy including the aims and objectives of their programs are mapped out.

3.2 LOCATION AND SITUATION OF STUDY AREA.

Nhamoinesu village is located in Zaka District, Masvingo Province in the South Eastern part of Zimbabwe (*Refer Figure 3.1).*

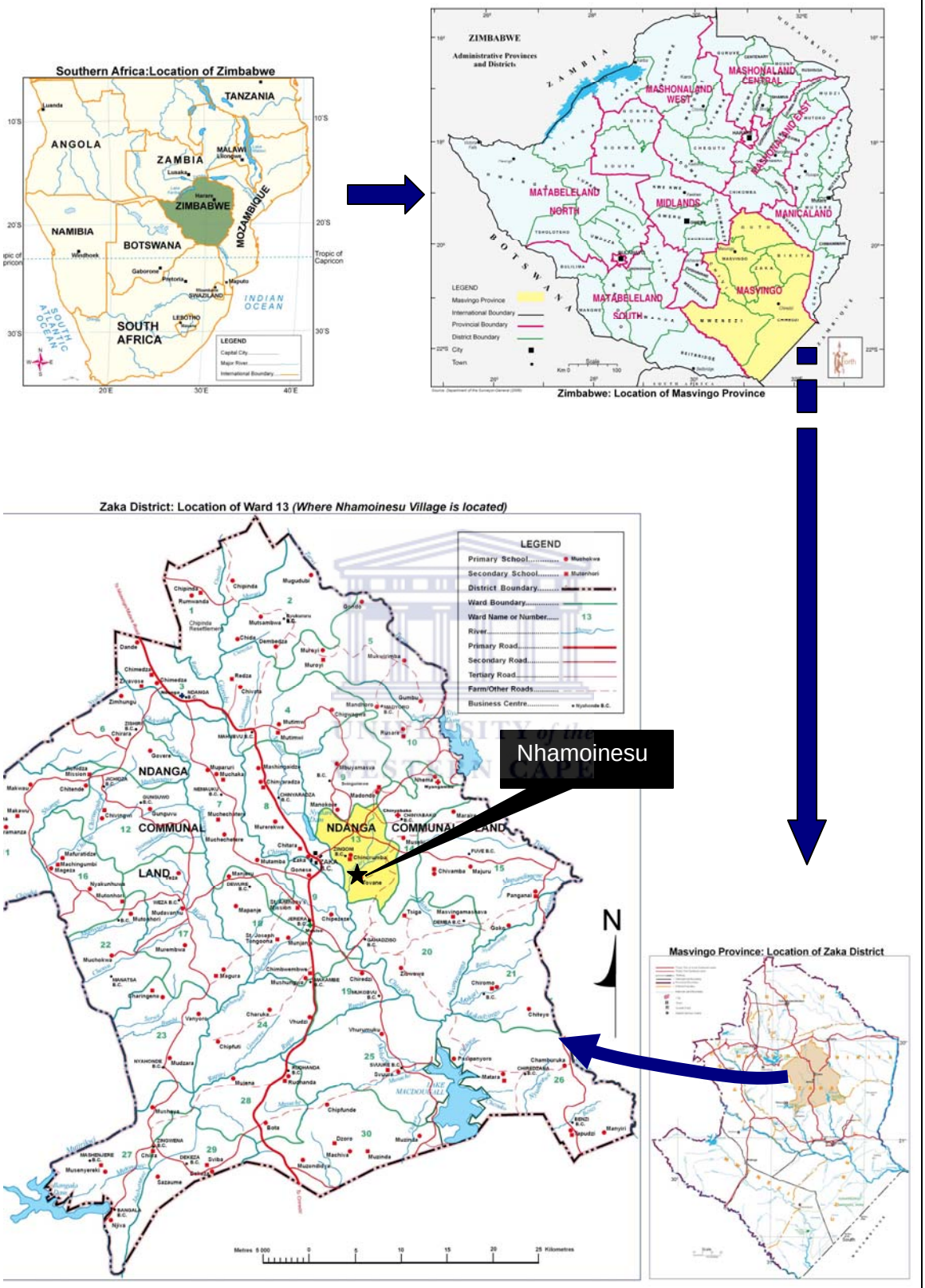


Figure 3.1 Situation of Nhamoinesu Village, Zaka District

3.3 SOCIO-ECONOMIC SETTING

The total population of the village is 206 people and there are 47 households in the village. The majority of household's heads (51.9%) are males with an average age of 40 years (Fieldwork).Of all the female households in Nhamoinesu village 61.5% are widows.14.8% of the breadwinners are currently chronically ill. 78% of male breadwinners in Nhamoinesu village are chronically ill.

The average household consists of 6 members with an average of five members contributing labor in the households. The dependency ratio for the interviewed households is generally low at 0, 2292 dependants /working family member. However households with chronically ill breadwinners were noted to have the highest dependency ratio of 0.5.

3.4 SOCIAL AND ECONOMIC DEVELOPMENT

3.4.1 EDUCATION

At least 91% of the children aged 5 to 18 are currently attending school. None of the households are receiving educational assistance from the state or NGO Organization. The school going children attend at a local school which is about 1 kilometer from the boundaries of the village. The schools has the primary (grade 1-7) and secondary (form 1 to form 6). At the schools HIV/AIDS awareness campaigns are conducted about once a month. HIV/AIDS peer education activities are conducted by teachers and pupils at the secondary school. The messages concentrate on passing information about prevention, care and support but condoms are not distributed at schools.

3.4.2 INFRASTRUCTURE

There are two homestead gardens in the village. These are individually owned. Apart from these two there is a community garden located at a dam about four kilometers from the village. The community gardens serves individuals from six other villages adjacent to Nhamoinesu.The participation in the community garden is voluntary although CARE International which has been providing inputs and engaging in repairs and maintenance of the dam with local support encourage HIV infected and AIDS affected households to be given preferential treatment in the allocation of plots. There is a rural health centre called Nyagambu and a satellite clinic called Chinyabako about seven and five kilometers from the village respectively providing primary health care including HIV/AIDS prevention, care and support materials to the village. The rural health centre and clinic services in the village include reproductive health, water and sanitation activities. Nyagambu rural health centre manages the hygiene and medicaments for Community Home Base Care Program run by an NGO called CARE International in partnership with Ministry of Health and Child Welfare. The rural health centre is the primary referral point for patients discharged from St Anthony's Musiso Mission Hospital and it also refers cases from the village to the St Anthony's Musiso Mission Hospital.The village is also close to Zingoni business center and Jerera growth point is about 10 kilometers from the community.

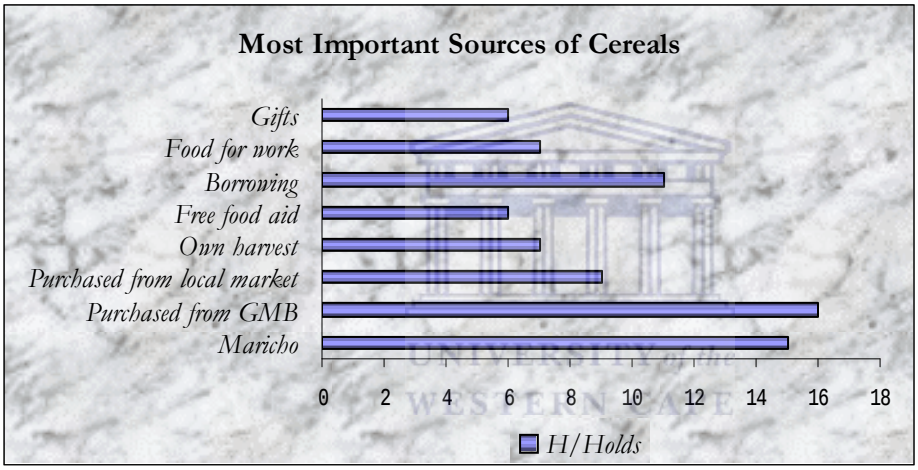
3.4.3 LAND USE

The majority of the households in Nhamoinesu has access to two acres of land and on average households utilizes 85.7% of the land to which they have access. A considerable number, 40.7% of the households from the interviews, failed to cultivate 100% of the land to which they had access and of those who failed to utilize the average it was also noted that the acreage uncultivated was similar to that of the previous years. The inadequacy of labor, seed, fertilizer and draft power (in order of significance) were noted to be significant factors in the failure to cultivate land.

3.4.4 HOUSEHOLD FOOD SOURCES

Of all the interviewed households in Nhamoinesu only 14.8% of the households currently had harvest from the 2005/2006 agricultural season in stock. These households represented 27% and the majority of those whose harvest was no longer in stock mentioned that their harvest lasted 4 months. The average cereal monthly consumption per household was 40.8 kg. The main sources of food (*Refer to figure3.3)* in the village were mentioned. (in order of importance) as coming from working for others *(Maricho),* purchasing from GMB, own harvest, free food aid, borrowing and food for work

Figure3.2Main sources of cereal



Source: Fieldwork

3.4.5 INCOME SOURCES AND LIVELIHOOD ACTIVITIES

Table 3.1(on the following page) below summarizes the major livelihood activities in Nhamoinesu village.18.5% of respondents receive cash from formal employment and of these 75% expected it to increase in the next 12 months while 25 % expected it to remain the same. Trading and self employment is the major source of livelihood in the village (51.9%) and this provided 58% of household livelihood income; 50% said they expected it to increase and 50% said they expected it to remain static.

Table 3.1 Income sources in Nhamoinesu

			Inc.Expected-12 Months		
Activity	**% Of h/holds who received cash from this**	**% Primary income source for those that engage in it**	**More**	**Same**	**Less**
Formal Employment	18.5%	100%	75%	25%	0%
Sales of livestock	7.4%	100%	50%	50%	0%
Trading & self employment	51.9%	58.%3	66.7%	8%	25%
Gold panning	3.7%	0%	100%	0%	0%
Remittances	37%	25%	0%	14.3%	85.%7
Gvt pub. Works	14.8%	33.3%	50%	50%	0%
Cereal & cash crop sales	14.8%	33.%3	66.7%	33.3%	0%
On-farm casual labor	22.2%	0%	40%	40%	20%
Off-farm casual labor	40.7%	63.6%	27.3%	45.5%	27.3%
Veg/Fruit sales	25.9%	14.3%	28.6%	42.9%	28.6%

Off farm casual labor and vegetable and fruit sales accounted for other considerable sources of household income 40, 7% and 25, 9% respectively. Based on the analysis of the multiple response section, the major sources of expenditure in the last four months were noted to be health/medical, food and school fees expenses.

3.5 LAND OWNERSHIP AND TENURE

The type of land ownership is communal based ownership. All communal lands are held in trust by the President. The village head (*Sabhuku*) is the administrator of land allocations at village level. The *Sabhuku* is the custodian of land and distributes it in the community. The chief is the highest level of traditional leadership in the community. This village lies under chief Nhema's chieftainship. In practice the village head is accountable to the Sadunhu, chief and state but he has semi autonomous rule on certain decisions such as allocation of land and settling of minor disputes and grievances. Even where there are issues with individuals for which the headman should be held accountable, community

members are hesitant to take further redress for fear of losing other privileges like extra land for grown up children or key strategic positions in village affairs in the future. The villagers have usufruct rights to the land. They cannot sell but they can rent land secretly. The *Sabhuku* allocates land to the individuals. Marriage and being a descendant of the community is the criterion of having access to land for a male. Females can inherit their husband's land or get land through their brother or father. Land can be allocated to females on condition that a male guardian would be responsible and answer to any issues and queries arising from the use and ownership of such land. Rituals like beer brewing as per request from the *Sabhuku* and other tokens of allegiance to the *Sabhuku* are supposed to be complied with, in order to retain the land. The land use rights can be transferred to the immediate deceased member's wife or male adult children. If a land owner fails to utilize the land, the *Sabhuku* has the authority to take away that land and give it to someone else. The owners have a right to develop and put in permanent infrastructures like wells. Apart from these traditional structures there are elected village level structures with the lowest unit being a Ward headed by a Councilor who is an elected member accountable for development activities in the community. Councilors work with the District head based at Zaka District office.

3.6 BACKGROUND OF HIV/AIDS IN NHAMOINESU

From the interviews with community members, the first case of HIV/AIDS was noted in the early 1990s. By then, *'the problem was mainly from the urban people and not for the community members and most people were thinking its witchcraft (kuposwa)'*. The early response to the epidemic was health centered and driven by the Ministry of Health and Child Welfare. During the 1980s till the late 1990s the HIV/AIDS approach and strategy was led by the medical practitioners with awareness campaigns addressing selective issues and practices like multiple partners and commercial sex. Non Governmental Organisations (NGOs) and Community Based Organisations (CBOs) interventions started after 1999 with the commissioning of National HIV/AIDS strategy. The community members claimed that they started to see programs teaching and providing care widely

after the mid1990s, when the formation of Ward AIDS Action Committees (WAAC), Village AIDS Action Committees (VAAC) and District AIDS Action Committee (DAAC) were introduced in the area. The churches were against the promotion of condom use saying it encouraged the sexual behavior.

3.7 INSTITUTIONS IN THE COMMUNITY

The institutions in the village range from traditional, government grassroots structures and other community based organizations which have cropped up as a result of community initiatives to try to cope and deal with the HIIV/AIDS pandemic.

Table 3.2 Institutions working in HIV/AIDS

Institution	HIV/AIDS Activities			Resources	Relationships and Partnerships	Participation in Network Activities: District Aids Committee (DAC) Meetings
	Prevention	**Livelihood support and Care**	**Advocacy**			
FAO		x		Technical support to AGRITEX and NGOs	CARE, AGRITEX	
DFID		x		Donor funding	CARE	
USAID(OFDA)	X	x	X	Donor funding	CARE	
UNICEF	X	x		Donor/Technical Support	CARE, MOHCW	
CARE International	X	x	X	NGO facilitation	USAID, FAO, SAFIRE, DAAC, UNCEF, PUMP AID	**x**
Southern African Alliance for Indigenous Forest Resources (SAFIRE)		x		Human Resources and Technical	CARE	
Pump AID		x		Infrastructure rehabilitation(technical)	CARE	
University of Zimbabwe /University of California Research (UZUCF)	X			Knowledge and information Life skills training	CARE (Collaborate)	
Population Services International	X			Counseling and Testing	Refer tested people to CARE and WAAC for Support	
Department of Social Welfare		x	X	Child Protection issues and support	Custodian of orphan issues	**x**
MOHCW	X	x	X	Treatment and support, Human Resources	Co-ordinates primary Health Care Activities	**x**
St Anthony's Musiso Mission Hospital	X	x	X	Treatment(ARV) and Support	District Mission Hospital pioneering ARV Treatment and initial pilot of 1000 patients	**x**
Rural District Council		x	X	Local governance issues	Co-ordinates all activities on the ground Including development activities	**x**
District AIDS Action Committee	X	x	X	Custodian of National AIDS Council(NAC) resources	Co-ordinates all activities and collection of data to feed to Province and National Statistics. Gives rations	**x**

Ward AIDS Action Committee	X	x	x	Human resources	Maintains the WAAC register and Refers it to	**X**
Village AIDS Action Committee	X	x	X	Human Resources	Feed into the WAAC	
Traditional leaders				Participants in the *Zunde ramambo* initiative.	Consulted and Attend WAAC meetings	
Traditional healer	X	x		Medicines	Community leaders and Community People.	
Auxillia Chimusoro	X	x	X	Support	CBO composed of tested individuals	
Zaka Antiretroviral Therapy Group	X	x	X	Support	CBO which is composed of patients Participating in the Pilot Antiretroviral Program run by St Anthony's Musiso Mission Hospital	

3.7.1 Donor Agencies

The major organizations in the community are the Department for International Foreign Development (DFID), United States Overseas Development Fund for Disaster Relief (OFDA) and United Nations Children's Fund (UNICEF). These are the main donors of HIV/AIDS related activities in Nhamoinesu. FAO is not directly funding activities but it provides agricultural technical support especially on gardens and HIV/AIDS related nutrition.

3.7.2 CARE International in Zimbabwe

CARE International has been working in the community since 1992. The Non Governmental organization responds to a number of relief and development initiatives including the following major ones:

- ***Drought Relief*** through distribution of emergency food aid to vulnerable children and adults; Households that have adopted orphans and the general population benefits from this program.
- ***Agriculture & Natural Resources Management*** The program provides access to water for irrigation purposes through repairing and maintaining existing small dams' infrastructure. The participation is voluntary though CARE International encourages the community to give preferential allocation to households with infected or affected members**.**
- ***Health*** In partnership with Ministry of Health and Child Welfare, CARE International facilitates the provision of Home Based Care through training community counselors and providing hygiene and medical articles in the community. Apart from providing counseling to the HIV infected and affected, the community counselors also serves as distributors of HIV/AIDS Information Education and Communication(IEC) materials and male and female condoms. The Program also has trained Youth Ambassadors who provide awareness campaigns in the community and at schools for the youth village members.
- ***Water and sanitation*** In partnership with an NGO called Pump AID, CARE International rehabilitate broken down boreholes and facilitates the construction of

pit latrines in the community. One well has been fitted with a rope and washer pump in the village

- ***Micro-finance services*** (savings and loans), CARE International trains voluntary community members to save through forming savings and lending groups. Community members are trained and encouraged to form savings and lending groups (5-7 people per group). These are trained on how to keep records, calculate interest and loan member contributions on a rotational basis. Membership to groups is usually based on commonwealth backgrounds so that everyone can afford the regular contributions. If a member fails to adhere to the group's agreed memorandum of understanding, their membership can be withdrawn or they can be penalized.

3.7.3 University of Zimbabwe-University of California (UZ-UCF)

University of Zimbabwe and University of California are collaborating in a project that undertakes research on behavior change in the community. The research Program is specifically targeting women and male and female youth with behavior change information and conducting evaluations on changes in behavior in the community. Apart from the above the project also trains youths in life skills like assertive behavior and making responsible and informed reproductive decisions. This Youth Peer education and behavior research program is also implemented through linking it with the CARE International Home Based Care, youth peer education Program in the school and village for out of school youths. The peer educators have access to male and female condoms for distribution but they are encouraged to insist on abstinence for the youths, unlike the adult counselors who give condoms as per need.

3.7.4 Population Services International (PSI)

The New Start Program for HIV testing and counseling started to run programs since 2003. The program was started and run by Population Services International to

encourage testing among sexually active adults and encourage positive living in the village. The New start works closely with other NGOs and CBOs offering prevention, care and support in the village. Occasionally village members are encouraged through awareness campaigns together with members from other adjacent villages to go to a central point where the mobile testing unit will be located. Individual members can undergo voluntary counseling and testing. The tested members who need extra psycho-social support are given a referral letter to the AIDS Action Committees so that they can get the relevant support that they would need be it home based care or counseling. Support is not automatic because of the need for a referral letter; the organizations would assess need on any individual basis and subject to the availability of resources. In such cases where they can not provide the referred services the individuals can be encouraged to find means and ways of finding the support on their own.

3.7.5 DAAC- District AIDS Committee/WAAC (Ward AIDS Action Committee DAAC- District AIDS Action Committee

The National HIV/AIDS framework saw the formation of the National AIDS Council. The National AIDS Council set in place structures from the National, Provincial, District, Ward and Village level to cater for HIV/AIDS related issues. All the levels have got a co-ordination responsibility for all the HIV/AIDS programs on the ground. Statistics on Chronic illness, Deaths and orphans are also collected through these nationally co-coordinated structures. NGOs and CBOs are supposed to update the National AIDS Council structures on their activities and programs on a regular basis. Statistics are collected and registers compiled at Village AIDS Action Committees and fed to the Ward AIDS Action Committees. From the Ward AIDS Action Committees the data is fed into the District AIDS Action Committees and from the District to the Provincial AIDS Action Committees and then to the National AIDS Council.

Apart from collecting data, the structures also procure Home Based Care provisions, provide school fees and at times provide training on prevention, care and support. The National AIDS Council and its affiliated provincial, district, ward and village level structures are also involved in food distribution, however the plans are made at National level such that when it comes to the district level the numbers who would benefit would be insignificant to the extent that when the researcher interviewed people

they know about the structures for collection of data and co-ordination but not those for providing food and support.

3.7. 6 Zaka Antiretroviral Therapy (ZAT)

ZAT is a CBO composed of HIV infected individuals who are benefiting from the scheme of Anti-Retro Viral Therapy being run by St Anthony's Musiso mission hospital with funding from donors from Switzerland. The beneficiaries formed a support group across the district whose main motto is-'*don't die, don't kill and have love'*. If you lack love you are going to kill more people. Members of ZAT claimed that they could no longer pursue their livelihood as petty traders and cross border traders due to their treatment demands which needed constant medical supervision. They needed income generating activities they could do within their communities.

3.8 CONCLUSION

Nhamoinesu has a number of organizations and programs targeting the HIV infected and AIDS affected, apart from those providing profiles of key institutions working in the village. The chapter has also described the livelihood activities in the village and has explored its general food sources and how the multi sectoral strategy has been implemented. The next Chapter 4 presents the researchers' field work findings.

CHAPTER 4: ANALYSIS OF RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter describes and analyses vulnerability context and the coping and livelihood strategies of HIV/AIDS infected and affected as well as the institutional arrangements for addressing the pandemic. The chapter starts with case summaries of infected and affected lives before giving an analysis of livelihood generation activities of the infected and affected in Nhamoinesu. The chapter gives an analysis of the life conditions and coping strategies of the HIV/AIDS affected. An analysis of institutions and interventions targeting the infected and affected is provided to map out the effectiveness of interventions in addressing the problems of those people in Nhamoinesu who are infected or affected.

4.2 VULNERABILITY CONTEXT

Due to the diverse nature and complexity of providing a generic definition of HIV/AIDS infected and affected households, this chapter presents brief life histories and comments from in-depth interviews obtained during research. The infected and affected in the village are not limited to the few cases described here. The voices present the gender, age and cultural manifestations of the pandemic, and reveal issues of networks and orphan care.

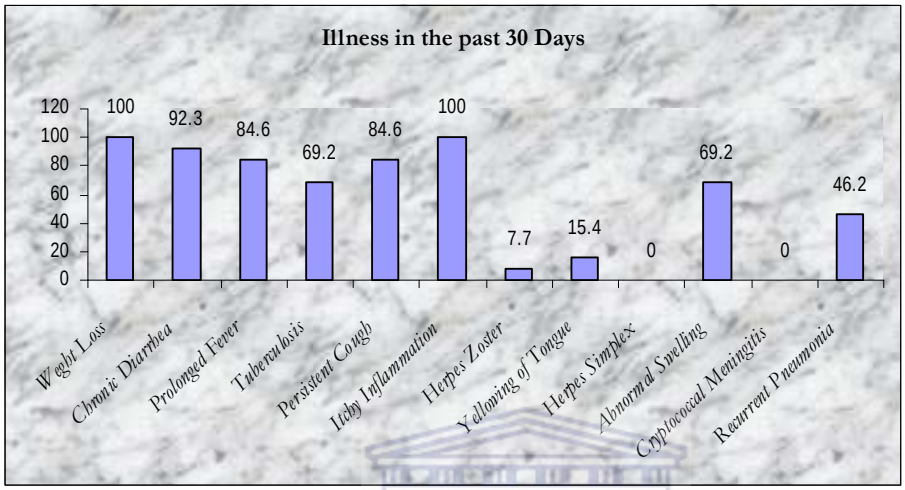
4.2.1 ANALYSIS OF MORBIDITY AND MORTALITY

During the previous three months18, 5% of the households had a member who was chronically ill. In the previous 12 months 7. % households had experienced death of a member due to chronic illness and 40.7% of the households had adopted orphans. Some households had a chronically ill member as well as having adopted orphans during the time of the research.

Figure 4.1 provides a proportion of chronically ill individuals who reported specific symptoms or illnesses in the previous 30 days. Symptoms were classified under the WHO (2005) HIV/AIDS surveillance criteria. WHO (2005) defines an AIDS case for surveillance purposes as an individual who has at least two of the symptoms in the

previous 30 days. The individuals who reported the symptoms were bedridden by the time of the research. Of the total number of individuals who had chronic illness 100% are symptomatic for AIDS.

Figure4.1Illnesses in the past 30 days



Source: Fieldwork

The uptake level of HIV testing was considerably higher in this village. Of the 18.5% household members who reported chronic illness, 61.5% had undergone a test for HIV and tested positive. Infection rates for children accounted for 38.5% of the HIV infected. The researcher found that most of the women were infected at a younger age and during their peak reproductive period and as a result were passing on the infection through Parent to Child Transmission. Even where women suspected that they had HIV, they reported that the pressure to have a child of their own was too high and as a result they took the risk.

The trend in data showed that females were becoming infected at an early age. The peak for chronic illness was 21- 40 years whilst for men infection starts to peak at later ages of 40-50 years. This confirms what UNAIDS (2006) has been claiming that the face of HIV/AIDS is becoming a female and a young female problem. Gender aspects were also shown in Nhamoinesu village, women were powerless on sex related issues and they were the providers of most care giving and this increased their susceptibility to HIV infection (Box4.1).

In-depth interviews with Lily and Zinsi revealed that despite perceiving the possible risk of contacting the virus and having the knowledge about the epidemic, they could not protect themselves due to the fact that they relied financially on their husbands. Others like Sissy (Box1) contracted the infection through poor infection control during care giving. Adult men still remained the main transmission vectors of the epidemic in the community and some of them transmit the virus knowingly as can be seen in the example of Dansi and Zinsi (Box 1 below).

Box 4.1 Profiles of the infected gender and social aspects

Sissy (HIV infected female - Age 21)

I grew up with a skin condition since birth but I did not have HIV. I was failing in school so I decided to quit after form two. Our neighbor's daughter came to collect me to work for her as a maid. When she and her husband fell ill I was caring for both of them without gloves and since I had open wounds I contracted HIV. I have never slept with any man all my life and now I am HIV positive.

Zinsi (*HIV infected female: Aged 21)*

"When my aunt became chronically ill in 2000 my Uncle accused his mother of bewitching my aunt and chased the old woman away. In 2002 my Aunt died due to AIDS and she left seven children who needed to be looked after. My father and the other relatives said I should marry my Uncle to protect the family wealth my aunt had worked for and the children. I had a kid who has since died and my husband is currently bedridden".

Dansi *(HIV infected Male: Age 42.)* *I was married to my first wife for 10 years and we have four children. When I became infected and I fell ill my wife ran away from me and she went back to her family of origin. She took all the kids away and left me with my elderly mother. My mother who was looking after me passed away and since my health had stabilized by then I married another wife, I do not have children with this women because I have been tested and I am HIV positive but I need someone to be there for me when I am ill".*

Lily *(HIV infected Female: Age 39)*

"I am married and have 3 children with my husband. When we got married about 13 years ago we were both staying in Bulawayo City and then I relocated to be based here in the rural area to farm and look after the homestead. After four years my husband started seeing other women back in the city and he fell ill with Herpes. At first he was saying he had been bewitched and later on he went for a test and he tested positive. I was also tested recently and I tested positive. I am staying with my husband and three children. I and my husband are always bedridden due to the HIV condition".

Infection rates for children are also increasingly higher; 30.8% of those currently chronically ill also reported that they have a child who is currently chronically ill and 7.7% of those currently chronically ill reported that they had lost a child due to chronic illness.

4.2.2 ORPHANHOOD

The interviewed households catered for a total of 65 children aged 18 and under. Among these children 68% were an orphan that is they had lost either one or both parents. A number of households reported that they had adopted orphans whose parents were not originally resident in Nhamoinesu. The majority of orphans had parents who were resident in urban areas for example Sarah and the orphan that was left at a home where his father was getting treatment. They were brought into Nhamoinesu by their adoptive household's heads after the deaths of their biological parents (Box4.2 below).

Sara Affected Orphan-Age 16

"My father was a policeman and we grew up in the city. My parents died during the same year. We were left at our rural homestead and my eldest brother who was 17 was encouraged by our relatives and church members to marry a 22 year old woman who had her child so that we could find a mother to look after us. The marriage did not last two years and the brother left for the city leaving us the younger siblings behind. When my brother failed to come back, my other sister also left home when she turned 17. It was difficult for me to find food and provide myself so I also deserted the homestead and came here to stay with my aunt.

Box 4.2(Interview with orphan)

Although households with a chronically ill member had orphans, it is mostly households without chronic illness who tended to adopt orphans.

The majority of household looking after orphans were headed by the elderly (75%) compared to 52.6% for the non-elderly headed households. For the majority of the

elderly headed households adopting an orphan was not a choice but the natural thing since the orphans were their grandchildren. In areas with high deaths of women and men in productive years like Nhamoinesu village it is the elderly who inevitably are left with the responsibility of caring and supporting the children. UNAIDS (2005) and UNICEF (2004) had identified and reported on similar trends in their studies of other areas in Southern Africa (Box 4.3 below).

Box 4.3 Orphan issues interviews

Prax (HIV and Aids Affected: Age 55)

"I had two children from my previous marriage. I do not have children with my current husband. My eldest daughter fell ill immediately after giving birth to twins. People said it was AIDS. The other twin died and I am looking after the surviving other who is now 10. He is on and off. Last year my second child who is my last remaining child came back from the city where she was working ill. I am now looking after two sick people. When I am old and sick who is going to look after me?"

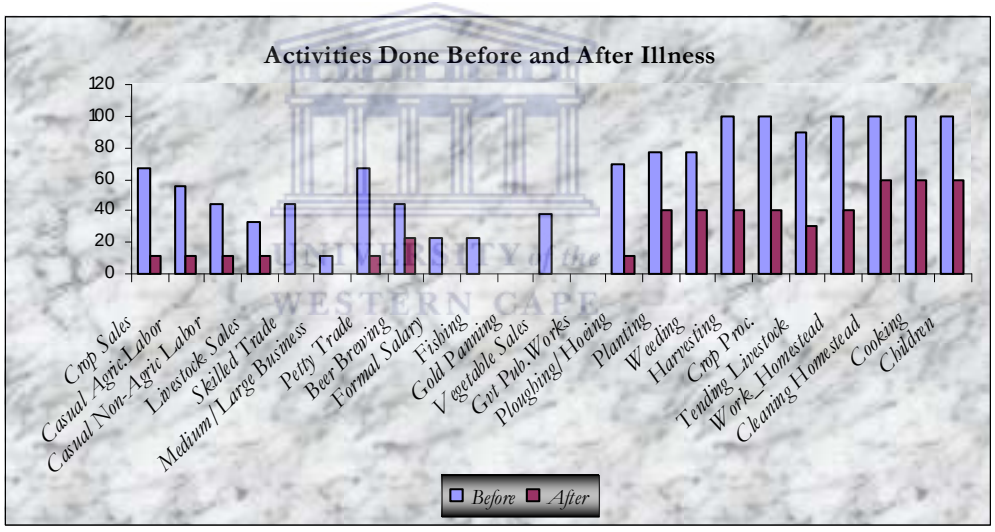
Chipo (Traditional Healer: Age 55)

"I am currently facing the effects of HIV/AIDS. I was treating a man and he died here. Because the family could not afford to bury him in his home they buried him in this village with the consent of the traditional leader. Now this man left his daughter whose mother had died earlier and the relatives do not want to take responsibility for her. Now I am stuck with her here."

4.2.3 ANALYSIS OF HOUSEHOLD LABOR AND AGRICULTURAL ACTIVITIES

The most significant losses in labor occurred in households with a chronically ill member and households that had lost a member due to chronic illness during the past 12 months. Figure 4.2 below gives a summary of activities that chronically ill individuals had previously done which they were no longer able to do. The percentage of chronically ill individuals who reported loss of ability to take part in activities they used to do before is quite high (figure 4.2). Whilst above 60% of the chronically ill individuals were involved in crop sales, the percentage has fallen to less than 20 %(figure 4.2).

Figure 4.2Activities done before and after illness for chronically ill



Source: Fieldwork

The highest percentage of loss of productive skill ability occurred in activities like ploughing, planting, and weeding, harvesting and crop production. The activities most affected which chronically ill people were no longer able to contribute labor to are crucial for livelihoods in rural areas. A similar trend had been reported by Rugalema (1999), Muchunguzi (1999), Gillespie (2003) and Kwaramba (1997). Comparisons between capacities to utilize land showed that households with chronic illness and which had experienced the recent death of a breadwinner had low capacity to utilize all the land they had compared to unaffected households in the village. The amount of land left fallow during the previous farming season was higher and estimates for the coming

agricultural season were higher for affected households compared to other households. Timeliness of crop production has been affected and all these aspects contribute to the decline in production with serious consequences in the long run on food security (Gillespie, 2003; SADC-FANR, 2003).

4.2.4 ANALYSIS OF FOOD SECURITY

Households with a member who was currently chronically ill and households that had lost a member due to chronic illness in the past twelve months had zero stocks harvested from the previous year's harvest (table 4.1). Despite the agricultural season for 2005-6 being a poor season in *table 4.1*, 18.2% households without chronic illness reported that they had stocks from the 2005/06 agricultural season compared to zero percent for households that had a chronic illness during the period of the research. 16% of households that had not lost a member due to chronic illness reported that they had stock from the 2006/07 agricultural season compared to zero per cent for households that had lost a member due to chronic illness.

Table 4.1 Household Food Sources and Stocks

	H/Holds with CI Member	**H/Holds without CI Member**	**H/Holds that have lost a family member due to C.I**	**H/Holds that have not lost a family member due to C.I**
Stock	0	18.2	0	16
Average Duration of Last Harvest (months)	2.6	2.7	1.5	2.8
Average Monthly Cereal Consumption (kg)	52kg	42	55	43.2
Primary Source of Cereal	HBC	Purchased-GMB	GMB/HBC	Maricho/GMB
Av. Cereal from On-Farm Labor (kg)	9.8	24	0	13.5
Av. Cereal from Off-Farm Labor (kg)	18	22.1	0	23.1
Av. Cereal from Gifts/Remittances (kg)	16	28.6	0	28.4
Av. Cereal from other Sources (kg)	54	14.5	0	23.6
Av. Cereal Purchased from GMB (kg)	80.9	140	73	325
Av. Cereal Purchased from Loc. Market (kg)	4	60.5	46	100
Av. Expected Cereals Purchased-GMB (kg)	40	49.1	41.2	125
Av. Expected Cereals Purchased-Mkt (kg)	40	50.5	46.4	75

Source: Fieldwork

Households with members who had a chronic illness had low capacity to purchase food on their own, despite higher percentage levels of cereal consumption recorded in *Table 4.1* above. They were beneficiaries of a feeding program under Community Home Based Care. The same pattern emerged for households that had recently lost a member due to chronic illness *(table4.1 above).* However, compared to households with chronic illness they had fewer social safety nets for food sources and weak capacity to venture into productive activities. The interviews revealed that relatives and organizations that offered support to affected households assumed that once the chronically ill person had died, the household could provide for itself. A higher

percentage of households that had adopted orphans had more gift remittances compared to other households (*table 4.1).*

4.2.5 ANALYSIS OF HOUSEHOLD INCOME

Rural livelihoods in Nhamoinesu like any other rural area are predominantly agricultural based livelihoods. Agriculture related productive activities contribute a major share to the household economy. In figure 4.2 (activities done by chronically ill before and after illness) income streams to households affected by HIV/AIDS had fallen drastically. In households where the chronically ill person was the breadwinner the illness meant loss of household income. Income streams for affected households fell drastically in the village. While data showed that households with chronic illness or that had experienced a death during the last 12 months needed more income to recover, capacity for income generation was very low compared to other households. Medical care was the major household expense and that trend has been reported to be the main cause of increasing vulnerability for HIV/AIDS affected (Kwaramba: 1997, Topouzis: 1998).

4.2.6 STIGMA AND DISCRIMINATION AND DISPOSSESSION OF ASSETS

Reported cases of direct stigma against the infected and affected are low. The level of sharing utensils with the HIV infected is quite high. There are incidents of vulnerable children losing their key assets such as livestock and land. The in-depth interviews revealed that in instances where care of orphans has been taken over by relatives, they also control and takeover homesteads. For instance Dansi an HIV positive man had his land taken away from him and given to another household.

Box 4.4 Interview with Victim of Asset dispossession

> *"Traditional leaders took away my fields when I did not use it because I was sick. but now I am better and I have a wife who is still strong but the traditional leader is using the excuse that my condition can worsen leading me to abandon the land to go and join my children, and they also accuse me of not cooperating with them."(Dansi, responding to an interview)*

The community showed support for what was done by the traditional leader. One person commented *"Airadza munda masabhuku akati tipe vanogona kuushandisa"* (direct English translation, "he failed to utilize the land and the headman said give us so that we can give to those who are able to utilize the land"). Incidences like this one show that where institutions governing resource allocation are insensitive to the HIV infected and AIDS affected, the livelihoods of affected and affected are detrimentally affected. Drimie (2002) had raised this problem about the need to map out the land/HIV/AIDS institutional issues.

4.3 EMERGING COPING STRATEGIES

4.3.1 ANALYSIS OF STRATEGIES FOR ALLEVIATING LABOR

Households which are experiencing labor shortages due to death and chronic illness have a higher incidence of younger children and the elderly contributing to labor. Some households adopt orphans to assist them in the household activities. The proportion of elderly women engaged in off-farm casual labor (brick moulding) was considerable. Some households get help from community volunteers working with CARE International in the village. Some affected families have reduced their participation in production activities in the community irrigated gardens due to the fact that they cannot cope with caring for the sick as well as other livelihood labor and demands on their time.

4.3.2 ANALYSIS OF STRATEGIES FOR IMPROVING FOOD SECURITY

Strategies for improving food security in the village are largely driven by external actors in the village. CARE International is promoting low maintenance crops like sweet potatoes and cassava and targeting the infected individuals and households. Some households are engaging in market gardening at the irrigated dam. The 2006/07 agricultural season has not been a successful one for Zimbabwe. Cereal Consumption levels are higher for affected households but these are generally households benefiting from relief food donated by CARE International, under its Community Home Based Care (CHBC) food supplement program in the area. CARE International is providing a supplementary food basket consisting of cooking oil, corn Soya blend, dried sugar beans and maize cereal for the household. The calculation of the household ration is based on the average consumption needs of the household. Households with a chronically ill member during the time when the research was carried out were benefiting from that program.

4.3.3 ANALYSIS OF STRATEGIES AIMED AT SUPPLIMENTING INCOME

Compared to male-headed households, fewer female-headed households rely on formal employment (16.7%), compared to males (21.4%). Only male-headed (14.3%) households are engaged in sales of livestock. The community highlighted the fact that the rate of asset disposal was higher in HIV/AIDS affected households as indicated in the following comments:-

"I used to have 4 head of cattle and 8 goats but I have sold those since I became sick and failed to provide for myself. Now I only sell chickens and some firewood for survival and growing some vegetables at the homestead."(Dansi, HIV Infected male)

"Golden is now a problem. He used to have a lot of cattle but now the rate at which he is selling them at the local butchery and at ridiculous prices is pathetic. Now he is only left with 10 cattle and we are worried because if he finishes selling all of them it means we have to take from our pockets to support him."(Comments from a relative during in-depth interviews)

For those individuals and households without assets, engaging in income-generating activities is not an easy option, as can be seen from the following comment from a woman,

"I used to brew traditional beer for selling, but since I became ill with Tuberculosis (TB), people do not buy my beer and vegetables. The Environmental Health Worker says it is illegal for me to sell food when I have TB so I sub-contract another person to brew on my behalf and sell. But there is no profit as I have to subtract costs for labor."(Mrs. Wedge, an infected woman).

4.3.4 DOES GENDER MATTER?

Among the affected, more women (58.3%) are engaging in trading and self employment compared to affected males (50%). Further analysis from in-depth studies revealed that more women resort to trading and self employment because they have a low asset base to convert into ready cash in times of stress. Traditional gender roles are changing with males becoming engaged in care and support also although numbers are still low (Figure4.2:54) and women still bear the greater burden of providing for the sick and orphans despite the fact that they have fewer resources to cope with HIVAIDS related demands.

4.3.5 SOCIAL CAPITAL

In Nhamoinesu village there was a general trend amongst households experiencing difficulties to rely on other community members, relatives and external agencies for different forms of support that are necessary for survival. Table 4.2 below shows the different levels of social support available to different households at different times. According to Table 4.2 below, 100% of households with chronic illness reported receiving agricultural support and cereal. This is through the Community Home Based Care program run by CARE International. More households with chronic illness (100%) also reported getting support from the clinic for medicines and other hygienic preparations to use for managing illnesses at home.

Table 4.2 Household Social Support and Coping Strategies

Type of Support the household relied on from other households and institutions.	All H/Holds	Female Headed	Female Widow Headed	Male Headed	H/Hold with CI Member
Agricultural Inputs	77.8	84.6	87.5	71.4	100
Cereal	59.3	69.2	75	50	100
Clinic/Hospital	55.6	61.5	75	50	80
Clothing	22.2	15.4	12.5	28.6	40
Draught	70.4	76.9	87.5	64.3	60
Funeral	81.5	61.5	87.5	85.7	60
Groceries	55.6	53.8	62.5	50	60
Labor	48.1	30.8	62.5	42.9	20
Loan	29.6	30.8	37.5	28.6	60
School Fees	37	38.5	50	35.7	40
Hoes	37	38.5	37.5	35.7	60
Plough	37	92.3	25	42.9	40

Source: Fieldwork

Funeral assistance is high across the community, 81% of the households reported being assisted with funeral expenses by the village. A higher proportion of female- headed households (62.5%) received labor support from the community. Households with chronic illness during the time the research was carried out received the least labor assistance (20%). Community members said other households were reluctant to share labor s with households with chronic illness ' *because the likelihood of them returning the same labor services to you is low since they already have problems of shortage of labor'*. Compared to other households a lower percentage of households with chronic illness (60%) reported receiving support for draught power. Households affected by HIV/AIDS failed to maximize their production, because evidence from this study

shows that despite 100% of households with chronic illness receiving agricultural input support, they got less labor support(20%) and help with ploughs 40% compared to other households. This has implications on the quality and quantity of their agricultural output.

4.4 ANALYSIS OF EFFECTIVENESS OF INTERVENTIONS

4.4.1 HIV/AIDS PROJECTS IN THE COMMUNITY

Despite a large presence of institutions doing HIV/AIDS work in Nhamoinesu village (Table3.2, page 42),only projects listed in Table 4.3 below were found to be operational during the time of carrying out the research. Whereas Table 3.2(p.42) indicates that 20 Organizations are involved in various interventions in the village, in reality, only 14 (Table 4.3 page 63) are active. Some of the organizations mapped out in Table 3.2 page- 42 could not point out any activities they were doing in the village.

The remaining 6 NGOs proved to be riding on top of efforts by the 14 active NGOs. Structures like the Rural District Council, Ward AIDS Action Committees, Village AIDS Action Committee and Ministry of Health and Child Welfare (MOHCW) and Traditional leaders are part of the coordinating teams of activities on the ground, so they form part of the key stakeholders in the community. The support groups like Auxillia Chimusoro and ZAT exist and are also beneficiaries in projects but they had no meaningful influence or activities on the ground to support their claims.

Auxillia Chimusoro claimed that they had a legitimate reason to be there because they were the first support and activist group of HIV infected individuals formed by the late Auxillia Chimusoro the first HIV positive activist to share publicly her HIV status. The Auxillia Chimusoro members asserted that they had a mandate to champion HIV/AIDS since they advocated for greater involvement of HIV infected persons in programs but believed their organization was being sidelined since some of its top members had misused National AIDS Council Funds. As they did not have financial resources to run programs on the ground, they joined other groups and institutions.

ZAT individuals claimed that they were powerless and a newly emerging group. They were responding to community concerns that providing anti retroviral therapy would mean that people with HIV would live longer and spread the infection to negative village members. The representative of ZAT in Nhamoinesu said despite not having resources they wanted to teach the community members about the importance and benefits of anti-retroviral therapy and to show the villagers that they were responsible individuals who cared about the wellbeing of other community members.

Table 4.3 Projects in Nhamoinesu

Project	Project Objectives	Source of Funding	Project Facilitation
Community Home Base Care/ Youth Peer Education	To provide care and support to Chronically ill clients and establish Youth Peer Education Centers in community	DFID/World Food Program	CARE in partnership with DAAC,WAAC,VAAC, CBOs and Community, MOHCW
Agric-inputs and improved farming methods	Provision of agric inputs and improved farming methods at community level (micro dose, conservation agriculture)	DFID	CARE
Promotion of Herbal gardens	Provision of Herbal and Medicinal medicines to affected and infected	DFID	SAFIRE in partnership with CARE
Community Savings and Lending	To build savings and loan schemes for rural communities specially targeting the infected and affected.	DFID and SIDA	CARE
Orphans and Vulnerable Children	Support for school fees and life skills for orphans	UNICEF	CARE

	and vulnerable children		
Vulnerable Group Feeding	Feeding support for vulnerable groups in Zaka	WFP	CARE
Bore hole rehabilitation	Borehole rehabilitation for supply of water pumps	USAID/OFDA	CARE
Elephant Pump Project	Construction of rope and washer pumps to provide clean and safe water for drinking.	DFID	CARE in partnership with Pump AID
Small Dam Rehabilitation and Irrigation	Rehabilitation of Dams and establishing irrigation	CARE	
Voluntary Counseling and Testing(PSI)	Mobile Voluntary Counseling and Testing	Global Fund For HIV/AIDS, DFID	PSI
Musiso Antiretroviral Support	Supply of Antiretroviral medicines and support services	Private Doctors based in Switzerland	Hospital provides medicine CARE provides food and support.
Regai Dzive Shiri	Youth Peer Education and Behavior Change Research	University of California	University of California and University of Zimbabwe
Zunde ramambo Initiative	Establishing reserves to feed the vulnerable	Community initiative	Community
Promotion of Herbal gardens	Provision of Herbal and Medicinal medicines to affected and infected	DFID	SAFIRE in partnership with CARE

4.4.1.1 Targeting

Whilst targeting is generally considered by Nhamoinesu people to be ineffective, most of the activities designed for HIV/AIDS infected and affected are effective in reaching the intended beneficiaries. The fact that vulnerability to HIV/AIDS remains rife is not an indication that targeting by NGOs has been ineffective. Vulnerability has multiple

causes, and interventions to reduce vulnerability are multi-faceted. Targeting is one aspect of intervention. Others are designing the project to suit the needs; another level is obtaining the effective involvement of the infected and affected.

4.4.1.2 Design and Appropriateness of Programs

Community Home Based Care (CHBC) provides hygiene articles and food supplements for households with a chronically ill member. Children and Adults who are not affected but cannot afford to provide adequate food are also benefiting from a vulnerable group food supplement initiative. While Community Home Based Care is perceived to be effective and recommended highly in the community, others complained that they want strong medicines and broad spectrum antibiotics like *cotrimoxazole.* The chronically ill who are benefiting from Community Home Based Care claimed that *Paracetamol* for pain control is ineffective in managing chronic pain. However the program has managed to help in improving knowledge and providing psycho-social support for the HIV infected and AIDS affected.

Beneficiaries of agricultural inputs who are HIV infected and AIDS affected claimed the input package is inadequate and in most cases has been delivered late. HIV/AIDS affected households complained the amount they are supporting the household with is inadequate and is usually delivered too late so that affected households who rely on this as their source of inputs were behind in cultivating their crop.

The Agricultural Research and Extension officers are supposed to give support to affected households as per the design of the program; however, one community member commented that,
"*AREX wants to work with Master Farmers who can produce, they have no time for the people who are sick who cannot travel to their demonstration plots"*.

Interventions which are meant to benefit the HIV/AIDS include the production of sweet potato varieties and improved farming methods like conservation farming are benefiting the households which have not been affected by HIV/AIDS. Even if the HIV/AIDS infected and affected households obtained agricultural inputs, most of them had sold assets like cattle which provide draught power and the average time of waiting

to get draught power was generally longer for the infected and affected compared to that of other households. As a result some of them end up bartering the inputs in exchange for draught power.

The same trend could be seen on projects like the Community Savings and Lending and Small Dams run by CARE International. In-depth interviews revealed that people are hesitant to include an infected member in their savings group because their rate of defaulting is quite high. A local carpenter participating in the savings commented,
"Those projects help people like us, who can save because we are engaged in meaningful production. If you are not productive what do you save, you only save two cents?"(Interview with community member)

In Small Dams, one beneficiary commented that *"Even if I want to participate, the garden is opened at 8 am and closed at 10 am for watering purposes to prevent stealing. At that time if you are sick it is too cold to go outside and we are told if you are positive you should avoid exposure to cold, at the end you cannot manage. You just stop going there"*.

Whilst overall the provision of water at community level is adequate and knowledge about the disease has improved, the programs are falling short in addressing the real causes and drivers of HIV/AIDS vulnerability. The community members despite praising projects that encourage the growing and utilization of herbal remedies revealed a tendency to rely on traditional herbs that they were getting from a local traditional healer.

A Community member during interviews added on,
"At least here we know you die but you would have wrestled with the virus because we have our traditional herbs that can cool the HIV virus".

Most of the chronically ill said they were getting herbs from the traditional healer because they trusted the herbs. The high uptake of Voluntary Counseling and Testing can be attributed to the traditional healers' in the community. (See box 4.5 below)

Box 4.5 Interview with traditional Healer

> *"I treat a wide variety of ailments, from headaches, diarrhea, backache, and a variety of other HIV/AIDS related opportunistic infections. My herbs are very strong so you cannot take them unless you have been tested and have been positive. Otherwise they can damage you. There are six currently chronically ill people who are treated here from the village. Demand for my herbs is high and herbs are now difficult to get, now I have to travel for more than 5 kilometers to get medication"*

4.4.2 IS THE MULTISECTORIAL STRATEGY EFFECTIVE?

During the institutional mapping it appeared to the researcher that whilst organizations and HIV/AIDS interventions are part of a coordinated multi sectoral strategy, in depth analysis revealed that it was often 'a marriage of convenience'. In order to gain approval organizations just mentioned partnerships. Partnerships between CARE, Pump AID and SAFIRE were based on mutual accountability. The other partnerships especially with CBOs are only partnerships on paper with people seeking funding but they were not operational. Real community concerns and the needs of the affected and infected were rarely in the fore front. It would be assumed that this only happened with external institutions but at community level, conflicts to control resources meant for the affected and infected were common between the traditional leaders and groups like Village AIDS Action Committees and Ward AIDS Action Committees. The latter ones fell under the Rural District Council and were more aligned to ruling structures and tended to override the concerns of the people on the ground. HIV/AIDS work in the village was dominated by service provision mode of work, where organizations concerned were delivering goods and services (food aid, and HIV/AIDS awareness materials (ZHDR, 2003). The main approach to addressing HIV/AIDS issues on the ground was from a health perspective.

4.5 CONCLUSION

This chapter has given a brief case summary of the HIV -infected and AIDS-affected. It went on define vulnerability context of affected households and individuals, emerging coping strategies in the community members and how house holds are coping with the condition. The term ‘coping’ was a misnomer since households were not coping but were struggling. The institutions mapped out in Chapter Three operate but evidence from this chapter reveals an increasing vulnerability of the infected and affected. Chapter 5 gives a summary of the key conclusions from the data and what gaps may exist for the HIV/AIDS players on the ground.

CHAPTER5: HOUSEHOLD AND INSTITUTIONAL STRATEGIES TO DEAL WITH HIV/AIDS IN NHAMOINESU: DISCUSSION AND CONCLUSION

5.1 INTRODUCTION

This chapter presents a discussion and conclusion on livelihoods and HIV/AIDS in Nhamoinesu village. The chapter discusses major findings on coping strategies adopted by households living with HIV/AIDS in their communities. The final part of the chapter gives recommendations for further research and policy formulations to influence programs that build on capabilities and strengths of affected individuals and households.

5.2 MAIN ARGUMENTS FROM THIS STUDY

The basic premise of interventionist strategies is that social networks provide an important safety net for households affected by crises, such as drought and HIV/AIDS. Social networks are seen as therefore providing households within rural communities with sufficient resilience so that drought-stricken or HIV/AIDS affected households could be assumed to be capable of 'coping' with crises. This study finds that the assumption that HIV/AIDS affected households can cope in this situation is misconceived, and use of the term 'coping' to describe such households is actually a 'misnomer'.

In the majority of cases, households are not coping but are 'struggling' to survive and in some instances, are dissolving completely. This research therefore proves that HIV/AIDS is a 'shock unlike any other shock'. It is different from shocks such as drought and other natural disasters. Individuals and households who live with HIV/AIDS experience subtle shifts and changes whose impact is of such magnitude that it eventually erodes the livelihoods of the HIV/AIDS affected.

The need for interventions that recognize this characteristic of the HIV/AIDS pandemic is critical.

Despite the fact that many organizations purport to champion the interests of HIV/AIDS affected households and individuals, the livelihoods of these people are increasingly deteriorating, with some households dissolving and becoming non-existent. Granted that the plight of HIV/AIDS households is influenced by a multiplicity of factors, the worsening of the crisis points to a possible misalignment between the needs and interests of HIV/AIDS affected households and the interventions adopted. This study shows, for example, that while some projects, such as CARE's CHBC program [see Table 4.1,P.56], have succeeded in enhancing food security of HIV/AIDS affected households, for others, such as the Community gardens; those garden regulations agreed upon by project participants in order to maintain and manage them make it impossible for affected households to participate in those schemes. On the other hand government departments under the Rural District Council (RDC), for example agricultural extension officers who are supposed to follow up on implementation of agricultural programs for inputs distribution with extension services, have not been sensitive to needs and interests of targeted beneficiaries. There is a need therefore to review interventions to deal with HIV /AIDS in the village. There is also a need to improve the coordination of interventions, particularly at the local levels.

Research findings indicate that interventions should be fine-tuned to take into account gender and age characteristics of the target population. The current epidemiological practice of lumping people into risk groups according to age is shortsighted. Many interventions focus on the most economically active segment of the population aged between 15-49 years because of an underlying assumption that this age group is most likely to be affected by HIV and AIDS. The reality, however, is that older and younger people also feel the impact of HIV/AIDS in their lives, (Seely and Pringle, 2001; Gillespie and Kadiyala, 2004; Drimie, 2004). Interventions should therefore broaden their focus to include the elderly and the very young as well. The study also shows that the HIV/AIDS pandemic adds to the problems rural women face as a result of gender division of labor and insecure human and land rights. Women are bearing the burden of caring for the sick and orphans. Evidence from the study showed that some women are forced into marriages in order to protect the welfare of men as in the case of Zinsi and Dansi thus perpetuating the vulnerability of women.

The case of Nhamoinesu village shows that illness of productive members in the household leads to a double loss. Productive individuals work less while the demand for care-giving increases. Thus, reduced productivity leads to reduced contributions to household assets such as income and well-being and, simultaneously, the increased demands for care erode the reduced household assets. Ultimately, the decline in household assets is accelerated to levels at which household resilience hangs in the balance. The survival of an HIV/AIDS affected household unit is usually more critically threatened than that of a household affected by other shocks (Baylies, 2001; Rugalema, 1999). The hardship inflicted by HIV and AIDS, through the loss of family members, the costs of care and the loss of workers, highlights the need for support for different livelihood strategies at times of crisis and beyond.

An in-depth understanding of the manner in which HIV/AIDS affected households respond to the pandemic is required. This study finds that knowledge of crisis management within affected households and extended families is limited. Some of the decisions made by household members affected by HIV/AIDS are sub-optimal and have major costs in the medium and long term. Responses such as the sale of household assets reflect a focus on short-term survival to the detriment of long-term resilience. Other strategies, like marrying young girls on the pretext of finding someone to care for an ailing man whose wife has either died or deserted, are a short-term survival strategy with long-term impacts on the household and persons involved particularly on the new woman or wife in the household.

Some of the coping strategies of older age groups are actually dysfunctional. For example, an increasing number of elderly women are engaging in activities which are not age-appropriate, such as Prax who engage in physically taxing work like brick moulding when culturally such elderly women should be expected to be doing lighter duties.

Other coping strategies, like deserting or breaking up a household, are more likely to be irreversible than strategies to ensure the adoption of orphans as a measure to counteract other shocks to livelihoods. Most orphans have been absorbed into households as a result of strategies to avert disaster within households that would have failed to cope and later on dissolved completely. While individuals in most affected households

manage to survive, the households themselves break up and their members, be they orphans, widows and/or the elderly, join other households.

The effectiveness of interventions is related to the degree to which HIV/AIDS program design and project instruments address needs and interests of the target population. However, the extent to which individuals within households influence and respond to interventions is also critical. The challenge is therefore for both interventionists and the target population to work together to improve the effectiveness of household, community and institutional strategies to deal with the HIV/AIDS pandemic. Community leadership is an important factor in the success or failure of such an approach. However, community leadership has not always acted in the best interests of members of the Nhamoinesu community. For that reason, conscious effort is needed to ensure that local leadership structures are accountable to all their constituencies, and do not stigmatize or undermine the security of HIV/AIDS affected households. There is also a need to ensure that interventions are sustainable in terms of funding, human resources capacity, linkages with existing institutions and interventions, ownership by local people and institutions and governance principles such as legitimacy, accountability, transparency and equity.

But the question that one poses is how they can be sustainable in the context that most of them rely on foreign funding. It is particularly important that projects by different institutions are coordinated in order to avoid duplication and competition.

5.3 CONCLUSION AND RECOMMENDATION

The study set out to explore how households affected by HIV/AIDS are coping and whether the interventions put in place are effective in dealing with HIV/AIDS vulnerability. Despite the fact that a number of organizations and programs have been implemented in the community, the interventions have challenges in effectively improving and building resilience. The current programs are externally driven and are facing challenges in understanding the complex livelihood dynamics of the affected people in the village. Interventionists come to address the weaknesses but fail to

address effectively the underlying causes of HIV susceptibility and vulnerability. Livelihood projects for the HIV/AIDS affected need to tap into the strength and resilience in existing coping strategies.

To effectively mitigate against HIV/AIDS impacts there is a need for a contextual analysis of livelihood vulnerability. While organizations may be providing food handouts, medicines and awareness campaigns, these are far from addressing the real causes of HIV/AIDS vulnerability and hence households are failing to graduate from being relief dependent to being independent households that can adequately produce and survive on their own. .

The programs like Community Home Based Care create a need to constantly go to the clinic for medical check ups and to collect medicines. Households that possess a scotch cart and draught power benefiting by hiring these services out to sick people who need to get to the clinic. All stakeholders, including policy makers and donors, need to pilot and inquire into investing in cheaper and efficient means of transport. A modified scotch cart can alleviate problems and losses which are related to the extra financial burden of transporting community members to the hospital.

Where this research has documented losses in labor in the communities affected by HIV/AIDS, individual members are not affected uniformly. There are other people who are benefiting from the HIV/AIDS pandemic in agricultural programs and savings and lending programs. There is a need to find practical ways of addressing the gender dynamics of the AIDS pandemic and advocacy and interventions are required in this area. Inequalities in gender roles need to be examined and ways explored to give a voice to women

Policy makers need to revise the way of thinking in which households are lumped into age groups and distinct descriptions. As result of HIV/AIDS households are complex and one would need to take a closer look at them in order to get a clearer understanding of the impact of the disease at household level, and how adequate the coping strategies are.

Stigma against the disease is no longer apparent. At face value communities say they do not stigmatize people based on HIV/AIDS status but a closer look at reality shows that such stigma still exists but is hidden and has drastic consequences to the victims. Land is being taken from them on the pretext of putting it to efficient use, but what happens to those orphans and dependants when they grow older and they find they do not have the means to a key productive asset when they need it? Key institutions governing resources at community level, although they know and can sing the song of the impact of HIV/AIDS well, have failed to adapt and meet the needs of people they need to serve.

To conclude, HIV/ AIDS has placed an enormous burden on the community as a result of which some households are struggling, others dissolving and yet others are managing to cope. If meaningful interventions are to be designed and implemented to assist affected households to cope, there is a need of further in-depth studies to map out what capabilities and strengths of affected households can be used. It is important to enable these households to graduate from being dependant on external handouts to being able to engage in meaningful livelihood activities for coping with the consequences of the scourge that has fallen on them.

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Appendices

Appendix I Household Livelihood Questionnaire

Household _Code ___ ___ ___ ___ ___

Date of Interview_____/_____/ 2006

Day / Month / Year

Name of respondent (breadwinner/spouse/household head) _____

A. Information on the Primary Breadwinner						
Q1	**Q2**	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**
What is their Gender Male (1) Female(0)	**What is their Age** (Years)	**Marital Status** 1=Married 2=Divorced/Sep 3=Widowed 4=Single(never married)	**Have you ever had a spouse die of chronic illness?** Yes(1) No(0) NA(99)	**<u>If yes toQ 10</u>** **How many years ago did your spouse die?** (years ago)	**Is the breadwinner Currently Chronically Ill** *(ill for at least 3 months)* Yes(1) No(0)	**Breadwinner's Primary Income Earning activity** (*see <u>codes</u> below*)
☐☐		☐	☐☐☐		☐☐	☐

CODES FOR BREADWINNER'S PRIMARY ACTIVITY

0=None(only farming) 1 = Crop sales 2 = Casual agric. labor 3 = Casual non-agric. labor 4 = Livestock sales
5 = Skilled trade/artisan 6 = Medium/large Business 7 = Petty trade (firewood, grass) 8 = Beer Brewing

9 = Formal salary/pension 10 = Fishing 11 = Gold Pan 12 = Vegetable sales 13=Gov't Public Works

B. Household Composition							
READ EACH QUESTION AND **FILL IN COLUMNS A-E**		**A** **Total**	**B** **Under 5**	**C** **5 to 18**	**D** **18 - 60**	**E** **Over 60**	
Q7	What is the **TOTAL** number of people **living** in your household? (*eat from same kitchen*)	#	#	#	#	#	
Q8	How many contribute **labor** to farming or other income activities	#	#	#	#	#	
Q9	How many are **Chronically ill** *(severely ill for 3 months)* *REMEMBER TO FILL OUT SECTION 'N' FOR EACH !*	#	#	#	#	#	

Q10	Has someone died of chronic illness (*severely ill for 3 months*) in the past 12 months? ☐ ☐ **Yes(1) No(0)**	
Q11	**If someone died**, was this person the breadwinner? ☐ ☐ ☐ **Yes(1) No(0) NA(99)**	
Q12	☐ ☐ Is there anyone who is a member of this household, but lives and works elsewhere? **Yes(1) No(0)**	
Q13	Is there anyone in your household who has returned from living/working in ☐ ☐ An urban area during the past 18 months? **Yes(1) No(0)**	
Q14	**If yes**, what is this person's plan for the near future (next 6 months)? ☐ 1=live at home unemployed / not farming 2=live at home and work / farm 3=establish a new homestead elsewhere 4=return to an urban area 99=NA	
Q15	Of those children aged 5 to 18 years, how many are currently attending school? **#** |_____|	
Q16 A-C	If children aged 5 to 18 years are **NOT** attending school, what is the main reason? (*see codes below*) **A. Child 1** ☐ **B. Child 2** ☐ **C. Child 3** ☐ **Codes: 1=Can't afford 2 = Working 3 = Refused 4 = Finish O level 5 = Pregnant 6=Other**	
Q17	Have you received assistance in the past year to help pay for education? ☐ ☐ **Yes(1) No(0)**	
Q18 A-D	What type of organization provides education assistance? (*check **ALL** that apply*) **A=NGO** ☐ **B=Religious Org.** ☐ **C=Government** ☐ **D=Other Specify**_____	
Q19	*(orphans are children who have lost one or both parents)* How many children under age 18, have lost **ONE** parent? **#** |_____|	
Q20	*(orphans are children who have lost one or both parents)* How many children under age 18, have lost **BOTH** parents? **#** |_____|	
Q21	Have you **sent orphaned** children under 18 to live with relatives in another household? ☐ ☐ **Yes(1) No(0)**	
Q22	Have any **orphaned** children under 18 **come to live with you** from another household? ☐ ☐ **Yes(1) No(0)**	

C. Household Food Sources and Stocks		
Q23	Does the household have cereal (*grain&ground*) from **last year's harvest** in stock **now?** **Yes(1) No(0)**	☐ ☐
Q24	**IF NO**, how many months did **last year's** harvest last? (*if no harvest last year, '0'*) **#** |_____| **Months**	
Q25	Estimated amount of cereal the entire household consumes in a month? **#** |_____|kg	
26 A-C	During the past **4 months** (*lean period*), what were the most important sources of cereal? (*see codes)* **A. Primary (1st Most)** |_____| **B. Secondary (2nd Most)** |_____| **C. Tertiary (3rd Most)** |_____| 1=From own harvest 2=Maricho 3=Borrowed 4=Gifts 5=Free food aid 6=HBC 7=School feeding 8=Food For Work 9=Purchased at GMB 10=Purchased at local market **99=NA**	

What other source of cereal did you earn during the past 12 months? (maricho inc.)		**Amount kg**
Q27	**On-Farm casual labor** *(working for food as payment)*	**#** **kg**
Q28	**Off-Farm casual labor** *(working for food as payment)*	**#** **kg**
Q29	**Remittances and Gifts sent to the Household**	**#** **kg**
Q30	**Other Sources** (*include borrowing*)	**#** **kg**
Q31	How much cereal did you purchase during the last **12 months** from the **GMB**? # |_____| **kgs**	
Q32	How much cereal did you purchase **at local markets** during past **12 months**? # |_____| **kgs**	
Q33	**If cereals had been available at GMB and no food aid was delivered**, How much cereal would you have been able to buy per month *on average*? # |_____| **kgs**	
Q34	**If cereals had been available at the local market and no food aid OR GMB were delivered**, how much cereal would you have been able to buy at local prices per month *on average*? # |_____| kgs	

D. Income and Expenditure (**** working for food (maricho) goes into Q77-78 above*)				
Did the HH participate in following activities in past 12 months? (*READ EACH ONE*)		**A** **HH received cash from this source** **Yes(1) No(0)**	**B** **Rank income sources based on est. amount (*1=most…*)**	**C** **What is the income expected for next 12 months** MORE(1) SAME(2) LESS(3) NA(99)
Q35	**Formal Employment**	☐ ☐	☐	☐ ☐ ☐ ☐
Q36	**Sales of livestock –** *split cattle, goats/poultry*	☐ ☐	☐	☐ ☐ ☐ ☐
Q37	**Trading & self-employment**	☐ ☐	☐	☐ ☐ ☐ ☐
Q38	**Gold panning**	☐ ☐	☐	☐ ☐ ☐ ☐
Q40	**Receives Remittances**	☐ ☐	☐	☐ ☐ ☐ ☐
Q41	**Government Pub. Works**	☐ ☐	☐	☐ ☐ ☐ ☐
Q842	**Cereal & Cash Crop Sales**	☐ ☐	☐	☐ ☐ ☐ ☐

Q43	**On-farm Casual Labor**	☐☐	☐	☐☐☐☐	
Q44	**Off-farm Casual Labor**	☐☐	☐	☐☐☐☐	
Q45	**Vegetable/Fruit sales**	☐☐	☐	☐☐☐☐	
Q46	**Remittances**	☐☐	☐	☐☐☐☐	
Q47 A-C	What were the three greatest sources of spending during the past **4 months**? (*Codes below*) **A. Primary (1st Most) |_____| B. Secondary (2nd Most) |_____| C. Tertiary (3rd Most) |_____|** 1 = Health and medical supplies for the ill (clinical and traditional) 2 = Food (cereal and groceries) 3 = School fees 4 = Funerals 5 = Travel 6 = Agricultural inputs **99=NA**				

E. Social Support and Coping Strategies			
Which types of support did you rely on from other households or institutions?		**Received in the past year** Yes(1) No(0)	
Q47	**Agricultural Inputs (seed or fertilizer)**	☐☐	
Q48	**Cereal**	☐☐	
Q49	**Clinic / Hospital expenses**	☐☐	
Q50	**Clothing**	☐☐	
Q51	**Draught cattle or donkeys**	☐☐	
Q52	**Funeral support**	☐☐	
Q53	**Groceries (***not mealie meal***)**	☐☐	
Q54	**Labor for farming**	☐☐	
Q55	**Loan of Cash**	☐☐	
Q56	**School fees**	☐☐	
Q57	**Hoes and Other Small Farm Tools**		
Q58	**Plough**	☐☐	

F. Chronic Illness Profiles *Fill out Section N for **Each** chronically ill member. These questions refer to the sick individual.				
Q59 Gender Male (1) Female(0)	**Q60 Age in Years**	**Q62 Relation to HH Head** (see codes)	**Q63 Marital Status** (see codes)	**Q64 # Years ago Fell Seriously Ill** *(if less than 1year, put 1)*
☐☐		☐	☐	**# Years ago**

CODES FOR RELATIONSHIP TO HOUSEHOLD HEAD
1 = household head 2=Spouse 3=Son/Daughter 4=Grandchild 5=Brother/Sister 5=Aunt/Uncle 7=Parent 8=Grandparent 9=other
CODES FOR MARITAL STATUS: 1=Married 2=Divorced/Separated 3=Widowed 4=Single (never married)

Q65	Has this person had an HIV test?	☐☐ **Yes(1) No(0)**

Q66	**If they are willing to disclose**, what is their HIV status? **Positive (1) Negative(0) NA(99)**	☐ ☐ ☐
Q67	Have you **ever** lost a spouse to a chronic illness? **Yes(1) No(0) NA(99)**	☐ ☐ ☐
Q68	(if less than 1 year, write '1') **If you have had a spouse die of a chronic illness**, how many years ago? # |_____| **years ago**	
Q69	Does this person have any children? **Yes(1) No(0)**	☐ ☐
Q70	**If they have children**, are any chronically ill? **Yes(1) No(0) NA(99)**	☐ ☐ ☐
Q71	**If they have children**, have any died of a chronic illness? **Yes(1) No(0) NA(99)**	☐ ☐ ☐
Q72	Is the person currently bedridden? **Yes(1) No(0)**	☐ ☐
Q73	In the past **30 days**, how many days have they been bedridden? **# |_____| days**	

Which of the following symptoms / Illness have they had in the past 30 days (*READ EACH ONE*)		**A** **Have This?**	**B** **Treated at Clinic OR hospital**	**C** **Traditional OR Religious**	**D** **Not treated**
Q74	**Weight Loss**	☐	☐	☐	☐
Q75	**Chronic Diarrhea** (*entire month*)	☐	☐	☐	☐
Q76	**Prolonged fever** (*entire month*)	☐	☐	☐	☐
Q77	**Tuberculosis**	☐	☐	☐	☐
Q78	**Persistent cough** (*not TB*)	☐	☐	☐	☐
Q79	**Itchy inflammation of the skin**	☐	☐	☐	☐
Q80	**Herpes Zoster (***Bandi***)**	☐	☐	☐	☐
Q81	**Yellowing of tongue**	☐	☐	☐	☐
Q82	**Herpes Simplex**	☐	☐	☐	☐
Q83	**Abnormal swelling** *(legs, neck)*	☐	☐	☐	☐
Q84	**Cryptococcal Meningitis**	☐	☐	☐	☐
Q85	**Recurrent Pneumonia**	☐	☐	☐	☐

Which activities did you do before and after becoming ill? *(READ EACH ONE)*		**A** **Did before Chronically Ill**	**B** **Does this NOW**
Q86	**Crop sales**	☐	☐
Q87	**Casual agric. Labor**	☐	☐

Q88	**Casual non-agric. Labor**	☐	☐	
Q89	**Sales of livestock –** *split cattle, goats/poultry*	☐	☐	
Q90	**Skilled trade/artisan**	☐	☐	
Q91	**Medium/large Business**	☐	☐	
Q92	**Petty Trade** (e.g. *small sales*)	☐	☐	
Q93	**Beer Brewing**	☐	☐	
Q94	**Formal salary or pension**	☐	☐	
Q95	**Fishing**	☐	☐	
Q96	**Gold Panning**	☐	☐	
Q97	**Vegetable sales**	☐	☐	
Q98	**Government Public Works**	☐	☐	
Q99	**Ploughing / hoeing**	☐	☐	
Q100	**Planting**	☐	☐	
Q102	**Weeding**	☐	☐	
Q103	**Harvesting**	☐	☐	
Q104	**Crop Processing** (e.g. *husking*)	☐	☐	
Q105	**Tending livestock**	☐	☐	
Q106	**Work around homestead** (e.*g. repairing kraals, fences*)	☐	☐	
Q107	**Cleaning homestead**	☐	☐	
Q108	**Cooking for household**	☐	☐	
Q109	**Caring for children**	☐	☐	
Q110	☐ What is the gender of his/her primary caregiver? **Male (1) Female (0)**		☐	
Q111	What is the age of the primary caregiver? |_____| **years**			

Appendix 2: Oral Informed Consent Form.

Livelihoods and HIV/AIDS: A study of Nhamoinesu village in Zaka District, Masvingo, Zimbabwe.

This interview is for a research that is done by **Loveness Makonese, an MPhil** student registered with the University of Western Cape, South Africa.

The research interview will gather information on the vulnerability context of HIV /AIDS infected and affected and how households are coping with HIV/AIDS. The research is also going to ask information on the institutions working in HIV/AIDS in the village and what they are doing for the infected and affected. I am going to talk to individuals and households.

The names of the people who agree to be interviewed will not be recorded without their permission and after data analysis on presenting the research findings the names are going to be changed.

Your participation is voluntary and there is no penalty for refusing to take part (If you do not take part, it will not affect any support you would normally receive). You may refuse to answer any question in the interview or stop the interview at any time.

Signature……

Date…….

Every aspect of the research outlined above has been fully explained to the respondent in Shona language (local language spoken in Nhamoinesu) and my contact numbers given for further questions and issues that may arise.

Adapted from FHI (2006)