

**COPING WITH HIV AND AIDS IN MARGINAL
COMMUNITIES: A CASE STUDY OF CHIVANHU
SETTLEMENT IN NEMANWA, MASVINGO,
ZIMBABWE**

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ABSTRACT

This thesis seeks to understand and analyse HIV and AIDS and rural livelihoods in Zimbabwe with particular reference to an isolated and marginalised informal settlement called Chivanhu in Masvingo Province. The focus is specifically on questions around HIV susceptibility, AIDS vulnerability and household resilience. In this regard, it is important to recognise that HIV and AIDS cannot be lumped together as one medical or social condition. Rather, there is a progression from HIV infection to AIDS-related chronic illnesses to possible death, and livelihood strategies often alter along this HIV and AIDS time-line.

Zimbabwe for over a decade now has gone through a series of economic and political crises which have impacted detrimentally on both urban and rural livelihoods, even for those households which are not directly affected by the HIV and AIDS pandemic. With the economy in free-fall, households have had to pursue a range of livelihood strategies in order to sustain themselves. These socio-economic conditions have in many ways facilitated susceptibility to HIV infection and vulnerability to AIDS. Many studies have examined this in relation to well-entrenched and stable communities in rural Zimbabwe. But the livelihood dynamics for such communities are significantly different to more unstable and informal settlements like Chivanhu, as thesis seeks to show. At the same time, the thesis offers a longitudinal study which is able to map the changes to the livelihoods of infected and affected households in Chivanhu. Though recognising the debilitating effects of the pandemic on these households, it also raises questions about the possible resilience of certain households despite great adversity. In doing so, it goes beyond the individual and household levels of analysis to consider the role of clusters (or groups of households) in responding to the impacts of HIV and AIDS. In this regard, particular emphasis is placed on gender and orphanhood.

In the end, the thesis offers a nuanced analysis of the everyday complexities and challenges for affected households in a marginalised and informal rural community in Zimbabwe and thereby makes a contribution to re-theorising HIV and AIDS and rural livelihoods more broadly.

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ACRONYMS

ABC	Abstinence, Be faithful to one uninfected partner or use Condoms
AGRITEX	Agricultural Technical Extension
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARDA	Agriculture and Rural Development Authority
ART	Anti - Retroviral Therapy
ARVs	Anti - Retroviral Drugs
ASOs	AIDS Service Organisations
AUSAID	Australian AID
BEAM	Basic Education Assistance Module
CBOs	Community Based Organisations
CHBC	Community Home Based Care
CI	Chronic Illness
CRS	Catholic Relief Services
CSWs	Commercial Sex Workers
DAC	District AIDS Coordinator
DAAC	District AIDS Action Committee
DFID/UKAID	Department for International Development/AID from the British People
ESAP	Economic Structural Adjustment Programme
FAO	United Nations Food and Agricultural Organization
FHI	Family Health International
GDP	Gross Domestic Product
GoZ	Government of Zimbabwe
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HBC	Home Based Care
HIV	Human Immune Virus
IDUs	Injecting Drug Users
IMF	International Monetary Fund
MDC - T	Movement for Democratic Change – Tsvangirai
MIPA	Meaningful Involvement of People living with HIV and AIDS
MOHCW	Ministry of Health and Child Welfare
MSM	Men having Sex with other men
MTP1	Medium Term Plan 1
MTP2	Medium Term Plan 2
NAC	National AIDS Council
NACP	National AIDS Control Program
NANGO	National Association of Non Governmental Organisations
NAP - OVC	National Plan of Action for Orphaned and Vulnerable Children
NATF	National AIDS Trust Fund
NGO	Non Governmental Organisation
NGOs	Non Governmental Organisations

OI	Opportunistic Infections
OVC	Orphaned and Vulnerable Children
PAC	Provincial AIDS Coordinator
PAAC	Provincial AIDS Action Committee
PDC	Provincial Development Committee
PLWHA	People Living with AIDS
PLWHIV	People living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
RDC	Rural District Council
SADC	Southern Africa Development Community
SADC - FANR	Southern Africa Development Community Food Agriculture and Natural Resources
STI	Sexually Transmitted Infection/s
STP	Short Term Plan
TANGO	Technical Assistance to Non Governmental Organizations
UC	Urban Councils
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	Joint United Nations Programme on HIV and AIDS
UNWOMEN	United Nations Organization for Women
USAID	United States Agency for International Development
USD	United States Dollars
VAAC	Village AIDS Action Committee
VIDCO	Village Development Committee
VCT	Voluntary Counselling and Testing
WAAC	Ward AIDS Action Committee
WADCO	Ward Development Committee
WFP	World Food Programme
WHO	World Health Organization
ZACH	Zimbabwe Association of Church Affiliated Hospitals
ZAN	Zimbabwe AIDS Network
ZIMSTAT	Zimbabwe National Statistics Agency
ZNASP1	Zimbabwe National Strategic Plan for HIV and AIDS 1
ZNASP2	Zimbabwe National Strategic Plan for HIV and AIDS 2
ZNNP+	Zimbabwe National Network for People Living With HIV
ZWD	Zimbabwean Dollars

CHAPTER 1: INTRODUCTION

1.1 Introduction

The HIV and AIDS epidemic is declining and stabilising but its impacts are far from being addressed. The thesis focuses on the problem of HIV and AIDS in a marginalised community in Zimbabwe. The chapter introduces the research site (Chivanhu) as well as introducing both the theoretical framework and the research methodology (and research objectives) used for guiding the study of Chivanhu. It also highlights gaps in the available literature on HIV and AIDS and livelihoods with particular reference to marginalised rural communities and, on this basis, it seeks to show the analytical significance of the thesis for furthering and deepening our understanding of HIV and AIDS and rural livelihoods. Finally the chapter gives an outline of the whole thesis.

1.2 HIV and AIDS pandemic globally and locally

HIV and AIDS is a global epidemic which is showing signs of decline and stabilisation in some of the most affected countries, but it is stabilising at higher levels (normally above a ten percent prevalence rate). Almost every country has experienced the challenges of HIV and AIDS; what differs is the depth and scope of the problem. An estimated 33 million people are currently living with HIV. Around 2.7 million adults were newly infected in 2008 and two million adult and children deaths through AIDS-related illnesses occurred in 2008. Sub-Saharan Africa, particularly southern Africa, remains the epicentre of the epidemic. HIV and AIDS is stabilising in some countries in the region (for example Malawi, Namibia, Rwanda and Zimbabwe) but the region still bears the greatest burden of HIV and AIDS in the world – with 35 percent of new HIV infections and 38 percent of AIDS deaths in 2007.

Treatment efforts in Africa are accelerating with over 2.1 million people currently on Anti Retroviral Therapy (ART). However, this is still far from the World Health Organization's universal goal of achieving 80 percent ART coverage. Sixteen countries in Africa have achieved 25 percent coverage in relation to the prevention of mother-to-child transmission and at the moment four countries have achieved more than 50 percent

ART coverage (with Botswana and Namibia exceeding 75 percent). New infections though outpace access to ART services; according to UNAIDS (2009), for every person put on therapy, two to three people are newly infected. Prevention efforts are paying off in most countries, but the problems posed by HIV and AIDS are far from over. Table 1 gives a summary of the prevalence levels of HIV in the southern Africa region.

Table 1: HIV prevalence by country in Southern Africa

Country	Prevalence (%)	Adults living with HIV	Women living with HIV
Angola	3.7	320 000	170 000
Botswana	24.1	270 000	140 000
DRC	3.2	1.0 million	520 000
Lesotho	23.2	270 000	150 000
Malawi	14.1	940 000	500 000
Mozambique	16.1	1.8 million	960 000
Namibia	19.6	230 000	130 000
South Africa	18.8	5.5 million	3.1 million
Swaziland	33.4	220 000	120 000
Tanzania	6.5	1.4 million	710 000
Zambia	17	1.1m	570 000
Zimbabwe	13.6	1.7 million	890 000

Source: NAC, 2012

Table 1 show that more than nine countries have HIV prevalence rates which are above ten percent. However some countries are above a twenty percent prevalence rate. The table also shows that the HIV and AIDS problem is a female ‘problem’, or females are at

least more susceptible to HIV infections. Women constitute more than fifty percent of the HIV-infected in all the countries, showing that social and economic inequalities (based at least on patriarchy) also fuel the spread of HIV. The Zimbabwean HIV epidemic is covered in Chapter Four.

1.3 Research significance: marginal communities and HIV and AIDS

HIV and AIDS affected households and individuals do not exist in a social vacuum. Researchers need to know more about the underlying factors in households' livelihood systems which interact with HIV and AIDS. According to Gurung and Kollmair (2005:10), marginality is a concept used to describe and analyse socio-cultural, political and economic spheres, where certain segments of a population struggle to gain access (societal and spatial) to resources and full participation in social life. Apart from struggling so, marginalised people are often condemned for making their living in such seemingly deplorable environments. This study focuses on a settlement characterised by grinding poverty, inadequate access to physical and social infrastructures, gender inequalities, social exclusion and human rights violations. Recent political and economic events in Zimbabwe of a crisis quality (as discussed in chapter four), including socio-economic processes and Zimbabwean state policies, have resulted in social and spatial marginalisation of certain households and individuals; and hence the significance of this study (Bryceson, 2006).

The events in Zimbabwe, notably since the 1990s, have resulted in the emergence of individuals and households marked by high levels of insecurity, risk, inequality and low levels of social cohesion, such as in Chivanhu settlement. The Economic Structural Adjustment Programme (as implemented in Zimbabwe in the early 1990s), as well as the economic turmoil subsequent to the fast track land reform programme from 2000, have led to new forms of social and spatial marginalisation by pushing vulnerable households in both urban and rural spaces into areas where they are dwelling at the margin of rural and urban societies (Bryceson, 2006; Gillespie, 2005). Research focusing on livelihoods and HIV and AIDS are abundant, but most existing studies have “overwhelmingly focused on subsistence smallholder production systems with very little literature on other

types of rural livelihoods (other than smallholder agriculture)” such as Chivanhu settlement (Harvey, 2003:27, Bryceson, 2006).

There have been numerous HIV and AIDS studies in Zimbabwe and elsewhere in southern Africa on established rural communities, but there are few studies on informal marginal settlements similar to Chivanhu. As well, empirical evidence about the scale and scope of the HIV and AIDS pandemic across different livelihood systems, as studied in this thesis, is limited. Overall, livelihoods that do not fit the conventional picture of subsistence smallholders have been neglected (Harvey, 2003:29; Nkurunziza and Rakodi, 2005). There is an existing bias in HIV and AIDS literature in favour of reasonably stable rural livelihoods (Baier, 1997; Barnett and Blaikie, 1992; Barnett, 1994; Baylies, 2002; Rugalema, 2000; Bishop-Sambrook, 2003; White and Robinson, 2000; Nkurunziza and Rakodi, 2005; Griekspoor et al., 2004; Harvey, 2003; Tobin, 2003). Moreover, many studies in rural areas are conducted by international agencies, and these are usually intended to guide specific policy interventions (Murphy et al., 2005). The result has been that policy initiatives that purport to focus on mitigation are in fact initiatives that address those conditions affecting only certain segments of the HIV and AIDS-affected. Current policies are driven by goals and outcomes determined by evidence which actually omit or obscure marginal areas which fall outside of the official rural (and urban) planning boundaries (Manderson, 1999). This makes a livelihood study of this nature (in this thesis) necessary for addressing the current gaps in HIV and AIDS livelihood literature.

Marginality creates various forms of vulnerabilities for households (Gurung and Kollmair, 2005). As a result, livelihoods of those surviving at the margins are characterized by high levels of informality, powerlessness and livelihood insecurity. Insecure livelihoods exacerbate the susceptibility to acquiring HIV and AIDS-related illness and subsequent deaths further increase vulnerability to HIV and AIDS infection, and this undermines livelihood options thereby forcing people to make decisions which involve making tradeoffs among basic needs (De Waal and Tumushabe, 2003; Drimie, 2003; Drimie and Gandure, 2005; Gillespie, 2006; Kadiyala and Gillespie, 2003). Highly vulnerable households have insufficient food security, low nutritional levels and a

decreased ability to cope with shocks. This leads to considerable reliance on migration, petty trading and the sex trade. Attention to gender and power highlights the social context of sexual relations as well as the meanings which men, boys, girls and women invest in sexual relationships. It also brings to the fore the distinctions that are made for explaining different sexual relationships “where sex is used as a survival or economic strategy within and outside of usual/normal/affective relationships” (Bryceson, 2006; Manderson, 1999:84).

In the light of the unique long wave and erosive nature of HIV and AIDS observed in rural livelihood systems which have social support services for the affected and infected, one is left to wonder about the extent of the impact in a context typical of Chivanhu settlement, characterised as it is by low levels of social organisation and cohesion. The Chivanhu settlement case study provides a different basis for understanding HIV and AIDS in a context where the overall social, economic and political configuration is marginal in nature. This study therefore focuses on a form of rural society other than the predominantly agriculturally-dependent societies that have been focussed on in most HIV and AIDS studies, at least in the sub-region. The study adds to the diversity of literature on different forms of rural livelihoods and specifically shows how HIV susceptibility, AIDS vulnerability and livelihood resilience manifest themselves in HIV and AIDS-affected livelihoods in a community that depends on many livelihood activities other than agriculture. The spatial and socio-economic location of Chivanhu settlement provides a unique opportunity for exploring and understanding HIV and AIDS-affected coping strategies of those households surviving at the periphery of mainstream economic, political and social processes.

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 and AIDS programmes, problems posed by the epidemic within affected households are far from being addressed (Baier, 1997; Baylies, 2002; Siplon, 2005; Topouzis, 2003;

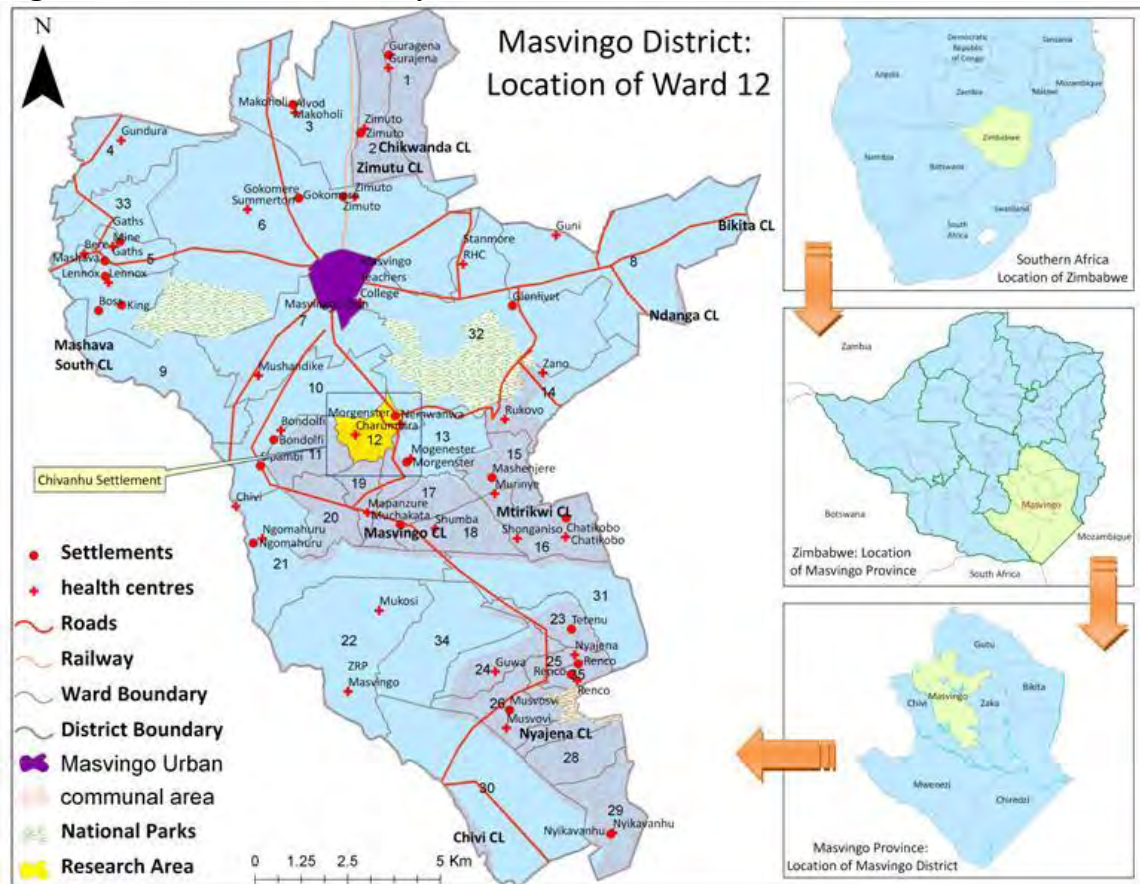
UNAIDS, 2005). In the current Zimbabwe HIV and AIDS multisectorial strategy, policies and programmes at community level are designed and embedded in the institutional structures (National AIDS Council, Provincial AIDS Council, District AIDS Committee, Ward AIDS Committee and Village AIDS Committee). The basic assumption is that these institutional arrangements are homogenous, operational, efficient and hence inclusive of all the HIV and AIDS affected. Tacoli (1998) observed that marginality is characterised in most cases by weak and *de facto* institutional overlaps (there are no clear cut boundaries around responsibilities and jurisdiction) and there is a need to know what this means for HIV and AIDS programming. Where certain households live in a context characterised by high levels of informality, and boundary fluidity, what are the implications on HIV and AIDS affected access to services?

The questions that need to be explored and answered in this context are varied. For instance, how are the rules and norms governing behaviour and values defined and what are the points of contact between policies, institutions and the HIV and AIDS affected in such a fluid and grey zone like Chivanhu settlement? Recent HIV and AIDS research has observed a mismatch between policy and reality on the ground. Scholars (Gillespie, 2006; Makonese, 2007) argue that institutional processes are in conflict with the real issue and concerns on the ground. This thesis examines how interventions relate to one another and how effective they are in addressing the livelihoods of HIV and AIDS affected households in Chivanhu settlement and the questions posed are crucial if the HIV and AIDS pandemic is to be successfully contained.

1.4 Chivanhu Settlement: an introduction to the settlement

The case study is located in Masvingo District in the south-eastern part of Masvingo Province (as shown in Figure 1). Masvingo Province falls in regions 4 and 5 of the country's ecological zones, which are characterised by intermittent rains of less than 500 mm per year. There are 35 wards in Masvingo Rural District (one of the districts in the province) and the case study is located in Ward 12.

Figure 1: Situation of the Study area in Zimbabwe



Chivanhu Settlement is a conflict-ridden area with high levels of social inequality, powerlessness and insecurity. Preliminary observations of marginal communities have indicated that high levels of informality, social and economic instability and social incohesion create a fertile ground for HIV transmission and AIDS vulnerability. Chivanhu Settlement was purposively chosen from Ward 12 (sometimes referred to as Nemanwa) due to its ability to speak to the proposed research problem and context and the researcher’s interest in unpacking the local rhetoric (*HIV yemuNemanwa haisi yekutamba nayo, haimisi, ichepfu* – the direct English translation: ‘Don’t mess with the HIV virus from Nemanwa, it is virulent’).

Since the early post-independence era, the Chivanhu area has been a heavily contested site with successive removals and the people resettling again. This area was previously owned by Morgenster Mission (a local Reformed Church mission), which used it for

cattle ranching. The original Morgenster Mission Farm extended up to Lake Mutirikwi including to what is now the Zimbabwe National Park. In 1978, during the liberation struggle, Morgenster Mission offered the land to the then chief of the area. Many families started settling themselves through various alliances with certain local village heads immediately after independence in 1980. Some of the early households occupied land in what is now the park and they were forcibly removed during the late 1980s to establish the park. Some households vacated but the remaining ones relocated to what is now Chivanhu Settlement.

The settlement continued to expand further into other unoccupied spaces through informal sales of land on the margins by the local headman without formal approval from the chief. At one point in 1999 the local chief got a court order to evict the people and their households and the homesteads were burnt. With the new resettlement and the disintegration of governance, the evicted people returned and the settlement is expanding again. Preliminary visits showed that there is boundary confusion as households are haphazardly settled in the community and many village heads claim to have control of the people in the settlement. Even the settlers are not clear who falls under whose jurisdiction. The whole area's settlement plan is not clear; the process was not legal according to interviews conducted during the preliminary field visit. There are no physical demarcations but the people know to which village head they belong.

The population is of mixed ethnic origin. Some of the households originated from deep rural places and some originated from Masvingo urban centre. Households which settled earlier occupy more land compared to households that settled later. Even among the latter occupiers, those who have the means can buy or seek favours through gifts to the village heads in order to gain more land. Chivanhu Settlement is a dynamic zone, operating outside of the mainstream. The majority of the population has reduced and restricted participation in public decision-making and are often discriminated against and stigmatised by the larger population in the area.

1.5 Sustainable livelihoods framework and HIV and AIDS

The thesis adopts a sustainable livelihoods framework for analysing poverty and HIV and AIDS, and does so by focusing on relationships between relevant factors at micro, intermediate and macro levels. The framework identifies and takes into consideration different assets (or capitals) that households can draw upon in pursuing their livelihood in times of stress, and how these assets interact with existing policies, institutional arrangements and processes in shaping different household's choice of livelihood strategies in coping with adversity. Households are viewed as rational economic agents which deal with adversity or shocks on the basis of the knowledge they have of their specific social environment (Ashley and Carney, 1999; Chambers and Conway, 1992; Rugalema, 2000; White and Robinson, 2000).

Households are assumed to exist in an institutional framework within which markets (or market-influenced interactions) are the prime mover, and the role of markets is to facilitate household involvement and investment in economic activity whereby resources to cope will be secured. When confronted with adversity, households and individuals will make rational decisions (or pursue strategies) to cope with the situation in a sustainable way in order to achieve livelihood security. Individuals and households may cope by drawing on their assets rather than through reliance on outside welfare provision (Rugalema, 2000). A secure livelihood can endure stress and recover from shocks, maintain or build its assets, provide durable opportunities for the livelihoods of successive generations and contribute net benefits to other livelihoods at local and global levels in the short and long run (Ashley and Carney, 1999; Chambers and Conway, 1992). A sustainable livelihood is achieved when a household has adequate access to resources to meet basic needs and realize basic rights.

The framework is a helpful tool for analysing HIV and AIDS because it is people-centred (Tobin, 2003; Seeley and Pringle, 2001). When people are taken as the starting point in understanding HIV and AIDS, it becomes possible to look beyond the health side of the epidemic to all aspects of people's social, economic and political lives (Seeley and Pringle, 2001). The livelihoods framework emphasises the effects of HIV and AIDS not

only on the HIV-infected, but also on the affected within the household and the broader community. It allows the examination to reach beyond the current epidemiological approach of lumping people according to risk age groups to incorporate other important factors across generations.

The sustainable livelihoods framework is particularly helpful in understanding the choices made by vulnerable households, through identifying the connections between different livelihood assets which facilitate people's agency and strengths (Tobin, 2003; Seeley and Pringle, 2001; Chambers and Conway, 1992). Scholars have realised that the livelihood strategies adopted by HIV and AIDS-affected households are similar to those that poor households resort to in times of crisis and need (Barnett, 1994; Barnett and Whiteside, 2002; Baylies, 2002; Drinkwater, 2003; Rugalema, 2000). HIV and AIDS-affected individuals and households engage in a suite of behavioural responses to enable them to cope (SADC-FANR, 2003:3; De Waal, 2002; Mutangadura, 1999). However other scholars (Baylies, 2002) argue that the term 'coping' when used with reference to HIV and AIDS-affected people is a 'misnomer' since HIV and AIDS is a "shock unlike any other shock" (Rugalema, 2000:5). HIV and AIDS-affected individuals and households experience subtle shifts and changes, and the impact is of such a magnitude that it may eventually erode their livelihoods. The characteristic of HIV and AIDS as a 'long wave shock' unlike drought and other disasters makes it difficult for households to avoid a long-term downward spiral in food security. Although affected individuals and households might temporarily avoid destitution through various response strategies, households never fully cope in the sense that they cannot simply return to some semblance of normalcy following a shock and, in most instances, households are dissolved completely (Mushongah, 2012; Baylies, 2002; Rugalema, 2000).

Various scholars have concluded that there are numerous gaps in evidence in relation to HIV and AIDS livelihood studies (Haddad and Gillespie, 2001; Drimie, 2003, Gillespie, 2005). Of particular significance for this thesis is the following: despite the existence of many HIV and AIDS livelihood studies covering southern Africa and despite many of these studies documenting the impact of HIV and AIDS on rural livelihoods (De Waal,

2002; UNAIDS, 2005, Nkurunziza and Rakodi, 2005), no identified study covers marginal rural zones like Chivanhu settlement (which forms of the focus of the thesis). Empirically-based HIV and AIDS livelihood studies with this focus, which target “HIV and AIDS vulnerable groups created by emerging socio-economic and political events” (Harvey, 2003:29), are necessary to close current gaps in the literature (Makonese, 2007; Murphy et al., 2005; Tobin, 2003). In this regard, it is also hoped that this study contributes to evidence-based mitigation and policy responses for HIV-infected and AIDS-affected people. The findings will not only be applicable to this case study, but to other marginal communities elsewhere in southern Africa and at a global level.

Given the magnitude of the epidemic, there is a tremendous need for more research on – and understanding of – HIV and AIDS with reference to individuals, households and communities across different spatial zones and socio-economic contexts. Efforts to mitigate the impact of HIV and AIDS must be based on sound theoretical analysis of the scale and character of the impact (Tobin, 2003). What are required are more detailed and nuanced community-based empirical studies which pay sufficient attention to both the contextual social dimension of HIV and AIDS and local cultural understandings of it. HIV and AIDS researchers have given disproportionate attention to reshaping sexual and behavioural practices (embodied in the ABC slogan, ‘Abstinence, Being faithful to one uninfected partner and if not Condomise’) at the expense of understanding the underlying causes of HIV susceptibility and AIDS vulnerability in different social and cultural configurations.

Apart from covering a largely invisible and omitted population in relation to HIV and AIDS research, this study also tries to link HIV and AIDS-affected micro-livelihood processes to wider macro socio-economic, spatial, historical and political processes. In this respect, HIV and AIDS research must seek to understand how HIV susceptibility and AIDS vulnerability are linked to broader economic, social and political processes to which households are exposed. The institutional response by the government is also related to key macro-economic and social conditions in existence. As state capacity to

respond was increasing, the burden of providing care and support and dealing with the impacts of HIV and AIDS were borne by households.

1.6 Research objectives and methodology

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 organisations have been engaging in HIV and AIDS programmes, problems posed by the epidemic within affected households are far from being addressed (Baier, 1997; Baylies, 2002; Strand, 2006; Topouzis, 2003; UNAIDS, 2005). 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 and AIDS-affected households, the impact of the disease on livelihoods and the effectiveness of interventions need to be explored.

Using the case study of Chivanhu as the basis for collecting relevant evidence, and in the light of the sustainable livelihoods framework, *the main objective* of this thesis is *to contribute to developing a conceptual framework able to understand and analyse HIV susceptibility and AIDS vulnerability with particular reference to marginalised rural communities*. In order to pursue this broad objective, the researcher also considered specific research questions and objectives. The key questions are:

- What are the broad short-term and long-term pressures that households in Chivanhu Settlement have been exposed to and what explains the options open to and adopted by households?
- What are the impacts of those strategies on HIV susceptibility, AIDS vulnerability and resilience?
- How are the formal and traditional institutional processes and arrangements influencing HIV susceptibility, AIDS vulnerability and resilience?

In this context, the subsidiary objectives are as follows:

- To investigate and identify the impact of short-term and long-term stresses on the livelihood strategies adopted by households and individuals in Chivanhu Settlement.
- To find out how the individual and household strategies adopted affect HIV susceptibility, AIDS vulnerability and resilience.
- To explore and analyse how traditional and formal institutions influence HIV susceptibility, AIDS vulnerability and resilience.

The pursuit of the main objective and of the subsidiary objectives calls for a multi-method research strategy (using quantitative and qualitative research techniques) that is capable of collecting arrays of both quantitative and qualitative data through progressive aggregation from individuals, through households to local community and upwards (Nkurunziza and Rakodi, 2005; Ulin et al., 2002). In this regard, it is important to acknowledge that livelihoods can only be fully understood in a specified social context, which demands a detailed understanding of contextual issues relating to the area and issues under study.

The following methods were adopted in the research:

- Review of secondary and primary data for context-specific background information, including documents and literature on HIV and AIDS, livelihoods and marginality.
- A cross-sectional livelihood survey involving the collection of demographic and livelihood data within Chivanhu, across all livelihood capitals (human, natural, physical, political, social and financial) and chronic illness profiles. Data collected through the household livelihood questionnaire was analysed through the Statistical Package for Social Sciences.
- Open-ended interviews and in-depth interviews with individuals in Chivanhu, concentrating upon livelihood trajectories since being affected by HIV and AIDS and mapping out the life histories of the HIV- infected and -affected. There were also focus group discussions and interviews with key informants.

Research on HIV and AIDS is necessary to enhance our sociological understanding of the pandemic in diverse spatial and historical settings, and to learn how to better improve existing strategies, services and public policies on programmes to help the infected and affected. But it is essential that such research be done in an ethical manner with careful planning and procedures to protect research participants. HIV and AIDS infected and affected persons and households are a particularly vulnerable group in communities where stigmatisation remains rife. Stigmatisation often results in unfair discrimination, the loss of livelihood assets such as land, employment; as well, HIV and AIDS infected and affected persons and households may lose access to social networks. Any investigation of HIV and AIDS issues therefore inherently carry significant risks for infected and affected persons and households. For that reason, this study gave particular attention to ethical considerations throughout the entire process of the research. An overriding concern in the research design and process was to avoid inadvertently exposing respondents to possible negative ramifications of research. Key ethical issues considered during the research included: consent, no deception, confidentiality, respect and beneficence, justice, privacy and sensitivity to real needs and potential problems (Rivera et al., 2001).

1.7 Outline of thesis

The theses is organised into the following chapters.

Chapter 2 focuses on the theories and concepts that have been adopted for understanding the factors pertinent to susceptibility, vulnerability and resilience amongst HIV infected and affected individuals and households. The sustainable livelihoods framework is therefore explored as a critical framework for exploring HIV susceptibility, AIDS vulnerability and resilience. The significance of a gendered analysis to these issues is also highlighted. Whilst the concepts of HIV susceptibility, AIDS vulnerability and resilience have been borrowed from analysis of other disasters like drought and pests, the chapter also shows the paradoxes that exist in current HIV and AIDS literature.

Chapter 3 focuses on describing the research process and the reasons why the researcher focussed on Chivanhu Settlement. The chapter describes the research design, data collection methods and data analysis tools that were used for and during the research in exploring and understanding susceptibility, vulnerability, resilience and gender in the research site of Chivanhu. The chapter also discusses the methodological challenges and ethical issues central in understanding HIV and AIDS issues in the study.

Chapter 4 gives an overview of key events that have shaped the scope and magnitude of the HIV and AIDS epidemic in Zimbabwe. The chapter describes the key social, economic and political events in contemporary Zimbabwe that are critical for understanding HIV susceptibility, AIDS vulnerability and resilience in marginalised communities like Chivanhu Settlement. It identifies the conditions that created a fertile ground for the HIV and AIDS epidemic to get a strong foothold in many communities across the country. The HIV and AIDS policy response is also discussed and analysed in the chapter.

Chapter 5 gives the historical and current background of Chivanhu Settlement. It offers a description of the population and demographic characteristics of households residing in Chivanhu, and of the basic infrastructure, social services and institutional responses that were in existence during the time of conducting the research. In addition, the chapter profiles the community in terms of HIV and AIDS infection rates and morbidity and mortality issues, and investigates the livelihoods activities of the general population. The chapter also begins to compare livelihood activities before AIDS-related chronic illness and after AIDS-related chronic illness as well as the effectivity of Anti Retroviral Therapy. The significance of orphans and orphanhood is highlighted.

Chapter 6 describes and analyses the various HIV susceptibility and AIDS vulnerability factors for different individuals and households members in Chivanhu Settlement. It discusses HIV and AIDS in terms of phases (namely the upstream, midstream and downstream phases) and the differential impacts of HIV and AIDS in relation to affected households and individuals. And, in this context, it analyses per phase the wide-ranging conditions within Chivanhu that create a vicious cycle of HIV susceptibility and AIDS

vulnerability (such as high levels of social inequality, gender inequality, intergenerational sexual relationships, food and livelihood insecurity, treatment access and adherence, fragmented social and family systems and gender discrimination).

Chapter 7 focuses on mapping out how household clusters within Chivanhu influence long-term coping with and adaptation to the impacts of HIV and AIDS. The chapter aims at showing the long-term impacts of HIV and AIDS and how social capital (in particular the kinship system) mobilises itself and makes decisions over time to look after the survivors and to preserve the household assets. The chapter shows that households are rarely self-contained units and that the impacts of HIV and AIDS are felt across a number of households that share critical resource arrangements. The case study of HIV and AIDS affected households that are clustered around one person (Machekeche) is used to illustrate and highlight these themes and issues. The chapter also shows the limitations of the kinship system and how decisions and priorities of who to look after, when and how are made across time.

Chapter 8 presents the discussion on the findings and conclusions gained from the study of HIV and AIDS in marginalised communities specifically Chivanhu. The chapter discusses how households in a marginalised community face a double threat of chronic food insecurity and the negative impacts brought about by HIV and AIDS. Some scholars are now arguing that, as the epidemic is stabilising, some of the early HIV and AIDS literature is no longer relevant. This concluding chapter though reveals that the impacts of HIV and AIDS for communities like Chivanhu Settlement are far from over. Although ART is reducing deaths, providing ART services in a settlement with ineffective governance structures and without providing an enabling environment, does not reduce AIDS vulnerability. In settlements like Chivanhu which are poor and marginalised, the plight of survivors is a big challenge for long-term sustainability of HIV and AIDS affected households.

1.8 Conclusion

The chapter has given the background to the study of HIV and AIDS in a marginalised community. The need for a study that focuses on different forms of rural settlements and communities has been clearly articulated. Investigating HIV susceptibility, AIDS vulnerability and resilience in relation to marginal communities is absolutely critical given the dearth of available literature on this topic and, in doing so; it provides an opportunity to contribute to refining a conceptual framework in a way more suitable to studying such marginal communities like Chivanhu. The following chapter covers in detail the theoretical issues around HIV susceptibility, AIDS vulnerability and resilience.

CHAPTER 2: THEORISING HIV SUSCEPTIBILITY, AIDS VULNERABILITY AND LIVELIHOOD RESILIENCE

2.1 Introduction¹

Theorising the impact of HIV and AIDS on households and communities is a complex issue. Since the epidemic started more than two decades ago, a number of concepts and frameworks have been developed and adapted in order to identify and analyse the factors that fuel the spread of HIV and the effects of HIV and AIDS on affected households. This chapter explores and analyses the concepts of HIV susceptibility and AIDS vulnerability, as well as the concept of resilience and the controversy around the term coping when referring to HIV and AIDS affected individuals and households. The chapter also discusses the relevance and challenges of using the sustainable livelihoods conceptual framework, and it considers the importance of integrating the notion of resilience into the framework in analysing the strategies for responding to HIV and AIDS within affected households. The interaction between HIV and AIDS and different livelihood capitals (social, human, political, finance, natural and physical) is covered. Attention is given to households' coping strategies, such as income strategies, food and consumption strategies, labour strategies, migration and cultural change strategies and related livelihood outcomes. Key discussions and gaps in the prevailing literature are identified and the pending research questions are discussed as the chapter progresses.

2.2 The sustainable livelihoods framework

This study is influenced by the concept of sustainable livelihoods and, by implication, unsustainable livelihoods. The concepts of HIV susceptibility, AIDS vulnerability and livelihood resilience are emphasised in this study insofar as they relate to the sustainable livelihoods framework. I seek to explore the ways in which HIV susceptibility, AIDS vulnerability and resilience unfold among HIV and AIDS-affected household members in a marginalised community. The livelihoods framework is used for understanding and analysing 'the causes of poverty, through analyzing relationships between relevant factors

¹ Throughout the thesis I use the phrase 'HIV and AIDS' rather than the more common 'HIV/AIDS'. See Appendix 3 about this and other HIV and AIDS- related terms.

at micro, intermediate and macro levels and prioritizing interventions' (Adato and Meinzen-Dick, 2003:152). In the words of Chambers and Conway (1992:9):

A livelihood comprises the capabilities (stores, resources, claims and access) and activities required for a means of living. A livelihood is sustainable which can cope and recover from stresses and shocks, maintain and enhance its capabilities and assets, and provide opportunities for the next generation.

The framework enables an understanding of the complex, nuanced and changing circumstances in people's lives and livelihoods. It takes into consideration the different assets drawn upon by individuals and households in pursuing their livelihoods, and how these assets interact with existing policies, institutions and broader processes in shaping the choice of livelihood strategies and livelihood outcomes. Secure livelihoods are based upon ownership or possession of (or at least some access to) resources or assets, which are used in productive activities to offset risks, ease shocks and meet contingencies. The conceptual analysis of livelihood outcomes, assets, household strategies, policies and institutions, vulnerability contexts, and adaptability and resilience form the basis of livelihood analysis (Scoones, 1999; Scoones and Wolmer, 2002; Alinovi et al., 2010). I will briefly outline these in turn.

Livelihood outcomes are the goals to which household members aspire and are the results of combining different livelihood strategies. The livelihood outcomes may include increased incomes, reduced household vulnerability, security of basic rights and access to basic services, and more sustainable use of resources. A focus on outcomes facilitates understanding of results emanating from different strategies as well as the reasons for pursuing those strategies and the ways in which household members respond to the opportunities and constraints in their livelihood context.

Livelihood assets are the resources that household members rely upon in building livelihoods and they play a critical role in the livelihoods framework analysis. Households with a broader range of assets (and more of one kind) are likely, comparatively speaking, to have greater livelihood options. There are traditionally five

categories of assets, sometimes called ‘capitals’ (namely, human, social, natural, physical and financial). However other livelihood scholars add a sixth category of assets: political capital (Tobin, 2003).

Livelihood strategies are combinations of activities which household members choose to pursue in order to achieve their livelihood goals, and these include productive activities, investment strategies and reproductive choices. These activities form a household livelihood portfolio which may be subject to constant adaptation in the face of fluid social circumstances.

Broader *policies, institutions and processes* represent the complex social, economic and political context within which household members negotiate their livelihood strategies. These institutions, policies and processes play a critical role in shaping the ability of household members to access, use and accumulate assets in pursuance of sustainable livelihoods.

The *livelihood vulnerability context* refers to economic, social and resource trends and shocks (for example, natural disasters like pests and droughts, and seasonal fluctuations in prices, production, employment opportunities and disease). The vulnerability context is usually externally formed and influenced by factors beyond the direct control of households and contingent on wider macro policies, institutions and processes.

Livelihood adaptability and resilience recognises a household as a complex adaptive system. The sustenance and survival of the household depends upon the ability or capability of the household to absorb the negative effects of – often – unpredictable shocks and strains impinging on the household system. This claim is borrowed from ecological studies and literature (Adger, 2000; Holling, 1973; Holling, 1996; Scoones, 1999). It means that the livelihood system is able at times to absorb the impacts of shocks without resulting in significant changes to its structural features.

In the sustainable livelihoods framework, people as active agents are centre stage in the analysis, while not ignoring broader structural features. These features involve both constraints and opportunities faced by poor people, and as often expressed by them. The framework therefore is helpful in understanding the choices made by vulnerable households through identifying the connections between different livelihood assets and strategies, and by articulating people's strengths as a starting point (Tobin, 2003). The framework is not a universal model that invariably incorporates all key elements of livelihoods of all communities and households irrespective of space and time. Rather, it is a heuristic and methodological device for stimulating thought and analysis, and it needs to be adapted and elaborated depending upon the situation and applicability of the guiding principles.

2.2.1 Sustainable livelihoods and HIV and AIDS

In regions where HIV and AIDS is generalised, as in the Zimbabwean context, the impact of HIV and AIDS on households has been often identified to be similar to that of other shocks and trends to household systems like drought, pests and diseases (Barnett and Blaikie, 1992; Baylies, 2002; Loevinsohn and Gillespie, 2003; Seeley et al., 2003; Bishop-Sambrook, 2003; Seeley and Pringle, 2001; Kwaramba, 1997; TANGO, 2002). Studies conducted for instance in Uganda, Kenya, and Tanzania show that, when confronted with HIV and AIDS- related adversity, households and individuals engage in a range of coping strategies, which are similar to the strategies they engage in with regard to other shocks and trends (Barnett and Blaikie, 1992).

According to Barnett and Blaikie (1994), who are pioneers in understanding HIV and AIDS, the livelihood responses that are adopted by HIV and AIDS affected households are similar to those that are adopted by households affected by other disasters like drought, famine or pests. In the event of exposure to HIV and AIDS, households make seemingly rational decisions (or pursue strategies) in trying to cope with the situation in a sustainable way in order to achieve livelihood security. The livelihoods literature on HIV and AIDS identifies and examines the fundamental causes and effects of individual

susceptibility and vulnerability to HIV and AIDS (Bishop-Sambrook, 2003; Seeley and Pringle, 2001; TANGO, 2002).

2.2.2 HIV susceptibility

The likelihood of becoming infected with HIV is referred to as susceptibility (Loevinsohn and Gillespie, 2003). This likelihood is shaped by, amongst other things, the economic, social and cultural characteristics of a society, relationships between different groups including along class lines, livelihood strategies, and the balance of power (particularly with regard to gender).

Loevinsohn and Gillespie (2003) are of the opinion that there is a two-way relationship between HIV susceptibility and food insecurity. Food insecurity may force household members to rely on livelihood strategies which make them more susceptible to getting infected by HIV. Evidence has shown that, in some communities in southern Africa, food insecurity therefore forces people to engage in sub-optimal coping strategies such as sexual transactions (person communication with Drimie, 2007). Food insecurity places women and girls in situations of risk, and they may feel obliged to engage in transactional sexual relationships in order to obtain food for their families. Poor people also may resort to migration resulting in transactional relationships for men who are away and women who are left behind (Harvey, 2004). The spread of infections and diseases are often indeed closely associated with patterns of human mobility (Drimie, 2002). Whereas traditionally there has been rural to urban migration in search of employment, urban to rural migration is occurring as a result of the “going home to die” concept. However Harvey (2004) notes that the empirical evidence to support this argument is weak and researchers have not managed to move beyond the hypothetical and anecdotal.

The other side of the coin is that HIV, in a kind of feed-back effect, will lead to chronic food insecurity for the HIV infected and AIDS affected households, as it impinges on the capacity of rural households to engage in agricultural activities and income-generating activities and also adds further expenditures to the affected household in the form of health care. My study in a marginalised community, where food insecurity is a chronic

situation experienced by the majority of the households in the settlement, provides an opportunity to explore the nexus between food insecurity and HIV susceptibility. In doing so, I try to map out the nature and extent of the two-way relationship between HIV susceptibility and food insecurity.

2.2.3 AIDS vulnerability

The initial studies on HIV and AIDS focussed on researching on factors contributing to individual HIV susceptibility and risk reduction (Topouzis and duGuerny, 1999). From the late 1990s, however, the focus shifted from a focus on individual risk to infection to vulnerability. Researchers soon realised that individual risk was the result of complex social factors and, therefore, they moved conceptually from a focus on immediate risk to seeking to understand the underlying dynamics that perpetuated the HIV and AIDS epidemic. The likelihood of suffering adverse consequences as a result of HIV and AIDS is referred as vulnerability: “To be vulnerable, means to be able to exercise little or no control over one’s risk of acquiring HIV and for those who already have the virus, to have little or no access to appropriate care and support” (TANGO, 2003:4). This – according to the prevailing literature – is mainly determined such factors as marginalisation, stigma and discrimination, poverty, fragmented social and family structures, inequity and gender relations, mobility and migration (Loevinsohn and Gillespie, 2003; TANGO, 2003); and the different forms of vulnerability lead to different levels of coping and resilience.

Nkurunziza and Rakodi (2005) point out that coping by HIV and AIDS infected and affected people, in the context of vulnerability, is related to their original asset base (such as land access), economic and social context, social and ethnic group to which the household belongs (including kinship patterns), and the quality and dynamics of the local settlement or community. For instance, households with a high degree of assets tend to cope better initially, but there has been no longitudinal study to trace the various coping strategies adopted at household level to identify the changes in household asset base across time. This thesis aims to trace these changes through the analysis of livelihood trajectories, particularly considering that livelihood insecurity exacerbates HIV risk and

increases AIDS vulnerability (TANGO, 2003; DeWaal and Tumushabe, 2003). Illness and AIDS-associated deaths undermine livelihood options forcing affected people to make decisions which involve problematic tradeoffs among basic needs (Drimie, 2003; Drimie and Gandure, 2005; Loevinsohn and Gillespie, 2003; Kadiyala and Gillespie, 2003).

According to Harvey (2003), the epidemic in southern Africa is taking place in a context of already fragile economies and the epidemic and fragile economies are mutually reinforcing. In the face of a scenario where household earnings and remittances have dramatically decreased in real terms, many households are resorting more to earning an income through for instance casual labour and informal activities (Bryceson, 2000). As well, HIV deepens existing vulnerabilities. Poverty, disease and famine, as well as political, economic and social instability and structural inequalities, continue to exacerbate the epidemic in rural communities. Many of the factors which fuel the HIV and AIDS epidemic are also those factors which seem to come into play in a context of rapid socio-economic deterioration. These factors create an extremely fertile social environment for the spread of HIV infection and the rise of AIDS-related diseases. The increasing levels of unemployment, hunger, malnutrition, lack of basic services, inability to pay for or access health services, disintegration of households, homelessness and often helplessness are the conditions that deepen the epidemic in southern Africa in general and Zimbabwe in particular. The prevailing political and socio-economic conditions have resulted in the dislocation of many households from their traditional places of residences and forced them to move into certain marginal places, thereby significantly increasing their susceptibility and vulnerability to HIV and AIDS.

Studies have revealed that the epidemic has disproportionately affected the most impoverished regions in the world and (within affected countries) infection is concentrated in the most marginalised communities and groups. However, HIV and AIDS-based livelihood studies have normally been conducted in stable agricultural communities, and hence the existing literature is a long way from reflecting the broader impact of the epidemic. In fact, aggregate figures on HIV and AIDS hide differences

within communities or between nearby communities. Nqwira (2002) (cited by Harvey, 2003:5) says infection rates and trends, and susceptibility and vulnerability, are sometimes found to vary dramatically over short distances. With the literature concentrating on stable agricultural communities, Ellis et al. (2003:8) point out that there is a risk that vulnerable groups and people are thereby being neglected in empirically-based studies. The HIV and AIDS and livelihoods literature, by overwhelmingly focusing on subsistence smallholder production systems in rural areas (with very few studies of the impact on other types of livelihood systems), fail to engage with marginalised communities typified by Chivanhu settlement.

Amidst contemporary high levels of material uncertainty and risk, many rural households and individuals have become more occupationally flexible and spatially mobile, and increasingly dependent on non-agricultural, informal and formal employment income-generating activities; diversification (in both rural and urban areas) has become the norm and it takes many different forms, including circular migration. Though diversification offers many opportunities, it also brings high levels of personal and financial risk to individuals and households. With any increased physical mobility arising from diversification also come the threats of HIV. In more marginalised rural communities, where agricultural production is inhibited, clusters of households and single households have reduced capacity to deal with the effects of morbidity and mortality. The HIV and AIDS epidemic is in fact happening in a range of communities which are typified by the absence of savings, non-accumulation of key livelihood assets and reduced income-earning opportunities. An understanding of varied communities provides a stronger basis for understanding the intricacies and complexities of HIV and AIDS and livelihoods.

Some scholars have raised concerns that the concept of vulnerability (irrespective of the type of community studied) has certain limitations when understanding the impact of HIV and AIDS. This is because it often connotes a passive state in which people fall victim to the pandemic rather than projecting people as active agents of social change and transformation in dealing with HIV and AIDS (Topouzis and duGuerny, 1999:9). In this sense, vulnerability analyses of HIV and AIDS-affected people may be describing the

impact of HIV and AIDS from the perspective of outsiders, rather than from the viewpoint of those perceived as vulnerable (Topouzis and duGuerny, 1999:10). This thesis is sensitive to this possible implication; nevertheless, it uses vulnerability as an analytical tool with which to scrutinise the factors that lead to the spread of HIV and exacerbate the impacts of AIDS.

The following sections examine the impacts of HIV and AIDS as identified in the existing literature. However, it is important to reiterate that most of the literature on the impact of HIV and AIDS on livelihoods (and vice versa) focuses on a specific type of rural livelihood (namely, agricultural production) and – in doing so – primarily at the household level (Kwaramba, 1997). There have been few studies on other livelihood groups and settings, like those dependent on casual labour (Bryceson, 2006; Bryceson and Fonseca, 2006; Harvey, 2004) and urban spaces (Crush et al, 2006; Nkurunziza and Rakodi, 2005). The impacts as outlined in this literature thus do not reflect the full diversity of rural people's livelihoods or the impact of HIV and AIDS on the full range of activities and income sources that poor households' members use to survive (Harvey, 2004; Bryceson, 2006; Bryceson and Fonseca, 2006; Ellis, 2000; Scoones and Wolmer, 2003). The strategies and activities of HIV and AIDS-affected households may include migration, petty commodity trading, and casual agricultural and non-agricultural labour, all of which feed into the relationship between HIV susceptibility and AIDS vulnerability on the one hand, and food insecurity and poverty on the other hand. This study shows that HIV regularly takes hold where livelihoods are already fragile, where conditions of marginalisation are rife, where supporting institutions are weak and where governance systems are at most insensitive to the needs of HIV and AIDS-affected people (see also Ellis, 2000).

2.2.3.1 Increased morbidity and mortality

HIV and AIDS normally attack those individuals who are at their prime productive age (15-49 years) (Rugalema, 1999; Mazzeo, 2005). For this reason, the epidemic has magnified existing social and economic problems for households (Baylies, 2002; Drinkwater, 2003; Loevinsohn and Gillespie, 2003; Mushongah, 2012). In countries like

Zimbabwe, which have been particularly hard hit by the pandemic, morbidity and mortality have risen and are expected to continue to rise (UNAIDS, 2006), although in some countries morbidity and mortality is decreasing due to Anti Retroviral therapy (ART) but the rates are still high. Chronic illness related to HIV infection has increased dramatically (Mazzeo, 2004; Mazzeo, 2011). The implications of rising morbidity and mortality are not only that HIV and AIDS is changing the demographic structure of households but that it is also taking a heavy toll on household resources and assets. As a result, any social and economic progress over the last few decades (such as in Africa) is being reversed, with serious effects on household livelihood systems. The loss of labour, income and managerial skills associated with the HIV and AIDS epidemic threaten the sustainability of livelihood systems (Mutangadura et al., 1999; Rugalema, 2000; Mushongah, 2012).

Scholars, such as Seeley and Pringle (2001), argue that the epidemiological practice of lumping morbidity and mortality incidences according to risk groups (such as the 15-49 age group) is short-sighted and has created many programming challenges. Many HIV and AIDS interventions and strategies have focussed on the most economically active segment of the population (aged 15-49) because of the underlying assumption that this is the most likely infected and affected age group. But this is done at the expense of other emerging and increasingly vulnerable age groups, including the HIV and AIDS orphans and elderly. Older and younger age groups also feel the devastating impact of HIV and AIDS on their livelihoods. As providers of care-giving in households, many elderly people are also succumbing to HIV infection, and infants are contracting HIV from their infected parents (Forster and Germain, 2002; Makonese, 2007; Seeley and Pringle, 2001). There is a need for studies that provide for an in-depth understanding of the manner in which different age groups (apart from the 15-49 age groups) are affected by HIV and AIDS and how they respond to the epidemic. This thesis makes such a contribution.

2.2.3.2 Reduced household labour and disruption of livelihood activities

HIV and AIDS have a direct impact on quality and quantity of agricultural labour available in HIV and AIDS affected households. In Malawi, 70 percent of households

face reduced labour contributions due to HIV and AIDS. In Tanzania, two thirds of all households face a 43 per cent labour loss. This must also be seen in the light of increased care-giving activities because of the pandemic; for instance, in Zimbabwe, around 38 hours per week on average for households with an HIV infected person are spent on care-giving (Cogill, 2002:14; TANGO, 2002). Children are forced to leave school early, due to lack of school fees and for girls in order to provide care and labour for other household activities, and there is a loss of indigenous knowledge transfer between generations (UNICEF, 2005; Topouzis and Hemrich, 1996; Barnett and Rugalema, 2001). And 80 percent of agricultural labour in sub-Saharan Africa is supplied by women, who also provide primary care to affected family members; indeed, the majority of women are shifting from agricultural production to provide care to sick family members (SADC-FANR, 2003; Shah et al., 2002; TANGO, 2002; UNAIDS, 1999a). In poor rural households, HIV and AIDS clearly cause severe labour shortages and economic constraints that disrupt agricultural activities (Mutangadura et al., 1999).

In labour scarce-households, land is increasingly left fallow or abandoned (Drimie, 2002). Land has been sold by some affected households to support livelihoods and to pay for medical and funeral expenses. Muchunguzi (1999) also records that households in Muleba District, Tanzania are 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 favoured less labour intensive and less nutritious crops (Kadiyala and Gillespie, 2003). HIV and AIDS decrease the productivity of household labour due to sickness, AIDS-related malnutrition and ultimately death. Existing studies reveal that the effect of chronic illness on the ability to provide labour to the household is devastating, with some households reporting losses as high as 60-80 per cent (Kadiyala and Gillespie, 2003; Rugalema, 1999; Ncube, 1999; Muchunguzi, 1999; Mazzeo, 2004). In central Malawi, productivity of land has gone down by 72 percent and production of maize and cotton has been reduced by 50 percent in Zimbabwe (Shah et al., 2002; TANGO, 2002).

Timeliness of agricultural operations has become problematic with affected households experiencing delays in key agricultural production activities like, planting, weeding and harvesting in Zaka District, Zimbabwe, as seen in a study conducted by Makonese (2007). Mazzeo (2005), based on his study in Masvingo and Midlands Provinces in Zimbabwe concluded, that even with access to good land and rainfall, HIV and AIDS affected households cannot maximise production and use natural resources effectively. In Uganda, crop diversity has decreased by 44 percent particularly in female-headed households. Cash crop production is often abandoned due to its now excessive financial and labour requirements. According to Muchunguzi (1999), in studies carried out in Tanzania, affected households have shifted to growing low maintenance crops (for example, tubers and sweet potatoes), which reduces the quality of nutritional intake in households, and decreases food quality and quantity. This almost abandonment of and disinvestment in land contributes to a decline in production in rural communities and to farm degradation in terms of a decrease in the agro-biodiversity.

A reduction in the availability of labour due to HIV and AIDS clearly leads to a reduction in the area under cultivation and in the number of crops for sale, as well as a process of transition to crops that require less labour and storage (Kwaramba, 1997; Shah et al., 2002; Topouzis and duGuerny, 1999). HIV and AIDS leads to difficulties in looking after different types of perennial crops and in producing for the market, and can have consequences in terms of diminishing production or even production may come to a complete standstill. In relation to responding to labour shortages within households, generational factors have also been identified in HIV and AIDS studies. Labour allocation patterns have changed in the sense that the elderly work later in life and children are beginning agricultural work at a younger age. It is generally believed that in affected households the labour force mostly comprises young children and the elderly.

Critical agricultural activities like weeding are now being abandoned and households have decreased consumption patterns and are resorting to wild foods consumption (TANGO, 2002; Muchunguzi, 1999). Land use patterns change as agricultural practices change with falling capacity for heavy labour. In Rakai District in Uganda, for example,

60% of households stated that parts of the land they usually cultivated had 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) states that, in Zimbabwe's Shurugwi District, there was a decline in livestock production, less time spent on tending animals and often less qualified labour used for labour activities such as identifying and treating animal injuries. Hammarskjöld (2003) notes that there is a transition by households to smaller animals (such as goats and poultry), as these require less tending time and knowledge of raising them. Current agricultural policies in some countries which promote tubers and other crops have been influential in farmers shifting to these crops, as has the 'positive living' initiative of encouraging community consumption of nutritionally-rich natural products (without using inorganic fertilisers and herbicides) that can be found or grown locally. These initiatives and policies are designed to manage the consumption and nutritional needs of the HIV-infected (Drimie and Gandure, 2005).

2.2.3.3 Reduced household incomes and increased household expenses

Some studies point out that in households with chronic illness the need for more income rises due to a rise in treatment and funeral costs but (at the same time) capacity for income generation within households decrease (Kwaramba, 1997; Mazzeo, 2005; TANGO, 2002). Empirical evidence has revealed that costs of drugs and medical treatment, as well as expenses for additional special foods and items such as extra blankets required for AIDS patients, negatively impact on the balance between household expenditures and incomes by increasing expenses. Faced with HIV and AIDS, farmers for instance often abandon market-oriented and high external input agricultural practices and shift to subsistence farming (duGuerny, 2004; Kwaramba, 1997; Topouzis, 1998; UNAIDS, 2004). Further, transfers of money to tend to sick relatives and for looking after AIDS orphans are leading to a deterioration of household income for affected extended family members (Forster and Germain, 2002; Forster and Williamson, 2000). Children are sometimes withdrawn from school to keep the limited money the household has for survival of the family.

The pandemic is also reducing sheer levels of income with resultant coping strategies. Some households have resorted to the selling of productive assets to cope with increasing demand for income. In Malawi, 40 percent 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. Some households are resorting to drawing extensively on savings to supplement declining incomes. In countries such as Tanzania, desperate widows have resorted to transactional sexual relationships and remarriage as a means of supplementing loss of income at the household level (Ntozi, 1997; Forster and Williamson, 2000). Some households are relying more and more on selling wild fruits and firewood in order to supplement income (Barany et al., 2005). The existing literature, as noted earlier, has a bias towards households in agricultural communities (rather than more marginalised ones), but even in these communities (Rugalema, 2006) affected households are selling livestock and other assets. As a result, there is a tendency for a concentration of the same disposed assets amongst wealthier individuals and households at community level.

2.2.3.4 Reduced household food security

Vulnerable households become even more vulnerable with the effects of HIV and AIDS. DeWaal and Tumushabe (2003) argue that HIV and AIDS-affected households may escape complete demise in the face of a food security shock through various coping strategies, but they cannot escape the longer term downward trend of food insecurity. In Kenya, Malawi and other places in southern Africa affected households have experienced a major loss of income and increased risk of infection, due to resorting to suboptimal coping strategies such as commercial sex work or transactional sexual behaviour (TANGO, 2002; Bryceson, 2006). The loss in the quality and quantity of labour for farmers has resulted in reduced crop and livestock production, hence less income. Studies of household economies have shown that, as HIV and AIDS infection progresses in a household (with resultant demands for care and medical expenses), the household economy becomes undermined until it becomes difficult to cope with day-to-day income demands.

As people affected by HIV and AIDS are less able to grow crops due to progression of the disease and widening sicknesses, they increasingly shift to gathering for their daily subsistence needs (Hammarskjöld, 2003; Drimie and Gandure, 2005). Studies reveal that ‘natural capital’ and common property resources increasingly contribute to household resilience as they serve as safety nets during agricultural shortfalls; affected households, even more so, 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 and nutritious, require minimal labour input and are particularly needed in times of stress. The reliance on the sale of forest products, like firewood and thatching grass, has led to concerns that increased dependency on forest products might result in forest degradation (Barany, et al., 2005). However other scholars argue that there is limited information to support this argument (Timko, 2011; Timko et al., 2010). Some HIV and AIDS affected household members ask their relatives to look after their children so as to absorb the extra burden of food demands when they are sick. In Zimbabwe, incidences of sending children to live with relatives are reported and this has been a common strategy in many Zimbabwean cultural traditions (Senefeld and Polsky, 2006).

2.2.3.5 Stigma and discrimination and dispossession of assets

Stigma and discrimination affect the participation of affected households in livelihood strategies and programmes. Furthermore, participation of HIV and AIDS-affected households and family members in livelihood activities is constrained due to the emotional burden of illnesses and lack of time for meaningful participation. AIDS-affected households are often deliberately excluded from political meetings and social gatherings in the community due to stigma. Lack of opportunities for involvement in community activities due to caring demands in households with chronic illness and because of exclusion as a result of often overt forms of discrimination mean that local deliberative processes may result in 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 which are long embedded in social systems, structures and processes on the ground may not accommodate the specific concerns of AIDS-

affected family members. Disturbingly, there is growing evidence in the literature which shows dispossession of key assets like land and cattle, particularly for AIDS widows and children, in communities with a patrilineal inheritance of key livelihood assets (Drimie, 2002; Drimie and Gandure, 2005).

Findings presented in this section reveal that HIV and AIDS increase morbidity and mortality in prime age adults. Increased morbidity and mortality in individuals at their prime productive and reproductive age groups have negative consequences in the households. This directly disrupts household labour and livelihood activities. Reductions and disruptions in agricultural activities lead to reduced agricultural production and incomes. HIV and AIDS reduces incomes at a time when income demands for funerals and health related needs are increasing for HIV and AIDS affected households. Reduced agricultural production and incomes has resulted in chronic food insecurity. Some households would resort to disposing household physical assets like livestock in order to deal with the impacts. Other HIV and AIDS affected households would resort to the consumption and selling of forest products to supplement reduced food and incomes at household level. Other HIV and AIDS affected households send children to live with relatives elsewhere.

2.3 Gender and HIV susceptibility and AIDS vulnerability

Women show a clear trend of being infected at an early stage, and certainly earlier than men (UNAIDS, 2007; Makonese, 2007). Studies have documented that the peak infection ages for women are between 21 and 40 years while, for men, infection starts to peak at later ages of 40-50 years. These figures for women are indicated by rates of HIV and AIDS-related chronic illness and antenatal attendance by women. Marriage for women in many African societies has not changed from being primarily about child-bearing and child-rearing. High HIV infection rates in adults who are at the peak of childbearing ages, in the context of high fertility rates and ineffective mother to child transmissions services, have resulted in high HIV rates for children in the 0-15 age group (Makonese, 2007). Most of the people in a study conducted by Makonese, who were chronically ill during the period of the study, reported to have lost a child due to chronic illness or had a child

who was chronically ill during that time (Makonese, 2007). Despite increasing levels of awareness, prevention of mother to child transmission (PMTCT) programmes are reporting problems of adhering to recommended child-feeding practices that reduce vertical HIV transmission from the infected mother to the child, in large part due to cultural taboos around breastfeeding and child feeding practises.

HIV and AIDS challenges have been traditionally considered from a medical point of view. In this regard, Meena (1992) points out that HIV and AIDS research needs to adopt a theory of gender about the changes experienced by women and men who are affected, especially with reference to the reconstruction of sex and sexuality as a response to the HIV and AIDS problem. The analysis of the different perceptions and responsibilities for both men and women and the various culturally-constructed power relations between men and women is critical for effectively addressing the root causes of risky sexual behaviour (Purnima and Aggleton, 2001). While growing attention has been given to the position of women in the epidemic, less attention has been focused on men. A deeper understanding of gender is crucial, and one which sees gender as a set of structures created by, and affecting both, men and women (Purnima and Aggleton, 2001). Most studies have focussed on women as a vulnerable group, with only minimal reference to men, and yet men are a critical part of the story about HIV and AIDS in the southern Africa region (Mutangadura, 1999; UNWOMEN, 2002).

Gender refers to the social relations between men and women, usually asymmetrical divisions and attributes connoting relations of power, domination and rule (and normally with respect to sexual interactions). However, gender relations are historical, malleable and changeable, and are subject to alternation often through every day activities and practices. Concentrating on women only, in the end, is erroneous and misleading in making sense of HIV and AIDS and its gender dimensions and dynamics.

2.3.1 Women as bearers of the HIV and AIDS burden

Because of their reproductive roles and their place in broader society, African women suffer the greatest burden of HIV and AIDS. Poverty-stricken people generally focus

more on their daily survival than their health and are stymied by a crushing sense of powerlessness and hopelessness. As women fall sick and divert time to care for sick family members, their ability to produce food and manage natural resources in a sustainable way is diminished. Women are especially vulnerable to HIV infection for social, cultural and biological reasons. Women's survival and that of their households and communities specifically depends on access to and use of land and natural resources. Where women are not entitled to land in the same way as men (as is normally the case in the prevailing patriarchal systems), documented research has shown that the living conditions of surviving widows and orphans are worse (Drimie, 2002).

Land inheritance patterns in particular have often disadvantaged widows in patrilineal systems (Seeley and Pringle, 2001; Muchopa and Mutangadura, 1999). In Uganda, women do not retain the lands of deceased husbands and, in Zimbabwe, male relatives often claim the land of the deceased husband. This has implications for increased inequalities along gender lines in local agrarian communities (Drimie, 2002). In certain cases the gendered division of labour (such as in Zimbabwe and Malawi) has changed, with some significance for women; for instance, women have entered into growing tobacco and cotton (often considered men's crops) and women are assuming some control over large livestock including cattle. Insofar as traditional knowledge of managing and producing livestock has been a male prerogative, the loss of males through AIDS-related diseases has implications on the quality of management and production systems of livestock and the overall quality of life for women (Kwaramba, 1997).

2.3.2 HIV and AIDS and the feminisation of poverty

Meena (1992) argues that HIV and AIDS and poverty are inseparable and women are more likely to be vulnerable to the poverty dimensions of the pandemic (Nkurunziza and Rakodi, 2005). Most HIV and AIDS-affected women experience negative social-economic outcomes primarily because of existing social, cultural and legal institutions which put them in a disadvantaged position. Institutions regulating access to and control of resources and livelihood assets are in large part in favour of men. In terms of the sexual division of labour in the spheres of production and distribution of goods and

services, women constitute the majority of the informal labour force, while also occupying the lowest positions in the formal sector as semi-skilled or unskilled employees. At household level (that is, in a key sphere of social reproduction), women perform most of the domestic and reproductive tasks, including child-bearing and -rearing, food processing and care of the sick and spouses; generally, this entails most of the functions needed for the reproduction of human labour. Women's responsibilities in carrying the main burden of caring for the sick (including HIV-infected household members) reduce their ability to engage in productive labour. They simply have decreasing amounts of time to earn cash income outside the home, often leading to a cycle of poverty and sickness.

Reproductive tasks are considered as a constraint on women's participation in the formal and informal sectors of the economy. A study by Bryceson (2006) in Malawi has seen casual labour though as a source of income especially for women in poor households. Field evidence suggests that the highly exploitative contractual terms which employers offer widens the gap between the haves and the have-nots, and has fuelled the risk of contracting HIV for most women involved in the study; they hence seek dependence on men (Bryceson, 2006). However, other writers like Veheijen (2011) dispute the transactional model of HIV risk for women. Her findings in Mudzi (in Malawi) reveal that, apart from economic benefits, there are self-providing (or financially independent) women who remain with risky partners due to cultural and other reasons, that is, other than direct financial benefits. For Veheijen (2011), even where there are material benefits, these relate to luxuries such as umbrellas and clothes rather than basic need support as alluded to in the transactional model. Many poor women are heads of households and they often head the poorest of households. Such women will often engage in commercial sexual transactions, sometimes as commercial sex workers. Most women are unable to sustain themselves in either formal or informal work; hence, in these instances, they are also less able to dictate the terms of sexual relationships and are more likely to engage in risky sexual behaviour.

Overall, there are many broader structures and processes which disadvantage women in the context of the pandemic and which contribute to the gendered quality of poverty. These include female illiteracy, economic dependency, weak land ownership and access rights, marginalised and subordinated inclusion in labour markets, significant time spent in domestic activities and an inadequate supply of supportive social services. Responses to HIV and AIDS can only be successful if investments in prevention and care (which are often underpinned by agency-based behavioural explanations for the pandemic) are combined with recognition of the structural and patriarchal bases for the pandemic – this would entail systematic support for national poverty reduction and action to address the developmental impact of the epidemic. Without a marked reduction in poverty and sustained advances in human quality of life, HIV and AIDS will continue to impoverish individuals, households and communities as a whole but women more specifically. Poverty alleviation will feed into the prevention of further infections. Improving women's incomes also increases their power in all aspects of life, including control over sexuality.

2.4 Orphan care and practices

Traditionally the paternal family inherited orphans in many African communities. In other communities, some orphans are fostered away outside the extended family network. Although the term 'orphan' exists in many parts of Africa, none of the terms used would apply normally to children staying with adult relatives (Forster and Williamson, 2000). The extended family remains the predominant caring unit for orphans in communities with the HIV and AIDS epidemic. However, the roles of the extended family and community in coping with orphans are in a state of flux. Where traditional community values are maintained especially in rural areas, the extended family safety net is better preserved. In marginal and semi-urban communities, the safety net has increasingly fallen away and this makes problematic the catering of, and caring for, orphaned children.

The impact of HIV and AIDS is compounded by the fact that orphaned children already live in communities disadvantaged by poverty, poor infrastructure and limited access to basic services. Further, some of the strategies for coping with HIV and AIDS have

negative impacts on the welfare of children. This include transfers of money to sick relatives, leaving kids to take care of sick relatives and absorbing cousins in the event of the death of aunt or uncle; all these can directly result in the deterioration in the quality of welfare for children (Forster and Williamson, 2000). Regrettably, preplanning and succession planning are rarely discussed explicitly in many African families, and hence there is often no strategy for ensuring that children, if they become orphaned, have a long-term safety net. Orphans may in fact seek employment locally and in nearby towns if there is no one to look after them. Overall, though, there are significant grey areas in the existing literature on the impact of HIV on orphans and the resultant coping strategies.

2.5 Is ‘coping’ the correct concept?

HIV and AIDS-affected households engage in a suite of behavioural responses to enable them to cope (DeWaal, 2003). When affected households are confronted with HIV and AIDS-related adversity, affected individuals do engage in certain mitigating or counteracting practices to deal with the adversity. The underlying notion is that when action is enacted to soften the impact of shocks and stresses, the affected households as a result return to some form of semblance of normalcy. This however raises questions pertaining to whether HIV-infected and AIDS-affected households are indeed coping, because certain literature points to some households dissolving completely as a result of failure to cope. Rugalema (2000) therefore argues that HIV and AIDS-affected households never fully cope in the sense that they cannot simply return to some condition of normalcy following a shock.

This can be understood in relation to the notion of sustainable livelihoods. Such livelihoods, especially in rural spaces, are about the sustainable utilisation of natural capital (Chambers and Conway, 1992). For instance, increases in the demand for timber products occur in the context of the pandemic. More timber is demanded for making coffins and firewood to warm the sick. A considerable increase in the consumption of timber for coffins in Kisumu (in Kenya) has led to increases in felling of trees in a forest reserve in Kakomega (Hammar skjöld, 2003). Selling off of productive assets like

livestock also leads to a loss of productive animals for traction and manure for crop production, and this reduces agricultural productivity (Gillespie and Kadiyala, 2005, Gillespie, 2006).

Certain of the existing literature highlights that the term ‘coping’ is a misnomer (Rugalema, 2000; Baylies, 2002; Makonese, 2007). HIV and AIDS is said to be a ‘shock unlike any other shock’. Individuals and households live with HIV and AIDS and, if one looks at the breadth and length of people’s lives, it is increasingly clear that individuals and households experience subtle shifts and changes whose impact is of such a magnitude that in the end (or in the long-term) it erodes whole communities. The basic premise of household livelihoods is that affected households can rely on social networks as fall backs in order to cope and deal with (and respond to) the impacts of HIV and AIDS. But in the majority of the cases from studies conducted, households are not effectively coping but are struggling and in some instances they dissolve completely. While individuals in most affected households manage to survive, the households themselves break up and their members, including orphans, widows and the elderly, join other households.

Local household knowledge and capacity to engage in household ‘crisis management’ is limited and ineffectual. The decisions made by household members affected by HIV and AIDS are suboptimal and have major costs in the medium and long term. So-called coping responses, such as the sale of household assets, reflect short-term survival responses with long-term negative impacts. Some HIV positive males marry young women in order to find someone to look after them in the event of succumbing to AIDS related chronic illness and hence infect their young partner. Some of the coping strategies of elderly-headed households actually represent ‘coping gone bad’; for instance, so as to be able to survive, large numbers of elderly women are engaging in activities such as brick moulding which are not age appropriate (Makonese, 2007; Rugalema, 2000). Some strategies, such as leaving or dissolving a household, are likely to be irreversible, certainly compared to strategies adopted to counteract other (non-HIV and AIDS) shocks to livelihoods. The very survival of the household unit, in the face of the pandemic, is therefore threatened. In this regard:

Some analysts are arguing that some of the originally observed impacts and coping strategies that led to these conclusions, that households do not cope, that were identified by researchers when the epidemic was at its peak, may have dissipated or changed as the epidemic has matured and stabilised (Rugalema et al., 2010:30-31). This makes it necessary to look at the possibility (or not) of long-term resilience and adaptive strategies of HIV and AIDS-affected households and coping strategies over the long haul.

2.6 Long-term adaptation and resilience

Research evidence on long-term adaptation mechanisms – what they are and how they work – are still limited (Rugalema et al., 2010:29). While vulnerability attempts to describe the likelihood of experiencing adverse consequences as a result of HIV and AIDS, resilience encompasses the ability of HIV and AIDS affected households to bounce back from a shock. Resilience means that a livelihood system is able to absorb the impacts of disturbances due to AIDS, without resulting in significant changes to its structural features or declines in livelihood outputs. It thus refers to the ability of HIV and AIDS-affected households to adopt responsive livelihood strategies to avoid negative consequences in order to rebuild their livelihoods faster and on a surer footing (Loevinsohn and Gillespie, 2003). Resilience is normally analysed through proxy indicators like the ability to preserve some assets, the condition of the homestead, the quality of life before and after, and the ability to re-bounce out a crisis. This thesis considers the matter of resilience and, in doing so, also profiles the contribution of ART in strengthening resilience. This is done through an analysis of livelihood strategies before HIV infection, during chronic illness but before ART, and once the individual has joined an ART regimen. In the context of my study of a marginalised community, particularly considering that most households are poor and generally asset deficient, social capital and political capital become critical for long-term coping and resilience.

2.6.1 The role of social capital

HIV and AIDS and the stigma and discrimination which accompanies it causes a deterioration in an individual's social capital by disrupting social networks, institutions,

organisations and social support mechanisms. Infected individuals regularly face social exclusion, loneliness, and lack of support and comfort from families and broader networks. Taylor et al. (1996:55) argue – in relation to both the infected and affected – that care-giving by household members and AIDS-based illnesses prevent individuals and households from creating and sustaining networks (Seeley et al., 1993). UNAIDS (2002) also notes social cohesion within households has been heavily compromised. Households in some instances will eventually dissolve, as parents die and children are sent to relatives for care and upbringing.

The growing impact of the AIDS pandemic is weakening community safety nets (Forster and Williamson, 2000). Reliance on social networks (involving reciprocal arrangements for sharing resources through gifts, loans of cash, food and labour between relatives) becomes more difficult as the demand for resources and assets has been intensifying with the progression of the condition. The loss of labour (both productive and unproductive) often strains the capacity of a household to mobilise social capital. Topouzis (1998:9) argues that HIV and 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”. Studies are confirming that families are failing to cope as demands for support are increasing and the social safety system is overburdened with the demands for care giving, cash and labour needs (Forster and Williamson, 2000). Community labour and credit groups, which have existed historically, are increasingly undermined by the number of affected persons. Findings from a study conducted by TANGO (2003) revealed that HIV and AIDS affected households had challenges getting assistance from kinship networks and there were challenges in mobilising the HIV and AIDS affected to participate in community activities. HIV and AIDS have led to the straining of local community-based institutions to the point of collapse (TANGO, 2002).

2.6.2 Grassroots politics and local power manifestations

Although evidence is mounting about the importance of political capital (or access to power) for HIV and AIDS-affected households’ survival strategies, Tobin (2003) found

out that insignificant research has been conducted on the linkages between political capital and affected households' coping strategies. Despite the fact that studies on the impact of HIV and AIDS on other livelihood capitals (such as human, physical, income, natural and social) exist, research on the impact of political capital is severely lacking (Nkurunziza and Rakodi, 2005; Tobin, 2003). Moreover, though the research that has been done has focused heavily on rural areas, none of it has covered marginal communities with their unique social configuration of power, as typified in Chivanhu settlement. To reiterate, further research is needed on other forms of settlements which do not fit the typical rural and smallholder agricultural systems setup. In many cases, because of the failure of community networks for dealing with HIV and AIDS and the shortcomings of traditional (often kinship-based) safety nets in coping with demands, new forms of social capital have formed. These new evolving forms of community-based safety nets (in the form of community-based organisations) are designed specifically for dealing with chronic illness and orphan care in the context of the pandemic, and they happen where there is committed leadership and organic community mobilisation.

Coping strategies at community level by HIV and AIDS-affected households are not devoid of local power manifestations. Various forms of political alliances and groups have been observed in dealing with the impacts of HIV and AIDS and also for harnessing and mobilising forms of support and resources for affected individuals. Empirical evidence has demonstrated that, even in comparatively stable communities with high levels of social integration and community cohesion, households report that the character and quality of support accessed or given depends on alliances that households have forged at community level (Makonese, 2007). As a result, households involved in influential alliances benefit more and at the expense of weaker and more vulnerable HIV and AIDS-affected households in the same community.

Community leadership is an important factor in the success or failure of community-based approaches for dealing with the effects of HIV and AIDS. However, recent studies reveal that community leadership does not always act in the best interests of community members (Makonese, 2007; Mazzeo and Makonese, 2009; Makonese and Chiweshe,

2008). Often, and this is the case in Zimbabwe, current multi-sectorial strategies for dealing with HIV and AIDS are designed and implemented through formal and traditional governance structures at community level. But the available literature has not critically looked into how effective these structures are in delivering the necessary support (Makonese, 2007). If political capital and its implications throw up these challenges in stable and coherent communities, one wonders what the scenario is like for other fluid communities like Chivanhu Settlement.

Policies governing HIV and AIDS resources and their allocation may not function efficiently, to the detriment of the sustainable distribution and management of the resources in general for HIV and AIDS-affected households. Recent political and socio-economic events in Zimbabwe have resulted in the rapid disintegration of many national and local governance structures. Studies are revealing that where institutions governing resource access and allocation are ineffective and insensitive to the needs of the affected and the infected, the livelihoods of HIV and AIDS households are detrimentally impinged upon (Makonese, 2007; Mazzeo and Makonese, 2009). Through combining vulnerability and resilience analysis, this thesis provides an opportunity to explore both passiveness and agency in the livelihood strategies of the HIV and AIDS-affected.

2.7 Conclusion

This chapter has set out the sustainable livelihoods framework and the reasons why it has been adopted as an analytical framework for understanding HIV and AIDS impacts on households. The chapter has also described the concepts of HIV susceptibility and AIDS vulnerability. The concepts are critical in understanding the factors that fuel the spread of HIV (or increase risk) and the factors that result in HIV and AIDS-affected households experiencing adverse consequences as a result of the impacts of the epidemic. The concept of long-term adaptability and resilience, which is more frequently entering debates in relation to HIV and AIDS coping mechanisms, has also been described and analysed. A focus on resilience is critical in understanding the long-term impacts of the pandemic and whether households are able to withstand the impacts and under what conditions. In outlining these critical issues, I highlighted the significance of particularly

gender to susceptibility, vulnerability and resilience, because insensitivity to gender fundamentally thwarts a nuanced understanding of rural communities (stable or otherwise) affected by the pandemic. The roles of social capital and political capital, as potentially critical to marginalised communities like Chivanhu, have also been detailed. The chapter has also identified certain gaps and paradoxes in the existing HIV and AIDS livelihoods literature and these will be explored, probed and analysed in the thesis. The following chapter focuses on the research methodology underpinning the thesis.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the research methodology used during the research process for the thesis, as well as bringing to the fore the rationale behind choosing Chivanhu as a suitable and relevant research site for this kind of study. It also refers to the methodological, ethical and practical problems which emerged during the fieldwork at Chivanhu. It shows clearly the relevance of the methodology for the main thesis objective as well as linkages between the sustainable livelihoods framework and the research methodology.

I am a Zimbabwean by birth and decent. I speak Shona, the predominant vernacular language used by people in Chivanhu Settlement. I also originate from Masvingo Province and my communal area is about 40 kilometres from the research area. I have also worked extensively on development issues in Zimbabwe and particularly in Masvingo Province at large, including working on gender and HIV and AIDS themes and challenges. Apart from that, I am a qualified HIV counsellor and this assisted me when discussing difficult and emotionally taxing topics with the research subjects.

3.2 Choosing Chivanhu Settlement

Chivanhu is about twenty kilometres from Masvingo town and two kilometres from the Great Zimbabwe Monument. The Nemanwa area, where Chivanhu settlement is located, is divided into thirty-five wards and the research focused on Ward 12 under the authority of Chief Charumbira. The work focused on households living under seven different village heads but residing in one settlement. Such a scenario is not common in Zimbabwe. The selection of Chivanhu Settlement involved interaction with several key stakeholders from August 2007 to March 2008, and I was fascinated in particular by the fact that NGOs had no presence in the settlement – unlike nearby communal areas. I was curious to find out why that is so, when in some districts in Masvingo Province there were up to twenty organisations purporting to be working and implementing projects in one ward or village.

A closer preliminary analysis revealed diverse issues which might contribute to the uniqueness of Nemanwa and specifically Chivanhu. These issues included boundaries of the settlement, historical setup of the settlement, origins of the household heads, community activity, the character of land possession, duration of stay in the settlement and livelihood sources. In this respect, the average land size for the majority of the households is much less than two acres, which is atypical of other rural communities in Zimbabwe where households have larger units of land for agriculture.

I had in worked in Masvingo Province as an HIV and Gender Specialist for an NGO called CARE International from 2003 to 2007 and this proved to be an effective negotiating point for research entry into Chivanhu. Entry into rural communities has been problematic (and in fact restricted) for researchers since the fast track land reform programme started in the year 2000, in large part because of the political tensions which have arose because of it; Chivanhu settlement was no different in this regard during my research period. From my involvement with CARE, I had come to know that the Nemanwa area was characterised by a high HIV prevalence rate and high morbidity. In 2008, soon after I left, CARE started to provide food assistance in the area; but, to emphasise, before 2008 there was no organisation providing any form of assistance to the settlement area. There was also virtually no evidence of any HIV and AIDS organisational structures and support systems operative in the area, and this realisation (along with other issues mentioned) finalised the selection of the settlement for my study.

My choice of the research area was also based on a number of other considerations. For instance, it offered the opportunity to explore the livelihood dynamics of HIV-infected individuals and AIDS-affected households in a settlement that is characterised by high levels of informality and low levels of social cohesion, by people who are of mixed ethnic and different socio-economic backgrounds, and by significant diversity in livelihood activities and household insecurity. The settlement also provided the chance to explore and map out the wider changes in the people's livelihoods brought about by processes of de-agrarianisation and spatial mobility.

Chivanhu settlement is divided into smaller land units, called homesteads. I made a household inventory (involving a survey) of all homesteads with the assistance of three research assistants between September and November 2010. The household livelihood survey was administered to two hundred and forty nine households. I used the results of the survey to identify and profile households which were marked by the presence of HIV-related chronic illnesses, by deaths in the previous twelve months due to HIV-related chronic illnesses, and by the existence of orphans and vulnerable children and widowhood. About 35 households were identified for detailed case histories. The large number of cases identified proved useful during the course of the research, due to high levels of mobility by members of the households targeted for detailed analysis. I had a large pool of identified households for case histories to fall back on in the event of losing track of some of the identified cases during the research. The profiles were triangulated with information from health centre records at the local Opportunistic Infection and Antiretroviral treatment centre and membership in emerging support groups for the HIV- and AIDS-affected. To allow for more focused research, I then selected specific cases from amongst these. I was not seeking statistical significance; rather, the aim was to capture empirically the livelihoods of the HIV- and AIDS-affected and the diversity of livelihoods.

The study focused on one community, namely Chivanhu, because of the (spatial and historical) context-specific character of livelihood and coping strategies of HIV and AIDS-affected individuals and households living in an atypical and marginal rural community. Such a specific focus allowed for a rich, in-depth and nuanced portrait of one community struggling in coming to terms with the complexities and shocks brought upon it by HIV and AIDS. The study is not statistically representative of any broader universe, even of other atypical rural communities in contemporary Zimbabwe. But it does raise a range of critical conceptual themes and empirical trends which are at least illustrative of the HIV and AIDS dynamics and processes elsewhere in rural Zimbabwe. In this sense, the findings emerging from this thesis have wider applicability.

3.3 Sequential qualitative and quantitative methodologies

According to Ulin et al. (2002), combining both qualitative and quantitative methods in the research process is heuristically helpful and beneficial in building a more complete picture of the social world of households affected by HIV and AIDS. Qualitative and quantitative forms of evidence are both assumed to have particular strengths and weaknesses, and hence the need for a combination of several forms and levels of evidence to allow for a proper examination and analysis of the broad social setting and specific processes internal to Chivanhu settlement (Gilman, 2002). Therefore, by combining methods, “each one is modified and used with others, producing a hybrid of methods which gives the research multiple sources of evidence with more relevant evidence to give a complete picture of the subject” (Yin, 2003:98). This hybridisation of the research process enables the researcher to identify and pursue the strongest possible methodology for the generation of nuanced evidence in the field (Gorard and Taylor, 2004). It also allows for the crosschecking of results for purposes of consistency and enhances confidence in the research findings (Seale, 2004). Triangulation therefore forms the cornerstone of my research methodology. It is used in this study to develop “converging lines of inquiry” (Yin, 2003: 98) and to deploy diverse sources of evidence in making any research-based conclusions. As a result, triangulation ensures that the researcher does not privilege *per se* one particular approach over others and helps in facilitating the exploration of different truths in the research process.

My study adopted in particular a sequential mixed methodology. Both the quantitative and qualitative data sets were critical in the research process. Interviews and focus group discussions were used during the initial stages of the research in the phases from 2008-July 2010. Data and insights gathered during this early qualitative phase helped in the framing and formulation of research assumptions and questions, and laid the foundation for the household livelihood assessment survey. The household survey captured basic demographic and socio-economic information on households, along with orphanhood, chronic illness, AIDS-related deaths, land sizes, consumption patterns and quality of social services in Chivanhu. The information collected through this survey was critical for guiding the researcher in the identification of specific households for in-depth case

histories. As well, it revealed the themes and patterns that guided the case history discussions with HIV- and AIDS-affected households. Household livelihood data was revisited (as the case histories were documented) in order to crosscheck their responses and validity. The information from the household livelihood assessment revealed the themes and pattern that guided the case history discussions with HIV and AIDS-affected households.

The research framework is based on the key questions and themes such as the following: How do households in a community characterised by high rates of HIV and AIDS, particularly a marginal community like Chivanhu, cope and survive if indeed they cope at all? What specific types of adaptation and coping strategies are pursued by HIV-infected and-affected individuals and households? Do the livelihoods and livelihood activities of HIV and AIDs individuals and households change over time insofar as HIV progresses to AIDS? How do households respond to the initiatives undertaken by key stakeholders in a community dealing with HIV and AIDS? Pursuing these themes entails – in a flexible manner – deploying, testing and possibly altering the analytical framework chosen for the study, namely, the sustainable livelihoods framework.

In essence, this entails an examination of livelihood trajectories of households as affected by the epidemic over time (Nkurunziza and Rakodi, 2005). And this is done against a defined set of critical elements pertinent to livelihood outcomes and sustainability success as derived from the existing academic and other literature. Livelihood trajectories are the consequences of the changing ways in which individuals and households construct a livelihood over time and within a specific socio-spatial setting. These changes (or adaptations) are contingent responses to sudden shocks and long-term alterations (sometimes structural) in the broader ecological, economic, social and political context; these adaptations in turn may shape, albeit only insignificantly and piece-meal, the prevailing context. As well, there are informal and formal institutional arrangements, often entailing interventions to counteract the effects of HIV and AIDS, which are prevalent within Chivanhu. To map all this out, historical evidence at individual, household and community level is vital and it must be linked to more systemic processes

even at national level. Besides offering rich analytical insight, such an approach will also provide useful understandings and assessments for policy and programmatic changes in making more effective interventions against the HIV and AIDS pandemic in Chivanhu and beyond.

3.4 Case study research design for Chivanhu Settlement

Case study research is consistent with triangulation and a sequential methodological design and it has both historical and spatial elements. It therefore highlights the significance of different kinds of evidence for understanding a particular socio-spatial setting and privileges historical depth. A case study, in utilising different research techniques, gives the researcher reasonable confidence about the integrity of findings generated and about their consistency with structured and lived reality. It is not though a panacea suitable for all research topics under all circumstances. Rather, as a “logic of design” it is “a strategy to be preferred when the circumstances and the researcher and problems are appropriate, rather than an ideological construct to be followed whatever the circumstances” (Platt, 1992:46).

In this regard, Moser and Kalton (1971:2) stress that case studies are selected as the research design when “one individual or one group or a community is investigated with the need for specific research questions to be answered through a diverse range of evidence”. Because of this, it is deemed a fitting strategy for pursuing this study of Chivanhu settlement in relation to understanding HIV susceptibility, AIDS vulnerability and livelihood coping and resilience in the face of the consequences of the pandemic. Such an examination requires identifying and understanding the structural, conjunctural and contingent conditions under which Chivanhu households pursue their livelihoods, as well as the short-, medium- and long-term pressures to which these households are exposed and their active and engaged livelihood responses to them. These responses have, in turn, effects on the three key focus issues for the thesis – HIV susceptibility, AIDS vulnerability and livelihood resilience.

This dialectical-type of interaction, understood simply as mutual interaction for my purposes, is often difficult to identify and grasp if only because, in social life, text and context are not discrete and separated ontological realities. Rather, their boundaries are seemingly porous and effectively blurred. Case study design is particularly sensitive to this and is best able to comprehend the blurred (and often messy) complexities of social processes and everyday existence. It is suitable, as a form of empirical inquiry, for investigating fluid contemporary social phenomena within a real-life context especially when the boundaries between phenomena and the context are not clearly evident. This entails a recognition for instance that Chivanhu settlement, while structurally configured, is constantly being reconfigured as an ongoing social process of set of processes. Susceptibility, vulnerability and resilience thus need to be understood as processual phenomena, and the case study design ably allows for this.

The adoption of the case study methodology allowed me to use multiple methods of data collection and multiple sources of evidence to analyse and evaluate HIV susceptibility, AIDS vulnerability and resilience amongst HIV and AIDS-affected households in a marginalised community like Chivanhu. Also, given that the thesis involves a study of a currently-existing socio-spatial site and the ongoing unfolding of events within this site (Chivanhu), it is believed that a case study design facilitates the understanding of susceptibility, vulnerability and resilience in their natural (i.e. actual or real-life) context. The design therefore was critical in understanding the various factors that influence susceptibility, vulnerability and resilience for affected households, including the how's and why's of this influence. As such, a case study provided the methodological room and scope for the use of wide-ranging forms of research techniques, which I pursued with vigour throughout the research process. These included primary and secondary data sources, interviews, case histories (through in-depth interviews), key informant interviews, field notes, focus group discussions, direct observation and participatory approaches. The case study, in guiding all the processes of social inquiry, is deemed as the most suitable design for this thesis on Chivanhu given the overall aims and objectives of the study.

The case study, by using multiple data collection tools, provides the researcher with significant levels of reliability and validity that is critical for any study. In this respect, it facilitates and incorporates an extensive and intensive chain of evidence for purposes of internal validity. Another researcher, who was not present or involved in the design and implementation of the original case, is able to follow the logic and research steps taken and come to the stated conclusions of the initial study. Further, in seeking internal coherence between data-sets, I was able in the case of Chivanhu to understand cross-check and verify any obvious inconsistencies – on the one hand – subjective and intersubjective meanings seemingly animating household activities and strategies and – on the other hand – actually-existing activities and strategies as they occurred independently of these meanings. This allows for the identification of actual inconsistencies between what Chivanhu residents think, say and do (or between different ‘levels’ of reality) in their everyday lives and to posit reasons for any existing inconsistencies.

Overall, then, the case study design provides a very strong basis for an authentic insight into the lives and livelihoods of HIV and AIDS households in Chivanhu. It is sensitive to spatial and temporal conditions and processes, incorporates different forms and scales of social reality, recognises the inherent complexity and fuzziness of lived reality, and focuses on questions of both structure and agency (Silverman, 2001). As a result, it complements the advantages of the sustainable rural livelihoods framework, as detailed in the previous chapter.

3.5 Data collection methods

Studies such as the current one (on HIV and AIDS in Chivanhu) call for a multi-method research strategy which is capable of collecting an array of both quantitative and qualitative data through progressive aggregation from individuals, through households to local community and upwards (Nkurunziza and Rakodi, 2005; Ulin et al., 2002; Mack et al., 2005). In this regard, as indicated already, the susceptibility and vulnerability of households and the resilience of livelihoods in Chivanhu can only be fully understood in their social, historical and spatial contexts, as well as in relation to formal and informal

institutional processes which impinge upon HIV and AIDS households in the community. Table 2 provides an overall summary of the main variables explored during the study (susceptibility/vulnerability, resilience, context and institutional processes) and the questions which guided the research process in relation to each variable. The table also shows the specific data collection methods used in addressing and seeking to answer the many questions related to the four interrelated variables. For each variable, it is important to highlight that different collection methods (and hence different sources of evidence) were adopted at different stages of the fieldwork research process. In this sense, the data collection methods were to some extent variable-dependent and research stage-dependent, though there was considerable uniformity in collection methods across variables and stages. The ensuing discussion speaks to and highlights the main points as contained in Table 2.

3.5.1 Unit of analysis

Both the household and the individuals within households are the units of analysis for the study. In this respect, it is critical not to assume homogeneity within households, particularly given that individuals rather than households engage in social practices. Relevant social categories (at both household and individual levels) such as class, age, gender and marital status are also considered of particular significance. Household and individual units of analysis offered an overall portrait of Chivanhu as a community. Below I detail the different research techniques used during the fieldwork.

3.5.2 Household livelihood survey

Household livelihood surveys are critical in identifying linkages and correlations between demographic characteristics, the social context, everyday activities and subjective meanings. It is a versatile and time-efficient method of data collection compared to other methods of data collection, specifically with regard to breadth and extensiveness of evidence rather than depth and intensiveness.

Table 2: Variable Operationalisation

Variable	Variable Operationalisation	Research tools
Context (geographical, Historical, Scio - economic and Political)	<ul style="list-style-type: none"> • What are the broad social, economic ad policy frameworks that have been formulated and implemented at national level that have shaped micro processes in Nemanwa and Chivanhu in particular? • What are the broad historical events that have occurred in Nemanwa and Chivanhu in particular? • What are the general broad livelihood activities? • What are the key political issues and events shaping events in general? • What have been the broader policies in the area? • What are the general food sources in the area? 	Secondary and Primary data review Focus group discussions Interviews Livelihood survey
Susceptibility and Vulnerability for HIV AND AIDS affected	<ul style="list-style-type: none"> • What are the demographic characteristics of the HIV and AIDS - affected? • What are the HIV and AIDS trends in relation to Livelihood Capita I (Natural, Economic, Political, Human • What determines HIV susceptibility and AIDS vulnerability? • At what stage across the AIDS timeline does one become vulnerable? • What are the cultural practices and how do they link with susceptibility and vulnerability? • What are the reasons and motivations for sexual behaviour across households and gender lines? • What are the household power dynamics and how are these manifesting in relation to HIV and AIDS? • Is there any incidence of gender based violence related to sex and sexuality? • What are the demands to cope with the epidemic (orphans, sick, pregnancy and reproduction) across age, gender and within households? • What explains the options adopted by households? • How has the impact of HIV and AIDS affected the livelihoods strategies? • What are the impacts of those strategies on ill health? • How are strategies affected through time (the illness progression)? • What is the role of original asset base in coping? • How are relationships between households and their wider families and networks changing as reflected in labour, marriage patterns, practises, migration, remittances, caring for dependants (sick and orphans), inheritance? • What attempts are being made to build up assets, increase security, protect against shocks and stresses and deal with the effects of HIV and AIDS on the affected livelihoods? 	Livelihood Survey, Focus group discussions, Interviews, Case histories
Institutional Processes	<ul style="list-style-type: none"> • What institutions are operating in Nemanwa and in Chivanhu in particular? • What are the roles and responsibilities of institutions? • Who are the stakeholders in HIV and AIDS issues? • What interventions on the ground are responding to HIV and AIDS? • What is the typology of an effective strategy to deal with HIV and AIDS? 	Focus group discussions, Interviews, Livelihood survey
Resilience and coping	<ul style="list-style-type: none"> • Do HIV and AIDS - affected households achieve security of basic needs and rights? • If they are achieving how and under what conditions? • If they are failing to achieve why? • What is the impact of short - term and long - term coping strategies on livelihood systems? • What are the links in both directions that is between the changing relationships and livelihoods strategies? • What are the outcomes of livelihood strategies adopted by HIV and AIDS - affected in terms of poverty and wellbeing? 	Focus group discussions, Interviews, Case histories

A household survey encompassing the entire Chivanhu settlement (249 households) was undertaken during the middle phase of the field data collection between September and November 2010. In September, the summer season is beginning and rural smallholders have normally finished harvesting; so it is a convenient time to conduct the survey for Chivanhu residents because the survey would not disturb key agricultural activities (with the exception of vegetable gardening) for the majority of households. Given that the agricultural season has just ended, September to November is an appropriate time to identify and assess questions around food security. The agricultural season (from October 2009 to April 2010) in Chivanhu involved comparably good harvests compared to previous years. The household survey is used to identify and describe the various livelihood resources prevalent or absent in Chivanhu (see Appendix 4 for the survey questionnaire).

In the previous chapter on the sustainable livelihoods framework and its relevance to HIV and AIDS, I noted the significance of capitals (or resources or assets) for the framework. In the discussion below, I briefly mention the types of capitals explored in the study (in the survey and through other research methods):

Natural capital: The questionnaire looked at land tenure, size of land holdings and land usages (for crops and grazing). As well, it considered land-based natural resources, including general access to and use of natural resources, wood for fuel and construction, and clay for brick making. This also included investigating the impact of such use on the replenishment of these resources and their future sustainable use.

Physical capital: The survey focused on the ownership and selling of tangible assets, as well as borrowing of these assets – including household assets, farm equipment or tools, livestock, wells, boreholes and latrines.

Human capital: The survey covered human capital concerns such as the following: age and gender composition of households, household dependency ratios and changes to this, and changes in size and composition of households; illness amongst household members, chronic illness and the frequency of chronic illness and deaths in the past twelve months and the causes of death; and educational levels and changes in children's school attendance. It also looked at and explored mobility into and from households and losses and gains of household members for a variety of reasons; this included additions of relatives to a household to assist

with care-giving or child care, loss of labour power leading to reduced work participation, and intra-household reallocation of labour.

Financial capital: The survey tracked use of self-insurance mechanisms (such as drawing on savings, selling of physical assets, and credit availability to household members), reliability of income (such as demand for services or products of the self-employed), and access to casual labour or regular employment. It also captured changes in income streams and the impact of these on expenditure and consumption patterns (such as the quality of food consumed, expenditure on social services including education and health, investment and divestment in assets, postponed expenditure, and resorting to foraging, scavenging and begging).

Social capital: The survey examined the presence of additional extended family members in a household, in- or out-fostering of orphaned children, frequency and duration of visits between relatives, and the amount and direction of remittance flows. Intra-household and intra-family tension and conflict related to HIV and AIDS was also considered. Also focused on were links to formal and informal organizations, membership of (or participation in) support groups, assistance received from specifically HIV and AIDS support groups, and community-based reciprocal groups concerned with community self-help and labour sharing (for housework, child care and care for the chronically-ill).

Despite the advantages of household livelihood surveys and the breadth of evidence collected by means of them, serious challenges relate to the availability of the respondents and their willingness to cooperate (an issue which is in many ways out of the researcher's control). I sought to minimise the possibility of this by explaining in full the importance of the research to the participants and by following research ethics protocol (see Appendix 1 and 2). Another challenge concerns the character of the data generated through a survey; surveys are unable to come to terms with the complexities of the social, spatial and historical contexts within which the phenomenon being studied is located. In my study I sought to address this through, as noted earlier, triangulation and the sequential collection of qualitative and quantitative data. A further challenge for the survey instrument is movement of residents to or from Chivanhu during the implementation of the survey in the field. This may lead to results which do not incorporate all residents and which remain insensitive to spatial motilities. To overcome this challenge as much as possible, the time period for collecting the field data using the survey was extended to include three full months. Because of this, the importance of mobility

became reasonably clear though this was validated through other research techniques. Failure to highlight mobility through field evidence would lead to skewed results, as mobility is considerable in relatively unstable communities like Chivanhu. In general, initial focus group discussions and interviews increased the sensitivity and relevance of the questions asked in the household livelihood survey and post-household survey data collected through other methods provided space for cross-checking survey results.

For the survey three research assistants were rigorously trained to minimise errors in interpretation and to understand the ethical issues around the study. I also personally engaged at times in field supervision of the assistants and I was involved in continual verification of the data collection process to minimise room for error. The information gathered from the survey was very detailed and it assisted in guiding the next step in the research process, namely, selecting households and individuals for case histories.

3.5.3 Case life histories

A life history approach allows a different type of analysis to occur. The process, according to Davies (2006), provides the researcher with an opportunity to identify life cycles for key individuals in the inquiry and it also provides for easier identification of repeated behaviour patterns. The approach involved a series of semi-structured interviews and it profiled comparative evidence from and about the cases. Variables like extended families, skills and education, religion, financial and household assets, household structures, social networks and power relationships were examined by means of the life histories. Social capital was a critical field of investigation in the Chivanhu study and the detailed life histories offered the platform for identifying power relations between and within households. Political capital, as a subset of social capital, was mapped out through discussing and highlighting the traditional power structures and alliances (along with resource allocation) which are or are not accessed by the household members. I focused in particular on critical events, incidents and factors identified by the individuals in relation to HIV susceptibility, AIDS vulnerability and livelihood resilience by HIV and AIDS-affected households.

The households were purposively sampled using preliminary analysis of the household livelihood survey, including a tentative mapping of power and social resources within the community. The categories that guided the selection involved the presence of orphans, a recent death in a household due to AIDS and the presence of chronic illness. Household

members of sampled households used for case analysis, with time, introduced the researcher to their relatives and associates (including those who fostered children). A snowball sampling strategy was also used to identify and understand inter-household dynamics through looking at clusters of associated households and individuals. This is seen most vividly in the study of the Machekeche cluster in Chapter seven on household resilience. Three clusters were identified, but during the course of the study only one cluster was successfully followed. The other two could not be adequately mapped out due to logistical and time constraints. Most of the households in the Machekeche cluster were located and members moving within a radius of 150 kilometres from Chivanhu were identified.

In increasing the spatial scale of the life histories, the life history residents were asked about other household members or relatives with whom there was considerable sharing of resources, and about other people in the community with whom relationships existed and which impinged on their livelihoods. In terms of highlighting temporal sequences, the case analysis also adopted a time-line approach. In this study, the time-analysis focused on the following: livelihood conditions of existence before HIV infection, conditions which predisposed one to becoming HIV-infected, and the dynamics during the period of AIDS-related chronic illness which created conditions for vulnerability. The life histories also concentrated on analysing the impact on survivors of AIDS-related deaths, and the different decisions which are made within and across households over time and which influenced individual and household livelihood vulnerability or resilience.

The life history approach I believe was particularly crucial and innovative, as it provided new insights into understanding HIV and AIDS issues over an extended period time in the livelihoods of individuals and households. In the past, few HIV and AIDS studies (in Zimbabwe or elsewhere) have focused on long-term coping and resilience of survivors. In this respect, the case histories allowed the researcher to follow the trajectories of HIV and AIDS-affected livelihoods and how susceptibility, vulnerability and resilience (or the absence of resilience) was shaped by key social, political and economic events and processes that were happening in Zimbabwe. The ebbs and flows of household livelihood activities are captured on this basis, including details on what happened, when and where it happened, and how the happening (or event) influenced susceptibility, vulnerability and resilience of HIV-affected households in Chivanhu. Such an understanding of infected and affected individuals and

households is not possible by and from cross-sectional surveys which predominate in the prevailing AIDS literature.

3.5.4 Key informant interviews

Key informant interviews are interviews with people who are selected for special knowledge or expertise on a particular topic. Key informants provide an important link to the research subjects (in terms of establishing rapport) and critical information (including important insights) about the community under study (Terre Blanche et al., 2006). In this regard, I identified a number of key informants with different social backgrounds, institutional locations and social roles, and conducted loosely-structured interviews allowing for free and unhindered flow of ideas. Some key informant interviews were conducted during the early stages of the research process, including during the formulation of the research topic and research problem. This involved state officials working within the field of HIV and AIDS as well as local Chivanhu community members who were HIV positive. Village heads in Chivanhu were also important in providing knowledge about the community and in giving guidance on how best to negotiate access into Chivanhu for research purposes.

In all, the key informants who were interviewed included health facilities staff; national, provincial, district AIDS staff; representatives from networks for people living with HIV; the local councillor, village heads; and teachers and other community members. The key informants provided different (and partial) perspectives on HIV and AIDS in Chivanhu and, in doing so, sensitised me to some of the key issues, themes and events unfolding in the community and shaping susceptibility, vulnerability and resilience amongst HIV and AIDS-affected households. In some cases their insights served to validate the findings and conclusions to the study and, in this sense, they acted as a source of verification.

3.5.5 Open-ended and in-depth interviews

Unstructured interviews are open-ended processes providing in-depth qualitative data. The open-endedness is important because it ensures that the evidence collected is solidly grounded in research subjects' perspectives and interpretations without these being filtered and shaped by the researcher's pre-established constructs and categories (Seale, 2004). Reflexivity on the part of the interviewer stimulates conversation which may produce viewpoints and insights relevant to the study which were not anticipated before the start of the interviews; in more structured and focused interviews, insights may be lost to the rigid imposition of the 'next'

structured question. Despite the flexibility involved in unstructured interviews, this research technique provides for thematic consistency across interviews and therefore offers the basis for comparative analysis (May, 1997).

Table 3: HIV infected and AIDS affected interviewed

HIV infected and AIDS affected Persons interviewed	Number	Age	Sex
Child headed household members	5	10,11,15,16,17	3 Males(2 HIV positive), 2 Females
Orphaned Children	4	7,8,10,16	2 Males and 2 Females
Widows	5	22,25,30,45,50	Females
Widowers	1	47	Male
Widowers who had remarried	4	45,46,47,55	Males
Single and unmarried	4	20,27,35,42	Females
Pregnant women	3	22,28,35	Females
Breastfeeding Women	2	23,25	Females
Chronically ill accessing Antiretroviral therapy	10	13,22,25,26,30,35,45,50,60,65,70	7 Females 3 Males
Chronically ill not accessing Antiretroviral Services	2	50,30	1 female(50) 1 male(30)

The researcher's conversation with the interviewee entails an internal validity check in the sense that the researcher can correct his or her possible misunderstanding or misinterpretation of an issue under discussion. The conversation in effect is a joint exploration of pertinent themes (by the researcher and interviewee) and "only a joint effort between an insider and an outsider can decipher the essential assumptions and their patterns of interrelationships" (Schein, 1983: 112). However unstructured interviews, if not properly managed by the researcher, may veer far from the topic at hand at times; and they are not particularly effective when seeking to obtain factual information about past events and occurrences because people easily forget these past happenings (Moss and Goldstein, 1979). Forty unstructured interviews took place with HIV and AIDS infected and affected individuals, in which they spoke about

their personal feelings, opinions and experiences in relation to the pandemic. Table 3 shows the age; sex and type of HIV and AIDS infected and affected individuals interviewed.

The unstructured interviews provided an important opportunity to gain knowledge about (and insight into) how these individuals perceive and understand HIV and AIDS-related events and processes which animate their lives and livelihoods and which constantly lead to everyday challenges. These in-depth interviews also involved the interviewees in positing or asserting causality in relation to susceptibility, vulnerability and resilience. HIV and AIDS of course is a highly emotive and sensitive research topic, and some of the discussions recalled very personal and painful experiences in the lives of those affected by HIV and AIDS. These interviews, involving one-on-one interaction based on some degree of rapport, proved to be appropriate for addressing sensitive HIV and AIDS issues. In fact, a number of elderly male HIV positive community members refused to participate in focus group discussions but they were comfortable discussing their individual experiences using unstructured interviews. Some unstructured-style interviews were also adopted for life histories and for key informants. At times, if the research participant seemed to have been emotionally moved by the experience of the interview, I facilitated his or her referral to a qualified counsellor at Morgenster Mission Hospital.

3.5.6 Focus group discussions

In the initial stage of conducting the research, focus group discussions were carried out to map out pertinent social and economic contextual evidence to guide and inform later stages of the research process. The members of five focus groups (with two separate discussions each) were randomly selected based on age groups and gender (Table 4) and hence the ensuing discussions produced diverse experiential accounts of life and livelihoods in Chivanhu. These initial accounts helped me in refining the focus and scope of the research problem for the thesis and in formulating questions for the household livelihood assessment. For instance, many individuals highlighted in one way or another issues related to HIV susceptibility, AIDS vulnerability and household resilience.

Table 4: Composition and themes of focus groups (2008 - 2009)

Focus group members	Number of Focus Group Discussions	Themes explored
Adult men 21 – 49	2	Sexuality, contextual issues, services, land access, sizes. Chronic illness and other institutional issues, orphans, food security
Adult women 21 – 49	2	Sexuality, contextual issues, services, land access, sizes. Chronic illness and other institutional issues, orphans, food security
Elderly men 50+	2	Sexuality, contextual issues, services, land access, sizes. Chronic illness and other institutional issues, orphans, food security
Elderly women 50+	2	Sexuality, contextual issues, services, land access, sizes. Chronic illness and other institutional issues, orphans, food security
Young Boys and girls 15 - 20	2	Sexual and reproductive health issues, services

In the later stage of the research process (and after the household livelihood assessment), a further seven focus group discussions took place with six focus groups (Table 5). In this case, purposive sampling was used through grouping individuals from households which were selected after analysing data from the household livelihood assessment.

Elderly men (fifty years and older) who are living with HIV (and who had been identified through the household livelihood assessment and various health records), refused to participate in the focus group discussions; hence no such focus group was formed. It was not ethical to conduct focus group discussions with minors who are living with HIV.

The focus group discussions were very lively and confirmed some of the evidence collected through the household livelihood assessment. They provided ‘thick’ descriptive accounts of the emergence of HIV susceptibility and progression to AIDS vulnerability, including their broader context and conditions of existence (Fern, 2001). In doing so, they articulated the voices which are regularly hidden behind the brute and numbing statistics on HIV and AIDS. Of particular significance were the seemingly diverse thinking processes between men and women and across age groups when it comes to trying to cope with livelihood impacts of the pandemic.

Table 5: HIV- and AIDS-affected focus groups (2010- 2011)

Focus group members	Number of Focus Group Discussions	Themes explored
Men and women caring for orphaned children	2	Social safety nets, access to support services for orphans, caring for HIV positive orphans, food security, livelihood changes
Adult men 21 - 49 HIV positive	1	Sexuality and reproductive issues, access to services, quality and constraints to services, livelihood activities and constraints, other related issues
Adult women 21 - 49 HIV positive	1	Sexuality and reproductive issues, access to services, quality and constraints to services, livelihood activities and constraints, other related issues, Prevention of Mother to Child Transmission services, feeding and care issues, Gender based violence
Elderly women 50+ HIV positive	1	Experiences with HIV, access to services, Stigma and orphan care issues
Child headed family members	1	Experiences, child care issues, access to services
People accessing services from Morgenster Mission Hospital	1	Quality of services

However, as with other research techniques, there are words of warning. Evidence collected from focus group discussions amounts to self-reported data and this relies upon participants' truthfulness and recall accuracy. Further, what the participants report about their experiences and activities may be quite different from what actually takes place in their lives. Of special concern was possible distortions of truth with reference to community concern and caring for HIV and AIDS infected and affected people (including questions of stigma and discrimination), and this was minimised by using individual in-depth interviews to cross-check information collected through the focus group discussions.

3.5.7 Observation

According to Ulin et al. (2002), observation is a qualitative method with its roots in traditional ethnographic research. It is time-consuming and involves the researcher interacting and observing research subjects in their real-life context and homes. In this respect, I attended and participated in local community meetings, visited the chronically ill in hospital and in their homes, attended burial meetings and listened to traditional dispute hearings in the community.

At times, community members asked me for advice and to comment on local issues. However, in all these proceedings, I made clear I was apolitical and neutral on many key issues.

I observed first-hand the socio-economic conditions of existence in Chivanhu (such as land holdings and land usages) and overheard everyday conversations between community members. At times I would break the observation by explicitly asking questions around issues which had been observed. All this helped me to map out relationships within and between households, and to identify different perspectives held by community members about the pandemic. Sustained observation during my many field trips facilitated the emergence of a nuanced understanding of the HIV and AIDS-affected households in Chivanhu which, in the end, could only be achieved through these personal and close experiences with community members. Most of the visits for observation purposes led to the breaking down of communication barriers and built trust, which helped in obtaining honest perspectives from the many local households under study over an extended period. However observation in Chivanhu was very tedious, as I observed and reflected on site but only wrote notes later; at times it was difficult to recall in detail the conversations that had taken place.

3.5.8 Primary documentation

Primary documents refer to information in its original form such that it is not interpreted, condensed or evaluated by another person. Information from primary documents offered me a unique opportunity to gain details about the HIV and AIDS problem in Chivanhu and the Masvingo Rural District more generally. In this respect, primary documents from the health centres, village head registers and the district AIDS council were reviewed. The health centre documentation complemented the data generated from the household livelihood survey in compiling a list of HIV and AIDS morbidity and mortality issues in Chivanhu. These documents also showed whether the HIV-positive patients were adhering properly or not to ART. The village head registers confirmed officially the identity and status of household heads residing in the settlement. Reports from the district AIDS council were examined to assist in determining the prevalence and complexity of HIV and AIDS in the community. In addition to these local documents which spoke to Chivanhu itself, a wide range of primary documents (including state documents) about the AIDS situation in Zimbabwe broadly were used to help in contextualising the local AIDS dynamics.

3.6 Validity and analysis of data

The data collected through the livelihood questionnaire was analysed using the Statistical Package for Social Sciences (SPSS). Qualitative data was analysed through identifying themes in the data and the various relationships between the themes. I made inferences into and about the collected data and, on this basis, identified key themes related to HIV susceptibility, AIDS vulnerability and resilience. The qualitative field data was then coded and arranged according to the identified themes. By analysing the data both quantitatively and qualitatively, validity was ensured through data triangulation and method triangulation. Data collected through different methods was triangulated to check for both consistencies and inconsistencies. The process of data collection was systematic and the multi-method sequential approach allowed me to cross-check later findings with the earlier findings and to conduct further enquiry to correct the inconsistencies and confirm the findings.

3.7 Reflections on the methodology

In reflecting on the research methodology used for thesis, two important points arise. First of all, there is the significance of multiple scalar levels of analysis and specifically the introduction of the cluster approach. According to Seeley et al. (2008), Drinkwater et al. (2006) broke ground in HIV and AIDS research through the researchers' adoption of a 'clustered' approach to HIV and AIDS study. Clusters range from five people (one household) to about twenty people (multiple households). They entail the establishment of significant links between households though not necessarily residing in the same geographical area. It is generally recognised that a household is rarely a self-contained productive and consumption unit, and that a group of households maintain critical resource flows of an informal kind. This does not necessarily involve direct resource exchanges, but rather a set of complex and multi-faceted interrelationships within and between the participating households.

Though this recognition exists in the prevailing academic literature, it is not studied with any vigour and rigour. If the unit of analysis is simply the household, Barnett and Whiteside (2002) – as cited in Binswanger (2006) – found out that households which

Dissolve or disappear which are arguably the most affected by HIV and AIDS are thus lost in the research process. They have noticed that with regards to HIV and AIDS, household level analysis fail to capture the complex interactions and relations between and within households, household clusters and at community level (Binswanger, 2006:7).

Thus, the cluster approach was adopted in this study and was used for identifying interconnected households. This approach, for my study, facilitated the mapping out of the impacts of HIV and AIDS across households; and it helped to identify the existence and relevance of livelihood decisions across clustered households in responding to the impacts of HIV and AIDS. Previous studies have not attempted to do this in any significant way but, for my study, this became critically important. My thesis therefore adds a new dimension to AIDS research, as it looks beyond household analysis and enables a more nuanced analysis of inter-household interrelationships. For example, it shows how chronic illness and death of a household member usually affects more than just the immediate household and often entails an inter-household or clustered response.

Secondly, this study – through combining qualitative and quantitative approaches – uses a complex process of triangulation to reduce the limitations of current approaches and methodologies in studying HIV and AIDS. For example, the household livelihood survey is used to scoop and identify the profiles of various affected households in Chivanhu. In addition, by means of an overall case study design, I am able to holistically examine the complex and differential impacts of the HIV and AIDS epidemic on household and community vulnerability, as well as the activities pursued to cope with the consequences of the pandemic. Triangulation also allows the researcher, as much as possible, to isolate the impact of HIV and AIDS from other deleterious effects on households. In this regard, Stokes (2003) argues that for research to map out the specific impact of HIV and AIDS on affected households, it needs to provide detailed (almost ethnographic) evidence to identify possible alternative causal factors likely to produce similar changes in livelihoods assets. The adoption of rigorous triangulated methods of data collection (of the kind used in the Chivanhu study) offers a strong basis for isolating those livelihood changes specifically related to the impacts of HIV and AIDS.

3.8 Conclusion

This chapter has described the research methodology pursued in my study of Chivanhu settlement, including the research design, research methods and data analysis. It has highlighted the significance of the research design (notably a case-study approach, triangulation, different scalar levels and a longitudinal study) for tackling the questions of susceptibility, vulnerability and resilience. This design was developed and chosen with

meticulous care as a strong basis for the collection of field evidence which speaks directly to the main research objective of the thesis along with all secondary objectives. The next chapter discusses questions about HIV susceptibility and AIDS vulnerability in Zimbabwe broadly as a pertinent contemporary social context for then looking at specifically Chivanhu in the following three chapters.

CHAPTER 4: HIV SUSCEPTIBILITY AND AIDS VULNERABILITY IN ZIMBABWE

4.1 Introduction

This chapter provides an overview of HIV and AIDS in Zimbabwe historically as well as offering a contemporary portrait. It discusses the prevalence of HIV and AIDS in the country and traces its development over time, noting that there has been a decline in the prevalence rate in recent years. It also describes the factors which make Zimbabweans susceptible and vulnerable to HIV and AIDS and in the ways in which women are affected especially. It details the Zimbabwean government's response to the pandemic in terms of policies, programmes and institutional arrangements, and it considers the role played by more locally-based governance structures and civil society groups in alleviating the impact of the pandemic (including in rural spaces). Though there has been significant progress in tackling the HIV and AIDS challenges at a national level, the following chapters on Chivanhu will be able to show if such interventions trickle down to rural marginal spaces like Chivanhu.

4.2 Background to HIV and AIDS in Zimbabwe

Zimbabwe is a landlocked country with a land area of 390,757 square kilometres. According to the 2002 census report, the total population in Zimbabwe was 11.7 million. The HIV epidemic is showing signs of decline in terms of prevalence rates: in 2002 (34%), 2004 (24.6%), 2006 (18.6%), 2007 (15.6%) 2009 (13.7%) and 15.3% in 2012. But the challenges from HIV and AIDS are far from over (MOHCW, 2009; NAC, 2010; ZIMSTAT and ICF, 2012). The gains in life expectancy at birth that were gained in Zimbabwe after independence were reversed as a result of HIV and AIDS. Life expectancy at birth has been reduced from around 60 in 1990 to 37 years in 2006 although, with improved nutrition and access to ART, it has risen to 50 years for men and 47 years for women respectively (Yikoniko, 2012). Even with the decline in recent years, Zimbabwe's prevalence rate remains amongst the highest in the world, along with other countries in southern Africa: "The country continues to experience one of the worst HIV infection rates in sub-Saharan Africa. In 2009 an estimated 1.1 million adults and children were living with HIV" (ZIMSTAT and ICF, 2012:218). In the case of Zimbabwe, heterosexual sex accounts for 92 percent of infections and mother-to-child transmission is also important in this regard, contributing to seven percent of all infections (GoZ, 2010).

The estimate of the year 2006 of a 37 years life expectancy from birth, which was at the time of the peak of the HIV and AIDS epidemic, is 23 years lower than it would have been without HIV and AIDS. The number of HIV-infected persons in the population rose from about 390,000 in 1988 to nearly 1.8 million by 2003, as the epidemic expanded rapidly through the country. The devastation of the epidemic can be seen by looking at the cumulative AIDS-related deaths over time. An estimated 1.5 million Zimbabweans have died as a result of HIV and AIDS. The number of orphans rose from 345,000 in 1988 to 1.4 million by 2003. By 2005, the HIV and AIDS epidemic had embedded itself in every part of the country, both urban and rural, and the situation worsened as increasing numbers of people already infected with HIV developed HIV-related chronic illnesses and died. Particularly disturbing is the pandemic's contribution to increased morbidity and mortality among the young and middle-aged adults, depriving households of a younger generation and of income-earning members. The economic effects of HIV and AIDS have been severe on households and their social reproduction as a result, for example, the loss of employment, loss of household income, erosion of savings and increased health and funeral expenditures (Garbus and Khumalo-Sakutukwa, 2003).

The first HIV case in Zimbabwe was identified in 1985. Initial responses in Zimbabwe to the HIV and AIDS epidemic have followed the patterns seen in other countries in the region and elsewhere. The initial responses were bio-medically informed and were concerned with reducing the number of new infections, often with the emphasis on behavioural changes, without addressing the socio-economic underpinnings of the infection (Garbus and Khumalo-Sakutukwa, 2003). The sentinel surveillance for HIV was initiated in 1991 and the subsequent antenatal HIV sentinel surveillance in 2000 showed that 35 percent of pregnant women attending antenatal services were HIV infected. However these early surveillance surveys had accuracy and methodological issues, hence the data accuracy of these early surveys has been challenged. Further initiatives undertaken by the Zimbabwean government, which have been of some significance, are discussed later in this chapter.

4.3 Factors influencing the HIV and AIDS epidemic in Zimbabwe

In Zimbabwe, HIV susceptibility and AIDS vulnerability is influenced by a complex interplay between broad structural factors, and more localised, contingent factors at community, household and individual levels (Gomo et al., 2003, Loevinsohn and Gillespie, 2003, GoZ, 2006, Fraser et al., 2011). The impact of the epidemic in Zimbabwe has been compounded by

the negative consequences of political conflict, social and economic decline and droughts. I am going to outline the broad structural and localised factors that have shaped the scope and nature of the HIV and AIDS epidemic in Zimbabwe. Although Zimbabwe is experiencing a mature and generalised HIV and AIDS epidemic, there are important age, gender and geographical differences in HIV prevalence. Its prevalence in small towns, farming estates and mines located in rural areas exceeds that in major cities, while transmission into and within rural communal and resettlement areas is also extensive.

The colonial and post-colonial social environments characterized by dramatic social and economic change at times, changing morals, high mobility, gender inequality, questionable macro-economic programmes and widespread and often deepening poverty are some of the factors leading to the spreading of HIV across the country. Apart from these broader social, political and economic factors, there are also factors at community level, notably cultural (such as concurrent multiple concurrent sexual relationships and intergenerational sexual relationships) and gender relations. However it is important to note that these existing community factors are also embedded within events happening in the broader social, political and economic environment. Sexual behaviours animating the HIV and AIDS epidemic in Zimbabwe are influenced by a complex array of social-economic and cultural factors. Vulnerable populations are adopting an array of survival strategies, including generating additional sources of food or income, migrating, children dropping out of school, and transactional sex entailing the exchange of sex for food or money (Gomo et al., 2003, NAC, 2006). I will outline all these issues in the following sections.

4.3.1 Colonial social engineering

The colonial policies and events leading up to 1980 have also contributed to the current scope and magnitude of the HIV and AIDS in Zimbabwe. Gomo et al. (2003) thus state that the current levels of HIV and AIDS are a manifestation of past colonial period social engineering and reorganization. For Gomo et al. (2003) the general vulnerability to HIV and AIDS experienced by people in Zimbabwe is not a recent happening, but must be located in a long process of social engineering which took place during a century of colonial governance. Colonial authorities, by fostering conditions of inequality and poverty along racial lines, in a sense created unintentionally an ideal template favouring the spread of HIV. For instance, in seeking to create a subservient working class, the regime in colonial Rhodesia passed legislation which took away land, livestock and access to water sources from the indigenous

population, facilitated the migrant labour system and undercut rural sources of livelihood from the black majority; all of this resulted in a dramatic spatial separation between residence and work. Working men were forced to move between their residences in urban centres (where they worked and stayed most of the year) and their rural home in communal areas (where their families stayed) during holidays and weekends. This produced an efficient transmission route for sexually-transmitted diseases and more recently HIV. Promiscuity of sexual life among urban workers was facilitated through the establishment of single-sex residential compounds in which beer drinking and prostitutes were available as antidotes for desires to be with one's family (Gomo et al., 2003).

4.3.2 Post-independence and economic structural adjustment policies

Apart from the conditions created in the colonial period, policy blind spots by the Zimbabwean government, adopted after independence in 1980, are also responsible for creating a fertile ground for increased HIV susceptibility and AIDS vulnerability in the country (Gomo et al., 2003). At independence, the Zimbabwean economy was more industrialised than most in Africa, with a diversified productive base and relatively sophisticated and developed infrastructure (Chattophadyay, 2000; Tibaijuka, 2005; Paradza, 2010a, Rakodi, 1995). Zimbabwe experienced a brief boom in the economy just after independence, spurred in large part by the lifting of international sanctions (Chattophadyay, 2000; Tibaijuka, 2005). Domestic demand for commodities expanded rapidly, while export incentives were eliminated and the real exchange rate was allowed to appreciate by 20 percent (Riddell, 1990:376; Chattophadyay, 2000). The average economic growth was 3.4 percent during the period from 1980 to 1992, and a positive balance of payments existed. In many ways, though, the early macro-economic policies differed little in principle from those followed by the fifteen years of Rhodesian rule under Ian Smith. In 1990, the manufacturing sector contributed 26 percent of the Gross Domestic Product (GDP), compared to agriculture's 13 percent (Economic Intelligence Unit, 1992:3).

Post-independence development programmes prioritised poverty reduction, and government spending was geared towards increased social sector expenditure in particularly health and education. The government introduced free medical services for people earning less than the minimum wage and substantially increased investment in rural health programmes. The increased access to medical facilities and investments by the government in preventative health care reduced child mortality increased life expectancy and improved the general well-

being of the population. By the end of the 1980s, the country was one of Africa's leaders in terms of overall access to health and education. However, a persistent high budget deficit was experienced by the government during the first post-independence decade.

Zimbabwe entered the 1990s with a huge fiscal imbalance and declining tax revenues caused by declining commodity prices. This was accompanied by stagnation of the economy and record levels of unemployment (IMF, 1997; Sithole, 1996, Chattophadyay, 2000). An Economic Structural Adjustment Programme (ESAP) was promoted as a home-grown economic programme, in order to address the challenges that were being experienced in the economy. The adjustment programme needed the support of the International Monetary Fund (IMF) for it to be successful and in order to get IMF support, the first phase of ESAP began with the introduction of trade liberalisation which scrapped import controls, removed subsidies and reduced spending on social services like health and education. User fees were introduced for access to medical and social services. Concurrently, the HIV and AIDS epidemic was also increasing during the same period. After ESAP reforms, poverty increased significantly with an estimated 35 percent of households living below the poverty line, compared to about 26 percent at the end of the 1980s. According to the United Nations Development Programme, based on an analysis of the total consumption poverty line, households in poverty increased from around 40 percent in the late 1980s to approximately 62 percent by the mid-1990s (Moyo and Murisa, 2008). ESAP led to increases in prices of food and other basic commodities, and cuts in government subsidies led to sharp increases in the cost of living, and of access to health and education facilities (Kanji and Jazdowska, 1993; IMF, 1999). The impact of the currency devaluation and the broader macro-economic reforms was the immediate downgrading of Zimbabwe from middle to a low income country status.

The first sector to face major impacts from the squeezing of public expenditure was the health care system. Total spending for health amounted to ZWD386,7 million in the 1994/95 budget against a figure of ZWD566,8 million for 1990/91 before ESAP (Chattophadyay, 2000). And the absolute size of the health care system declined consistency from the mid-1990s. The effect of recurrent government cuts on health system spending has been felt throughout the health system. Preventive health and outreach programmes including HIV prevention services, particularly in rural areas, were among the hardest hit. In this regard, real earnings for health workers declined by nearly 30 percent from 1991 to 1995. Although health workers were protected from retrenchment, reductions in Ministry of Health administration and

maintenance staff reduced efficiency and compounded other difficulties. In reducing health spending by a third, and by introducing user fees for health services, government action led to a cutback in outreach activities, drug shortages, declining clinic attendances, increased infant mortality and loss of health staff due to the brain drain (Basset et al, 1997; Paradza, 2010a). In addition, life expectancy which had peaked at 60 years by 1990 dropped to 52 years in 1997, to 43 in 2003 and to 37 in 2006 (GoZ, 2006). Maternal deaths increased from 73 per 100,000 in 1997 to 144 per 100,000 (World Bank, 1997; MOHCW, 1997, MOHCW, 2011).

The cuts in health care could not have come at a worse time, especially in light of Zimbabwe's emerging HIV and AIDS crisis. In 1996, it is estimated that around 300 people were dying a week from AIDS-related chronic illnesses (Chattophadyay, 2000). ESAP went against the social expenditure on health during the 1980s and generally deepened livelihood insecurity, and this contributed to people becoming susceptible to HIV and vulnerable to AIDS. ESAP also induced changes in communal areas by significantly altering the dynamics of mobility patterns. In some instances, contraction of urban employment opportunities resulted in return migration to rural spaces; and removal of agricultural subsidies resulted in reduced incomes for smallholder agriculture and caused rural to urban movements. The non-delivery of policies like ESAP in the short and long term further reinforced conditions of vulnerability and insecurity, and this put increasing socio-economic pressure and stress on both the rural and urban population to adopt alternative, highly migratory and sometimes risky, survival strategies such as commercial sex work.. Among these survival strategies was increasing mobility in search of sustenance not only within the country but in the region and abroad. As more companies and factories closed during the ESAP era, this also dovetailed with losses of employment in the formal sector and the erosion of real wages. Increasingly urban populations turned to the land for sustenance, and this sometimes led to informal and unofficial occupation of urban lands for agricultural purposes. As well, because of dwindling real wages in urban economies, supplementary social reproduction strategies in the countryside were pursued (Moyo and Murisa, 2008, Paradza, 2010a; Paradza, 2010b).

The cumulative impacts of all these processes, in terms of the ways in which people handled them, resulted in higher levels of susceptibility and vulnerability to HIV and AIDS. Apart from ESAP, during the 1990s, the hardships caused by economic restructuring were compounded by a culture of political patronage, where populist measures were implemented at the cost of meaningful economic and political reforms. One such decision during this phase

was particularly costly, namely buying off the challenge from war veterans (ex-combatants from the civil war in the 1970s) and their demands for compensation. Thousands of war veterans were granted lump sum payments of ZWD50.000 plus ZWD2.000 as an ongoing monthly pension (Bond, 1998, Tibaijuka, 2005). The cumulative impact of all these socio-economic processes was deepening economic stagnation plus pronounced tendencies of rising inflation, declines in real wages, job losses, unprecedented levels of poverty and desperation among the general population. This resulted in HIV finding a fertile ground or environment conducive for its rapid spread. Individual's responses to the harsh economic conditions made people highly susceptible to HIV infection.

There is high mobility and migrancy within Zimbabwe as well as within the southern African region. Migrant labour separates men from their families, places them in close proximity to high risk sexual networks, and may result in their having an increased number of concurrent sexual contacts or networks. Multiple concurrent partnerships are often linked to mobility, including labour related mobility; those staying behind may themselves have other partners (Coffie et al., 2007; Lurie et al., 2003). Concurrent relationships in partnership with high viral load, acute HIV infection and the low level of male circumcision, have contributed to the rapid spread and the high prevalence levels. Sexual partner networks that include concurrent partnerships lead to higher HIV and AIDS epidemic rates than do networks without concurrent partnerships (Epstein, 2007; Morris and Kretzschma, 1997). Again, it is important to note that ESAP's effects on gender inequality were particularly disastrous (Kanji and Jazdowska, 1993; Paradza, 2010b). Simultaneously, it may also lead to women's reliance on sex to supplement their incomes while their male partners are away for long periods.

4.3.3 Fast track land redistribution

The ruling party (ZANU-PF) lost significant popularity in the 1990s due to the economic downturn, currency collapse, food shortages and unemployment (McGregor, 2001; Hartnack, 2005:178). Realising that ESAP was not a panacea but in fact further fuelled general economic vulnerability, the government developed home-grown strategies to address socio-economic imbalances: the land question in Zimbabwe resurfaced dramatically as a legitimate means for poverty reduction. In 1999, with lobbying from war veterans, land invasions accelerated particularly in the lead up to the 2000 parliamentary elections (Chaumba et al., 2003). In 1999, a new political party was formed and ZANU-PF began a process of violent campaigns and intimidation aimed at undermining the new party (Movement for Democratic

Change). In the context of widespread land occupations of primarily white commercial farms (starting in early 2000), the emerging political conflict resulted in the launch of the accelerated land reform programme (known as fast track) on July 15, 2000. Besides addressing land shortages amongst communal farmers, fast track also sought to undo the tensions resulting from the earlier austerity measures and economic decline.

The land reform programme led to the disruption of commercial agriculture and it negatively affected the country's industrial base which was largely agro-based. Because they undermined private property rights, the land occupations and subsequent fast track were denounced internationally. This prompted the imposition of targeted sanctions from the European Union, the United States and several Commonwealth countries. While the sanctions were not targeted at the economy *per se*, they contributed to the polarisation of political conflict within Zimbabwe and led to negative travel advisories which heavily affected the lucrative tourism industry (Tibaijuka, 2005). Overall, the country's economy continued to deteriorate after the land reform programme. The impacts went beyond manufacturing, agro-based industries and tourism to other sectors of the economy like mining and the service sector. By January 2005, the Zimbabwean economy was characterised by a massive inflation rate, severe shortages of foreign currency, restricted access to the supply of essential imports needed for industrial and agricultural production, and limited fuel and basic commodities. The declining formal economy also had a negative impact on the government's revenue base.

The economic and political disruptions had a major impact on the coping strategies of HIV- and AIDS-affected people. Proper food and nutrition, which is critical for long-term survival with the virus, was out of reach for many households. Further, the funding basis of the government's National HIV and AIDS Trust Fund was eroded due to the dwindling of the revenue collection base through loss of taxes and foreign currency. The nutritional and food security status of many people was precarious, forcing the majority of the people to engage in livelihood strategies that fuelled the spread of HIV. Without access to life saving drugs like ART, access to adequate and nutritious food was the major strategy for the HIV infected to manage and live longer with the HIV virus, before developing AIDS-defining opportunistic infections. Given the political and economic situation arising from the year 2000, many donors reduced their funding to activities in the social sectors (including HIV and AIDS), human rights and governance programmes. But even this was restricted to urban centres and communal lands, as donors refused to fund activities of NGOs in the new fast track farms.

Given that the state provided only limited post-settlement support to these farms, livelihoods amongst fast track settlers were compromised to some extent.

Fast track land reform was accompanied by large movements of people, the re-constitution and regroupings of household and family units, and exposure to new sexual networks (Garbus and Khumalo-Sakutukwa, 2003). Hence, an important downside to land resettlement was that it weakened kinship ties as people moved and lived apart from their kin. It therefore brought with it social disruption, and social institutions of sexual behaviour censorship were weakened. Because people moved into new areas, new sexual networks and alliances were entered in these areas. Most of the former commercial farm areas did not have access to health services and were inaccessible; and the people who had moved to reside in these emerging settlements lost opportunities for sex education and socially controlled courtship. This increased the HIV susceptibility and AIDS vulnerability of the people who were involved in land reform related mobility. The majority of the beneficiaries of land reform also maintained homes and sexual alliances in their original communal lands and urban homes, becoming bridges for transmission across different areas and geographical zones.

4.3.4 Operation Restore Order

In May 2005, the Zimbabwean government implemented Operation Restore Order aimed at destroying illegal dwellings in urban and rural areas. The operation continued until June 2005 and it affected virtually every town and rural business centre in the country from Mt Darwin in the north to Beitbridge in the south (Action AID, 2005; Tibaijuka, 2005; Paradza, 2010). The numbers of people estimated to have been displaced vary from 300,000 to one million (Tibaijuka, 2005). The apparent motives behind the operation included a general concern felt by government to tackle the chaos and congestion that characterized housing and informal businesses in urban areas and to undermine the parallel foreign currency market. The operation led to the destruction of people's homes and sources of livelihood, and it blocked access to services, business premises and property in urban areas.

High on the list of those affected by the operation were the following: women and girls, households with orphans, chronically-ill persons, female-headed households, the elderly, homeless orphaned children and homeless people living with HIV and AIDS. The HIV-infected who were on anti retroviral treatment (before Operation Restore Order) were able to access their drugs at nearby government hospitals and clinics and had other support systems.

HIV and AIDS people were forcibly removed by the operation from their places of residences and were prevented from accessing resources (including treatment) and assistance from the support groups (Action AID, 2005). The operation clearly increased hardships experienced by special categories of people, including people living with HIV and AIDS (a significant number of whom were already bedridden or receiving antiretroviral treatment) and children orphaned by AIDS. People who were displaced from urban areas and who did not have rural homes, sometimes moved into informal settlements like Chivanhu Settlement. Some of them had challenges coping and were pushed further into highly mobile livelihood strategies and resorting to transactional sexual alliances for women and young girls.

4.3.5 Cultural and gender factors

Apart from the factors that have been mentioned in previous sections, there are other social and behavioural practices as well as gender inequality relations at community and household level that have also interacted with these broader social and economic factors. Local cultural values allow for a number of practices which make Zimbabwean men and women susceptible to HIV. Of particular significance is polygamy, as 15 percent of married women in Zimbabwe are reported to be in polygamous relationships. Widow inheritance, girl-pledging and forced marriages also make women particularly prone to infection.

Traditional support systems do not favour women. Most ethnic groups in Zimbabwe follow patriarchal systems where lineage is traced from the father's side. These systems impose strict controls on female sexual behaviours whereas the attitude towards male sexual behaviour is more lenient. Further, Zimbabwe's constitution permits discrimination against women on the basis of customary law, under which women are designated as minors. In the Zimbabwean context, female ignorance of sexual matters is considered a sign of purity and, conversely, knowledge of sexual matters and the reproductive system is viewed negatively. The equation of ignorance with innocence may inhibit some women from seeking information that is critical for their well-being in the face of the pandemic. Certainly, lack of vital information among women and girls in Zimbabwe limits their ability to adopt risk-reducing behaviour and to identify early abnormal symptoms that could signify a sexually-transmitted infection.

Women's subordinate economic status affects their susceptibility to acquiring HIV but, also once infected, it affects their vulnerability to AIDS due to challenges in accessing care and support services. As well, HIV and AIDS affects women by increasing their care load in the

home and leaving many women widowed. Women therefore face competing demands for engaging in livelihood strategies and care of family members suffering from AIDS-related illnesses.

Arguments by scholars Siplon (2005) suggest that most HIV and AIDS strategic plans are failing to curb the pandemic in part because they are insensitive to or do not privilege institutionally-embedded cultural systems which dis-empower women and which place unnecessary burdens on them. Counteracting this, and tackling HIV and AIDS, would entail repositioning women both culturally and institutionally. There are also widespread reports of gender-based violence across all ethnic groups in Zimbabwe. In fact, violence within marriage is widely tolerated. Furthermore, if a woman dies, in the event of the husband's remarriage her children are likely to be fostered by an elderly woman and she normally has serious material and social constraints in caring for HIV-infected children or orphans (Matshalaga, 2005)

4.4 HIV and AIDS policy responses and HIV susceptibility and AIDS vulnerability

The policy and institutional response regarding HIV and AIDS, and the way it was designed and implemented, are also factors that have influenced HIV susceptibility and AIDS vulnerability in Zimbabwe. The current HIV and AIDS response is implemented through traditional and formal governance structures. In rural spaces, traditional structures are the village heads, headmen and chiefs. The formal governance structures are the village development committees, ward development committees and rural district councils. Institutional challenges affecting the functioning of traditional and formal governance structures are critical in understanding HIV susceptibility and AIDS vulnerability in Zimbabwe. Traditional authorities, although they are usually associated with governance issues for communal areas, claim in certain cases jurisdiction over informal settlements like Chivanhu Settlement. I first detail the overall Zimbabwean national response to the pandemic, historically.

4.4.1 Early responses to the HIV and AIDS epidemic

The Zimbabwean response to HIV and AIDS seems to follow the same pattern as has happened in other countries with a significant AIDS epidemic: denial, complacency or a *laissez faire* attitude, followed by panic and finally acceptance. The duration of each stage depends on a complex mix of culture, access to scientific knowledge and politics. The HIV

and AIDS crisis in Zimbabwe is in large part the result of an extended period of complacency. Countries that stayed longer in the complacency stage are likely to have a more substantial epidemic than those whose complacency stage was shorter.

HIV was first discovered and identified among marginalized groups (men who have sex with men (MSM), commercial sex workers (CSWs), and injection drug users (IDUs) and this made mainstream society define it as an isolated problem and exclusive to certain groups. The early discussions and messages about HIV and AIDS were informed by this attitude. Apart from the fact that it was considered a marginalized group condition, the fact that HIV is spread through heterosexual contact tended to further fuel the denial in the Zimbabwean context, where people do not talk publicly about sex. In addition, an attitude prevailed amongst policymakers in Zimbabwe that a medical solution to the problem would be found soon due to advances in science (Gomo et al., 2003). After this early stage of complacency and denial, the Zimbabwean response moved to panic, with HIV and AIDS being declared a state of emergency. The problem though was that panic produced paralysis in practice, especially because the problem soon became overwhelming.

After the first AIDS case was identified, the government's initial response involved the introduction of universal screening of blood and blood products. The first coordinated response was implemented in 1987, through the establishment of a Health Experts Advisory Committee to give advice on HIV and AIDS. The National AIDS Control Programme (NACP) was also formulated in relation to this, and the establishment of a one-year emergency Short Term Plan (STP) on HIV and AIDS was put in place from 1987 to 1988 (MOHCW, 2000; NAC, 2010). The STP was aimed at creating awareness about HIV and AIDS through information, education and communication, and the training of health personnel in different aspects of HIV and AIDS prevention and control. The emergency plan also sought to provide surveillance for the disease Garbus and Khumalo-Sakutukwa, 2003).

The short-term plan was followed by the Medium Term Plan 1 (MTP1) from 1989 to 1993. This plan focussed on consolidating and expanding interventions initiated during the short term plan, motivating appropriate change in sexual behaviour among specific populations groups, counselling and caring for people with HIV, and monitoring the epidemic through effective epidemiological surveillance. In recognition of the deteriorating AIDS situation and the need to mobilise other sectors to participate actively in the fight against HIV and AIDS, a

multi-sectorial approach was adopted. The adoption of this approach led to the development and implementation of the multi-sectorial Medium-Term Plan 2 (MTP2) from 1994 to 1998. The main objective of the MTP 2 was focussing on reducing HIV transmission and other sexually transmitted infections (GoZ, 1999; Garbus and Khumalo-Sakutukwa, 2003). The multisectorial approach acknowledged that the causes and consequences of HIV and AIDS in the country could not be understood as a medical problem and could not be addressed through the health sector alone (Garbus and Khumalo-Sakutukwa, 2003). Furthermore, apart from these challenges in a narrowly focussed medical approach, an evaluation done by a joint donor-government team showed that although a national AIDS control programme was put in place in 1987, it also lacked personnel to implement its mandate and there was limited political support and leadership for the HIV and AIDS struggle during the early stages of the epidemic. This led to the development of a National HIV and AIDS Policy for Zimbabwe in 1999 (Gomo et al., 2003; Garbus-Khumalo-Sakutukwa, 2003).

4.4.2 National AIDS policy 1999

The policy failures resulted in increased HIV susceptibility and AIDS vulnerability in the 1990s. The increasing levels of HIV infection, especially among youth, coupled with the many impacts (such as deaths and disease burden) of the epidemic, forced the Zimbabwean government to acknowledge that its actions against HIV and AIDS had been inadequate and limited in scope and effectiveness. The government realized that it did not have a comprehensive HIV and AIDS policy to guide its HIV and AIDS response and it also realized that although it had recognized the enormity of HIV and AIDS for some time, its response was slow and poorly designed, implemented and coordinated. In 1999 a comprehensive HIV and AIDS Policy for Zimbabwe were developed. In May 2000, the following year, the National AIDS Council (NAC) was created through an Act of parliament (National AIDS Act 15:14 of 1999), to implement and coordinate the National HIV and AIDS Policy. The NAC'S role was to coordinate, facilitate, mobilize, support and monitor the decentralized national multi-sectorial response to HIV and AIDS (through provincial, district, ward and village action committees), and to administer the National AIDS Trust Fund and donated resources. The National Trust Fund, which was financed by a three percent levy on all income tax paid to the government, was established to finance the national AIDS response. The National AIDS Trust Fund was created to disburse the levy revenue to address issues pertaining to HIV and AIDS in general (versus solely treatment and care). An AIDS levy administered by the

National AIDS Council was introduced in 1999 to supplement the Ministry of Health and Child Welfare's (MOHCW) HIV and AIDS budget.

However, the AIDS levy has been a contentious issue. In pursuing this response, the government was criticized for insufficient consultation with all stakeholders especially people living with HIV and AIDS. The fund was also introduced when the working classes were experiencing widespread challenges, and this further squeezed disposable income available for many people in the country. The initial fund disbursements were haphazard and civil society has argued that the initial disbursements were politicized and disbursed through ZANU-PF (Garbus and Khumalo-Sakutukwa, 2003). Furthermore, even in 1999, after realizing the shortcomings of a narrow medical focused approach, the multi-sectorial response on the ground

Remained largely biomedical in its early stages. The HIV and AIDS problem, it was argued, would be solved largely by and within the health sector. The HIV virus was seen as a 'social bug', such that attention was focused on the virus's bodily impact and not on broader questions about social behaviour and socio-economic circumstances which may lead to the virus entering the body in the first place (Garbus and Khumalo-Sakutukwa, 2003:45).

The current HIV and AIDS approach has been accused of being a one size fits all approach with no regard for nationwide differences in susceptibility and vulnerability to HIV and AIDS.

Apart from the contentious issues mentioned above, NAC initially faced capacity problems and limited resources (both human and financial), as well as overwhelming and competing demands for its services. The National AIDS Council also faced internal struggles about viability and power. The civil society group, Networks of People Living with HIV, claimed that they lobbied for the set up of the NAC, and civil society composed of HIV and AIDS NGOs and CBOs also wrestled for control of NAC and its resources. Stigma and denial around HIV and AIDS was also rife in policymaking circles, making it difficult for NAC to deliver on its mandate. Without adequate financial and human resources, it was difficult for NAC to bring more than 300 different stakeholders together. Zimbabwe's HIV and AIDS policy did not provide a clear framework for its implementation. Given the country's early myriad and interrelated crises, the government lacked motivation and the ability to focus on and support HIV and AIDS policy. Many of the various stakeholders had accountability

challenges as well. With the dwindling of the economic base from which NAC was drawing its funding, NAC was not spared from the decade long economic decline and HIV susceptibility and AIDS vulnerability was increasing during all this time.

4.4.3 National AIDS strategic frameworks (2000-2004, 2006-2010, 2011-2015)

Zimbabwe developed National AIDS Strategic Frameworks (ZNASP); the first in 2000, the second in 2006 and the last, which is the current one, in 2011. The basic principles guiding all of the strategic frameworks on HIV and AIDS are as follows: understanding HIV as a national emergency; the requirement that all stakeholders work together in a multi-sectorial manner; addressing gender inequality and stigma; the need for adequate resources; committing Zimbabwe to achieving international HIV and AIDS goals; and adopting evidence-informed and effective strategies to contain the HIV and AIDS epidemic. The initial framework was first published in November 1999 and it was adopted in 2000, and it covered programme implementation and coordination from 2000 to 2004. It focused on district, community (ward and village) response initiatives through community-driven planning, implementation and monitoring processes.

The framework called for greater mobilization and commitment to fight HIV and AIDS from political, civil, economic and traditional leaders; and it argued for an integrated response through multi-sectorial participatory mechanisms involving relevant sectors and interest groups to ensure accessibility of resources to communities. In June 2006, the second strategic plan was published after a thorough review of the first one and of the 1999 AIDS policy. Other sector strategies (for instance, agriculture and transport) have been developed but they are guided by these national strategic instruments. However, some officials still said that the strategy was not clear; according to one key informant interview:

ZNASP 2 was novel, it had everything and it was difficult to put resources in a focused response. The strategy gave room for everyone to come with their weird ideas and call them HIV and AIDS programmes².

The current 2011-2015 strategy, comparatively speaking, is putting more resources towards prevention, treatment and effective coordination. NGOs and CBOs implementing HIV and AIDS feel that there is no room for articulating and pursuing their programmes in the current strategy.

² Personal Communication with Tonderai, ZNNP+ Activist.

Furthermore the current ZNASP is being accused of being narrowly focused on medical issues and not adequately addressing the underlying social, economic and political factors influencing increased HIV susceptibility and AIDS vulnerability in the country. In this regard, one NAC official commented to me privately that

We have failed to contain HIV, so we are focusing on treatment and scaling up behaviour change³.

However the response from the same NAC official on following up on these allegations was as follows:

HIV is a complex issue, we are realizing that although prevention has reduced new infections, we cannot stop people from having sex, and these days it is complex because it is being spread in social networks which are difficult to target with our messages. So we would rather focus on Prevention of Mother to Child and Transmission (PMTCT), circumcision or treating those who are already HIV infected, and resources for HIV and AIDS are also dwindling now⁴.

In all the strategic frameworks, communities are regarded as the key to addressing HIV and AIDS through sustainable initiatives.

The frameworks provide for an HIV and AIDS institutional response with coordination from the National AIDS Council. The current system in place (see Table 6) provides for the setting up of de-centralised Provincial AIDS Action Committees (PAC), District AIDS Action Committees (DAAC), Ward AIDS Action Committees (WAAC) and Village AIDS Action Committees (VAAC). There is one NAC, 10 PAACs and 85 DAACs⁵. The design of the system is embedded within the established traditional and formal governance structures in the country. For collaborating institutions like the Ministry of Health and Child Welfare, Ministry of Agriculture and ZNPP+, the organization of the response also followed the structure adopted by NAC. Table 6 provides a summary of the key coordination structures for HIV and AIDS under the multi-sectorial strategy, and it outlines all the traditional and formal institutions that guide HIV and AIDS response in the multi-sectorial strategy. Formally, every village and ward is supposed to have structures of representation and collaboration all the way up to the national level. The WAAC, if fully operational, mobilises the village structures so that the latter organise grassroots HIV and AIDS initiatives and lobby for resources from the

³ Personal Communication with NAC official who requested withholding of his identity.

⁴ Personal Communication with NAC official who requested withholding of his identity

⁵ Although there are eight provinces, Harare and Bulawayo urban centres are considered provincial areas.

DAAC; the HIV and AIDS activities are then incorporated in the district's consolidated development programme by the DAAC.

However, coordination at lower level structures faces a number of challenges in the country. In some wards, certain critical stakeholders like the village health worker and Agricultural Extension Officer (AGRITEX) officials are not participating due to financial and time constraints. In some cases, some stakeholders are simply overpowered by local political contestations, such that one ZNNP+ official commented:

At ward level, AGRITEX officials and other key people who should attend and contribute in WAAC meetings are overshadowed by officials from the Ministry of Women's Affairs and Community Development. Women representatives of the ministry get an allowance from their ministry unlike other members who should attend the WAAC meetings, and those women end up pushing their own politicised agenda, and pushing aside the HIV and AIDS issues.⁶

The reality on the ground, in different districts around the country, shows that a range of factors including parallel traditional and formal governance structures at community and village levels affect in a negative way the implementation and the effectiveness of intervention programmes for HIV and AIDS.

4.4.4 Post-independence traditional and governance institutional arrangements

The post-independence government created parallel formal structures to traditional governance structures that were there during the colonial period (Paradza, 2010a:85). The colonial government of Zimbabwe during the pre-independence era used traditional leadership institutions to control and administer local people in communal areas (Mohamed-Katerere, 1996). The chiefs were supported in their role by the sub-chiefs or headman (*Sadunhu*) and village heads (*Sabhuku*). The chief and sub-chiefs administer hearings over cases such as domestic violence, conflicts between communal areas residents and land allocation. The sub-chiefs and headmen assist the chief to perform his duties, including reporting to the police the commission of any crime in his area. Broadly, they are there to carry out all lawful and reasonable orders by the chief and to enforce all environmental, conservation and planning laws. The independent government initially marginalized the traditional leaders because of their alleged collaboration with the colonial government.

⁶ Personal Communication with ZNNP+ official who requested withholding of his identity.

Table 6: Organisation of HIV and AIDS Institutional Response under the Multisectoral Strategy

Level		Existing Development structures	AIDS Action Committees	Remarks	Traditional Leadership	AGRITEX	ZNNP+	Child Protection
1	National	MOHCW	NAC board and secretariat	Established by Act of Parliament and administers the National AIDS Trust Fund from National AIDS Levy.	Appointed by the President or through lineage	Head office	National Office	National Office
2	Province	Provincial Development Committee (PDC)	Provincial AIDS Action Committee PAAC as subcommittee	Manicaland Province Midlands Province Masvingo Province Matabeleland South Matabeleland North Mashonaland East Mashonaland West Mashonaland Central Bulawayo Province Harare Province		Provincial AGRITEX Officer	Provincial Secretariat in all the 9 Provinces	Provincial office
3	District/Rural/Urban	Rural District Councils (RDC) Urban Councils (UC)	District AIDS Action Committee DAAC as a subcommittee of Social services/health committees	58 Rural District Council 9 Local authorities) 23 Urban Districts under local authorities.	Chiefs	District AGRITEX Officer		District Office
4	Ward	Rural Health centre community nurse, Councillor, Ministry of Women and Community Development		Range of 10 - 40 wards per district	Headman	AGRITEX officer	Ward secretariat	Ward Child Protection Committees
5	Village	Village Health Worker	Village AIDS Action Committee		Village Head			Village Child Protection Committees

Source: Maboreke, 2008: 7, Guidelines for the District Planning Process for HIV/AIDS

At independence, the government sought to reduce their power and role at all levels. The 1982 Communal Lands Act gave Rural District Councils the overall responsibility for communal areas and the power to allocate land in communal areas and hence officially took this power away from traditional authorities; though this was to take into account customary practices. Additionally in 1984, the then Prime Minister-ordered directive was given on Rural District Councils to establish a system of localized Village and Ward development committees: Village Development Committees (VIDCO) and Ward Development Committees (WADCO). As well, the office of an elected Ward councillor was to take the place of traditional leaders in local rural areas (Brand, 1991). The spatial and the administrative boundaries of the VIDCO and WADCO system coincided with the administrative and spatial boundaries governed by the sub-chief (*sadunhu*) under traditional leadership authority. The purported objective of this directive was to define the administrative structures at provincial and district level and the relationships and channels of communication between all participants in the development process at provincial and district level in order to achieve coordinated development in all provinces and districts (Mohamed-Katerere, 1996; Brand, 1991; Anderson, 1999). Under this new administrative arrangement, the Provincial Governor became the official head of the VIDCOs and WADCOs. In practice, though, chiefs continued to assert their right to allocate land, and this increased the conflict between traditional and elected leaders (Anderson, 1999; Paradza, 2010a). From 1998 to 2001, with the adoption and amendments in 1999 and 2001 of the Traditional Leaders Act, the government made a near complete turnaround and reinstated the power that the chiefs held during colonialism, The Traditional Leaders Act of 1999 has enhanced the authority of traditional leaders, and this seems to be an attempt by ZANU-PF to extend its hegemony deeper into rural areas and to entrench it (Makumbe, 2010; Paradza, 2010a).

Interestingly, the HIV and AIDS response is designed and implemented through traditional and formal governance structures: Provincial AIDS Action Committee (PAC), District AIDS Action Committee (DAAC), Ward AIDS Action Committee (WAAC) and Village AIDS Action Committee (VAAC). In the current set up, the District AIDS Action Committee and the Ward AIDS Action Committee fall under structures that are governed by the local government authority, that is, the Rural District Council. However, the VAAC is governed by the village head and this means it falls under the Traditional Leaders Act. This is the broad institutional context for understanding many of the HIV and AIDS dynamics in Chivanhu Settlement According to Makumbe (2010), there is evidence of increasing struggles between

traditional leadership and Rural District Councils around issues of authority. The Rural District Council Act established, as noted earlier, a local government that excluded traditional leaders.

The current system in both the traditional and local authority (RDC) governance structures does not promote accountability to local rural communities but makes them functionaries of higher coordinating mechanisms. Although there are district-consolidated HIV and AIDS plans in place, any two-way feedback mechanisms between communities and the coordinating structures are non-existent. The RDC structures governing HIV and AIDS are accountable upwards and not downwards. This shapes the nature of participation and partnerships around HIV and AIDS issues. Broadly speaking, the actually-existing institutional governance practices affect the coordination and participation of HIV and AIDS activities and participation by groups such as People Living with HIV (PLWHIV), as will be found out on subsequent chapters on Chivanhu Settlement (thereby increasing HIV susceptibility and AIDS vulnerability).

4.4.5 Donors and civil society

Zimbabwe relies heavily on funding from international donors for its HIV and AIDS programmes. Major donors for HIV and AIDS include Global Fund for AIDS, British (UKAID), Australian AID (AUSAID), European Union, Germany and Japan. Norway, Sweden and Netherlands sponsor smaller programmes. In the early 2000 era, international isolation due to the adoption of the post-2000 land reform programme affected HIV and AIDS external funding opportunities for Zimbabwe. Many bilateral donors reduced or ended their government assistance as a result of this, and many are opting to channel HIV and AIDS funds through non-governmental organizations and UN agencies. Despite all their donors, the Zimbabwean HIV and AIDS response is the least externally funded HIV and AIDS response in sub-Saharan Africa. Lack of adequate national and donor funding for HIV and AIDS is responsible to some extent for the levels of HIV susceptibility and AIDS vulnerability.

Grassroots efforts also provide a significant amount of care and support to persons living with HIV and AIDS and their households in Zimbabwe. Zimbabwe AIDS Network (ZAN), formed in 1990, coordinates AIDS Service Organisations (ASOs) that is NGOs and CBOs in Zimbabwe. ZAN is a membership-based coordination network of organizations working on HIV and AIDS. AIDS Service Organisation's membership in ZAN and is not mandatory,

hence some HIV and AIDS service organizations can opt out of joining the ZAN network. Despite the formation of ZAN to coordinate the NGO response, some NGOs decided not to collaborate with it. This creates challenges of monitoring quality and activities in HIV and AIDS civil society in Zimbabwe. Apart from possibly being members of ZAN, HIV and AIDS organisations (like all other NGOs and CBOs) must register with the Department of Social Welfare, under the Ministry of Labour and Social Welfare, in compliance with the Private Voluntary Organization Act. The National Association of Non-Governmental Organizations (NANGO) also registers both national and international organizations. Registering with the Department of Social Welfare is mandatory and this process is arduous.

The Zimbabwe National Traditional Association represents herbalists, spirit mediums, faith healers and traditional midwives. Under the auspices of NAC, it has developed a national HIV and AIDS prevention project using traditional care systems to provide assistance to those affected by HIV and AIDS. Further, it has developed traditional methods aimed at reducing HIV transmission, as well as increasing awareness of HIV and AIDS for prevention purposes, caring for people with HIV and AIDS and creating a supportive environment for people living with HIV and AIDS. Many religious organizations, for example Catholic Relief Services (CRS), Salvation Army and Zimbabwe Association of Church Affiliated Hospitals (ZACH), are carrying out HIV and AIDS projects and are present in almost every community nationwide. They play an important role in the emotional, social and spiritual aspects of the Zimbabwean population. In addition, they are active in home-based care, education and awareness, HIV and bereavement counselling, supplementary nutrition feeding, schemes for orphans and vulnerable children, special youth programmes, and income-generating projects (Garbus and Khumalo-Sakutukwa, 2003).

Another challenge is that, with poor coordination and accountability for civil society, the HIV and AIDS coverage of activities has not been uniform across different geographical areas and even within the same districts and wards. Some districts are overrepresented while other district and wards are completely left out. This has an influence on HIV susceptibility and AIDS vulnerability for populations residing in different geographical zones in the country. Since most of the civil society response to HIV and AIDS emerged because of the existence of funding from donors, and because programmes are subject to funding cycles rather than focusing constantly on problems on the ground, addressing HIV susceptibility and AIDS vulnerability for civil society groups can be intermittent and irregular. Short funding cycles

also mean that most NGOs want to implement programmes in areas which are easy to negotiate access; and, in fact, most current funding is conditional in that it must focus on urban and traditional communal areas. Newly resettled areas under fast track are not normally targeted presently. Informal settlements are also not specifically targeted and many of them (like Chivanhu Settlement) occupy uncomfortable spaces between communal and former commercial farming areas; are not favourite areas for projects by many civil society players. All these factors contribute to HIV susceptibility and AIDS vulnerability in zones like Chivanhu Settlement.

4.4.6 HIV and AIDS Associations

Zimbabwe National Network of People Living with HIV (ZNNP+) is an association of people living with HIV and AIDS in Zimbabwe which was formed in 1992 and is registered as a private voluntary organisation with the Ministry of Labour and Social Welfare. The association coordinates support groups for People Living with HIV and AIDS (known as PLWHA) across all the provinces in Zimbabwe. The support groups create avenues for PLWHA to provide each other with moral support, as well as information and advice on problems relating to some shared characteristics or experiences. They meet regularly to provide each other with various types of non-professional and non-material help.

The mission of ZNNP+ is to contribute to advocacy and lobbying for the rights of PLWHA through information dissemination and networking. In fact, its members are among the early lobbyists for the multi-sectorial strategy for HIV and AIDS. It also seeks to improve the quality of life of PLWHA by means of resource mobilization and capacity building of the infected and affected. It has over 3,000 support groups of HIV positive members across the country, with an average number of 15 to 20 people per group. In the context of HIV, support groups provide ancillary support such as serving as a voice for the public in engaging in advocacy. They provide up-to-date and accurate information, influence positive living and health-seeking behaviours, act as ‘clearing-houses’ for experiences, serve as public relations voices for the affected, help deal with stigma and misconceptions about HIV, and offer information on treatment, adherence, the management of opportunistic infections⁷ and other related issues affecting PLWHA. They are generally managed by the group members themselves, through a constitution drawn up by the members. The groups generally meet on a

⁷ There are parasitic, bacterial, viral and fungal infections which are able to cause disease once the immune system has been damaged by HIV. These are the most common clinical manifestations that establish the diagnosis of AIDS.

weekly basis and have an open format; that is, group members have an option of attending when it is convenient for them. For them, the open format allows them some degree of anonymity and to participate as they feel comfortable.

There are two types of support groups that are managed by ZNNP+. First of all, there is the lay people support group, which consists of HIV infected people who meet in their locality regularly. These are coordinated and managed by the members at local level. Secondly, there is group sessions support groups, which is a group led by professionals or therapists. These professionally managed group sessions are managed through 'New Life', a programme funded by Population Services International (PSI), NGOs and CBOs, hospitals and clinics. A person living with HIV, family caregivers or orphaned and vulnerable children are entitled to join a support group. However, before being accepted, membership is screened by other group members based on need and other factors determined in the group constitution for the respective support group. In terms of total membership, 80 percent of ZNNP+ members are women and the balance are males.

The ZNNP+ network has also faced viability and coordination challenges that had plagued other HIV and AIDS coordinating agencies like NAC and ZAN. Since its formation in 1992,

*The association was dissolved and closed twice. Reasons for these closures include lack of finance and internal struggles within the association*⁸.

Even when it has been in operation, problems have arisen. According to an interviewed ZNNP+ official,

*We are in every structure from NAC, PAAC, DAAC, WAAC and VAAC, but sometimes our effectiveness can be compromised because the person chosen to represent us might not have capacity to push for our agenda*⁹.

However unlike NAC and ZAN, the human and financial resources for ZNNP+ are enormous. The coordination activities had improved during 2010, due to a financial grant from Global Fund, and it successfully coordinated advocacy on the need to change drug regimens and addressing sexual and reproductive health needs of youths who are HIV positive. However, by June 2012, the then Director had been voted out by the members. The change in leadership affected the coordination. The other challenge is that in districts and provinces, ZNNP+ does not have institutional presence through established offices. Members who come to meetings

⁸ Personal Communication with Tonderai, ZNNP+, 26 April 2011, last surviving founder member of ZNNP+.

⁹ Personal Communication with Willie Makanda, ZNNP+ Masvingo.

also keep on changing thus affecting the coordination effectiveness of the network. In Masvingo, I constantly struggled to trace the member representatives due to the fact that they had no fixed office. All these challenges have an influence on HIV susceptibility and AIDS vulnerability.

4.5 Conclusion

This chapter has given a background to the HIV and AIDS epidemic in Zimbabwe. The chapter analysed the historical and contemporary social-economic and political factors that have interlinked in creating a fertile ground for the spread of HIV and increased AIDS vulnerability. It also presented and discussed the policy responses and frameworks adopted by various players in the AIDS response, notably the state itself but also civil society groups. The factors identified in animating the HIV and AIDS pandemic in Zimbabwe and the institutional responses highlighted are critical for contextualising the chapters on Chivanhu that follow in relation to HIV susceptibility, AIDS vulnerability and resilience. In the case of Chivanhu, like all local spatial settings, the factors have their own specific dynamics which have arisen historically. Also, the institutional responses (though having a national presence) play themselves out in a contingent manner in local settings like Chivanhu or, even, do not play themselves out at all. The next chapters discuss Chivanhu in the light of the theoretical chapter (chapter 2) and this chapter on the broad politics of HIV and AIDS in Zimbabwe and (in doing so) the specific marginal features will be brought to the surface.

CHAPTER 5: INTRODUCTION TO CHIVANHU SETTLEMENT

5.1 Introduction

This chapter provides an introduction to Chivanhu Settlement. It presents the history of Chivanhu and offers a profile of the households in Chivanhu including their areas of origin and the make-up of the household heads. The extent and character of HIV infection in Chivanhu (including questions about morbidity and mortality) is outlined along gender and age lines, with a focus particularly on women. Access to land and livelihood activities are presented and this is further examined in relation to the stage of progression of HIV and AIDS; this is analysed in further detail in the following chapter. Local institutional dynamics, notably in relation to traditional authorities, are highlighted because of their significance for institutional interventions for tackling the pandemic locally.

5.2 Location, history and population of Chivanhu settlement

Chivanhu settlement is situated in Masvingo Rural District within Masvingo Province in southern Zimbabwe. The province falls under agro-ecological regions 4 and 5, which are characterised by intermittent rains of less than 500 mm per year. The area of Masvingo Rural District comprises small-scale commercial farms, large-scale commercial farms, resettlement areas, communal areas and informal settlements. In addition, there is a growth point (called Nemanwa), the Great Zimbabwe monuments, Lake Mutirikwi (the largest inland lake in Zimbabwe) and the Zimbabwe National Park. Chivanhu Settlement is situated in (but on the outskirts of) Ward 12 of Masvingo Rural District. As shown in Figure 2, Chivanhu is located at the boundary between Charumbira communal area and former commercial farm land (now fast track resettlement land). It is an area that had been used as unofficial grazing land by the village members of nearby communal lands, since independence

Ward 12 falls under Headman Nemanwa, who is under Chief Charumbira. Chivanhu has seven village heads, whose names are Chivanhu, Chirengarenga, Muzoroza, Sani, Muzvimwe, Masvaya and Masotcha. The village heads are under the jurisdiction of Headman Nemanwa, residing in Chief Charumbira's area. All of them, with the exception of Chivanhu who resides in the settlement, are residing in Charumbira's communal area a distance away from the settlement, where their village boundaries existed before they settled people in Chivanhu. Some of the village heads stay as far as eight kilometres from the settlement, but they claim

jurisdiction over settlement dwellers because they facilitated the settlement of some of the inhabitants of Chivanhu Settlement. As a result of this, most settlement residents are not officially registered¹⁰ by their traditional leaders in the official village head register which is accountable to the local government authority and used for development assistance planning and targeting.

The settlement pattern in Chivanhu does not entail distinct villages with clearly-demarcated boundaries between villages (over which there is a head). There is significant boundary confusion or no real boundaries at all, as households are haphazardly settled in the community and seven village heads claim to have control over people in the settlement. Even the settlers are not always clear who falls under whose jurisdiction. The process of settling in the area was not legal according to interviews conducted during the field visits, although village heads were involved. The area is not designated as communal area and, secondly, in terms of government land use planning it is officially designated as intensive conservation area, where there should be limited land use and human settlement. The number of households in Chivanhu settlement fluctuated between 238 and 249 over the duration of the research period. The household sizes in the settlement were mainly between 6 to 10 people, but some households had more than 15 people.

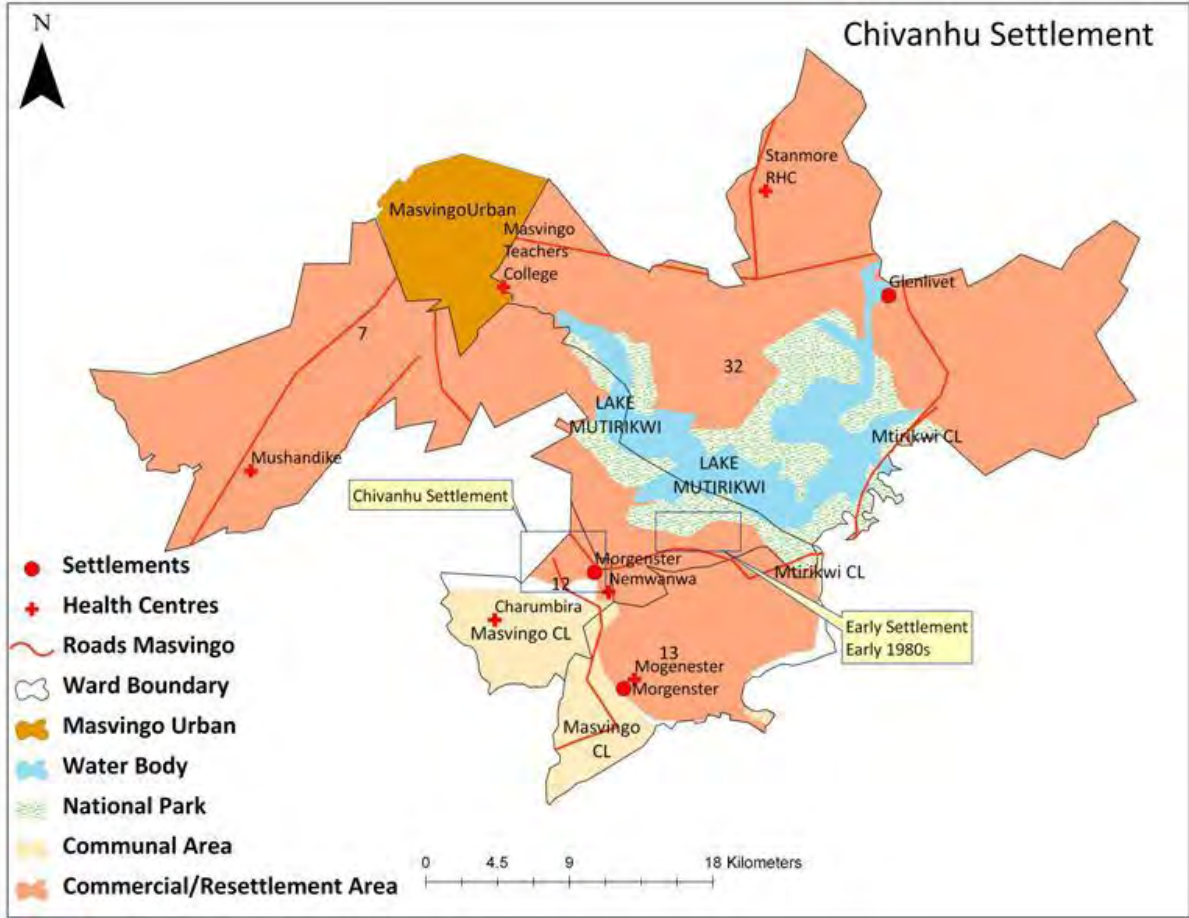
Chivanhu Settlement does not have a long history. In the early independence years, people started to spontaneously settle on land that was previously owned by Morgenster Mission and a deserted commercial farm owned by a colonial farmer known as Barney. Morgenster Mission, a local Reformed Church mission, previously owned the area as a cattle farm until 1978 at the height of the liberation war when they handed over the area to Chief Mugabe¹¹. The original Morgenster Mission farm extended up to Lake Mutirikwi to what is now the Zimbabwe National Park. Since independence in 1980, people moved into the area through collusions and clandestine land sales with various traditional leaders (including the headmen mentioned) in the area. ZANU-PF politicians like the late Edison Zvobgo encouraged the

¹⁰ Official village head registers are used for beneficiary registration for accessing services like BEAM, food assistance, agricultural inputs and other NGO-facilitated services; however, this does not hinder them from voting in elections.

¹¹ Interviews with traditional leaders revealed that, during the war, Mugabe's origins were not clearly disclosed and the missionaries thought by handing over the disputed land to Chief Mugabe they might contribute to the end of the liberation struggle. However land given to Chief Mugabe was also partially owned or claimed by Headman Nemanwa and Chief Charumbira.

early movements into the area. Early settlements were closer to Lake Mutirikwi into what is now demarcated as Zimbabwe National Park (see Figure 2).

Figure 2: Map extract showing the early 1980s and current location of settlement



In 1987, the original settlers were forcibly removed by the government and the land use was re-gazetted as land for the Zimbabwe National Park. The area was reclassified and reserved for the Zimbabwe National Park; however, there is no wildlife in the park. The fence for the Zimbabwe National Park has been removed by the Chivanhu residents and the Zimbabwe National Park area is used for grazing cattle. The displaced people comprised only a handful of households and these were relocated around Sikato area (area marked early settlement on figure 2) and some closer to Nemanwa growth point. The area where Chivanhu Settlement is now located was set aside as grazing land for the relocated people. During the late 1990s, individual village heads started to allocate land in the area that had been set aside as grazing land.

The settlement continued to expand further into other unoccupied spaces through informal sales of land on the margins of communal and former commercial farm land by the local

village heads without formal approval from the chief and the local authorities. The population steadily increased from the late 1990s and the early 2000s despite challenges in 1999. In November 1999, the reigning Chief Charumbira successfully got an eviction order against the settlement dwellers from the courts. The settlers claimed that he evicted them because he wanted to set up an irrigation scheme. Police officers followed the instructions on the court order and burnt the homesteads and forcibly moved everyone residing in the settlement area. However, with the advent of the fast track land reform in the year 2000, Chief Charumbira received land from the former Agricultural Rural Development Authority (ARDA) farm which lies about five kilometres from the settlement¹² and the village heads, facing pressure from residents who had given them money to settle initially, encouraged the settlers to resettle again.

The 1990s period and the concomitant economic and political challenges in the country also coincided with the disintegration of formal governance structures, and problems in the Natural Resources Board and local authorities. In this context, traditional authorities (including headmen) saw an opportunity of undermining the position of the Rural District Councils. Concomitant with the disintegration of formal governance structures was the increased autonomy of traditional leaders through the revised Traditional Leaders Act, 1998, and amendments of 1999. Traditional leaders, in Chivanhu Settlement, took advantage of these developing processes and expanded the settlement into areas that were not previously designated for habitation, including those formerly gazetted as grazing lands. There are no clear-cut boundaries due to these factors.

5.3 Origins of the inhabitants of Chivanhu Settlement

The population of Chivanhu is of mixed ethnic origin and diverse origin (Table 7). The distance of the areas of origins (from the settlement) range from 4 kilometres to 417 kilometres. Only 21 places of origin, including 133 households out of 249 households, are within a 20-kilometre radius of Chivanhu. Distance from original area is important in maintaining kinship networks for survivors, that is, orphaned children and surviving widows.

¹² Local residents claim that, apart from the chief, the land beneficiaries under fast track are not from Masvingo Province; they claim that they were overlooked during the resettlement process.

Table 7: Average length of stay and origin of Chivanhu residents

Place of Origin	Distance from Settlement in kilometres(km)	Number	Length of stay in settlement	Place of Origin	Distance from Settlement	Number	Length of stay in settlement
ARDA Farm	5km	3	0 - 4	Mashava	65km	1	10+
Banga	10km	9	5 - 9	Masvingo	20km	11	5 - 9
Mugabe	15km	2	0 - 4	Mhene	15km	2	10+
Beitbridge	313km	7	5 - 9	Muchakat	15km	4	5 - 9
Bikita	150km	5	5 - 9	Munazuv	15km	1	10+
Bulawayo	305km	3	5 - 9	Murinye	20km	15	5 - 9
Charumbira	15km	11	5 - 9	Mushandi	35km	6	0 - 4
Chegutu	358km	1	10+	Mushawa	35km	2	0 - 4
Chikarudzo	15km	12	10+	Mutare	317km	3	5 - 9
Chinhengeni	15km	1	5 - 9	Zimunya	310km	1	0 - 4
Chihota	386km	1	0 - 4	Mwenezi	85km	4	10+
Chirumanzu	145km	9	5 - 9	Nemanwa	4km	36	10+
Chivi	85km	10	5 - 9	Nhikita	5km	6	0 - 4
Gokwe	395km	7	5 - 9	Nyajena	25km	7	5 - 9
Gunikuni	10km	1	0 - 4	Panganai	145km	6	5 - 9
Guruve	417km	1	10+	Rusape	389km	1	10+
Gutu	110km	13	10+	Sani	4km	2	10+
Gweni	10km	1	10+	Shumba	4km	1	0 - 4
Harare	317km	4	5 - 9	Sikato	5km	1	5 - 9
Kadoma	323km	1	5 - 9	Togarepi	4km	1	5 - 9
Kwekwe	251km	1	0 - 4	Triangle	155km	6	0 - 4
Machitenda	15km	9	0 - 4	Zaka	121km	7	5 - 9
Mapanzure	25km	5	0 - 4	Zimuto	25km	3	10+
Marisa	15km	4	10+	Zvishavan	122km	1	0 - 4

Forty five households (18%) had stayed in the settlement for a period between 0-4 years, 122 households (49%) had stayed in the settlement for a period ranging from 5-9 years and 82 households (33%) had stayed for more than 10 years. The 33% of households included the earlier settlers and those who settled during the late 1990s. The household and community structures in Chivanhu are dissimilar to other (more established) rural areas in Zimbabwe

where households have descended from the local area, have resided in the area for several generations and hence have long-established kinship networks. Chivanhu households' origins are varied and diverse, and the settlement has a short and problematic history of relocations and resettlements. This has serious implications for any sense of community and for support networks with respect to the absorption of the impacts of HIV and AIDS across several households.

The length of stay was correlated to gender, marital status and age of the household head. Most of the households heads aged between 15-35 years of age had stayed in the area for 10 years or less. Household heads aged above 40 years of age had generally been settled in the area for more than 10 years. Most single female headed households' average stay was less than 4 years, and most of this category of female headed households had moved into the area after the death of a spouse or because of divorce. Other settlers moved in due to the burden of maintaining an urban household in the context of high unemployment after the ESAP era and the recent economic meltdown in Zimbabwe. Many younger heads of households (15–24 years of age) inherited the homesteads because of the death of the parents due to chronic illness.

This demographic context is critical in understanding HIV susceptibility and AIDS vulnerability of households in the settlement. Unlike other contexts studied by for example Drinkwater (2005), Rugalema (2000) and Makonese (2007), where HIV and AIDS came as stressors and the households (in comparatively stable communities) find ways of coping, households in Chivanhu are already on the margins of survival. Their coping strategies differ from those of more established households and communities. In particular, the origin of household heads is critical in understanding the household coping strategies and the resilience factors within the households in the settlement. Understanding the livelihood dynamics in Chivanhu Settlement is influenced by the fact that household heads originated from all over the country and settled during different periods.

5.3.1 Population characteristics and land ownership

As noted earlier, the average number of households ranged from 238 to 249 households during the three years of conducting the research. During the peak of conducting the research, the breakdown of households by household head was as follows: 168 were male-headed and 81 were female-headed. Of the male-headed households, one head of household was

divorced, 2 were widowed and 6 were single. The rest were married. The 6 single male head of households were child-headed households, that is, where the head of household was below the age of 18. Of the female-headed households, 67 females were widows, 10 were divorced or separated and 4 were single. There were movements in and out of the settlement because of selling of commodities and other reasons (such as inheritance after the death of the breadwinner or the head of household), but the numbers remained largely constant. The ages of household heads had the following ranges and frequencies: besides the 6 child-headed households (below 18 years), there were 118 heads of households in the age group 18-30, 58 heads aged 41-50 years, 38 from 51 to 64 years and 27 were aged 65 and above.

There are a high number of single and double orphans in Chivanhu settlement, that is, children who had lost either one or both parents respectively. The following table (Table 8) gives a breakdown of the number of single and double orphans per household in the settlement.

Table 8: Households with single and double orphans in Chivanhu Settlement

Single orphans in household	Number of households reporting that number	Total	Double orphans in households	Number of households reporting that number	Total
1	54	54	1	21	21
2	29	58	2	14	14
3	10	30	3	7	21
4	8	32	4	3	12
5	4	20	5	1	5
7	2	14	7	1	7
Total	107	208	Total	47	90

Out of a total of 247 households, 154 households had either single orphans (numbering 208), that is a child who has lost one parent, or double orphans (numbering 90), that is a child who has lost both parents. This means that about 43 percent of households had single orphans and about 16 percent of the households had double orphans. It is important to note that the number of households with two or more orphans was also high for both single and double orphans. In the case of single orphans, 50 percent of households had two or more orphans; in the case of double orphans, the respective figure was over 50 percent. Some households had up to seven orphans. These high numbers of orphans are significant considering that most of the household in Chivanhu Settlement had few resources for their livelihood security and

sustainability. Out of those households, 23 had sent orphaned children elsewhere as a way of coping with livelihood insecurity, and 36 households had absorbed households from elsewhere. Of particular importance was that the majority of the orphans originated from the settlement – only 14 percent of the total households with orphans mentioned that the orphans had migrated from elsewhere and only nine percent of the households reported during the course of conducting the research that they had sent orphans to stay elsewhere (other than within the settlement) as a coping strategy.

At least 91 percent of the children aged 5 to 18 are currently attending school. Nine percent of the households are receiving educational assistance from the Basic Education Assistance Module (BEAM)¹³ which is being administered by the government through the Ministry of Labour and Social Welfare. There are two primary schools serving the community; one, called Chirichoga Primary School, is about seven kilometres from the area. The other, Sikato Primary School, is about 4 kilometres from the settlement. The schools cater for Grades 1 up to 7. There is also a day secondary school providing secondary and high school education, which is about 7 kilometres away. However despite the high percentage of children aged 5-18 attending school, an estimated forty percent of the households accounted for the nine percent of children aged between 5-18 years who were not attending school. Children not attending school were found in households that had reported the presence of orphaned children.

In Chivanhu settlement, despite having paid for the land, the residents had limited rights to the land. The tenure security was not very different from the tenure systems in communal areas where villagers have usufruct rights to the land. They cannot sell but they can rent land secretly. Being a descendant of the community, and hence inheritance, was a key criteria for obtaining and possessing land for a male. Females can inherit their husband's land or access land through their brother or father. Therefore, land use rights can be transferred to the immediate deceased household member's wife or male adult children. Land can be allocated to females though only on condition that a male guardian is responsible and answers to any issues and queries arising from the possession and use of such land. However, as evidence from this research will show, these forms of inheriting and land possession were overridden in many cases with detrimental effects for certain HIV and AIDS affected households and individuals. Rituals like beer brewing as per a request from the village head and other tokens

¹³ BEAM is the Basic Education Assistance module which provides educational support to orphaned and vulnerable children.

of allegiance to the village head are supposed to be complied with by both men and women in order to retain the land. If a possessor of land fails to utilize the land, the village head has the authority to take away that land and give it to someone else. Land possessors have a right to develop and put in permanent infrastructures like wells.

The majority of the households in Chivanhu Settlement have access to 0.5 to 1 acre of land and, on average, households utilise all the land to which they have access. Households which settled earlier occupy more land compared to those that settled later. Even among the latter occupiers, though, those who have the resources can buy land or seek favours through gifts to the village heads in order to gain more land. According to one village head,

The yearly tax for land is USD3. If someone deserts his home and I pay the tax for two consecutive years on behalf of the household head, in the third year the homestead and the land belongs to me the village head and I can transfer the ownership of the land to someone else. If the roofing was asbestos, I remove those for safekeeping waiting for the owner to come back and claim them back (interview with village head, 2010).

Nearly all of the households cultivate most or some of their allocated land. About 15 percent of the households fail to cultivate their land. For those households which do not cultivate, 41 percent cited being absent from Chivanhu during the time for agricultural activities as the reason for their failure to utilise the land. Another 15 percent mentioned general lack of labour within the household as one of the major reasons. Lack of labour was a particularly critical issue in child-headed households and in households where the breadwinner was chronically ill. Some households (about 26 percent) attributed lack of seeds and other agricultural inputs as the main reasons for their failure to utilise the land. Other households also mentioned lack of fertiliser and the need to maintain the land fallow because the soil fertility was currently very low. Many of these problems, in different ways and to different extents, were experienced by households which cultivate.

Adequate rainfall was a problem highlighted by all households, both those which cultivate and those which do not. Rainfall is critical considering that the settlement relies on rainfall for agricultural purposes. In the 2010/11 agricultural season, most of the crop in the area was written off as a result of the prolonged dry spell in late January and February. During the research, cereal production for the 2008/09, 2009/10 and 2010/11 agricultural seasons was generally low as a result of erratic rainfall patterns. Although Chivanhu Settlement is located in the Lake Mutirikwi catchment area, nearly all households in the settlement reported on

several occasions that they did not have access to the dam and only 10 percent of the households had access to irrigated gardens (these were beneficiaries from a CARE International community garden project). Some other households that had gardens had established these in the lake vleis in the Zimbabwe National Park area. There is a *svikiro* for Nemanwa who is based at the Great Zimbabwe Monuments, where she poses as a traditional healer. The *svikiro* spirit medium coordinates the annual rainmaking ceremonies, which are conducted at the beginning of every rainy season at the chief’s homestead.

5.4 Livelihood and income sources in Chivanhu Settlement

The income streams in the settlement were wide and varied. Although Figure 3 reveals a diversified base; the proportion of people pursuing these is insignificant. In this respect, the livelihood base is very shallow for most households in Chivanhu Settlement. Figure 3 therefore shows the main income sources and hence livelihood strategies in the settlement. Overall, 56 percent of the households were engaged in farming only as their source of livelihood and only two percent were engaged in crop sales. Table 9 shows the major field crops grown in Chivanhu Settlement by households which reported being engaged in farming.

Figure 3: Major Sources of Income in Chivanhu Settlement

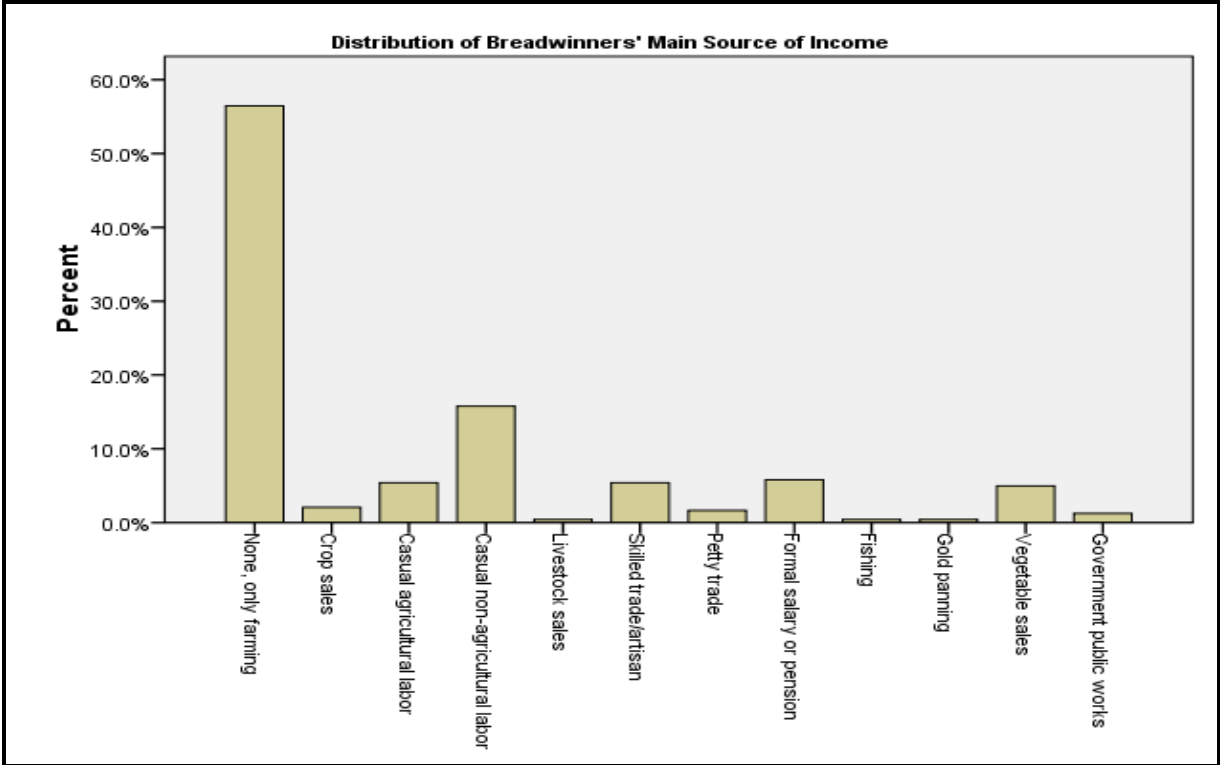


Table 9: Major Field crops grown in Chivanhu Settlement

Type of Crop	% of Households reporting	Mode
Maize	98.8	1 acre (61.7%)
Sorghum	93.2	0.25 acres (64.7%)
Rapoko	91.6	0.5 acres (42.9%)
Groundnuts	32.1	
Sweet Potatoes	28.9	
Cow Peas	2.4	

Before discussing the livelihood strategies broadly, I focus specifically on crop production given its overall significance for the community. The major crops grown in Chivanhu Settlement are maize (98.8%), followed by sorghum (93.2%) and rapoko (91.6%). Maize, rapoko and sorghum are all cereal crops. The majority of households cultivate an average of one acre (61.7%) per annum for maize; most households that grew sorghum typically cultivated 0.25 acres (64.7%) and for rapoko the relevant figure is 0.5 acres (42.9%). The average land cultivated is very low and, as a result, very few households were growing adequately for household consumption and only eight percent of the households that were growing cereal reported selling excess. Apart from the main cereal crops, the other crops grown are groundnuts, sweet potatoes and cowpeas. The main hindrance for most households in growing different varieties of crops was inadequate land sizes.

Apart from growing field crops, households that had access to a water source or a garden were also engaged in vegetable growing as shown in Table 10.

The most common vegetables grown are covo, tomatoes, onions and rape. However the table shows that only a minority of households were in fact growing these staple vegetables. Households which reported that they were growing vegetables had homestead water well or were members of the community garden project sponsored by CARE International. About five percent of the households relied on vegetable selling as their main source of livelihood. Less than one percent of households are involved in livestock sales.

Table 10: Garden Crops grown and proportion of households reporting

Vegetable Type	% Proportion of Households reporting
Covo	37.8
Tomatoes	31.3
Onions	23.7
Rape	19.3
Pumpkins	8.0
Okra	3.2
Sugar Beans	2.4
Carrots	0.8
Broccoli	0.4
Spinach	0.4

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As Figure 3 shows, a number of households including those who reported farming as their main source of income in Chivanhu Settlement are engaged in casual agricultural labour as a source of income. This casual agricultural labour is seasonal, during the planting-harvesting cycle in the month of November to late April; no winter cropping takes place. However, because the average land sizes are very small, local opportunities for non-agricultural labour are limited. The majority of those households that relied on casual agricultural labour also engaged in casual non-agricultural labour (during both the summer and winter months). This form of labour was the main income source for 15 percent of the households. About five percent of the households relied on skilled work. Some of the skilled tradesmen were builders, tailors and dressmakers, mechanics, fence repairers or makers, brick moulders, well-diggers and thatchers. Obtaining thatching grass was usually done at night from nearby farms because in the settlement there were fewer patches of grass fields. The same situation exists in the case of firewood for brick making, with a scotch cart of firewood costing about USD28 for both

hiring a scotch cart to fetch the firewood and cutting the wood from the nearby farms. The resource poor households would report to poaching the firewood and grass at night. Brick making accounted for most income from non-agricultural labour; 3000 bricks are sold at an average cost of about USD120 and it was the well-off households which could afford to engage labour for this purpose. Overall, the majority of the households that relied on agricultural and/or non-agricultural labour obtained their main opportunities outside Chivanhu, from the surrounding farming communities in the former ARDA resettlement scheme and in the former commercial farming areas (now fast track farms).

Petty trade for goods like clothing, both new and used, small electrical goods, curios and groceries was another opportunity for earning a livelihood in the settlement. The proximity of the settlement to Nemanwa growth point and Morgenster Mission provides a market for many petty traders. And the settlement is also strategically located at the borders of former commercial farms with former farm workers being the market for some petty commodity traders. The Great Zimbabwe Monuments and the Lake Mutirikwi area provide access to tourist markets for ornaments and died cloth for petty traders living in the settlement. About six percent of the households relied on pensions and formal salaries. The majority of families relying on salaries had members working in Masvingo, South Africa or Botswana. Some of the household members in this category, especially older members who originated from the local district, were working as tour guides at Great Zimbabwe Monuments. Recipients of pensions largely consisted of widows drawing pensions after the death of their spouses.

Less than one percent of households were engaged in fishing as a source of livelihood. It seems that close proximity to the major dam did not facilitate the emergence of households relying on fishing as a major livelihood source; though fishing as a livelihood was likely underreported because of its illegality. Those engaged in fishing therefore were mainly poaching and their incomes were fluctuating as a result of restrained access to the lake. The National Parks department requested that settlement residents apply for fishing permits but Chivanhu regularly circumvented that process by poaching. As one respondent commented during focus group discussions:

National Parks charge us around USD3 per fishing trip, and you are not certain that you are going to catch anything, so you rather resort to poaching, and in this community if you are not fishing you are nothing [or unable to survive].

Chivanhu residents claimed that, despite residing in the vicinity of Lake Mutirikwi, they were being denied easy access for fishing purposes because they lived in an informal settlement. They also indicated that residents could not benefit from the abundant fish resources in the lake because the community was fragmented and could not organize themselves and negotiate collectively for access to fishing rights. Other communities that resided around the south-eastern side of the lake in Zimuto had (according to informants) managed to negotiate for unlimited fishing rights without paying for permits from National Parks. However, the distribution of the poached fish in the settlement was well-organised. Individuals would not openly admit that they were poachers, but the network included a local shop and butchery owner who would even arrange for transport from the lake if the catch was sufficient. The owner supplied shops and butcheries in nearby Masvingo town.

Cases of cattle rustling are also common in the area and on more than five occasions during my field research, I witnessed dead remains of cattle that had been skinned and butchered by the rustlers. The distribution network was in Masvingo town. Some of the villagers were involved in fuel draining from vehicles in Masvingo, with the prime target being truckers plying the Masvingo-Harare road. On one incident, one of the local settlement residents (who is a truck driver) had fuel drained by one of his neighbours who had watched his movements. Gold panning is done about 40 kilometres from the settlement, along the Runde River Basin. Younger males and school dropouts were the main groups of people resorting to this form of livelihood source. However, local residents looked down upon these groups because they claimed the following:

The law of gold panning is that the money should not go home, so you spend it on beer and women as soon as you get it.

This made people more susceptible and vulnerable to HIV and AIDS, it was argued.

More female-headed households (63%) than male-headed households (37%) have farming as the main livelihood activity. Some women also rely on casual agricultural labour, petty commodity trading, pensions and vegetable sales as major sources of income. For those households who engaged in crop sales, men were the recipients of any income generated from this, though women were the main agricultural labourers. Of the women who reported the sale of livestock, they had to undertake their transactions discreetly. Thus a woman whose husband was in South Africa had to lie to the husband that a cow had been found butchered when in fact she had sold it. There was a problem though in transferring the cow to the

purchaser's dipping book and it took about two years for the purchaser to finally confront the husband to enact the transfer. When he did, the husband refused to honour the sale and reported the case to the police, claiming that his wife and the purchaser were conniving to steal his cow. Child-headed households engage in casual agricultural labour and casual non-agricultural labour as their major income sources. They often resort to government public works.

There are income source differences according to age group. The 18-30 year old age group members (particularly for men) were mostly engaging in fishing and gold panning, or receiving a formal salary, as their mean of survival. They were the ones resorting to cross-border employment seeking in South Africa and Botswana. The truck driver who resided in the settlement had an average of two trips per month to and from Zimbabwe and South Africa. He provided transport and illegal crossing for people who wanted to cross illegally into South Africa, and for spouses whose husbands were working as illegal immigrants in South Africa. Other women who were single also took advantage of this and it is said that they would offer sexual favours in exchange for groceries and money from him, despite the fact that he had two wives of his own already. On one occasion I witnessed a community gathering where the wives were complaining that the single women would phone him and wait for him in Beitbridge (at the Zimbabwe-South Africa border) on his return from South Africa, and collect groceries and money from him such that he would not have anything left for his own family. The 40 and above age groups (especially 51 to 65 years), who had settled earlier, were the majority of the people engaging in agriculture. They were also the only ones with an average of more than four heads of cattle and hence engaged in livestock sales.

5.4.1 Access to livelihood assets

There is one large homestead garden in the village and one community-managed garden targeting the most vulnerable in the settlement. The private garden is located at the homestead of one of the elite families, in which the husband is a truck driver, who can afford the fencing necessary to protect the garden. The community garden, as noted earlier, is being funded by CARE International. Twenty-six percent of the households access drinking and cooking water from unprotected deep family wells. About 24 percent of the households in the settlement were getting drinking and cooking water from unprotected shallow wells scattered about. Only 26 percent of the households had access to a communally-owned borehole. Most of the wells that were used by household members were unprotected and, for households with

chronically ill members, they were reporting frequent cases of diarrhoea and dysentery to the local clinic. More than 54 percent of the households did not have built latrines despite having a high prevalence of HIV and AIDS-related chronic illness, and the disposal of contaminated wastes was a challenge for most of these households. Apart from the incidence of diarrhoea and dysentery for household members with chronic illness, the incidence of diarrhoea was also quite high for the general population in the settlement. Dysentery, scabies, bilharzias and malaria were also occasionally reported at the clinic during the research period.

Ownership of key household assets was also low during the research period. About 22 percent of the households owned ploughs in the settlement, nine percent owned a scotch cart, 52 percent owned a wheel barrow, 17 percent used a bicycle and 34 percent had a radio. The ownership of these assets was not directly linked to the age of household heads or length of stay in the settlement, but rather was linked to the household's ability to be engaged in meaningful income-generating activities and the level and form of that engagement. Distress sales of key household assets were common in the general population in periods of illness, death and other emergency cases. The households relying on official pensions and formal salaries had proportionally high levels of asset ownership. However, the majority of households had challenges in accumulating assets. Most households started with limited or no assets on first arriving and residing in the community and, in the main, they have been unable to earn sufficient disposable income to purchase important household assets.

Ownership of livestock was also generally low, as mentioned previously. About four percent of the households owned cattle but the number of cattle was generally four and below. In the case of goats and sheep, 35.9 percent possessed these (ranging from one to ten head); and 81.5 percent owned chickens. The number of chickens owned per household ranged from one to fifteen. One household head was engaged in broiler chicken production on a commercial basis and he had 200 chickens. Some households in the settlement had no livestock at all: 68,8 percent of the households did not own cattle, 64.1 percent did not own either goats or sheep and 18.5 percent of the households did not own chickens. The levels of new purchases of chickens were very low during the research period; there were actually a higher number of reported sales compared to new purchases. Only ten households purchased chickens during the research process and some of the chickens were eaten as soon as they were purchased. One male resident who was working in South Africa complained:

These women cannot think properly and run a successful home. I bought 8 hens for breeding and after a month when I came back they had eaten all the chickens and there is nothing right now to show off for my investment.

5.4.2 Food security and household consumption patterns

Ninety-three percent of the households did not have in storage the previous season’s cereal stocks. Cereals grown include maize, rapoko and millet. Generally most households in Chivanhu settlement, though being HIV and AIDS-affected and requiring good nutrition, are chronically food insecure. Table 11 gives a summary of the patterns of consumption time for the previous cereal harvest. It indicates that 26.1 percent of the households failed to harvest enough to last them a month. These households in fact consumed most of their produce while it was still in the fields. About 32.8 percent of the households in the settlement had their cereal stocks for 2 months and 15.4 percent lasted 2 to 3 months. Only a quarter of the households have cereal stocks for more than three months.

Table 11: Average duration of last season’s cereal stocks

Length of consuming last season’s cereal crop	Percentage households reporting
Less than a month	26.1
1 - 2 months	32.8
2 - 3 months	15.4
More than 3 months	25.2

The vast majority of households do not have adequate land to engage in meaningful agriculture (or are not able to productively utilise their land) to provide adequate stores for meeting their annual consumption requirements. The plight of HIV and AIDS-affected households is dire considering that the main sources of cereal (as depicted in Table 12) demand that one actively engages in a meaningful income-generating activity – as only 8.6% percent rely on their own harvest as the main source of cereals.

Table 12: Main Sources of Cereal for Chivanhu Settlement Households

Main Source of cereal for households	Percentage of households reporting
Purchased from local market	50.2
Maricho ¹⁴	36.2
Own Harvest	8.6
Borrowed	2.4
Gifts	1.6

The average number of meals consumed was also measured and the researcher adopted the three-day recall method to assess the dietary adequacy and the frequency of taking meals for the general population. The average meals taken per day were two meals but, in 2008¹⁵, some households went for more than two days without eating. Cereals were difficult to access and some households resorted to eating vegetables and wild fruits during that time. There was however a general lack of basic food commodities throughout the country in 2008 and hence this problem was not only isolated to Chivanhu. Problems of malnutrition were very high in the settlement during the research period, and this was especially the case with child malnutrition during the weaning stage. Kwashiorkor and marasmus were common, but some community members mistook the voracious appetite of children with marasmus to be caused by witchcraft. Because of this, their village heads organized *gumbwa* (going as a whole community to inquire about witches in the community) twice during the research process. Although the average consumption levels were at least two meals per day, the protein consumption remained very low for the majority of the households.

5.5 Governance institutions in Chivanhu

This section presents evidence on the types and character of governance institutions in Chivanhu Settlement. It deals with both traditional and formal institutions that were operational and their influence on activities in the settlement. A detailed analysis of institutions which are critical for coping with HIV and AIDS was already provided in Chapter 4, when discussing HIV and AIDS in Zimbabwe.

¹⁴ Casual labour, it can be agricultural or non agricultural.

¹⁵ 2008 was the peak period during the Zimbabwean economic crises; there were massive shortages of basic food items and inflation was at its peak.

In terms of formal institutions, the Provincial Governor is the head of villages and communal areas in Masvingo Province. The province as an administrative unit is subdivided into districts which are administered by District Administrators. Masvingo rural district, in which Chivanhu is located, is subdivided into 35 wards. A ward is a subunit of the Rural District Council and is headed by an elected councillor. The elected councillor for Ward 12 (a woman) is a member of the opposition Movement for Democratic Change Tsvangirai (MDC-T).

In Chivanhu Settlement the traditional governance structures claim jurisdiction over the residents, although the reality on the ground showed that this was situational. The residents could only be governed in situations where it suited the traditional authorities, and ignored in other situations where accountability for the residents was required. Traditional authorities are represented by a chief, and chiefs have a council in the parliament of Zimbabwe. The chiefs govern the communal and increasingly the resettlement areas, though in the past they governed communal lands only. Chivanhu settlement, as stated earlier, falls under the jurisdiction of Chief Charumbira. Chief Charumbira's area is subdivided into sub-chieftainships (*Sadunhu*) and each sub-chieftainship is under the authority of a headman (*Sadunhu*). Chivanhu settlement falls under the jurisdiction of Headman Nemanwa. As elsewhere, sub-chieftainships or headmen's spatial boundaries coincide with the administrative wards of the Rural District Council such that the elected councillor for Ward 12 is responsible for the same area as headman Nemanwa. Formally, headman Nemanwa is assisted in his role by the village heads, though considerable confusion exists in Chivanhu regarding village heads and their areas of jurisdiction.

There are 62 village heads under the Charumbira chieftainship. Most of the village heads in the area have inherited the headmanship through the lineage system. About a quarter of the current village heads are purported to have gained the village headship through paying money and cattle to the chief. During the research, for instance, there was a dispute between Chivanhu and his stepbrother. The stepbrother was fighting against Chivanhu, pushing for the splitting of the people between the two of them. The residents were ordered to go to Nemanwa growth point by the Headman Nemanwa, in order for them to decide which village they want to side with in the event of the split being successful. Everyone present refused to side with Chivanhu's stepbrother, except his mother and his wife. After the meeting the unsuccessful contestant approached individual households trying to force them to be under his

headmanship. The village members said that what he wanted was to have people under his authority and then to ensure that anyone under him found guilty of offences would be brought to court; once found guilty, members said that he would chase them away and 'sell' their land to other people.

The number of households at Chivanhu far exceeds what would be expected in terms of district rural council regulations about the size of communities falling under headmen and village heads. This explains in part why so many households at Chivanhu remain unregistered in terms of reports submitted by village heads (kept as village registers) to the district council. In fact, insofar as there are many unregistered households in the general area, most of these likely fall within Chivanhu settlement considering the chequered history of the settlement. Field interviews revealed that village heads could not officially account for the residents that they had settled illegally because according to one village resident:

Everyone at the Rural District council knows that all the village heads are complaining that they are overpopulated, so if you add 30 more people to your old village register, the council would raise its eyebrows, to ask, where did you get the extra land to settle those extra households (interview with Chinama:Chivanhu resident, 2010).

The majority of households that reside in Chivanhu settlement fall under these circumstances. They were under certain village heads but were not formally accounted for or recognised, such that services like food aid and seed inputs bypassed them

In Chivanhu Settlement, political parties being organised from the official communal areas claimed jurisdiction over the residents of Chivanhu Settlement. Although from the viewpoint of the RDC the residents were not officially accounted for, for voting and political issues they were accounted for by both the ZANU-PF and MDC-T political parties. ZANU-PF traditionally has had cell and branch units which parallel the village and ward development committees respectively. In addition to these structures, and overseeing them, the ruling ZANU-PF party has had a ward coordinator who reports to the provincial governor directly and this is the ultimate authority in the ward. The village heads are the ZANU-PF cell heads while the elected councillor is from the opposition MDC- T.

5.6 HIV and AIDS in Chivanhu Settlement

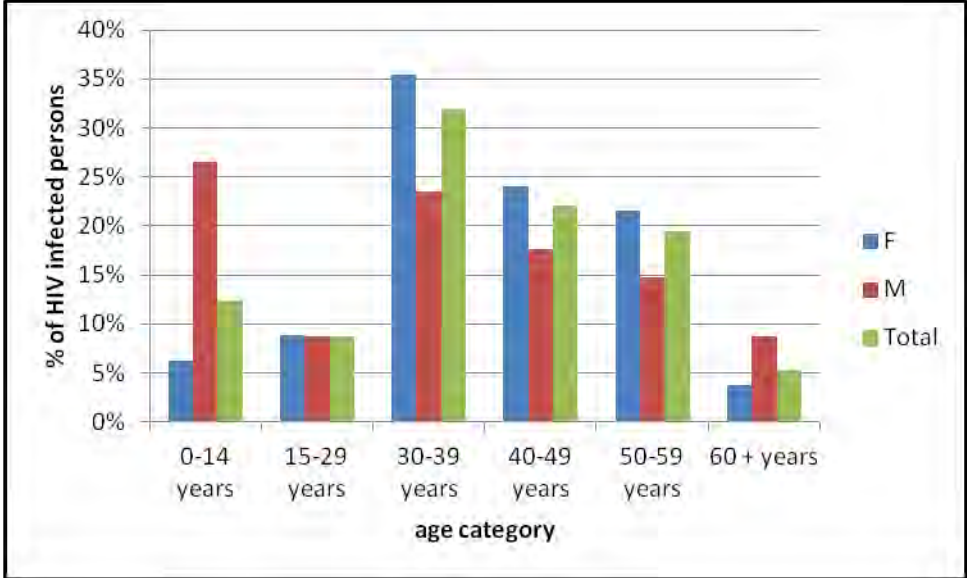
The previous sections have discussed the location and history of Chivanhu Settlement as well as the livelihood and income sources in the settlement and the governance institutions. These

are all critical in understanding HIV susceptibility and AIDS vulnerability in the settlement. This section covers HIV and AIDS issues in Chivanhu. The information presented in this section was collected using information from the household livelihood survey, and gaps in the household livelihood survey were triangulated with records from the rural health centre, the opportunistic infection centre at Morgenster Mission Hospital and other records maintained by the researcher during the research process.

5.6.1 HIV and AIDS morbidity

Figure 4 provides a summary of the age, sex and total distribution of the HIV-infected in Chivanhu settlement. It shows that, of the total female population with HIV, 6.3 percent are aged 0-14 years; the respective figure for the male population is 26.5 percent.

Figure 4: Age, sex and distribution of HIV infected in Chivanhu settlement



There were no solid reasons for differences between HIV infection for males and females in this age category, since HIV infection for most of the children in this age category was a result of vertical transmission from an infected mother to a child. The combined total for male and female in that age category is 22.5 percent. In the age group 15-29 years, 8.9 percent of the female population that is infected are in this age category, while the figure for men is 8.8 percent. Further in-depth analysis reveals that, while these figures are lower than projected national estimates for the same age categories (HIV rates normally peak at this age group in national surveys), the study had sampled actual cases of the chronically-ill and the HIV-tested. Since most people are usually tested when they are chronically ill or when they are having children, the majority of the members in this age group (15-29) had not yet developed

chronic illnesses or the symptoms that can be attributed to HIV and AIDS. Another important issue in this regard is that members of this age group are highly migratory and most of the time during the course of conducting the research they were not present in the settlement.

Infection rates according to Figure 4 peak in the 30-39 age groups for both males and females. However, more females are infected compared to males, with the respective figures being 35.4 percent and 23.5 percent. These findings confirm earlier studies that generally women are infected at earlier ages than men (Bene and Merten, 2008; Shisana, 2004; Shisana and Davids, 2004; Seeley et al., 2004; Whiteside et al., 2003; Zungu-Dirwayi et al., 2004). The reasons for these age and gender differentials are going to be explained later. It is also important to highlight that the evidence reveals high infection rates in the age category 30–39, which is the peak reproductive ages. The infection rates in this age category also translate into high infections for the 0-14 age group (boys and girls combined) through vertical transmission from an infected mother to a child.

For the age group 40–49, rates of infection continue to be high for both males and females but the rates for females are still higher compared to that of males. While studies (Fraser et al., 2011; Gregson et al., 2009; Gregson et al., 2010; Seeley and Pringle, 2001) have profiled infection rates for this age category, my study's findings indicate that the ages 50 and above are also experiencing high rates of HIV infection. Women in the 50-59 age category are proportionally more than men; most of these women were in fact surviving widows and they had been infected by HIV from their husbands or partners who had died earlier. Some of the women were also being infected by their marital partners who were engaging in concurrent multiple sexual partners. In the 60-69 age category, male infection rates are comparatively higher than women's, and some of these infections are attributed to higher male rates of multiple sexual partners and commercial sex as well as age mixing between these older males and women in the lower age groups with higher rates of infections. There were several reasons attributed for the higher rates for older males above 50 years of ages, and these included the lack of older-person friendly services for reproductive health training and the beliefs that the elderly are no longer sexually active.

The duration of living with HIV for the HIV-infected ranged from 1 to 20 years. However, evidence from the study shows that most people who were infected with HIV were progressing at a fast rate from HIV infection to a stage where they started suffering from

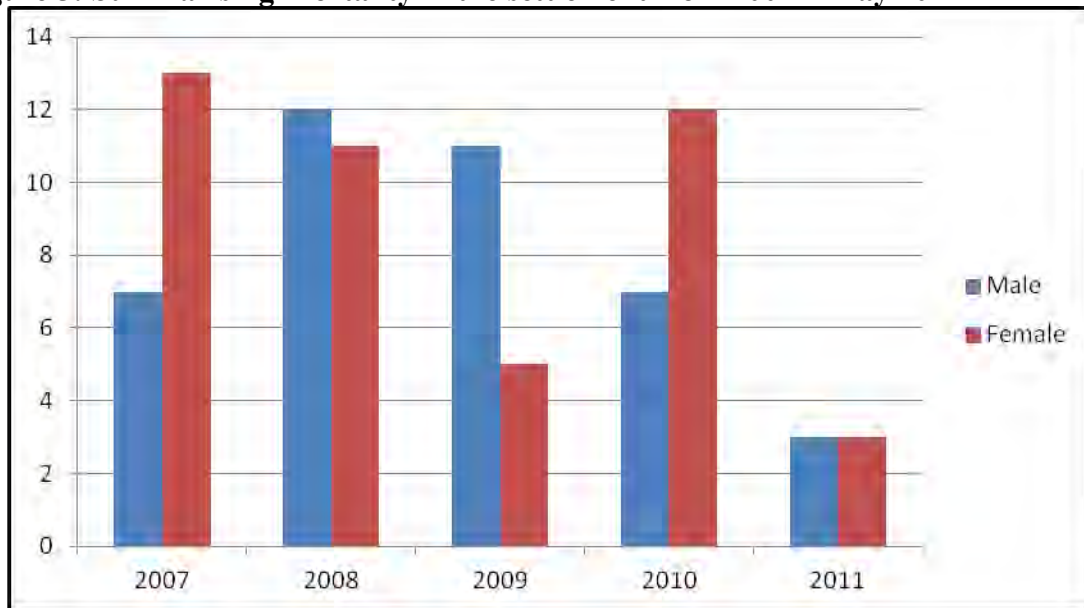
AIDS-defining opportunistic infections. The average period of surviving with HIV was much lower, because 54.3 percent of the HIV population were recent infections who had lived with HIV for an average of 2 years. At the same time, 16.7 percent of the HIV-infected were bedridden. The rate of access to ART was high at around 82.3 percent. Most of the HIV-infected on ART were accessing drugs from Morgenster Mission Hospital, and only a few were obtaining relevant services from Masvingo General Hospital. Some of the HIV-infected on ART reported experiencing interruptions in drug supplies (11%) and the reasons given were lack of money for travelling to the health centre, transport and mobility problems especially for the bedridden, and cross border travels leading to people missing drug supplies due to migratory livelihood activities. Adherence to the drug regime, without disruptions, is often seen as a critical factor for effective ARV therapy. About 37 percent of the chronically ill also had a spouse who died due to AIDS. The years after they lost their spouse ranged from 1 to 12 years. About 82.9 percent of the currently HIV-infected had minor children and 15.6 percent of those children were also HIV positive. Some 10 percent of the chronically ill had lost a child due to AIDS-related chronic illness.

5.6.2 AIDS Mortality

The study findings (Figure 5) reveal high mortality rates during the time of conducting the research though (as indicated above) there is a high uptake of ARVs existing through the support of Morgenster Mission Hospital. I discovered that ART support alone, without considering other support services and contextual factors for both men and women, was not adequate in reducing AIDS mortality.

High levels of migration in search of livelihoods and lack of money for treatment of opportunistic infections were some of the reasons said to be contributing to high mortality rates in the settlement. Out of a settlement with 249 households, almost 60 households had experienced a death during the course of conducting the research. More women died of AIDS-related chronic illness compared to men. Mortality rates for women were quite high during the year 2007 due to challenges of support services in the hospitals.

Figure 5: Summarising Mortality in the settlement from 2007 – May 2011



In 2007 and 2008, the rural health centre had no drugs and was not offering any meaningful services, with those who were breastfeeding experiencing serious challenges. But by 2009 and 2010 the situation had improved for HIV infected pregnant women. The rates of pregnant women giving birth at home due to lack of finances for registering at the hospital were high. Other issues were that the hospital did not have drugs and other hygiene essentials like gloves and disinfectants and these posed additional risks for HIV positive pregnant women. Patients and expecting mothers had to supply their own stationery, gloves, sutures, disinfectants and, if they could not supply those items, they were turned away by the nurses. Another reason for high mortality rates was that the ART coverage rates were still low in 2007 but, by 2008 as more women than men were tested, more females had been initiated on ART; hence mortality rates were stabilising. In 2008, the situation stabilised through funding for the supply of those essentials, especially for HIV positive pregnant women. In 2008 and 2009, mortality rates for males were quite high compared to that of females.

One of the reasons was that more men were migrating to South Africa, Mozambique and Botswana in search of employment and other livelihood initiatives. Adherence to ART drugs becomes disrupted and in most cases they lost access to their ART drug supplies, because supplies are normally replenished on a monthly basis. They would go for weeks without any supplies and come back when they are already bedridden and at times when they have developed resistance to the medication. The year 2010 saw the numbers of women who died as a result of HIV rising compared to that of men. Further inquiries reveal that these women

were in most cases surviving spouses or partners of the deceased men who had passed away earlier. Lack of medicines, in the event of being ill, was a challenge for most women. The chronically-ill persons, even those on ARV, always complained that

At Morgenster what you get for free are ARVs, but you have to pay money for the card; all the other medicines that you need they ask you to pay money, so even if I get ARVs for free, I am asked to pay for the other opportunistic infections. Going to the hospital is of no use to us the sick people.

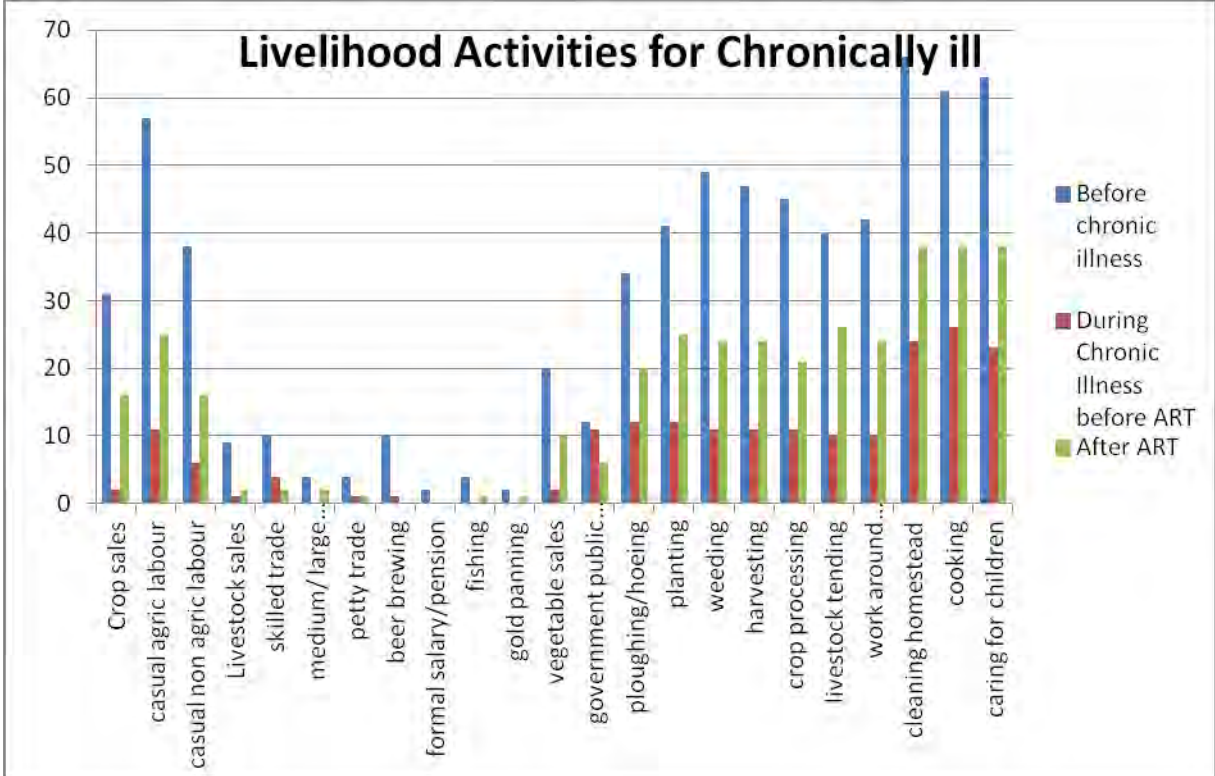
5.6.3 Broad livelihood strategies of the HIV and AIDS-affected

HIV results in the loss of adults who are key producers in the family. AIDS is more than a health problem as it is multi-dimensional (Gillespie and Kadiyala, 2005). The livelihood systems and the livelihood pathways of affected people need to be understood and analysed in recognition and appreciation of the multi-dimensional impacts of HIV and AIDS on individuals and households (Ziervogel and Drimie, 2008). The effects and impacts of the pandemic are characterised longitudinally as a series of waves or phases (Kadiyala and Gillespie, 2003, Ziervogel and Drimie, 2008, Rau et al., 2008). The first stage is the HIV infection, followed by the episode of opportunistic infections, where an individual suffers from a number of AIDS-related infections including tuberculosis. The third stage involves the deaths and the survivors, widows or orphans. After the deaths, communities deal with the responsibility of looking after orphans and having to lose prime age adults; the results of the impacts are experienced beyond the household level and also at community and national level (Gillespie and Kadiyala, 2005). High rates of HIV infections in prime age adults and resultant deaths result in adverse impacts on people's livelihoods for many HIV and AIDS affected households (Gillespie and Kadiyala, 2005, Mazzeo, 2011). These negative impacts create a vicious cycle for further possibilities of HIV susceptibility and AIDS vulnerability for many already infected and affected HIV and AIDS individuals and households (Gillespie, 2006). Throughout all these different HIV infection and AIDS progression stages, the livelihood needs and strategies of HIV and AIDS-affected household members and individuals are not static; for, Ziervogel and Drimie (2008) argue, they are dynamic and change with time and the stage of disease progression.

According to Figure 6, the broad livelihood activities for the HIV-infected in Chivanhu range from crop sales to caring for children. The figure shows the percentage of chronically ill who reported that they were engaged in an activity and across three key stages or periods. Data

collection was done to identify and profile the livelihood activities of the HIV-infected before being chronically ill, during chronic illness (but before commencing on ART) and after commencing with drug therapy.

Figure 6: Livelihood Activities for chronically ill at different stages (before chronic illness, and after ART)



The majority of the HIV-infected and chronically ill were engaged in casual agricultural labour and casual non-agricultural labour as livelihood strategies. Even before becoming chronically ill, only 32 percent of the HIV infected respondents were engaged in crop sales. These were from the earlier settlers who had more land compared to the others who were not engaged in crop sales. Despite being less than three kilometres from Lake Mutirikwi, less than three percent of the respondents were relying on fishing. For those few who were fishing, they were relying on poaching during the night, because according to the respondents during focus group discussions, fishing permits from National Parks were difficult and expensive to get. Only a small number of the affected were engaged in skilled trades or were getting a formal pension in Chivanhu Settlement. For those who had left work on medical grounds and settled in Chivanhu, even after ART commencement it was difficult for them to go back to their previous work before they were chronically ill.

Livestock selling is small because livestock ownership is low in the community. Government public works are also minimal in the settlement. Most of the reported activities, caring for children, and working around the homestead, cleaning and cooking are unpaid work at home. The asset base for the chronically ill is little to begin with, such that even if they die, the surviving widows and orphans are starting on a high level of vulnerability. Unlike in many other studies of rural communities, the livelihood income streams are limited and the livelihood pathways are constrained because of these contextual issues. Evidence summarised in Figure 6 shows that the HIV-infected on ART, compared to before chronic illness, are not able to engage in a range of livelihood and income activities. But, compared to after becoming chronically ill and before taking ART, ART users are able to be more productive member of the community. ART to some extent contributes to increased wellbeing and ability to contribute to labour activities that people before ART were failing to do.

5.6.4 Health facilities and services available to Chivanhu Settlement

At the time of conducting the research, there was one mission hospital at Morgenster Mission, at which there is a doctor. The hospital offered a number of services including ART services. On average, 2,500 people (including from Chivanhu) are receiving drug support from the Opportunistic Infections Treatment Centre at Morgenster Hospital. There is also a Rural Health Centre near Sikato Primary School offering primary health care services and other support services to the mission hospital. There are two nurses at the health service centre but, during 2007 and 2008 (before the introduction of health incentives such as an additional allowance on top of the salary from the Global Fund support), nurses and other staff were rarely on duty at the Rural Health Centre. The situation of staff and drug support has improved but user fees were also reintroduced. The Rural Health Centre used to rely on voluntary staff from the rural areas like the village health worker and the chloroquine holder. But as of now, despite the improvements in the economic situation, the Rural Health Centre did not have village health workers servicing Chivanhu settlement during the time of carrying out the research. The chloroquine holder was also not there during the time of conducting the research.

The village health workers are supposed to support the community outreach activities of the Rural Health Centre and the chloroquine holder provides education on malaria and distributes medicines for treating malaria. The village health workers and chloroquine holders are also supposed to form the Village AIDS Action Committee (VAAC) and the community nurses at

the rural health centre are supposed to contribute to activities at the Ward AIDS Action Committee (WAAC) level. During the research, the VAAC was not operational; the WAAC existed, but there was no participation and representation by any member from Chivanhu settlement. However, at ward level, there was a Behaviour Change Facilitator sponsored by United Nations Population Fund (UNFPA). The facilitator was engaging with other villages in the ward but he never conducted any support services in Chivanhu. Traditional birth attendants are also trained and the register of names maintained at the rural health centre. There was as well a Morgenster Mission initiative (coordinated by a missionary woman) for supporting orphaned and vulnerable children. This missionary-led initiative provided food rations and there was a house that was built for use in providing HIV and AIDS related community services at Nemanwa Growth Point. But during the research period, the house was rented out for commercial sex activities and the church was considering taking the house back from the beneficiary women.

5.7 Conclusion

This chapter has provided a background to Chivanhu Settlement, including livelihood activities, asset ownership and institutions governing the settlement. The chapter also discussed the origin and duration of stay of household heads in the settlement. The settlement is a newly resettled area, with most of the household heads having moved into the area less than 20 years ago. The duration of stay has a direct impact on social cohesion, development of social capital, and the progression from HIV to AIDS to death (as will be discussed in following chapters). The epidemic in Chivanhu is a mature HIV and AIDS epidemic. Different households have experienced specific waves of HIV infection, chronic illness, AIDS deaths and orphanhood and the next two chapters will map onto these trends issues pertinent to HIV susceptibility, AIDS vulnerability and resilience.

CHAPTER 6: HIV SUSCEPTIBILITY AND AIDS VULNERABILITY IN CHIVANHU SETTLEMENT

6.1 Introduction

The previous chapter focussed on the Chivanhu Settlement in general. It set the context for understanding HIV susceptibility and AIDS vulnerability which is the main focus of this chapter. This chapter distinguishes between three phases (or a time-line) in the possible progression of the pandemic as it affects individuals and households. It argues that each phase is marked by specific characteristics (from susceptibility to vulnerability to possible death) and specific to each phase are a range of factors which enhance the prospects of these characteristics. This is outlined and examined with specific relation to Chivanhu with specific examples of individuals and households from Chivanhu being used to illustrate the key points.

6.2 Susceptibility and vulnerability

It is important to reiterate what HIV susceptibility and AIDS vulnerability entail. According to Loevinsohn and Gillespie (2003), the likelihood of becoming infected with HIV is referred to as susceptibility. This is determined by such factors as the economic and social conditions of a society or community, power relationships between groups, livelihood strategies, culture and gender, and biological factors (DeWaal and Tumushabe, 2003; Haddad and Gillespie, 2001; Stokes, 2003; TANGO, 2003). The likelihood of suffering adverse consequences as a result of HIV and AIDS, including chronic illnesses and death, is labelled as vulnerability. This is determined by, amongst other things, poverty, power relations, gender inequality, and fragmented community and household structures (Kadiyala and Gillespie, 2003). Vulnerability to HIV and AIDS results from a combination of pre-existing conditions in the livelihoods of individuals and households, leading to different levels and forms of coping and resilience. Hence, “insecure livelihoods exacerbate the risk and vulnerability environment for HIV and AIDS” (Drimie and Mullins, 2005:2). AIDS-associated illnesses and deaths undermine livelihood options, which forces affected households to make decisions which involve tradeoffs between basic needs (Drimie, 2003; Drimie and Gandure, 2005, Kadiyala and Gillespie, 2003). Nioef et al. (2010) argue that while there have been significant medical advances in understanding and responding to HIV and AIDS, the wider set of social and economic conditions animating the HIV epidemic and the multiple downstream impacts of AIDS on societies are less well-known.

The research on Chivanhu settlement is intended to deepen our understanding on these matters. The kinds of interaction between the pandemic on the one hand and HIV/AIDS-affected individuals and households on the other is shaped and mediated through and by time (Ziervogel and Drimie, 2008). There are three broad identifiable phases in HIV susceptibility and AIDS vulnerability which warrant attention (Gillespie, 2006), and the chapter is designed to discuss these in relation to Chivanhu. First of all, there is the upstream phase relating to the risk of an individual becoming exposed to and infected with HIV; secondly, there is the midstream phase during which individuals are at risk of developing opportunistic infections after HIV infection; and, thirdly, there is the downstream phase involving the risk of serious impacts on households and communities affected by the pandemic. Each of the three different phases has particular conditions of existence and particular consequences, and there is the possibility of a vicious cycle as the impacts of AIDS vulnerability may in turn increase the risk of HIV susceptibility.

6.2.1 Upstream phase factors which create HIV susceptibility in Chivanhu settlement

This section discusses the factors that create conditions for susceptibility to HIV infection in Chivanhu settlement. In relation to most of the factors, specific case studies of individuals and households in Chivanhu are presented and discussed which identify the working out of the factors that predispose individuals to HIV or increase the risk of getting HIV infection. The factors that influence susceptibility in the upstream phase include: high levels of social and livelihood insecurity, gender and social inequalities, power relations, intergenerational sexual relationships, multiple concurrent partnerships and inefficient governance institutions. However, as presented in the case studies, some of the factors that influence susceptibility are also similar to factors that will influence vulnerability in the middle and downstream phases. In the case studies, these conditions facilitating HIV infection often become manifested jointly or in combination and lead to the complex character and vicious cycle marking HIV infections and progression to AIDS.

6.2.1.1 Unstable marriage unions

In the context of unstable marital unions, this sub-section highlights the significance for women of livelihood insecurity in being susceptible to HIV, by presenting five case histories. The case histories show the ways in which livelihood and food insecurity along gender lines produce conditions which enhance the prospects that women (and men) will enter risky livelihood coping activities leading to HIV infection. The first life history is of a woman

(Susie) who resorted to having multiple boyfriends after her husband's death; the second is of a woman (Hesi) who resorted to commercial sex work after her divorce; and the third case is of a man (Govo) who engaged in gold panning around nearby Mashava Mine and was highly migratory and engaging in risky casual sex. I first outline their stories briefly and then comment on them together.

Susie, aged 36, was infected with HIV because of her various relationships after the death of two husbands. She relates her story as follows:

My first husband died and left me with two children to look after. I remarried after two years and I have a child from the relationship. My second husband died after about two years together. All my three children are currently going to school and they are supported under the BEAM programme. I have tested HIV positive, although I am not yet on ART, because my CD4 count is still high. I have boyfriends who provide me with different kinds of support and some of them are concurrent. Most married women in this settlement feel threatened by me and they think I am spreading HIV to their husbands. I need these relationships so that I can survive. This year I did not get anything from my agricultural plot because of rainfall shortages, but I still need to provide food for my children.

Hesi, a 47-year old woman, relates a similar story:

I was married to a headmaster and I was divorced because I was accused of being a witch. I tried to claim maintenance from him so that the children could go to school but I was unsuccessful. The pressure of finding money for survival, forced me to join my sister who was surviving through commercial sex work. For me it was the only alternative means of earning an income to look after myself and my children, and now I am HIV positive.

Govo is aged 42 and he tested positive for HIV in 2008. He was engaged in gold panning around Mashava Mine about thirty kilometres from Chivanhu. Certain women from different places in Masvingo Province would come to sell foodstuffs in the mining area and some of them would spend overnights in the *makorokoza* area. Govo and a number of other men, often under the influence of alcohol, would take advantage of this arrangement and sleep with the women. They would often exchange women and he has passed on the HIV infection to his wife such that she is also now HIV positive. At the moment Govo and his wife are not yet

bedridden; and they are surviving through gardening and the husband is also involved in brick making. When the wife discovered that she was HIV positive, she went to her parental home. Whilst she was at her parents' home, Govo's wife fell in love with another man, and became pregnant with a child. The love relationship did not last long and she came back to reunite with Govo. The child from the other relationship while she was estranged from Govo is also HIV positive.

In Chivanhu settlement, the average land holdings are too small for a household to engage in sustainable agricultural production and income-generating opportunities are limited for the majority of the households. There is chronic food insecurity because of this, and throughout the year. As a result, many livelihood strategies adopted by various household members increase their risk of HIV infection. Some men, with influence or resources (like Govo), take advantage of the dire livelihood circumstances of women (such as Susie and Hesi) and request sexual favours in return for assisting them. Because of their economic and social dependence on men, women report that they have difficulties in saying no to unprotected sex.

Most of the women and young girls living in Chivanhu have few opportunities for pursuing a sustainable livelihood and they have few (and often no) assets to dispose of, or to derive a livelihood from, in order to cope with day-to-day living. With limited financial resources to begin with, vulnerable young women and adult women mostly engage in transactional sexual relationships with men to survive. In this context, the women in the two cases would resort to transactional sexual relationships or commercial sex work. Men also are not spared from the risks of HIV infection. The Govo case shows that migratory livelihood strategies like gold panning, where there are the likelihood of alcohol and casual sex, increase the HIV susceptibility of the men and their partners.

The next three examples bring to the fore more clearly the significance of unstable marriage unions in terms of generating susceptibility to HIV, and how this links to the pursuit of livelihood security. The following case histories involve, firstly, a woman and man who are in a long-term monogamous union and at the same time both of them have concurrent sexual relationships with other partners. The second case is of an elderly man who is in a permanent marital relationship with a much younger woman. He is having serious challenges providing materially for the woman and his wife has several transactional relationships with other men in the settlement. The third case history involves a woman whose husband engages in

transactional sexual relationships with women who want fish from him. The cases show the various complexities between unstable marital unions, unsustainable livelihoods and HIV infection risks.

Chando is a woman aged 36 who is involved in commercial sex work. Chando's regular boyfriend who claims to be her official husband John went to Zambia looking for work and, when he returned, he found Chando engaged in sex work. Chando says that she is a sex worker in order to provide food for her children. She claims that she did not become infected through sex work, but was infected by her regular lover on his return from Zambia in 2010. She has six children, two with John and the other four children with four different men. At the moment the husband is currently hospitalised; he is bed-ridden and the children are not going to school. Chando stays at Nemanwa the growth point where she is a caretaker for a house which is being built.

Born in 1918, Zekie is very old and he cannot engage in any activities to support or assist him. He is married to a young wife and he has eight children, five of his own and three from his current wife. He is from the Johane Masowe religious sect and he used to be a prophet; through this, he managed to marry a very young wife. The wife is engaging in multiple extra-marital affairs saying that the husband is very old and that she wants younger men of her age. On several occasions, I witnessed disputes between the husband and the wife being handled by the village head. The young wife is chronically ill and the eldest son of Zekie (from his current wife) and the son's own wife sides with his mother (Zekie's wife) in these disputes. If Zekie complains, the eldest son tells his father to keep quiet because the mother is the breadwinner. The boy was married in early 2011 and the mother paid lobola for him. The second eldest child, who is around 17, no longer goes to school and she is involved in commercial sex work. She brings her patrons to the homestead and the father cannot reprimand her, because if he decides to reprimand her, he is threatened by his eldest son with his wife and his own wife. The family chronically experiences food shortages.

All five cases in their own way show that HIV transmission in Chivanhu settlement is embedded in complex social networks, which in turn are intricately linked to livelihood insecurity and to the general day-to-day livelihood coping strategies of individuals and households. This connects to the cultural position of women in marriages in Chivanhu and elsewhere in rural Zimbabwe. Culturally the subordinate position of women prevails, for

instance through the payment of lobola by men for their wives. This animates the marital relationship – marriage produces and maintains conditions and mechanisms which lead to male abuse of authority and control and which affect women's powers of negotiation on sexual matters. Common narratives from my fieldwork show women as victims of men's risky sexual behaviour. Women at times seek to use their prospects of sexual liaisons with men to facilitate livelihoods, though not as equal partners. Therefore, the sexual behaviour of both males and females is critical for increasing the likelihood of HIV risk. Where marital or long-term unions are unstable and spouses are straddling between stable unions on the one hand and being part of a larger sexual network on the other hand, a fertile ground for HIV arises.

Although these cases depict that HIV risk for women is influenced by the sexual behaviour of their male partners, in these cases the sexual ideas and practices of the females vis-à-vis HIV also increases the HIV risk for themselves and their regular partners as well. Most married women in Chivanhu believe that marriage protects one from HIV infection and, even though the women knew (and accepted it if only in terms of compliance) that their husbands had extramarital affairs, they held a low risk perception and hence they reported that they did not demand protection from their husbands. According to a claim from one wife,

People believe marriage is a safe haven and they are not taking precautions or insist on safer sex.

Another woman indicated:

The challenge is if we are associating with each other for more than three months, we are no longer using condoms, even if we have not undergone HIV testing. Although sex workers are considered to be a serious risk, as women most of us we do not think that our husbands can pass on the HIV virus to me.

Most men commented that after associating with a woman for three months or more (whether a casual relationship or not), they assumed that their partner was safe (or HIV negative) and they stopped using condoms in their sexual encounters. Most men stopped using precautions even if he and his partner had not both undergone HIV testing.

HIV positive women in permanent relationships noted that most men do not want to hear about condoms despite the fact that the men know about the challenges of re-infection¹⁶. For these women, who were aware of the personal risks to themselves, protecting themselves from further re-infection was a daily challenge but the possibilities of demanding the usages of condoms was remote. For discordant couples, HIV positive women reported the burden of the added stigma associated with their HIV status. In the event of the wife being positive and the husband negative, divorce ensued. As a result, most HIV positive women who had undergone HIV testing would not disclose their HIV status to their partners. As one woman put it:

Man positive, woman positive that is an acceptable scenario, but man negative and wife positive, that is an unacceptable scenario, in most families.

Despite the fact that women are powerless to negotiate in favour of safe sex and condom usage, they are the ones who experience the most negative experiences in the event of becoming HIV infected.

6.2.1.2 Intergenerational sexual relationships

Closely related to the points in the previous section are intergenerational relationships between girls (or young women) and older males which are also linked to livelihood insecurity. These are common in Chivanhu, and the two case histories here show how young women are subject to increased risk of HIV infection arising from these relations. The limited local livelihood opportunities force some women to migrate to South Africa, leaving their children in the custody of elderly people or in some cases on their own. Some of the minor girls in these circumstances would resort to transactional sexual relationships with adult males, while others are encouraged by their grandmothers to resort to commercial sex work as depicted in the following case histories. The first case is of an elderly-headed household where the grandmother was encouraging her five teenage grandchildren to engage in transactional sexual relationships in order to access food and other basic commodities. The second case is of a minor who is left behind when her mother goes to South Africa and she is now HIV positive as a result of transactional sex.

Mbuya Mai Ruu has five grandchildren and the household is in state of chronic food insecurity. According to other concerned community members:

¹⁶ Even if both partners are HIV positive, they are encouraged to always use condoms because the HIV strains that they have might be different. If they do not use condoms correctly and consistently, chances are they might re-infect each other with a different HIV strain and that can have serious health consequences.

Grandmother, she stays with her grandchildren. The old lady has a habit of encouraging her grandchildren to engage in transactional sexual relationships. At the moment all five of her grandchildren are HIV positive: two are in their teens and three are in their early twenties. At one time we reported her to the chief, but she never repented from her behaviour. Now that the grandchildren are HIV positive she wants to chase them away saying that they should go and search for their relatives from the fathers' side.

The transactional sexual relationships that these five grandchildren are involved in are not with young men of their age group but involve much older men. In this respect, for many girls and young women who are experiencing livelihood insecurity challenges, the proximity of the settlement to Great Zimbabwe Monuments (a tourist resort) and the Harare-Beitbridge highway leading to South Africa, facilitates transactional and commercial sex work as alternative livelihood strategies, while at the same time increasing their risk of HIV infections. Some young girls (as young as sixteen) were going to Masvingo and operating from a certain house there, offering their sexual services to the older truckers passing through Masvingo.

Mpo is fifteen years old and attends Form Three at the local secondary school. During the time of conducting the research, Mpo's mother and father were separated; both of them are working in South Africa and they send money back to Mpo intermittently. She is staying with her aunt in Chivanhu but the aunt is not able to control her wayward behaviour. Mpo is HIV positive (she was tested at the mobile Population Services International (PSI)¹⁷ clinic in 2010). At the time of testing she was asked to bring her guardians, but she could not go with her mother because the latter was in South Africa. She is 'sleeping around' with anyone from boys to adult men. At one time, I witnessed a dispute with one of the neighbours because she was engaging in sexual relations with the seventeen year-old nephew of a man named Machekeche (who is enrolled in Upper Six in nearby Zaka) as well as with Machekeche's married young brother who is aged 26 and resides in Harare. The 26 year-old was found sleeping in the same house with Mpo. At the same time, Machekeche's two wives were complaining that he was also co-habiting with Mop's mother in South Africa. When Machekeche and the other community members were discussing and deliberating on the issue, they were more worried that Mpo might pass the HIV infection to their nephew and married brother than on the abuse the young girl was suffering. Many community members (mostly

¹⁷ PSI is an NGO specialising in HIV and AIDS services; they conduct mobile visits to areas where voluntary HIV and AIDS testing is limited and provide the HIV testing and counselling services.

married women who were worried about Mpo getting involved with their husbands) complained that they had notified Mpo's mother but according to the concerned people, it seems that Mpo's mother is not concerned about her daughter's behaviour.

Females heading households with young children are often faced with a 'catch twenty-two' scenario: they have the need to earn an income, but at the same time they have the responsibility for ensuring the social reproduction of the household primarily through taking parental care of children. In a marginalised community like Chivanhu, where the traditional social arrangements for protecting children and governing sexual behaviour are not functional, and there are no readily available extended family networks to look after children, women end up with fewer livelihood options. Income-earning opportunities (like sex work), leading to HIV infection, only serve to compromise the long-term social reproduction of the household. Surprisingly, unlike in other communities in Zimbabwe where Forster and Williamson (2000) recognised that it is difficult to find orphan-headed families because extended family systems absorbed orphans, in Chivanhu (where rights and institutional arrangements for governing social behaviour are ignored and not recognised), it becomes difficult to access extended family networks to assist in absorbing the demands for caring after extra children.

6.2.1.3 Social and cultural reproductive factors

The problems highlighted with reference to unstable marriages and intergenerational relations relate to a number of social and cultural reproductive factors which increase HIV-susceptibility in Chivanhu. Women are often taught to leave sexual initiatives to men and to behave in sexual ways which please men. In Chivanhu settlement, women are expected to keep quiet and tolerate the sexual behaviours of their male partners. As one woman said:

As women we are trained to please men, and most women here use dry agents so that the men can enjoy the sexual activity. And in the process there are tears to the sexual parts. But we cannot stop doing that because, if you do not please him sexually, he will leave you for another available woman.

As part of marriage and other long-term unions, women are expected to meet the sexual needs of males. In this respect, Chivanhu women reported that they are not supposed to refuse sex. Male sexual pleasure and power are the dominant factors animating sexual relationships, while the HIV risks to the female partner are unlikely to be considered in most instances. The desire to have a child (for cultural and social reasons) is one of the key forces pushing many

women (and men) to have children. This contributes to the high rates of infection in the 0-14 age group as infected men and women in the reproductive age groups are the major source of infection for young children and infants. It also contributes to the large number of orphans in Chivanhu. Condom use is incompatible with pregnancy and, in the context of marriages and long-term unions in Chivanhu where there is a strong social pressure to demonstrate fertility, most of the HIV-infected persons are reluctant to use them.

Fear of violence for pregnant women also results in many women passing HIV to their unborn children. All pregnant women in Zimbabwe are tested for HIV when they seek antenatal services. If a woman is tested, in most cases the partners refuse to go for testing and accuse the women (if positive) for being the one who brought HIV to the homestead in the first place. One pregnant woman in Chivanhu had to wait until the last trimester before seeking access to antenatal services. The hospital was demanding both partners' HIV test results before they could enrol her for antenatal care. The husband was away at the time in South Africa and refused to come home to be tested for HIV. By the time the hospital received the HIV test results, she was already in the third trimester of her pregnancy. Late registration for antenatal services reduces the effectiveness of Prevention of Mother to Child Transmission (PMTCT) services, contributing to higher avoidable HIV rates in young children¹⁸.

In addition, some breastfeeding babies are susceptible to becoming infected with HIV from their infected mothers. Most women in Chivanhu who are HIV positive face challenges accessing alternative feeding sources to that of breast milk. For those who wanted to opt out of breastfeeding, they had challenges from their mother in laws. As one woman put it,

If your mother-in-law sees that you are not breastfeeding, then she considers that you are a witch.

There are thus a number of problems encountered by women in Chivanhu arising from cultural and social reasons which focus on the role of women as child-bearers and which increase the risks of contracting HIV. In this context, one HIV-positive activist (from ZNPP+ Masvingo, at a workshop with other HIV positive people in Chivanhu) said:

If you are tested and both of you are positive, you are discouraged by health officials from having children, but some are still young and they still want to have children. You

¹⁸ Current policy in Zimbabwe requires a woman to be initiated for PMTCT services at 14 weeks during pregnancy, to increase the effectiveness of the prevention programmes.

are supposed to go to the clinic before you are pregnant; you plan together and you are monitored and you are supposed to work together with the nurses, but that is not happening due to all these challenges [as discussed above] and if you do not comply the child is born HIV positive.

6.2.1.4 Failure of health services to align to the needs of age groups

Problems though do not simply relate to gender and specifically women in terms of HIV susceptibility, as there are challenges also in terms of age groups. The field observations at the health sites with the staff revealed that most of the HIV and AIDS services available to Chivanhu settlement residents are biased towards providing services to the 15-49 age groups (male and female). At the present moment, in Zimbabwe, prevention messages and services have been focussing on reducing new infections in males and females within the 15-49 age groups (which has been identified by the policy makers as the most at risk age group). The evidence from the survey though showed a considerable proportion of older males and females (50 years and above), but particularly males, who are HIV infected. Post-menopausal abstinence for most women was indicated as the cause of lower infection rates for women above 50 years of age. In Zimbabwe, most women believe that if a woman continues to have sex after menopause, then semen will collect in her stomach and in the end the woman will suffer from the problem of *Chimimbamutekwa*¹⁹.

However, some elderly women were refusing outright to have sex with their husbands despite the latter's persistence, suspecting them of engaging in extramarital affairs with other women. In most of these instances, the women would depend on the financial and material support of their grown up children. In this respect one older woman commented:

I was tested and found negative and since then I have stopped having sex with this old man because he is very promiscuous and my children are grown up now and he cannot do anything to me. If he initiates divorce, it is him who should go and he will also lose support from our children.

While many older women refused sex (citing reasons such as that above), older men were pursuing sexual services from commercial sex workers and from transactional relationships with younger woman in the community. Most of the elderly men had settled in the area soon after independence in 1980, and they had larger pieces of land and more physical assets

¹⁹ Most women believed that if you continue to engage in sex after menopause, you develop a false pregnancy as a result of semen accumulating in your stomach.

compared to later settlers. They could obtain sexual favours in exchange for loaning scotch carts or providing draught power to local women for farming purposes.

With specific reference to the younger groups, the rates of HIV infection are higher for young women compared to that of young men. Girls in the Chivanhu community who are sexually active are doing so with men who are significantly older than them. For fear of stigma, when they contract sexually transmitted infections, they are often afraid to go and seek treatment. In most instances, as well, they indicate that they would not be able to afford the fee that the hospital charges for accessing treatment and for the treatment itself. A normal course of antibiotics ranges from USD3 to USD7 which is beyond the reach of most of the people living in Chivanhu.

However, despite their high infection rates, the reproductive health needs of older and younger people in Chivanhu are not given proper attention and this has important implications. Most of the sexual health and reproductive support schemes are focussed on providing family planning services for adults, and they are not user friendly for young girls and boys who are not deemed to be mature enough to be married, and for the elderly who are perceived to be beyond reproductive age groups: hence these services have tended to neglect the needs of both older men and younger children. Access to HIV information, as well as treatment for other infections which facilitate the transmission of HIV, are exceedingly limited for these age groups; this in large part is due to current health workers being under-resourced and lacking the skills necessary for offering support to these groups. In addition, in fieldwork discussions, the elderly said they were afraid to seek health counsel on suspected cases of sexually-transmitted infections because according to one elderly woman:

Nurses have stayed here for a long time and they know and respect us. Can I grow old with nurses telling me to remove my skirt so that they can see what's wrong? I would rather die than expose myself to such humiliating behaviour.

6.2.1.5 Ineffective governance institutions and tenure insecurity

The two cases in this sub-section highlight questions around governance institutions and tenure security in Chivanhu with regard to HIV susceptibility. Some of the traditional leaders in Chivanhu expose themselves to HIV infection, as well as their spouses and vulnerable female members under their jurisdiction (through abusing their authority and power). In a context where there is no or only limited community organisation independent of the

chieftainship system, Chivanhu households were afraid to challenge the authority of the traditional leaders openly, due to fear of losing their access to land.

Zex, at the age of 48 and with three wives, is one of the Chivanhu settlement village heads. The youngest wife, who is barely in her twenties, is alleged to have brought the HIV infection into the household. In the past, she was involved in cross border buying and selling and spent a long time away in South Africa selling her goods and artefacts. Zex and his three wives are all HIV positive and they are on ART. The youngest wife no longer frequently travels to South Africa because of her chronic illness. The husband is involved in extramarital affairs. As village head, he also exchanges land for money and food. He has a high position in the ruling party (ZANU-PF), so all party members who want to campaign in the area give him money in exchange for support. The whole family is in conflict as a result of the HIV infections. During the rainy season, because all four of them are too ill to engage in any meaningful agricultural labour, they are no longer able to plant crops in their field. No income is being generated by the household. In addition, the youngest child of the youngest wife is currently sick and even both parents of the village head are HIV positive and currently ill. There is no one person who is able to look after the other members of the household. The grandmother, under tremendous stress from the HIV infection, has requested that her son divorce all three wives. Apart from having his three wives, Zex also demands sex from other women especially widows under his jurisdiction.

Roxon is also a village head in Chivanhu; he is aged 44, with one wife and seven children. He is currently abusing his position as village head by forcing widows staying on their own to sleep with him. Mostly during the evenings when he is coming from the beer hall, he goes to houses of widows and demands sex from them. Because of fear, most of the widows comply with his sexual demands; and most of them claim that they are HIV positive as a result of this abuse. They do not report him because they are afraid to be chased away from the village and therefore lose their land (*‘Wokuudza hapana nokuti vanotyva kudzingwa muraini’*). His wives are also HIV positive. According to village head Chivanhu and other people in Chivanhu, most households in Chivanhu settlement are under Roxon’s jurisdiction. Although Roxon is still fit physically and is able to provide for his family, people were complaining that many of the widows that he has abusing are currently too sick to look after themselves and some are bedridden.

Unequal and oppressive gender relations play themselves out in different ways in Chivanhu, including in relation to the chieftainship system and sexual coercion as shown in this subsection. In fact, as this entire section on the upstream phase in HIV susceptibility shows, direct and indirect sexual coercion are widespread especially for women who are single and widows in the settlement. Females of all age groups, but especially girls and younger women, were also victims of sexual abuse and violence.

This section has highlighted a number of factors that influence HIV susceptibility in Chivanhu Settlement. The section has revealed that high levels of livelihood insecurity often animate HIV susceptibility. This though is coupled with low levels of social capital as it seems that, in struggling to make ends meet, individuals often do not have any kinship relations (or any other social network) to turn to for sustained support. Gender as well is critical as the dominance of men in gender relations is reflected not only in husband-wife relations but in everyday relations between men and women and even in relations between traditional leaders and women. It permeates all areas of social life and leads to manly control over sexual relations and the terms of such relations. At the same time these susceptibility factors are complicated further by health services which are failing to address the different reproductive health needs of specific age groups in Chivanhu. The following section focuses on the midstream factors that lead to increased vulnerability for the HIV and AIDS infected in Chivanhu Settlement.

6.2.2 Midstream: vulnerability to chronic illness in Chivanhu Settlement

This section discusses the factors that create conditions for AIDS vulnerability in Chivanhu settlement, and case histories of individuals and households are presented which illustrate these factors. To reiterate, AIDS vulnerability relates to the likelihood of experiencing significant adversity as a result of AIDS affecting individuals and households. Vulnerability across the HIV timeline happens during the midstream phase (chronic illness) and the downstream phase (death and the impacts of AIDS for survivors). The midstream period, like the upstream phase, has its own set of dynamic factors. The same factor though can feed into different phases and the relevance of specific factors varies across both individuals and households. Hence, factors that influence HIV susceptibility like high levels of livelihood insecurity can also result in increasing AIDS vulnerability after being infected by HIV and during AIDS-related chronic illness. The relevant factors for this phase include access to food, coexisting infections, household capacity, problems pertaining to governance, and access and

adherence to treatment. The cases of individuals who are at the chronically-ill stage are used to highlight these factors.

6.2.2.1 Household food and nutritional insecurity

This sub-section presents the case histories of Ndaizevei and Chido. The livelihood portfolio for most households in Chivanhu is exceedingly limited. Yet access to adequate and nutritious food in sufficient quantities is critical for one to live longer with HIV. This access to food delays a HIV positive person's progression from HIV infection to the AIDS stage. HIV and AIDS-affected persons like Ndaizevei and Chido become vulnerable to other infections due to chronic food insecurity.

Ndaizevei is a thirty-five year old widow. She relates her story as follows:

My husband died in 2007 and he was involved in petty commodity trading in many areas (chikorokoza). Most of the time he was away and that led to him contracting the HIV virus, and he passed on the virus to me. He left me with 4 children to look after. I know he died of AIDS, I am currently sick on and off but I am afraid of the mental stress that comes with knowing my status. What you do not know does not kill you. No one in the settlement wants to assist me, and I do not have any relatives in the community since my husband was originally from Mozambique. If I ask for help, even draught power, the man asks for sexual favours in return, they demand kundigara nhaka²⁰, although this can only be done for relatives and not for people who are not relatives. I am surviving mostly from Maricho and some support from the village head. All my children are HIV negative, but two of the children are no longer going to school. My 14 year old daughter went to Bulawayo beginning of 2011 although she had not finished school. The boy aged 12 is at home helping me in doing Maricho, but we are struggling to find adequate food to meet our daily needs as a family.

Chido aged 18 indicates:-

I am now sick and I cannot continue staying in Masvingo. Although I am on ARVs, I am having problems accessing food for my day to day up keep, so I just had to come back. My parents died four years ago, and we were having a lot of challenges as a

²⁰ *Kugara nhaka* in Zimbabwe tradition means that if the husband died, one of the male relatives especially brothers or nephews would inherit the wife of the deceased man. Only relatives of the husband could inherit the deceased wife and the children under their custody and not any other community person who was interested.

family. One of our female neighbours introduced me to commercial sex at Engen bar in Masvingo, which is frequented by commercial truckers. Before becoming ill, I could manage to earn enough to feed myself, but since I have been sick, it is difficult for me to get clients who pay me adequately to provide adequate food for myself. It's difficult to recover, because without food, the body cannot respond well to medicines.

Most households in Chivanhu experience chronic food shortages. For HIV-positive individuals, surviving in times of food insecurity is an even more daunting task and this leads to very high rates of death due to HIV. Even with access to ART, the mortality rate for the HIV-infected in Chivanhu is high due to the challenge of food insecurity. Despite the fact that the length of survival with HIV in Chivanhu ranged from one to twenty years, the majority of the HIV infected did not take long to progress to the AIDS stage and death because of chronic food shortages. One HIV-infected person commented '*you need food if you are HIV positive*' (Chirwere chinoda chikafu).

6.2.2.2 Treatment access, adherence and coexisting infections

The following cases reveal the challenges relating to accessing treatment, adherence to treatment and the prevalence of coexisting infections, and how these impacted on vulnerability to AIDS. In the first case, the wife is adhering properly to treatment but the husband (who works and lives in South Africa) regularly misses collecting his tablets on time. The second case is of a woman who, although she is HIV positive, does not want to take ART tablets because of her religion (her religion specifies that only holy water can be used for medicinal purposes).

Mukai and Fidelis is a couple who has been tested and found to be positive of the HIV virus and the couple is on ARV therapy. They have four children and the youngest child is also HIV positive and she is presently chronically ill. Mukai indicates:

I am married to Fidelis. Both of us have been tested and found to be HIV positive. I got HIV from my husband Fidelis, who was a fish monger, some women who did not like to pay with money for fish, engaged in transactional sexual relationships with Fidelis. That's how he became HIV positive and now I am also HIV positive.

The husband regularly travels to South Africa and his adherence to the ARV regimen is very sporadic since he misses his pills on several occasions. At the same time, he is sexually promiscuous, has sexually-transmitted infections and passes these infections onto the wife when he is back in Chivanhu. He also does not want to use condoms and this creates

conditions for re-infection. . The wife is happy during the times when her husband is away in South Africa, because she complains that he frequently passes sexually-transmitted infections to her and this compromises her health. He can no longer undertake fishing as a livelihood because of his deteriorating health and any money earned while in South Africa is never remitted back to Chivanhu. During the periods when he is away, she survives through stealing firewood from the Zimbabwe National Game Park and selling this to community members, and also through *Maricho*.

John is aged 17 and head of his household. When his parents died in 2006, he went to the surrounding farms to look for employment. He spent three years there and came back to Chivanhu in December 2010. The houses left by his parents are all dilapidated and he is staying in a house without a door and whose roof is almost falling down. Right now he is sick but he is not on ARV treatment. He begs in the community and the last time I interviewed him he was begging for support to assist him in rebuilding the houses that were dilapidated. Because of his many challenges, the village head gave him space to make bricks for rebuilding and he also wants to go back to one of the farms to collect his belongings which he left there. The community though is not keen to help him because they were rumours that he was involved in stealing.

Nomathemba is a Johannes Masowe prophet before she was diagnosed with HIV. She is married to a husband with two other wives. She has six children aged between five and sixteen. She was self-supporting financially through her prophecy work. Now that her status is known and due to the fact that her religious sect does not allow adherents to the sect to take tablets, her condition is worsening. She certainly could never be seen taking ARVs when – as a prophet – she was publicly denouncing the taking of ARVs by other community members. Before her chronic illness, she would be sought out and invited for her prophecy services but (since becoming chronically ill) no community members was inviting her or seeking her out. Her livelihood portfolio has changed dramatically, with her household members relying on *Maricho*.

Breadwinners in the HIV and AIDS-affected households regularly die first (before other household members) and most households affected by HIV and AIDS experience chronic food shortages. Food insecurity leads to some HIV-positive people taking ART drugs on an empty stomach. But the cost of the course of antibiotics (from USD3 to USD7) is beyond the

reach of most of the people living in Chivanhu and hence some infected people are not on treatment. Some men and women, who migrate to South Africa and Botswana either occasionally or regularly, overstay their visits and at times fail to collect their drugs in Chivanhu when required to do so. As well, certain people living with HIV in the settlement complain that they were experiencing side effects from the drugs and, without adequate counselling and assistance from support groups, they would prefer to withdraw from the regimen and stop taking the drugs. Two people living with HIV in Chivanhu had been initiated on ART in South Africa, and their type of anti-retroviral drug was not yet available and administered at Morgenster Mission Hospital. For this couple to access the medication they had to obtain a prescription from a doctor and the monthly cost of the prescription was USD45. Since the couple is unemployed and without a regular income, they were not taking the ART drugs. Adherence for young children is a critical dilemma. Initially when my research was starting, the local nurses had not been trained to manage ART for young children, so most young children were not accessing the drugs. However, by the end of conducting the research, the Bill Clinton Initiative had donated drug formulations for children and some of the children were accessing the drugs. Young HIV-positive children who were also orphaned had a further challenge as their guardians would ignore the treatment requirements and, as a result, some of the children's health was not improving

6.2.2.3 Gender discrimination and abuse in HIV discordant couples

Discrimination against women in Chivanhu settlement has had implications for seeking counselling and testing services. For example, there are many incidences of women who tested positive but did not disclose their status publicly and to men specifically. Some of the cases where a woman was found hiding her HIV status from the male partner (who was said to be HIV negative) were even sent to traditional leaders for hearing in order to penalise the woman who was found hiding her HIV status. There seem to be far fewer cases of men hiding their HIV status from current or prospective partners, and Chivanhu residents generally sympathized with HIV-positive men as compared to HIV-positive women. Cases of woman caught (or revealed as positive) after hiding their status became quickly sensationalized as if they would have committed a big crime, despite the fact that the same predicament was quietly accepted for men. In some instances they were so sensationalised that it would be difficult for the woman concerned to stay in the settlement. At times traditional healers would even publicly denounce the women, but there was no case that was handled in a similar

manner for HIV-infected men. In the following discussion, I refer to the case of Jo, a local shop owner.

Jo owns a shop at Nemanwa growth point. Before he ventured into the business he had one wife. After the business was established and became successful, he started engaging in extramarital affairs. The other relationships were short-term until he fell in love with a woman called BC. Jo instructed BC to go for HIV testing before they could live together. BC went for testing alone and tested positive, but she tampered with the documentation and changed her HIV positive code to negative. She lied to Jo about her status and – on this basis – he divorced his first wife in order to marry BC. After a short while, the woman fell pregnant and they went for testing together according to the requirements at Morgenster Mission; in doing so, BC tested positive while Jo tested negative. She was subsequently physically battered by Jo and that is when she disclosed that she had lied earlier to him about her status. The husband started to attack her even more violently, accusing her that she wanted to kill him. By the time of conducting my research, she was in her early stages of pregnancy and she gave birth to a baby boy who tested negative. Jo has reconciled with his first wife and he is not supporting BC. BC cannot exclusively breastfeed for six months because she does not have adequate food to maintain her nutritional status; hence she is doing mixed feeding for the baby. She was also claiming though that she had several boyfriends who were providing the basic necessities for her upkeep. Jo continues to not want anything to do with BC and, apart from having his first wife back, in December 2010 he impregnated a local school-going girl; the girl is no longer going to school and is staying with him at Nemanwa growth point. Although the girl's parents know about this and acknowledge the HIV and AIDS risks, they accepted *lobola* (or dowry from him) for impregnating their daughter.

In the case above, the man ordered the woman to be tested before having sexual relations with her and the woman lied about the test results. After she became pregnant and they were tested together and her status was revealed, her conduct was treated as something extraordinary (or even unheard of) in the community and therefore denounced. At the same time, the inhumane treatment he had given to his first wife (namely, divorcing her suddenly for another woman) was discarded as something normal. In taking back his first wife, he first ordered her to undergo a HIV test; in fact, a HIV negative result was the condition for taking her back. This took place in August 2010 but, as noted above, a few months later he impregnated a school girl. During the time of conducting the research, Jo was waiting for the child from his second

wife to be tested. If the child tested positive (at eighteen months of age), then he indicated that he would not look after the child; but if it tested negative, then he would consider whether to support the young boy.

In situations like Chivanhu where women are socially, culturally and economically dependent in a fundamental sense upon men, critical HIV and AIDS services such as PMTCT end up – unintentionally – as tools which cater for the interests of men. Men demand that women partners undergo testing where they (men) perceive themselves to be at risk and even where they are the ones perceived to present a risk to women; rarely do men voluntarily undergo HIV testing and counselling. To complicate matters, even traditional leaders in Chivanhu were very critical of the new policies which require both husband and wife to undergo testing when expecting a child and for the results of the tests to be officially recorded before registering the pregnancy at the local clinic.

Some women from Chivanhu though were taking a stand and emulating the behaviour of the men. Another widowed man from the community was having problems remarrying after his wife died, as the women he dated insisted that he be tested. The men from Chivanhu sympathised with his plight and saw the insistence of these women as unacceptable, vindictive and mean behaviour. But, in this specific instance, the fact that the man was particularly poor and chronically ill heightened the desire and need on the part of the girlfriends to make the HIV testing demand. Other men who have resources could ask for favours without having such demands made on them.

6.2.2.4 Ineffective governance and HIV and AIDS institutions

The situation in Chivanhu differs from many other areas in Zimbabwe broadly and Masvingo District specifically with regard to supportive institutions. Though other wards in the district had more than 20 NGOs in each ward operating and providing services, as well as Village AIDS Action units and a Ward AIDS Action unit, in Chivanhu such NGOs and units were not in existence or not functional. One of the challenges was that the village heads in Chivanhu were pro-ZANU PF while the councillor, who is supposed to coordinate activities in the ward and give direction to village heads on how to mobilise people and HIV activities at village level, was elected on an MDC-T ticket. HIV activities at both the village and ward levels were not operational in large part because of issues of power contestation between political parties

locally. Even the District AIDS Coordinator for Masvingo Rural District, who is supposed to coordinate HIV and AIDS activities and programmes, commented:

Ward 12 and that area of Chivanhu in particular is a no go area for me. They give me problems, I work with all the other wards which are cooperative, but I do not have the energy for fighting and squabbles that go with working people in that area; it's difficult to understand whether it is a new resettlement or communal area.

According to her it is difficult to understand the correct way of engaging the people at Chivanhu because of its informal status. The District AIDS Coordinator commented that communal areas are effectively organised compared to other settlements like fast track resettlement lands or informal settlements like Chivanhu Settlement. The MDC Councillor reiterated this; he spoke about the existence and functioning of the District AIDS Action Committee

But in this area [Chivanhu] they are afraid of the chief, traditional leaders and [ZANU-PF] politicians; hence they do not want to be involved with the community. In this community, NGOs and other stakeholders say we don't have time to sit down and clap hands for your traditional leaders.

The challenge of grassroots party politics interfered with the organisation and coordination of support activities for the HIV infected and AIDS affected. As a result, all the AIDS service organisations which were supposed to be providing HIV and AIDS services for the Chivanhu community were not operational.

At district level, resources and activities were planned (including the area around Chivanhu settlement), but at the grassroots level no activities were taking place. In other wards, in rural areas in Zimbabwe there are behaviour change facilitators who provide information, education and communication about HIV, but in the case of Chivanhu that was not the case. Even CARE International, which had potential for negotiating access²¹, cited a number of issues that affected the effectiveness of its activities²². According to one of the Chivanhu settlement members:

CARE International started in 2007; before that CARE was hesitant to implement programmes in the area because of the challenge of politicization. Even when CARE

²¹ CARE International has been operational in the province since 1992, and it had maintained strong linkages with key stakeholders in most areas.

²² By the end of conducting the research, CARE International was one of the NGOs that had been banned from distributing food aid by the Governor of Masvingo.

International started food distribution in the village, the chronically ill were left out by the village heads. They were the ones compiling the beneficiary registers and they were saying that the village heads are not the ones that brought the AIDS related sickness to the HIV infected, so there was no need for the village to give preference to the HIV infected during the registration for food distribution. Some village heads are saying they cannot give food to prostitutes.

In a scenario (such as contemporary Zimbabwe) where most development programmes are emergency humanitarian programmes, there are short and inflexible implementing time frames. Implementation schedules are not flexible enough to allow space for long periods of negotiating access to rural communities (Helliker, 2008) As a result NGOs such as CARE International opt to work with communities where there is easier access and less political influence and complexities. During the time of negotiating for research access for this thesis, I was in fact discouraged to go to Chivanhu by the District AIDS Coordinator for Masvingo citing some of these problems.

In Chivanhu settlement, there was one support group for people living with HIV and AIDS and it proved to be critical in providing assistance through education and peer support on treatment adherence for those members accessing antiretroviral therapy. The leader of the support group in Chivanhu said that, although the capacity to provide support was limited, support groups provided some kind of opportunity to give each other moral and psychosocial support. According to one of the support group members,

We meet on a weekly basis; we do not meet to just talk about nothing, but we tell each other that even if we do not have food, we should ensure that the medication should always be taken.

However, overall, the sensitive political situation in the settlement affected the effectiveness of services to provide treatment, care and support for most HIV-positive and AIDS-affected people in the community. Support group members in Chivanhu are supposed to meet regularly in groups of 8 to 12 people, but political representatives (especially from the ruling party) wanted to attend and monitor the discussions since one of the support group leaders and members was the councillor from the opposition party. The following quotations from one the leaders of the support group illustrate the problems that arise:

The group meets at the councillor's residence (and this is a politically sensitive area); you inform the chief first before meeting, and the boys from the ruling party will be there listening and recording what you are discussing. In the end you end up not

discussing anything at all. And right now if you meet as a group of 10 people, the ruling party youths come uninvited and you cannot tell them to go away.

These challenges increase vulnerability for the HIV infected. In other areas where there are more and well coordinated support groups, they are an important avenue for providing peer counselling and treatment literacy and they provide opportunities for advocacy.

This section has analysed the various factors in the midstream phase that increase AIDS vulnerability for the HIV infected. Chronic food insecurity and high levels of livelihood insecurity undermine the nutritional status of the HIV infected. Access to a balanced and nutritionally adequate diet delays progression to the AIDS chronic illness stage for many HIV infected people. Chronic food insecurity also has an impact on treatment adherence, as does the absence of income for accessing treatment. The presence of other infections like sexually-transmitted infections and multiple concurrent relations result in the immune system being compromised. Discordance creates challenges especially for women who are HIV infected and ineffective governance systems undermine the effective functioning of support groups for people living with HIV. The following section focuses on the downstream factors that influence AIDS vulnerability in Chivanhu. In the downstream phase, the main emphasis is vulnerability after chronic illness and deaths of HIV infected. The focus is on the vulnerability of survivors in AIDS affected households.

6.2.3 Downstream: vulnerability to impacts of AIDS in Chivanhu Settlement

This section discusses the factors that create conditions for downstream (post-infection and post-death) AIDS vulnerability in Chivanhu settlement. Case histories of individuals and households are presented, which show the ways in which the impacts of AIDS morbidity and mortality play themselves out at different levels and in different forms. AIDS vulnerability in the downstream phase has its own set of particular factors and consequences, though some of these may be similar to those in the midstream phase. However, whereas the midstream (and upstream) phase tend to involve individual HIV risk and AIDS vulnerability with reference to chronically-ill individuals, the impacts of the downstream phase potentially encompass the whole household (even threatening its very existence). The downstream AIDS vulnerability factors can also contribute to further HIV infection for any surviving members of AIDS-affected households.

This section therefore speaks about households which have experienced AIDS-related chronic illnesses and deaths. The cases reveal how the households are affected adversely in terms of vulnerability but also how they deal with (or handle) the HIV and AIDS impacts at household level. Households that demonstrate some form of coping or even resilience are presented in the following chapter (Chapter 7). It is critical to emphasise that vulnerability in Chivanhu is deepened by the fact that, in such a marginalised community, there are minimal opportunities for coping mechanisms for the HIV and AIDS affected. Furthermore, the initial livelihood portfolio is narrow to begin with for the majority of HIV and AIDS-affected households.

Downstream AIDS vulnerability in particular is pronounced because, generally speaking, households are asset poor in Chivanhu, and there are limited livelihood options for the majority of the households. Some households who had scotch carts would poach firewood in the Zimbabwe National Park area, but towards the beginning of 2011 the Environmental Management Authority strengthened its presence in the Lake Mutirikwi catchment area. Because of this, it was becoming increasingly risky to survive on firewood poaching. If anyone was caught, the management authority would confiscate the scotch cart and demand that the culprit pay a fine of USD80.

In Chivanhu, the responsibility for looking after orphaned children shifts between different households and the chronically ill are moved from one household to another. Most HIV positive men continue to migrate to South Africa to engage in commodity petty trading. For some men, especially those who migrated into Chivanhu as a place to call home temporarily and as a place to die, HIV and AIDS has left them in a state of ultra-poverty. The recent male migrants into the settlement do not have adequate land for further investment in agriculture, nor do they have physical assets to dispose of in the event of increased income demands. Indeed, livelihood assets and food security are heavily compromised for the majority of households in Chivanhu, and this has negative consequences during the downstream phase.

This picture of Chivanhu is in contrast to what has been documented in other rural studies, such as by Rugalema (2000), Rugalema et al. (2010) and Makonese (2007). These studies of agrarian communities (dependent largely on agriculture) show – amongst other actions – that land will be left fallow, physical assets disposed of and children withdrawn from school in order to cope with the impacts of HIV and AIDS. However, for households surviving in Chivanhu, the livelihood portfolio base is exceedingly limited, with land being scarce and few

households having livestock and other physical assets to dispose of in the event of HIV and AIDS-related livelihood stresses. The situation of HIV and AIDS-affected households in Chivanhu therefore brings to the fore an extreme vulnerability condition for the HIV and AIDS-affected, certainly when compared to more long-term and stable rural communities (whether in Zimbabwe or elsewhere). In this context, several factors are presented below with specific reference to the downstream phase for Chivanhu households, including fragmented social and family structures, the poor livelihood asset base, gender discrimination, insecure tenure, and insufficient institutional capacity to mobilise people to respond effectively to HIV and AIDS impacts at community level.

6.2.3.1 Fragmented social and family structure

This sub-section shows how survivors of HIV and AIDS become vulnerable in terms of household sustainability due to the impacts of AIDS in Chivanhu settlement. This is examined in relation to a child-headed household and an elderly-headed household. The impacts are deepened in the case of Chivanhu because most of the HIV and AIDS-affected households do not have close relatives or close relationships with other community members upon which they could rely as an overall coping mechanism.

The Zivhu household is marked by orphanhood. The grandmother was the head of the household during the early phases of conducting my research. She died in 2010 and left seven orphaned children from her late children who died of AIDS related illness. The ages of the children ranged from between five and seventeen at the time of her death. Two of the eldest surviving grandchildren are now pursuing commercial sex work, one in South Africa and the other in Masvingo urban area. When the grandmother died, the village head and other traditional leaders failed to locate any close relatives in the local area to take care of the seven children, since the family had migrated into the area from elsewhere. Later on, the village head managed to trace some distant relatives so that they could take custody of the children, but these distant relatives are failing to provide the foster care for the children. The children are occasionally placed under foster care through arrangements made by the village head named Chivanhu in exchange for labour services during school terms but the challenge is that, during the school holidays, the children return to the deserted homestead at Chivanhu and have problems accessing food and other basic necessities. Indeed, they spend the whole holiday participating in *Maricho* in order to obtain food. The other two teenage boys aged 14 and 15 of the seven grandchildren are drop-outs and are no longer attending school; instead,

they spend their days looking after other peoples' goats in nearby Charumbira communal lands. The girl who was engaging in commercial sex work in Masvingo is now chronically ill due to AIDS. The last time I communicated with her, she indicated that she could no longer stay in town and was contemplating coming back home because of her illness. She is on ARVs but is having challenges getting adequate food; because of this, the medication is not working effectively. She is currently selling the few assets that had been accumulated by her grandmother in exchange for maize and other food items. The girl in South Africa, at the time I was completing my data collection, claimed that she was cohabiting with a South African man and that she was expecting a child with that man.

Vandi is in her early seventies and is looking after eight grandchildren. There are five teenage girls and three boys below the age of ten. All these are children of her absentee daughters in South Africa. The mothers in South Africa spend three years or more without returning to Chivanhu or even sending money to their children. In fact, during my fieldwork, the mothers were never present in Chivanhu. The grandmother was struggling to manage the household. As the girls grow older, they are no longer listening to their grandmother; for instance, at the beginning of the year 2011, two girls who were only around sixteen eloped to be married. Another granddaughter, who is HIV positive and lives in South Africa, was reported to be very sick and is currently bed ridden. Vandi used to produce sufficient food through growing crops for her grandchildren, but currently food stocks are inadequate because of recent bad harvests and some of the grandchildren have dropped out of school.

The fragmented family structures characterised by skipped middle generations experience increased vulnerability. The ability of the household heads to engage in meaningful livelihood activities is already compromised by age, and young children are forced to assume adult and independent roles at an earlier age. Young men and women in Chivanhu are often forced to become independent at a relatively young age. Poverty and the consequences of HIV and AIDS compel them to either become active economic participants in the household or to leave the dwindling security of the household at a very young age. These tendencies limit their ability to develop their productive capabilities and potential to pursue opportunities and fulfil their aspirations, sometimes because they discontinue their education. This leads to despair and results in the erosion of moral and social responsibility as well as risky social behaviour. The young men and women end up resorting to suboptimal livelihood coping strategies that increase their risk of getting HIV infected creating a vicious cycle of HIV susceptibility and

AIDS vulnerability The limited choices available to young HIV and AIDS-affected individuals lock them into unproductive livelihood pathways and further exacerbate the cycle of susceptibility and vulnerability to HIV and AIDS. Orphaned children from affected households (in a context like Chivanhu where there are low levels of social cohesion and the deceased parents often do not have any nearby relatives) become susceptible to HIV infection, notably girls who engage in commercial sex work. Opportunities for transactional sex work abound, both locally within the community as well as in nearby Masvingo town and beyond. Girls easily travel by bus or walk to nearby Masvingo urban centre; in Masvingo, there is a brothel catering for truck drivers from which girls operate. The more daring operate more openly from Engen Service Station in Masvingo, which is a major truck stop for commercial truck drivers. In the case of boys, in order to sustain themselves, they often found work such as herding cattle or *Maricho* but under highly exploitative conditions.

Looking after particularly young children in the event of their parents dying from AIDS was a major challenge for traditional leaders in Chivanhu, as they were responsible for locating the nearest kinship relations; in most cases, because households had originated from far away, it was difficult to locate any next of kin. Traditional leaders themselves already had their own sets of problems arising from the pandemic, and they were not in a strong position to provide food and other basic necessities for the children. Hence the children turned to sex work (girls) or became trapped in exploitative work relations (boys).

6.2.3.2 Gender Discrimination and fewer livelihood options for widowed women

This sub-section explores the specific vulnerability that many widowed women in Chivanhu face. Apart from dealing with the fact that they are HIV positive, and that they have been left with limited livelihood assets after the death of their husband, they also face discrimination from the deceased husband's extended family system. Two cases of HIV- and AIDS-affected women are presented.

Zet is a HIV-positive widow in her late forties with five children. Her husband died in a car accident and she started engaging in multiple sexual relationships. The family of her husband was extremely unhappy about this and they tried unsuccessfully on several occasions to take the children from her. The husband's relatives are not helping her with any financial or emotional support. The children are going to school but they have been sent home on several occasions due to the failure by Zet to pay school fees on time. She wants to get married, but

currently men do not wish to marry her since they know that she is HIV positive. Zet's husband left her with significant moveable assets and she is selling this property during her times of need and also to replenish her supplies for the Great Zimbabwe Craft Centre where she is engaged in a craft-selling business. Widowed women who engage in relationships have challenges where the extended family members expect them to remain loyal to their dead relative as long as they are residing in the same homestead as prior to the death of their mate.

Mai Matie's husband died as a result of AIDS in early 2011. Her husband used to work in South Africa, where it is alleged that he became infected with HIV. He then transmitted the infection to his wife. The husband's relatives accuse the wife of engaging in extramarital affairs when the husband was away. After the death of her husband, the relatives chased her away from the homestead; they have since sold the homestead and converted the money from the sale for their personal use. They have never given her even a cent from the proceeds, despite the fact that she has seven children and is currently bed ridden because of AIDS. She is currently looking after a neighbour's homestead that is in South Africa, in exchange for cultivating the land. Her children are no longer going to school, and they are engaging in *Maricho* so that they can find food. Recently, they have not harvested anything from cropping.

HIV infection and the progression to full-blown AIDS have a direct impact on the character of livelihood portfolios and the strategies in which household members engage. Women bear the greatest burden of the HIV and AIDS epidemic. In the case of surviving widows in an unstable settlement like Chivanhu, there are normally few assets available which can be disposed of by the widow for everyday basic expenses. In addition, relatives of the deceased husband regularly disinherit the surviving widow and this obviously has implications for the widow (and children of the marriage) in terms of coping strategies. Older women, who had been widowed as a result of HIV, had settled earlier at Chivanhu and hence they had more land and more stable livelihoods compared to younger widows. But, overall, there were many cases of women and stories of widows who were engaged in transactional sexual relationships. Widows were often blamed for these relationships. For instance, traditional leaders on several occasions would call for *bembera*²³, where they would publicly declare that they are hearing that there is a woman taking another woman's husband. The target of

²³ Publicly denouncing a person's conduct, rather than directly confronting the person privately on a one-to-one basis.

denunciation was almost always women, such that rarely were men targeted or their sexual behaviour condemned.

The insecure land holdings and the high demand for land in Chivanhu put most women at risk in the event of the husband dying first. Older men from the community often lure young women (even teenagers) into marriages (and soon afterwards die from AIDS-related diseases) such that it is not uncommon to see widows as young as twenty in Chivanhu. Most young widows have problems retaining her household's homestead and land in the event that they plan to remarry or if found to be having sexual relations with other men; the husband's relatives invariably seek to control the homestead and land in these cases. One woman who lost her husband when she was nineteen moved to Harare to search for employment where she was impregnated by a man who then deserted her. She found herself homeless, because her late husband's father told her that she could not raise another man's child in the family home in Chivanhu.

But problems with relatives do not arise only for widows. In another case, the husband had moved to South Africa four years earlier and there were rumours that he had married a South African. The young wife aged 28 in Chivanhu engaged in an affair and became pregnant; she then sought a backdoor abortion that left her with major health complications. She became ill after the abortion. The husband's family refused to take care of her and her mother was staying in Zaka about 121 kilometres from Chivanhu. The mother would visit occasionally, and later on when the wife became critically ill (from AIDS) she was taken by her aunt in Harare where she passed away. The husband has never returned subsequently, and the homestead has been taken over by the husband's younger brother who has since married a second wife to take care of his brother's surviving children.

6.2.3.3 Insecure tenure and social discrimination for HIV infected males

Some HIV infected males were also experiencing increased vulnerability, although the cases were fewer compared to those for HIV infected women. However, vulnerability differed depending on the period of residing in Chivanhu and the original livelihood asset base before suffering from AIDS. For the male heads of households who had settled early in Chivanhu's history and who had more land and moveable assets, they experienced less AIDS vulnerability compared to those men who settled later (the latter had less land and limited livelihood assets to fall back on in the event of becoming chronically ill). There were

instances of HIV infected men who had experienced serious adverse effects. Some of these men were showing signs indicating that the very future of their household is being compromised, in large part because the opportunities for recovery are very minimal.

Zvada is originally a Mozambican citizen who migrated to Zimbabwe during the early 1980s. He does not have a Zimbabwean identity document and, because of this, he could not obtain land on his own accord. In order to receive land and a homestead, he used his wife's name and identity document, such that the household was registered with the traditional authorities in the name of the wife. Zvada's wife died of AIDS in 2004 and she left behind an eight-month old child. The traditional leaders dispossessed him from his land and homestead, claiming they did not know him. According to one of the male discussants,

That man really suffered, you would see him with his child on the back. He gets a field to work on in Chivanhu and would put his child away to sleep in the field [normally it is rare to see a man doing that] and with a can of mahewu and overnight sadza for feeding the baby. But at least the child has now grown up. No one could assist him because you would have your own business to take care of. At the moment he is squatting with his child at a nearby former ARDA farms and is surviving through providing Maricho."

Boroma was 45 years old when I first met him. His wife died in 2007 and he was left with two children (a boy and a girl). He is also looking after his elderly parents. The wife was HIV positive, but he is refusing to be tested for HIV although he is chronically ill most of the time. The homestead structures in which he is staying are in a deplorable condition. He claims that he is building a helicopter and every time I visited him he was 'working' on the helicopter or repairing batteries. He does not engage in agriculture and most community members suspect that he is stealing from their plots during harvest time. His children and elderly parents are surviving by engaging in *Maricho* for their daily upkeep. He tries to enter into relationships with women, but women desert him when they realise that he does not have a stable livelihood income; so he tends to have uncommitted relationships with women.

The cases of Zvada and Boroma show the other side of AIDS vulnerability by focusing on men. In a settlement like Chivanhu, basic rights even of men are at times ignored and not recognised especially by the traditional leaders who are supposed to be the custodians of those rights; in this context, being infected by HIV or affected by AIDS poses an additional vulnerability. For men to successfully engage in sustainable livelihoods, they mostly depend

on women for the care and support of children. While cases of women's vulnerability to HIV have dominated existing literature on HIV and AIDS, experiences of men as found in Chivanhu settlement show the long-term and dramatic effects on households headed by widowed men during the downstream phase.

6.2.3.4 Low social cohesion and weak institutional responses for HIV and AIDS

The vulnerability context of the HIV and AIDS-affected in Chivanhu is clearly related to the limited social and institutional capacity to organise at grassroots level. The ineffectiveness of the VAAC and WAAC structures has produced a crisis of organisation of the AIDS-affected in mobilising people and resources for the AIDS-affected. Most of the households in Chivanhu settlement are not officially registered in the formal village head registers. This presents a serious challenge because these registers are used for humanitarian assistance targeting. Most providers of humanitarian assistance plan and implement their projects using village registers. This means that in the rare instances where support is provided to the settlement, only about seven households receive any kind of support while all other households are bypassed.

In the presence of weak grassroots organisation and social in-cohesion, the capture of external projects by elites is possible and exacerbates vulnerability. In this regard, there has been a tendency for the village heads and a few local elites to try to maximize personal benefits for themselves from the projects as can be seen in the Fatini Project. This project has been running from 2005 to the present-day, but it has been experiencing a number of challenges which impact on its viability. In 2005, a white tourist couple visited Great Zimbabwe and acquainted themselves with a local hotel employee called Rusike. The couple wanted to provide financial support to start projects for the chronically-ill and orphans arising from HIV and AIDS. Rusike introduced them to a man who was HIV positive and chronically ill named Fatini. Fatini used to go to the same church as Rusike. The couple sent Rusike to negotiate access with the local chief. The chief said that he does not authorise a project for one person only; hence the couple would have to assist the whole settlement of Chivanhu.

The donors promised the community that they would assist the community with poultry projects and the initial batch of layer chickens came in 2007. The beneficiaries of the layer chickens though were one of the village heads (and four other families who were close friends with the village head) and Fatini. The beneficiaries could not afford layers mash to feed the

chickens and most of the chickens were slaughtered for meat. As a result, there are no households with chickens at the moment. Fatini died in 2008, but Rusike and the other beneficiaries continued to ask for support from the white couple. The donors were told of the food crisis in Zimbabwe and, from 2008, they were donating USD50 every month to sustain community projects in Chivanhu. At the time of conducting my research, the same families were benefitting from the monthly USD50 donation; though they are not by any means the poorest in the community.

In 2010, Rusike wrote a request to the white donors that the community wanted two water pumps for a garden project. He claimed that the people no longer wanted chickens but garden projects. The two pumps came: Rusike retained one and gave the other pump to the other same beneficiaries. But, in March 2011, the other beneficiaries declined the donated pump because Rusike had refused to request money to purchase fencing for the garden and for digging the well for the proposed garden. By the time of completing my research, the families were requesting an audience with the donor so that they could explain why they declined the water pump. It was only Rusike though who knew the names and the contacts of the white donors.

The Fatini project is a typical example of project failure. Certainly, the beneficiaries of this project are not the most vulnerable people in Chivanhu. Despite the fact that significant funds and resources have been given by the donors, weak organisational arrangements and problematic institutional accountability produce a complex social web which inhibits the effectiveness of such interventions. In this respect, dubious grassroots politics and governance issues multiply the vulnerability of the AIDS-affected.

Overall, whereas some villages within the same district as Chivanhu are benefitting from nationally-mobilised resources for reducing AIDS vulnerability, like National Plan of Action for Orphaned and Vulnerable Children (NAP-OVC) for orphans and vulnerable children, the majority of the AIDS-affected households in Chivanhu receive no such support. The local District AIDS Coordinator notes that there is a need for further vulnerability analysis studies in Chivanhu. Though there seem to be adequate resources and effective institutions vis-à-vis the pandemic in Masvingo province, these seem to occur only down to district level in many cases. At grassroots level, where WAACs and VAACs operate, a range of social and political issues block institutional accountability and thereby add further fuel to the vulnerability of the

AIDS-affected in Chivanhu and other rural settings. The pathetic nature of the situation is highlighted in the following comment by one village head:

There was a call for us to register all orphans so that they can get assistance, but the challenge is you have to go to the councillor who in this instance is MDC-T. If you are seen as a village head going there with names, you are in trouble, so you do not just register them.

Downstream AIDS vulnerability in Chivanhu is influenced by many factors that have been presented and analysed in this section. Fragmented family structures have challenges in addressing and absorbing the impacts of AIDS on the household. Gender discrimination and fewer livelihood options for HIV infected widows also increase their AIDS vulnerability. There are fewer livelihood assets to inherit in the event of death of husband and the situation is further complicated by the position of women in traditional patriarchal systems. HIV infected males are also not spared from the discrimination, especially those who are poor and foreign and hence do not have adequate financial and material resources to buy favours and alliances from the village heads. Low levels of social cohesion and weak institutional responses for HIV and AIDS also fuel downstream AIDS vulnerability. The institutional response for HIV and AIDS is further undermined and complicated by ineffective governance systems and grassroots politics, in the process creating avenues that undermine the success of the few projects targeted for the HIV and AIDS affected.

6.3 Conclusion

This chapter has discussed and analysed the upstream, midstream and downstream HIV and AIDS impacts on HIV and AIDS affected households and individuals. The chapter has analysed the conditions within Chivanhu Settlement that create a vicious cycle of HIV susceptibility and AIDS vulnerability. High levels of social inequality, gender inequality, intergenerational sexual relationships, multiple concurrent partnerships and ineffective governance systems create a fertile ground for increased risk of getting HIV in Chivanhu Settlement. In the midstream phase, food and livelihood insecurity, coexisting infections, household food insecurity, time and capacity for providing care at household level, treatment access and adherence, and disabling institutional and governance systems are that factors influencing AIDS vulnerability. In the downstream phase, there are fragmented social and family systems, poor asset bases and gender discrimination, tenure insecurity and poor and ineffective governance institutions. The factors highlighted in the different phases, and

illustrated by a number of examples, are not mutually exclusive and one particular factor may occur in different phases. Nevertheless, it is critical to recognise that there is a time-line in the progression from HIV to AIDS to death and that – quite often – different factors and specific combinations of factors animate different phases. This time-line analysis also relates back to the discussion in the previous chapter where I outlined the different livelihood activities of households over time (from before chronic illness, to chronic illness before ART, to live under ART treatment). It specifically isolates the relevance of adherence to treatment as a factor in possibly inhibiting the progression into the downstream phase.

The type of analysis outlined in this chapter provides a basis for understanding in a nuanced fashion the complexities of HIV and AIDS with regard to specific households. In a sense, this is what the next chapter seeks to do. But, in this case, the emphasis is on the possibility of household resilience in the face of the epidemic and the conditions which facilitate such resilience.

CHAPTER 7: THE MACHEKECHE CLUSTER AND RESILIENCE – ROLE OF KINSHIP AND SOCIAL CAPITAL

7.1 Introduction

This chapter is a case study of households in the Machekeche cluster. The Machekeche cluster provides an opportunity to find out the role of social capital (notably kinship relations) in sustaining resilience and reducing vulnerability to the impacts of HIV and AIDS. Three sets of orphans are linked to Machekeche and their case studies are presented here. The history of each set of orphans shows how accessing care and support through social capital is embedded in negotiated relationships and networks which may even extend beyond a specific locality (beyond Chivanhu in this case). The case studies identify how decisions on orphan care are made within the households and how resilience is possibly strengthened over time. The three cases outlined focus on the households of the following women: Precious, Respina and Rumbidzai. The cluster consists of four households, with the household headed by Machekeche absorbing most of the impacts across all the households. Overall, the case studies reveal the ways in which different households forming a cluster share critical resource flows and how kinship networks (as an example of social capital) cope with the impacts of HIV and AIDS over time and potentially facilitate resilience. In doing so, the chapter attempts to address some of the existing gaps cited earlier in much of the available literature on HIV and AIDS and livelihoods (Drinkwater et al., 2006; Samuels et al., 2006; Seeley et al., 2008; Samuels and Drinkwater, 2011; Drimie and Gandure, 2005).

7.2 Resilience and clusters

HIV and AIDS affect all facets of people's livelihoods, including through chronic illness, death and the subsequent care of orphans. Not all households and individuals are affected by the loss of livelihood security and not all HIV and AIDS-affected households dissolve or discontinue. Some households survive and continue, and are able for instance to maintain key livelihood assets. But the challenge in most HIV and AIDS studies has been to show which households dissolve and which households continue, and to offer a full account of the processes leading to dissolution or continuity. In this respect, a range of factors condition people's ability to respond to the impacts of AIDS. This chapter explores the concept of resilience in the context of HIV and AIDS-related adversity and suffering. Resilience is seen as the responses which enable households to persist or at least to adapt to the difficulties caused by HIV and AIDS. Resilience is the opposite of vulnerability. Whereas the condition

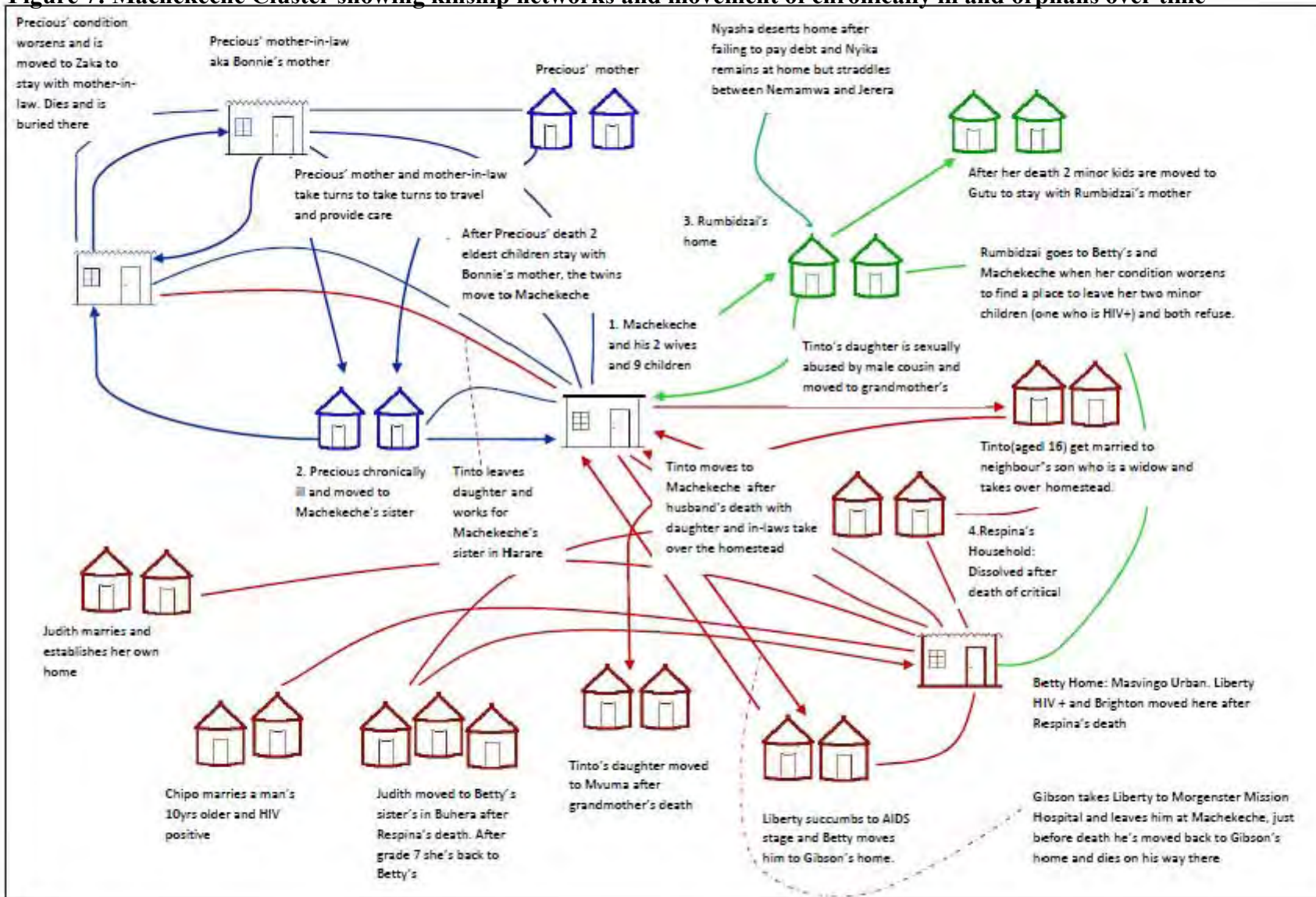
of vulnerability encompasses an inability to cope, disruption of livelihoods and loss of livelihood security, resilience denotes an ability to cope with the impacts of HIV and AIDS.

One of the main objectives of this study, as indicated in the research methodology chapter, is to show and emphasise that households are rarely self-contained units and that a complex array of interrelationships often (but not always) exist between groups of households (or clusters). The household case studies that are presented and discussed in this chapter demonstrate that a fuller picture of HIV and AIDS vulnerability and resilience over time requires an examination beyond the level of the individually-affected household. In this chapter, unlike in the previous chapter on vulnerability and susceptibility, I move beyond a household analysis in order to offer a nuanced analysis of the complex interrelationships within and between households. In particular, the chapter shows how the illness and death of a household member usually affects more than just the immediate household, and how households in the cluster become active and mobilised in handling the loss and minimising its effects. The case study of the Machekeche cluster therefore brings to the fore coping strategies and resilience, and over an extended period of time.

7.3 Machekeche Cluster

The Machekeche cluster consists of four HIV and AIDS affected households. Machekeche is the central household that absorbs most of the HIV and AIDS affected from the other three households (for Precious, Respina and Rumbidzai). The total number of households in this cluster is 15 as shown in Figure 8. Precious' kinship networks and movement of the chronically ill and the orphans is represented by the blue colour. Respina's kinship networks and movements of chronically ill and orphans are represented by the red colour and the Rumbidzai networks are represented by the green colour. The Machekeche cluster reveals the long term dynamics which influence coping with the impacts of HIV and AIDS. The case studies of the households are going to be discussed and analysed in the following sections to reveal how the impacts of HIV and AIDS are absorbed beyond the household as well as the ways in which resilience in the face of HIV and AIDS is embedded within the kinship social system in this context.

Figure 7: Machekeche Cluster showing kinship networks and movement of chronically ill and orphans over time



7.3.1 Precious case study: resilience after the death of a critical adult

This section discusses the specific case of Precious, and it does so by isolating key episodes across the HIV and AIDS timeline. Firstly, it discusses her progression from infection to death and the ways in which the kinship system seeks to deal with the provision of care and support of a chronically ill person. Secondly, it considers the strategies to care for orphans. Thirdly, it outlines the preservation of the assets of Precious's household. Lastly, I draw lessons from this particular case study. Overall, this case study demonstrates how a cluster of households responds to the loss of an adult within a particular household and thereby ensures the survival of children and the maintenance of the homestead. In doing so, I identify the factors existing before and after the death of the adult which contribute in some way to long term coping and resilience in the Chivanhu settlement.

7.3.1.1 Strategies adopted to deal with chronic illness

This sub-section describes Precious's household characteristics and livelihood activities before HIV infection. Her household was asset poor and experienced multiple displacements which undermined the process of livelihood sustainability; this, in turn, increased the susceptibility to HIV infection for her household. Precious is an individual whose progression from HIV infection to AIDS-related diseases and then to death was comparatively rapid. She died in 2006.

Precious was married to Bonnie in 1990. Both were Ordinary Level school dropouts and the couple had four children, two boys and two girls. The husband Bonnie was unemployed and he was in and out of jail for various crimes. Bonnie and Precious moved into the area in 1997 from Zaka after buying a piece of land from one of the traditional leaders. Bonnie's sister, who works in Harare, provided the money to buy the homestead plot and to build the houses. Apart from handouts from his mother and sister, Bonnie was straddling between Chivanhu settlement and Porta Farm from 1999 (a former illegal settlement about 30 kilometres from Harare, where he was engaging in fish poaching).

I first outline the 1991-2004 phase before infection and chronic illness. While at Porta Farm, Bonnie became involved with a commercial sex worker and they cohabited. In November 1999, as noted earlier, the local chief Charumbira managed to secure a court order to evict the residents of Chivanhu Settlement; they were deemed to be illegal squatters. The police burnt down the houses and forcibly removed the residents of Chivanhu. They were not allocated

any alternative land to reside since they were deemed to be illegal residents. Most people including Precious left the area and she temporarily moved back to Zaka to stay with the mother-in-law; by then Bonnie was residing in Porta farm. In mid-2000, during the fast track land occupations, the Chivanhu village heads, taking advantage of the situation, started resettling the people in Chivanhu again. Bonnie who had now joined his wife in Zaka, heard of the new developments and his wife renegotiated access on their previous homestead site at Chivanhu. In the meantime, Bonnie tried poaching fish in Lake Mutirikwi but the market in Masvingo was not as lucrative as the one in Harare. He therefore ganged up with others and started cattle rustling in the area. He got caught and sent to prison but was released in 2004. Previous was accused of engaging in extramarital affairs with Bonnie's relatives while Bonnie was in jail. In June 2004, Bonnie crossed the border to South Africa and, within six months, he had remarried and he has never been back since then.

The year 2004 to January 2006 was a time of chronic illness for Precious. In 2005, Precious started to fall sick and people attributed it to witchcraft. Her condition became worse and, around this time, Machekeche (Bonnie's younger brother) acquired a deserted homestead about one hundred metres from Bonnie's homestead in Chivanhu Settlement. Machekeche's wife moved from Harare to settle in Chivanhu and she alternated between Harare and Chivanhu settlement. As Precious's condition worsens further, fights soon ensue within the cluster about who is responsible for looking after her. Bonnie's mother and the other relatives expected Machekeche's wife to stay in the traditional homestead and look after Precious, but Machekeche's wife is very young and is overwhelmed by the demands of care-giving. The kinship extended system in the Machekeche cluster arrange for Precious's mother and Bonnie's mother to alternate visits from Zaka to come and look after Precious, but the elderly women only come for an average of three days per visit and then go back to their homesteads in Zaka. In the meantime, Bonnie's relatives (who believe that her illness is caused by witchcraft) accuse Machekeche's wife of bewitching Precious. Simultaneously, the relatives of Bonnie are spreading the rumour that the illness resulted from complications emanating from Precious's desire to terminate a pregnancy through backdoor practices. As care and support for Precious is not properly forthcoming, Machekeche is encouraged to bring his second wife (or 'small house'), who by then has a child, to come and stay at Precious's homestead and look after her. There are fights over this and Machekeche's second wife also fails to adequately look after Precious.

The last phase is from February to June 2006, involving the late stage of chronic illness and death. Bonnie's sister residing in Harare comes and takes her to her home in Harare. Bonnie's sister takes care of the treatment costs and medical care of Precious. After getting confirmation from doctors that Precious would die at any time, Bonnie's sister informs Bonnie's mother and Precious's relatives in Zaka about the serious progression of Precious's illness. Bonnie's mother and Precious's relatives advise the sister to transport Precious to Zaka, to cut on transport costs to Chivanhu. Precious's children who were residing with her in Chivanhu had been taken custody of by Machekeche and his wife; hence they remained in the Chivanhu area. There still remains the strong belief that Precious was bewitched and traditional and religious faith healers continue to be consulted. Precious dies and her relatives receive her few belongings while Machekeche's second wife moves into Precious's bedroom in Chivanhu.

7.3.1.2 Strategies for looking after orphans

This sub-section presents evidence on the ways in which the kinship system mobilizes itself in order to provide care and support for orphaned children. Before and after the death of Precious, the two eldest children of Bonnie and Precious were residing in Zaka with Bonnie's mother; the youngest twins were the ones that had moved with their parents to reside in Chivanhu. When Precious died in 2006, their eldest child was aged sixteen and in Form Four, a daughter was fourteen and in Form Two, and the two younger twins were eleven and in Grade Seven. I logged the movements and activities of the children subsequent to the death of Precious as well as the kinship-based care and support for the children. I first detail the activities of the four children.

Chou, the eldest boy, stayed with his grandmother (Bonnie's mother) in Zaka until he finished Ordinary Level general examinations in 2006, which he failed. He twice repeated writing the exams and failed both times. In 2010, his aunt (Bonnie's sister) in Harare took him in to Harare and sent him to a private school. He passed all eight subjects at this school and (by the end of conducting the research) he was doing Advanced Level schooling. By then he was staying again with his grandmother and she was the one who was paying school fees. The other young brother was enrolled in secondary education at Chirichoga Secondary School in Chivanhu. In his second year of secondary education, he started engaging in petty theft in the community and, by then, Machekeche was finding problems paying his school fees. He ran away from Chivanhu in October 2010. He returned to the area in December 2011 and was

staying with his grandmother in Zaka, where he was attending school. Blessings (the older daughter) was in Form two at the time of death of her mother. She subsequently failed her Ordinary Level exam. Like Chou, she also moved to Harare to stay with her aunt (in 2011) where she failed again. By the end of my research, she was repeating her Ordinary Level year once again and staying with her grandmother in Zaka. Ruu the twin sister and Manu (the boy twin) were attending grade seven in 2006. She was given money by Machekeche for registering for her Ordinary Level examinations but she apparently lost the money. In late 2011 she was reported to have gone to stay with her grandmother in Zaka and had enrolled back into school.

7.3.1.3 Strategies for preserving physical assets

This discusses how the few assets in Precious's homestead have been preserved over time. While other HIV and AIDS-affected households in similar circumstances have lost their assets, decisions were made from the time when Precious died up to the time when the research ended, to preserve the homestead and the land. The condition of the houses was better than it was before Precious died in 2006.

After Precious's death in 2006, Machekeche, with the encouragement of his mother and Precious's mother moved his second wife to stay in Precious's homestead and to take care of the surviving twins. His first wife was temporarily chased away from the village; she was accused of having bewitched Precious; according to Machekeche's mother, "*AIDS was there, but witchcraft was there to speed up the process*". Machekeche's first wife returns after 4 months and finds that her kitchen has been destroyed during her absence and she is forced to share Precious's kitchen with Machekeche's newly acquired wife. They use Precious's kitchen until 2011, when Machekeche started to renovate Bonnie's original home in preparation for the *kurova guva* ceremony for his late father. Machekeche plastered and renewed the thatching on the houses in preparation for the ceremony. According to Machekeche, a spirit medium told his mother ancestors will bring blessings to him if he continues to maintain his brother's homestead on behalf of the minor surviving children. He pays the annual USD3 tax to the village head and cultivates the field. However by the end of conducting the research in January 2012 there was fighting between Machekeche and Bonnie's eldest son Chou: Machekeche was complaining that he was stopped from cultivating Bonnie's fields by the boy and he was threatening that he was not going to continue retaining the land on behalf of the children. According to Machekeche, "*the boy is behaving in a foolish*

manner, and I am not going to cultivate the fields and to pay the USD3 tax". The system of village heads in the area is that if you do not use the land or pay the tax after two years, they dispose you of the land. The grandmother was claiming that she would retain the assets on behalf of the grandchildren.

7.3.1.4 Insights from the Precious case study

The insights derived from this study will be discussed in terms of chronic illness, looking after orphans and livelihood resilience over time.

Chronic illness – Bonnie, as noted, secured a homestead at Chivanhu from 1997 and 2000, and is purely sustained by remittances from his mother and his sister. But the sister marries and Bonnie's household is affected by this; she could no longer send money for Bonnie's sustenance because of her own household's demands. Bonnie moves to Norton and ends up at Porta Farm and engages in fish poaching. He immediately gets involved with a woman from the area and does not send any remittances to his wife in Chivanhu Settlement. As the wife is grappling with the absence of Bonnie, the settlement is burned down by the police officers and she is uprooted with the children. They go back to Zaka. As the farm occupations result in local governance breakdown, the settlement dwellers take another chance and come back to settle again. Bonnie tries poaching in Lake Mutirikwi, but he is not getting enough proceeds to sustain his family. He engages in stealing cattle, he is caught and sent to prison. The wife at the same time, whilst Bonnie is in jail, is engaging in affairs. After he returns and finds it hard to leave with the stigma of being in jail, he moves to South Africa and again immediately gets involved with another woman there. In the meantime, Precious progresses to the AIDS stage and starts suffering from AIDS-related chronic illnesses.

The extended kinship system is experiencing a shock. At the same time Precious has to be looked after and there is also the demand of maintaining the homestead. Coping mechanisms during the illness are challenged because, at the end of the day, there is only Machekeche and his wife (and no other relatives and close extended family members in the settlement to assist with the care giving). The other challenge is that the household has not stayed in the area long enough to maintain reciprocal support in the community. There is no sense of community; hence, it is difficult to cope with the Precious's HIV chronic illness. Machekeche (Bonnie's brother) although he is staying close by, his wife cannot adequately offer any kind of support, and she is young and has got three young children. The other reason is that she is maintaining

dual homes in Harare and Chivanhu; at the same time, her husband Machekeche is in the process of formalising his relationship with his soon-to-be second wife. Precious's mother and Bonnie's mother stay 121 kilometres away in Zaka and they have their own individual homesteads to take care of. Precious's two children are too young to take care of her. As the family is searching for ways to cope, they make a decision that Machekeche should bring his extramarital partner who has since had a son to come and stay in Precious's homestead and take care of Precious. She agrees because for her it is an opportunity for her relationship with Machekeche to be formally recognised.

The impact of HIV and AIDS and the demands of care do not affect the household alone. The impacts and coping demands extend beyond the household to the extended family. This research shows that some of the decisions and the coping strategies to deal with the challenges brought about by HIV and AIDS are made collectively by members in different related households, which share critical resources and relationships with the affected household. Women bear the greatest demand in terms of the care burden for the chronically ill. In the absence of materials and financial resources to provide care to the chronically ill, households engage in a suite of responses in order to make sure that the service is provided. However, some of the strategies have a negative impact on certain individuals on whom demands are placed. In this case Machekeche's wife, due to her powerless position within the extended family network, ends up bearing the greatest burden of the impact of HIV and AIDS.

The Precious case study shows how a household is affected by HIV and AIDS over time. During the start of the research, when the researcher identified the household, the household was a typical example of a household that was going to dissolve and have its assets disposed of. Social capital has proved to be a critical element in the livelihood security of the HIV and AIDS affected in this household cluster. Before HIV infection, the nature of the livelihood portfolio increased its risk of getting HIV infection. The husband was very mobile and they had moved into the area with a limited asset base for them to obtain a sustainable livelihood. The husband's reliance on theft, led him to be in and out of jail, thereby exposing him and forcing his wife to engage in transactional sexual relationships during periods when he was away. This study provides a detailed analysis of the role of kinship system in increasing household resilience to HIV. The social capital prove in this case study to be a critical household asset, that influence coping during chronic illness and coping after the death of a critical adult due to AIDS.

The case study has also profiled how the kinship system mobilises care and support for the AIDS affected members. When Precious succumbed to chronic illness, the demands for providing care fall on Machekeche's wife. In this context, Precious's mother and Bonnie's mother who are supposed to provide the care, have their homes in Zaka that is about 121 kilometres away. The support in other contexts is often provided by home-based caregivers and faith-based institutions, but in the context of Precious's case, there are no effective institutional strategies for providing care. As a result, the system places the burden of providing care upon the women within the kinship system: in this context, Machekeche's wife. When Machekeche's wife fails to provide the care, the system invites Machekeche's mistress to come and reside at Precious's home so that she can provide the care. This fails and Precious is moved to Harare to be looked after by her sister-in-law. This case study shows the different and complex decisions that are made in order to provide care for an infected member within a kinship system. In other areas, elderly women may endure the burden of providing care and support. In this context, the elderly women cannot leave their homes in established areas to come and settle there; but decisions for providing care and support are being made and in the process making Machekeche's wife a victim.

Despite the fact that the household did not have the financial resources to dispose of during chronic illness, the household relied on its extended kinship system for the provision of care and support. Most households in Chivanhu context did not have this strong kinship system to fall back on during times of crisis. As a result, most of them ended up being vulnerable after the onset of AIDS - related chronic illness. A strong social network and capital base has been identified to be a critical factor in increasing household resilience to manage the adverse impacts of HIV and AIDS at household level Portes (1998) and, Wiegiers (2008) argue that social capital function as an informal safety net to ensure survival during periods of insecurity. Social capital may compensate for the lack of other types of capital, as is the case in this case. The household is asset poor to begin with, it has weak, financial, human, and physical capital to draw on in times of crises, and however the kinship network draws on its resources to provide the support on behalf of the household. Very few individuals and households in Chivanhu Settlement had adequate social capital to draw on, as is the example of the Precious case study (Seeley et al., 1993; Taylor et al., 1996).

Looking after orphaned children – The demands and pressures on households do not end with the death of the chronically-ill person, as the presence of orphans present further challenges.

Machekeche, as a way of forcing his first wife to contribute to the caring of the inherited orphans, destroys his wife's kitchen and ends up making certain decisions. Identified literature has focused on HIV and AIDS-affected households dissolving completely but, in this case, some of the households that are related to the affected household merge with the original household of the deceased. Because of all the demands and the strategies to provide security for the orphans, the financial demands on Machekeche's own household are overwhelming and he ends up failing to provide basic resources to his own household. On the other hand the strategies, though suboptimal and unreasonable from an outsider's perspective, ensure the survival and contribute to the resilience of the surviving children. All the children manage to attend primary and secondary school with the exception of the young boy who decided to run away.

Apart from Machekeche bearing the largest burden in the process, the role and importance of social capital in household resilience can be seen. The aunt from Harare has a greater part to play in absorbing some of the pressure on childcare and care giving. Although these people are not residing in the area, they provide the needed support when it is needed. Resilience for coping in marginal communities is not directly related to the original financial, human and natural capital available to the household before and during chronic illness, as social capital available to that household (or social networks in the form of kinship in this case) is critical in coping. While the household can be categorized as asset poor in relation to a range of capitals or resources, the household relies more on extended family relationships for coping. Most HIV and AIDS household studies have focused on the impact of HIV and AIDS-illnesses on immediate income and food security in large part because the research design used involves cross-sectional surveys. My study is deeply qualitative but has also a longitudinal design, and this allows for understanding the decisions made over time, including who makes the decisions and how those decisions contribute to coping in the long run.

Although the social capital is overwhelmed in the Precious case, and despite the fact that Bonnie is still alive (but is not contributing anything to the children), Machekeche, the sister in Harare and Bonnie's mother are sharing the burden of ensuring that the children grow up. It is social capital for households that are asset poor which ensures the survival and resilience of the surviving members notably orphans. This even occurs when the supporting households do not have the financial capacity to meaningfully engage in strategies to ensure survival. Literature identified has shown relatives disposing of the orphans and taking their resources,

but findings from this study reveal households at times dispossessing their own family members in order to accommodate the demands of the orphans. Machekeche once commented during the research period in this regard: “*Other people inherit property when their relatives die, but in my case I inherit people and their problems.*”

Long term household resilience after HIV and AIDS – The Precious case study reveals that household resilience is achieved, but at a cost for the wider extended family system. Current kinds of studies might fail to account for the challenges faced by other households especially Machekeche’s household and first wife as the kinship system tries to absorb the impacts of HIV. Machekeche saw an opportunity to bring his mistress to Bonnie’s home, so that she can provide care for the minors at home. Literature has recorded sub-optimal coping strategies in HIV and AIDS affected households; however the behaviour by the whole Machekeche kinship network proves that there are times when other non-household members also make suboptimal decisions in order to deal with consequences of HIV. The kinship system assures the care of the survivors but at a cost to some members within the system.

Machekeche’s mother in Zaka (121 kilometres away from Chivanhu) wields considerable power in this regard. She insists that since Bonnie was the first to settle in Chivanhu (before Machekeche) and he was the eldest between the two brothers, his home should be maintained for family traditional rituals like *kurova guva*. As a result, when Machekeche was supposed to conduct the ritual of *kurova guva*, he had to renovate and renew the thatching on Precious’s homestead because that is where the family ceremony was going to be conducted. He was in fact cultivating the fields and paying the yearly US\$3 tax to the village head in order to retain the land and the homestead. Other affected households in Chivanhu which failed to do that were disposed of their land. From this life history of Precious’s coping with HIV and the resilience shown, it seems in this instance that resilience was deeply imbedded in the cultural, traditional and spiritual frameworks of the cluster. More specifically, ceremonies like *kurova guva* presented the larger extended family with an opportunity to make demands on repairing and preserving assets like houses.

Available studies have managed to realize that while some households are adversely affected by the pandemic, other households manage to show evidence of resilience. But these studies have failed to penetrate deeply into the households and intra-household relations to capture and analyze the issues which influence resilience and preservation of assets within

households. In starting my research in Chivanhu, I expected to find low levels of resilience due to the nature of the economic and social configurations. However, despite initial observations of poor asset base overall for most of the households, it soon became clear that there was another story to tell. For clusters like the Machekeche cluster, the household's social networks and resources were mobilized beyond Chivanhu Settlement, including in Zaka and Harare. These critical resource flows were necessary for coping and maintaining resilience in the households affected by HIV and AIDS. The extended family network's influence in the whole process is another element that had not been looked at closely in previous studies; including decisions about coping with chronic illness and orphans and how to redistribute and maintain the human and physical capital base in HIV and AIDS affected households.

Spiritual beliefs and practices had an impact on how household members make tradeoffs in terms of priorities for managing scarce resources after the impact of HIV and AIDS. To an outsider, it might be difficult to understand how and why the condition of Precious's homestead was maintained despite the fact that the children were still minors and did not have any resources. The spiritual belief system maintained the extended family system together and was consulted in the context of making critical decisions pertaining to the upkeep of the children and the homestead. In this respect, there were instances during the research when Machekeche would reveal that he was being strained and would threaten to cut off support to Precious's children, but eventually on other occasions he was making other critical investments in the homestead because on his worldview and cosmology centred on kinship relations and traditional culture. In identified literature on HIV and AIDS, spiritual issues are normally documented in so far as they influence coping with a terminal condition for those who are diagnosed with a chronic illness condition. My study indicates the relevance of spirituality for overall resilience at cluster level in the face of the pandemic.

7.3.2 Respina case study: Failure of kinship system to reduce vulnerability

This section presents the Respina case study. Respina was a commercial sex worker who was alternating between getting married and engaging in commercial sex work. She had five children from four different men. The children were a result of unions that started as casual relationships and all the unions ended in divorce. Respina was an aunt to Machekeche, and she is the one who facilitated Machekeche's brother Bonnie's access to a homestead in Chivanhu settlement. Respina conducted most of the commercial sex activities in Triangle

Sugar Estates, which is about 155 kilometres from Chivanhu Settlement and when she was in Chivanhu Settlement she would go to Nemanwa Growth Point to do the same. The eldest child was born in 1980 and the youngest child was born in 1996. All the five children were born out of wedlock and they have been staying with Respina's aunt. One child died in 2007 during the initial stages of conducting the research and he was HIV positive. The youngest surviving child is also HIV positive. The other three are alive. Respina's stepsister in Masvingo urban was responsible for the children but, as the economy worsened, she was no longer able to handle the responsibility. Regina died in 2005 and her case is similar to the Precious case study because she did not have any physical assets and any financial capital for her children to fall back on. The homestead in Chivanhu where she occupied when there in fact belonged to her mother *Mbuya vaMary*.

Despite the similarities between Precious and Respina on some levels, the course and the character of the support for the orphans is very different. In Respina's case, not all the orphans were in the same vulnerable position and only one was HIV positive. So, in this regard, orphans within the same household should not necessarily be lumped together, such that the plight of survivors is not homogeneous. While some orphans are vulnerable and passive, some orphans are actively looking within the extended kinship system to where they can be looked after properly.

7. 3.2.1 Differential vulnerability of orphans

Chipo is the eldest of the children in the Respina case study. She is married to a man who is 10 years her senior and who was bedridden during the time of conducting the research. She resides in Chivi about 85 kilometres from Chivanhu Settlement. Chipo has two children with her husband and she is HIV positive. I met with her during one of her visits to Tinto, one of her siblings who resides at Machekeche's household on some occasions.

Tinto was 16 years old by the time Respina died, and she was not going to school. She left school at Grade Seven. She got married to a widower who was their neighbour. She has a child. After two years of marriage the man died and Tinto moved to Machekeche's home with her two-year-old daughter. After residing there for about two months, Tinto is taken to Harare by Machekeche's sister to work as a domestic worker. She leaves her child with Machekeche's wife. By then Machekeche (who is a truck driver) is involved with another woman and chases away his wife from the homestead. Tinto's child is left staying with a

another cousin staying at Machekeche's home. The male cousin starts to sexually abuse the young girl, is caught, and is sent to prison. Tinto's child is moved back to stay with her paternal grandmother. After eight months, the grandmother dies and Tinto's child is moved about 120 kilometres away to stay with the late grandmother's sister who resides in Mvuma. By then Tinto is involved in a love relationship with another man in Harare, she gets pregnant and the boy deserts her. She goes back to the rural home and her dead husband's father says she cannot stay at there with another man's child. She goes to Machekeche's home and there she is told to move since she can influence badly the young girls residing in the Machekeche home. She moves to stay with Judith her younger sister but, after 5 months, she is chased because they accuse her of spreading rumours about Judith. By the time of the end of the research she was working as a domestic worker in Masvingo with the young child; the eldest child was still in Mvuma.

Despite the fact that they share the same mother, two children (Judith and Brighton) of the five have not experienced the same levels of vulnerability as the other three children. Interviews with Judith showed that, although she could not be classified as wealthy, she was in a stable marital union and her husband had a sustainable livelihood source. He was gainfully employed at a farm, which was about 20 kilometres from Chivanhu. Judith is two years younger than Tinto. By the time her mother was chronically ill, Judith was taken in by one of Respina's sisters who resides in Buhera. Judith stayed there until she finished primary school education. After finishing her primary education, she was employed as a house cleaner in Masvingo urban area, where she met her husband and was married to by the time of ending the research. Brighton was 12 when his mother succumbed to AIDS related illness. He was taken in by Betty, one of Respina's cousin sisters. He stayed with Betty until he finished his ordinary level. During the school holidays, Brighton would provide agricultural labour at Betty's newly resettled farm in exchange for payment of school fees. After failing his ordinary level, he moved to stay at Machekeche's homestead. Nevertheless, occasionally he would move between Machekeche's homestead and Betty's homestead.

7. 3.2.2 Coping with HIV chronic illness of survivors

Kinship systems regularly need to support an orphan who is HIV positive. Liberty was the youngest child in the Respina case study. The whereabouts of his father was not known. Liberty was six when his mother died in 2007 and he was also HIV positive. After the death of his mother, Liberty was moved over to Betty's home with his other brother Brighton. He

was in advanced stages of HIV at that time, getting in and out of hospital. When Liberty was diagnosed with tuberculosis in 2009, Betty could not handle the treatment demands and the stigma of living with someone who is HIV positive. Betty took Liberty to one of her brothers who stay in Zimuto. The brother was not staying with his wife, during that time, so he could not look after him. But he took Liberty to Morgenster Mission Hospital for treatment. During Liberty's treatment at Morgenster Mission Hospital, the brother took the opportunity to relieve himself of the burden and left him at Machekeche's homestead.

Liberty stayed at Machekeche's homestead at the time when the researcher met him, and he was in advanced AIDS stages. Although he was on treatment for opportunistic infections, he was not on ART treatment. During that time there was no treatment facilities at Morgenster Mission Hospital. Every time the researcher passed by the homestead, Machekeche's first wife was always complaining that

This boy is a burden; he is not able to do anything. Every time he is awake, he is sitting by the fireplace and waiting to be given food to eat. You cannot even send him to collect firewood or to tend livestock. We are not benefitting from having him here.

They tried to send him back to Zimuto but he was refusing. When his condition worsened and he was showing signs of dying, Machekeche's wife said:

We were worried that in the event of him dying here, the headman would ask to pay a beast as a penalty. In this area, the village heads are quick to ask for Ndongamabwe²⁴. Machekeche ordered us to put him in a wheelbarrow and send him back to Zimuto. He passed away on our way there and he was buried there. Even the siblings did not want anything to do with him up to the time of his death

7.3.2.3 Insights from the Respina case study

In households that are asset poor, HIV and AIDS create a double vulnerability. HIV and AIDS create a trap where it becomes difficult for the survivors to escape or survive the situation in which they find themselves. Wiegiers (2008) argues that the nature of coping across time is not documented in existing literature. When a parent like Respina dies, who does not have a fixed place to call home and always struggled financially (without any physical or financial capital) then surviving becomes an even greater challenge for surviving orphans. The research started when Respina had already died due to AIDS. Interviews with

²⁴ Ndongamabwe, according to the community members is a penalty for burying someone who is not originally from the area. If someone comes to in the area and dies, the village heads in the area charged a penalty.

survivors show that the main push factor for the union that Chipo got into with her current husband was finding a place to stay and someone to look after her. In the case of Tinto, a male neighbour who was sick took advantage and married her despite being a minor. The person died after two years living with Tinto, now a widow at 19 with a two-year child to support. In the case of Respina, her children had no original homestead to call their own and they were forced to move from one place to another as a way of coping. The relatives of the mother did not have the resources to look after them such that five years after her death, the children broadly speaking have had troublesome pasts and are not doing well.

The vulnerabilities not only affect the children, but also the grandchildren of Respina. While first generation adults who succumbed to AIDS left the children with their grandparents, people in the situation of Tinto do not have parents to look after their children in the event that they die or fall sick. After moving to Harare to work as a domestic worker, Tinto has a dilemma. Other affected children were relying on their mothers to look after their children, but Respina is not there for her, and she has no option other than to leave her child at Machekeche's home. In the event of Machekeche having problems with his wife, the wife goes to her homestead or origin with her biological children and leaves Tinto's child with a distant male relative. Again, despite the fact that the child is abused, Tinto has no option other than to move her daughter to her mother-in-law. The mother-in-law, who was now staying with Tinto, died after six months in mysterious circumstances according to the family members. Tinto moves the child to the late mother-in-law's homestead in Mvuma, which is about 120 kilometres away. In addition, when her boyfriend deserts Tinto after being impregnated with a second child, she cannot go and stay at her late first husband's homestead. In this instance, her late husband's father is saying that culturally it is not possible to bring another man's child into the homestead. She wants to go back to Machekeche's homestead, but by this time Machekeche is feeling overwhelmed because he has other orphaned children to look after. By the time of finishing the research, Tinto was staying in Masvingo urban where she was working as a house cleaner, but the employer could only accommodate her and her younger child (the eldest child was still staying in Mvuma). Where the social capital, in this case kinship relations, is overwhelmed with responsibilities, the HIV and AIDS-affected experience adverse conditions.

Despite the high level of resilience shown in Tinto, coping with the impacts of HIV and AIDS for households that are not stable provides a challenge. A closer analysis of what happens in

households over time is very critical for understanding the household and intra-household dynamics brought about by people affected by HIV and AIDS. In the case of Tinto's child in this cluster, apart from having the burden of being an orphan, she is also facing the challenge of abuse in the process. She needs extra support in order to heal from the abuse, but she is finding herself being moved from one homestead to another. At the time of finishing my fieldwork, one of the siblings (Chipo) and her husband were chronically ill from AIDS. This means that the cluster, which is currently struggling to sustain itself, may soon be confronted with a new set of orphans from Chipo; and this means an even extra burden for individuals who are barely managing to achieve a livelihood. The Respina case study shows that the challenges brought about by HIV and AIDS in the household do not only affect the generation of surviving orphans of the deceased person or persons. Rather, the consequences are widespread and affect households of relatives whose resources are already stretched; in addition, future generations of surviving children (in this case Tinto's child) and even more orphans (possibly Chipo's children) are also affected by the HIV and AIDS pandemic.

The cases of Judith and Brighton show that, in situations where orphans are split, it is possible to find some orphans fairing much better than their siblings who remain behind. Only Brighton of the five siblings had managed to attend secondary education, although he failed. However, by the end of the research he was aged seventeen and he was being pushed to look for a homestead of his own so that he can provide a home for his sisters and their children. Succumbing to the pressure and also by the fact that he was unemployed, he was now being accused of petty theft in the settlement. Machekeche's first wife chased him away and his whereabouts were not known. In Shona culture, sending some children to wealthier relatives has been one of the coping mechanisms. However, social capital is showing its limitations in providing care and support for orphans such that, in this sense, social capital or social networks are effectively safety nets with holes. Unlike in the Precious case study, where the whole kinship system got together to ensure that orphaned children are taken care of, in this instance relatives seemingly select which children to support and which children not to support.

The Liberty case shows the plight of children who are orphaned and at the same time HIV positive. The kinship system, although it would wish to assist, in this instance shows that when the costs of looking after a chronically ill orphan are increasing, households would prefer to preserve their financial capital and in the process look for the next person within the

kinship system to give the burden of caring for an HIV infected child. The relatives would offload the sick Liberty but, at the same time, remain with his brother Brighton because Brighton was providing agricultural labour during his school holidays. The situation was made worse towards the end of Liberty's life, as his caregivers of Liberty were more concerned about the implications in the case of him dying in their custody. Moving him from one homestead to another as a way of avoiding paying the burial penalties from the traditional authorities added to this problematic scenario. In most cases, people were complaining about him in his presence and I had felt compelled to talk to them about the impact of what they were doing to the chronically ill child. The complaints from Machekeche's wife, that no one was benefitting from the very existence of Liberty, reveals that when extended families make decisions to look after orphans, they also look at benefits from them: in this instance provision of labour.

The plight of children who were in similar circumstances as Liberty is disturbing. I identified three children who were HIV positive and orphans at the same time. It appeared during the interviews as if the guardians were regretting that they opted for taking custody of the children in the first place. According to them, they are dealing with a double burden: looking after orphans and dealing with their own HIV positive status as well. In the Chivanhu context, the plight of the children is worsened because of insensitive and opportunistic village heads. Whilst penalties like *Ndongamabwe* according to the people are meant to ensure and deter people from burying *vatorwa* (aliens), traditional leaders needed to assess each situation before applying a blanket penalty. The researcher lobbied with the village heads to review this practice, but it was a challenge because it was a source of livelihood for the village heads in the area.

7.3.3 Rumbidzai case study: fragmented household after death of critical adult

This section presents details about another household (centred on Rumbidzai) in the Machekeche kinship system cluster. The household consisted of four children. The eldest was no longer a minor by the time of her mother's (Rumbidzai) death in April 2011; she was 22 and had two children out of wedlock, but she was still staying at her mother's homestead. The next child was a boy aged seventeen and the two younger sisters were aged 12 and 10. The youngest child of the siblings was HIV positive. Their mother Rumbidzai was Machekeche's stepsister from his father's side, and she was older than Machekeche. She was residing near Jerera Growth point in Zaka about 131 kilometres from Chivanhu settlement.

7.3.3.1 Chronic illness and death

I first provide a brief history of Rumbidzai and the key events that happen during her chronic illness and after her death. This will show how the siblings become vulnerable and how the extended kinship system (that is already overstretched by the time Rumbidzai dies in the year 2011) decides to care for the upkeep of the survivors. The conditions within which survivors find themselves clearly influence the nature of coping in the event of a parent dying. This is an example of a household that splits in order to deal with the impacts of the HIV epidemic within the household. In the Rumbidzai case, members of the household and the extended kinship system make decisions for the survivors.

The first phase deals with the period 1989-1994. Rumbidzai was Machekeche's stepsister. She grew up with her maternal grandmother in Jerera. She was married and had her first child Nyasha when she was in Form 3. The marriage lasted one year. After the divorce Rumbidzai is chased by her maternal grandfather's sons; they tell her to move to her father's home. She goes to Triangle Sugar Estates where Machekeche and Rumbidzai's father resides. She starts engaging in commercial sex work in order to get extra income. The father disowns her, after he discovered that she was engaged in commercial sex work. She goes back to Jerera to her maternal grandfather's homestead. In 1994, she gets into a relationship with her neighbour's son and the relationship ends in marriage. She has a son from the relationship, Nyika. The marriage lasts two years and ends in divorce after she engages in a fight with her mother-in-law. Rumbidzai moves to her maternal grandfather's home, stays there for about 6 months and moves to Gutu where her mother stays with her husband. She stays there for about a year and is chased away. She returns to Jerera and after about a year she gets involved in a relationship with a man who stays about 10 kilometres from Jerera, and the relationship ends in a marriage.

The second phase deals with the period 1994-2008. The man who gets married to Rumbidzai is a widow and it is alleged that his wife died of AIDS-related illnesses. Rumbidzai has two children with the man and the youngest one is HIV positive. The man refuses to accommodate Rumbidzai's elder children from previous marital unions, and they are left with her maternal grandmother. The husband dies and Rumbidzai is chased from the marital home by the husband's son, who had inherited the homestead. According to them she could not inherit because she did not have a male child. Rumbidzai returns to her maternal grandmother's home and she by now has advanced HIV illness. The mother's relatives are worried that if she

dies, she might leave them with a burden to care for her four children and, by then, her first child Nyasha had a child from a neighbour's son at 16 and she was divorced. She engages in selling firewood at Jerera Growth Point and approached Machekeche, who gave her money to buy a stand close by and she built two huts. She is enrolled in ART at Musiso Mission Hospital, but her health never improves. When Nyasha's child was 10 months old, Rumbidzai arranged for her to work as a house cleaner in Harare and she (Rumbidzai) stays behind with the child so that she could provide food for the family. Nyasha stays there for three months, comes back and gets involved sexually with a neighbour. She moves to South Africa and comes back four months pregnant and gets involved with another young man who was working as a temporary teacher. The man discovers that she was already four months pregnant when she got involved with him and he dumps her; she later has a baby. During times when she did not have food, she would receive food from Machekeche.

The third phase deals with the period 2008-2011 when Rumbidzai was in an advanced AIDS stage and dies. By then Rumbidzai's condition was deteriorating and she had fears that in the event of her death no-one was going to take care of her children. Two months before she died she approached Machekeche who said that he could not absorb any more orphans. She goes to Betty (mentioned previously) and Betty also says that she cannot take any more orphans. In interviews with Rumbidzai in February 2011 she says:

I am more worried about these two young children. My maternal grandmother is old and the other uncles are saying before I die, I should make sure that I do not leave them problems. They had problems looking after me when I was growing up, and they cannot have problems with my children again. My eldest children, none of them are working and none of them have the capacity to look after these two young children especially the other one who is HIV positive.

7.3.3.2 Coping with orphans

After Rumbidzai's death later in 2011, Betty attended the funeral. Machekeche did not attend the funeral due to fear that the other relatives would give him the responsibility of caring for orphaned children. Rumbidzai's mother took custody of the two youngest children and moved with them to Gutu where she resides. Both of them are attending school and the HIV infected one is getting treatment at Gutu Mission Hospital. When Rumbidzai died, she did not have any physical or financial capital of any significance. There was no food to eat even during the funeral. Nyasha and Nyika (the two older children) are left to fend for themselves as they are

assumed to be adults. Nyasha borrowed USD100 from a neighbour to buy food and after the end of the month she could not afford to pay it back. When there was pressure to pay back, she took her children and moved to Machekeche's home. Machekeche's wife complained and Machekeche's sister eventually chased her away from Chivanhu. Her whereabouts are not known, but some people say she is a commercial sex worker around Masvingo. The boy Nyika also soon moved to Machekeche's home; he was told to go to his mother's maternal relatives. The last time I got into contact with him he was saying that he had volunteered to be an evangelist with the Seventh Day Adventist church and he had joined teams that were moving around preaching and getting food from the handouts from well-wishers where he was preaching. He seems to be faring better a year after the death of his mother, although in most cases he has failed to cultivate the fields left by his mother in Chivanhu.

7.3.3.3 Insights from Rumbidzai's case study

In the case of Rumbidzai, the social and economic circumstance surrounding her creates conditions for increased HIV susceptibility and AIDS vulnerability. The study, by tracing households over time, is able to profile the historical and social complexities of the lives and livelihoods of individuals making up Rumbidzai's household. The personal histories of specific individuals like Rumbidzai are enmeshed in a set of social conditions, circumstances and relations which predispose them to HIV infection. In this case, before being infected with HIV, the nature of Rumbidzai's coping mechanisms was creating a fertile ground for her to become HIV infected. She did not have a stable home to call her place, and the multiple displacements and a sense of hopelessness led her to depend on commercial sex work as a coping mechanism. Her mother had remarried and the husband did not want to assume the responsibility of looking after her. She is left to reside with her maternal grandmother who is powerless to defend her against being chased away. She has unstable marital unions and in each case they end in divorce. Insecure livelihoods produce suitable conditions for getting HIV infection.

In the second phase outlined before, Rumbidzai gets married to a man who is HIV positive. By then it is not known whether she got HIV from the man she married, or whether she was already HIV positive considering the past sexual relationships she had been engaged in. The marital union produces two children, but she does not have a male heir. In the event of the death of this husband, the husband's child from his first marriage inherits the homestead and she is dispossessed of the homestead. In this sense, patriarchal practices pertaining to lineages

and inheritance, and the decisions linked to them, worsen the conditions of AIDS affected widows. This situation has left many widowed women more vulnerable because of AIDS. Rumbidzai's husband dies: she is HIV positive and has two children from the man one of whom is HIV positive; she is also homeless and returns to her maternal grandmother to rejoin her other two children from her first two marital unions. The extended family is wary of taking her in, and they are forcing her to make arrangements about where her children will stay in the event that she dies. The situation is complicated by the fact that her first child already has a child out of wedlock. In order to cope, she embarks on selling firewood and gets extra support from Machekeche to buy a homestead. Nevertheless, she is setting up a homestead when she is already in advanced HIV stages of infection.

Most child-headed households in Chivanhu Settlement who were facing adverse conditions came from households that were set up in this way. The HIV-infected household head, on realising that he or she might die at any time, would look for a home to die and leave the children there. In cases such as these, the household head would not have adequate time to build and strengthen social networks that are critical for the orphans' survival in the event that the chronically-ill household head dies from AIDS-related complications. As a way of ensuring food security, Rumbidzai encourages her eldest child to leave her 10-month-old baby so that she can work as a house cleaner. However, as noted, the daughter soon returns, becomes pregnant from someone in South Africa and on return enters into another relationship. In the process, this creates a vicious cycle for her increased susceptibility for getting HIV infection. In order to get food during her illness, she gets support from Machekeche; the other relatives are exhausted and do not want anything to do with her and her household.

Despite the fact that she was on ART, Rumbidzai's condition did not improve. At the same time, like all AIDS sufferers with dependents, she had the challenge of ensuring that her children are taken care of. When I met with Rumbidzai in February 2011 she was wasted physically; she was carrying her HIV positive daughter (who was also chronically ill) on her back because she had difficulties moving. The situation presented the pathetic condition and situation of AIDS sufferers. It also leads to the prevalence of child-headed households, as the now dead parent or parents are sometimes unsuccessful in securing a place for the orphaned children amongst relatives or other guardians. The extended family and the whole cluster in

the case of Machekeche were already overstretched. Machekeche had three different sets of orphans to look after and he could not look after anymore.

The case history of the Rumbidzai household has successfully managed to closely study how decisions for the care of survivors are made within and across the kinship system. In this instance it shows that, although eventually the AIDS-infected person failed to secure a suitable stable place for the survivors, the associated households in the cluster actively sought a place that they deemed to be the best place for the upkeep of the orphaned children. None of the older surviving orphans in fact had the capacity or resources to sustain themselves. In a patriarchal system, where lineage is traced from the father's side, the children are not valued in their mother's family. While in the case of Precious the extended family system made important sacrifices so that her children are taken care of, the same family system was reluctant to take responsibility for the children of Rumbidzai who are deemed to be born out of unsuccessful marital unions. In the case of Respina's children, Betty was willing to make the sacrifice for they belonged to her sisters; but in the case of Rumbidzai's children, according to the extended family, "*she grew up with her mother's relatives and they should take responsibility for the children.*" At the same time her mother's relatives were reluctant to take over the children. They had looked after the children when the children grew up fatherless, but they could not look after her children again.

Betty attended the funeral, representing her late brother (Rumbidzai's father). Machekeche, in order to avoid having any responsibility for the orphans, does not go to the funeral. Rumbidzai's mother takes over the minors and moves them to Gutu. The two eldest children, despite the fact that they are not engaged in any meaningful livelihood activity, are effectively left to fend for themselves. Nyasha borrows as a coping mechanism to provide food, but she fails to pay back and runs away from the homestead. Only Nyika is left at the homestead but he has challenges accessing food. He moves to Machekeche's household and then is forced to go back. Nyasha also moves to Machekeche and she is forced to move away. Orphans, especially older ones, are not passive victims only but are active agents looking for a place where they can be looked after. Because the extended family considers Nyasha an adult, she ends up in full time commercial sex work in Masvingo, creating further HIV susceptibility and AIDS vulnerability for her children. For the first three months when all the survivors seem to have moved away from the homestead, the homestead can be deemed dissolved. However, a year later, Nyika is still there due to pressures and after having failed to secure an

alternative place to stay. He looks to the church networks for survival and, in the meantime, it helps. He is not cultivating the land left by his mother but he is able to scrounge for food and basic upkeep. The plight of Rumbidzai shows both the vulnerability and resilience of survivors.

It also shows the way claims are made on social networks (or social capital broadly), including kinship networks. The first claim is made on the social capital of kinship and, when this fails in the context of Nyika, he opts for getting support from the church system. The case history of Rumbidzai also demonstrates that it is not a given that survivors automatically receive support through social networks; any support is contingent on the character of pre-existing relationships and the stresses currently embodied in those relationships. While Nyika is able to capitalise on the church system for survival, Nyasha fails to capitalize on networks because of her lifestyle decisions. This case study thus highlights the limitations of the kinship system in providing care for survivors. Literature has shown that, where HIV- and AIDS-affected households face food and livelihood insecurity, they send some members away to be cared by others. However not every member of the household, under any circumstances, can be so easily accommodated or absorbed by others.

The livelihood futures of older orphans in particular may be compromised in this way. Rumbidzai, as her condition worsens, faces the dilemma of leaving four children and two grandchildren without any sustainable means of livelihood. The household could not survive when she was alive and there was the even greater challenge of finding a secure environment for the six survivors. The eldest child Nyasha was 21 years old and by the orphan definition was indeed an adult who was old enough to look after children, but she did not have any skills for engaging in a meaningful source of livelihood which would minimise HIV risks. She was engaging in transactional sexual relationships with almost any man who was willing to offer her anything in return for the services. The second child Nyika was 18 but had failed his ordinary level. At one time, six months after his mother died, he was saying that he wanted to get married but the aunt discouraged him. He could not even maintain the homestead given the fragility of local livelihood systems. As a coping mechanism Nyika would go to Machekeche's home, but by then Machekeche's homestead was overwhelmed and Machekeche's capacity for caring for survivors had reached its peak. When Nyika realized that it was difficult to find any relatives to take him in, he opted for the church where he

volunteered to be an evangelist. He spends three weeks at a time on crusades and food and accommodation are provided.

7.4 Conclusion

The chapter has discussed the long-term coping mechanisms of individuals and households affected by HIV and AIDS, particularly in relation to surviving orphans. In doing so, it shows in sequence the steps which are taken by HIV- and AIDS-affected individuals and households to ensure survival – the steps of both the chronically-ill person who is in the throes of death and the associated cluster households which face the prospects of caring for the orphans. There is no necessary and universal response by households (even kin-related) to the death of a member in an associated household. In the end, the response is a negotiated one and one which is the subject of considerable controversy and conflict at times. The type of response is therefore a contingent one dependent on a range of variables such as the age of the orphans, the specific status of the deceased person, the stresses currently borne by associated households and the influence of patriarchal practices. These variables also impact on the persons or households that eventually bear the responsibility of orphan care, if indeed anyone takes that responsibility. In the end though it is important to note that, even in marginalised informal settlements like Chivanhu, the possibility of some kind and level of resilience (as arranged at the cluster scale) exists.

CHAPTER 8: CONCLUSIONS

8.1 Introduction

This thesis has focussed on the livelihoods of the HIV and AIDS affected in a marginalised settlement in Zimbabwe. A study into the livelihood issues of the HIV and AIDS affected in marginalised communities like Chivanhu is necessary because there is a dearth of studies on the impacts of HIV and AIDS and the resultant coping strategies in the short- and long-term for households residing in forms of rural communities other than traditional stable, agriculturally-based rural communities. There is a need to understand and analyse the impacts of the pandemic and the coping strategies of HIV and AIDS-affected households and individuals in other segments of rural societies which are not predominantly depended on agriculture. Rural communities in Zimbabwe have experienced significant changes as a result of post-independence government policies, the collapse of the economy and the general breakdown and disintegration of governance systems during the past fifteen or more years. The conditions and processes in the country at large forced people from both rural and urban areas to reside in settlements which are characterised by high forms of marginalisation and informality in terms of organisation, governance, provision of basic services and basic rights.

These conditions of marginality have an influence on increasing HIV susceptibility and AIDS vulnerability and generally worsening the impacts of AIDS on affected individuals and households. Such a social environment created a fertile ground for the spread of HIV and for increased vulnerability for HIV and AIDS-affected households. The long-term resilience and adaptations of affected households was also affected in this social and economic environment. This study has established that HIV susceptibility, AIDS vulnerability and adaptation and resilience are embedded within the contextual conditions prevailing in settlements that are characterised by social, economic and political marginalisation in Zimbabwe. The study has established that, in marginalised settlements, the prevailing conditions of high livelihood and food insecurity, low social cohesion and gender inequality increase HIV susceptibility and AIDS vulnerability and affects long-term coping and resilience.

8.2 Understanding HIV susceptibility in marginalised communities

The findings from this study reveal that, in marginalised settlements typical of Chivanhu Settlement, high levels of livelihood insecurity, gender inequality and inequity, social inequality, power inequality, intergenerational sexual relationships, multiple concurrent

sexual networks, inefficient health delivery systems and weak and ineffective governance systems create a complex web and vicious cycle that increase HIV susceptibility for adults and children residing there. This relates to the upstream phase in the HIV and AIDS time-line. To begin with, the findings reveal that the average land holdings for most of the households are too small for a household to engage in meaningful agricultural production. Although the households revealed a variety of livelihood strategies for generation of income and accessing food, for the majority of households the opportunities for sustainable sources of income and food are limited. Hence the bulk of households residing in Chivanhu often experience chronic food insecurity as they do not have the capacity to produce adequate food for meeting the annual food consumption needs. There are also income inequalities between men and women, especially elderly men who settled earlier and hence have large pieces of land and more assets. There are also high numbers of female-headed households and widows in Chivanhu Settlement. Female-headed households do not have assets to fall back on in times of need, and hence the evidence shows that in times of need they had a higher likelihood of relying on transactional sexual relationships. On the other hand, young men and other adult men, who relied on highly migratory livelihood strategies, also have an increased risk of getting HIV through engaging in risky sexual behaviour.

Furthermore, the evidence shows high rates of multiple concurrent sexual networks. Multiple concurrent sexual networks increase the chances of getting HIV infection. The sexual networks in Chivanhu Settlement are intricately linked to household members' livelihood survival strategies. Both male and female behaviour in this context is critical for understanding HIV susceptibility. As well, the existing health services are biased towards providing sexual and reproductive services for the 15-49 age groups. The services for HIV and AIDS and other reproductive health services are provided in a silo approach. This results in other risk-prone age groups (like older males and females, and young girls) not receiving critical prevention information. This is also worsened by other cultural belief systems that stigmatises post-menopausal women who want to continue having sexual relationships. Intergenerational sexual relationships are also common in Chivanhu and there are high rates of older people above 50 years of age who are HIV positive. At the same time, ineffective governance for land and other critical resources create barriers for accessing information and create opportunities for sexual abuse and dispossession of survivors. Reports of direct and indirect sexual coercion were high in the settlement, and some of them involved the traditional leaders.

8.3 Understanding midstream AIDS vulnerability in marginalised communities

The study sought to find out what factors determine AIDS vulnerability in the midstream phase: that is, during chronic illness and when someone is living with HIV. The findings from this study show that, during HIV infection, several factors interplay to contribute to AIDS vulnerability. The following factors were identified in this study: age, household food and nutrition insecurity, access to treatment, treatment adherence, the existence of other infections, time and capacity of households to provide care and support, and ineffective governance systems. Some of these factors are also found to be critical for increasing the risk of HIV infection. Rates of death and the number of people who were found bedridden on several occasions were high considering that most people are accessing ART from Morgenster Mission Hospital.

Most HIV and AIDS-affected households were among those that experienced chronic food insecurity. The challenge of accessing food was found to be the big challenge contributing to poor adherence to taking ART drugs. Most of the HIV-infected showed that they were fast progressors²⁵. Although there are exceptional cases of people who had survived with the HIV virus for periods longer than 10 years, most of the HIV-infected progressed from HIV infection to opportunistic infections at fast rates (in most cases they developed symptoms within two years of being infected with the virus). Access to food is critical for delaying progression to AIDS opportunistic infections. The other challenge was accessing treatment. Due to highly migratory livelihood strategies, the findings are revealing that there are a high number of people with these migratory livelihood strategies reporting missing collecting doses on time. Some would come back when they are in advanced chronic illness stages and die due to having developed drug resistance. The availability of second-line treatment for individuals who developed resistance or were experiencing negative side effects was also a challenge. Findings reveal that some were initiated on ART in South Africa and Botswana; they would fail to replenish their ART at the hospital, and would be forced to buy from the market.

In addition, records of men lost in follow up were frequent. Most HIV infected adults are supposed to use condoms to reduce re-infection, and the majority of men did not want to use

²⁵ This means progressing fast from HIV to the onset of AIDS-defining opportunity infections. On average before ART, the period ranged from 2-10+ years. Fast progressors move from HIV infection to the AIDS stage faster (on average between 2 -5 years faster).

condoms resulting in re-infections and frequent STIs. Treatment for opportunistic infections required payment, and most of the HIV infected in Chivanhu reported that they were foregoing treatment due to lack of money for payment. The other factors that increased AIDS vulnerability in the midstream are the challenges of capacity for providing care and support to the chronically ill. Some households' members did not have the capacity to provide care and support. This was also worsened by the fact that there were no community home-based care facilities due to other constraining factors, unlike in other communities in Zimbabwe where there are secondary community providers of home-based care services to complement the household. The plight of the HIV-infected in child-headed households especially was pathetic. Treatment for children with HIV was available but the ART initiation took more time. The laboratory services for minor children are centralised and they took time to be processed. The members were supposed to pay for transporting the specimens and this resulted in some HIV infected children who needed ART drugs failing to access the drugs. Multiple HIV-infected individuals in specific households (some of whom were chronically ill) would fail to get the needed care and support where the household had challenges proving support, in large part because the people who are supposed to provide support are also chronically ill themselves. The situation was worsened by ineffective governance systems and political interference that affected the effectiveness of support systems like ZNPP+ support groups.

8.4 Understanding downstream AIDS vulnerability in marginalised communities

The study found out that, downstream, the vulnerability of survivors to the impacts of HIV and AIDS are influenced by a number of factors: fragmented social and family structures, poor and weak original livelihood asset bases, gender discrimination, insecure tenure, stigma and discrimination, low social cohesion, and weak and ineffective institutional responses, all interact in complex ways to create increased AIDS vulnerability for HIV and AIDS-affected households in Chivanhu Settlement. Downstream factors of AIDS vulnerability focus on the factors that determine vulnerability for HIV and AIDS-affected households. The downstream differs from midstream: whereas the midstream factors focus on vulnerability factors for individuals, the downstream affects households as an entity. They also go beyond the individual affected household to other households with critical resource exchanges between households. The findings from this study reveal that, in marginalised settlements characterised by poor livelihood asset bases and weak or underdeveloped social cohesion and social capital, the survivors in HIV and AIDS-affected households experience adverse conditions as a result of HIV and AIDS.

Moreover the weak social cohesion undermines the sense of community responsibility for survivors, as has been observed elsewhere. The findings from this study reveal that survivors are often forced to become independent at a relatively early stage. Most young people in HIV and AIDS affected households are left to fend for themselves. Women, notably young and widowed, experience a number of challenges. The weak and poor livelihood asset base inherited by female survivors increase their vulnerability. The findings reveal that apart from facing the challenge of dispossession from male kinship relatives, they also face the challenge of being disposed by the traditional authorities who are supposed to play a critical role in assisting HIV and AIDS-affected members to retain those assets. Access to other forms of capital (like natural resources), which have in other settings proven to provide a buffer, is also limited and restricted. High levels of insecure tenure and stigma and discrimination increase the vulnerability for the HIV and AIDS survivors. The plight of child-headed households is a big challenge, as is the plight of orphaned children who have lost the mother and are surviving with their fathers.

The vulnerability condition of the HIV and AIDS-affected is further worsened by weak social and institutional responses for addressing the challenges of HIV and AIDS. In other communities, where households fail to deliver, external institutions assist households with food, care and support. In the context of Chivanhu settlement, the findings are showing that grassroots politics interferes with the set up and functionality of VAAC and WAAC structures. In other communities in Masvingo District, a number of NGOs are implementing a number of projects whilst for Chivanhu almost none have visible activities on the ground. The findings show that, in Zimbabwe where an entire national HIV and AIDS multi-sectorial response is organised and implemented, grassroots political processes affect the presence and social organisation for the HIV and AIDS-affected in marginalised and isolated communities. The findings also show that weak social cohesion undermines the success of projects targeting the HIV and AIDS affected. Village heads and a few elites, who are not affected, benefit even from these; and possible infighting between them undermines the long term viability of the purported community initiatives.

8.5 Resilience and long term adaptation for HIV and AIDS -affected

Resilience in the context of HIV and AIDS encompasses an ability to cope with HIV and AIDS impacts and ensure long term survival. Studies on long term coping and survival are few. The findings of the study show that although some households appear to have dissolved

in the short term, there are households that manage to survive and regroup as viable households units in the long term. Previous studies, which were more short term in nature, failed to account for long term household resilience and adaptation strategies. The findings demonstrate that, in the context of marginalised settlements like Chivanhu Settlement (where most HIV and AIDS affected households inherit a poor or weak assets base), households with a well-developed kinship system absorb the impacts of HIV and AIDS and cope better in the long term. However the kinship system as a social safety net has its own limitations and challenges. Findings from the study show that poor and weak kinship systems cannot do much for survivors. It is kinship systems with more resources and capabilities which can afford to absorb the negative impacts. The study has also shown how decisions are made across the whole kinship system in order to ensure survival of the survivors. The study went beyond looking at the household as an isolated economic and reproduction unit, and looked at inter-household decision making processes at cluster level. The study findings show agency in dealing with the impacts of HIV and AIDS. Orphans are active, especially the older, including the chronically ill actively searching and trying within the wider kinship system to find a household where they can be looked after properly. However, the study also reveals the limitations of the kinship system. The kinship system has been deemed as social capital with holes; and there are other people who are left to slip through the holes. Where demands for looking after survivors are overwhelming, priorities are made within the kinship system as to which orphans to look after and which ones to neglect. The HIV-infected household head's capacity to build and strengthen social networks before they are ill and die also influence the contribution of the kinship system in ensuring survival of survivors.

8.6 Key arguments from this study

The main argument from this study is that current studies on livelihoods and HIV and AIDS, which have focussed on stable rural agricultural based livelihood systems, have given an incomplete picture on livelihoods and HIV and AIDS. Marginalised communities typical of Chivanhu present a unique picture on how households with HIV and AIDS cope with the epidemic.

A key argument of this study is that households affected by HIV and AIDS cope (though not necessarily sustainably), and that social networks potentially provide an important safety net for households affected by crises such as droughts and HIV and AIDS. Some of the coping strategies adopted by household members are suboptimal and create a vicious cycle for further

susceptibility and vulnerability. This study sought to find out how HIV and AIDS households survive and cope in a marginalised settlement in Zimbabwe. In this regard, the study found that HIV and AIDS affected household members in a marginalised context have unique challenges that are not found elsewhere in rural communities which are more stable and that this compromises sustainability. For a household to be sustainable, according to Chambers and Conway (1992), it has to have assets and capabilities that it can draw upon for it to achieve a sustainable livelihood. A sustainable livelihood can recover from shocks and without undermining the asset base for future generations. Where the original livelihood asset portfolio is scarce or minimal as in the context of Chivanhu, the question arises whether it is appropriate to talk about sustainable livelihoods.

The study found out that the original asset base and social capital are critical for coping among the HIV and AIDS-affected. Households with strong social capital and a firm asset base cope better with the impacts of HIV and AIDS than those households which do not have these advantages. Households with insecure tenure of land due to various factors within the settlement suffer more fully from the negative impacts of HIV and AIDS. The issue of tenure security is critical in these settlements in order to reduce the negative impacts of HIV and AIDS among the infected. In marginalised settlements like Chivanhu that are characterised by high levels of livelihood insecurity and where land sizes are small to begin with, sustainable livelihoods for the HIV and AIDS-affected become a misnomer.

Achieving livelihood security of basic needs and rights becomes an unattainable challenge for most of the HIV and AIDS-affected households. In this respect, cases of orphans and widows being dispossessed of land are very common and this has a direct impact on household and individual coping. Crucially important in this respect is treatment and adherence. While many HIV infected people are accessing ART, the problems posed by HIV and AIDS are far from over. Accessing ART without access to adequate food supplies and sustainable livelihoods presents challenges for people living with HIV. Although ART has improved livelihood strategies for the HIV infected in Chivanhu, this has occurred in a context where the livelihood asset base is narrow. In this respect, migration remains a key livelihood strategy for many of the HIV infected. Outmigration for those who are on ART presents challenges in terms of adherence to the treatment regime resulting in higher HIV and AIDS mortality rates for the infected on ART. The findings though prove that ART improves wellbeing.

Social capital, at least in the form of kinship relations in Chivanhu, is of some importance particularly in the downstream phase. But, in the face of high levels of livelihood insecurity, it seems clear that (generally speaking) social capital is scarce – as witnessed in the cluster’s attempts to absorb the pressures posed by a high orphan burden. In a context where the next of kin are distant and the household has not resided in the area long enough to establish kinship networks, survival of the deceased’s household is a daunting challenge. What has been documented by Samuels and Drinkwater (2011) in Zambia and Mazzeo (2011) in Zimbabwe (that the impacts of HIV are absorbed across several households with critical resources flows) is not experienced by most households residing in the Chivanhu settlement though it does exist.

I was able to conclude this through adopting a household clustered analysis and longitudinal approach to data collection, which enabled the study to obtain a closer and nuanced perspective on what happens at intra-household level and within households. What I did find was that there are movements of orphans between households and there are various decision making processes during the movement of orphans across households. In this regard, the plight of orphans changes over time. Whilst a patrilineal cultural system poses a challenge in terms of power imbalances across gender in the case of Machekeche case study, the matrilineal systems ensure the survival of orphaned children and the preservation of household assets. But, at times, orphans are simply abandoned.

The issues of power and structural inequalities also came up in this study’s findings. The issue of power as a livelihood capital critical for understanding the HIV and AIDS-affected comes out clearly in the context of marginalised communities like Chivanhu Settlement. In the context of this study, power and inequality have a detrimental effect on how a household copes or becomes vulnerable to the impacts of HIV and AIDS. Findings show that coping with HIV and AIDS in marginalised communities is not devoid of local politics, and also national party politics. The current HIV and AIDS institutional arrangements are aligned around traditional and formal governance structures. The HIV and AIDS-affected face a double tragedy and their future generations face an even more challenging future.

One example is the Zunde Ramambo initiative. For a person to benefit, the household head has to be formally recognised by the chief and the Rural District Council. For the majority of settlers in Chivanhu, the majority of the household heads are not registered in the village

register; they are only known by the respective village head that facilitated their settlement. They do not have any rights because technically and administratively they are not recognised by the chief and the Rural District Council. Hence they cannot organise themselves or demand access to basic services. They cannot benefit from programmes because they are not formally recognised. It becomes a challenge for them to access any form of support through social networks. The success of institutional interventions depends on functional grassroots organisation and (in the Chivanhu context) they are ineffective in addressing the needs and challenges of the HIV and AIDS-affected. Orphans and vulnerable children are not accessing school fees support and they are not registered for programmes. Support groups are not functional. The WAAC and the VAAC structures are ineffective due to power struggles between traditional authorities, ZANU PF and MDC - T.

The thesis also focused specifically on the question of gender and inequality. In this regard, it sought to find out motivations for sexual behaviour and the challenges of bearing the burden of HIV and AIDS. Findings reveal that women are bearing the greatest burden. They provide care and also bear the greatest burden of rearing children, with minimum resources, in an environment where there are few social support networks and limited livelihood opportunities. Their children face abuse and exploitation if they migrate to search for livelihood opportunities; they end up in a catch twenty two scenario. Sexual networks are posing a new threat and HIV is no longer about promiscuity but is embedded in sexual networks; and current prevention initiatives are failing to respond to this new challenge.

8.7 Theoretical insights

The sustainable livelihood framework was adopted as an appropriate and relevant perspective for understanding and analysing the impacts of HIV and AIDS on household livelihoods in marginal communities like Chivanhu. Initially, the idea was to examine the contributions of strategies such as accumulation and asset disposals to livelihood security in the face of HIV and AIDS. But I soon realised, primarily through the survey, that the most of the households were asset poor, they owned small pieces of land and there were a high number of households reporting orphaned children and experiencing chronic food insecurity. Because of this, the question of sustainability was thrown into question and a different understanding of Chivanhu slowly emerged. The subsequent research began to reveal that most of the HIV and AIDS-affected households migrated and settled in Chivanhu Settlement as a coping strategy in dealing with the impacts of AIDS vulnerability; especially for households that had looked for

a place to die and a home to leave for the children. Interestingly, over time, some households showing typical signs of AIDS vulnerability later showed signs of recovery. This also challenged an early assumption about livelihood vulnerability.

To address these challenges I merged vulnerability and resilience analysis in order to explore and explain these paradoxes. In doing so, I would hopefully obtain a more accurate and fuller picture of what happens over time in HIV and AIDS-affected households. Although some households which had dissolved would remain with fragments of household members and some would take a long time to regroup as viable economic entities, strategies that were adopted in the short term and long term somehow ensured the survival of some members in the case of certain households and all members in other households. The surprising part was that I had assumed that orphans are passive and would be shuffled from one household to another. Some of the orphaned children were initially struggling and seemed to be mere victims, but at times they (including some who were chronically ill) were actively looking for places in which they thought or knew they would receive care and support.

I also found out that the food and HIV susceptibility nexus at household level (Harvey, 2004; Gillespie, 2006) could not be analysed in isolation from contextual factors at macro- and meso-levels as these factors created both constraints and opportunities for HIV and AIDS affected households. The findings of this study show that, across the HIV and AIDS time-line (from HIV infection to chronic illness to death and survivors) concepts of HIV susceptibility, AIDS vulnerability and resilience achieve a more holistic analysis if they are intricately articulated and combined in the theoretical framework and subsequent analysis in a way which is sensitive to structure and agency. It is true that an understanding of individual risk factors is necessary in order to understand the individual factors that lead to people getting HIV infection. And it is correct that an AIDS vulnerability analysis is critical for understanding the external factors and underlying factors in diverse contexts that increase the adverse impacts of HIV and AIDS on HIV and AIDS affected households. However, HIV susceptibility and AIDS vulnerability will give a partial view of how HIV and AIDS interacts with the livelihoods of the HIV and AIDS affected (Rugalema et al., 2010; Alinovi et al., 2010). Vulnerability will present the HIV and AIDS affected as passive agents and victims to the HIV and AIDS impacts. The resilience approach assists in giving opportunity for a complete analysis of the internal adaptive capacity of the HIV and AIDS affected. It gives room for exploring agency and the active decisions that are made by HIV and AIDS-affected

household members. Current and future HIV and AIDS studies focussing on livelihoods should adopt a resilience lens, as this is critical in understanding ability and failure to cope over time.

Surprisingly, many scholars are arguing that the impacts of HIV and AIDS have changed as the HIV and AIDS epidemic is maturing. While to some extent the magnitude of the impact is somewhat less than before, the impacts of HIV and AIDS on households remain dramatic. The nature of HIV and AIDS as ‘a shock unlike any other’ (Barnett and Blaikie, 1994; Baylies, 2002; Rugalema, 2000) is still relevant for marginalised communities. As the epidemic is maturing, the clustering dimension of the pandemic reaches beyond individual households. Unlike in early years when it was clustering in households through affecting parents and children born to HIV infected parents, the HIV infection and AIDS chronic illness clusters are also now beyond individual household units and occurring across both households and generations. This continues to make HIV and AIDS ‘a shock unlike any other shock’. Surprisingly, even though people can access Voluntary Counselling and Testing Services earlier now, it is difficult to prepare for HIV infections and to make contingency plans to respond to the shock as can be done for other shocks like droughts and floods. This has implications for livelihoods research as the epidemic matures.

Although livelihood analysis is important, as shown in this study, there are other considerations which need further attention. Resilience should be more fully integrated into the analysis as do gender dimensions – as this study does. Also important are human rights. In this respect, the focus in HIV and AIDS studies is regularly on protection of rights from stigma and discrimination (that is, a direct violation of rights of individuals and groups of people living with HIV). But there are other broader human rights violations which often take place in times of heightened political conflict, as in contemporary Zimbabwe. But certainly rights specifically in relation to the infected and affected are important for analysis. This study therefore shows that lack of effective entitlements and rights, for both male and female HIV and AIDS-affected households, has reduced the capacity of the HIV and AIDS-affected to demand critical services necessary for effective prevention, care and support.

8.8 Methodological insights

Rugalema et al. (2010) argue that early studies had methodological and conceptual challenges. The studies were mostly cross-sectional and short-term in design focussing on

individual households (Rugalema et al, 2010). This study has tried to minimise the limitations of earlier studies through adopting a longitudinal and HIV and AIDS time-line approach. A longitudinal and time-line approach is critical for mapping out and analysing the nuances that happen in HIV and AIDS affected livelihoods over time. The household clustered analysis allowed the researcher to go beyond the household and map out how the impacts of HIV and AIDS are shared across a network of households with critical resource flows and exchanges. Such an analysis is difficult to achieve in the short-term cross-sectional studies. The study, by conducting a systematic analysis over time, allowed the researcher to pick households which recover and which might have dissolved earlier. This also facilitates the mapping out of coping over time: an initial study may show that households cope in the short term due to asset disposal, but over time the same households might fail to cope. There is a need to find fresh approaches for capturing how decisions are made across different households and how they influence long term coping. This would enable linkages between a theoretical perspective which stress resilience and a research methodology of a longitudinal character which traces the complex array of everyday decisions made within and between households.

8.9 Implications and recommendations

The findings from this study have a number of implications for HIV and AIDS researchers, government, NGOs and policy people in HIV and AIDS. Firstly, the findings mean that, for marginalised communities typical of Chivanhu Settlement, marginalisation processes at grassroots level and political issues at that level create further challenges for the HIV and AIDS-affected households. Even if access to ART is made available, as seen in the context of this study, without addressing or analysing the other contextual processes then the HIV and AIDS affected will continue to be marginalised in the national HIV and AIDS response. Secondly, the findings reveal that addressing issues of basic rights and entitlements is a critical issue in order to reduce vulnerability and increase the resilience levels of the HIV and AIDS-affected in marginalised settlements. Thirdly, the findings show that unique institutional responses for responding to HIV and AIDS are needed in marginalised communities. Fourthly, as the epidemic matures and stabilises, the orphan problem is still a big challenge and should be integrated in the response for HIV and AIDS. Fifthly, strengthening of livelihoods for the HIV and AIDS-affected are critical as more people are initiated on ART and showing signs of recovery. There is a need to come up with livelihood programmes targeted at the HIV-infected on ART. Providing ART without addressing the nutrition and livelihood security issues is a partial response, and it does not go further in

reducing the vulnerability of the HIV and AIDS-affected. Sixthly, addressing gender and rights is also critical for marginalised communities.

The study results and implications show that there is a need for the multi-sectorial response for HIV and AIDS in Zimbabwe to revise its approach. Current top down programmes are failing to address the local social realities and complexities that influence HIV susceptibility and AIDS vulnerability. There is a need to revise the current national response which is embedded in traditional and formal institutional structures. The national approach should respond and adapt to the needs and challenges on the ground. This would entail for example coming up with integrated HIV and reproductive health services, which target the needs of all age groups including the elderly. Apart from that, the issues for marginalised communities cannot continue to be ignored; there is a need for strong advocacy strategies for responding to the everyday challenges of the infected and affected in communities like Chivanhu. Ways of strengthening social cohesion and increasing grassroots institutional capacity and accountability are also important. The donor and stakeholder engagement process should look into the long-term consequences of neglecting the so-called newly resettled communities (that is, fast track farms) in the development approaches. Donors should not see HIV and AIDS as a stand-alone problem. They should not continue to channel money and resources to HIV and AIDS programmes run by NGOs focussing on support and mitigation, but need to start addressing the development agenda, firstly focussing on marginalised settlements.

8.10 Conclusion

This thesis has analysed the interaction between household livelihoods, HIV susceptibility and AIDS vulnerability in a marginalised settlement. It is critical that HIV and AIDS livelihood studies understand the epidemic and the lives and livelihoods of the HIV and AIDS affected in diverse socio-spatial settings so as to understand and analyse the contingent character of these lives and livelihoods. In the case of Chivanhu, a marginalised community, this thesis has made a three-fold contribution. First of all, there is an empirical contribution. It has provided rich descriptions and accounts of HIV and AIDS livelihoods in a kind of community which has not been centre stage in HIV and AIDS research and studies. Secondly, it has made a contribution to research methodology by highlighting the importance of longitudinal and time-line studies for HIV and AIDS studies. And, thirdly, in relation to the sustainable livelihoods framework, it has made a theoretical contribution by arguing in

particular for a nuanced integration of the notions of vulnerability, sustainability and resilience which prioritises both structure and agency.

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APPENDICES

Appendix One: Ethical considerations in the research

1. Consent and Assent

The AIDS epidemic has prompted difficult ethical issues regarding informed consent for research. Full consultation took place with the community in order to foster a sense of partnership with respect to the research project. All decisions regarding participation by respondents were shared decisions between the researcher and the volunteers and their representatives. Respondents were informed about the purpose of the research, how they had been chosen to participate, data collection procedures and whom to contact with questions and procedures. The length of the data collection process and what the data was going to be used for was explained and clarified in Shona (the language in Chivanhu). 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, respondents were made aware of their right to accept or decline the invitation to participate in the research, to ask questions before, during and after each interview or questionnaire, and to terminate an interview or questionnaire at any point. To deal with these possible negative results, participants were protected by assuring freedom not to answer questions they think are of a sensitive nature. For minors (i.e. below 16 years), the researcher sought consent from their parents or guardians prior to the interviews. However, this did not preclude these minors' individual right for assent to accept or decline the invitation to participate in the research, to ask questions or to terminate interviews when they so wished.

2. No Deception and Confidentiality

The researcher did not use concealment or deception in seeking information that she felt might encroach on respondent's privacy. Data collected through the research was not accessible for unauthorized observation. Respondents were assured during and after the research process that the information would be kept confidential and that the researcher was not going to be professionally negligent.

3. Respect and Justice

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 respect the research subjects by maximizing possible benefits and minimizing possible harm

to them, so the researcher adhered by 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. Justice refers to such questions as who will benefit from the research and who will bear its burdens. The study was designed in a way that distributed equally the risks that are brought about by participation in the research. Where matters besides the intended issues were raised by research subjects during the research, the researcher made referrals to appropriate sources where it was necessary and possible.

Appendix Two: Oral informed consent form

Coping with HIV and AIDS in marginal communities: a case study of Chivanhu Settlement, Masvingo, Zimbabwe.

This interview is for a research that is done by Loveness Makonese, a PhD student registered with Rhodes University, South Africa.

The research interview will gather information on HIV risk, impact and your various responses to the impacts. The research is also going to ask information on personal issues and how the formal and traditional institutions influence coping. It will also map out the gender issues around HIV and AIDS. 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 Chivanhu Settlement) and my contact numbers given for further questions and issues that may arise.

Adapted from Rivera et al., (2001)

Appendix Three: Definition of concepts

1. Acquired Immune Deficiency Syndrome (AIDS)

Over time a person infected with HIV cannot fight infections that someone with a healthy immune system can resist. It is referred to as a syndrome because the infection is not a single one but is several infections, which can attack a person at the same time. HIV infection progresses in stages. As time passes the infection worsens leading to death. The condition of acute immune deficiency as a result of HIV infection progressing along the HIV time-line is what is collectively referred to as the AIDS stage.

2. Human Immune Virus (HIV)

HIV is the virus that causes AIDS. If you are infected with HIV, it does not literally mean that you have AIDS. HIV is a life- long infection that weakens the body's natural ability to fight off diseases. Generally it takes about 2 to 15 years before one transgresses from HIV infection to AIDS.

3. HIV and AIDS

Since HIV does not mean one has AIDS, the correct way of referring to the terms is 'HIV and AIDS' and not 'HIV/AIDS'. The thesis seeks to clearly distinguish between HIV as an infection and AIDS as a chronically-ill condition.

4. HIV discordant couple

This is a scenario where one of the partners (either male or female) is HIV positive and the other partner is HIV negative.

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.

6. HIV and AIDS affected

HIV and AIDS affected refers to individuals and households whose lives have been affected because they are infected with the HIV virus; have lost a spouse, child or relative because

AIDS-linked diseases; are looking after a chronically-ill person; or 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.

7. Orphan

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

Appendix Four: Interview Schedules

1. Key Informant Interview Schedule

Date	Key informant	Place
15/07/2010	Nurses at Clinic	Chivanhu
16/07/2010	Opportunistic Infections nurse	Morgenster Hospital
16/11/2008	District Administrator	Masvingo Rural District Council
08/2007 and 16/11/2008	District AIDS Coordinator	Masvingo
18/11/2008	Masvingo Provincial AIDS Coordinator	Masvingo
21/03/2010	ZNNP+ Masvingo Office	Masvingo
22/08/2011	ZNNP+ Founder member	Masvingo
10/11/2008,12/08/2010	Councillor	Nemanwa
13/07/2010	Teacher	Nemanwa
13/07/2010	CARE Staff member	Masvingo

2. Open ended and In-depth Interview Schedule by category

Child Headed Households

Date	Age	Sex	Description
16/12/2010	17	Male	Child headed head of household
16/12/2010	16	Female	Child headed head of household
13/12/2010	15	Female	Member of child headed household
10/04/2011	10	Male	HIV positive member of child headed household
10/04/2011	11	Male	HIV positive member of child headed household

3. Orphaned Children

Date	Age	Sex	Description
28/03/2011	7	Male	Orphan from elsewhere
28/03/2011	8	Female	Double orphan
25/03/2011	10	Male	Single orphan(lost father)
25/03/2011	16	Female	Single orphan(lost mother)

4. HIV Positive Widows

Date	Age	Description
15/03/2011	22	Widow with 2 children dispossessed
15/03/2011	25	3 children engaged in transactional sexual relationships
16/03/2011	30	4 Children staying between South Africa and Zimbabwe
17/03/2011	45	Older women coping positively
18/03/2011	50	Older women looking after children and one eldest daughter HIV positive

5. HIV positive men

Date	Age	Description
08/03/2011	45	Lost wife had remarried
09/03/2011	46	Lost wife had remarried
09/03/2011	47	Lost wife had remarried and had young child HIV positive
11/03/2011	55	Lost wife, remarried 3 times after wife's death

6. Pregnant HIV positive women

Date	Age	Description
10/04/2011	22	Both husband and wife HIV positive
10/04/2011	28	Wife HIV positive, husband HIV negative
11/04/2010	35	Late registration for antenatal services husband refusing to be tested for HIV

7. Breastfeeding HIV positive women

Date	Age	Description
13/04/2011	22	On PMTCT but not complying with exclusive breastfeeding
13/04/2011	25	Child one and half years HIV positive

8. Chronically ill accessing ART services

Date	Age	Sex
12/06/11	13	Female
12/06/11	22	Female
13/09/11	25	Female
14/09/11	26	Female
14/09/11	30	Female
15/09/11	35	Male
16/09/11	45	Female
16/09/11	50	Female
17/09/11	60	Male
17/09/11	70	Male

9. Chronically ill not accessing ART services

Date	Age	Sex
18/09/11	50	Female
18/09/11	30	Male

10. Interview Schedule for Machekeche Cluster

Date	Name and Description	Place
05/10/2011	Precious's mother	Zaka
05/10/2011	Precious's mother in law(Bonnie's mother)	Zaka
03/10/2011	Machekeche's sister	Harare
06/10/2011	Judith and Husband	Gokomere
07/10/2011	Chipo	Chivanhu
15/10/2011	Betty's sister	Buhera
08/11/2009	Liberty	Chivanhu
05/01/2010	Gibson at Liberty's funeral	Mangonjo
06/01/2010 and 08/10/2011	Betty and Husband	Masvingo
06/01/2010 and 08/10/2011	Brighton	Masvingo
09/10/2011	Tinto's father in law	Chivanhu
07/10/2011	Tinto	Chivanhu
09/01/2011	Rumbidzayi	Chivanhu
18/04/2011	Nyasha and Nyika at Rumbidzai's funeral	Jerera
16/10/2011	Nyika	Chivanhu
05/11/2008,06/11/2009 08/10/2011	Machekeche and first Wife	Chivanhu
05/11/2008	Precious's eldest and youngest daughter	Chivanhu

11. Households for case life histories

Household head name	Sex	Age	Description
Susie	Female	36	Widow, HIV positive
Hesi	Female	47	Divorced HIV positive
Govo	Male	42	HIV positive
Zekie	Male	94	Young wife engaged in multiple sexual relationships
Chando	Female	36	HIV positive and engaged in commercial sex work but in a relationship
Mbuya Mai Ruu	Female	70	Living with five grandchildren
Mpo	Female	17	HIV positive , school going and engaged in occasional commercial sex work and transactional sexual relationships
Ndaizivei	Female	35	Widow HIV positive
Chido	Female	18	HIV positive commercial sex worker
Mukai and Fidelis	Female and Male	42 and 43	HIV positive couple
Jo's wife	Female	32	HIV positive in HIV discordant relationship
Zivhu	Male	17	Child Headed Household
Vandi	Female	72	Elderly looking after eight grandchildren
Zet	Female	48	HIV positive widow with five children
Mai Matie	Female	42	HIV positive widow
Zvada	Male	46	HIV positive male
Boroma	Male	45	HIV positive male

Appendix Five: Chivanhu Household Livelihood Questionnaire

7 Digit Questionnaire ID: Household _____

Village _____

Date of Interview _____ / _____ / 2010
Day / Month / Year

Name of respondent (breadwinner/spouse/household head)

A. Information on the Primary Breadwinner							
Q1	What is their Gender	Q2	What is their Age	Q2	Marital Status	Q3	Have you ever had a spouse die of chronic illness?
	Male (1) Female (0)		(Years)		1=Married 2=Divorced/Se p 3=Widowed 4=Single (never married)		Yes (1) No (0) NA (99)
	<input type="checkbox"/> s <input type="checkbox"/> no						<input type="checkbox"/> x <input type="checkbox"/> xx
							<input type="checkbox"/> xxx <input type="checkbox"/>
							<input type="checkbox"/>
CODES FOR BREADWINNER'S PRIMARY ACTIVITY							
0=None (only farming) 1 = Crop sales 2 = Casual agric. labour 3 = Casual non - agric. labour 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=Go's Public Works							

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

Q10	Has someone died of chronic illness (severely ill for 3 months) in the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> no	
	(0)	Yes (1) No		
Q11	If someone died, was this person the breadwinner?	<input type="checkbox"/> yes	<input type="checkbox"/> xxx	<input type="checkbox"/> no
	(99)	Yes (1) No (0) NA		

Q12	Is there anyone who is a member of this household, but lives and works elsewhere? <input type="checkbox"/> yes <input type="checkbox"/> xxx <input type="checkbox"/> no 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? <input type="checkbox"/> yes <input type="checkbox"/> xxx <input type="checkbox"/> no (0) Yes (1) No
Q14	If yes , what is this person's plan for the near future (next 6 months)? <input type="checkbox"/> no 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 <input type="checkbox"/> no B. Child 2 <input type="checkbox"/> no C. Child 3 <input type="checkbox"/> no 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? <input type="checkbox"/> no <input checked="" type="checkbox"/> x <input type="checkbox"/> o (0) Yes (1) No
Q18 A - D	What type of organization provides education assistance? (check ALL that apply) A=NGO <input type="checkbox"/> B=Religious Org. <input type="checkbox"/> C=Government <input type="checkbox"/> 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? <input type="checkbox"/> yes <input type="checkbox"/> no (0) Yes (1) No
Q22	Have any orphaned children fewer than 18 come to live with you from another household? <input checked="" type="checkbox"/> Y <input type="checkbox"/> Ex <input type="checkbox"/> on (0) Yes (1) No
Q23	For how long have you been staying in this village? Specify no of years _____
Q24	Where were you staying before residing here? Specify no of years _____

D. Land Use

Q25	(1 acre= 0.4 ha) What estimated amount of land your household own / rent / given (combined)? # _____ acres
Q26	What was the size of land cultivated this main season (in acres)? # _____ acres
Q27	This year, did you leave land uncultivated that is normally cultivated? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> six <input type="checkbox"/> no (99) Yes (1) No (0) NA
Q28	If land was uncultivated , how many acres were uncultivated? # _____ acres
Q29	If land uncultivated , was it more , less or same as compared to last year? (check only ONE) 1=More land this season <input type="checkbox"/> 2=The Same <input type="checkbox"/> 3=Less land this season <input type="checkbox"/> 99=NA <input type="checkbox"/>
Q30 A - C	If you left land uncultivated during the main season, what were the reasons? (see codes below) A. Primary (1 st Most) _____ B. Secondary (2 nd Most) _____ C. Tertiary (3 rd Most) _____ 1=Lack labour 2=Lack seed 3=Lack draught power 4=Lack rain 5=Fallow 6=Lack fertilizer 99=NA

Q31	Compared to last year (04 - 05), do you or expect to harvest more , less or the same quantity of cereal (<i>Check only ONE</i>) 1=More cereal this season <input type="checkbox"/> 2=The Same <input type="checkbox"/> 3=Less cereal this season <input type="checkbox"/>
Q32	Does the household have access to a dam? <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
Q33	Does the household have any access to any gardens? <input type="checkbox"/> 1=Irrigated garden 2=Vleis garden 3=Both 4=None

(1 acre= 0.4 ha)		CURRENT SEASON							<i>check only one</i>			NEXT SEASON	
	Crop Planted	A. Land Planted (acres)	B. Amount Harvested (# 50kg Bags)	C. Amount Still Standing (# 50kg Bags)	D. Amount Expect to Sell (# 50kg Bags)	E. Main Source of Seed (see codes)	F. Amount seed <u>all</u> <u>sources....</u> (kg)	G. Did you have enough seed?			H. Want to plant next season (Check if yes)	I. Expected <u>main</u> source of seed (see codes)	
								Yes	No, can't afford	No, not available			
Q34	Maize	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q35	Sorghum	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q36	Millet	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q37	Rapoko	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<i>Check if yes</i>	NA	NA	<i>Check if yes</i>	See Codes	NA	Yes	No, can't afford	No, not available	<i>Check if yes</i>	See Codes	
Q38	Broccoli	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q39	Carrots	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q40	Covo	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q41	Cow Peas	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q42	Cucumber	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q43	Garlic	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q44	Groundnuts	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q45	Okra	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q46	Onion/Shallot	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q47	Potato (ordinary)	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q48	Potato (Sweet)	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q49	Pumpkin/Squash	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q50	Rape	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q51	Round Peas	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q52	Spinach	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q53	Sugar Beans	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q54	Sugar Cane	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q55	Tomato	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q56	<input type="text"/>	<input type="checkbox"/>	NA	NA	<input type="checkbox"/>	<input type="checkbox"/>	NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

MAIN SOURCE OF SEED CODES – *if multiple sources, choose the main source*

1 = Retain unplanted seed (not home-grown) 2 = retain home-grown seed 3 = seed crop 4, NG0 5 Government 6 Purchase 7= Borrow 8 Gift 99=NA

E. Agricultural Inputs and Extension Services	
Q57	Have you received any agricultural advice/attended any field days this season? <input checked="" type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
Q58	If yes, who provided this agricultural advice (<i>check ALL that apply</i>) A. AREX <input type="checkbox"/> B. NGO <input checked="" type="checkbox"/> C. Neighbour <input type="checkbox"/> D. None <input type="checkbox"/>
Q59	Do you use chemical fertilizer <input checked="" type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
Q60	If no, what is the reason? (see codes) <input type="checkbox"/> 1=Cannot afford it 2=Not available 3=Don't know how to use it 4 = Prefer not to use 99=NA
Q61	Do you practice conservation farming? <input checked="" type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
Q62	Do you plant sweet potato using the new born again variety? <input checked="" type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
Q63	If yes, what is the source of the sweet potato planting material? (see codes) <input type="checkbox"/> 1=NGO (specify name) 2=Local nursery 3=Other farmers 4=Other, specify

F. Household Food Sources and Stocks	
Q64	Does the household have cereal (<i>grain ground</i>) from last year's harvest in stock now? <input checked="" type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)
Q65	IF NO, how many months did last year's harvest last? (if no harvest last year, '0') # Months
Q66	Estimated amount of cereal the entire household consumes in a month? # kg
Q67	During the past 4 months (<i>lean period</i>), what were the most important sources of cereal? (see codes) A. Primary (1 st Most) B. Secondary (2 nd Most) C. Tertiary (3 rd 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.)	
Q68	On - Farm casual labour (<i>working for food as payment</i>) # kg
Q69	Off - Farm casual labour (<i>working for food as payment</i>) # kg
Q70	Remittances and Gifts sent to the Household # kg
Q71	Other Sources (<i>include borrowing</i>) # kg
Q72	How much cereal did you purchase during the last 12 months from the GMB? # kgs
Q73	How much cereal did you purchase at local markets during past 12 months? # kgs
Q74	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
Q75	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

G. Income and Expenditure (***) working for food (maricho) goes into Q66-67 above)									
Did the HH participate in following activities in past <input type="text" value="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)			
Q76	Formal Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q77	Sales of livestock – split cattle, goats/poultry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q78	Trading & self-employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q79	Gold panning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q80	Receives Remittances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q81	Government Pub. Works	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q82	Cereal & Cash Crop Sales	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q83	On-farm Casual Labor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q84	Off-farm Casual Labor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q85	Vegetable/Fruit sales	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q86	Remittances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
87 A-C	What were the three greatest sources of spending during the past <input type="text" value="4"/> months? (Codes below) A. Primary (1 st Most) <input type="text"/> B. Secondary (2 nd Most) <input type="text"/> C. Tertiary (3 rd Most) <input type="text"/> 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								

H. Assets										
Type of Asset (READ EACH ONE)		A Own Yes (1) No (0)		B Borrowed in past year Yes(1) No(0)		C Purchased in past year Yes(1) No(0)		D Sold in past year Yes(1) No(0)		E Reason for selling (codes below)
Q88	Plough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q89	Ox Cart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q90	Wheelbarrow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q91	Bicycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Q92	Radio/TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

CODES FOR REASON FOR SELLING ASSET (see E above)
 1=No longer needed 2=Pay daily expenses 3=Buy food 4=Pay medical expense 5=Other emergency 6=Pay debt
 7=Pay social event 8=Pay funeral 9=Pay for school fees 99=NA

I. Livestock													
*Do not count livestock (especially cattle) that HH is keeping for others, but doesn't own													
Livestock Type (READ EACH ONE)		A # Own		B # Purchased in Past year		C # Sold in Past year		D Main Reason for Sale (codes below)		E Hire In/Borrow Past year Yes(1) No(0)		F Hire Out in past Year Yes(1) No(0)	
Q93	ALL Cattle	#	#	#	#	#	#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q94	Of total cattle, # used for draught power	#	#	NA=99		#	#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q95	Donkey	#	#	#	#	#	#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q96	Sheep & Goats	#	#	#	#	#	#	<input type="checkbox"/>	<input type="checkbox"/>	NA=99		NA=99	
Q97	Poultry	#	#	#	#	#	#	<input type="checkbox"/>	<input type="checkbox"/>	NA=99		NA=99	

CODES FOR MAIN REASON FOR SALE (see D above)
 1=No longer needed 2=Pay daily expenses 3=Buy food 4=Pay medical expense 5=Other emergency
 6=Pay debt 7=Pay for Social Event 8=Pay Funeral 9=Pay school fees 99=NA

J. Borrowing	
Q98	During the past 4 months , did you or any member of your household borrow money? <input type="checkbox"/> s <input type="checkbox"/> no (0) Yes (1) No
Q99 A - C	If you borrowed money , what were the reasons to borrow money? (see codes) A. Primary (1 st Most) _____ B. Secondary (2 nd Most) _____ C. Tertiary (3 rd Most) _____ 1 = Food 2 = Health care 3 = Funeral 4 = Social event 5 = Avoid selling assets 6 = Agriculture inputs 7 = School fees 8 = Pay Deb 99=NA
Q100 A - E	If you borrowed money , from whom did you borrow money? (check ALL that apply) (NA=99) A. Relative/Friend <input type="checkbox"/> B. Money Lender <input type="checkbox"/> C. Savings Group <input type="checkbox"/> D. Micro Finance Instit. <input type="checkbox"/> E. Bank <input type="checkbox"/>
Q101	(NOT a gift) <input type="checkbox"/> s <input type="checkbox"/> no During the past 4 months (lean period), did the household borrow food? Yes (1) No (0)

K. Water and Sanitation and Health	
Q103	What is the primary source of water? (drinking, cooking, washing) (see codes) <input type="checkbox"/> s 1=tap 2=borehole 3=deep well 4=shallow well 5=family well 6=other protected source 7=unprotected well 8=unprotected spring 9=river
Q104	How many minutes does it take to walk there (one way)? # _____ minutes
Q105 -	How many minutes does it take to fill a 20 litre bucket full of water? # _____ minutes
Q106	What amount of water is collected per day? _____ litres
Q107	What type of latrine does your household use? (see codes) <input type="checkbox"/> s 0=No latrine available 1=Single Blair latrine with hand washing facility 2=Single Blair latrine, no hand washing 3=Double Blair latrine with hand washing facility 4=Double Blair latrine, no hand washing 5=Other latrine (not specific)

Which of the following did the household have in the past 60days ?		A.? (check if yes)	B How many members were ill?
Q108	Diarrhoea	<input type="checkbox"/> no	# members
Q109	Dysentery	<input type="checkbox"/> no	# members
Q110	Scabies	<input type="checkbox"/> no	# members
Q111	Bilharzias	<input type="checkbox"/> no	# members
Q112	Malaria	<input type="checkbox"/> no	# members

L. Food Consumption	
Q113 C	How many meals did the ADULTS eat in your household in the past THREE days? A. DAY 1 # _____ meals B. DAY 2 # _____ meals C. DAY 3 (yesterday) # _____ meals
Q114 A - C	How many meals did the CHILDREN eat in your household in the past THREE days? A. DAY 1 # _____ meals B. DAY 2 # _____ meals C. DAY 3 (yesterday) # _____ meals
Which of the following did somebody eat as part of a meal or snack in the past THREE days? (check food item if consumed at least once in the past three days by anyone) YES (1) NO (0)	
Q115	Sadza
Q116	Other cereals (including CSB)
Q117	Cassava / Potato /Other tubers
Q118	Sugar / Sugar products
Q119	Legumes (beans, peas, grnd. nuts)
Q120	Vegetables / Leaves (include wild)
Q121	Bread
Q122	Fish
Q123	Cooking Oil / Fat
Q124	Milk
Q125	Meat (include wild)
Q126	Fruits (include wild)
Q127	Eggs
Q128	Mahewu

M. 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)
Q129	Agricultural Inputs (seed or fertilizer)
Q130	Cereal
Q131	Clinic / Hospital expenses
Q132	Clothing
Q133	Draught cattle or donkeys
Q134	Funeral support
Q135	Groceries (not mealie meal)
Q136	Labor for farming
Q137	Loan of Cash
Q138	School fees
Q139	Hoes and Other Small Farm Tools
Q140	Plough
Q141	Specify: _____
Q142	Specify: _____
Q143	If you borrowed draught power, how many days did you have to wait? _____ # days
Q144	If you repaid the owner with labour, how many days of labour did you owe? _____ # days

IF THERE IS NO CHRONICALLY ILL MEMBERS... THIS IS THE END!!!

N. Chronically Ill				
*Fill out Section N for Each chronically ill member. These questions refer to the sick individual.				
Q145 Gender	Q146 Age in Years	Q147 Relation to HH Head	Q148 Marital Status	Q1149 # Years ago Fell Seriously Ill

Male (1)	Female(0)		(see codes)	(see codes)	(if less than 1 year, put 1)
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	# 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)					
Q150	Has this person had an HIV test?				<input type="checkbox"/> Yes(1) <input type="checkbox"/> No(0)
Q151	If they are willing to disclose, what is their HIV status?				<input type="checkbox"/> Positive (1) <input type="checkbox"/> Negative(0) <input type="checkbox"/> NA(99)
Q152	If they are willing to disclose, are they taking anti-retro-viral therapy(ART)				<input type="checkbox"/> Yes(1) <input type="checkbox"/> No(0)
Q152	Is the person currently bedridden?				<input type="checkbox"/> Yes(1) <input type="checkbox"/> No(0)
If No go to Q155					
Q153 A-C	What type of organization is providing ART drugs? (check ALL that apply)				
	A= Private <input type="checkbox"/> B= ZACH Hospital <input type="checkbox"/> C=Government Hospital <input type="checkbox"/> D=Other <input type="checkbox"/>				
Q154	Of the following constraints in accessing drugs, are they experiencing any of these? Circle the appropriate 1=Interruptions in supply 2=Lack of money 3= transport problems 4= disruptions due to mobility from area 5=other(specify)				
Q155	Have you ever lost a spouse to a chronic illness?				<input type="checkbox"/> Yes(1) <input type="checkbox"/> No(0) <input type="checkbox"/> NA(99)
Q156	(if less than 1 year, write '1')				
	If you have had a spouse die of a chronic illness , how many years ago? # _____ years ago				
Q157	Does this person have any children?				<input type="checkbox"/> Yes(1) <input type="checkbox"/> No(0)
Q158	If they have children, are any chronically ill?				<input type="checkbox"/> Yes(1) <input type="checkbox"/> No(0) <input type="checkbox"/> NA(99)
Q159	If they have children, have any died of a chronic illness?				<input type="checkbox"/> Yes(1) <input type="checkbox"/> No(0) <input type="checkbox"/> NA(99)
Q160	Is the person currently bedridden?				<input type="checkbox"/> Yes(1) <input type="checkbox"/> No(0)
Q161	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
Q162	Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q163	Chronic Diarrhea (entire month)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q164	Prolonged fever (entire month)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q165	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q166	Persistent cough (not TB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q167	Itchy inflammation of the skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q168	Herpes Zoster (Bandi)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q169	Yellowing of tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q170	Herpes Simplex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q171	Abnormal swelling (legs, neck)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q172	Cryptococcal Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q173	Recurrent Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q174	Has this person EVER migrated outside of the rural area in the past?				<input type="checkbox"/> Yes(1) <input type="checkbox"/> No(0)
Q175	If they have migrated, what YEAR did they first leave their rural home? (99=NA)				_____
Q 176 If they have migrated in the past, where did they migrate to <i>most</i> of the time? (see codes) 1=Harare 2=Gweru 3=Mutare 4=Zvishavane 5=Jerrera 6=Chiredzi 7=Bulawayo 8=Masvingo 9=Beitbridge 10=Other Rural Area 11=Other Town 12=International 99=NA					
Q177	If they have migrated, when YEAR did they last return home? (99=NA)				_____
Q178	When they last returned home, were they seriously ill and in need of care? Yes(1) No(0) NA(99)				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Which activities did you do before and after becoming ill? (READ EACH ONE)		A Did before Chronically Ill	B Does this now Before ART , but still chronically ill	C Does this now on ART
Q179	Crop sales	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q180	Casual agric. labor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q182	Casual non-agric. Labor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q183	Sales of livestock – split cattle, goats/poultry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q184	Skilled trade/artisan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q185	Medium/large Business	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q186	Petty Trade (e.g. small sales)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q187	Beer Brewing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q188	Formal salary or pension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q189	Fishing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q190	Gold Panning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q191	Vegetable sales	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q192	Government Public Works	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q193	Ploughing / hoeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q194	Planting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q195	Weeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q196	Harvesting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q197	Crop Processing (e.g. husking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q198	Tending livestock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q199	Work around homestead (e.g. repairing kraals, fences)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q200	Cleaning homestead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q201	Cooking for household	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q202	Caring for children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q203	What is the gender of his/her primary caregiver?	<input type="checkbox"/> Male (1) <input type="checkbox"/> Female (0)		
Q204	What is the age of the primary caregiver?	_____ years		
Q205	What is the relation of the primary caregiver to the sick person? (see codes) 1 = household head 2=Spouse 3=Son/Daughter 4=Grandchild 5=Brother/Sister 5=Aunt/Uncle 7=Parent 8=Grandparent 9=other	<input type="checkbox"/>		

Q206	In the past 24 hours , how many hours were spend providing care to the sick? # _____ hrs	
Q207 A-J	Which of the following services are provided by the primary caregiver? (<i>check ALL that apply</i>) (<i>check=1, no check = 0</i>)	
A. Hand Feeding	<input type="checkbox"/>	F. Provide emotional comforting and prayer <input type="checkbox"/>
B. Bed bathing	<input type="checkbox"/>	G. Administer medicine <input type="checkbox"/>
C. Treating wounds	<input type="checkbox"/>	H. Accompany to clinic/hospital <input type="checkbox"/>
D. Care for their children	<input type="checkbox"/>	I. Clean-up their living area <input type="checkbox"/>
E. Cook for them	<input type="checkbox"/>	J. Help them get around <input type="checkbox"/>
Q208	Does anyone provide care to the sick from the community? (<i>not living in the household</i>) <input type="checkbox"/> <input type="checkbox"/> Yes (1) No (0)	
Q209	If there is someone outside of the household who provides care, how many times have they visited in the past week ? # _____ visits	
Q210 A-J	Which of the following services are currently provided by the community member to the sick? (<i>check ALL that apply</i>) (check=1, no check = 0)	
	A. Hand Feeding <input type="checkbox"/>	F. Provide emotional comforting and prayer <input type="checkbox"/>
	B. Bed bathing <input type="checkbox"/>	G. Administer medicine <input type="checkbox"/>
	C. Treating wounds <input type="checkbox"/>	H. Accompany to clinic/hospital <input type="checkbox"/>
	D. Fetch firewood/water <input type="checkbox"/>	I. Clean-up their living area <input type="checkbox"/>
	E. Cook for them <input type="checkbox"/>	J. Help them get around <input type="checkbox"/>
Q211	Have you received any donated medicines or assistance to buy drugs in the past year? <input type="checkbox"/> <input type="checkbox"/> Yes (1) No (0)	
Q212 A-D	What type of organization provides assistance with medications? (<i>check ALL that apply</i>) A=NGO <input type="checkbox"/> B=Religious Organization <input type="checkbox"/> C=Government <input type="checkbox"/> D=Other <input type="checkbox"/>	
Q213	Do you share eating utensils with the sick? <input type="checkbox"/> <input type="checkbox"/> Yes (1) No (0)	
Q214	Is leftover food of the sick eaten by someone else? <input type="checkbox"/> <input type="checkbox"/> Yes (1) No (0)	
Q215	Does the sick have regular visitors from outside the household? (<i>include relatives</i>) <input type="checkbox"/> <input type="checkbox"/> Yes (1) No (0)	
Q216	Has the sickness caused a change for the worse in relations with others? <input type="checkbox"/> <input type="checkbox"/> Yes (1) No (0)	
Q217	Is the community less willing to include the sick in activities? <input type="checkbox"/> <input type="checkbox"/> Yes (1) No (0)	
Q218	What is the main cause of the sickness? (<i>see codes</i>) 1=Curse 2=Bewitched 3=Natural Causes 4=Other <input type="checkbox"/>	