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**Coping Strategies and Social Resources**

**An Exploratory Study of the Resources Used By, and the Coping Strategies of Poor  
Urban Households Affected By HIV/AIDS in Harare City**

**By Vimbayi Mutyambizi**

**Dissertation submitted to the School of Economics, University of Cape Town, in  
partial fulfillment of the requirements for the Masters Degree in Health Economics.**

**September 2002**

## DECLARATION

This research is my original work and has not been submitted for any academic and/or examination purposes at any other university.

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Vimbayi Mutyambizi

This research paper has been submitted for examination with my approval as the University Supervisor.



Professor Di McIntyre

30/08/02  
Date

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## ABSTRACT

Zimbabwe like many other countries in Sub-Saharan Africa is being ravaged by the effects of HIV/AIDS. Prevalence levels currently stand at between 15-35% (for women aged between 25-29), and are expected to grow to 50% by the year 2010. The economy is suffering from the loss of productive labour, the health sector is over-burdened and unable to cope with the increased demand for health services due to AIDS related illnesses. Many households have lost their principal breadwinners to the disease and have become impoverished as a result. Despite a myriad of interventions aimed at preventing the spread of the infection, and mitigating its effects on the health system, the economy, and households, the infection still presents a problem for the country. Poor urban households in particular, are susceptible to poverty induced by the effects of this illness. It is therefore important to not only assess the costs of the disease on these households, but also to understand the strategies which they employ to cope with the impact of the illness.

The main aim of this study was to assess the costs (direct and indirect) incurred by poor households as a result of HIV/AIDS, and to explore the strategies which they make use of in dealing with the effects of the disease. Social capital was examined as a resource which households utilize in order to mitigate the impact of HIV/AIDS related ill health on the household. Data was collected from interviews of people living with HIV/AIDS (using a structured questionnaire), focus group discussions and key informant interviews. The sample of 110 people living with HIV/AIDS was drawn from two poor urban communities with different wealth profiles. The questionnaire was structured in order to obtain information on the costs incurred by households as a result of the disease and about the strategies employed to cope with the disease.

The results indicate that HIV/AIDS places a heavy economic burden on affected households, many of whom already struggle to meet their basic needs. The results show that that most households (72%) enter into debt, and few make use of household savings and Medical Insurance as mechanisms for coping with the high costs of ill health. Both

communities exhibited high levels of certain types of social capital resources, with the lower income community exhibiting higher levels of social capital resources in general. A pattern in the results reveals that the resources and forms of assistance (financial and non-financial) that households in the two communities had available to them for coping with the disease differed according to the type of social capital held by the respondents in the each community.

An analysis of these results suggests that introducing structures to assist affected households in meeting their basic needs such as food and education would improve the ability of households to cope with the economic impact of the disease. The institution of means tested exemption systems for health care services for these people would greatly improve the ability of their households to cope with the high illness costs. The results also suggest that organisations and actors involved in HIV/AIDS interventions should coordinate their efforts so as to be effective in mitigating the effects of the disease on these households. It is also suggested that policy makers develop capacity in the area of social capital and HIV/AIDS so that interventions targeted at assisting communities affected by AIDS are informed by an understanding of the complete resource set (including differing social capital endowments) that households have at their disposal.

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## **LIST OF ACRONYMS AND ABBREVIATIONS**

<b>AIDS</b>	Acquired Immune-Deficiency Syndrome
<b>ARV</b>	Antiretroviral
<b>ATP</b>	Ability To Pay
<b>CBO</b>	Community Based Organisation
<b>CCZ</b>	Consumer Council of Zimbabwe
<b>CIDA</b>	Canadian International Development Agency
<b>CSO</b>	Central Statistical Office
<b>DFID</b>	Department For International Development
<b>EDL</b>	Essential Drug List
<b>EPI</b>	Expanded Program on Immunization
<b>FEWSNET</b>	Famine Early Warning System Network
<b>FGD</b>	Focus Group Discussion
<b>GOZ</b>	Government Of Zimbabwe
<b>GP</b>	General Practitioner
<b>GDP</b>	Gross Domestic Product
<b>HDR</b>	Human Development Report
<b>HIV</b>	Human Immunodeficiency Virus
<b>PLWA</b>	People/Person Living With AIDS
<b>USAID</b>	United States Agency for International Development
<b>MOHCW</b>	Ministry Of Health and Child Welfare
<b>MOH</b>	Ministry Of Health
<b>NACP</b>	National AIDS Coordinating Program
<b>NAC</b>	National AIDS Council
<b>NGO</b>	Non - Governmental Organization
<b>ORT</b>	Oral Rehydration Therapy
<b>PHC</b>	Primary Health Care
<b>SaFAIDS</b>	Southern Africa AIDS Information Dissemination Service
<b>SSA</b>	Sub-Saharan Africa
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS

<b>UNDP</b>	United Nations Development Program
<b>UNICEF</b>	United Nations International Children's Fund
<b>UN</b>	United Nations
<b>USAID</b>	United States Agency for International Development
<b>US\$</b>	United States Dollar
<b>WASN</b>	Women AIDS Support Network
<b>WHO</b>	World Health Organization
<b>WTP</b>	Willingness To Pay
<b>ZAN</b>	Zimbabwe AIDS Network
<b>ZAPSO</b>	Zimbabwe AIDS Prevention and Support Network
<b>ZHDR</b>	Zimbabwe Human Development Report
<b>ZDHS</b>	Zimbabwe Demographic and Health Survey
<b>ZNNP+</b>	Zimbabwe National Network for PLWA
<b>Z\$</b>	Zimbabwe Dollar
<b>ZWS</b>	Zimbabwe Dollar

## CHAPTER 1: INTRODUCTION

**Chapter overview:** This chapter serves to introduce the main issues underlying this study and provides a skeletal overview of the thesis. The research problem is stated: households employ a variety of strategies and draw on a complex resource set to cope with the illness costs of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome). The study explores what these strategies and resource sets are and how they impact on the household's livelihood. The rationale for the study is also discussed: HIV/AIDS has wreaked havoc in many poor urban households in Harare Zimbabwe. Affected households are finding themselves unable to cope and thus being thrown into deeper levels of destitution and poverty as a consequence of the financially debilitating costs of the disease. The objectives of the study are clearly specified and the chapter concludes with an outline of the dissertation.

### 1.1 The Research Problem

HIV/AIDS is a different disease for households in Zimbabwe's urban poor communities as compared with what it entails to middle and upper income households. In these communities most breadwinners are not formally employed, and have little or no form of insurance against the catastrophic effects of the disease. The lack of formal employment means that little or no savings characterize the households, which also tend to lack pensions to fall back on should employment end. People Living with AIDS (PLWA) tend to be principal breadwinners in their productive years, with many dependants to take care of (Bollinger et al 1999; Ainsworth and Over 1992). These characteristics of the poor urban household and the characteristic impacts of HIV/AIDS on the breadwinner presents a concerning picture of how households survive and cope with the consequences of the disease.

Households employ a variety of strategies and draw on a complex resource set to cope with illness costs of HIV/AIDS. The study explores what these strategies and resource sets are and how they impact on the household's livelihood. The resources employed and the vulnerability of the households is influenced to a great extent by the characteristics of the community in which the household is located. Thus, when two poor urban communities are compared, one with a higher income profile than the other, PLWA in the same low-income brackets in each community may have different methods of coping and varying degrees of reliance on social resources as coping strategies due to the general income level of the community they reside in. Kawachi et. al. (1997) and Veenstra (2000) suggest that social capital may mediate the relationship between income inequality and health status. By analyzing the complete resource set that households use to cope with illness such assertions can be empirically tested (Russell 2001).

## **1.2 Rationale for the Research**

Zimbabwe, together with many other African countries is faced with a high incidence of HIV/AIDS. The disease has wreaked economic and social havoc in the country; hospital patient numbers and workloads (MOHCW<sup>1</sup> 1999, Hansen et al 1997), absenteeism, unemployment (Bollinger 1999) and orphanhood (USAID 2000) have all escalated as a consequence of this disease.

Much work has been done on assessing the incidence of the disease (Gregson et al 1996), assessing prevention and treatment interventions and the costs of these (Kumaranayake et al. 2000). Macro level studies have been performed to assess the impact on the economy and education (human capital) (Bollinger et al 1999, Cohen 1997, Ainsworth and Over 1992), but little work has focused on how households cope with this illness, and what contributes to the varying degrees of coping between households. The fact that households are losing the incomes of principal breadwinners and incurring spiraling costs of treating the disease in a medical insurance vacuum raises concern. In view of this, this

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<sup>1</sup> MOHCW: The Ministry of Health and Child Welfare of Zimbabwe

study seeks to assess the strategies which households use to deal with the direct and indirect costs of this illness. These strategies involve reliance on the health system, social safety nets, and other tangible and intangible resources. Also of key concern, is the impact of the disease on poor urban households, and what different strategies are employed by PLWA poor in urban communities, which have recognized income differentials.

Many studies on the demand for health care in developing countries have focused on willingness to pay (WTP) and unfortunately equated this with ability to pay (ATP) for health care, paying little attention to the opportunity costs involved in paying for this care (Heller 1982). Paying for care by the poor in many developing countries often involves sacrificing basic needs such as food, and education, and may result in distress sales of productive assets, or indebtedness which compromises the household's already insecure income (Russell 1996). Some work is now being done analyzing household's ability to cope in the context of the tangible and the non-tangible resources that household use to pay for care (Russell 1996, 2001, Wallman and Baker 1996, Sauerborn et al. 1996). It is necessary to investigate a household's ability to pay in terms of its ability to cope with health care costs without entering into "illness induced poverty ratchets" (Corbett 1989).

Households affected by HIV/AIDS in particular, have a limited resource set; this is because the person afflicted with the disease is commonly the principal breadwinner. On top of that, the stigma attached to the disease means that community assistance in the way of friends and neighbours, which is usually present when a household member becomes seriously ill, may be absent or experienced to a lesser extent, when the illness is HIV/AIDS. The costs of the disease are very high, particularly for African economies (Bollinger et al 1999) whose currencies generally tend to be valueless on an international scale (and therefore cannot afford to purchase expensive HIV/AIDS drugs), and whose overstretched health services (Hansen et al. 1997) cannot provide adequate care for PLWA. These factors all contribute to the PLWA not receiving adequate care because they are perceived as "going to die anyway" due to the lack of affordable interventions.

It is therefore necessary to develop holistic measures of ability to pay based on the resource set available to these households. Such measures may inform policy on more affordable health care for PLWA, and foster debate around interventions to support and strengthen these households. It is imperative that policy initiatives are put in place that *enable* the constructive, and *reduce* reliance on the destructive (destitution inducing) strategies which these households may use for survival.

### **1.3 Objectives of the Study**

#### **1.3.1 Summary of Specific Research Objectives**

The paper aims to explore the household impacts of HIV/AIDS, and focus on: costs incurred by households as a direct result of HIV/AIDS; and the interrelationships between the household's coping strategies, the health system and social resources as coping mechanisms. The objectives of the study are:

- 1) To identify the direct and indirect costs incurred by households, and the financial burden imposed on households as a result of HIV/AIDS.
- 2) To outline the methods (coping strategies) adopted by households in order to cope with and minimise the impact of the costs associated with HIV/AIDS.
- 3) Determine the influence and effectiveness of social resources as a coping mechanism and to assess its contribution to improving access to health care (and how cross community differentials in income influence this)
- 4) To develop a conceptual understanding of the methods used by households so as to assess the affordability of health care services, when faced with this chronic illness.
- 5) To direct attention to those factors/structures (which government, Non-Governmental Organisations (NGOs) and donors might support or enable) which protect the poor from high illness costs making them robust against illness cost burdens which tend to cause asset depletions and indebtedness.

These objectives are identified as a means to:

- Assessing the effectiveness of health systems in reaching the poor (urban poor) in the face of health system re-structuring and the HIV/AIDS disease burden.
- Assessing the role that social resources and other material resources play in mitigating the household impact of HIV/AIDS and improving access of the urban poor to health care.

### 1.3.2 General Research Objectives

The identification of the reliance (or lack thereof) of households on the health system and social resources as a means of coping with the impact of HIV/AIDS, is important as it gives policy direction to enforce strategies that strengthen social capital resources and other household resources, so as to strengthen the ability of poor households to cope. The major issues to be addressed by the paper include:

- 1) *Evaluating the economic impact of HIV/AIDS on poor households:*
  - By identifying the direct and indirect costs of HIV/AIDS and,
  - Determining the impact of the disease on household basic needs expenditure
- 2) *Reviewing the provider options available to the households and the resulting cost burdens:*
  - Households' choice of healthcare providers (public/private/traditional), and the cost implications for the household.
- 3) *Evaluating social resources as a coping mechanism for households:*
  - Social resources in the form of relational links, community networks and formal support structures (such as NGOs) are analyzed as a coping mechanism available to households.

#### 4) *Suggesting potential policy responses:*

- These policy responses should be aimed at: protecting poor households from further impoverishment, (either through systems of exemption for healthcare costs, and viable insurance mechanisms), and providing strategic support for affected households through collaborations between all the major actors.

This study is particularly relevant to Zimbabwe. The country has a struggling economy, and a high incidence of HIV/AIDS which is proving to impoverish poor households further and adding strain to the failing health care system (Bollinger et al. 1999). The study is also of particular relevance because great importance is attached to extended family and community support (taking all forms including friends, NGO programmes etc). These links are identified as being crucial aspects of the way in which households cope with the burden of AIDS in this country. The poor economic situation being faced in the country means that it is imperative that those strategies that do not lead to further impoverishment of the disease stricken household should be formally enabled.

### **1.4 Outline of Thesis Structure**

This section presents an outline of the study linking each chapter to the objectives set forth previously. Chapter two presents an analysis of Zimbabwe. This chapter assesses the socioeconomic situation in the country in order to understand the specific context in which the study is performed. A health profile, which analyses health sector reforms, health care providers and financing, together with an overview of the HIV/AIDS situation in the country is included. This chapter is relevant as it helps in assessing the influence of the health system as a resource for PLWA, and gives a sense of the magnitude of the HIV/AIDS problem in the country.

Chapter three provides a review of the literature around coping strategies and in particular social resources as a resource for coping with the costs of illness. In this chapter literature is presented which assesses the usefulness and applications of social

resources as a mechanism for coping with the high costs of ill health. This then informs the conceptual framework and the choice of social resources types chosen for analysis in the study.

Chapter four provides a detailed description of the research methodology. In this chapter the data required to successfully complete the study are set forth. The methodologies employed by other researchers analyzing coping strategies are detailed to inform the decision on appropriate research techniques for such a study. The appropriate research and data collection methodology for a study of this nature in the particular country is then presented and conclude the chapter.

Chapter five presents the results of the data analysis and discusses these results in the context of the research objectives set forth. The demographics of the study sample are assessed; the direct and indirect costs of the disease are analyzed, as are the health care providers frequented by the PLWA. A detailed discussion on resources used to pay for care is followed by an assessment of the coping strategies identified, with particular attention being paid to social resources. In order to assess differences in coping between households in the two communities chosen, most of the results are presented in a comparative context. The conclusions and policy recommendations presented in chapter six complete the study.

## CHAPTER 2: ZIMBABWE - A COUNTRY ANALYSIS

**Chapter Overview:** This chapter provides a detailed analysis of Zimbabwe and sets the scene for rest of the thesis. The chapter begins with a detailed socio-economic assessment of the country, which outlines: the macroeconomic situation; the size of the population; unemployment and per capita income levels; urbanization; poverty; and food security. This is followed by a very brief and concise profile of the country's health system, which includes an analysis of the health care providers, a very brief examination of health sector reforms and financing. The chapter concludes with a detailed discussion on the HIV/AIDS situation facing the country.

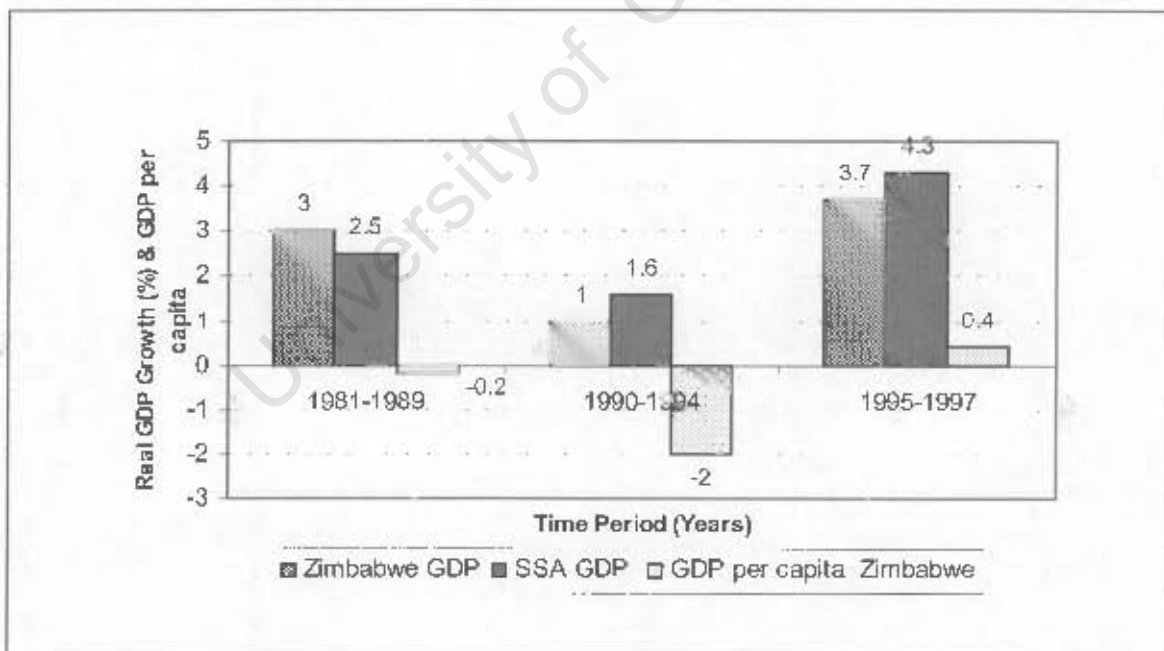
### 2.1 Socio-economic Overview

Zimbabwe is a landlocked country in Sub-Saharan Africa, sharing borders with Zambia to the north and northwest, Mozambique to the east, South Africa on the south, and Botswana to the west. The country is well endowed with natural resources with 8.6 million hectares of potentially arable land and more than 5 million hectares of forests, national parks and wildlife estates (ZDIHS 2000:1). The mineral wealth, arable land and the warm and wet climate explain the economy's bias towards agriculture and mining. These abundant natural resources and the production of agricultural products (tobacco, maize, cotton, sugar and groundnuts) for export earned the country the enviable position of being named the potential breadbasket of Africa in the 1980's and the early 1990's.

The economy has however experienced a rapid decline from being a potential breadbasket of Africa to being a net importer of staple foods. The early 1980's proved to be a stable period for Zimbabwe's economy, with real Gross Domestic Product (GDP) growing at an average rate of 4.3% per annum from the period 1981-1990 despite the effects of exogenous shocks such as a drought and globally low primary product prices

(ZHDR 1998). GDP growth slowed dramatically in the early 1990's to 1% per annum. This decline in gross domestic product is associated with the implementation of the Economic Structural Adjustment Program commonly referred to as ESAP, and coincidental severe droughts in 1991/92 and again in 1994/95. Figure 2.1<sup>2</sup> indicates the trends in GDP for Zimbabwe compared to that of the rest of the Sub-Saharan African (SSA) region<sup>3</sup>. This graph shows that since the 1990's Zimbabwe's economic performance has lagged behind the rest of the region. It is interesting to note, that although GDP over the past two decades grew at an average rate of 4%, population growth was also increasing at a rate of 3% per annum, these figures imply a real per capita income expansion of less than 1% annually from 1980-1998 (see figure 2.1). Further analysis of GDP per head indicates that the 1997 figure (at 1990 prices) of Z\$ 2025 was only Z\$45 higher than the figure 17 years prior of Z\$1980 (HDR 1998).

Figure 2.1: Zimbabwe and SSA Real GDPs, and Zimbabwe's GDP Per Capita



<sup>2</sup> This data is drawn from the UNDP's 1998 Human Development Report for Zimbabwe (ZHDR).

<sup>3</sup> More recent reliable data which allows for such a comparative analysis was difficult to obtain over the study period. The HDR of 2000 focuses on governance and human capital indicators and doesn't present such explicit comparative statistics

The country's current macroeconomic situation as detailed in Box 2.1 is quite grave.

### **Box 2.1 The Current State of the Economy**

"The Governor of the Reserve Bank of Zimbabwe, in his January 2001 monetary policy statement, outlined the problems besetting the economy. The inflation average for 2000 was 55.7 percent, four times the regional average. GDP was forecasted to decline by 4.2 percent in 2000, mainly due to the fall in the performance of mining (-13%), manufacturing (-10.5%) and transport and communication (-14%). The economy is estimated to decrease further by at least 2.8 percent in 2001 and inflation is expected to increase to 70 percent this year. The economy also faces acute balance of payments problems. Investment declined from 23.4% of GDP in 1995 to 13 percent in 1999. Savings fell from 20 to 9 percent of GDP between the same periods." (Government of Zimbabwe (GOZ) 2001)

Prime interest rates are escalating making it impossible for the man on the street to borrow or initiate new business. The well-educated populace are facing unemployment levels of between 40 and 50% (ZHDR 2000), as the economy is not growing fast enough to absorb new entrants into the labour market. Urbanization continues to increase resulting in rising unemployment in the urban areas and increased informal sector activity (King et al 2001). Urban poverty is a persistent problem. According to the 1992 census, 73% of the population in Harare, the capital city, live in high-density areas. Some of these households live on minimum private sector wages of approximately Z\$2500 per month, well below the poverty datum line of Z\$8310 (at June 2000 prices (ZHDR 2000)). Many are informally employed as small-scale vendors with inconsistent incomes and are therefore classified as poor households. Food security<sup>4</sup> has become a major policy issue in the country as the majority of the population is faced with stagnant or no incomes and rising food prices. People's incomes are being eroded by spiralling inflation, with official inflation rates in this hyperinflationary environment, reaching 103.8% *per annum* in late

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<sup>4</sup> The escalating problem of food insecurity is presented in more detail in Chapter 5; specifically in Box 5.1 which shows that the incomes of PLWA interviewed are well below those needed for them to cover their basic needs expenditures.

2001 (King et al. 2001) The country is also faced with declining investments in education. . The rising costs of education to households and the declining public sector allocations to education point to increased future unemployment.

In sum, Zimbabwe is faced with an economic crisis; falling GDP and investment levels are coupled with spirally unemployment, uncontained inflation rates, and increasing food insecurity. On top of all this the country is faced with an HIV/AIDS endemic which is further inflating its economic woes. This is detailed in the following section which provides an overview of the country's health sector and HIV/AIDS situation.

## **2.2 Health Sector Overview**

### **2.2.1 Introduction**

An examination of the post independence health status indicators, and the policies of the Ministry of Health (MOH), reveals statistics which correspond with most other sectors in Zimbabwe's economy – a brief period of improvement in the first post independence decade followed by a decade of decline attributed to policies instituted in line with the economic reform program and drought. This introduction provides a concise background of the trends occurring within the health sector in order to set the stage for the rest of the analysis of the health sector which provides an overview of the health sector over the more recent years to date. This is necessary in order to understand what is at the heart of this study: issues around access to health care for PLWA.

At the onset of independence, the MOH under the new government set about redressing the inequalities of the past colonial era by instituting policies aimed at achieving equity in health. The two pronged approach which was established in order to achieve this goal, consisted of an application of WHO's primary health care (PHC) concept, and the provision of free treatment for anyone earning below the Z\$150 per month threshold (Naidoo et. al 1996). In order to implement this strategy of primary health care for all, the Ministry of Health garnered the operation and costs of all local health services, including

those held under the auspices of religious missions to form an integrated and centralized Ministry of Health. Public health initiatives such as malaria and tuberculosis control were decentralized to provincial and district health levels. Further reforms in the structure and functioning of the Ministry are dealt with in slightly more detail in section 2.2.4 under Health Sector Reform.

This post independence era saw great strides being made in the country's public health arena including: greater investment in the Expanded Program on Immunization (EPI); and the provision of water and sanitation to the poorly serviced black communal areas - both rural and urban. Other important initiatives included the education of mothers on basic primary health care such as Oral Rehydration Therapy (ORT) for infant diarrhoea; and the control of drug use by limiting use to the WHO (World Health Organization)-recommended Essential Drug List (EDL) (Hongoro and Chandiwana 1994; Naidoo et. al 1996). These efforts to improve the health status of the general population by adopting a Primary Health Care (PHC) approach focusing on preventative and promotive rather than curative care resulted in some noteworthy successes such as reduced child mortality rates, increased life expectancy, and improved access to water and sanitation. These successes are summarized in Box 2.2, with Box 2.3 providing a useful health profile of the country.

**Box 2.2 Post Independence Achievements in the Health Sector**

“The country achieved tremendous progress in extending health care programs and facilities to the rural and urban populations. As a result of this expansion, 85% of the population now lives within eight kilometres of a health facility. Life expectancy at birth increased from 56 years in 1980 to 61 in 1990. During the same period the infant mortality rate fell from close to 100 to about 66 deaths per 1000 live births. Weight for age malnutrition in children under three years fell from 22% to 16% and the percentage of fully immunized children rose from 25% in 1980 to 77.9% in 1991” (MOHCW 1999:1).

### Box 2.3 A Health Profile

According to the Central Statistical Office (CSO) the country's population is growing at a rate of 3.4% per year between 1992 and 2002 (UNDP, 1998), reaching a projected 14 million (14 275 513) by 2002, using the 1992 census results CSO (2001). Life expectancy at birth has declined dramatically from 61(1992), to 57(1997) to 44(1998) (CSO and Macro International, 2000). This decline has been attributed to the ravages of the HIV/AIDS epidemic. The population still exhibits a rather high dependency ratio with 87 persons in the dependent age for every 100 persons of the working age (1999 figures) (CSO and Macro International 2000) which is however an improvement from the 1994 figures of around 100%. Mortality rates have shown an interesting trend; the post independence period of the 1980's showed remarkable improvements in child mortality, due to the government's investment in primary health care and vaccinations programs. The figures for the 1990's reveal a worrying increase in child mortality from those of the previous decade. This has been attributed to the country's worsening economic situation and the HIV/AIDS epidemic. There continues to be a marked difference between the child mortality rates of children coming from different socio-economic backgrounds, notably higher rates among poor urban families, than rich urban families and higher rates in rural families compared to urban families.

### 2.2.2 An Examination of Health Care Providers

Government facilities provide health care for most of the population. The provision of care is fairly decentralized with Primary, Secondary (district and other referral hospitals) Tertiary (2<sup>ND</sup> referral) and Quaternary (Central –3<sup>rd</sup> referral) hospital levels (MOHCW 1998). The institution of user fees means however, that many people cannot afford even the most basic care at a primary clinic. Consultations at a polyclinic per symptom presented cost the user Z\$120, and an outpatient consultation requires the purchase of a hospital card costing Z\$300<sup>5</sup> at Central Hospitals. Long stays in hospitals inevitably

<sup>5</sup> The consultation fees of Z\$300 for Central Hospital cards, and Z\$120 for Polyclinics, are recorded as such in a schedule of fees and charges published by the MOHCW (2001), however interviews with several PLWA and key informants reveal that patients are being charged at inflated fees of Z\$579 and Z\$130 for consultations at Central Hospitals and Poly clinics respectively.

result in bills running into the thousands and often require some form of prepayment. These fees make health care unaffordable for the majority of Zimbabweans, many of who earn the minimum wage<sup>6</sup> and below if they are in the informal sector. Although there is a very strong private sector<sup>7</sup>, only the high-income earners can afford the use of these services as a single consultation with a doctor in the private sector costs approximately Z\$2000. The private sector has a great deal of human resource capacity employing 1000 of the 1600 registered medical practitioners, and 8000 of the 15000 registered nurses (MOHCW 1999). NGOs provide limited and specific health care such as provision of basic health care to the poor and those afflicted by particular and neglected diseases such as AIDS. Traditional healers are also an important provider of health care.

### **2.2.3 Health Care Financing**

Health care is mostly financed by tax revenues in the form of allocations from the budget; user fees constituent an insignificant supplement to these finances. Government health expenditure in the first decade of independence reached 3.1% of GDP and accounted for 6.2% of total government spending in 1990/1991(US\$23.6 per capita). There has been a drastic reversal of this trend with expenditures representing only 2.2% of GDP and 4.2% of total government spending in 1995/1996. The more recent figures are even more alarming; the MOHCW's budget of Z\$3.7 billion for 1999 is equivalent to an expenditure of less than US\$10 per capita (MOHCW 1999). This financial austerity coupled with the added demands placed on the health system by HIV/AIDS related illnesses and the high costs of medical staff retention have resulted in the burden of financing health services being shifted from government into the hands of the individuals (MOHCW 1999). Donor funding, though a diminishing source of funding, is an important source of finance. The government also indirectly partly finances the private provision of care by allowing the treatment of contributions to Medical Aid Schemes as tax deductibles.

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<sup>6</sup> The minimum wage was Z\$5100 per month in 2001 (King et al. 2001) (US\$1=55 official rate, and US\$1=300 parallel market)

<sup>7</sup> "Of the total national expenditure on health, about 50% is private spending by the approximately 30 Medical Aid Societies" (MOHCW 1999:77)

#### **2.2.4 Health Sector Reform**

The early post-colonial era (early 1980s) saw the implementation of health sector reforms, which were geared towards redressing the inequities inherited from this era. The Government of Zimbabwe (GOZ) instituted free care for anyone earning below Z\$150 per month (about US\$ 150 at the time). These individuals (almost 97% of the population) were entitled to free care in the public sector. Other reforms at the time were aimed at strengthening the MOH, so as to enable it to administer care to the majority of Zimbabweans who had previously remained out of its ambit. Around 1985, policies were instituted to decentralize the functioning of the MOH, with the establishment of provincial and district health organization. In 1991 policies for cost recovery through user fees were implemented as a condition for aid under ESAP (Naidoo et al 1996). Currently the MOHCW is working under a "National Health Strategy 1997-2007." The major priorities under this plan being: the improvement of the quality of health services; the development of a sustainable human resource plan; the strengthening of the health system based on decentralization and community involvement; addressing equity issues; and the coordinated mobilisation and effective use of financial resources. Other key issues being targeted are: strengthening the prevention and control of HIV/AIDS and Sexually Transmitted Infections (STI) and promoting methods to mitigate their impact. The section which follows provides a detailed analysis of the impact of HIV/AIDS in Zimbabwe.

### **2.3 HIV/AIDS in Zimbabwe**

#### **2.3.1 HIV/AIDS - A Catastrophe in Sub-Saharan Africa**

HIV/AIDS is no longer an impending calamity whose size and effects can only be estimated by mathematical projections; it is a real, immediate and mutating catastrophe in Sub-Saharan Africa (SSA). What follows in Box 2.4, preceding the comprehensive discussion of AIDS in Zimbabwe, is a brief but informative overview of the extent and impact of the AIDS epidemic in the Sub-Saharan region.

#### **Box 2.4 AIDS in Sub-Saharan Africa: A Real and Immediate Catastrophe!**

Recent figures from a UN (United Nations) (2001) report show that HIV/AIDS is truly a catastrophe for SSA. The number of adults (adults: 15-49 age group) and children living with HIV/AIDS stands at 28.1 million (using 2001 population figures) in Sub-Saharan Africa. This is more than half of the global population (40 million) of AIDS sufferers. Slightly more than half (55%) of these HIV positive people are women. Of the 5 million new infections and the 3 million AIDS deaths recorded in 2001, 3.4, and 2.3 million respectively were recorded in SSA. Sadly almost 50% of all new infections are women and about 50% are 15-24 year olds.

#### **2.3.2 The HIV/AIDS Problem in Zimbabwe**

The HIV/AIDS epidemic has been escalating, and has had a profound impact on Zimbabwean households, and the economy as a whole. By 1995, nearly 52000 cases had been reported (NACP 1995), but due to extensive under reporting the actual figure at that time was estimated to be three times this number. Gregson et al. (1996) in their study<sup>8</sup> of HIV prevalence in the rural areas of Zimbabwe recorded prevalence levels in the range of 15-35% (for women aged between 25-29). Other studies recorded a national prevalence rate estimated at between 20-25% during the same time period (NACP 1995). Projections made for the year 2010 estimate that 50% of rural women in the 15-50 age band will be infected (Gregson et. al. 1996). More recent statistics obtained from voluntary testing sites in urban areas estimate the incidence of HIV to be approximately 22% in urban areas<sup>9</sup>.

Other recent data<sup>10</sup> show that AIDS is no longer an impending calamity but an immediate catastrophe: an estimated 1.8 million people in the country are living with the disease, the

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<sup>8</sup> HIV-1 prevalence data for this study was collected from local antenatal clinics; most official prevalence data for the country is collected in this manner.

<sup>9</sup> These statistics only reveal the percentage of those who came forward for testing and were tested positive for HIV at these testing sites. These statistics were obtained from NEWSTART testing centres an initiative of USAID.

<sup>10</sup> This data was obtained from an Aid organisation, from documents which were not yet official at the time of sourcing the data.

disease accounts for 60-80% of deaths among adults aged 15-49 and a shocking 2400 AIDS deaths are recorded per week. With the prevalence rate standing at 36%, it is estimated that by 2010 1.5 million people will have died from AIDS. As Bollinger et al (1999: 3) correctly asserts, the disease creates severe economic impacts for African countries especially since unlike most diseases “it strikes people in the most productive age groups and is essentially 100% fatal.” The major effects of the disease are a reduction in the labour supply and increased direct and indirect costs (see Box 2.5).

#### **Box 2.5 The Possible Effects of HIV/AIDS**

In assessing the future impact of HIV/AIDS epidemic, Bollinger et al. (1999) made the following projections:

*“The effect on labour supply:* The loss of young adults in their most productive years will affect overall economic output. If AIDS is more prevalent among the economic elite, then the impact may be much larger than the absolute number of AIDS deaths indicates.

*The effect on costs* The direct costs of AIDS include expenditures for medical care, drugs and funeral expenses. Indirect costs include: lost time due to illness; recruitment and training costs to replace workers; and the costs of caring for orphans. If these costs are financed out of savings, the reduction in investment could lead to significant reduction in economic growth” (Bollinger et al 1999: 3).

The economic impact of AIDS is certainly felt first by the individual and their family, and then ripples outwards to firms, the health sector and the macro economy. In order to understand the severity of the AIDS problem in the country this section outlines the impact of the disease at each of these levels.

### 2.3.3 The Effect of HIV/AIDS on Zimbabwean Households

AIDS has had a devastating impact on Zimbabwean households. These impacts usually involve: the loss of the principal breadwinner's income; increasing household expenditures for medical expenses; intra household substitution of labour as household members (usually female) miss school or lose time from work in order to care for the sick person. Other costs include: the costs of death including funeral and mourning costs; the removal of children from school due to lack of funds; increasing dependency ratios due to caring for AIDS orphans, and families being headed by children. Box 2.6 provides a brief summary of these effects.

#### **Box 2.6: AIDS Takes its Toll on Zimbabwean Households**

In 1995, a large percentage of the population lived below the national total consumption poverty line of Z\$ 2132.33 with a bed ridden AIDS patient adding an additional burden of US\$23-34 per patient per month. (Bollinger et al 1999). The hyperinflation experienced in the years since 1995 points to reduced real incomes and substantial increases in the financial costs of caring for an AIDS patient per month. Any additional expenditure by low-income households on transport, and medical costs means cutting down on food. Funeral costs of over Z\$4500 add additional financial pressure resulting in higher dependency ratios, reduced labour, and rapid impoverishment. On top of these extreme financial burdens most households lose their material belongings when the principal bread winner dies, as many widows have no legal documents to protect them from their husband's relatives claiming the family belongings. Orphans are another unfortunate result of the disease with many households having to look after at least one orphaned relative, and in extreme cases households become headed by children. "Close to one in 4 rural households are already fostering one or more children that are not biological children of either parent(s)" (Bollinger et al 1999:5). Orphans are a specific case in point: it was estimated that by the year 2000, 670000 children (that is one in 6 children under 18) will be maternal or double orphans due to AIDS (NACP 1995), and that this figure will peak at 1.2 million by 2005 (33% of children under 15) (Hunter and Williamson 2000). It has been recognized that orphans place a heavy burden on the extended family, resulting in the rapid erosion of extended family resources; who are commonly seen as social sponges with an infinite capacity to soak up orphans (USAID 2000).

Although the focus of this study is the impact of HIV/AIDS on the household, it is also important to understand the impact on the health sector and the macro economy. This provides a holistic view of the potential coping mechanisms available to be utilized by households within the country context. The remaining sections of this chapter assess the impacts of the disease on the health sector and the macro economy.

#### **2.3.4 HIV/AIDS and The Health Sector**

AIDS also has a harsh effect on the health sector. Although the disease impacts the health system in many ways, in sum AIDS affects the health system in two major ways.

Firstly, the disease increases the burden on the already over-burdened health services as more and more people seek care for a multitude of AIDS related ailments. Secondly, AIDS interventions are generally more expensive than interventions for other diseases (Kumaranayake et al. 2000).

The result is that governments are forced to make tradeoffs and these involve: deciding whether to treat AIDS versus preventing HIV Infection; treating AIDS versus other illnesses, and spending for health versus spending for other objectives (Bollinger et al. 1999). The private sector has also felt the devastation of the epidemic with claims spiraling due to increased General Practitioner (GP) and hospital visits and patients' increased drug requirements. Box 2.7 depicts the calamity faced by the Zimbabwean health sector as a result of AIDS.

### **Box 2.7 AIDS takes its Toll on the Zimbabwean Health Sector**

It has been shown that in Harare's State Hospitals, more than 50% of the patients are AIDS patients. These patients cost more per stay, and also stay longer in hospital than non-AIDS patients. The total cost per stay in Parirenyitwa (Provincial Hospital for Harare) for an AIDS patient (Z\$3033.40) was almost double that of a non-AIDS patient (Z\$1800) for the period July 1994-June 1995 (Charamba 1996). Bed occupancy rates in 1994/5 in the two major referral hospitals in the capital city ranged between 72-95%, with over 70% of patients admitted being diagnosed with an underlying HIV infection (Hansen et al.1997). Home based care was perceived to be a viable alternative to hospital care which was crippling the already over extended hospital system, until studies suggested that it too was unaffordable. A few home care programs cost even more than hospital care; some studies have shown that the cost of one home visit can be almost equivalent to 1-3 days in hospital (Bollinger et al 1999). The general consensus however is that most programs do not cost that much. Hansen et al (1997) assert that the cost of a home visit in two urban programmes studied was estimated to be Z\$129(US\$16) in one, and Z\$183(US\$23) in the other, and for rural programmes the cost ranged from Z\$313(US\$38) to Z\$343(US\$42) (US\$1=Z\$8.2 at 1994 rates). A significant proportion (56-76%), of this cost was attributed to the cost of getting to the patient (Bollinger et al. 1999, Hansen et al 1997). The private sector is also hard hit recording the average direct costs for an AIDS case as US\$309.50 in 1994, US\$429.80 in 1995 and US\$722 in 1996 (Average Rate US\$1=Z\$9) (Bollinger et al 1996; Hore 1997). At the end of 2001 antiretrovirals (ARVs) were costing between US\$1993-4049 (Key informant interview) and were thus out of the reach of many PLWA, and also could not be provided by the public health sector.

### **2.3.5 HIV/AIDS and The Macro Economy**

The macroeconomic impacts of the disease can include the following (Bollinger et al 1999, Ainsworth and Over 1992, UNAIDS/World Bank 2001): A reduction in the number of trained experienced and thus productive workers; higher domestic production costs and loss of international competitiveness and foreign exchange shortages; the potential loss of skilled teachers resulting in decelerating human capital formation; and reduced worker productivity and investment leading to fewer jobs in the formal sector.

Many of these effects are already taking their toll in Zimbabwe. The poor performance of the economy is however the result of many other factors including poor governance, and inappropriate economic policy and not solely AIDS (ZHDR 2000). Box 2.8 outlines the predicted macroeconomic impacts of the disease on the economy.

#### **Box 2.8 AIDS Takes its Toll on the Zimbabwean Economy**

Statistical projections performed by the UN (Cohen 1997) point to: the infant mortality rate doubling; the child mortality rate quadrupling; and the crude death rate rising by over 6 times by the year 2010. Life expectancy is expected to decrease from 70 to less than 35 years, and an overall population decline of 0.5% is expected by the year 2010. Early projections from a macroeconomic model found that the need for foreign assistance would increase by 27%, or about Z\$575 million, by the year 2000. In the absence of increased foreign resources, per capita income will become significantly lower, falling from a baseline level of Z\$1607 to Z\$1573. This study also projected that medical costs would increase from US\$1.6 million in 1991 to US\$8.1 million in 2000, if lifetime costs are assumed to be Z\$1000 (US\$292) per case. Due to the worsening economic conditions latest figures show that these projections are not too far off, and in some cases have been exceeded, as shown in Box 2.1 which details the current state of the economy. Box 2.7 (shown previously) shows that the medical costs by are considerably higher than estimated in the predictions presented above by Cohen (1997).

**Chapter Summary:** This chapter provided an assessment of the socioeconomic environment in Zimbabwe. This analysis detailed the developments of the economy from independence in the early 1980's and culminated in a bird's eye view of the current state of the economy. An overview of the health sector and the impact of HIV on households, the health system and the macro economy result in a comprehensive appraisal of the environment in which PLWA in Zimbabwe have to survive. A struggling economy epitomized by hyperinflation, high unemployment, escalating food insecurity, a shrinking and poorly resourced public health sector and spiraling health care costs; it is against this

backdrop that the coping strategies employed by PLWA will be evaluated. Chapter 3, which follows, presents the literature review.

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## CHAPTER 3: LITERATURE REVIEW

**Chapter Overview:** The preceding chapter served to provide a necessary contextual understanding of the socio-economic situation in Zimbabwe, the state of the health system and the HIV/AIDS situation. The introductory chapter outlined the research problem, rationale for the study and the objectives of the research so as to direct the study. This chapter outlines the underlying theory of the study through the literature review, which then informs the conceptual framework and methodology.

### 3.1 Introduction

The aim of this review is to evaluate the literature available around the fundamental theories underpinning this study. The review includes:

1. A brief review of literature on poverty and access to health care resources, and ability to pay for health services. (Objectives 1 and 4)
2. Coping strategy literature: this literature presents a conceptual analysis of coping strategies in order to gain an understanding of the resources that households mobilize in attempting to minimize the impact of household livelihood shocks such as HIV/AIDS. (Objectives 2 and 3)
3. Social capital literature: this literature presents a conceptual overview of social capital as part of a household's livelihood and asset framework and discusses its use as an intrinsic component of a household's mechanism for coping with livelihood shocks such as HIV/AIDS (objective 3)

4. A summary of the literature reviewed, and the household livelihood set as a means of assessing household's ability to cope with a chronic illness such as HIV/AIDS.

### **3.2 Income Inequality, Access to Health Care and Ability to Pay**

Studies in the field of access to health care and income inequality have consistently shown that low-income households have poor access to health care resources. Results have shown that although lower income groups have less income to spend on health care than their more privileged counterparts, they often spend a greater proportion of their incomes on care due to their inability to contribute to medical pre-payment schemes (Pannarunothai and Mills 1997). It has also been shown that poor health causes low income, and that persistent poverty is more harmful to health than occasional episodes of poverty, and that income reductions have a more significant effect on health than income increases (Benzeval and Judge 2001).

It has been widely accepted that willingness to pay (WTP) and ability to pay (ATP) for health care are not synonymous terms (Russell 1996). Empirical work has clearly indicated that households may be willing to pay for care by mobilizing a range of resources at their disposal in order to cover these costs. However, because the mobilization of these resources may include the sacrifice of basic needs such as food and clothing, health care is essentially unaffordable to these households as they are clearly not able to pay without impoverishing the individuals in the households (Russell 1996). Wallman and Baker (1996) document a variety of formal and informal resources that households employ to pay for treatment. Responses to illness costs may include: borrowing, delaying treatment, and distress sales of productive assets that may impoverish and make households more vulnerable to increased poverty (Russell 1996). This study looks at the resources used by poor urban households in dealing with the chronic disease, HIV/AIDS. It is proposed that a household livelihood approach which considers the resources used by households, and the effects of these on the household, as

a more appropriate measure to determine whether households are in fact, able to pay for care and essentially survive when faced with this chronic illness.

### **3.3 Coping Strategies - A Review of the Concepts**

The concept of coping strategies evolved from extensive literature on household responses to food shortages during the famines experienced in the Sahel and Horn of Africa in the 1980's. Coping strategies are identified as "the bundle of poor people's responses to declining food availability and entitlements in abnormal seasons or years." (Davies 1993:60).

Coping in its strictest sense is "a short term response to an immediate and inhabitual decline in access to food." (Davies 1993:60) Permanent changes in the way in which food is acquired, or permanent changes in the livelihood and rule systems are defined as "adaption." (Davies 1993). Gore (1992:16) adds further clarity by distinguishing coping as "acting to survive within the prevailing rule systems." This distinction is important as coping strategies are the methods used by households to deal with livelihood and income shocks *within* the set of prevailing fundamentals as opposed to those strategies which adapt these rule systems to meet the livelihood needs of households.

The identification and documentation of the types of coping strategies employed by households during these famines became important for two reasons. Firstly it was a means of monitoring food security since a proliferation of these strategies could be considered an indicator of imminent famine (Famine Early Warning System (FEWS)). Secondly it served as a guide for instituting policies which enable rather than undermine those strategies which strengthen household's food security (Davies 1993). The latter is of prime importance in this thesis.

Davies' definition of coping mentioned above, very importantly not only focuses on declining food availability but also on entitlements. Sen's (1981) "entitlements theory"

lies at the very heart of all literature on coping strategies. This is because the strategies employed by households in response to food crisis are determined by the “entitlement set” (Sen 1981). A household’s entitlement set includes (Russell 2000):

1. The labour and land assets that it owns (or ‘endowments’);
2. The direct food entitlements these produce (through own production of crops or livestock); and
3. The money these endowments and direct entitlements can be exchanged for, which can then be used to purchase other commodities (exchange entitlements).

The goods and services, which a household can access through government provision, for example food subsidies, health care and education, also fall into the grouping of a person’s or household’s entitlement set. “Extended entitlements” – well-established conventions and social relations that enable people to make claims are an important inclusion in the entitlement set (Dreze and Sen 1989).

Illness like famine can be viewed as a livelihood shock, which can break down a household’s asset base causing it to plummet into illness induced destitution, poverty and vulnerability - resulting in a “poverty ratchet” (Chambers 1997). While the focus has been on coping strategies in relation to food insecurity, the literature, although it is still limited, has begun to expand and consider how households cope with ill health, examples being Pryer (1989), Sauerborn, Adams et al (1996), Sauerborn, Nougara et al (1996), Corbett (1989) Chambers (1989) and Russell (2001).

The entitlement set theory presents a useful and plausible alternative to assessing a household’s ability to pay for health care Russell (1996). This concept combines all the assets, commodities, incomes and extended entitlements that a household has command over to assess a household’s ability to cope with illness as opposed to merely focusing on demand for care as an indicator of ability to pay. Using this formulation, households can be assessed and their ability to cope analysed by determining whether illness increases vulnerability and impinges on a household’s ability to sustain its livelihood. Demand-

based studies work on the assumption that if a household demands care it is able to cope with the costs of care, without looking at the damaging effects that paying for care may have on poor and vulnerable households; it may lead households into a poverty ratchet that depletes their entitlement set. Of key importance is the use of extended entitlements; the inclusion of these allows an analysis of how non-material resources, especially institutions provide access to health care through entitlements and social relations - the social capital mentioned previously.

Sen's (1981) entitlement theory motivated further work by various development economists and sociologists: assessing household vulnerability to livelihood shock induced destitution (Corbett 1989, Chambers 1989); the choice of sequencing strategies in response to production and income shocks (Devereux 1993); refinements and extensions of the asset bases that households have at their disposal (Swift 1988); and shifting the focus from the rural poor to understanding the "complex asset portfolios" that the urban poor utilize (Moser 1998).

Corbett (1989) synthesizes the relationship between household vulnerability and the economics of coping with sickness. The analysis breaks down the possible economic effects of ill health (lost income, reallocation of work and domestic responsibilities, distress sales of assets, indebtedness and increased dependency ratios) and argues that these negative effects are exacerbated in vulnerable households, which tend to have little or no insurance against such eventualities. Chambers (1989) augments Corbett's (1989) work by distinguishing between vulnerability and poverty and emphasizing the potential of illness to further impoverish (make more vulnerable) resource-poor households. Both these authors argue that "vulnerability more than poverty is linked with net assets" (Chambers 1997:1), and that poverty ratchets result from increasing vulnerability to livelihood shocks due to dwindling social and tangible capitals. Chambers also hypothesizes that sickness related poverty ratchets might be on the increase since allopathic treatment is becoming more widely available in developing countries but at a high cost (Chambers 1989).

urban households. In the study by Moser (1998) of four urban areas, she identifies the poor as being “managers of complex asset portfolios” specifically *tangible assets* (labour, human capital and housing) and *intangible assets* (household relations and social capital) and emphasizes that labour is the most essential asset available to the poor. The next section analyses one particular asset in this asset framework - social capital, which has been identified as one of the assets which improves a household’s access to health care.

### 3.4 Social Capital - A Conceptual Review

Building a framework that captures the various resources and strategies that households employ to gain access to care and sustain themselves in the face of various income shocks (illness, famine), involves analyzing a household livelihood set which encompasses physical, social and financial resources. This is in line with the broad typology of assets belonging or available to a household as discussed previously (Sen 1981, Moser 1998, Davies 1993, Bebbington 1999 and Swift 1988). Social assets in particular have been widely recognized as important means by which households gain access to health care resources, and/or try to mitigate the impacts of health care costs (Wallman and Baker 1996, Rose 2000, Cattell 2001). The discussion on social capital is pertinent for understanding and informing the inclusion of it in a framework for analyzing the resources and strategies that households utilize when dealing with the income shock that AIDS frequently creates in Zimbabwean households. The discussion is structured as follows:

- A synopsis of the theoretical underpinnings of social capital based on literature written by principle theorists, and a brief overview of its application across the social sciences.
- An outline of its application in the economics of health and in particular as is relevant to this study, its influence on access to health care, and the relationship between social capital, income levels, inequality and health care.

- The discussion cumulates with a concise summary of the character of the social capital to be assessed in this study, which informs the conceptual framework that follows.

### 3.4.1 Social Capital – What is it?

The concept of social capital has been gaining popularity in the development economics, political and public health fields but there still remains a great deal of ambiguity around its meaning and application. There are a myriad of definitions, which have been put forward by its principal theorists, encapsulating the concept of social capital (Bourdieu 1985, Portes 1988, Coleman 1988, Putnam 1995). The definitions need careful analysis as their different meanings have implications for the methods applied to empirically assess social capital in the different social sciences. The following analysis of the different definitions is particularly important in this study, as it informs the levels and types of social capital to be included in the conceptual framework that directs this study.

Bourdieu (1985:248), the “father” of contemporary writing on social capital identifies it as “the aggregate of the actual potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition.” Bourdieu (1985), argues that social capital consists of both the social relationship itself, which gives claim to access to resources possessed by others, and the actual amount and quality and type of these resources. As an example: through social capital, actors can gain direct access to economic resources (subsidized loans, investment tips, and protected markets such as the market for antiretroviral drugs in Africa) (Portes 1998:3). Loury (1977), also attributed differentials in access to opportunities in the labour market to lack of social connections thus alluding to the concept of social capital.

Coleman (1988) extends this definition and presents one of the most comprehensive analyses of the concept by clearly defining the term, distinguishing between the different forms of social capital, and describing the social structures that facilitate some of the different forms of social capital. His rigorous refinement of the concept allows for

empirical applications of the concept. Coleman (1988:S98) presents social capital, as a “particular kind of resource available to an actor” which exists in the *relationships* between individuals:

***“Inhering in the structure of relations between and among actors, it is thus not lodged in the actors themselves or in physical implements of production... but exists in the relations among persons and comes about through changes in these relations among persons that facilitate action”(Coleman 1988:S98, S100)***

Coleman conceptualizes three different *forms* of social capital namely:

- ❑ Obligations, expectations, and trustworthiness of structures
- ❑ Information channels
- ❑ Norms and effective sanctions

And the *social structures* that facilitate social capital are

- ❑ Closure of social networks
- ❑ Appropriable social organization.

In sum, this definition identifies three functionally different forms of social capital, the facilitating social structures, and most importantly the fact that it is a productive resource belonging to *individuals*. It is extremely important as it allows for an individual/micro-level and also macro level empirical analysis of the concept thus providing:

***“An aid in accounting for different outcomes at the level of the individual...the concept of social capital allows taking such resources and showing the way they can be combined with other resources to produce different system level behaviour or, in other cases, different outcomes for different individuals...something of value has been***

*produced for actors who have this resource available and that value depends on social organization.”(Coleman 1988:S101)*

The most notable application of this definition is Coleman’s (1988) work which empirically promotes the idea that social capital is essential in promoting the creation of human capital. This is a view shared by Sen (1997) who also argues that social capital is essential in human capital and capability development.

Putnam (1995:2) refers to social capital as “features of social organization, such as trust, norms, and networks, that can improve the efficiency of society by facilitating coordinated actions” Using Putnam’s definition of social capital as inhering within groups as opposed to inhering within individuals (Coleman 1988) it becomes possible to consider the relative stocks of social capital within a community, for example by levels of involvement in voluntary organizations. This view of seeing social capital as a “feature of social organizations such as networks, norms, and trust, that facilitate action and cooperation for mutual benefit” Putnam (1995:2) makes for an interesting conceptual twist. This definition which conceptualises social capital as a feature of social organisation that facilitates action rather than accruing to individuals because of their insertion into networks or broader social structures (Portes 1998), has allowed for progressive empirical analysis of the concept by many social scientists (Kawachi 1997, Narayan 1999). It has to be dealt with carefully though, because its application may suffer from the problem of “logical circularity” (Portes 1998: 19). This problem could arise because when social capital is viewed as a property of communities and nations rather than individuals, social capital can be both a cause and an effect. An example of this is considering a community which is “civic” as doing civic things, and a community that is “uncivic” as doing “uncivic” things (Portes 1998)<sup>11</sup>. This inability to separate the cause and effect of social capital in societies can lead to incorrect inferences in empirical work. Putnam’s work has prompted a substantial amount of work on social capital and governance in communities (Beall 1997, Petro 2000, Krishna 2001). Being aware of this

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<sup>11</sup> Portes (1998) uses this example to show the logical circularity problem inherent in Putnam’s (1995) definition of social capital. Using this definition social capital can be viewed as both a cause and an effect.

potential problem, the conceptual framework and the methodology detailed will specify the relationship to be measured between communities and the levels of social capital.

Portes (1998) adds clarity to Coleman's (1988) conceptualization of social capital by differentiating between the mechanisms that generate social capital and the consequences of its possession. Coleman's (1988) definition of the term, its different forms and the necessary social structure that facilitates the different forms, embody both the sources and effects. Portes (1998:5) argues that it is important to distinguish the resources themselves from the ability to obtain them by virtue of membership in different social structures. The sources and consequences identified are summarized in Table 3.1.

**Table 3.1 Summary of Sources and Effects of Social Capital**

Sources:	Effects:	
	Positive	Negative
<ul style="list-style-type: none"> <li>□ Value introjection<sup>12</sup>;</li> <li>□ Bounded solidarity<sup>13</sup></li> <li>□ Reciprocity exchanges</li> <li>□ Enforceable trust</li> </ul>	<ul style="list-style-type: none"> <li>□ Source of social control (Norm observance)</li> <li>□ Source of family support</li> <li>□ Source of benefits through network mediated benefits</li> </ul>	<ul style="list-style-type: none"> <li>□ Restricted access to opportunities</li> <li>□ Restrictions on individual freedom</li> <li>□ Excessive claims on group members</li> <li>□ Downward levelling of norms</li> </ul>

(Adapted from Portes 1998: 8)

<sup>12</sup> Value introjection: refers to value or norm introjection during childhood.

<sup>13</sup> Bounded solidarity: refers to social capital that is an emergent product of peoples with a common fate; actors in this instance are "bounded by the limits of their community" (Portes 1998: 8)

### 3.4.2 Social Capital: More Key Features

Thus far the discussion has detailed the importance of the different levels and forms of social capital as identified by principal theorists. Of key importance also, is the density of the relationships, that is the extent to which actors are integrated into their networks (Woolcock 1998; Evans 1996; Hawe and Shiell 2000).

Two terms have been developed to describe the different extents of social relations: “*embeddedness*” and “*autonomy*.” Hawe and Shiell (2000) state that embeddedness at the *micro* level refers to dense intra-community ties or the extent to which individual members are integrated into their networks, while autonomy refers to an individual’s looser, extra community ties or the freedom they have to interact with others outside of the immediate grouping (the strength of *linking* ties). At the *macro* level the terms imply slightly different things: embeddedness refers to state-society connections, or the extent to which there is synergy between the state’s actions and the interest of the populace; autonomy deals with the capacity of institutions and organizations to act independently, free from the influence of vested interest – termed “*integrity*” by Woolcock (1998).

This detailed illustration of the principal ideas conceptualizing social capital shows that it is impossible to answer the question “what is social capital” with one idea. Hawe and Shiell’s (2000) review of social capital succinctly captures this somewhat schizophrenic nature of the term:

***“Social capital is not ‘one thing’. It has relational, material and political aspects and it may have positive or negative effects. It can refer to both dense and loose networks and it takes on a different form depending on whether one is concerned with the individual***

*and his or her immediate group membership or the interaction between social institutions”* (Hawe and Shiell 2000:873).

Armed with an understanding of the complex concepts encapsulating the term “social capital,” it is now useful to assess how it is applied in health policy and pinpoint specific studies on health and social capital which are able to inform this study, which analyses the resources available to AIDS stricken households.

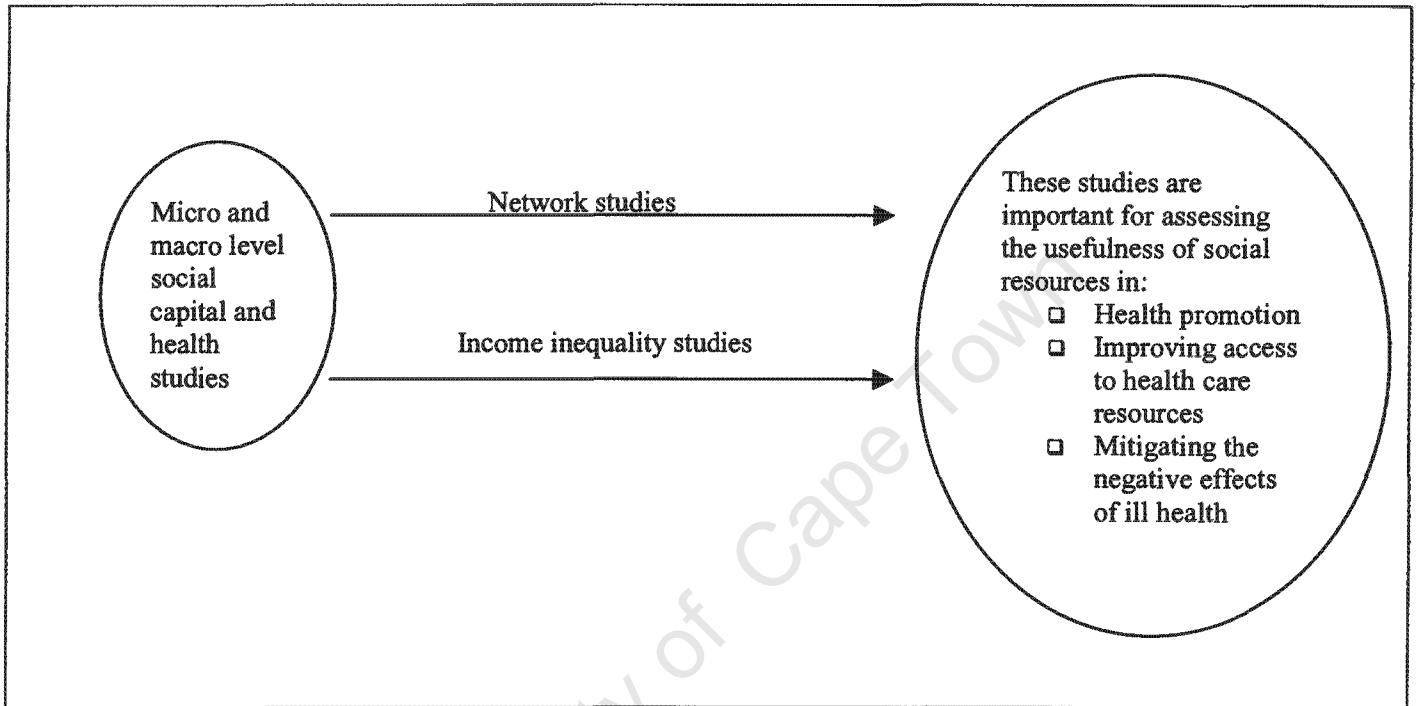
### **3.4.3 Health and Social Resource Studies**

Literature on social capital and health has mainly focused on how the levels of social capital influence the health status of a whole community. The relationship between social and economic factors and health has been well researched. The above discussion of the different forms and applications of social capital suggest that there are a variety of ways of analyzing the inter-relationships between social capital and health. Many studies have looked at the relationship between social capital, income inequality and health, others have looked at social network structures and functions and their influence on health. Figure 3.1 which follows, conceptualizes the types of studies and their contribution to health policy. Table 3.2<sup>14</sup> which follows pinpoints specific health and social capital studies, and looks at what aspect of social capital was researched and which principal theorist’s work the research was based on. These illustrations are important as they inform the conceptual framework which will be developed to guide this study.

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<sup>14</sup> Based on Hawe and Shiell (2000:877), Rose (2000), Cattell (2001), and Veenstra (2000)

**Figure 3.1: An Illustration of the Health and Social Capital Study Categories and Their Potential Contributions to Health Policy**



**Table 3.2 Applications of Social Capital Theory in Health Studies**

Author	Application	Level/Type/Form	Principal Theorist and their Ideology
Cattell (2001)	Relationship between social networks and exclusion on well being	Micro-analysis: -Relational social capital -Network structures: dense; weak; homogenous -Perceptions of inequality as a source of social capital <sup>15</sup>	*Coleman (1988): -forms of social capital -facilitative social structures *Portes (1998) -Sources and consequences of social capital *Woolcock (1998), and Evans (1996) -Imbeddedness
Rose (2000)	Relationship between human and social capital as determinants of health	Micro-analysis: -Relational social capital -Involvement/exclusion from networks -Friends to rely on when ill -Control over one's own life and trust	*Coleman *Portes *Woolcock, and Evans
Veenstra (2000)	Relationship between individual level elements of social capital and self rated health status	Micro-analysis -Relational social capital: relationship between trust, commitment, participation in clubs	*Putnam (1995): Measure of social capital via an index of participation in civic activities *Coleman *Portes
Wilkinson (1996)	The influence of social and income inequality on mortality rates	Macro-analysis -Relational and material aspects of social capital	*Putnam
Kawachi et al (1997)	Income inequality leads to increased mortality via disinvestments in social capital	Macro-analysis -Relational aspects of social capital (e.g. trust) and their correlations with income inequality	*Putnam *Coleman
Lynch and Kaplan (1997)	Income inequality and health	Macro-analysis -Material aspects of social capital: under- investment in health and social infrastructure has health consequences	*Putnam

<sup>15</sup>Inequality can adversely affect health as Wilkinson (1996) suggests. Cattell (2001) however presents the idea that perceptions of inequality may be a source of social capital, as some respondents in her study decided to use their wealth and positions of power to help those who were less fortunate- they hated the inequality and poverty they saw in their communities.

The focus of this study is to assess the resources that households use to access health care and mitigate the negative effects on a household affected by a specific disease (HIV/AIDS) and not just ill-health as many studies have done. The review of the literature on social capital shows that it is a multi faceted concept; therefore an analysis of it as a resource to the poor urban HIV/AIDS stricken Zimbabwean household means that the analysis must consider the different levels and the different types of social capital. The levels of social capital to be assessed are:

- **The capital inherent in community networks and neighbourhood groups:** with a view to gaining an understanding of how and whether these groupings improve household coping with the disease, and access to the other health care resources. As Portes (1998:4) asserts, “through social capital, actors can gain access to economic resources.”
- **The capital held within intra-household relationships:** this helps to understand strategies employed within households, such as intra-household substitution of labour (Corbett, 1989).

Russell (2001) synthesized three broad categories of functional social capital from key literary sources (Narayan 1999; Portes 1998; Woolcock 1998; Putnam 1995 and Coleman 1988). These are bonding, bridging and linking social capital. The negative effect of restricted access is also analyzed in this study as PLWA are often excluded from accessing care for instance. The types of social capital studied in this paper are:

- **Bonding social capital:** “the strong ties connecting people from the same immediate group: (encapsulating Portes’ (1998) ‘bonded solidarity’) family members, neighbours, close friends, and business associates sharing similar socio-demographic characteristics” (Russell 2001:50). In this study they are to be studied as a method of mitigating the harsh consequences of chronic illness in a household through for example intra-household substitution of labour and sources

of non-financial assistance, for example care taking of the ill family member. The influence of this form of social capital is limited however as the individuals within the grouping have similar resource endowments (Questionnaire questions 12 and 17.3: Appendix B).

- **Bridging social capital:** “weaker ties with people from the same socio-economic status but different ethnic, occupational or geographical groups” (Russell 2001:50). These together with sources of linking social capital are proposed by Narayan (1999) as being more influential to improving access to health care resources (Questionnaire questions 16, 17.3 and 20 Appendix B).
- **Linking social capital:** “vertical ties between people from different socio-economic groups and positions of power, such as links between poor people and actors in positions of influence in formal organizations such as political parties, banks, schools, hospitals, housing authorities, or the police” (Russell 2001:50). As mentioned previously these ties are invaluable for improving access to resources as they open the door to financial and social resources outside of the individual’s immediate grouping. (Questionnaire questions 17.3 and 20)
- **Restricted access to opportunities:** belonging to a particular grouping can have negative social capital consequences, for instance restricting access to medical aid and sources of credit for PLWA.

### 3.5 Summary of the Literature

This literature review has provided a review of the concepts underpinning this study. It has been shown that poor households pay a greater proportion of their scant incomes towards health care costs (Russell 2001, Pannarunothai and Mills 1997, Wallman and Baker 1996). The literature has also shown both that poverty may lead to greater ill health and that ill health can also result in increased poverty. The coping strategy literature provides evidence of households employing a variety of resources (financial and non-

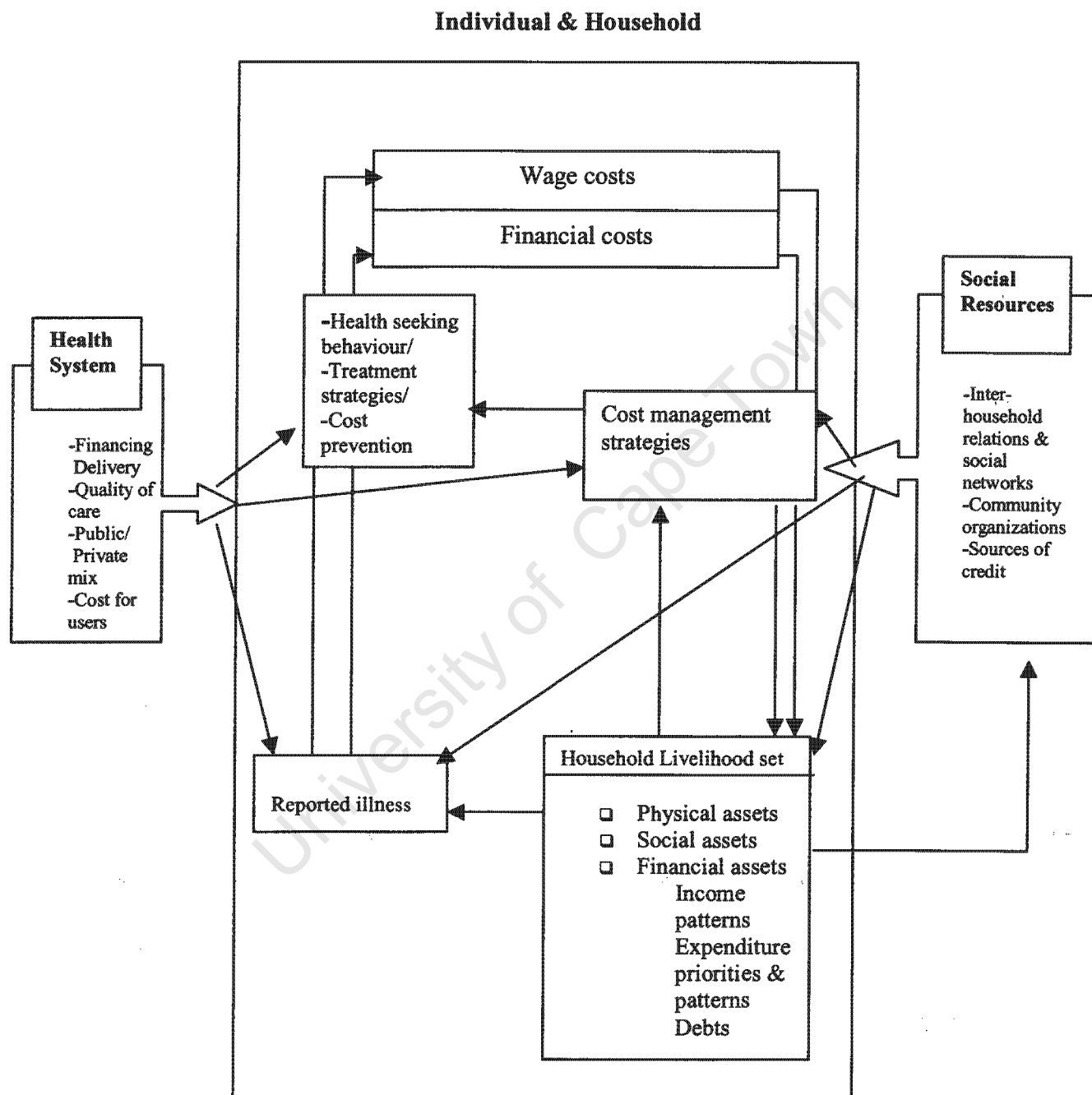
financial) to deal with ill health (Pryer 1989, Corbett 1989). The literature also points to the fact that illness like famine can be viewed as a livelihood shock, which can break down a household's asset base causing it to plummet into illness- induced destitution, poverty and vulnerability - resulting in a "poverty ratchet" (Chambers 1989). The complexities of social capital are assessed and its applications in this study are stated. This literature review serves to inform the conceptual framework, which presents a framework for assessing the resources available to or used by households to mitigate the effects of HIV/AIDS to determine whether households can survive the onslaught of this disease.

### 3.6 Conceptual Framework

The preceding literature review laid the foundation for a conceptual framework which draws from a variety of literary sources. The literature review illustrates that using an ATP framework for assessing how households manage illness costs results in misguided conclusions about the impacts of the health care costs on the economy of poor households. The complex array of resources drawn upon to gain access to health care and to contain the costs of health care cannot be measured in a singular framework such as one which looks at the payment for care as an indication of ability to pay/cope. To gain an understanding of these complexities, a framework is needed which captures the wide range of resources that households use to cope with health care costs. This framework (outlined in Figure 3.2), drawn from the preceding literature review considers the following:

- **Coping strategies:** this literature review gave a framework of the various resources (tangible and intangible) that households mobilize for dealing with health care costs
- **Social resources:** these are a subset of the resources captured by the coping strategy literature, and are considered a very important part of a household's resource base.

Figure 3.2: Analytical Framework



(Adapted from Russell 2001:26)

### **3.6.1 Review of the Analytical Framework**

The household was chosen as the main unit of analysis since the objective is to determine how the household as a unit is affected by illness costs. Justifications for using the household as the unit of study include:

- ❑ The illness costs tend to affect the household's budget since most poor urban households do not have access to health insurance.
- ❑ Strategies employed to cope with the costs of illness usually affect all household members (children may lose time at school because of looking after the PLWA, expenditure on basic needs may be reduced to finance illness costs)
- ❑ It is usually the adults in the family, the main breadwinners who fall sick and as a result children or other dependants within the household are mobilized to access resources: through informal jobs, and accompanying the PLWA to get treatment, etc.

This study considers four main issues: the illness costs incurred as a result of the disease, the treatment strategies employed by households when there is an HIV positive individual in the household, the cost management strategies employed to cope with the preceding illness costs, and the impact on the household's livelihood and poverty.

This is a disease specific analysis so the starting point of the analysis is the reported illness, which in this case is HIV/AIDS. There is a dual role of the health system in this study: firstly it is analyzed in order to assess the costs incurred by households in seeking care from the health system; it is also assessed from the viewpoint of being a resource outside of the household which the household can draw on. The health system is also important because the treatment strategies, which are used, are influenced by the costs of care, quality of care and access to care.

Once the illness is reported the costs of the action taken in response to the illness are considered. These costs include:

- Financial costs: expenditure incurred in seeking care (transport, medicine etc)
- Wage/time costs: the wages/income lost as a result of the days of work lost due to the illness

The financial costs of illness will be measured in terms of the money spent and the wage/time cost measurements will give an indication of the extent of the indirect costs.

Cost management strategies are another important variable to be considered. These refer to the range of strategies which households employ in order to manage the financial and wage costs incurred because of the illness. Financial cost management strategies may include: cuts in expenditures on other basic needs such as food; education and clothing; use of savings; asset sales or debt. Wage cost management strategies include intra-household substitutions of labour or hiring external labour.

The resources which the households have at their disposal for managing these costs include: physical assets, social assets and financial assets (human capital is another asset frequently assessed in such studies but is ignored here). When looking at financial assets the study considers the influence of incomes, expenditure priorities and patterns and debt on household's ability to cope with the direct and indirect costs of illness. Social assets are particularly drawn on in this research as a resource which households look to for coping with managing the costs of illness (direct and indirect). The social assets are also at the community level because social resources, external to the household, provide more help in mitigating costs than internal resources, which are limited. The community level social resources that are considered include inter-household relations and social networks and neighbourhood groups or CBOs, all of which provide access to or actual resources for the households.

The study also looks at impact of the illness costs and cost management strategies on the household's livelihood and poverty. Questions that are considered include: are basic expenditure sacrificed, savings eroded or is debt incurred; all which are clear indicators that households are not able to cope with the illness costs although they may pay for the care, essentially showing that ability to pay and ability to cope are not one and the same thing. Households should not become poor due to illness costs.

**Chapter summary:** This chapter has presented a detailed analysis of the concepts of coping strategies and social resources. The discussion of the literature informed the types of social capital to be analysed in this study and the analytical framework. The analytical framework provides an important link between the literature, the methodology used to collect data, and the discussion of the results which follow in chapters 4 and 5 respectively.

## CHAPTER 4: RESEARCH METHODOLOGY

**Chapter Overview:** The study aims to reflect the wide variety of coping strategies employed by poor urban households in dealing with the economically and physically harsh impacts of HIV/AIDS. It is a multi-faceted study considering not only the tangible resources relied on by PLWA but also the myriad of non – tangible resources partly captured in the form of social capital. A methodological framework using a rather eclectic toolkit of quantitative and qualitative research techniques was used in order to gain a holistic picture of all the resources that PLWA use in coping with their illness. This chapter provides an in-depth description of the research methodologies used, and justifies their application to this study within the particular environment in which the study was performed. The chapter begins with a breakdown of the data requirements necessary to undergo the study, presents an analysis of the research methods used by other similar studies, and concludes with an in depth description of the data collection methods employed.

### 4.1 Data Requirements

This study considers households' ability to cope with the direct and indirect costs of HIV/AIDS through a basic needs and household livelihood approach (i.e. in the context of the assets available to households). The data collected needed to reflect the following:

1. The socio-economic details of the respondents (incomes brackets and expenditures)
2. The individual, household and community demographic details; these are needed in order to analyze the complete resource set available to the PLWA.

3. The direct and indirect costs of HIV/AIDS
4. The workings of the health system since it presents a potential coping resource
5. The personal experiences of the PLWA which are reflective of the real issues they face in coping with the disease.
6. The types of community support structures, their resilience and sustainability.

## 4.2 Methods Used by Similar Studies

The majority of studies which have attempted to assess the strategies employed by households in coping with income shocks, have employed longitudinal research frameworks. This allows, not only a general assessment of the type of strategies employed by households in dealing with income shocks, but also allows for an analysis of how the strategies employed change over time and the ordering of such strategies. Due to time and budget constraints it was not possible to undertake a longitudinal study. A cross sectional cohort study approach was used instead, with structured interviews of PLWA from two purposefully selected communities, focus group discussions (FGD) with PLWA from each community, and key informant interviews (see Figure 4.1 which summarizes the data collection methods).

It is worth mentioning from the outset that the collection of information relating to HIV/AIDS in Zimbabwe is a very sensitive and difficult process, this is due to the stigma still being associated with the disease. Although information around AIDS is now widely available, gaining formal access to PLWA for direct interviewing (facility based interviews for example) is still a difficult procedure. The research methodology had to be adapted to deal with this problem (section 4.3 presents the methods used in this study). Table 4.1 presents a variety of studies, which assess coping strategies, and details the research methodology. The methodologies used in these research projects helped to inform the decision on the appropriate methods to use in this particular study.

**Table 4.1: Study Approaches Applied in Various Coping Strategy Research Projects**

Author(s)	Research Title	Data collection methodology
Sauerborn, and Adams (1996)	Household Strategies to Cope with The Economic Costs of Illness	Longitudinal study using qualitative and quantitative methods: structured panel interviews on households selected using a theoretical sampling approach (the same households were visited 6 times between March and October 1992)
Seeley, Kajura and Mulder (1995)	Methods used to study Household Coping Strategies in Rural South West Uganda	Longitudinal study of the coping strategies of purposively selected households over a year.
Munthali (1998)	Socio-economic Impact of HIV/AIDS in Malawi: Focus Group Discussions on Community Impacts and Coping Strategies	Cross-sectional study, using qualitative methods: Focus group discussion with AIDS sufferers or caregivers. Key Informant Interviews and Institutional interviews
Mutangadura and Webb (1999)	The socio-economic impact of Adult Morbidity and Mortality on Households in Kafue District Zambia	Cross- sectional study, using quantitative and qualitative research methods: Structured interviews on a systematically sampled selection of rural and urban households.
Russell (2001)	Can households afford to be ill? The role of the health system, material resources and social networks in Sri Lanka	Longitudinal study using qualitative and quantitative methods: structured interviews on households selected using a theoretical sampling approach, case study households were then selected from the household survey, and were then used in extended case studies almost panel case studies (table 4.2 provides the detailed methodological framework used by the study).

Russell (2001) included in Table 4.1, drew on a variety of methodologies in order to study how the poor cope with illness in Sri Lanka. These include: a household survey, from which households were chosen for extended case studies over 8 months, key

informant interviews, frequent presence in the communities' and engagement in community activities. These methods and their rationale are presented in detail in Table 4.2. This is the kind of detailed and intensive study approach necessary when attempting to comprehensively analyze all the resources and strategies that households use when seeking care.

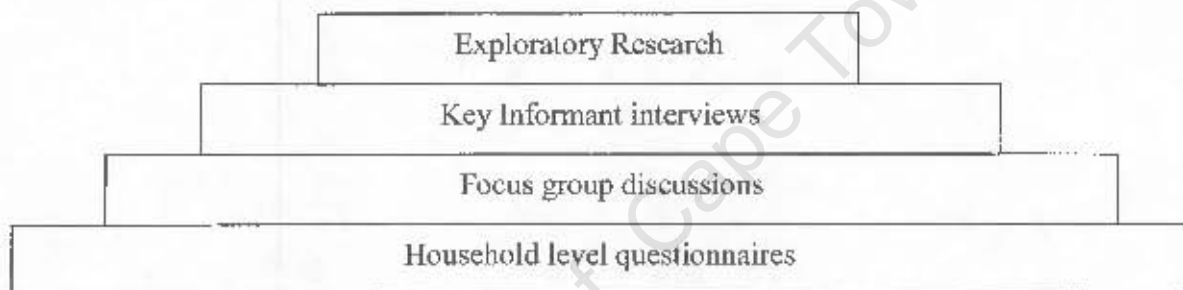
**Table 4.2 Research Methodologies Employed by Russell (2001: 69)**

Methodology/approach	Rationale
<b>1. Conceptual Frameworks require in depth household research</b>	
Extended case study approach (n=32)  (Longitudinal study over 8 months)	<ul style="list-style-type: none"> <li>□ Enables detailed investigation of household assets (especially social networks), income and expenditure patterns, illness costs and coping strategies.</li> <li>□ Captures variations in illness, treatment and illness costs over time, and fluctuations in household income available to meet the costs of illness.</li> <li>□ Captures the medium and long term impact of illness costs and coping strategies on household assets, income and expenditure patterns</li> </ul>
<b>2. Conceptual frameworks highlight the importance of context</b>	
Key informant interviews  Frequent presence in communities  Engagement in community activities  Household survey (n=423)	<ul style="list-style-type: none"> <li>□ Enables understanding of actors, events and activities in the two areas through conversation, observation, or more formal interviews</li> <li>□ Enables data collection on neighbourhood groups and CBOs in each community</li> <li>Household survey:               <ul style="list-style-type: none"> <li>□ Generate extensive data for statistical generalization on illness, treatment, treatment costs and coping strategies.</li> <li>□ Used for selection of case study households.</li> <li>□ Locates case study households in their wider context (socio-economic, illness and treatment).</li> </ul> </li> </ul>
<b>3. Conceptual frameworks require complementary quantitative and qualitative data</b>	
Range of methods used	<ul style="list-style-type: none"> <li>□ Makes use of the advantages of each method</li> <li>□ Enables complementarity and triangulation</li> </ul>

### 4.3 Research Methods Employed in this Study

Although the longitudinal study approach used by Russell (2001) (see Tables 4.1 and 4.2) would have been ideal for this study, time and budgetary constraints made this difficult. The underlying study approach chosen was a cross sectional approach. Figure 4.1 presents the four-tiered data collection methods used to collect all the information required to successfully complete the study (detailed under section 4.1).

Figure 4.1 Pyramid of Methods Used to Collect Data.



#### 4.3.1 The Questionnaire<sup>16</sup>

In order to obtain information on households, their demographics, income and expenditure patterns and cost management strategies a questionnaire was drawn up which was directed at one individual within a household, the PLWA (the demographics are indicated in the results section in chapter 5).

<sup>16</sup> A copy of the questionnaire is shown in Appendix B

#### 4.3.2 The Study Sample

The study employed the use of a stratified sample of 110 respondents found in two poor urban communities in Harare (55 from each community). A stratified sample approach allowed for an analysis of the different resource sets that households in different communities employ. The two communities were chosen in order to assess how ability to cope differs with income differentials. This allowed for a cross community comparison of ability to cope with HIV/AIDS based on income differentials between the communities<sup>17</sup>. Demographic and socio-economic details of the two communities are cited in the results section in chapter 5.

The two communities chosen were Mabvuku (located in the Eastern part of Harare) and Glen View (located in the Western part of Harare). These two communities were purposefully chosen as they were identified as having a high prevalence of HIV/AIDS, being high-density areas with a significant population of poor households<sup>18</sup> and exhibiting varying degrees of social support structures for PLWA.

Although Mabvuku was identified as the poorer community, it was also recognized as possessing higher levels of social support for PLWA, while Glen View although identified as being the "wealthier" of the two communities was acknowledged as having lower levels of social support for PLWA and their families. These two communities, characterized by their relatively high HIV/AIDS prevalence levels, low and differential incomes and varying degrees of social support for PLWA proved to be ideal subjects for this study.

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<sup>17</sup> The respondents selected from each community were all classified as "poor". Income differentials between individual respondents may be slight, but are explicit between the two communities, this allows for an analysis of how social resources may mediate the relationship between income inequality (in communities) and health status, that is, we are able to see if individuals in different communities may have better coping abilities based on the general income level of the community and the available social resources.

<sup>18</sup> The decision to use these two communities was informed through extensive discussion with Mr. Eliot Majunge: the Advocacy Officer of "The Centre" - a proactive AIDS support body.

### 4.3.3 The Respondents

All the respondents who were interviewed lived in the afore mentioned communities and were affiliated to "The Centre"<sup>19</sup>. The respondents were identified by employees of "The Centre", and were invited to come to interviews by way of posters and word of mouth. They are classified as PLWA, who are unemployed, or self-employed in the informal sector (for example vegetable vendors), and in the lowest income bracket. This pre-selection of the study sample although resulting in highly biased results was unavoidable as the city's health authorities<sup>20</sup> refused to allow people who have been diagnosed with HIV/AIDS to be interviewed at health facilities.

**Table 4.3 Priority PLWA Survey Sample Description**

Name of Community	Number of PLWA Interviewed	Number of FGDs
Glen View	55	1
Mabvuku	55	1

### 4.3.4 The Interviews and FGDs<sup>21</sup>

The respondents were requested to attend a day of interviews. In addition to the questionnaire, focus group discussions were conducted in order to gain a more in-depth

<sup>19</sup> "The Centre" is a proactive community based support group principally involved in providing counseling, support group structures and other activities for PLWA. "The Centre" was identified after many consultations with organizations involved in HIV/AIDS activities including Zimbabwe AIDS Network (ZAN), Women and AIDS Support Network (WASN), National AIDS Coordination Programme (NACP) and Zimbabwe AIDS Prevention and Support Organization (ZAPSO)

<sup>20</sup> Although PLWA may be given care as recognized AIDS patients, the health system in the country does not allow for the official documentation of an individual as having HIV/AIDS.

<sup>21</sup> The structured questionnaire is presented in Appendix B, and the FGD, and Key Informant Interview Schedules are presented in Appendix C and D respectively.

understanding of how the households of PLWA cope with the costs of the disease. These discussions allowed respondents to express their views on access to health care; the impact of the disease on the household's livelihood; resources used to cope with the disease (especially social resources), and also which households have access to social resources as coping strategies.

The interviews took place over a day with each of the 10 interviewers interviewing 11 respondents. The interviewers were required to partake in a day of training prior to the actual day of interviews and FGDs. This training day included a review of the questionnaire and FGD schedule, simulations of questioning sessions and an overview of what the project was proposing to achieve.

The respondents from one community were interviewed in the morning while those from the other community were interviewed after midday. Focus group discussions were held concurrently with a couple of the PLWA (from each community) who were waiting to be interviewed. Three focus group discussions were held in total: one with Mabvuku respondents only, another with Glen View Respondents only, and one with the ten interviewers who were also PLWA from these two communities, who are also actively involved in the activities of The Centre.

It was impossible due to the political environment prevailing<sup>22</sup> in the country at the time to perform interviews at homes or specific sites in any of these two communities. Large gatherings were potential targets for political violence as were people walking around who appeared to be approaching other people or households as this was often perceived as political activity, thus making interviewers targets for politically fuelled violence. The interviews and FGDs were thus conducted at a church in the city centre, which was accessible for all the respondents. The respondents were interviewed by other PLWA with whom they were familiar (the interviewers were mostly key personnel from The Centre); this was suggested in order to make the PLWA feel comfortable enough to

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<sup>22</sup> The data collection took place in January-February 2002, this was a time of political unrest as the country was having an election in March of the same year, and many incidents of political violence had been reported in these areas, which are plagued with low incomes and high unemployment.

disclose information, which would otherwise appear to be intrusive. Thus the study took a slightly participatory nature (with the involvement of some the PLWA as interviewers, and partakers in FGDs) and this greatly facilitated the data collection

#### **4.3.5 The Key Informant Interviews**

Key informant interviews were also conducted. These interviews with key informants were conducted in order to obtain an overview of the different actors in the HIV/AIDS arena in Harare City. The key informants were people working in developmental agencies and community based organizations involved in HIV/AIDS, namely DFID, Island hospice, Mashambanzhou, USAID and "The Centre". The purpose of these interviews was to: obtain an understanding of the major failings of the health system in dealing with the AIDS pandemic; identify actions that government could take to minimize the impact of the illness costs on households and assess the sustainability of the different organizations' work in mitigating the pandemic. Additional interviews were held with a variety of different people within the communities who were involved with work around HIV/AIDS.

#### **4.3.6 Exploratory Research**

This involved collection of qualitative and quantitative data from sources within the health sector (MOHCW, and the National AIDS Co-ordinating Programme (NACP)) and NGOs involved in HIV/AIDS research (DFID, World Bank, USAID). Additional, secondary data was gathered from AIDS resource and information dissemination bodies such as Southern Africa AIDS Information Dissemination Service (SAfAIDS). This included information from previous studies on the impact of AIDS on households in Zimbabwe, general literature on HIV/AIDS in Zimbabwe, the region and the globe.

#### 4.3.7 Data Analysis Tools

The data from the interviews of PLWA was analysed using STATA (Intercooled STATA 6.0), a statistical package, and MS EXCEL spreadsheets.

#### 4.4 Limitations of the Study

The study design has some limitations:

- i. **The Problem of Bias:** It is recognized that the study is subject to a great deal of bias since all the respondents, although they were from two different communities, were drawn from the same AIDS support body. A random study would have been ideal, as it would eliminate the problem of bias; this was not possible however because it is exceedingly difficult to identify PLWA from the hospitals and government clinics as their status is not formally disclosed. It was necessary therefore to approach an activist AIDS group such as The Centre. The results may therefore be blurred as these respondents who are in support networks may indicate coping levels, which surpass those of the general PLWA in poor urban communities in Harare.

It is also recognised that data may exhibit additional bias due to the use of employees of “The Centre” as interviewers. For example, the interviewees may have wanted to “please” the interviewers as they are in some ways dependent on The Centre’s support

- ii. **The Choice Between a Cross Sectional/Longitudinal Study:** It is recognized that in order to assess the impact of the disease on a household’s livelihood, a longitudinal study approach may have been more appropriate in order to assess changes in livelihood over time. Ideally, (as shown by the analysis of

methodologies used in other coping strategy studies) a longitudinal study should have been used in order to capture the sequencing<sup>23</sup> of strategies and the decline (if any) of a household into poverty as this can direct policy initiatives to assist households in such situations. Such a longitudinal study, which may have taken the form of extended case studies, was compromised by the limited time period available to collect the data, budgetary constraints and the political unrest prevailing at the time of the study.

- iii. **Timely and Reliable Secondary Data:** Obtaining reliable timely quantitative, and qualitative data, proved to be difficult. Therefore some data pertaining to HIV/AIDS in particular may be slightly outdated. Obtaining reliable data on the household economy also proved to be quite difficult. This is a phenomenon experienced in many studies, as households tend to either understate their incomes or overstate their expenditures.

**Chapter summary:** This chapter presented the data required to successfully complete the study. In an attempt to identify acceptable study approaches, the research methods employed in other studies, which analyze coping strategies, were also presented. The study approach, which was ultimately selected, was detailed along with the variety of data collection methodologies used. The chapter was concluded by a discussion of the limitations of the study.

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<sup>23</sup> Devereux (1993) argues the importance of analyzing the sequencing of strategies when studying coping strategies, this is discussed in Chapter 3:28

## CHAPTER 5: RESULTS AND DISCUSSION

**Chapter Overview:** This chapter presents the results of the analysis of the data collected. The results combine the quantitative and qualitative research performed, in a detailed discussion, which is linked to the conceptual framework, and research objectives stated in chapters 1 and 3 respectively. References and links are also made to other chapters within the report. The analysis begins with a synthesis of the demographic and socio-economic characteristics of the respondent population. This is followed by an analysis of the direct costs of HIV/AIDS to the household. The indirect costs are considered separately from the direct costs since the analysis and implications of the two differ considerably. The characteristics of the health system as a resource, which households draw on, are also considered. A comparative examination of the general "coping strategies" employed by PLWA then follows and precedes a detailed analysis of the resources which these households use to pay for care. Social resources as a cost management strategy are then considered in detail. Lastly an attempt is made to assess the extent of vulnerability that the disease has imposed on the households. The chapter concludes with a summary of the key issues.

### 5.1 Demographic and Socio-economic Analysis

The demographic analysis is performed on the study sample as a whole whilst the socio-economic analysis is also performed on the study sample as a whole and then separately on the two communities assessed. This allows for an understanding the intricate differences between the two communities, which aids later discussion on differences in social capital.

### 5.1.1 Demographic Analysis

The study sample demographics (Table 5.1) reflect interesting results. The gender bias of participation, 76% women, is indicative of the general consensus that HIV/AIDS is a women's disease, not in terms of having the disease but in terms of awareness and participation in HIV/AIDS related programs. A key informant attributed this to the fact that women become aware of their status after testing at antenatal clinics. Men, however, have no such facility and participate in self-diagnosis such as a convincing a wife to have a child and then determine their status by whether that child lives or dies from AIDS related conditions (Key informant and FGD interviewees).

**Table 5.1: Demographic Analysis (Entire Sample)**

Variable	Results							
Gender (%)	Males	24	Females	76				
Marital status (%)	Single	15	Married	40	Divorced	15	Widowed	29
Respondent's age	Ave	33	Max	56	Min	16		
# Of own children	Ave	3	Max	9	Min	0		
# Other children	Ave	1	Max	10	Min	1	Relation's children (%)	63
Household members	Ave	6	Max	24	Min	1		

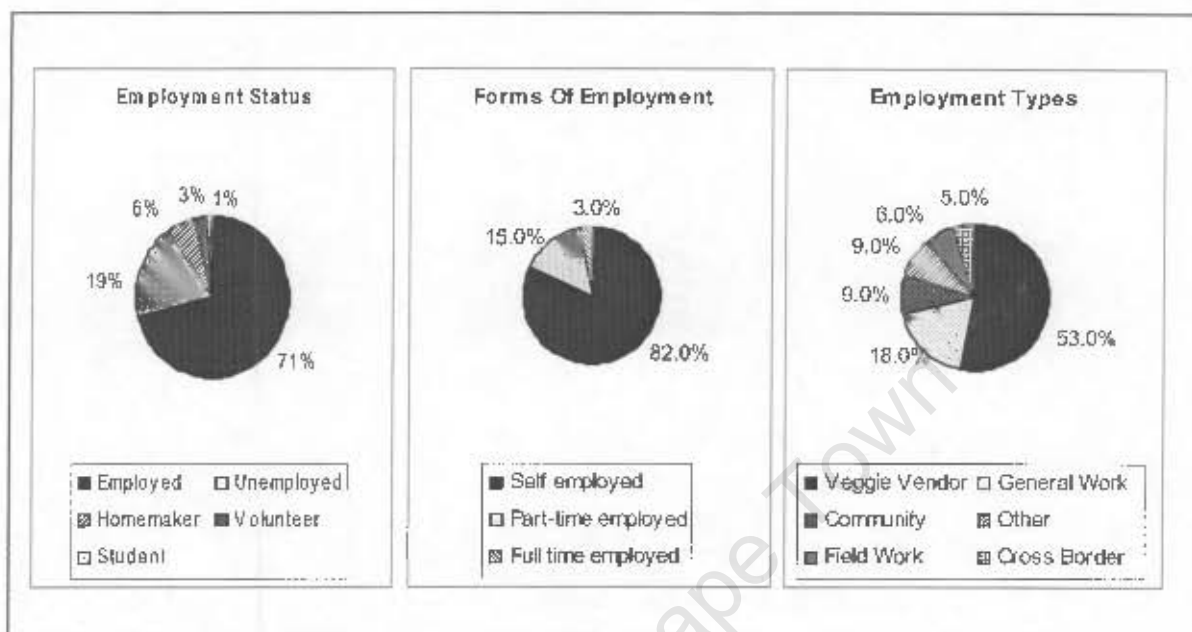
The mean age reflects the widely held consensus that HIV/AIDS is "primarily affecting adults in their economic most productive years" (Ainsworth and Over 1992:4) who are likely to be the principal breadwinners. The low percentage (15%) of single respondents indicates the extent of the HIV/AIDS burden on households as we can assume that in the remaining 85% of the households, both household heads (mother and father) are afflicted with or have died as a result of the disease. This means that their role in the family either

as a breadwinner or a homemaker has been eroded or replaced by others within the household (it is hypothesized by many that children take on this role although it is difficult to measure as child labour is illegal and respondents are not keen to admit that their very young children are working to support them). Pryer (1989) showed that children between the ages 5-15 contributed to the household budget in poor households. Although the average number of own children within the respondent household is quite low (3) this can reach 9 children in some households with an added 1 extra child in the household on average. Although the number of other children being looked after can reach 10, 90% of the households look after 1,2, or 3 children with only 10% looking after more than that. A large number of respondents (63%) are looking after someone else's child. All of the respondents who are looking after someone else's children are looking after their relative's children, not their friend's children (See the Questionnaire in the Appendix B).

### **5.1.2 Socio-economic Analysis**

This section assesses the employment, income and expenditures of the two communities, and provides an overview of the HIV/AIDS statistics and interventions in each community. An analysis of the employment status of the respondents within the sample (Graph 5.1) reveals that the majority of the respondents, more than 70% are employed, with 63% of respondents being principal breadwinners.

**Figure 5.1: Employment Status, Forms of Employment and Employment Types<sup>24</sup>  
(Entire Sample)**



This high percentage of employment was recorded across both communities with the highest level of unemployment being recorded in Mabvuku (31%). These levels of employment may seem extremely high in a country facing growing levels of unemployment, of between 40 and 50% in some areas (ZDHS 2000). Incongruent as they may seem, these employment statistics are plausible, however, when considered in light of the *form* of employment: 82% of the respondents are self-employed, and only 3% formally employed. The majority (53%) of the respondents are self-employed as vegetable vendors, and general workers (18%). The proportions of the type of employment differ considerably between the communities as evidenced in Appendix A, with Mabvuku having considerably more general workers and considerably less

<sup>24</sup> Explanation of Employment types: General Worker- refers to domestic work; maintaining other peoples gardens or houses; Community-refers to working in community programs; Field work –involves ploughing fields for subsistence or ploughing other peoples fields; Cross border trading involves going to neighbouring countries for example South Africa buying goods there and reselling them on the local market, tuck shop operators are also included in this category; Other- includes sewing and knitting for resale, painting landscaping, and carpentry, and river sand sales.

vegetable vendors than Glen View. In order to get a sense of the incomes and expenditures of the respondents in the two communities, respondents were asked to disclose their basic needs expenditures<sup>25</sup> (Figure 5.2).

**Figure 5.2 Breakdown of Basic Needs Expenditures in The Two Communities<sup>26</sup>**

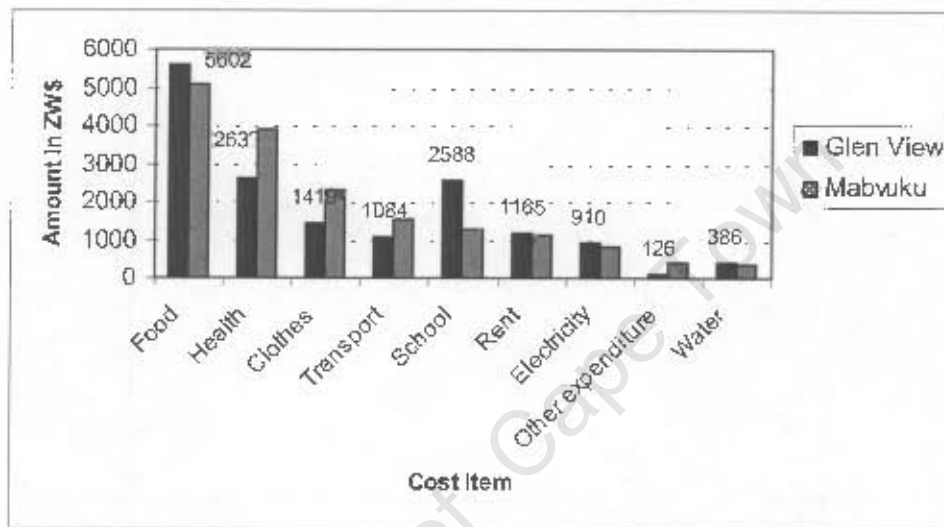


Figure 5.2 shows some interesting variations in the expenditures between the two communities; Glen View respondents spend more on food and education related expenses than Mabvuku respondents who in turn spend more on health care (this excludes expenditure on HIV/AIDS related costs) and clothing. Total expenditures shown in Figure 5.4 (section 5.2.1) show that although Mabvuku is the poorer community (refer to Box 5.1) their basic needs expenditures are marginally more (ZW\$800) than those of Glen View respondents. This may be due to the Mabvuku respondents receiving external

<sup>25</sup> Respondents were asked to detail their expenditures rather than incomes. This is because households have a variety of different income sources (formal and informal) which they might not want to disclose since they may be illegal, involve child labour, or may exclude respondents from attaining additional financial aid (river sand sales are an example of illegal income generating activities in Zimbabwe, but are a means of survival for many households and were identified as an occupation by some respondents see footnote 24). Using expenditure patterns allows for an extrapolation of what incomes households may have as shown in Box 5.2

<sup>26</sup> The official exchange rate in January 2002 was US\$1=55 ([www.fingaz.co.zw](http://www.fingaz.co.zw) 14/08/2002) The rate on the parallel market was closer to US\$1=Z\$300)

assistance with regard to meeting health care and clothing needs, the two items of expenditure where Mabvuku respondents “spend” more than Glen View respondents (Figure 5.2).

#### Box 5.1 Basic Needs Expenditure

This brief account tables the differences between the basic needs expenditure recorded by this study and that of the Urban Vulnerability Report produced by the Famine Early Warning System Network (FEWSNet) and the Consumer Council of Zimbabwe (CCZ)(King et al. 2001).

**The Harare Urban Vulnerability Report and Updates (King et al.2001):** assesses the income and expenditure patterns of households across different income categories in Harare city using a consumer expenditure basket which includes: maize, other food, daily non food expenditure, education, health, accommodation, transport, clothes and other items. This basket has been monitored since 1980 and was valued at Z\$22, 503.00, “poor households considered this the desired basket and anyone who could afford such a basket was considered ‘better off’” (King et al 2001:1). The results of this study point to an expenditure basket consisting of food, transport, electricity, water, rent, education, clothing, health care and other items costing these poor households Z\$16, 341.00. The expenditure basket set out in the urban vulnerability report costs poor households approximately Z\$4, 000.00 in July 2001 and Z\$6, 300.00 in September, a 57% increase over the quarter. These differences (between basic needs expenditures recorded in the urban vulnerability report and those recorded in this study) may mean that respondents of this study indicated their *desired* basket (although it is difficult to attribute the large difference between Z\$16, 341.00 and Z\$6, 300.00 to this), *or* may have costs such as education and health care met by other formal or informal structures such as, credit lines, Government bodies (social welfare) and NGOs. This would mean that these households do not pay for them directly from their incomes. Box 5.2 shows that these incomes are estimated at being between Z\$4,000.00 and Z\$8,000.00, which is way below their level of expenditure. The difference (in the expenditures recorded by the two studies) could also be as a result of the time lag; this report was conducted in late January 2002, while the latest vulnerability report referred to in this study used September 2001 figures. Zimbabwe’s run-away inflation over the period could also partly explain the difference between what poor households in this study valued their expenditure basket at and what the vulnerability report assessed a poor household’s basket to be costing.

### **Box 5.2 Classification of Income Brackets of Study Households**

**The Harare Urban Vulnerability Report** (King et al. 2001): classified those with an income source from one able bodied person in a family working on the lowest level job in the formal sector or a small scale vending informal sector activity earning Z\$4000 as poor households. The next income level (Z\$4000-8000) includes households with one slightly higher formal sector income source (factory workers, security guards, shop assistants) and informal sector home industries (small tuck shops, carpenters, welders, hair salons and some vendors). Thus when using employment type as an indicator of income, the majority of respondents fall into the lowest income brackets. Rent levels are also considered a good indicator of poverty as opposed to location of dwelling. Merely because a household resides in a high-density area doesn't automatically mean they are in the lowest income band. Rent levels, which are paid, are a better indicator. The Harare Urban Vulnerability Report (King et al.2001): indicates that as at May 2001 the poorest households were paying rentals of Z\$1000 –Z\$1200, average rentals recorded in this study were Z\$1119.63 (Mabvuku) and Z\$1165.27 (Glen View) (see Figure 5.2). Comparing the characteristics of the “urban poor” in terms of employment types, residence and amount of rent paid presented by the Urban Vulnerability Report and the employment types, and rentals paid by the respondent population of this study confirms that respondents in this study are correctly classified as the “urban poor.”

(Note: The official exchange rate in May 2001 was US\$1=53.70. The rate on the parallel market was closer to US\$1=Z\$140, (King et al 2001))

Box 5.3 gives a bird's eye view of the two communities detailing the population levels, HIV/AIDS prevalence levels and community activity around HIV/AIDS.

### Box 5.3 Birds Eye View of the Two Communities

Both Mabvuku and Glen View are classified as high-density areas. They were identified as ideal communities for a study such as this as they both exhibited high incidences of HIV/AIDS and showed income differentials – Mabvuku being identified as the lower income community (Key Informant Interview and King et al. 2001:11). The Urban Vulnerability Report (King et al. 2001) identified the lowest rents as being paid in Mabvuku (ZWS\$ 350 for shacks) compared to ZWS\$600-800 in Glen View. Most of the households studied did not own the home they were residing in (FGD) Although Mabvuku is the poorer community, the respondents identified in this study showed similar income/expenditure profiles as those from Glen View, this is interesting as it allows for a detailed study of social resources amongst respondents with similar income profiles in communities exhibiting different wealth profiles.

*Glen View* is a high-density area located in the West South West District of Harare. It has a general population of 190320 (NAC 2002). Employment statistics are a cause for concern with 75% of the population being unemployed or informal traders. HIV statistics based on 2000 data reveal that 12.9% of the population was identified as having HIV, and 1729 reported STD cases (NAC 2002). NGO activity is said to be marginal in this area with Island Hospice providing a very limited service and Mashambanzhou (also in very limited way) providing food and home based care for the poorest households affected by HIV/AIDS (Key informant Interviews). There is very little support from churches for PLWA in this area.

*Mabvuku* is a high-density area located in the Eastern District of Harare. It has a general population of 87556 (NAC 2002). The prevalence of HIV/AIDS is considered to be very high but exact figures cannot be ascertained. Unemployment figures are also very high with over 70% of the population estimated to be unemployed or informal traders (Key Informant Interview and NAC 2002). The levels of NGO activity (related to HIV/AIDS) in Mabvuku are quite high as compared to those in Glen View with Island Hospice (Principal researcher site visit and key informant interview), Mashambanzhou and various churches having a dedicated presence in the community.

## 5.2 Costs of HIV/AIDS

### 5.2.1 Direct Costs to Households

The direct and indirect costs of the disease were measured in order to assess the impact of the disease on households in resource poor settings, and to gain an understanding of the extent of the burden of the disease on households. Figure 5.3 presents a comparison of the direct costs of HIV/AIDS between households in the two communities.

Treatment costs at the facility most frequently used by the respondent constitute a significant proportion of the direct costs incurred by the households. Transport costs are low due to the facility most frequently used by the respondent being found within the community. Transport costs would be prohibitive however, if respondents were to seek care outside of the community. Households in Mabvuku, the poorer community, pay more in total for *treatment* (Z\$2000 more on average) than individuals in Glen View, the wealthier community. This result supports the common assertion among researchers in the field that the poor pay more (both as a proportion of income, and in absolute terms) for care than their wealthier counterparts (Pannarunothai and Mills 1997, Gilson 1988, Mills 1991).

It is interesting to note that although the Mabvuku households may pay more for treatment, the types of social support that they get from their linking social resources in particular NGO interventions, focus on home based care, testing, and prevention, and income generation; compared to Glen View residents whose linking social resources give them access to direct financial resources for example loans, and financial gifts, (see section 5.6).

Figure 5.3: Cross Community Comparison of Direct Costs<sup>27</sup> of HIV/AIDS

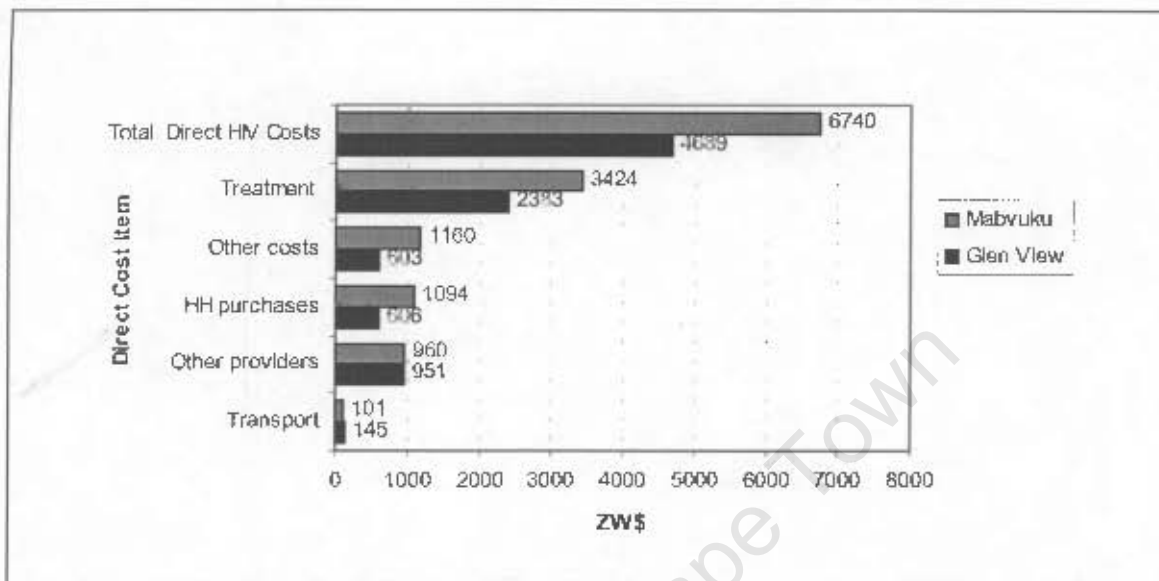
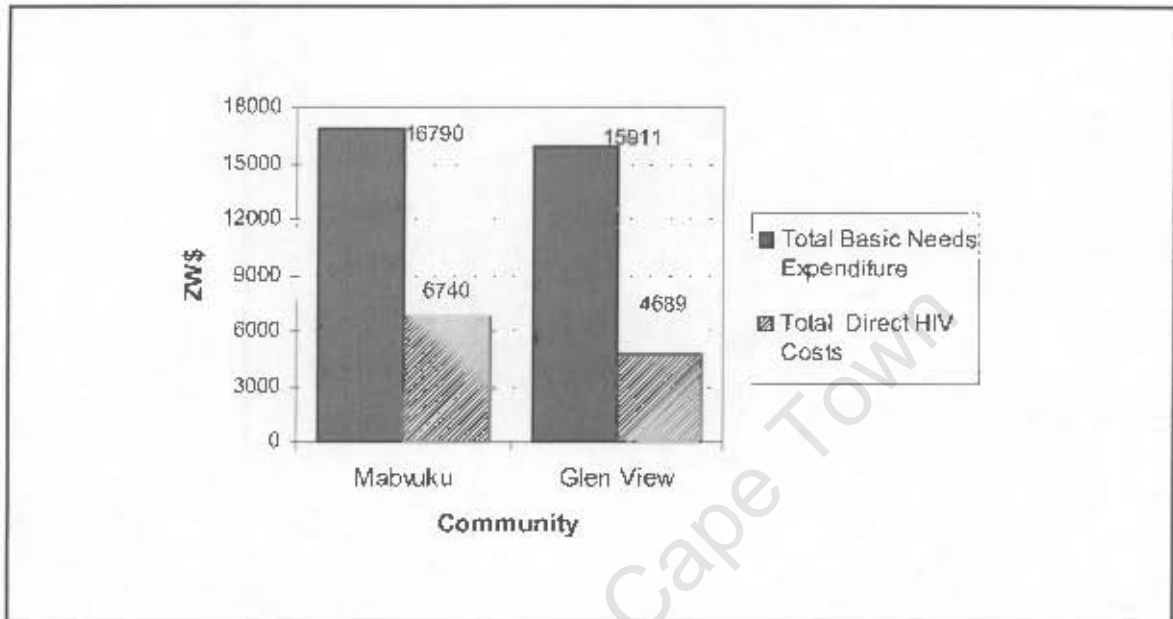


Figure 5.4 contrasts households' basic needs expenditures and direct costs incurred as a result of HIV/AIDS. Across both communities these direct costs are approximately a third of the expenditure incurred to meet basic needs. This result confirms that HIV places a heavy financial burden on households.

<sup>27</sup> Direct Cost Item Explanations: Treatment includes consultation costs, drugs etc.; Other costs: these are other costs that the respondent may incur, the most frequently cited being a "special diet" including herbs such as garlic etc; HH: purchases are purchases included in the household budget for bandages disinfectants for the PIWA care; Other Providers include all costs incurred at providers other than the one most frequently used by the respondent (these could be private practitioners, traditional healers or any other provider). Transport: this is the cost of a single trip when a PIWA pays for transport to seek care at the facility they frequently use.

**Figure 5.4: Cross Community Comparison of Household Basic Needs Expenditure and Total Direct Costs of HIV/AIDS**



University of Cape Town

### 5.2.2 Indirect Costs of HIV

The indirect costs of HIV are those time/production costs incurred as result of the disease. These may result from the economically active individual losing time from work due to illness or even losing their job. They are also incurred when other income earners within the household have to care for that individual and thus lose income. In addition, these costs encompass the loss to the household when a school going child has to take care of a sick individual, as the household is losing valuable human capital investments (Ainsworth and Over 1992, Pryer 1989, Chambers 1989).

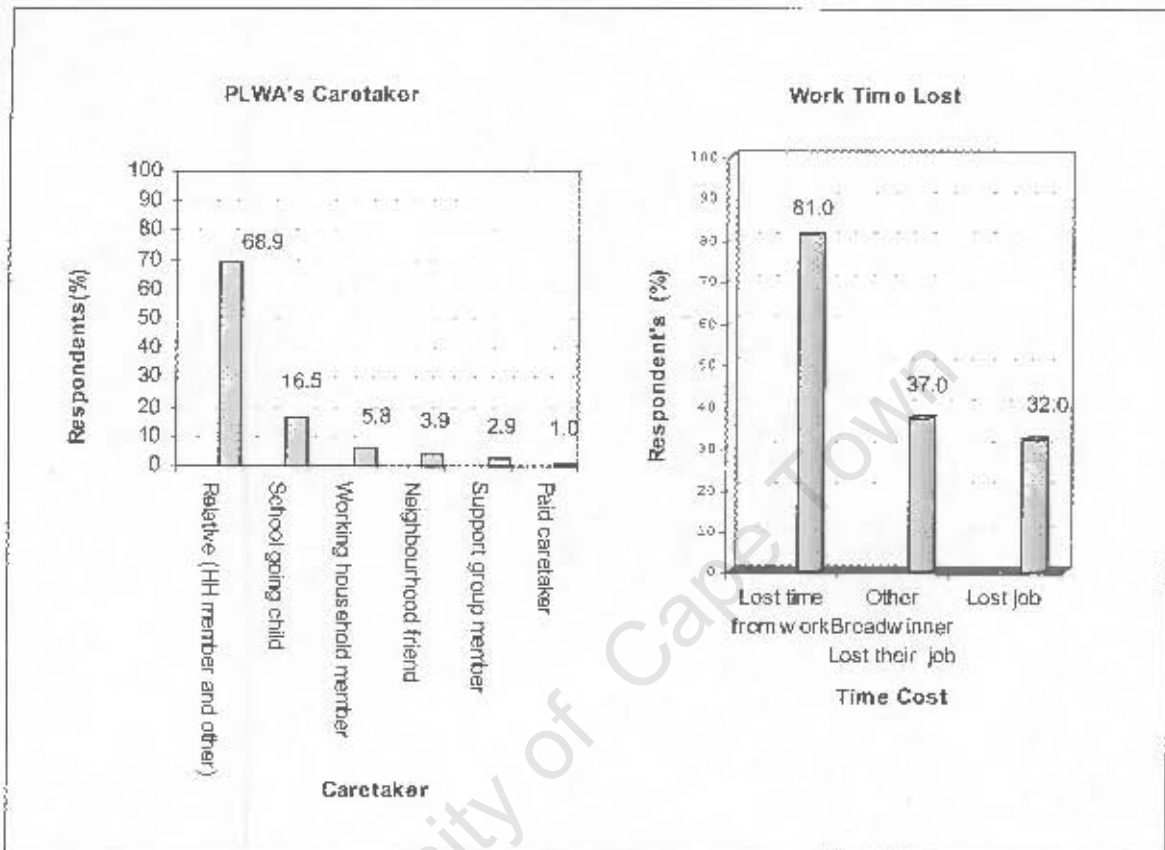
The extent of these illness related income losses indicate whether households' livelihoods are likely to be affected through expenditure cuts, borrowing or asset depletions. The ability of households to cope with illness is severely compromised if treatment costs need to be met even when the household has no cash income or reduced income. In such cases households are likely to fall into debt, or reduce expenditure on basic needs.

Table 5.2 shows who accompanies the PLWA to the clinic and quantifies the amount of time spent at the clinic as indicators of the indirect costs of the disease to households. Figure 5.5 presents indicators of the indirect costs of the disease to the household.

**Table 5.2 Indicators of Indirect Costs of HIV/AIDS on Respondent Households**

Indirect Cost Variable	Result
Respondents accompanied to the clinic by a working person	19.19%
Respondents accompanied to the clinic by a student	28.28%
Average Number of times respondent visits the clinic per month	3 times
Average time spent at the clinic per visit	109 minutes

Figure<sup>28</sup> 5.5: Indirect Costs Indicators: PLWA's Caretaker<sup>29</sup> and Work Time Lost to The Household



The majority (69%) of the respondents are taken care of by a relative who is assumed to be in the household. Although this relative may not be a school going child or a working household member, their labour is being sacrificed to look after the PLWA and this is a cost to the household. The relatively lower incidence of school going children looking after the PLWA (16.5%) is still quite worrying however, as this means that these children are sacrificing their investment in education and greater earnings potential which would

<sup>28</sup> The graph showing work time lost shows that 81% of all respondents lost time from work, 37% experienced another breadwinner lose their job, and 32% lost their jobs. These were separate questions in the questionnaire (Appendix B)

<sup>29</sup> The questionnaire (Appendix B) did not distinguish between relatives who are within the household or outside of the household, for this question, therefore a relative for this particular question may mean a relative who is a household member (this is proposed as the most likely scenario) or a relative who is outside of the confines of the household.

ultimately aid the household. The incidence of working household members taking care of the PLWA is also very low in comparison, but it is also a cause for concern since as pointed out previously (in section 5.1.2) 63% of the respondents are principal breadwinners.

The majority (81%) of these principal breadwinners have lost time from work, and a significant number (32%) lost their job as a result of the illness. On top of that, 37% of other breadwinners in the household also lost their jobs because of the illness. In addition to taking care of the PLWA, working household members and school going children also accompany the PLWA to the clinic, approximately three times a month spending approximately 2 hours on average at the clinic per visit (see Table 5.2).

These figures suggest that a significant number of households are experiencing a serious erosion of their income bases because of the disease. Considering the time being lost from school by children because of care taking and the limited income to pay for school fees (resulting from income earners either being too sick to work or the loss of employment), these families are not likely to be better off in the future because of these disinvestments in education (Section 5.6.7 shows that only 12% of respondent households have access to some form of social support to pay for school fees). The details on who takes care of the PLWA will be discussed further under social resources (section 5.6.).

### **5.3 Health Care Providers**

The analysis, which follows, assesses the respondents' use of particular health care providers and details reasons for their varying reliance on these providers. Table 5.3 records the frequency of use of the different providers while Table 5.4 assesses the respondent's motivations for using specific providers.

**Table 5.3 Visits to Health Care Providers**

Health Care Facility	Average Number of Times Visited
Government clinic	3 times a month
Other government Facility (Provincial Hospital)	6 times a year
Private doctor	4 times a year
Traditional healer	7 times a year

**Table 5.4: Reasons Cited For Visiting Specific Health Care Providers**

Facility	Most popular reason	Frequency	Reason Least Frequently Cited <sup>30</sup>	Frequency
Government clinic	Close-by	25.96%	Availability of Drugs	3.85%
Other Government facility (Provincial Hospital)	Effective treatment	48.98%	User fees	4.08%
Private Doctor	Effective treatment	36.84%	Exemptions	7.89%
Traditional Healer	Effective treatment	34.00%	Close- by	6.82%

An analysis of the health care providers reveals that respondents rely heavily on government clinics within their vicinity, visiting them almost on a weekly basis. The most commonly cited reason for seeking care at these facilities as detailed in Table 5.4, being their proximity to the respondents.

<sup>30</sup>The respondents were asked to choose the specific explanations about why they visited a specific provider, i.e. "I go to this specific provider because of reason X" (see question 14, of the questionnaire in Appendix B.) The reason chosen most frequently for each provider was tabled as the strongest motivation for going to a specific provider. For example respondents chose government clinics mostly because they are close by. The least frequently cited reasons are examined within the text, for example; the small number of respondents choosing the availability of drugs at government clinics as a reason for seeking care at these facilities is taken as an indicator that drugs are not easily available at local government clinics.

Less than 4% of respondents indicated that the reason for visiting government clinics was the availability of drugs suggesting that drug availability may be a problem. Figure 5.2 (section 5.2.1) shows that when transport costs are incurred in getting to the health care facility most frequently visited by the PLWA, they are relatively high as a proportion of income. This further justifies this preference for local public clinics, where most respondents do not incur transport costs in seeking care. Although the local public clinic was recorded as a popular provider, there were some associated limitations expressed by the PLWA in the FGD, Box 5.4 details the problems associated with seeking care at local polyclinics.

**Box 5.4 The Public Health System: Providing Inappropriate Care**

Although the local polyclinic was a popular provider, a particularly strong limitation was brought up in the FGD. PLWA felt that the health care professionals at these clinics are not adequately trained to deal with poor patients who have AIDS. The medical advice they give them usually entails expenditures on food and medicines, which are out of the reach of PLWA living in these communities. PLWA felt that the advice they received from support group structures relating to positive living (good diet etc) was much more applicable to their economic situations. For example from support groups they learnt how to maintain inexpensive herb gardens in their homes, which included basic medicinal herbs such as garlic. They also learnt to use these herbs as inexpensive treatments for conditions such as skin infections as opposed to using the very expensive prescriptions and expensive diets given to them by health care professionals. In some cases PLWA expressed that they felt that such advice relating to interventions, which, although they would keep them healthy, were *unattainable* to them, made them believe that they were sentenced to die (since they could not access those medicines and foods which they were told would help them to live). The general consensus was that government health care professionals need to become more sensitive to poor PLWA, and perhaps work with AIDS support group leaders so they can learn about inexpensive interventions that can prolong the lives of people, and so that they too could teach these leaders some basic health care tips which can be passed on to their support group members. (FGDs)

The Provincial hospital was the other government facility utilized by most respondents, but was used less frequently than polyclinics, about once every two months on average. Less than 5% (Table 5.4, previously shown) of respondents indicated that the reason for visiting Provincial hospitals was the payment of user fees suggesting that high user fees may be a problem prohibiting PLWA from using these clinics. Section 2.2.2<sup>31</sup> provides details on these prohibitively high user fees. PLWA partaking in the FGD, expressed the unaffordability of hospital care, it was asserted that a stay in hospital can cost Z\$21000, for a relatively short stay, and that admittance usually requires some form of prepayment. Provincial hospitals, were however, commonly chosen by respondents for providing effective treatment (Table 5.4 previously shown).

Traditional healers were visited slightly more frequently than Provincial hospitals (Table 5.3, previously shown). The results show that respondents chose to seek care at traditional healers because of the perceived effectiveness of the treatment received, (Table 5.4 previously shown) irrespective of their proximity to them.

Private doctors, although also perceived as providing effective treatment (Table 5.4) are least frequented by respondents. Respondents visited private providers only once every three months (Table 5.3) in stark contrast to the almost weekly visits to local public clinics. Only a few respondents (7.89%, Table 5.4) chose exemptions as a reason for going to a private doctor, it is speculated therefore, that very few private doctors exempt their patients with AIDS (this is to be expected, as exemptions are a feature of the public health system).

In summary, local government clinics proved to be the most popular health care provider, followed by traditional healers and provincial hospitals, which were almost equally as popular, with private doctors being the least popular provider. The most commonly cited reason for visiting any facility was effective treatment, followed by proximity to the respondent; the reason least frequently cited being high user fees.

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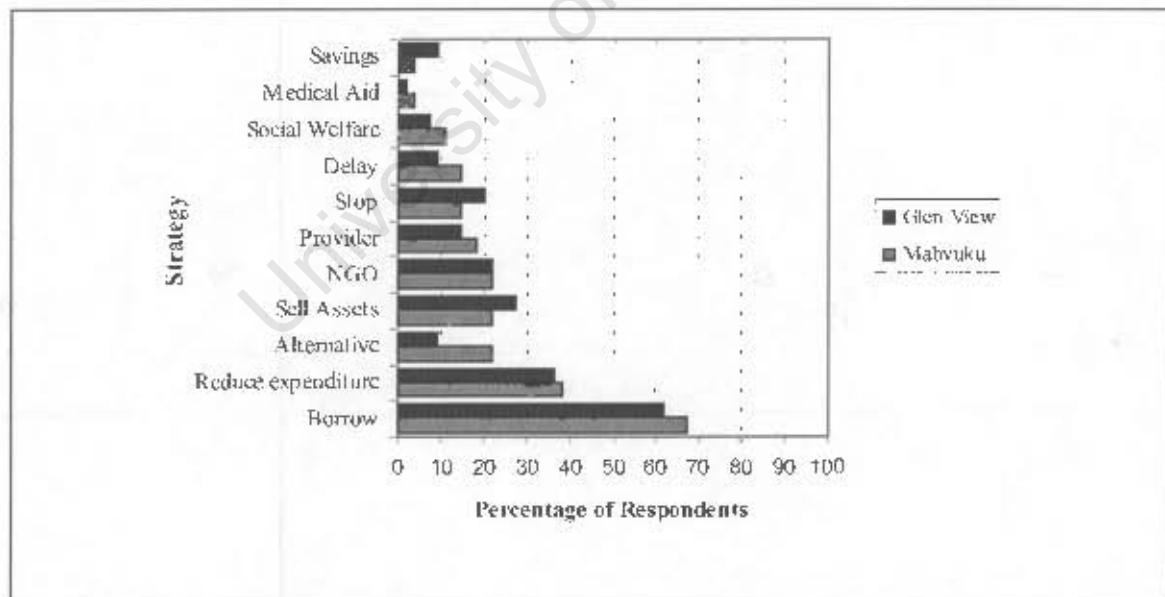
<sup>31</sup> Section 2.2.2 "An Examination of Health Care Providers"

## 5.4 Strategies Used to Cope with the Direct Monetary Costs of AIDS

This section presents and discusses the strategies employed by households to cope with the costs of ill health caused by HIV/AIDS. The analysis is a comparative one detailing the differences between the methods relied on by the two separate communities in order to understand the intricate differences in coping with illness in communities whose general income levels differ. Before launching into the discussion though, Table 5.5 presents the coping strategies identified by other Zimbabwe based studies, which examine the strategies used to cope with income shocks.

Many of the strategies identified by these other studies, presented in Table 5.5 are also identified in this study as shown in Figure 5.6.

**Figure 5.6: Cross - Community Comparison of the Strategies<sup>32</sup> Used to Cope with HIV/AIDS**



<sup>32</sup> Explanations of what each of the strategy means: Alternative: - seek alternative treatment - for example from a traditional healer; NGO: - seek NGO support; Provider: - seek a cheaper provider for example government or NGO; Stop: - stop the treatment; Delay: - delay the treatment; Social Welfare: seek assistance from a government social welfare group. See question 16, of the questionnaire found in Appendix B.

Referring to Figure 5.6 (shown previously) the most common strategy used to cope with the financial costs of ill health is to borrow, with almost 70% of Mabvuku respondents employing this strategy. One of the greatest differentials between the two communities' use of a strategy is evident in this method with 6% more Mabvuku respondents using this method than Glen View respondents. The only strategy that showed a greater differential was when respondents cope by seeking alternative treatment. Box 5.5 discusses borrowing as a strategy in greater detail.

#### **Box 5.5 Borrowing as a Coping Strategy**

The above result indicates that residents from Mabvuku *may* have access to a bigger pool of social resources (in the form of credit sources), as they are able to borrow more than Glen View residents. This is a positive result as it indicates that these poorer residents may be able to improve their access to health care resources by making use of this pool of social resources. Section 5.6 in an attempt to assess the type and strength of social resources, provides a detailed analysis, of who the respondents borrow from. The downside of this result however, is that extensive borrowing may indicate current and pursuant economic vulnerability. This is of concern since it is theorized that poverty ratchets result from increasing vulnerability to livelihood shocks due to dwindling social and tangible resources (Chambers 1989).

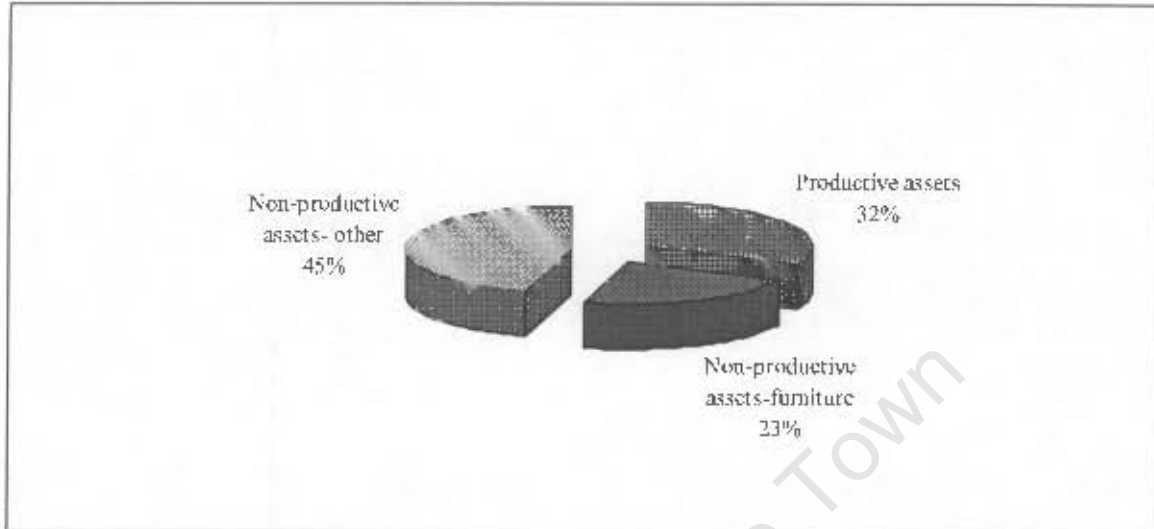
Figure 5.6 also shows that reducing expenditure on other basic needs follows as the next most popular method to cope with the increased financial burden imposed by the illness. Approximately 37% of households across the sample reported cutting down on all expenditure; this statistic was evident in each of the two communities. Considering that most of the households in these communities fall into the income brackets where they are unable to cover their basic needs (Boxes 5.1 and 5.2), coping by reducing expenditure means that they are likely to fall further and further below the basic needs line as a result of illness related costs.

An analysis of items of expenditure which households cut back on showed that most (61% Mabvuku and 50% Glen View) reduce their food consumption, with no Glen View households cutting back on education related expenses compared to 6% of Mabvuku respondents. Reduced expenditure on clothing was more variable with almost 15% of Glen View households cutting back on clothing and no Mabvuku households doing so. It is most likely that these households were not spending much on clothes prior to the illness costs.

Almost 25% of respondents, in Mabvuku cope by seeking alternative treatment, with a relatively low proportion of respondents coping by stopping or delaying treatment.

Selling assets and seeking NGO assistance show up as quite popular strategies with about the same proportion (approximately 20%) of respondents choosing these strategies. The sale of assets becomes a concern when productive assets, which have the potential to generate future earnings streams, are sold as opposed to unproductive assets. Graph 5.7 explores the types of assets sold, and shows that a greater proportion of non-productive assets compared to productive assets were sold. Although more non-productive assets are sold than productive assets, the very fact that productive assets are being sold is still a problem. The sale of any productive assets to pay for care or cope with illness related costs is still a concern though, as it indicates that households are losing their asset bases and therefore becoming more vulnerable to the illness related poverty ratchets referred to in the literature review (Chambers 1989).

Figure 5.7: Breakdown of Assets Sold By Type<sup>33</sup>



Referring once again to Figure 5.6, it is evident that a fairly high proportion of respondents, almost 22% seek assistance from NGOs as a method of coping. It is also interesting and surprising to note that more Mabvuku respondents make use of medical insurance (although the majority of respondents who said they used medical aid, used that of a relative, especially a sister or brother's medical aid). Few respondents used household savings to cope with illness related costs; this is understandable in these communities where the incomes of the residents are insufficient to cover their basic needs expenditures (see Boxes 5.1 and 5.2). In the FGD it was mentioned that most of the households did not own their own homes, and were thus particularly vulnerable since they would have to pay rent with their inconsistent informal trader incomes. When the home belongs to the household, it could prove to be a valuable coping mechanism, as rooms of the house can be let out to lodgers, thus earning the homeowners additional

<sup>33</sup> **Productive assets:** these include: sewing machines, bicycles, cars, stoves, ploughs; **Non-productive assets – furniture** include: chairs, wardrobes, tables, TVs, videos, radios, kitchenware, beds, fridges; **Non-productive assets other** include: clothes etc.

income. Prostitution was also identified as a common means of coping with the lack of income and high illness costs (FIGD).

In sum, across both communities, borrowing features as the most popular, and using Medical Aid the least popular strategy for coping with illness costs. Respondents in both communities employ roughly the same strategies with differentials occurring between the proportions of respondents using a specific strategy in each community.

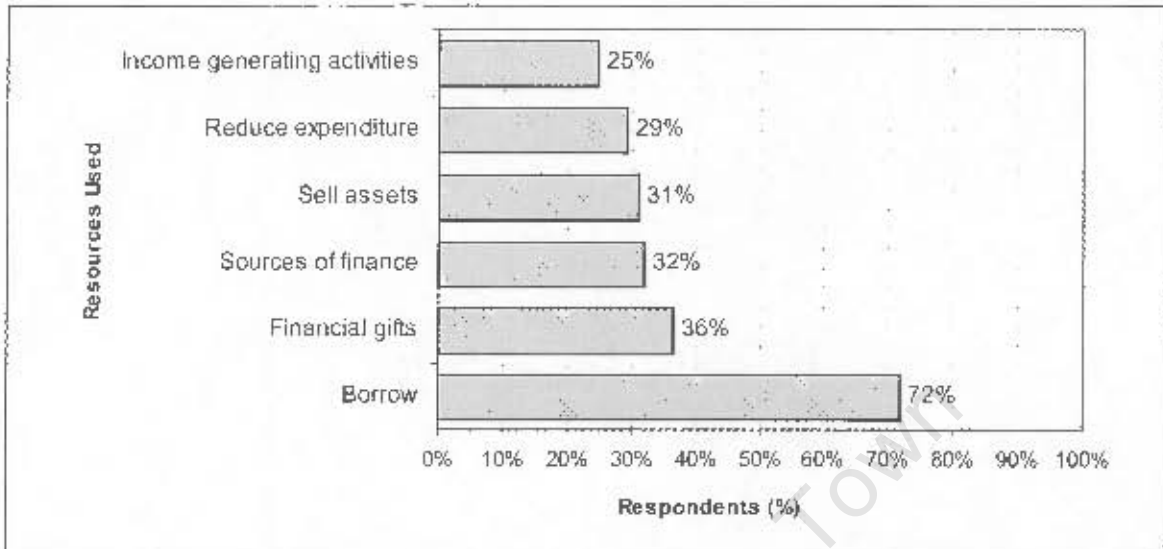
## **5.5 Resources Used to Pay for Care**

This section identifies the resources, which the households use to pay for care. Resources identified in this study are presented and discussed.

### **5.5.1 Resources Identified in this Study**

The respondents' responses showed evidence of reliance on a number of different resources. Figure 5.8 shows that most respondents (72%) used debt as a resource for paying for care. Financial gifts from relatives and friends also proved to be a popular resource for paying for care. Selling assets and reducing expenditure also free up financial resources, which are then used to pay for care, these have been analysed extensively in section 5.4. Using income from income generating activities associated with NGOs proved to be the least popular resource. This is quite surprising and points to the limitations of the income generating projects (see Box 5.5) as over 80% of respondents in both communities have associated with NGO income generating projects (Figure 5.10).

Figure 5.8: Resources<sup>34</sup> Used To Pay For Care



<sup>34</sup> **Sources of finance:** savings, medical aid, pawn valuables, social welfare; **Reduce expenditure:** reduce expenditure on basic needs; **Income generating activities:** these are income-generating activities of NGOs and community based bodies.

Box 5.5 presents some opinions on the subject of the problems facing income-generating projects.

**Box 5.5: Key Informants on Income Generating Projects and CBOs**

**Patrick Osewe (MD) Senior HIV/AIDS Advisor USAID:** Identifies one of the major limitations of these income-generating projects as the lack of planning and business logistics. Many soap making projects, for example, he says make such poor quality soap, which does not generate or maintain sustainable markets. Other projects fail because of lack of market analysis - a batik-making project may not succeed because the target market is already saturated. As a result, USAID has actively assisted these projects by using business people from the United States to teach project managers about such critical business issues.

**Ms Miriam Temin Assistant Advisor HIV/AIDS DFID Central Africa:** "CBOs are constantly running on a shoe string—they have limited, finite resources and have to spend a great deal of energy on fundraising. The personnel often lack the skills to do convincing accounting and monitoring, which limits their fundraising ability. Their capacity to absorb significant funds is often limited as well, so lack of funds is not the only problem"

*(Key Informant Interviews)*

## 5.6 Social Resources – A Comparative Study

This section presents the results of the analysis of data relating to the social resources used by the respondents. Social resources are cost management strategies which are assessed comparatively between the two communities. This allows for an analysis of the different stocks of social resources, and provides the opportunity to draw inferences about their use in improving access to care. It is hypothesized that social resources may improve a PLWA's access to resources and thus raise the household's livelihood to a higher level than possible without these resources. This would be evidenced by expenditures on basic needs such as food, education and health care, which are higher than what the household's income alone is able to support. This phenomenon is evident in the analysis of basic needs expenditures and incomes of the respondents in this study (Boxes 5.1 and 5.2).

The analysis will look at both the stocks of social capital within each community (by comparing chosen indicators of *stocks* of social capital), and the *types* of social capital evident within each community. This is done in order to determine to what extent these resources can aid PLWA in coping with the effects of the disease. The stocks of capital to be investigated are the *capital inherent in community networks and neighbourhood groups*, and the *capital held within intra-household relationships*. The types of social capital assessed are described in the literature review Section 3.4.3 and are: *bonding, bridging, linking* and to a lesser extent *restricted access to opportunities*.

The analysis, which follows, considers the existence of the social links by assessing the respondents' use of NGOs as a coping strategy, and the proportions of respondents employed in these community based bodies. The types of activities that the respondents are associated with in these bodies are examined in order to further assess the *types* of social relations. This is followed by an analysis of the social resources evidenced by who takes care of the PLWA. The sources of credit and financial gifts, which are also an indicator of stocks of social capital in a community, are then assessed with special focus on whether the sources are inside or outside the community, and who exactly the PLWA

borrow and receive gifts from. These comprehensive analyses are necessary as they provide an opportunity to assess the types of social bonds held by the respondents in the different communities, this is important as it indicates the strength and usefulness of the social resources.

### **5.6.1 The Use of NGOs as a Coping Strategy: an Indicator of Social Capital**

Most community based bodies and networks which work with PLWA are those initiated by NGOs. These non-governmental bodies, which base their activities at the community level, provide an important linking social resource as they extend the vertical ties between people from different socio-economic groups and positions of power. These are a powerful indicator of stocks of social capital.

The analysis of this type of social resource across both communities reveals that most, (almost 80%) PLWA do not access this type of resource as a coping strategy when they do not have money to pay for care ( i.e they cannot get money from an NGO to pay for their care or get the NGO to pay for their care.) This indicates that the linking social capital which these community based bodies offer PLWA may provide resources and influence *other* than financial resources needed to pay for care. This is confirmed by the results shown in Figure 5.10, which shows the types of assistance and activities which PLWA are exposed to through associations with these community based bodies. Box 5.6 details the type of assistance that one specific NGO provides.

**Box 5.6 Mashambanzhou: An Example of The Type of Help That PLWA Receive From  
NGOs**

Sister Margaret of Mashambanzhou, an NGO which does a great deal of work with PLWA had this to say about the work of Mashambanzhou and the impact of HIV. Mashambanzhou focuses on home-based care, skills training, orphan outreach, prevention and education for life services. The focus of the work in the past few years though, has been dealing with the issue of poverty and AIDS. Most of the work has been in trying to feed people since the problems of food insecurity and unemployment have started to outweigh the problem of AIDS. As Sister Margaret aptly said “the pain of poverty is greater than the pain of the virus,” for example even if there are support groups to help people deal with the impact of the disease on their lives, these are irrelevant to PLWA if they have no income, thus no food and therefore cannot even get up out of bed to attend the support group meetings! (*Key informant interview*)

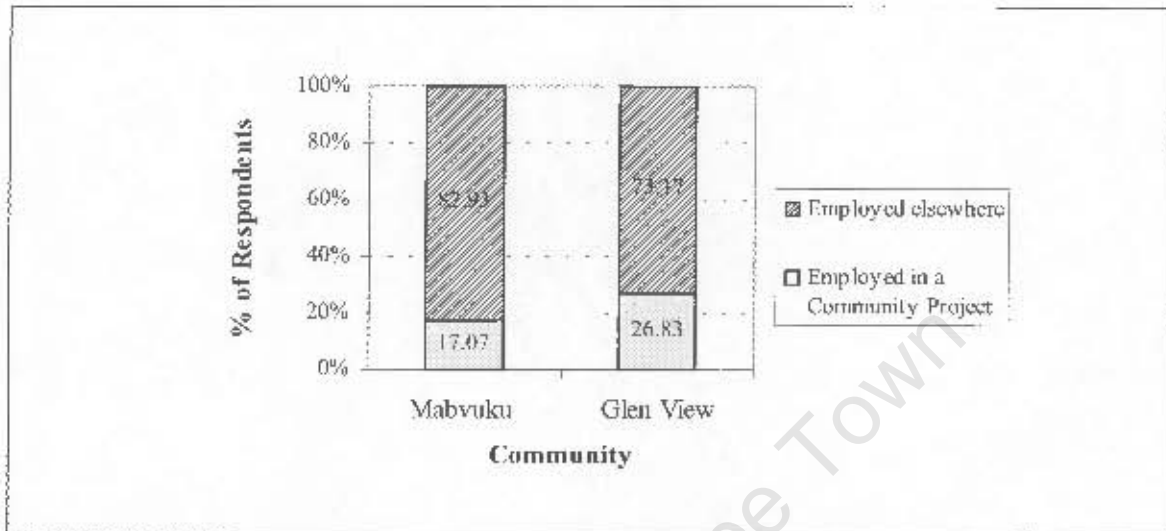
### 5.6.2 Community Employment As An Indicator of Social Resources

Employment in a community income-generating project (these are mostly run by NGOs) is substantially greater in Glen View<sup>35</sup> with approximately 27% of respondents stating that they are employed in a community project, compared to only 17% of Mabvuku respondents (see Figure 5.9). Employment in a community project indicates strong linking social capital, which, as stated in the literature review, is influential in improving access to resources and influence outside of the close knit bonding group. The fact that an NGO's project employs people within the community is indicative of the potential of linking social capital to improve the livelihoods of those PLWA within that community.

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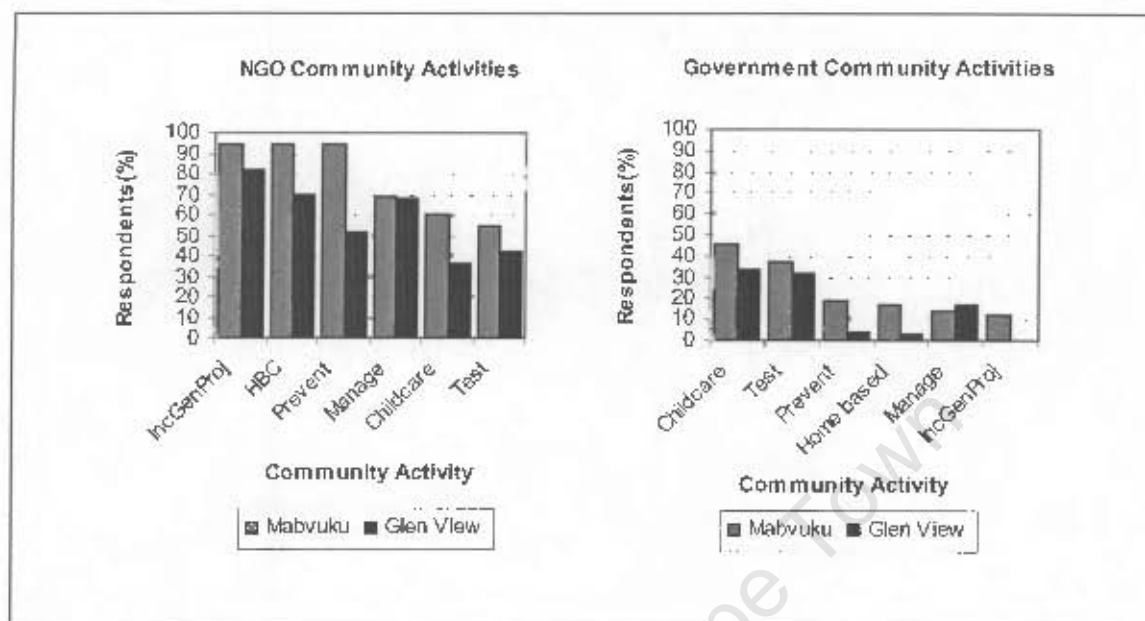
<sup>35</sup> These results may be slightly biased as “The Centre”, the activist AIDS body from which the respondents were identified has a counseling and support group centre in Glen View as opposed to just having counselors and support groups as it does in Mabvuku, i.e. in Mabvuku there is no formal meeting place and in Glen View there is for PLWA belonging to The Center. Some Glen View respondents may therefore be employed under this formal structure.

**Figure 5.9: Cross-Community Comparison of Respondents Community Employment**



Glen View respondents have more access to this resource as inferred by the results, which show that 10% more Glen View residents are employed by such community based organizations than Mabvuku residents. On the whole the stocks of this type of social resource are quite low, as most respondents who are employed are not employed in these community-based organizations. The predominant resources that respondents have access to through their linking social capital are evident in their associations with NGOs and Government bodies; these are detailed in Figure 5.10.

Figure 5.10 Comparison of NGO and Government Community Activities<sup>36</sup>



### 5.6.3 Involvement In Community Activities: An Indicator Of Social Resources

In this instance, Mabvuku respondents appear to have access to greater linking social capital as reflected by the extent of their associations with NGO activities in their community (Figure 5.10). Although they may have low dependence on NGOs for direct monetary assistance as a coping strategy (section 5.6.1) and less employment in community organizations than Glen View respondents (Figure 5.9), the results shown in 5.10 point to Mabvuku respondents having powerfully embedded<sup>37</sup> relations with NGOs in their community. The proportion of respondents involved in these particular NGO activities are high across both communities, indicating that PLWA-NGO associations provide a strong linking social resource. The substantially higher figures for Mabvuku point to stronger linking social relations of this type in this community than in Glen

<sup>36</sup> HBC—Home based care; IncGenProj = Income generating projects

<sup>37</sup> Howe and Shiell (2000) state that “embeddedness” at the *micro* level refers to dense intra-community ties or the extent to which individual members are integrated into their networks (This is taken from chapter 3.4.2 - Social capital- more key features)

View. Approximately 94% of Mabvuku respondents associate themselves with income generating projects, home based care initiatives and preventative programmes as opposed to 82%, 69% and 51% for each activity in respectively in Glen View (see Figure 5.10)

Boxes 5.7 and 5.8 describe some of the social resources that are helping Mabvuku residents cope with the impacts of HIV/AIDS.

#### **Box 5.7 Social Resources as a Coping Strategy: The Case of Mabvuku**

The levels of NGO activity in Mabvuku are quite high as compared to those in Glen View with organizations such as Island Hospice having a dedicated presence in the community. Island Hospice provides palliative care including home based care for seriously ill patients, and drugs (mostly multivitamins, cough mixture, pain killers, antiseptics, bandages, soap a small amount of antibiotics) for HIV/AIDS patients on a weekly basis. They also train volunteers in the area and provide workshops for PLWA. Mashambanzhou, apart from providing food for the poorest households also provides maternal resources, a drop in counseling centre, pre and post counseling facilities and skills development and income generating initiatives for women. The Catholic and Anglican churches are also a powerful support service for PLWA in this area, one example being an Anglican church based in Avondale (a more privileged community), which goes to Mabvuku every month. This church assists about 30 families in the area with school uniforms; supplies for school for example books and other stationery; a small "clinic" providing basic drugs and soap; and basic food supplies – beans, cooking oil, mealie meal, vegetables and soap. In rare instances donations form overseas links include carpentry equipment allowing a fortunate family member to be sent on a local carpentry and building course. Where families have had their electricity and water cut off the church, when able, pays for the bill, but this kind of assistance is very rare though. *(Principal researcher site visits and key informant interviews)*

#### Box 5.8 Virginia's Women's Centre:

The Women's Centre in Mabvuku run by Virginia, a PLWA, is an example of the kind of community-based activity being initiated in Mabvuku. The Centre receives no funding but was started up with donations of equipment. The purpose of the Centre is to: provide counselling for PLWA individually and through support groups; provide basic home based care for other PLWA (bathing them, and washing their clothes for them) and to teach PLWA skills that can enable them to earn a living as self employed people (as the possibilities of formal employment are marginal due to the stigma of HIV/AIDS and the general lack of education among PLWA in Mabvuku). The skills include typing, sewing, carpentry, paper technology and jewellery making. The PLWA are tutored by other trained PLWA who are paid by the money from fees paid which are marginal (Z\$200 for 9 weeks of training). Virginia has received some positive responses from PLWA using her centre: many feel they enjoy the support groups as they are free to talk with people who understand their plight; they receive informal assistance and advice from other PLWA for example being told that raw tomato helps cure thrush. In addition they feel at home and comfortable to ask for assistance from other PLWA since in some of their homes they are not "at home" as some household members even refuse to wash the plates from which the PLWA eats. The centre is therefore a good information source (social resource) as PLWA learn about: how to cope with the illness; are told about where they can go to for help with school fees for instance and how to get in touch with support bodies such as Island Hospice, Mashambanzhou and the department of social welfare. Virginia cited the efforts of Island Hospice in providing basic drugs and care for PLWA and Mashambanzhou for helping people with basic foodstuffs such as mealie and beans and soap as useful for PLWA in the community. Virginia is a member of WASN the Women's AIDS Support Network, a proactive women's AIDS group; she is therefore an important link between the PLWA in her area and this organization, which receives funding from international bodies. Such links are important if the help that aid bodies (USAID, DFID to mention a few) are providing for fighting HIV in Zimbabwe is to be felt at the lowest levels of the community where help is needed most.

Going back to the results presented in Figure 5.10, it is evident that associations with community based bodies such as churches, and community based NGO activities, are relied on more heavily by respondents than associations with government bodies/activities. This is evident when comparing the proportions of respondents engaged in the same activity in community bodies versus government bodies (Figure 5.10). It is interesting to note that no Glen View respondents identify association with government income generating projects. Mabhuku residents also appear to have stronger linking ties with government bodies involved in the selected activities, this is shown by the greater proportion of Mabhuku respondents associating themselves with these activities than Glen View respondents.

In sum, the assessment of the stocks and types of social capital in the two communities points to both communities having high levels of social resources, with Mabhuku exhibiting higher levels in general. Although more Glen View respondents are employed in community projects and NGOs, Mabhuku respondents seem to have stronger and more embedded linking social ties with community bodies whether they be governmental or non- governmental.

There is however a low incidence of employment<sup>38</sup> in these community bodies/projects across the board, despite respondents indicating high associations with community income generating projects (the limitations of income generating projects are detailed in Box 5.5). Respondents from both communities have a low incidence of direct financial assistance from NGOs as a coping strategy.

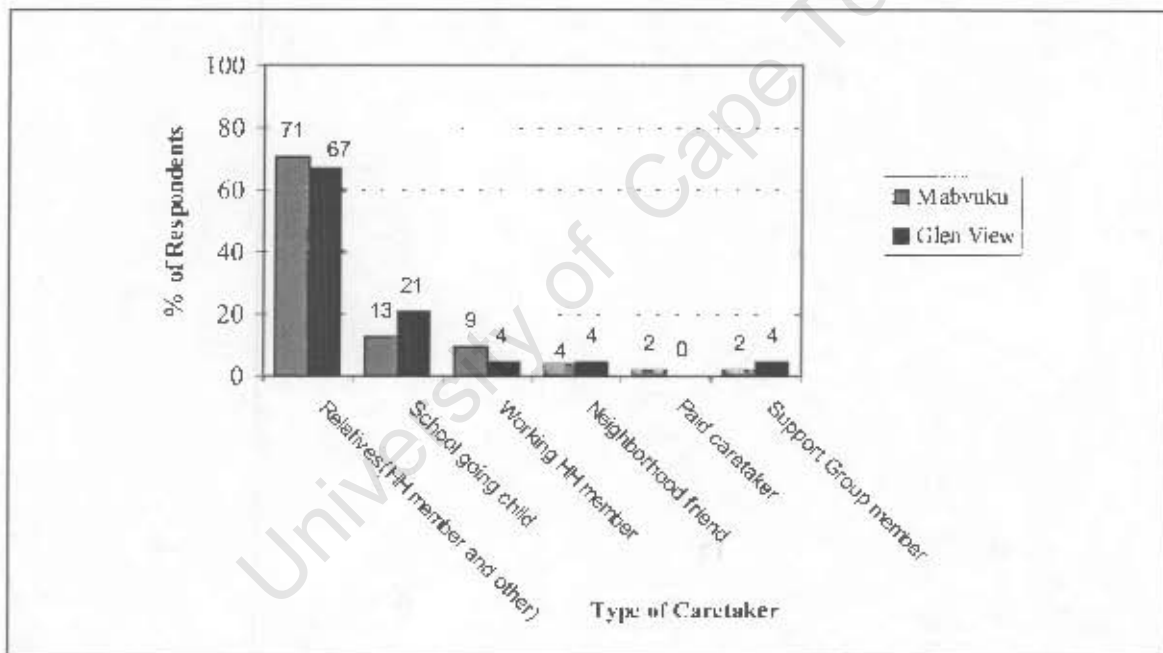
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<sup>38</sup> Employment in CBO and NGOs refers to PLWA as direct employees of the organizations and their specific projects, whilst associations with income generating projects refers to PLWA having at some point associated with these projects, but not necessarily have become employed due to the projects. Refer to questions 6 and 24 of the questionnaire (Appendix B), for clarity, on how this information was sourced.

#### 5.6.4 The PLWA's Caretaker: An Indicator of Bonding<sup>39</sup> Social Capital

An analysis of who takes care of the PLWA allows for further discussion of the different types of social capital in the two communities. Figure 5.11 presents a comparative analysis across the two communities. Here bonding social capital is measured by the proportion of respondents in each community who are taken care of by a working household member, a school going child, neighbourhood friends, and support group members (these are taken as being within the immediate community).

Figure 5.11: A Comparison of the PLWA's Caretaker Across the Two Communities



The comparison of PLWA's caretakers shown in Figure 5.11 shows that most PLWA are taken care of by relatives. It is assumed that these relatives consist of household members

<sup>39</sup> *Bonding social capital*: "the strong ties connecting people from the same immediate group: family members, neighbours, close friends, and business associates sharing similar socio-demographic characteristics" (Russell 2001:50). In this study they are to be studied as a method of mitigating the harsh consequences of chronic illness in a household through for example intra-household substitution of labour and sources of non-financial assistance, for example care taking of the ill family member. The influence of this form of social capital is limited however as the individuals within the grouping have similar resource endowments. (Section 3.4.3 Health and Social Resource Studies)

and other relatives found in the community, as it would be very difficult for caretakers to travel outside of their own communities to go and take care of a relative living with AIDS in another community. This high proportion in both communities points again to high and almost equivalent levels of bonding social capital. Children are more prevalent as caretakers in Glen View than in Mabvuku. Children are the second most common type of caretaker in both communities, this result, which is evident in Figure 5.11, is supported by statements made in the FGDs, as detailed in Box 5.9 (HIV/AIDS and children in the home). Such high levels of child caretakers raises concern about the impact of the disease on the development of the children of PLWA.

#### Box 5.9: HIV/AIDS and Children in The Home

In the FGDs, the plight of the children of PLWA in poor urban areas was brought t to the fore. "Children are now housemaids in many households, they are taking care of their sick parents with little support or knowledge of how to take care of them (bathing incapacitated parents). Many of them can see death approaching, not just at one point; they see it approaching everyday as they watch see their parents become skeletons. They become psychologically affected as they see this and endure the stigma placed on them and their parents; other children and even teachers then ostracize many of them at school and even at church. If they are able to be in school they end up doing badly because of all this; school things seem insignificant compared to issues at home and thus they neglect school. A cycle of HIV/AIDS occurs because the children, while they are experiencing all this are not being educated about AIDS and are lacking parental guidance in their lives. So even though a parent may die from AIDS, the children also end up contracting the disease due to the environment they grow up in. Other adults whether they be at school, in the church, or in the community at large do not know how to handle the situations they see in these families and just watch as children, as young as 6 or 7 cook and become their parent's parents". (FGD)

In sum the results of the analysis of social capital embodied by who the PLWA's caretaker is, shows that both communities exhibit high levels of bonding social capital.

The social capital embodied by Mabvuku respondents points to bridging and linking relationships which are more strongly embedded than those enjoyed by Glen View respondents.

### 5.6.5 Sources of Credit: An Indicator of Bonding, Bridging and Linking Social Capital

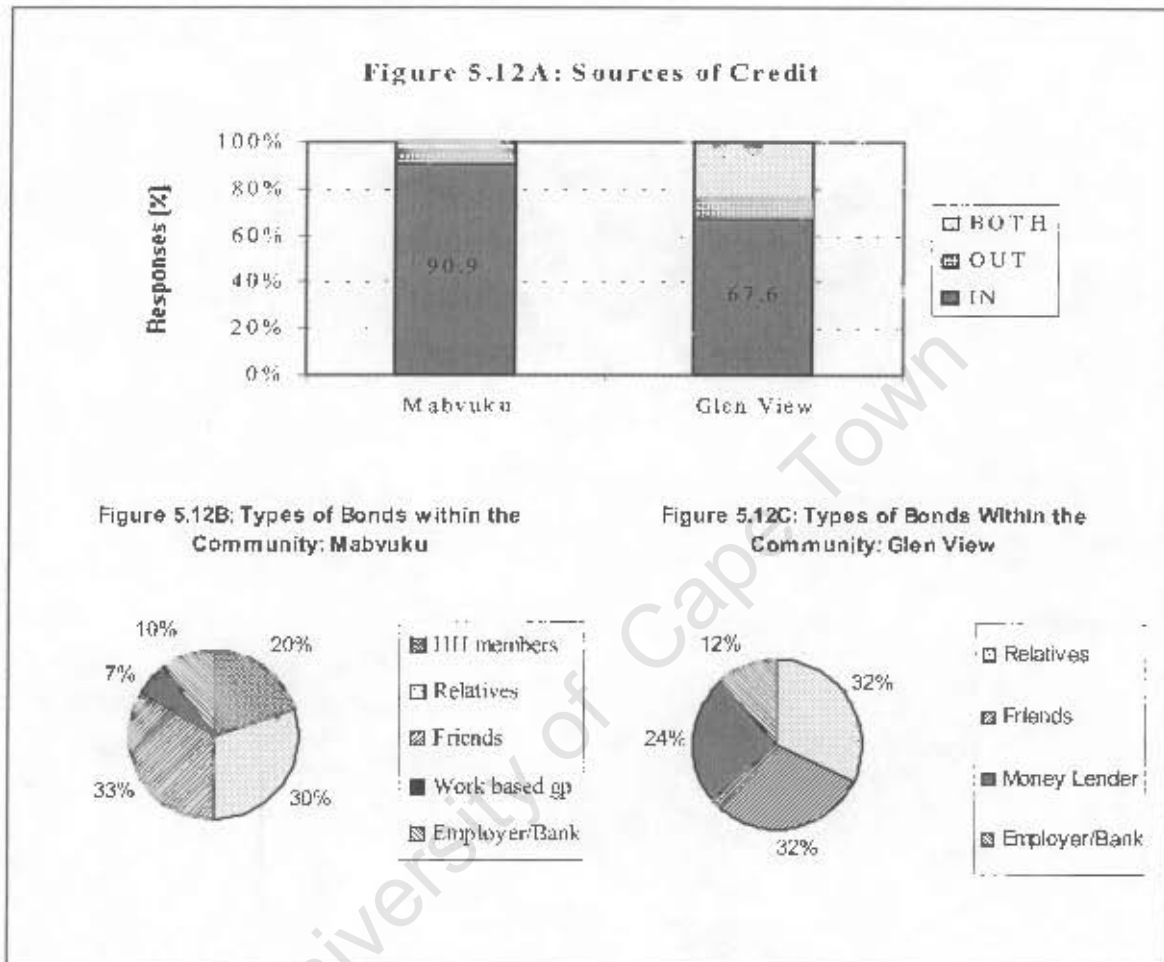
Social capital is described as a resource through which “actors can gain direct access to economic resources (subsidized loans, investment tips, and protected markets such as the market for antiretroviral drugs in Africa)” (Portes 1998:3). Although incurring debt may increase these low-income households’ vulnerability, this coping strategy has proved to be the most common in both communities (see Figure 5.6). An examination of sources of credit allows a further analysis of the differences in the types of social capital present in the two communities. As stated previously (section 3.4.2) bonding social capital, although useful for mitigating the harsh effects of chronic illness, provides little help for households in gaining access to or improving access to resources compared to bridging<sup>40</sup> and linking<sup>41</sup> social capitals. The graphs in Figure 5.12 show a comparison of the sources of credit and then present an analysis of the types of links within the community exhibited by these sources of credit.

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<sup>40</sup> *Bridging social capital*: “weaker ties with people from the same socio-economic status but different ethnic, occupational or geographical groups” (Russell 2001:50). These together with sources of linking social capital are proposed by Narayan (1999) as being more influential to improving access to health care resources. (Section 3.4.2)

<sup>41</sup> *Linking social capital*: “vertical ties between people from different socio-economic groups and positions of power, such as links between poor people and actors in positions of influence in formal organizations such as political parties, banks, schools, hospitals, housing authorities, or the police” (Russell 2001:50). As mentioned previously these ties are invaluable for improving access to resources as they open the door to financial and social resources outside of the individual’s immediate grouping. (Section 3.4.2)

Figure 5.12: Comparison of Sources<sup>42</sup> of Credit



Most respondents in both communities (91%: Mabvuku, 68% Glen View) borrow from people, or formal credit structures within their community (Figure 5.12A). This indicates high stocks of bonding and/or bridging social capital within each community and more so in Mabvuku. It should be noted that the figures for sources of credit inside and outside of the community may be slightly understated as some respondents received credit from

<sup>42</sup> Figure 5.12A: IN= respondent's sources of credit within the community. OUT= respondent's sources of credit outside of the community. BOTH= respondent's sources of credit are both in and out of the community

sources both in and out of the community (especially in the case of Glen View which has a substantial number of respondents receiving credit from both), and this would be recorded under “both”.

Figures 5.12B and 5.12C further explore these sources of credit within the communities to assess the types of social links they represent. Loans from household members, or other relatives and friends, are a proxy for bonding social capital. These represent 83% (Figure 5.12B; 20%, 30% and 33% respectively) of all loans received by Mabvuku respondents and 64% (Figure 5.12C; 32% each for friends and relatives) of loans received by Glen View respondents. This confirms that respondents in Mabvuku have higher levels of bonding social capital than those in Glen View.

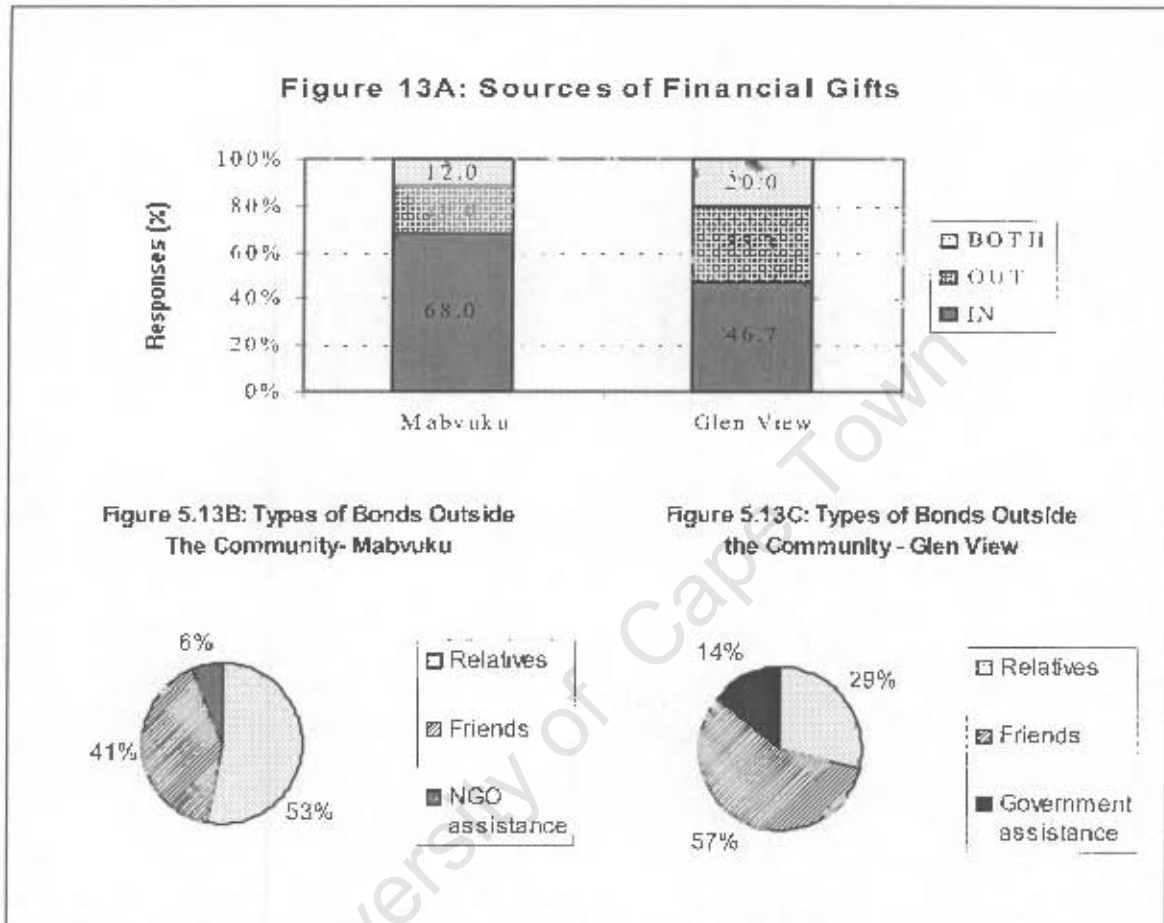
Loans from a work based group, money lender, employer or bank are a proxy for bridging and linking social capitals and these represent 17% and 36% of loans received by respondents in Mabvuku and Glen View respectively. This indicates that Glen View residents may have less bonding and more bridging and linking social resources, which enable direct financial assistance, compared to Mabvuku residents. This means that these respondents are more likely to gain access to financial assistance for managing the costs of the disease than Mabvuku residents.

This allows for a clear differentiation between the types of resources which the linking social capital gives residents in the different communities access to in helping them cope with the effects of HIV/AIDS. Mabvuku residents proved to have linking social assets, which gave them access to resources, which focused on specific HIV/AIDS interventions (section 5.6.3; home based care, activities around AIDS management, prevention and testing), whereas here Glen View residents have linking social relations, which gain them greater access to direct monetary assistance.

### 5.6.6 Sources of Financial Gifts: An Indicator of Bonding, Bridging and Linking Social Capital

As shown in previously in figure 5.8 (section 5.5.1), 36% of the respondents in the sample use financial gifts to pay for care. Figure 5.13A shows that across both communities the greatest proportion of these financial gifts come from people or formal structures within the communities (Mabvuku 68% and Glen View 47%). Mabvuku's relatively larger proportion (68%) of financial gifts from within the community than Glen View's (47%) points again to Mabvuku respondents holding higher levels of bonding social capital than their Glen View counterparts. However substantially more assistance from outside the community is evident for gifts than for credit. Figure 5.12A in the previous section showed that very little credit is extended to the PLWA from sources outside of the community. It is interesting therefore to analyse the types of links which are represented by these out of community sources of financial gifts as shown in Figures 5.13B and 5.13C.

Figure 5.13 Comparison of Sources of Financial Gifts

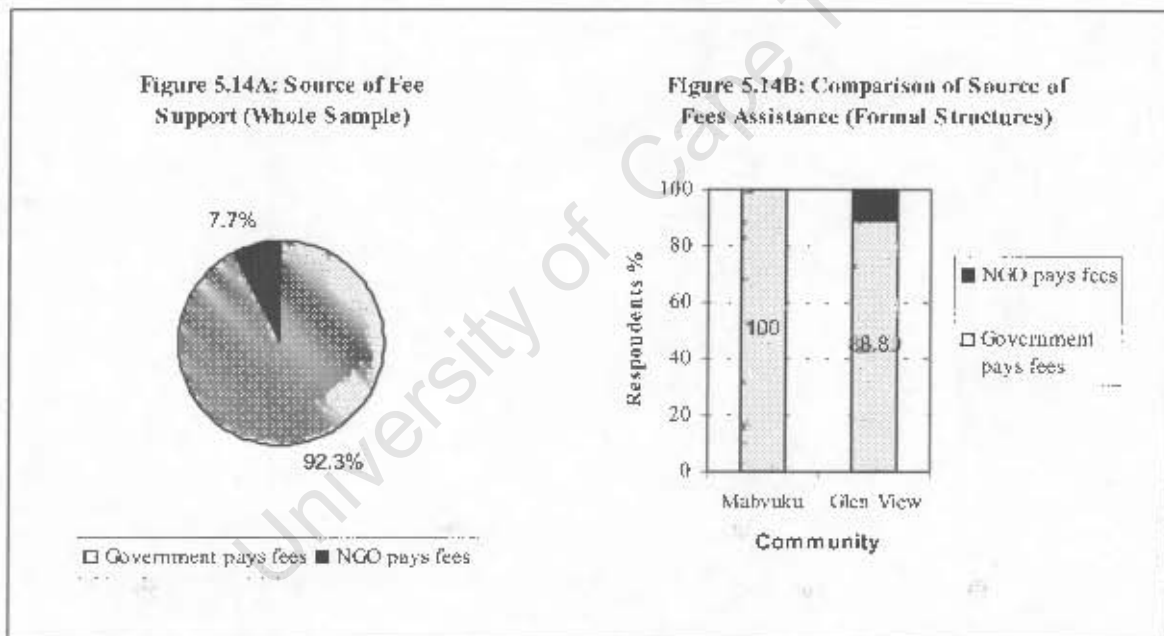


Since Figures 5.13B and 5.13C examine social links *outside* of the community, in the form of sources of financial gifts from those with greater resource endowments, they are effectively assessing either bridging or linking social capital. Financial gifts from relatives and friends outside of the community are used as proxies for bridging social resources, and financial assistance from and NGOs and government are proxies for linking social capital. This means that Mabvuku respondents have fewer (6%) linking social resources, from which they can draw financial resources than Glen View residents (14%), but greater bridging resources (94%), than Glen View residents (86%).

### 5.6.7 Other Sources of Social Support

A small percentage (12%) of the respondents said that they had school fees for their children paid for by a formal structure (NGO or government). Of these almost 93% had their children's fees paid by a government body and only 8% were paid by an NGO (Figure 5.14A).

Figure 5.14 Educational Support for the Children of PLWA



All of the Mabvuku respondents who had their children's school fees paid for by the above named formal structures had them all paid by government, the same applied to Glen View respondents to a lesser extent though, with 89% being paid by a government body (Figure 5.14B). The government provides school fees assistance through the social welfare department and the Zimbabwe National Network for PLWA (ZNNP+). The low

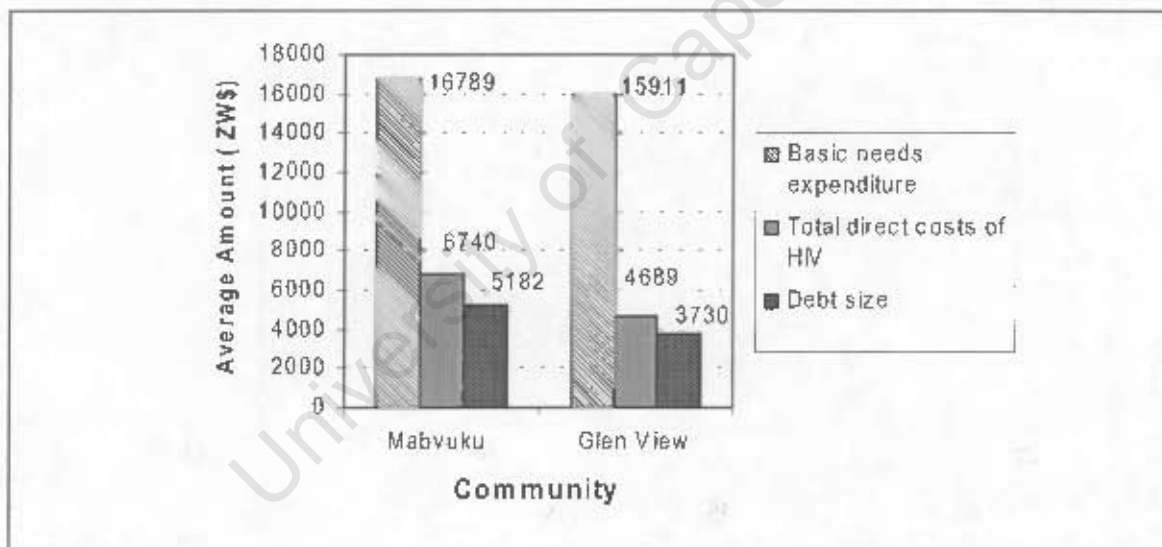
percentages of PLWA who access this resource provides evidence that it is either inaccessible to most PLWA for one reason or another (the mismanagement of funds, or the improper applications of means tests), or that PLWA are not aware of this resource (though this is assumed not to be the case).

In sum, the analysis of social resources across the two communities shows that there are quite high levels of social resources within the two communities with Mabvuku dominating. The types of social resource however, are what determine to what extent PLWA can rely these resources to mitigate the effects of HIV/AIDS. Such resource are able to mitigate the effects of the disease by: improving access to care, providing financial assistance to enable HIV/AIDS interventions such as home based care, income generating projects, and HIV/AIDS management programs. The social resources, which are enjoyed by Mabvuku respondents, are strong linking social ties with NGOs based at community level. These linking ties provide assistance to respondents via interventions related to HIV/AIDS for example income-generating projects for PLWA, home based care and other forms of help with managing the disease. Mabvuku respondents also have quite high levels of bonding social resources (in absolute terms and as compared to Glen View residents). These types of social resources are also important for mitigating the harsh consequences of the disease through non-financial assistance, for example through intra-household substitutions of labour and the care taking of an ill family member. The social resources which are enjoyed by Glen View respondents, are to a lesser extent, bonding resources, and also linking relations, which provide access to direct financial resources (loans and gifts) as opposed to the interventionary resources that linking social ties afford Mabvuku residents.

## 5.7 Economic Vulnerability

Economic vulnerability for the purposes of this study is examined by comparing averages of the household's basic needs expenditures, the total direct costs of HIV/AIDS and the amount of debt held. Figure 5.15 shows that households across both communities are economically fragile. The total direct costs of HIV/AIDS and the debt owed increase the economic burden on these households which cannot even meet their basic needs.

**Figure 5.15 Cross-Community Comparison of Basic Needs Expenditure, Direct HIV Costs and Debt Size**



Although Glen View respondents have less debt on average, households in both communities exhibit similar patterns of economic vulnerability. Figure 5.15 portrays the extent of these households' vulnerability, and provides a potential indicator of households on the brink of the commonly referred to "illness induced poverty ratchet" (Corbett 1989). Details on some of the poignant issues discussed by PLWA in the FGD are presented in Box 5.10 before the chapter is concluded.

#### **Box 5.10: Concluding Commentaries: The Experiences of PLWA**

The FGD discussions brought out some of the real issues faced by PLWA- these are presented here:

***The Impact of HIV/AIDS on the household:*** the PLWA agreed that the impact of the disease on the household was overwhelming. Many said that it was difficult because they, as women, had to become the heads of the home, from previously being underdogs without the skills to look after the family. It was also noted that when husbands died the property goes to his relatives, since the wives are not yet educated about the new laws around this issue. The lack of money for the household was expressed as a major issue. Home based care was agreed as a non-starter in some cases, as it didn't work as care was only targeted at the PLWA even in cases where there were over 6 people living in a two bed roomed house, and the overcrowding meant that they were all exposed to diarrhoea, vomiting, and T.B. In some cases the PLWA said that due to the sale of assets (fridges, televisions and cows) they were left with nothing.

***Coping with the effects of the disease:*** "Rova nhowa, chamuka inyama" this was the statement used to describe how households end up coping, it essentially means, "whatever comes our way is how we survive." One day they may survive because of a gift from a relative or friend, another day they may get money from cleaning someone's house, and on another prostitution may be the method of survival.

***Support from organizations working in the communities:*** Only some churches offered assistance to PLWA, as there is still a stigma around having HIV/AIDS. The work of NGOs such as Mashambanzhou was recognized as useful, but not effective because they had too many people to look after, and are thus not able to care for them all. Some PLWA said that they thought that it was better for such organizations to help a few families significantly than to try and help out everyone a bit, whereas others thought it was more important for these organizations to help everyone just a bit to ensure the survival of as many families as possible. The PLWA said that they also thought that if these NGOs and government bodies such as the National AIDS Council (NAC) had PLWA involved the administration of HIV/AIDS related matters they would be more effective in dealing with the problems faced by PLWA (a case of the sick understanding the issues faced by the sick).

***What determines which households make use of social resources?*** The general consensus was that it seemed that people with access to some form of help kept getting more assistance. Those who are in support groups learn about where they can go to for help and thus get more help. Those who are well informed find out about other sources of assistance and thus get more assistance.

**Chapter summary:** this chapter provided a detailed discussion of the results arrived at from the analysis of data. Data collected from a questionnaire, FGD, key informant interviews and exploratory research was analysed and discussed. It was found that the costs of HIV/AIDS, added additional pressure to the PLWA's households, most of whom were already living below their basic needs line. It was also found that many PLWA are taken care of by their children, and relatives. Local polyclinics were identified as the preferred providers of care; this was mainly due to the high costs of accessing care at other providers.

The most common coping strategy employed was borrowing from friends and relatives, and most of the resources use to pay for care came from funds accessed by the extension of credit. The coping strategies identified in this study was similar to those identified in other studies on how Zimbabwean families cope with income shocks. The study of social resources showed that Mabvuku residents and higher levels of bonding social capital than Glen View residents, and that the two communities had linking and bridging social resources, which enabled access to different forms of assistance. Mabvuku residents' linking resources enabled access to interventions to cope with HIV/AIDS, such as home based care, HIV/AIDS management, testing and some income generating activities, whilst Glen View residents' linking social resources often enabled access to direct monetary assistance. Examples of the types of social resource available to the residents of the two communities were provided.

The chapter was concluded by commentaries made PLWA regarding their plight. Chapter 6, which follows presents the conclusions, proposes appropriate policy recommendations and identifies future areas of research around the subject of HIV/AIDS, coping strategies and social resources.

## CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

**Chapter Overview:** This chapter presents the conclusions arising from the discussion of results and presents recommendations based on these. The study sought to assess the direct and indirect costs of HIV/AIDS on two poor urban communities in Harare City, and to examine how households in these communities cope with these costs. Using a “household livelihood set” approach, it was possible to examine the incomes, assets-tangible and non-tangible which the households had access to in order to help them cope with the disease. The study sought to understand whether households cope differently in the two communities based on the resources available to them. It also sought to determine whether community income differentials affect the types of social assets available to the households, and how they rely on these social resources to mitigate the harsh consequences of HIV/AIDS. This chapter presents the conclusions arising from the analysis and presents policy recommendations based on these conclusions. The chapter concludes with suggestions for future work around the subject of household coping with HIV/AIDS and social resources.

### 6.1 Conclusions

#### 6.1.1 Direct Costs of HIV/AIDS to Households and Basic Needs Expenditures

It is evident from the results that across both communities respondent households' incomes fall far below their basic needs expenditures. The direct costs of HIV/AIDS amount to a third of the household basic needs expenditure and are generally higher than the households' income. The results also point to Mabvuku respondents incurring higher financial costs of care than those in Glen View.

### **6.1.2 Indirect Costs of HIV/AIDS**

Respondent households incur high indirect costs, with a large percentage stating that the principal breadwinner lost time from work because of the disease, and quite a number losing their jobs. The results also point to a large depreciation in the human capital endowments of households as school children are involved in looking after PLWA, and are possibly being pulled out of school as the household's income base falls. The low level of financial assistance for paying for school fees further exacerbates the problem.

### **6.1.3 Health Care Providers**

Most PLWA prefer to use their local government clinic when seeking care, mostly because of their proximity. The treatment at provincial government hospitals is cited as being most effective, but unaffordable in terms of direct treatment costs and transport costs. Private doctors are generally not an option for those respondents seeking care. Traditional healers are, however, widely regarded as an effective care provider.

### **6.1.4 Coping Strategies**

Across both communities borrowing features as the most popular, and using Medial Insurance the least popular strategy for coping with illness costs. The debt incurred is generally above the income levels of the respondent households meaning that the households are made more economically vulnerable by debt. Respondents in both communities employ roughly the same strategies with differentials occurring between the proportions of respondents using a specific strategy in each community. Of the households that use the sale of assets as a coping strategy, most of them sell non-productive assets. Although the sales of productive assets are lower than sales of non-productive assets, such asset depletions are a cause for concern it means that these already poor households are compromising future potential earnings streams. There is a

low incidence of coping by delaying or stopping treatment, and also a low incidence of using household savings and medical insurance as coping mechanisms. The fact that many households cope by reducing expenditure on other basic needs supports the conclusion that these households are living below their basic needs expenditure and are therefore made more economically vulnerable by the disease.

#### **6.1.5 Social Resources**

Both the communities exhibit high levels of social capital as evidenced by the presence of community-based organizations and the associations which PLWA have with them. The extent of these social relations differs between respondents in the two communities, as do the resources, which the PLWA gain access to, through them. For Mabvuku respondents the social links provide interventionary help in the form of: bonding social capital – household substitution of labour, and assistance from friends within the community and linking social resources – HIV/AIDS related community interventions such as testing, prevention, income generating and home based care programs. For Glen View residents the social links provide more direct monetary assistance in the form of bridging social capital-loans and financial gifts from relatives and friends outside of the community, and linking social resources – such as loans, financial aid and employment opportunities from formal structures or friends inside or outside of their community.

## **6.2 Policy Recommendations**

### **6.2.1 Direct Costs of HIV/AIDS to Households and Basic Needs Expenditures**

Across both communities respondent households' incomes fall far below their basic needs expenditures.

- It is recommended therefore, that specific structures be put in place to provide assistance with items of basic need such as food, health, education and housing which make up the greatest expenditures. Improved home based care services, which are affordable and sustainable in these resource poor communities would help reduce the financial costs of care for affected households. Increased financial assistance in paying for school fees, and other education related expenditures such as school uniforms, would greatly relieve the financial burden on these households. It is also recommended that structures be put in place to ensure that such services are accessible to all needy PLWA.
  
- It is recognized that in order for the above-mentioned structures to be effective and provide sustainable support for PLWA, the efforts of all actors involved in such work around HIV/AIDS (government, NGOs, and churches) should be united. The lack of unity between these bodies in their work around HIV/AIDS was identified as a factor limiting the effectiveness and sustainability of their interventions. It is further recommended therefore that structures be put in place which focus on co-ordinating the disjointed efforts of government, churches and NGOs.

The direct costs of HIV/AIDS amount to a third of the household basic needs expenditure and are generally higher than the incomes of most respondent households.

- Policy should also be directed toward providing specific exemptions from health service user fees for PLWA who have no form of income or financial support.

The results show that Mabvuku respondents incur higher financial costs of care than Glen View respondents.

- It is recommended therefore that policy making be directed towards building capacity within support bodies (whether they be governmental or non-governmental bodies) in order to identify differentials in need between PLWA in different resource poor communities. It is suggested that Aid organisations build structures enabling them to identify the *types* of support needed by PLWA in different communities. In this instance, the type of assistance directed toward PLWA in Mabvuku and Glen View should differ.

### **6.2.2 Indirect Costs of HIV/AIDS**

Respondent households incur high indirect costs, many principal breadwinner lost time from work because of the disease, and quite a number lost their jobs.

- This suggests that policy should be directed towards educating employers about their workforce and AIDS. Employers need to be educated about the fact that PLWA when given the appropriate support, can continue to live healthy lives and be productive employees.
- The above recommendation is applicable only to PLWA who are formally employed; this study has shown that many PLWA in these communities are

self-employed as vendors with mediocre and inconsistent incomes. It is recommended therefore that policy makers direct efforts towards assessing the possibility of a community based health insurance for such low-income groups.

- As many of the PLWA are self-employed, it is recommended that Aid organisations and government prioritise policies which are directed at strengthening the skills base of these people so that they can make a reasonable living out of the work they chose to do.

### **6.2.3 Health Care Providers**

Most PLWA prefer to use their local government clinic when seeking care as they incur low or no transport costs when seeking care at these facilities.

- This conclusion suggests the need for strictly enforced exemption system for PLWA at their local facility as they currently have to pay ZW\$130 every time they present themselves there with a different symptom. Such a structure should allow for effective means testing of PLWA, before they are entitled to such an exemption.

Treatment at provincial government hospitals is cited as being most effective, but unaffordable.

- It is recommended therefore that policy be directed toward structuring specific exemptions (partial or full), or special payment terms for hospital care for PLWA. Again such structures should use appropriate means testing of PLWA before they receive exemptions. This conclusion again brings to the fore the need for a

community based health insurance system for PLWA which allows hospital coverage.

The results show that private doctors are not an option for those respondents seeking care. Traditional healers are, however, widely regarded as an effective care provider.

- The results suggest therefore that policy should be directed towards supporting and recognizing traditional healers as plausible health care providers.

#### **6.2.4 Coping Strategies**

Across both communities borrowing features as the most popular, and using Medical Insurance, and household savings the least popular strategies for coping with illness costs. The debt incurred is generally above the income levels of the respondent households meaning that the households are made more economically vulnerable by debt. A small number of households cope by selling their productive assets. Many households cope by reducing expenditure on basic needs such as food and education

- It is recommended that government and non-governmental groups co-ordinate their efforts to develop sustainable income generating projects. These projects would help PLWA cope with the costs of the disease, prevent deepening indebtedness and improve access to necessary health care. The success of these projects may be catalytic and propel the institution of community based medical insurance systems. Such systems could possibly improve access to care for PLWA and reduce sickness induced poverty cycles.

- The above recommendation would also encourage savings and use of medical insurance as coping strategies. It is envisaged that these initiatives would reduce the incidence of coping by selling assets, and transform these currently economically vulnerable households, into economically robust units, which are resilient to illness induced poverty.
  
- It is also suggested that formal structures be put in place to assist households living below their basic needs; a key concern being food security. It is once again recommended that government and NGOs coordinate their efforts so that sustainable structures can be put in place to ensure that the households' of PLWA still have access to the basic needs of food, accommodation and education.

#### **6.2.5 Social Resources**

Respondents in both communities exhibited a strong reliance on their social resources as a coping mechanism. Mabvuku respondents showed higher levels of bonding social capital. Their bridging and linking social capitals provided resources for managing, preventing and testing for HIV/AIDS and also assistance with income generating projects and other interventionary assistance. Glen View respondents showed high levels of bridging and linking social resources which gave them direct financial support through loans, financial gift and employment opportunities.

- These conclusions suggest that social resources should be an integral part of any policy considerations. It is recommended that policy makers build capacity with respect to understanding the implications of how social resources can help aid in the understanding of a household's ability to cope with AIDS, and how the community at large can deal with the social problems resulting from the disease.

- Poorer communities may exhibit higher levels of bonding social capital; the strengthening of these particular social resources could help PLWA and their households deal with the deleterious effects of AIDS. Structures may need to be put in place however to build and strengthen the PLWA's bridging and linking social relations with actors outside of their communities so as to improve their access to financial and health care resources.
  
- Relatively wealthier communities may exhibit bridging and linking social resources, which improve their access to financial, but few other resources. A policy response may be to encourage the use of these very important linking and bridging resources to disseminate information and psychological support for PLWA, and other types of financial assistance.

### **6.3 Suggestions for Future Work**

Future research in this area should go a step further and develop indicators for the types of coping strategies used by different income groups. This should be done with a view to strengthening those strategies which make households economically robust and reducing reliance on those strategies that make households vulnerable to illness induced poverty.

The construction within health literature, of indicators of the early warning signs of illness-induced poverty similar to the famine early warning system in food security literature is another area of future work. This methodology would allow for analyses which determine how households progress into poverty and the documentation of the precursors to illness induced poverty ratchets.

Further work also needs to be done around developing frameworks for co-ordinating the efforts of governments, NGOs, churches and all other organizations involved in mitigating the effects of HIV/AIDS on the poor urban household.

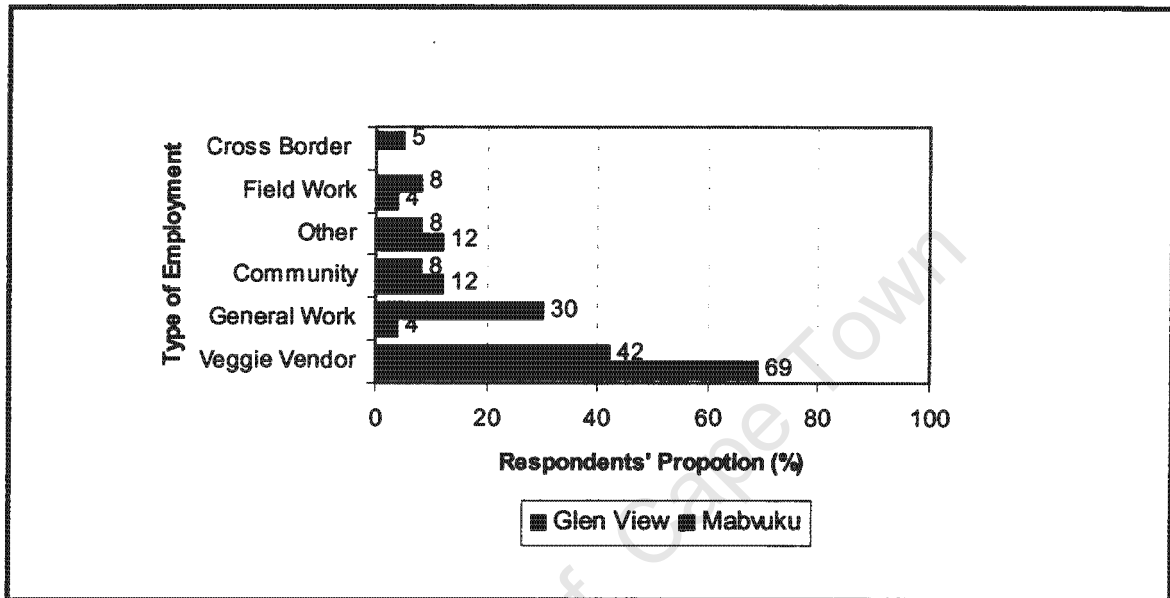
More empirical work still needs to be done on the subject of income inequality, HIV/AIDS and social resources. Such work should identify whether social resources improve the health status of PLWA in different communities, and if so to what extent.

In conclusion, the importance of the household livelihood set approach to assessing a household's ability to cope with the effects of HIV/AIDS cannot be over emphasized. Such a framework allows for an assessment of the true impact of the disease on the household. The types of strategies and resources used and their impact on the household varies according to the characteristics of the household and its community. As such interventions aimed at assisting households in their struggle to cope with the impact of HIV/AIDS, should be implemented after careful consideration of the complete set of resources that households have at their disposal.

This study addressed the concern that poor urban PLWA in Zimbabwe are not able to cope with the impact of HIV/AIDS. The direct and indirect costs of the disease leave many households vulnerable to illness induced poverty ratchets. The study identified the coping strategies being used by poor urban households in coping with the impacts of the disease. Social resources in particular were analysed and found to be a resource heavily relied on by households as a coping mechanism. Some of the strategies relied on by households to cope with the impacts of the disease, for instance, borrowing and selling assets may at times make households more economically vulnerable. It is therefore necessary to identify and enable those strategies which make household economically robust and protect the households from using those strategies which plunge them into deeper levels of poverty.

## APPENDIX A

### CROSS-COMMUNITY COMPARISON OF TYPES OF EMPLOYMENT



## APPENDIX B: QUESTIONNAIRE

### Interview Schedule

Instructions to the interviewer: Obtain the consent of the patient before proceeding to interview him/her. **Read Greeting:**

Hello, I am ..... from the University. We are trying to find out how HIV/AIDS has affected households, how households are managing to cope, in order to give ideas about what should be done to support households affected by the disease.

I would like to ask you some questions about you and your family and how HIV/AIDS has affected you, and some of the questions are of a personal nature. These questions will relate to how much you spend on your care and what your family and your community does to help you.

I will not write down your name, and everything that you tell me will be kept secret. You do not have to take part in this study. If you do take part, you do not have to answer particular questions or group of questions if you do not want to, and you may stop the interview at any time. The information that you provide is strictly confidential and will be used for the purposes of this study only. If you have any questions about the study, I will be happy to answer them.

May I continue? \_\_\_\_\_

Name of the interviewer \_\_\_\_\_

Interview date \_\_\_\_\_ (dd/mm/yy)

Time interview started \_\_\_\_\_

Time interview ended \_\_\_\_\_

Questionnaire Number \_\_\_\_\_

Facility name \_\_\_\_\_

**1. Details on the respondent**

- 1.1 Age: \_\_\_\_\_ 1.2. Gender: a) Male  b) Female   
1.3 Marital status: a) Single  b) married  c) divorced  d) Widowed

**2. Household Demographics**

- 2.1. How many people reside in your home? \_\_\_\_\_  
2.2. Are you looking after anyone else's children? **YES / NO**

If **NO** go to 2.4.

- 2.3. How many \_\_\_\_\_ and \_\_\_\_\_ whose (circle): Relation / Neighbourhood friend  
2.4. What are the ages of all the children in the household \_\_\_\_\_

3. Are you the principal breadwinner? **YES / NO**

**4. Employment status:**

- a) Employed   
b) Homemaker   
c) Student   
d) Unemployed   
e) Other (specify) \_\_\_\_\_

5. Are you  
a) Full-time  b) Part-time  c) Self employed

6. Is your employment part of a community based income-generating project? **YES / NO**

7. Does your illness regularly prevent you from doing your work? **YES / NO**

**Go to Q 10**

8. Did you lose your job due to your illness? **YES / NO**

9. Have you started any activities to raise income while at home since the onset of he illness (can be as simple as having a lodger)? (Specify) \_\_\_\_\_

10. Have other breadwinners in your household e.g. your spouse lost their job due to this illness. YES/ NO

11. Have any household members started to work or increased the numbers of jobs worked since the onset of your illness? YES / NO

If NO go to 12

11.1 If YES how many people? \_\_\_\_\_

11.2 Where do they work? (e.g. NGO project) \_\_\_\_\_

12. Who has been *regularly* taking care of you since the onset of your illness?

Working Household member	School going child	Neighbourhood friend	Relative	Paid Caretaker	Other (specify)
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13. Does anyone *regularly* accompany you to the clinic? YES / NO  
If NO go to 14

13.1. If so does this person work or go to school?

	Work
YES	School
NO	

13.2. How many times on average do they take you to the clinic *per month*? \_\_\_\_\_

13.3. On average how long do they spend with you at the clinic on each visit? \_\_\_\_\_

**14. Questions on Choice of Provider**

	Frequency			Reason (Tick the appropriate column)						
	W	M	Y	E	UF	FS	ET	CB	DA	CT
How often do you visit the clinic? and why do you choose this facility?										
Do you visit other public facilities? And if so why?										
How often do you go to a private doctor? And if so why?										
How often do you visit a traditional healer? And if so why?										
Do you use the health services of any other organizations? Churches, NGOs?										

**Abbreviations: Frequency: W = per week; M = per month; Y = per year Reasons: E= Exemptions; UF= user fees; FS=friendly staff; ET=effective treatment; CB=close by DA=drug availability; CB=treatment on credit**

**15. Direct Costs**

How much do you spend on:

Item of expenditure	Amount	Frequency		
	ZWS	T	W	M
Treatment at the facility you attend most frequently (total costs including doctor & nurse consultation, drugs, tests, X-rays)				
Transport to get there				
Health care costs at other providers				
Household purchases for your care (bandages, disinfectant, sponge etc)				
Other costs related to your condition (specify)				

Abbreviations: T = per trip, W= per week, M=per month

**16. What do you do when there is not enough money available to pay for your treatment? Tick where appropriate.**

Method	Most recent treatment
Stop the treatment	
Delay the treatment	
Seek alternative treatment-traditional healers	
Seek cheaper provider – government, NGO	
Reduce expenditure on other goods (education, food, clothing, health care of other household members)	
Use Medical AID/Insurance	
Use savings	
Borrow	
Sell assets	
NGO support	
Other (specify e.g. social welfare)	

**17. Methods of Paying for health care**

17.1. When were you first diagnosed? (year) \_\_\_\_\_

17.2. How many times have you been seriously ill ever since your diagnosis? \_\_\_\_\_

17.3. How do you pay for the treatment that you receive when you are ill? Tick where appropriate

<b>Method of payment</b>	<b>Most recent Illness</b>
Paid for by medical aid	
Use household savings	
Pawn valuables	
<b>Use income generated from:</b>	
Savings clubs,	
Income generating projects)	
Home based labour	
Other (specify)	
<b>Borrow from</b>	
A household member	
A community leader	
Relatives in the community	
Relatives outside of the community	
Friends within the community	
Friends outside of the community (work mates etc)	
Work based group inside the community (craft club etc)	
Work based group outside the community	
Moneylender inside the community	
Moneylender inside the community	
Past employer/current	
A commercial bank	
Other (specify)	
<b>Sale of assets (state asset type)</b>	
<b>Reduced spending on</b>	
Food?	
Children's education e.g. change of schools	
Health care treatment for other family members e.g. cheaper facility	
Clothing e.g. Christmas clothes?	
Other (specify)	
<b>Financial Gifts from</b>	
Relatives within the community	
Relatives outside of the community	
Friends/neighbors within the community	

Friends outside of the community	
Moneylender inside the community	
Current/past employer	
Other (specify)	

**18. Household Expenditure Patterns**

How much does your household spend on:	Expenditure ZW\$(either weekly or monthly)	Per week	Per month
Food			
Transport			
Electricity and paraffin			
Water			
Rent			
School fees, books, uniform			
Clothing			
Health care			
Other major expenses (specify)			

19. Have you accumulated any debt as a result of illness?

YES / NO

19.1 If so how much

ZW\$ \_\_\_\_\_

20. Community support:

**What kinds of activities exist in your community/ the health care facilities that you associate with, which support and educate individuals and families affected by this disease?**

<b>Organization Activity</b>	<b>Community (NGO, Church)</b>	<b>Government Facilities</b>	<b>Private doctors; traditional healers</b>
Adverts/campaigns on:			
Prevention of HIV/AIDS			
Testing for HIV/AIDS			
Management (Medication, diet, exercise)			
Income generating projects			
Child minding			
Home based care			
Other (specify)			

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## **APPENDIX C: SCHEDULE FOR FOCUS GROUP DISCUSSIONS**

The focus group discussions will be held with individuals who have been identified by NGOs and other CBOs as having HIV/AIDS but having difficulty with access to health care facilities. The objectives will be to

1. Ascertain why these people are not always able to use the health services when ill: access problems, financial barriers, and lack of faith in their usefulness.
2. Get a general description of the impact of the illness on the household.
3. How they are managing to cope with the effects of the disease: maintain household expenditure, look after the sick individual
4. The extent to which the CBOs provide support, both through the provision of basic health services, education and financial support
5. What determines which households make use of social resources (e.g. households with few productive assets)? Which households have access to social resources as a coping strategy?

## **APPENDIX D: SCHEDULE FOR KEY INFORMANT INTERVIEWS**

These interviews aim to supplement the information given by the respondents

1. Ascertain the income levels, Unemployment levels, conditions within the community chosen
2. Ascertain why people are not using the health care facilities
3. Determine whether the health services are doing enough with regard to educating people not just about how to prevent contracting AIDS, but informing households on the importance of good nutrition as a cost management and cost prevention strategy
4. Give ideas about how this situation could be improved
5. Gain an understanding of the impact of user fees on utilization by HIV/AIDS patients
6. Ascertain what NGO and CBO leaders see as the major weaknesses (strengths) of the health system and how it could be improved
7. The informants opinion on the sustainability of the CBOs work and involvement in the community
8. Identify the keys things that government could do to minimize the impact on the households, e.g. provide support for NGOs

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