

UNIVERSITY OF KWAZULU-NATAL

**THE IMPACT OF HIV/AIDS ON THE HUMAN SECURITY OF HOUSEHOLDS IN
BULAWAYO**

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DECLARATION

I Milton Gadina declare that

- (i) The research reported in this dissertation except where otherwise indicated, is my original research.
- (ii) This dissertation has not been submitted for any degree or examination at any other university.
- (iii) This dissertation does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.
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DEDICATION

This work is dedicated to my lovely wife Chenai and beloved son Micha-Yahu, Michael Gadina

Shalom Haverim

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First and foremost I am grateful to God Almighty for giving me an opportunity to study at University of KwaZulu Natal, without him I would not have had such an opportunity.

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ABSTRACT

This qualitative research sought to examine the actual impact of HIV/AIDS on the human security of households in Bulawayo. The two research questions in this study were, how does HIV/AIDS affect the seven areas of human security? and has the economic crisis in Zimbabwe increased the impact of HIV/AIDS on households? This study utilized both primary and secondary data in which the later was consulted in constructing the literature review and to address specific aims one and two. These specific aims were: to assess the human security conditions in Zimbabwe and to examine the potential impact of HIV/AIDS on human security. Data was gathered in the form of two focus group discussions held in Bulawayo with faith-based support groups and also in the form of in-depth interviews with households which were not connected to the faith based support groups in Bulawayo. A total of 29 participants took part in this research representing 29 households. 19 of these households were represented in the two focus group discussions while the remainder of, 10 households were represented in the in-depth interviews.

Human security is presented as different from traditional security in that the later seeks to protect nations from external threats while the former seeks to protect people from both external and internal threats such as threats of chronic diseases, hunger, unemployment, crimes, social conflicts, political repressions, environmental hazards and HIV/AIDS. These threats can be natural, manmade or both. Human security was assessed in light of the seven areas of threats to human security which are economic, food, health, environment, personal, community, and political security. Four major themes emanated from this research these being: the financial, health, nutritional and societal impacts of HIV/AIDS on the households in Bulawayo, chief of these being the financial impact in form of increased expenditure, reduced income and diverted investments of households.

This study came up with recommendations that aim at reducing and ultimately eradicating the impact of HIV/AIDS on households these being economic empowerment, food aid, ARVs provisions, training in survival skills and orphan care. The major challenge was given to individuals, families, society and NGOs especially the FBOs to take the lead in implementing these recommendations as the government is not yet in a position to do so.

ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
AFZ	Air Force of Zimbabwe
ART	Antiretroviral Therapy
ARV	Antiretroviral
BICC	Brethren in Christ church
CD 4	Cluster of differentiations 4
CRPS	Conflict resolution and peace studies
DRC	Democratic republic of Congo
FG D	Focus group discussions
FAO	Food and Agriculture organisation
FBO	Faith-based organisations
Forex	Foreign exchange
GNU	Government of national unity
GVT	Government
H.I.V	Human immunodeficiency virus
HEARD	Health Economics and Research Department
HDR	Human development report
IDI	In-depth interviews
ILO	International labour organisation
NGO	Non-governmental organisations
NSSA	National social security authority
OIC	Opportunistic infections clinics
PLWH	People living with HIV
PSI	Population services international
STD	Sexually transmitted diseases
STI	Sexually transmitted infections
T B	Tuberculosis
UDHR	Unilateral declaration of human rights
UDI	Unilateral Declaration of Independence
UK	United Kingdom
UKZN	University of Kwa-Zulu Natal
UN	United Nations
UNAIDS	United Nations AIDS
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly
WFP	World food program
WHO	World Health Organization
ZANU PF	Zimbabwe African National Union
ZANLA	Zimbabwe African National liberation army
ZIPRA	Zimbabwe people revolutionary army
ZNA	Zimbabwe National Army
ZRP	Zimbabwe Republic Police

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CHAPTER I

1. INTRODUCTION

1.1. Introduction

Human immunodeficiency virus (HIV)/ Acquired immune deficiency syndrome (AIDS) has enormous impacts on individuals, families, societies as well as on nations worldwide. Global estimates of 38.6 million people were living with HIV/AIDS as at 2008 (UNAIDS 2008). 22.5 million People were estimated to be living with HIV/AIDS by the end of 2007 in Sub-Saharan Africa, 61% of these being women (The World Bank 2008:8). HIV/AIDS claimed over 1.5 million lives in 2007 alone and has orphaned an estimate of 11.6 million children in the Sub-Saharan Africa (The World Bank 2008:11).

An estimated 1 320 739 Zimbabweans were living with HIV/AIDS at the end of 2007 (UNGASS 2008:4-10). Zimbabwe currently has a HIV/AIDS prevalence rate of 15.6 %, which is a significant reduction from the 25.7% in 2002 (UNGASS 2008:10). The reduction in HIV/AIDS prevalence has, however, not reduced the impact of HIV/AIDS in Zimbabwe. HIV/AIDS has and still continues to claim more lives than all the wars in the history of Zimbabwe (Nation master encyclopaedia n. d and UNGASS 2008). This concurs well with the region in which Zimbabwe fall under, the Sub-Saharan Africa region which is the worst HIV/AIDS affected region of the world (Piot et al 2001: 969).

Zimbabwe has a high HIV/AIDS mortality rate than other countries in Sub-Saharan Africa even though some of these countries like Botswana and South Africa have higher prevalence rates because it does not have the same human security conditions like these nations (AIDS epidemic update 2007:3-6). An example of these human security conditions are the likes of better nutrition and medication in the form of availability of free antiretroviral drugs.

It is in light of such differences that this study sought to examine the actual impact of HIV/AIDS on the human security of households in Bulawayo.

1.2. Motivation for this study

The two main elements of this study are HIV/AIDS and human security. My interest in researching on HIV/AIDS was stirred at a University of KwaZulu-Natal (UKZN), Health Economics and Research Department (HEARD) meeting held at Westville campus in March 2008. At this meeting, students being sponsored by HEARD were challenged by the contribution of HEARD to the global fight against the HIV/AIDS pandemic especially through research. From that time, I aspired to contribute to this fight in all possible ways and particularly with research.

My interest on the human security was inspired by the reading requirements for my first assignment in Theories and Issues Module (T&I) at University of Kwa-Zulu Natal (UKZN) in the Conflict Resolution and Peace Studies (CRPS) program. In these readings, I was exposed to the difference between traditional security and human security.

My assessment then of the Zimbabwean situation made me to realize that territorial security was over-emphasized at the expense of human security. This was evidenced with the way military service and personnel are supported at the expense of human security, which emphasizes people instead of territory (HDR 1994:24).

It was in light of these interests that I thought of undertaking a study on the impact of HIV/AIDS on the human security of households in Bulawayo, the city that has been my home for the past 7 years. I hoped to come out with recommendations that I, other people, organisation and hopefully the government would use to alleviate these impacts, which in-turn serves to improve human security of households in Bulawayo in a context of the HIV/AIDS Pandemic.

1.3. Research questions

This study sought to address two research questions,

- How does HIV/AIDS affect the seven areas of human security?
- Has the economic crisis in Zimbabwe increased the impact of HIV/AIDS on households?

1.4. Overall Objective

The overall objective of this study was to research and analyze the actual impact of HIV/AIDS on the human security of households in Bulawayo in a time of economic crisis.

1.5. Specific Aims

This work explored three specific aims which are listed below:

- To assess the human security conditions in Zimbabwe;
- To identify the potential impacts of HIV/AIDS on human security;
- To examine the actual impact of HIV/AIDS on the human security of households in Bulawayo in a time of economic crisis.

1.6. Background

Understanding the background of Bulawayo enabled me to put a lot of things into perspective in the undertaking this study.

1.6.1. The context of this study

Bulawayo, a historic city derived its name from an isi-Ndebele term “Ko-bulawayo” which means, “place of the slaughtered one”. Bulawayo established around 1872, was the capital of the Ndebele state of King Lobengula. It was burnt down by the settlers in 1893 and they established their new settlement there. In 1897 Bulawayo was given municipal status and city status in 1943.

In the present day it is the second largest city in Zimbabwe, 439km southwest of the capital Harare. The city of Bulawayo is also known as the “City of Kings” home to an estimated 2 million people who are part of the 31% of Zimbabwe’s urban dwellers (FAO/WFP 2008:7). A large percentage of people in Bulawayo are from the Ndebele speaking tribal groups, these are minority to the Shona speaking and majority tribal groups in Zimbabwe. Bulawayo used to be the industrial capital of Zimbabwe before the Zimbabwean economic crisis. This city a connection hub between South Africa to the south, Botswana to the west and Zambia to the north is located in the worst HIV/AIDS affected region: Sub-Saharan Africa (Piot et al 2001:969).

1.6.2. The history of Zimbabwe

The nation of Zimbabwe was formed in 1980 when it obtained its independence from the Ian Smith-led Rhodesian government. This government had declared its independence from Britain, the colonial powers in 1965 in what was known as the Unilateral Declaration of Independence (UDI). Zimbabwe's independence came after 22 years of a liberation struggle in which the two main liberation movements fought against the Rhodesian forces backed by the Apartheid South African government and using British weaponry. The strongest liberation front, the Zimbabwe people revolutionary army (ZIPRA) was led by an Ndebele nationalist Joshua Nkomo and it operated from Matabeleland in which Bulawayo falls under while the weaker liberation front, the Zimbabwe African National liberation army (ZANLA) was led by a Shona speaking leader operated from Mashonaland (Ndlovu-Gatsheni 2003:18).

This war of liberation claimed an estimate of 30 000 civilians' lives (Nation Master Encyclopaedia), an initial settlement of a so called "puppet government" in 1979 led by Bishop Abel Muzorewa was rejected by the liberation fighters. This war was finally settled by the Lancaster House conference where the Smith government agreed to give the nationalist their independence. However this conference sidelined the Ndebele nationalist Joshua Nkomo in favour of the Shona leader Robert Mugabe. This was fulfilled on the 18th of April 1980 when Zimbabwe was granted its independence under the leadership of Robert Mugabe's Zimbabwe African National Union (Karumbidza 2008).

At the formation of this nation, security was mainly understood as protecting the nation from external threats. This saw the massive formation of the Zimbabwe National Army (ZNA), Air Force of Zimbabwe (AFZ) and Zimbabwe Republic Police (ZRP). Candidate for these security forces were drawn mainly from the former liberation fighters. The post independence period was marred incidence of violence, a huge part of it perpetrated by the security forces. This period also saw a negligence of developing the Matabeleland by the Mugabe led government in what is believed to be a strategy to structurally oppress the Ndebeles. This affected the development of the city of Bulawayo.

1.6.3. Violent history

The Zimbabwe armed forces have been of great help in some ways but in other ways not to the benefit of many Zimbabweans. In fact they inflicted costs on the ordinary Zimbabwean in that resources that were supposed to be used for the common good of Zimbabweans were diverted to financing the brutal killing of fellow Zimbabweans in the early 80's by the North Korea trained ZNA fifth brigade. This was commonly referred to as *Gukurahundi* which is Shona for rain that washes away ashes; in this case the ashes were the Ndebele (tribe) militia and civilians. The Zimbabwean army also supported Frelimo-led Mozambiquean army in its civil war against the South African supported Renamo which ended in 1992. One of the major involvements of the Zimbabwean army was its involvement in the DRC civil war (1998-2002) where they helped the government army fought against the Congo based rebels in 1998-2002 war. The decision to be part of this war was solely made by President Robert Mugabe without the cabinet consent, because he had presidential power to do so.

The involvement in the DRC war is thought to have benefited a few Government officials as they received personal diamond mines for the service of Zimbabwean Army. The DRC war drained a great deal of rate payer's money. It is cited as one of the causes that led to the devaluation of the Zimbabwean dollar and it claimed an undisclosed number of Zimbabwean army officials lives, left some of them injured, in addition, massive military equipment and armoury were lost (Johwa2004). Tambudzai (2005:6) asserted that Zimbabwe's military burden rose from 2.6% in 1998 up to 4.9% in 2000 owing mainly to the DRC war. This is not to say nations should not use their resources to help other nations in times of threats, saying that would be grossly wrong especially with the realization that Zimbabwe liberation fighters received military help from countries like China, Russia and were hosted by Mozambique and Zambia in the liberation struggle against the Ian Smith regime. However any nation must make sure its citizens are a priority hence would not neglect its own challenges in favour of helping other nations. Zimbabwe neglected the human security challenge that it had at hand and diverted its resources to financing a war in terms of paying salaries, armoury and operational cost (Johwa 2004).

While Zimbabwean resources were being used to fund the DRC war, the nation faced a major human security threats: the drought of 1992, which is known as one of the worst droughts in Zimbabwe. HIV/AIDS was also becoming a great threat to Zimbabwe in those years. These threats could not be addressed militarily. It is in light of this realization that traditional security falls short of meeting people's fears and wants, hence human security has to be emphasized so that it can compliment national security in Zimbabwe.

1.7. The need to study about human security in Bulawayo

Bulawayo, as a city and Matabeleland, as a region have not benefited much from the returns from the natural resources that surround them, such as the coal fields in Hwange, the national parks in Matopos, Hwange and Gona reZhou, the historic site of Matopo hills where Cecil John Rhodes was buried and the magnificent Victoria falls which are one of the seven wonders of the world. The post independence years also saw the centralisation strategy that was used by the Zimbabwean government to move major companies and major government offices from Bulawayo to Harare. This has had economic implication on the city of Bulawayo. It is in light of this that Bulawayo and Matabeleland are not very developed. All these factors make Bulawayo to be economically insecure, which in turn its human security since economic security is one of the major areas of human security. It is in light of all this that I thought it was necessary to study the human security of Bulawayo.

This forces young people from this region to cross the boarder, most of them illegally in search of better opportunities. These young people from Matabeleland struggle to fit in the capital city of Zimbabwe because their language is not recognised even in their own region as seen in the way the government has been deploying officials to diffuse their language thus destroying their identity. On the other hand these Ndebele speaking Zimbabwean youngsters find it easy to fit into the South African context than their own nation.

1.8. Methodology

I undertook a qualitative research which utilized both primary and secondary data. This qualitative research method drew from personal experience of people whose human security has been adversely impacted by HIV/AIDS. This study consulted secondary data to build its literature review and address specific aims 1 and 2. This study also gathered data in the form of focus groups discussions (FGDs) and in-depth interviews (IDIs) to address specific aim 3.

1.8.1. Focus groups

This study utilised two focus group discussions that were done with two different faith based support groups in Bulawayo as a way of gathering data. These support groups were, “Touch the Hem”: a ministry of Lobengula Brethren in Christ (BICC) and “Fellowship 6:2”: a ministry of Praise and Worship centre. Focus groups discussions were utilised because they allow the researcher to gather information from many people at once. This saves time as well as cost of the intended research such as transport costs to different locations for interviews. In addition to that, it helps to quickly identify common trends between the experiences of the participants and it is also a ready source of recommendations. The other reason why I chose to use focus group discussions methodology is that it utilizes positive peer pressure in that participants are encouraged to contribute by the involvement of their peers especially when they share life experiences. This gives them confidence to share their story with others.

I chose to have these focus groups discussions in the context of HIV/AIDS support group because they are ready gatherings of people living with HIV/AIDS who come together regularly for the purposes of encouraging, supporting and educating each other on positive living. The other reason why I chose to have my focus group discussions with HIV/AIDS support groups is that people in these support groups have already accepted and opened up about their HIV status. Some of them are now used to meetings that discuss issues of HIV/AIDS and can easily contribute on how their households have been affected by the HIV/AIDS with fear of stigmatization. This made focus group discussions to be the best method that I could use as it fitted within the limited time and resources that I had to complete this research.

1.8.2. In-depth interviews

The researcher followed up the focus group discussions with in-depth interviews which utilized a questionnaire with open and closed questions as an interview instrument to fulfil the intended goals. This instrument was also used to follow up to gather more information about the impact of HIV/AIDS on the human security of household in Bulawayo from participants who had not participated in the focus group discussions.

Six participants from the two FGDs also participated in these IDIs together with 10 other participants who had not participated in the FGDs. The total of participants in the IDIs then is 16 however for the purpose of clarity this study will refer to 10 participants since the other six are already counted in the participants of the FGDs. The 10 participants were recruited by two nurses that work at two OIC in the western high density suburbs; Nguboyenja municipal clinic and Luveve infectious clinic, while the six participants that had already participated in the FGDs were recruited by the facilitator and the researcher. All the participants in the IDIs were recruited using the judgment sampling as suggested by Mouton (2001: 148-150). The IDIs also served the purpose of capturing data from participants from households that are not members of the faith based support groups in Bulawayo.

1.9. Dissertation structure

Chapter 2	Literature review
Chapter 3	Methodology
Chapter 4	Data analysis
Chapter 5	Conclusion, limitations and recommendations

CHAPTER II

2. LITERATURE REVIEW

2.1. Introduction

This chapter focuses on literature review which Mouton (2001:81) named, “the scholarly review”. In my endeavour to examine the actual impact of HIV/AIDS on the human security of households in Bulawayo. I needed first of all to explore what scholars have established in regard to the subjects in this topic.

This chapter reviews definition of terms as they are understood in this study. It also reviews human security, HIV/AIDS, and the impact of the later on the former. The section on HIV/AIDS explores its background and its impact, arranging it in a chronological and case study structure from the 1990’s, 2000’s and 2010’s. It begins with the global context, then Sub-Saharan Africa context and narrows down to the Bulawayo: Zimbabwe context (Mouton 2001:91-94). The section on human security explores the seven areas of threats to human security namely, economic security, food security, health security, environmental security, personal security, community security and political security (UNDP HDR 1994:24).

2.2. Definition of terms

This work employ terms that may be understood differently by different people, it is in light of this that this work explores these terms in order to establish the meaning they assert in this work.

2.2.1. Definition of HIV/AIDS

HIV is an abbreviation of “Human immunodeficiency virus”. This virus causes “Acquired immune deficiency syndrome” abbreviated AIDS. Many viruses can easily be controlled by the body’s immune system, however, the HIV virus takes hostage the same white blood cells also known as CD4 cells that are supposed to defend the body and destroy them.

This results in a person having a weak immune system. AIDS is a most advanced stage of HIV where one has a weak immune system and is susceptible to opportunistic infections (OIs) which will in turn causes one's death (Cadman 2003).

2.2.2. The definition of the concept of human security

The concept of human security is a fairly new concept. The term was first used officially by Dr. Mahbub ul Haq in the 1994 Human Development Report (HDR) of the United Nations development program (UNDP) (Fourie and Schonteich 2001: 1). The same HDR listed, "freedom from fear and freedom from want" as the two major components of human security. Human security is better explained by its absence and it can be divided into seven areas of threats mentioned above (UNDP HDR 1994:24).

Hubert 1999 in Fourie and Schonteich (2001: 1) defined Human security as,

...safety for the people from both violent and non-violent threats. It is a condition of state of being characterized by freedom from pervasive threats to people's rights, their safety or even their lives....It is an alternative way of seeing the world, taking people as its point of reference, rather than focusing exclusively on the security or territory of governments. Like other security concepts- national security, economic security, and food security- it is about protection. Human security entails taking preventive measures to reduce vulnerability and minimize risk and taking remedial action where prevention fails.

The term security is derived from a Latin root meaning, "lack of care", in the sense of concern or anxiety about something (Dower 1995:19). Security then is the absence of threats in the present and in the future in any of the seven areas of threats. The security that was emphasized before 1994 was in fact state security what is referred to as traditional security. This security lacked an element of protecting people as it focused on protecting the state from external threats. This is where human security compliments the traditional view of security.

2.2.3. Definition of Household

Different people in our world today live with different dynamics such as culture and economic status. These dynamics make it difficult to have a uniform definition of a household. The Reader's Digest Oxford Complete Word Finder defines a household as, "the occupants of a house regarded as a unity" (Tulloch (ed.) 1994: 725). On the other hand Statistics South Africa defines a household as, "people who live under one roof (be it a house or a shack) for more than 4 nights a week including the migrant workers these may not necessarily be immediate relatives/ family" (Naidu and Harris 2006: 417). This work adopted the later as its definition of a household because it best resembles the households in Bulawayo. The HIV/AIDS pandemic has and continues to impact on the family structure, leaving many children as orphans. Some of them become leaders of child headed households.

According to Murphy et al (2005:269), the household is usually the primary unit of analysis and the most vulnerable institution that receives most of the impacts of HIV and cannot easily offload these impacts to other people or institutions. Some households are forced to dissolve by the diseases when parents die and children are sent to relatives for care and upbringing.

2.3. Human security

The concept of human security goes beyond 1994 when it was first used. It was one of the two desired products that brought about the formation of the United Nations (UN) as people and territories were given equal weight from the onset of the formation of UN in 1945. However, over the years, security was defined mainly as territorial security. Such a perception of security was limited in that it did not cover the human element which was one of the major initial concerns of security. From the formation period of UN up to the cold war years, the world witnessed massive built-up of military and arms in the nations of the world. This produced super powers and weaker nations and this process saw many governments having huge military expenditures in their budgets.

As time went on, the world security needs changed as territorial threats reduced. After the cold war years, new threats to humanity which could not be dealt with militarily were encountered. These threats included the likes of hunger, natural disasters such as floods, earthquakes, water and air water pollution. It was such threats that precipitated the focus on what came to be known as human security, which is different from the traditional concept of security which sought to protect nations from external threats. (UNDP HDR 1994:22) states that, human security seeks to protect and prevent humanity from internal threats such as “threats of chronic diseases, hunger, unemployment, crimes, social conflicts, political repressions and environmental hazards” These threats can be natural, manmade or both. Human security is different from human development but the two are inter-related.

The term security has been understood in the past as referring to traditional security which seeks to protect a state from external aggression. Traditional security relies on building up national power and military defence, hence from this view each state’s security is measured by its ability to deter and defeat its enemies. Human security is different from traditional security in that it is concerned about individuals and the community. Human Security Now (2003:6) added that, “Human security also includes protection of its citizens from environmental pollution, trans-national terrorism, massive population movement, HIV/ AIDS, oppression and deprivation”.

Human security is presented as the ability to protect importance elements of human lives in a way that enhances human freedoms and fulfilment (Human Security Now 2003). Its focus is to protect people from severe and widespread threats and dangerous situations. It does this by creating political, social, environmental, economic, military and cultural systems that give people building blocks of survival, livelihoods and dignity. Since human security is a broad concept, it is difficult to itemize it. It is better explained by its absence and it can be looked at in terms of its seven areas of threats as noted above

2.3.1. Economic security

Economic security is a category of human security, without which the former one cannot have the later. One is said to have economic security if he/she is assured of a secure and liveable income/ resources to support a standard of living in the present and in the future. For many people in the world today, economic security is a desired position because only a quarter of the world's population have secure jobs that give them a liveable salary (HDR 1994:25). The continuing global economic challenges in the world have resulted in many people losing their jobs in 2008 and many more are still losing their jobs in this current period. This has increased the rate of economic insecurity in the world; even developed countries have not been spared. Since only a few are employed and earn liveable incomes in the world many children, wives and families tend to depend on income from household members who work. These can be parents for children, or adult son /daughter for the elderly or relatives. These helpers can be local or abroad, and in the case of Zimbabwe, many of these are outside Zimbabwe, mainly in South Africa and the United Kingdom (U.K).

2.3.2. Food security

Food security is another category of human security, without it, one's human security is not complete. HDR (1994:27) asserts that there is enough food for everyone in the world, yet 800 million people in the world, 240 million of which are in Sub-Saharan Africa, live in poverty. These people do not live in poverty because there are food shortages in the world but because food is poorly distributed and not everyone is able to afford it. In the case of Zimbabwe, 7 million which is over 50% of Zimbabwe were in need of food aid as of March 2009 (Zimbabwe food security update Feb 2009). 33% of the people in need of food aid in Zimbabwe are urban dwellers like those who stay in Bulawayo, the focal city of this study. Many of the households are now living on one or two meals, these meals are mainly carbohydrates in the form of Sadza, the staple food and vegetables as a strategy of coping with the food insecurity situation (Zimbabwe food security update Feb 2009). Food security depends on individuals, families and a nation's economic security, because economically insecure people would not be able to afford enough food.

2.3.3. Health security

Health security is another element of human security which aims at providing protection from diseases in a world in which the majority of deaths are caused by various diseases. According to HRD (1994:27-38), poor nutrition, lack of access to health services, unsafe environment and HIV/AIDS are some of the major causes of health insecurity. The failure by the Zimbabwean government to contain the cholera outbreak which started in August 2008 which infected over 100 000 and claimed over 3 100 lives, is a sign of health insecurity. The shortages of drugs, the hospitals that are operating at low capacities because of lack of resources and manpower also tell of how Zimbabwe's capacity to provide health security for its citizen has deteriorated.

The HIV/AIDS pandemic also denigrates the quest of providing health security in countries with high HIV/AIDS prevalence in that it demands that health institutions invest more in HIV/AIDS, thus cutting down on other health needs. This creates health insecurity for other people who might have needs that need that would have been sidelined and priority is given to HIV/AID (Bollinger 1999:8).

2.3.4. Personal security

Personal security is the most crucial of all human security; it is a human right which was universal declared (UDHR) in UN 1948. It aims at protecting people from personal, interpersonal, internal and external state violence. Violent crime is at the apex of all threats to personal security, both in developing and developed countries. Child abuse, rape and gender-based violence fall under the categorisation of threats to personal security.

Political security

The political violence that occurred in the 2008 pre and post-election times in Zimbabwe tells of how Zimbabwe failed to protect its citizens from internal threats. In fact, it tells of how political security is not regarded as needs, as the authorities that were supposed to provide political protection were actually the perpetrators of these violent crimes which left unaccounted injuries and death.

Whiteside 1989 noted that service industries such as the military also suffer from the impacts of HIV/AIDS, such as losing key leadership, as officers die or are discharged on health incapable grounds. This leaves a nation with an inadequate service industry, which is a huge threat for the nation. For example, a nation with an ill security force, the military and police will not be able to contain riots, social and political unrest. This may have huge implications for a nation such as the predicted wars in Zimbabwe and Mozambique by Toffler and Toffler (1993:93). All this shows that without political and personal security, there cannot be human security.

2.3.5. Environment security

The area of environmental security is the least explored and also has less empirical evidence however it is also an area which can affect human security especially of households. Economic insecurity and HIV/AIDS forces helpless people to engage in activities that are not environmental friendly such as gold panning, over-harvesting of natural resources including fruits, insects and chopping firewood as an alternative way of generating income and alternative living strategies in Zimbabwe (Shoko n. d). This in turn affects our environmental security. The impact may not be visible today because it has long term effects that will manifest at a later day in the form of health implications, as many people who live in congested locations are resorting to firewood because of load shedding of electricity by the Zimbabwe electricity supply authority (ZESA). This leaves the environment polluted. This will affect urban dwellers in the form of respiratory diseases in the future.

One of the greatest environmental threats, especially in developing countries is the ability to control, treat and avail clean water. Failure to provide these resulted in the health insecurity challenge of the Zimbabwe cholera outbreak.

2.3.6. Community security

Communities provide a sense of security. These can be religious groups, extended families, organizations, racial or ethnic groups. These mainly give practical support and protection to weaker members of the community. Our human security is affected if we do

not have community security. Huge threats to community security are the like of crime or prostitution and individualism.

2.4. HIV/AIDS

2.4.1. Background

HIV/AIDS was first recorded in 1981 in America in Los Angeles and New York (Dixon 2004:11). The real origin of HIV is unknown but it is assumed that it originated in a group of African monkeys, themselves being immune to the disease; it is also believed to have started way before its discovery in 1981 (Crystal (ed.) 1990:19).

Heineken (2001:121) acknowledged that HIV/AIDS pandemic is the most devastating disease ever known in human history. It spreads through various ways, such multiple usage of an injection amongst infected drug users, mother to child transmission, heterosexual and same sex intercourse. HIV/AIDS normally affects sexually active young adults as its major way of transmission is through sexual intercourse. These young adults die when they are most needed by their families, society companies and nations.

HIV/AIDS prevalence seems to have reached its peak and is now declining (The World Bank 2008: 10), however the decline in the prevalence does not mean that its impact are also decreasing, in fact, the impacts of HIV/AIDS are on the increase. The current impact of HIV/AIDS as seen today is only a fraction of its future impacts in that HIV has a long lag between infection and severe AIDS. The disease intensifies with time, as the latency period for HIV to reach full blown AIDS on average is 10 years and patients need long-term care and support (Oluwagbemiga 2007: 669). The impact of HIV/AIDS progresses as it develops even beyond the time of its victim's death as impacts on orphans lives (Piot et al 2001: 968).

2.4.2. The impact of HIV/AIDS in the 1990's

In the 1990's, HIV/AIDS had already had massive impacts at global, regional and national levels.

2.4.2.1 Globally

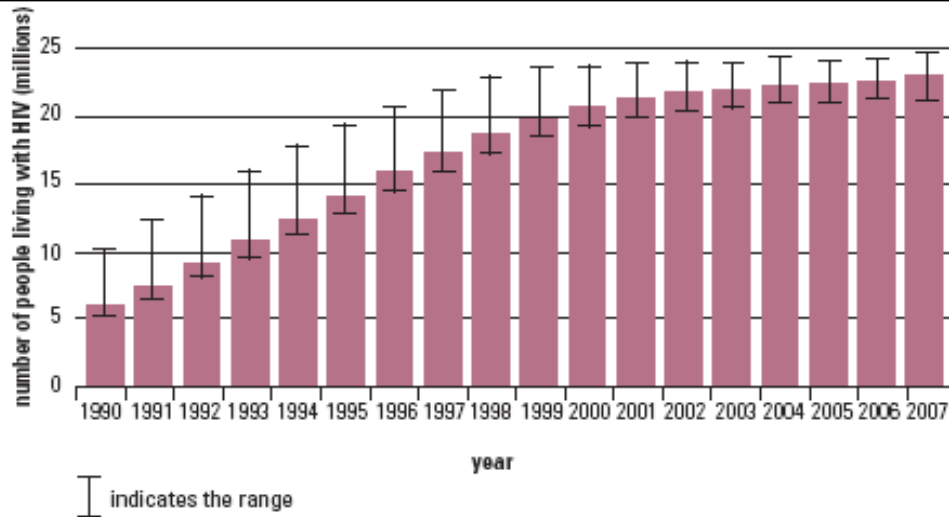
An estimated 8 million people were living with HIV/AIDS globally in 1990. HIV/AIDS exerts multifaceted impacts on all facets of life, be it on individuals, families, societies, firms, groups, nations on global context. These impacts are across the board whether one is in the rural areas or in the urban areas. The impacts also transcend national borders and all facets and levels of security (Heinecken 2001:120). The impacts of HIV/AIDS range from, population structures, economic growth, environmental security, social capital, life expectancy, household livelihood, human security impacts, territorial security impacts, food security impacts, health security impacts, human development impacts, society-wide impacts, economic impacts, exacerbating poverty, reduction of life expectancy, increased infant and adult mortality, and many children left as orphans. On the economic impacts, households both rural and urban, companies and nations, experience temporarily reduced labour when some workers are temporarily absent from their jobs off sick, when they attend funerals . They also experience permanent effects when they leave their jobs to take care of the sick or when the worker dies.

Fourie and Schonteich (2001:2) summed up the global impact of HIV/AIDS saying, “it is reducing life expectancy, raising mortality, lowering fertility, creating excess men over women and leaving millions of orphans in its wake”.

2.4.2.2 Sub-Saharan Africa

The table below shows that over 5 million people were living with HIV/AIDS in Sub-Saharan Africa in 1990 (UNAIDS 2007). This region also includes Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. HIV/AIDS is no longer regarded as a health issue only but as a critical human security issue (Kristofferson 2000). Piot et al (2001: 968) elaborated on that saying, “HIV/AIDS constitute one of the most serious crises currently facing human development in Sub-Saharan Africa”. Piot et al (2001: 971) noted that, HIV/AIDS has a negative impact on education as it reduces the supply of teachers as die from the disease. It also reduces the capacity of children to continue in school as infected and affected children. Infected children are hindered to continue in school by poor health while affected children are hindered by lack of resources as households battle to survive in the face of HIV/AIDS.

Table 1 Estimate of people living with HIV/AIDS in Sub-Saharan Africa 1990-2007



Source UNAIDS 2007 cited in The World Bank (2008: 11)

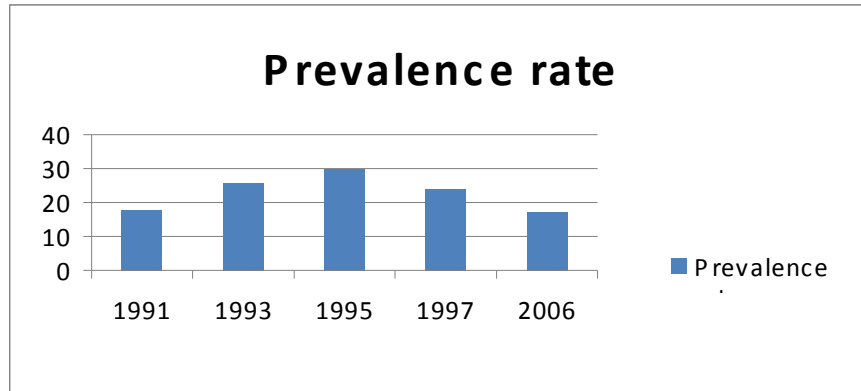
2.4.2.3 Zimbabwe

HIV/AIDS was first recorded in Zimbabwe in 1985, since then, the occurrence and impact of AIDS has escalated drastically. In the 1990s, Zimbabwe had 710, 000 people living with HIV/AIDS (2008 Report on the global AIDS epidemic and UNAIDS/WHO July 2008). In 1994, Zimbabwe had a higher human development level than the average Sub-Saharan Africa, an illustration of this was the fact that its life expectancy was eight years longer than other sub-Saharan Africa countries (HDR 1994:46).1% of men and women workers lost their jobs due to HIV/AIDS in 1990 (ILO 2004:18)

Bulawayo

HIV prevalence rose in the 1990's, reached its peak in 1995 and has been on the decline in Bulawayo for the past 14 years. Ungass (2008: 16) revealed that in 1991, 17.8% of the pregnant women who visited antenatal clinics were infected, in 1993, 25.8% were infected, in 1995, 30% of them infected, in 1997, 24% were infected and 17.3%, in 2006 were infected (UNGASS 2008:16). These statistics are shown in the table below

Table 2 Pregnant women HIV prevalence surveillance in Bulawayo



Developed from information gathered in UNGASS (2008: 16)

2.4.3. The impact of HIV/AIDS in the 2000's

Piot et al (2001: 968) rightly affirmed that, “Over the 20 years since it was first identified the HIV/AIDS epidemic has continues to exceed all expectations in the severity and scale of its impact.”

2.4.3.1. Globally

Piot 2001 revealed that in 1991, the World Health Organization (WHO) had forecasted, that the cumulative global totals of infections would be 40 million, however by 2000 HIV/AIDS had claimed an estimate of 20 million lives, 33 million people were living with HIV/AIDS, giving a total estimate of 56 million. This reflects 16 million more than was anticipated. The number of HIV/AIDS global orphans was estimated at over 11.6 million.

Heinecker (2001: 121) affirmed that, “never before, even in the case of Bubonic plague that ravaged Europe in the Middle Ages, has there been a disease as devastating to mankind as the current HIV/AIDS pandemic”. Piot et al (2001:968) revealed that there were 5.3 million estimated new HIV infections globally in 2000. Piot in Heinecken (2001:120) elaborated on the impact of HIV/AIDS saying, “that it is proving to be tenfold more destabilizing than the wars that have been and are still being fought in Africa”. That is why HIV/AIDS has been described as the scourge of Africa and Zimbabwe (Matizirofa and Smith 2006:502).

2.4.3.2. Sub-Saharan Africa

While HIV/AIDS is a worldwide challenge, geographically, Sub-Saharan Africa was the core of this pandemic in this time period (Murphy et al 2005: 266). This region was the worst HIV/AIDS affected region of the world and the devastation of its impact are increasing. The mobility that comes from the extensive transport infrastructure, work and social migration has been cited as some of the drivers of the epidemic in the Sub-Saharan Africa (Piot et al 2001:969).

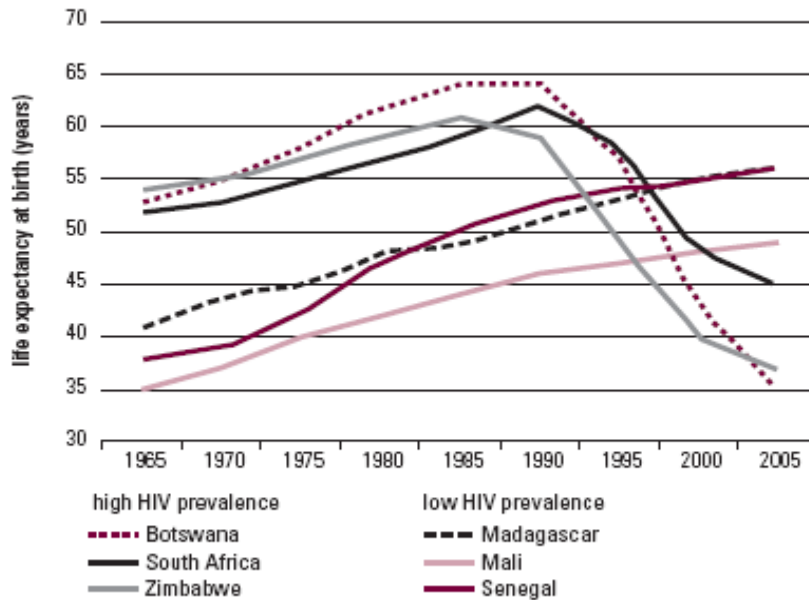
By the end of 2000, an estimate of 25.3 million people were estimated to be living with HIV/AIDS in the Sub-Saharan Africa, this being three quarters of the global toll (Piot et al 2001:968). There were 3.8 million estimated new HIV infections in Sub-Saharan Africa in 2000, this was the case also for 1999 (Piot et al 2001:969). Transmission of HIV was mainly by heterosexual sex, together with a significant level of mother to child infections. By end of 2000 1.1 million children under the age of 15 were estimated to be living with HIV/AIDS in Sub-Saharan Africa. 90% these children contracted the diseases from their mothers (Piot et al 2001:969), this shows that mother to child transmission was high then.

HIV/AIDS was and still is the leading killer in the Sub-Saharan Africa.

In 1998, armed conflicts in Africa claimed 200,000 lives while 2.2 million people died of HIV/AIDS (Fourie and Schonteich 2001:3). HIV/AIDS is responsible for one in every five deaths, twice as many as for the second leading cause of death (Piot et al 2001:971) and it caused 20% of deaths in 2000 (The World Bank 2008: 10). Botswana was leading with a 36% adult prevalent rate followed by Swaziland, Zimbabwe and Lesotho which had prevalence rates between 24 and 25% (Piot et al 2001: 969).

HIV/AIDS wiped out decades of gains in life expectancy. In Southern Africa the average life expectancy rose from 44 years in the early 1950's to 59 years by the late 1980's and in is returning to under 45 years (Piot et al 2001: 971), as shown in the table below.

Table 3 Changes in life expectancy estimates 1965-2005



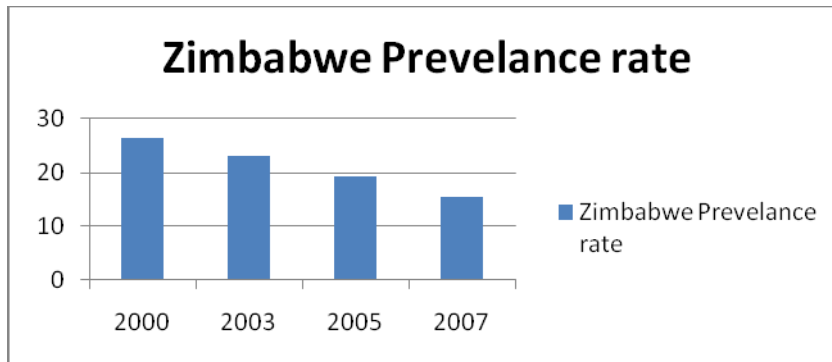
Source World Bank 2007b cited in The World Bank (2008:15).

Murphy et al (2005:265) cited HIV/AIDS as the major drivers of hunger. Dewall and Whitehead 2003 added that AIDS undermines long term food security. Clover 2003 in Murphy 2005 also agrees on this saying that, “all dimensions of food security are affected where prevalence of HIV/AIDS is high.”

2.4.3.3. Bulawayo, Zimbabwe

The 2008 Report on the global AIDS epidemic and UNAIDS/WHO 2008 concurred on the 1.9 million estimate number of Zimbabweans living with HIV/AIDS in 2000, these represented 25% of the Zimbabwean population aged 15-49 (Kristoffersson 2000:2). The United General Assembly (UNGASS) (2008) reveals that the current levels of infection have declined. In 2001, HIV prevalence in Zimbabwe was estimated to be 26.5%, a decline was seen in 2003 to 23.2%, and 19.4% in 2005, and 15.6% in 2007. The decline in HIV prevalence is attributed to mortality and a decline in HIV incidence due to behavioural change (UNGASS 2008: 6). 11% of men and women worker lost their jobs due to HIV/AIDS in 2000. The Table below show the decline in the prevalence in Zimbabwe from 2001 to 2007

Table 3 Decline of the HIV prevalence in Zimbabwe



Developed from information gathered in UNGASS 2008

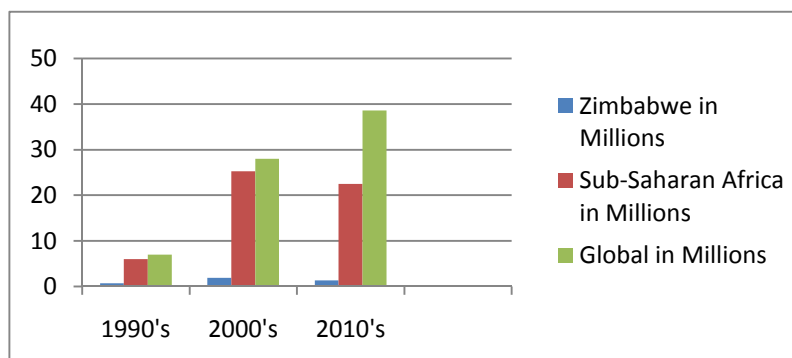
2.4.4. The impact of HIV/AIDS in the 2010's

The epidemiology of the HIV/AIDS epidemic is understood much better today than it was in the last decade. The same is true with its transmission as continued research has attributed better understanding of the HIV/AIDS pandemic (The World Bank 2008: 120).

2.4.4.1. Globally

UNAIDS 2007's recent global statistics of people living with HIV/AIDS were at 33 million as of 2007. There is a rapid spread of HIV in Russia and other Eastern bloc countries. In South East Asia, the spread of HIV/AIDS threatens to dwarf the African problem (Dixon 2004:15). 33 million people are estimated to have died globally by 2007 (Population service international 2008). More than 96% of these were in low middle income countries. There were over 7, 400 new HIV infections a day in 2007 (PSI 2008: 2)

Table 4 People living with HIV/AIDS (PLWH)



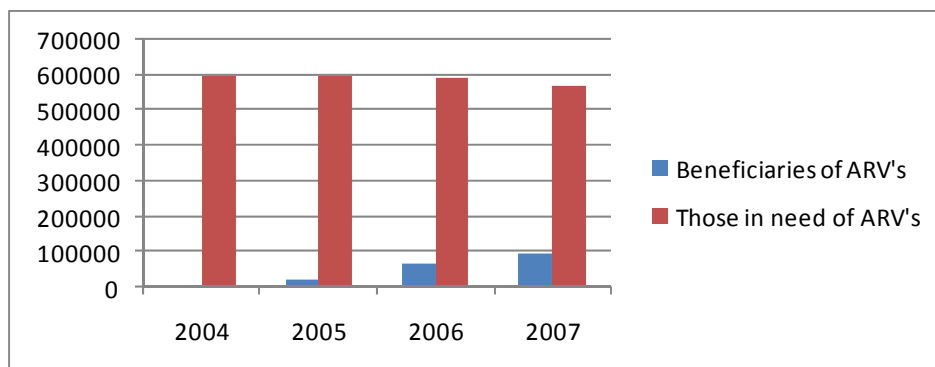
Developed from UNAIDS Global report 2008

2.4.4.2. Sub-Saharan Africa

22. 5 million people were estimated to be living with HIV/AIDS in Sub-Saharan Africa as of 2007 (UNAIDS 2007) down from 25.3 million at the end of 2000. This number shows a fall of 2.5 million, this is accredited to mortality. This region currently has the highest prevalence of HIV/ AIDS throughout the world with new infections occurring amongst people under the age of 25 though the eastern block is threatening to overcome Sub-Saharan Africa. The World Bank (2008:11) notes that over 1.5 million lives were lost in 2007 alone and 11.6 million children orphaned due to HIV/AIDS in the Sub-Saharan Africa. Among these nations South Africa has a high rate of infections which stands at 5.5 million as of the year 2006 (UNAIDS 2007). Most of the Sub-Saharan countries have seen a reduction or a stabilizing of their population because of HIV/AIDS mortality, migration and family planning. The impacts of HIV/AIDS are better in countries that have adequate supply of ARVs such as Botswana and South Africa. In comparing Zimbabwe and other Sub-Saharan countries, Zimbabwe does not have adequate supply of ARVs. (PSI 2008: 3; UNAIDS 2007).

The Table below shows the number of people that have been receiving ARVs against those that need the drugs. In 2004 it was 8, 000 against 600, 000, in 2005 it was 25,000 against 600,000, in 2006 it was 67,000 against 590,000 and in 2007 it was 98,000 against 570,000. These figures show the increase in the number of people receiving ARV year by year however against the number of those in need of the A R V's and those that receive a only a small fraction (UNGASS 2008).

Table 5 Beneficiaries of ARVs program in Zimbabwe



Developed from (UNGASS 2008)

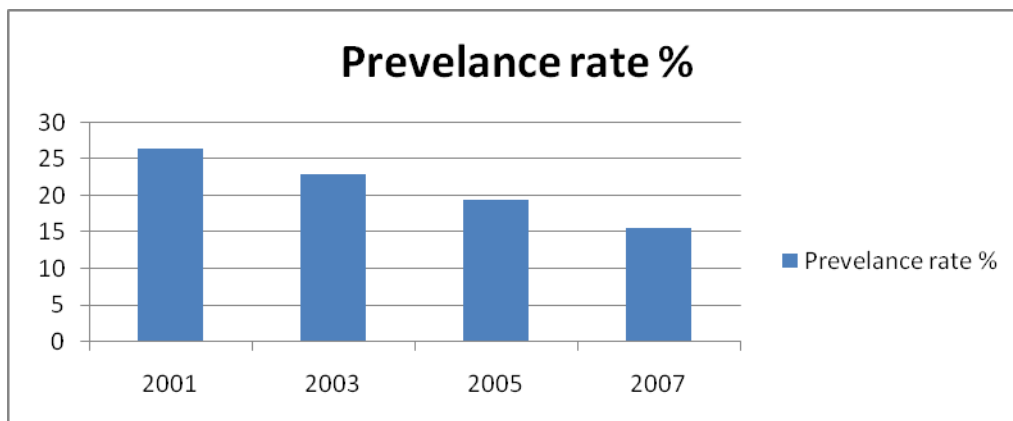
Feminization of the epidemic in Sub-Saharan Africa

60% of the 22.5 million people who were living with HIV/AIDS in Sub-Saharan Africa at the end of 2007 were women. This has been termed the feminization of the epidemic (PSI 2008:4). The reasons why the pandemic affects many females in Sub-Saharan Africa range from oppressive cultures, their physical make up that causes them to live longer with the disease as well as the fact that they are the majority of those who are tested for HIV/AIDS whether willingly or through compulsory methods like testing all pregnant women visiting antenatal clinic. ILO (2004:4) alluded to the impact of the pandemic on women by estimating that 31% of working men will lose their jobs due to HIV/AIDS while a higher percentage of 38% of working women will lose their job due to HIV/AIDS. These statistics do not include the number of women that leave their jobs to care for family members infected with HIV/AIDS.

2.4.4.3. Zimbabwe

An estimated 1, 320, 739 Zimbabweans were living with HIV/AIDS at the end of 2007 with a prevalence rate of 15, 6% among the adults (UNGASS 2008:4-10). There is massive substantiation from several authentic sources that there has been reduction in the HIV prevalence in Zimbabwe from 26.5% in 2001, 23%, in 2003, 19, 4% in 2005 to 15.6% in 2007 (UNGASS 2008: 4 and Aids epidemic update 2007:2). The decline in HIV prevalence is attributed to mortality and a decline in HIV incidence due to behavioural change (UNGASS 2008: 6).

Table 6 Decline of the HIV prevalence in Zimbabwe



Developed from information gathered in UNGASS 2008

Although HIV prevalence rate has dropped it is still very high as compared with other nations. In fact, despite the reduction in the HIV/AIDS prevalence, Sub-Saharan Africa still accounts for three quarters of all AIDS deaths in the world. The Zimbabwean Government spent 14.7 million US Dollars in 2005 and 63.4 Million US Dollars on HIV/AIDS from the national fund (epidemiology fact sheet on HIV and AIDS Zimbabwe 2008).

2.5. Impact of HIV/AIDS on the human security of households

Economic impact on household

HIV/AIDS poses economical impacts on households in that it increases expenditure in the form of direct costs, indirect costs and diverted revenue. Direct costs encompass medical care costs, drugs and funeral expenses. Indirect cost encompass lost time due to sickness, illness, attending funerals, recruitment and training cost in replacing workers who die or leave their jobs to care for the sick. Diverted revenue encompasses diverted savings, investments as survival strategies to compact the effects of HIV/AIDS (Bollinger et al 1994:3).

Health impacts on household

HIV/AIDS affects the human security of households in that it gives momentum to some of the causes of health insecurity especially amongst the poor. HIV/AIDS causes many to fail to provide good nutrition for their family. It does this by diminishing their economic security which is a prerequisite for provision of food stuffs that provide good nutrition. It also overwhelms the health services by increasing the demand on the health resources such as drugs. Such a demand would not be there if HIV/AIDS was not there. Some of the drugs that are used in treating HIV/AIDS are expensive.

Hubert 1999 cited in Fourie and Schonteich (2001: 1) asserted that, “human security of a household is measured in its ability to protect its members from violent and non-violent threats”. The former range of threats are the likes of violence such as gender violence, rape and war while the later range of threats are such as hunger (provision of adequate food) and shelter.

HIV/AIDS causes a wide range of personal security impacts on households, such as the violence which innocent girl children suffer. Some people believe if they have sex with a girl child they will be healed of AIDS. It also causes intra-personal violence as some commit suicide or go on a spree of spending all their savings when they realize they are HIV positive. It also causes interpersonal violence as some widow and children are evicted from their late husbands/parents property because they can no longer pay the bills or because some relative is claiming the property. HIV/AIDS also causes disadvantages to people, some of whom end up as street kids, orphans and easily find themselves in poverty. This forces some of them to commit street violence and prostitution as they seek the means for survival. In most instances, such children are left as orphans with no parental or financial support after the death of their parents; this forces many children in such a situation to drop out of school thereby, being denied them of their basic human right to be educated. UNGASS (2007:2)

Piot et al (2001:971) asserted that, “AIDS generate greater medical, funeral and legal costs, and has long-term impacts on the capacity of households to stay together.” These multi-faceted challenges posed by the pandemic on household’s drains its resources and alter the household patterns. Most of HIV/AIDS victims are open to abuse, exploitation, malnutrition and lack of adult love affection, socialization, guidance, education and support child headed households, widows and orphans (Bollinger et al 1995:5).De Waal and Whiteside (2003:1234) contributed on this issue by saying, “HIV/AIDS has created a new category of highly vulnerable households namely, those with ill adults or those whose adults have died”.

HIV/AIDS also impacts households by leaving many women as widow and children as orphans, it is estimated that HIV/AIDS has caused over 15 million to be orphaned so far and the number keeps increasing (Fourie and Schonteich 2001:7). Most of the orphans and widows are pushed into economic insecurity by these deaths. In the case of Zimbabwe, it is even worse because the nation is trying to recover from a serious economic crisis in addition to the global economic challenges that the world is experiencing.

HIV/AIDS affect the sources of economic security as well as food security of households. De Waal and Whiteside (2003:1235) explored results of household-levels studies that showed a decline in agricultural production attributable to the effects of AIDS.

2.6. HIV/AIDS human security synthesis

HIV/AIDS is both a cause and a result of human insecurity, in that HIV/AIDS can cause people to be economically insecure by reducing their income because of sickness however economic insecurity can also cause people to engage in sexual relation so as to earn a living out of it thereby being at risk of contracting HIV. HIV/AIDS is not considered as a health issue only but also as a human security issue as was adopted in the 1308 resolution by the United Nations Security Council (Kristoffersson (2000:1). Poit (2001:968) calls for sustained social mobilization to combat one of the most serious crises facing human security. Such efforts like provision of ARVs will go along way in reducing the impact of HIV/AIDS on the human security of households in that the patients are able to continue with their normal lives, especially ways of generating income for their households. Bollinger et al (1999:13-16) also explored literature suggested on poverty alleviation, ARV provisions, economic empowerment, gender empowerment and prevention of new infections as the way forward to reducing the impacts of HIV/AIDS on the human security of households.

2.7. Conclusion

This work reviewed the literature to establish what other scholars have established in regard to human security, HIV/AIDS and the impact of the later on the former. The structure of this section followed the flow of the specific aims of this research project. This work served as a basis on which the impact of HIV/AIDS on the human security of households in Bulawayo is explored. The main point that I arrived at from interacting with these sources is that human security is different from traditional security because it emphasizes people and it was one of the needs on which the foundation of United Nation was formed. I also learnt the need to emphasize human security as a way of alleviating the impacts of HIV/AIDS on the institution called household. The major impact posed by HIV on the human security of households is that of the economic challenges it brings on households that are already struggling because of the economic crisis in Zimbabwe.

CHAPTER III

3. METHODOLOGY

3.1. Introduction

This chapter explores the research methods employed in the undertaking of this study on the impact of HIV/AIDS on the human security of households in Bulawayo. This study sought to address two research questions,

- How does HIV/AIDS affect the seven areas of human security?
- Has the economic crisis in Zimbabwe increased the impact of HIV/AIDS on households?

3.2. Methodology

Collins et al (2000:236) asserted that, “qualitative data is generated by an in-depth inquiry that gives us detailed descriptions”. This study sought to do that by engaging the people living with HIV/AIDS to speak out about how they have been affected by this pandemic. Exposing the impact of the disease helps us to pave a way towards responding to these impacts.

This qualitative research utilized both primary and secondary data in which the later was reviewed to create a literature review and to address specific aims one and two. The secondary data sources ranged from academic books, to journals and authentic reports. Human Development Report 1994 was the major source for understanding human security. UNAIDS reports and United Nations General Assembly (UNGASS) 2008 Zimbabwe report were utilized to gather information on HIV/AIDS on a global, Sub-Saharan and also Zimbabwean context. Primary data in the form of focus group discussions (FGDs) and in-depth interviews (IDIs) were collected to address specific aim three which sought to gather first hand information on the impact of HIV/AIDS on the human security of households in Bulawayo. Primary data was drawn from participants who are members of infected and affected households.

3.3. Sampling

An attempt to undertake a research on the actual impact of HIV/AIDS on the human security of all the households with people living with HIV/AIDS in Bulawayo was impractical for my study especially given the limitation of time and resources for this study hence I needed a good sample that resembled the majority of households with people living with HIV/AIDS.

I surveyed potential sources for such a sample for my study and found out that the most plausible source was to work with Christian organisations which are on the forefront in caring for HIV/AIDS patients in Bulawayo. I contacted two support groups that I knew about in the city about my intended research and I found out that they were more than willing to participate in this research. I then worked with the two leaders of these faith-based support groups in preparing for the focus groups that we had scheduled.

I also wanted to expand my study to non-faith-based support groups so I contacted a New Start support group which meet in the city centre however their leadership turned me down saying, their schedule was too busy to incorporate as research session.

3.3.1. Focus group participants sampling

The first support group; *Touch the Hem* has a membership of 70 members since it is a ministry of a mega church, Lobengula BICC which had membership of over 1500. The leader of this support group is a member of Lobengula BICC, she works at local clinic and she is also HIV positive. I, Mrs Xaba (not real name) the leader of this support group and a fellow researcher; Miss N. Moyo had to use judgemental sampling to come up with 15 prospective participants for my first focus group discussions Mouton (2001: 148-150). We invited these prospective participants, 4 in with word of mouth and 11 telephonically. Those that accepted the invite were furnished with an invitation letter appendix 1 that explained the nature of the study. 7 managed to come for the focus group discussions. The researcher was looking for prospective participants who met the following criteria to participate in the focus group discussions:

- ✓ Be HIV positive or come from a household with a member who is HIV infected
- ✓ Has started ARV treatment “ “ “ “
- ✓ Be a member of one of the two HIV/AIDS support groups and of a household

I and Mrs Ncube the leader of the second faith based support group; *Fellowship 6:2* met for the process of sampling prospective participants using judgment sampling to select participant's group discussion from a membership of 32. We came up with 18 members and I invited them by word of mouth at one of their Bi-weekly meetings. Out of these 18, 12 managed to come for the focus group discussions. The same criterion for the first focus discussion participants was used in recruiting participant for the second focus group interviews. Those that accepted the invite were furnished with an invitation letter appendix 1

3.3.2. In-depth interview participants sampling

In-depth interviews participants were sampled from two points. The first sample came from the FGDs, where 10 FGDs prospective participants were invited to participate in the in-depth interviews. The researcher together with the facilitator approached five prospective participants from each of the focus group discussions using judgmental sampling. Out of the 10 that were invited six participated in the in-depth focus group. Two of them were from first focus group discussion with *Touch the Hem* support group and four of them from *Fellowship 6:2* support groups. These that accepted the invite were furnished with a letter on appendix 5

The second group of participants in the in-depth interviews were recruited by two nurses that work at two OIC in the western high density suburbs; Nguboyenja municipal clinic and Luveve infectious clinic, while the six participants that had already participated in the FGDs were recruited by the facilitator and the researcher. All the participants in the IDIs were recruited using the judgment sampling as suggested by Mouton (2001: 148-150). The IDIs also served the purpose of capturing data from participants from households that are not members of the faith based support groups in Bulawayo. 10 participants managed to participate from these two clinics. These also accepted the invite were furnished with a letter on appendix 5

The participants in the in-depth interviews were required to meet the following criteria in order to qualify for selection

- ✓ Be HIV positive or come from a household with a member who is HIV infected
- ✓ Has started ARV treatment
- ✓ Be a member of a household

3.4. Focus groups discussions

Lewis 2000 cited Kreuger 1988 as having suggested that focus group interviews were envisaged in the late 1930's. The term focus group was coined in 1956 by Merton et al (n.d) referring to a situation in which the interviewer draws information from group members or participants on specific subjects as the participants discuss about a subject. This work adopts Kreuger's (1988: 18) definition of a focus group as a "carefully planned discussion designed to obtain perceptions in a defined area of interest in a permissive, non-threatening environment."

I used this methodology because focus groups allow the researcher to gather information from many people at once. Merton et al. 1990 cited in Lewis (2000: 2) rightly concurs with this saying, "focused interviews with a group of people will yield a more diversified array of responses..." This saves time as well as cost of the intended research such as transport cost to different location for the interviews. This methodology fitted well my research with the limited time I had of one semester.

I chose to have these focus groups in the context of HIV/AIDS support groups because HIV/AIDS support groups draw together people living with HIV/AIDS for the purpose of encouraging, supporting and education each other on positive living. HIV/AIDS support groups then become the best group for researching the impact of HIV/AIDS. I also chose to have my focus group discussions with HIV/AIDS support groups because the people who are in HIV/AIDS support groups have already accepted and opened up about their HIV/AIDS status. Some of them have attended several meetings that discuss issues that pertain to HIV/AIDS and can easily contribute on how their households have been affected by the HIV/AIDS without much fear of stigmatization.

3.5. Instrumentation

This research made use of two instruments, the focus groups discussion questions appendix 3 and the in-depth interview questionnaire appendix 4. The former instrument has one question with four parts as suggested by Kreuger (1988) in Lewis 2000:4, who suggested that focus group interviews should have less than 10 questions. Each of the four parts addresses the third specific aim of this study. The later instrument was developed from question structures of Kaschula, S's (PhD candidate) work on HIV/AIDS, rural livelihoods and food security: an action research project. This in-depth interview instrument sought to reveal the household member statistics, the impact of HIV/AIDS and other additional information that the interviewee may want to bring to the attention of the researcher. The focus group discussions supported by in-depth interviews complimented each other and helps to clarify issues that can be generalized in focus group discussions.

Table 7 The instruments used to fulfil the specific aims in this study

Specific aims	INSTRUMENT Secondary Data	INSTRUMENT Focus group questions	INSTRUMENT Interview questions
AIM 1	✓		
AIM 2	✓	✓	
AIM 3		✓	✓

Developed from the crosswalk concept by McDade (1999: 67)

3.6. Permission issues

The researcher sought permission from the support group leadership and host churches these being Lobengula BICC and Praise and Worship centre to undertake a primary data collection through focus groups with the two support groups at their usual meeting place. Permission was granted in form of verbal and official permission letters received by the researcher, forwarded to the supervisor. The permission letter from Lobengula BICC is attached on appendix 7 and one from Praise and Worship centre/ Endumisweni (ESCAP) is attached on appendix 8. The two focus group discussions were conducted and they were very successful.

3.7. Ethical issues

The researcher met the ethical requirements of master's research as ascribed by the University by using codes such as participant one/four in compiling the gathered data instead of names as a way of safeguarding the confidentiality of the participants. Participation in this project was voluntary where the participants were not obliged to participate in the focus group discussions or in the in-depth interviews. They were also free to withdraw their participation for any reason at any time, should they have wished to do so without any consequences. The participants confirmed their consent to participating in the research project by signing the consent form provided see appendix 2 and 6.

3.8. Data collection process

The data collection process was conducted well and it was very educative to the researcher in that it exposed new information that the researcher had not been exposed to as well as confirmed some supposition the research had on this subject as well as to correct some presuppositions. In the focus group discussions, data was gathered in two ways these being by note taking, and video recording. In the in-depth interviews, a questionnaire (appendix 4) was used as a way of gathering data as participants responded to the questions in writing. This qualitative research concentrated on words as well as observations as the participants expressed themselves in the FGDs of their real experiences as suggested by Lewis (2000: 2). These observations were noted down as part of the finding of this research.

3.9. Challenges and limitations

I encountered several challenges in my research. The first one was that in my first focus group there was some resistance in participating by some participants, I cited the video recording as the possible source of this resistance. This changed when we were on tea break (while we were waiting for tea) where the participants concerned opened up and had a good discussion which was not recorded on. I and the facilitator had to capture these valuable contributions as notes. The participants contribution improved slightly in the second session which was recorded but not as they had done while on break.

Though the group had agreed that we could have a video recording I think some had a problem with video recording. I had to record from one stationary position and did not have face close up so as not to discourage the participants to discuss freely.

I also encountered some mechanical problems with my recording equipment. I discovered later that my audio recorder did not record well in our first sessions; I however used the video which recorded well. Another challenge I also had was that I could not involve a lot of people in the preparation of this research such as people who prepared tea for us. This could have made the participant think that all these people knew that they were HIV positive. The researcher, Mrs F Moyo (Mathe) had to work at running the interview as well as preparing the tea. This caused us to finish our meeting later than we had planned.

Morgan 1988 is cited in Lewis (2000: 3) suggesting that, "it is best to over recruit by 20% as some people may not wish to participate or turn up on that day. It was in light of this suggestion that I invited 15 people to attend the first focus group session only eight managed to come. Some failed to come because the weather was rather cold for people in their condition. One failed to come because she had gone for a funeral. It was in light of the realization such challenges that are prevalent amongst people living with HIV/AIDS that I had to invite 15 people instead of a straight 10 as the suggested maximum number for an effective focus group so that if other fail to make it I would have a good number for focus group discussions (Lewis 2000:3). The same was done for the second focus group discussions where 20 prospective participants were invited and 12 of them managed to attend. Since they were not obliged to come if they did not want, I do not know the reasons why they did not come however I suspect that it had to do with economic challenges of transport to town their usual meeting place.

The participants in these focus groups were limited to Christians as they are the one that attend faith based support groups as the ones partnered with in this research. I tried to organize a focus group with the only known non-faith based support group however the leadership of this support group could not allow me to have focus group with them in the confinement of my available research time.

In light of this the views and inputs from people that are not Christians and who are not member of support groups were not captured in the focus group discussions however they were captured in some of the in depth interviews (IDIs) that complimented the focus group Discussions (FGDs).

3.9.1. Interviews

The researcher followed up the focus groups discussions with in-depth interviews in the form of a questionnaire. These in-depth interview questionnaires were organized in a funnel approach, with questions of greater importance coming early and questions of less importance coming later on, as suggested by Steward and Shamdasani 1990, cited in Lewis (2000: 4) as one way of engaging the interest of participants quickly.

3.10. Coding and analyzing data

This research utilized codes instead of names, focus group participants were coded as FGD then numerical number according to their sitting arrangement. The same was also done for the second FGD. The first note on the participant was recoded together with the sex of the participants. The in-depth interviews participants were coded according to the number in which they brought back the questionnaires prefixed with IDIs.

3.11. Limitation of this methodology

The first limitation of the focus group discussion was that the participants in these focus groups were limited to Christians as they are the ones that attend the faith based support groups involved in this research. This means that views and inputs of people that are not Christians and are not member of the two support groups were not captured in the FGDs. The researcher had wanted to involve non-Christians in the focus group discussion as the third focus group however the non-faith based support group could not allow me to have focus group discussion with them as they said their program was fully booked could not accommodate the research. The researcher purposed to capture the views of those who are not part of the faith based support groups by involving them in the depth interviews (IDIs) that complimented the focus group discussions (FGDs).

3.11. Reliability and Validity

Collins (2000:191) explained reliability as, “the degree to which a scale yields consistent results or score”. This study is reliable in that it concurs with discoveries that have been done by other scholars with regards to HIV/AIDS impact on household as recorded in secondary data on Sub-Saharan region. It is also valid because it explored personal experiences of real people living with the HIV/AIDS pandemic in Bulawayo although it did not research every household it examined a sample of people that have the same level of disease, as all participants are on ARVs, it also explored people in the same economic bracket as most of the people are living below poverty datum line. The commonness of the impacts they experience also add to the validity of this research and example is the transport problem which all of the participant alluded to as well as the challenge of not being able to afford ARVs. The research revealed that only 4 participants are not on the NGOs/ government ARVs program. Two household receive these drugs from their family members in the UK and the other two households are the only households out of the whole sample of 29 households who are able to afford their own ARVs medication, they buy them from their private doctor. These two households are in a different economic class from all the other households. It is commonly believed that they are only two economic classes in Zimbabwe and in Bulawayo these being the extremely poor and the extremely rich which are also called the “haves” and “have not” as the middle class was eliminate long ago.

3.12. Conclusion

This chapter explored the methodology, sampling, recruitment of participants, data collection, instruments utilized in this study. It also explored how the ethical aspects of the study been conducted and the validity and reliability of this study.

CHAPTER IV

4. DATA ANALYSIS

4.1 Introduction

The previous chapter explored the methodology utilized in researching the impact of HIV/AIDS on the human security of households. This study sought to address two research questions,

- How does HIV/AIDS affect the seven areas of human security?
- Has the economic crisis in Zimbabwe increased the impact of HIV/AIDS on households?

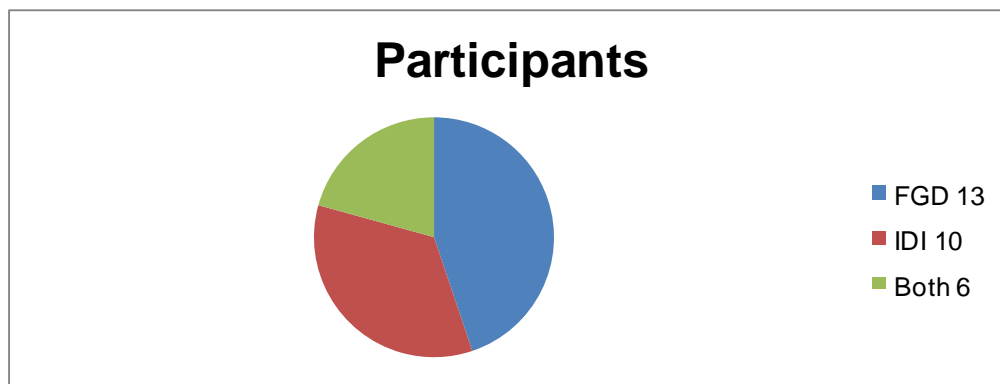
The three specific aims of this study were

- To assess the human security conditions in Zimbabwe
- To identify potential impacts of HIV/AIDS on human security.
- To examine the actual impact of HIV/AIDS on the human security of households in Bulawayo.

These specific aims utilized both secondary and primary data. The later was gathered in form of two focus group discussions and in-depth interviews.

4.2. Research overview

Table 8 Research participants



Key: **IDI** = In-depth interviews **FGD**= Focus group discussions **Both**= participated in the FGD and IDI

This study was undertaken in the high density suburb of new Lobengula and in the city centre of Bulawayo with a sample of 29 participants representing 29 households. 13 participated in the focus groups discussions alone, 10 participated in the in-depth interviews alone and 6 participated in both the focus groups discussions and in-depth interviews as shown in the diagram above. For the purpose of clarity this study will regard the 6 participants who participated in both the FGDs and IDIs with the FGDs to make them 19 FGDs participants and 10 IDIs participants giving us a sum of 29 participants that represent 29 households.

4.2.1. Households

This work adopted Naidu and Harris (2006: 417) definition of a household as, “people who leave under one roof (be it a house or a shack) for more than 4 nights a week, including the migrant workers. Members of such a household may not necessarily be immediate relatives/ family”. This definition was adopted in this study because it best resembles the households in Bulawayo. The concept of a household as a measuring instrument on the impact of HIV/AIDS was adopted because a household is, “the most vulnerable institution that receives most of the impacts of HIV and cannot easily offload these impacts to other people or institutions” (Mtika 2001 cited in Murphy 2005: 269.)

4.3. Focus groups discussions participants

Merton et al 1990 cited in Lewis (2000: 2-3) said, “focus groups interviews yield a more diversified array of responses”. This was proven to be correct in this research in that the participants brought up several views of how HIV/AIDS has impacted the human security of households. The participants spoke from a background of having experienced the impacts of HIV/AIDS at a household level. The two focus group discussions started with explaining the purpose and process of the focus group discussions. This was followed with signing of consent forms by the participants. The facilitator then presented the four fold questions below which participants discussed in light of their personal experiences.

1. How has HIV/AIDS impacted your household’s economic status?
2. How has HIV/AIDS impacted your household’s ability to provide adequate food?
3. How has HIV/AIDS impacted the health of your household?
4. How has HIV/AIDS impacted your household’s relationships in the community/ in general your whole household lifestyle?

4.3.1. Focus group discussions

This study had two focus group discussions that were done with two different faith based support groups in Bulawayo. These support groups were, “Touch the Hem”: a ministry of Lobengula Brethren in Christ (BICC) and “Fellowship 6:2”: a ministry of Praise and Worship centre. *Touch the Hem* support group has a total membership of 70 and 68 of them are females and only two are males. They normally meet once a month, on the second Wednesday. The leader of this support group is a member of Lobengula BICC, she works at local clinic and she is also HIV positive. She helped me, alongside a lady pastor from her church to recruit possible candidates for the focus group discussion using the theoretical / judgment sampling to come up with 15 potential candidates. This sampling method was adopted from Mouton’s work (2001: 148-150). These invites were done telephonically. Two of the 15 prospective participants were the two male members of *Touch the Hem* support group. Out of the 15 invited seven female participants managed to come for this focus group discussion. The first focus group discussion was facilitated by a fellow Conflict Resolution and Peace Studies (CRPS) student Mrs F Moyo (Mathe).

The second focus group was done with members of another faith based HIV/AIDS support group called “Fellowship 6.2”. This support group is co-led by two female leaders and it has a membership of 32. I also worked with the one of the leaders using the judgmental sampling to invite 18 members to come for the focus group discussions. Out of the 18 that were invited, 12 managed to come for the focus group discussions. Four of these participants were males. I facilitated this focus group discussion and another fellow student in the CRPS program, Miss N Moyo, was taking notes.

In these two focus groups, I had over invited participants because of two reasons. The first reason was that, I was not assured of how many people would participate since they were not obliged to be available if they did not want, hence I thought if I invite more the probability of having a good attendance would be great.

The second reason stemmed out of the realization that the prospective candidates live with a lot of challenges that can easily hinder them from participating in the focus group discussion, such challenges like they might not be feeling well or other pressing needs might arise that might need urgent attention such as going to see a doctor. It was in light of these challenges that I had to over invite participants. Morgan 1988 cited in Lewis (2000:3) suggested that, “it is best to over recruit by 20% as some people may not wish to participate or may not turn up on that day”. I had also had prepared to divide the participants to make two smaller focus group discussions in case all the 18 invited participants would have come for the second focus group discussion.

Qualification for using these focus groups

I used these two support groups in this research because they are the only support groups that agreed to be part of this research. *Touch the hem* support group has been a good source for people and organization that are in HIV/AIDS research including one of my fellow Zimbabwean students in CRPS program, Miss N. Moyo whom I have already mentioned above as my research partner. We both did our separate research with this support group, while we helped each other on the research projects as facilitators and note takers. Some groups were not willing to participate in research programs. I had approached the leadership of a New Start non-faith based HIV/AIDS support group that meets in the city centre and was turned down as they said they had a busy schedule that could not accommodate a research project.

4.3.1.1. First focus group discussion participants

The first focus group discussion was attended by seven participants. All of the participants were females. They all stay in the western high density suburbs of Bulawayo. All of them are living with HIV/AIDS and are on the government ARVs program at different health institutions in Bulawayo.

4.3.1.2. Second focus group discussion participants

The second focus group discussion was attended by 12 participants. Four of these participants were males. Three of them were elderly women. The youngest participant was male student who is studying his Advanced level (A. Level) and is 18 years old.

4.4. In-depth interviews

This study also utilised in-depth interview to a gather data from participant that represented their households. 10 households were represented in this study.

4.4.1. In-depth participants and their selection

As already shown in the chart above this research drew 10 IDIs participants representing 10 households to make a total of 29 households represented in this research, 19 of these representatives had already participated in the FGDs. These 10 participants were recruited by two nurses that work at two OIC in the western high density suburbs of Bulawayo. These participants were recruited using judgmental sampling, which looked at people living with HIV who had the potential to be part of this research (Mouton 2001: 148-150). The two nurses approached different patients and 6 and 4 from each of the clinics. They gave their consent to participate in this research by signing consent forms; a copy of the form is attached as appendix 5. This was done as a way of extending the research to households whose input was not captured in the faith based support group discussions.

An additional six participants who had taken part in the FGD were invited by the FGDs facilitators and the note taker to participate in the IDIs. These participants were invited using judgmental sampling of their participation in the FGDs. The in-depth interviews utilized a questionnaire which had both open ended and closed questions; this questionnaire is in the appendixes at the end of this work

The table below show the data collected from the IDIs about the participants households

Table 9 Household Data on IDIs

P	F M	E M	S J	I M	Income	Major expenses	MPD	Comments
1.	6	0	0	2	Handout and donation	Rent, food and meditation	Two	Lost husband the bread winner and Job as a
2.	7	2	0	1	Nil	Rent, food and school fees	Two	Husband passed away and her business swallowed by inflation
3.	4	0	0	1	Donation from an aunty in Norton	Rent, School fees and food	Two	Cannot work anymore and the wife passed away in 2006
4.	7	3	2	2	Business man and wife on salary	Rental, fees, medication and food	Three	
5.	6	3	1	0	Vending, donations and salary	Rent, food and school fees	Two	Infected parents are all dead now and have left orphans
6.	5	2	0	1	Selling vegetables	Food and school fees	Two	Often sick and stay his elderly parent (father)
7.	5	3	1	1	Salary and donations	Rent, food and medication	Three	Stigmatized
8.	2	0	0	1	Selling goods from vegetables and clothes	School fees and food	Two	Medical care, stays with old grandma, father passed away, mother remarried because of desperation
9.	9	2	0	1	Market gardening	Food and school expenses	Two	Father migrated to South Africa with another woman
10.	4	0	2	1	Salary	Rent and school fees	Three	
11.	10	5	0	1	Selling vegetation	-	One	Desire to educate her 3 children
12.	5	0	0	2	-Nil	-	Two	Desire long life and good future
13.	7	0	0	1	Salary	Medication, rent, school fee	Two	Lost her job and that stressed her a lot
14.	3	-	-	-	Selling vegetables		One	Lost her Job because of sickness
15.	9	2	0	1	Rentals from their houses and food donation	4*School fees and food	One	Gifted sculpture and a profession
16.	8	4	3	1	Salaries, donation and crop harvest	Rent, school fees and food	Two	Low productivity

Key

P= participants

EM= Extended family members

I M=number of infected member

FM= Number of family member

SJ= those with secure jobs

MPD=meals per day

4.5. Findings of the study

This study sought to research the potential impacts of HIV/AIDS on the human security of households which have been asserted as, “numerous and affecting all sectors of life, from micro to macro levels” by Lundberg et al. (2001).

Lundberg asserted that, “HIV places great strain on household earnings, agricultural output, food security and ability to cope due to adult morbidity and mortality from HIV/AIDS in the context of his study”. Lundberg estimated that HIV/AIDS causes a decline in household income by as “much as 40 to 60 per cent”. The researcher sought to establish impacts of HIV/AIDS on the Bulawayo context to see if there are any similarities or differences to the impacts asserted by Lundberg.

The findings of this study were analyzed in light of the seven threat areas of human security as explored in the 1994 HDR. These seven threat areas are economic security, food security, health security, environmental security, personal security, community security and political security (UNDP HDR 1994:24). This research assessed the human security conditions and the impact of HIV/AIDS on the human security of households in Bulawayo by exploring the presence or absence of the seven categories of human security since human security is said to be easily identified through the absence of these seven threats (HRD 1994:24).

4.5.1. Economic security

This section explores the impact of HIV/AIDS on the economic security of households in Bulawayo. The findings revealed that this was the major impact of the pandemic on households. The economic impact also threatened other household securities such food and health security because the later depend on the economic security of the households.

4.5.2. Secure jobs

The first focal area in assessing Zimbabwe’s human security conditions was looking at economic security of its citizens according to HRD (1994:25); economic security is dependent on how many people have an assured basic income. Zimbabwean statistics revealed that only 6% have an assured basic income as the unemployment rate was at

94% as at 03 February 2009 (Sapa-AP-AFP 2009:1). These statistics do not capture migrant workers in other nations neither do they include those that are self employed, who are the majority of workers in Zimbabwe. However, not all these excluded workers bring home an assured income every month, hence, the point still stands that that the majority of Zimbabweans are economically insecure, since economic security emanates from having a secure liveable income.

The research findings revealed that out of the 19 FGD participants only five had secure jobs that assured them a salary every month. Out of the 10 households involved in the IDIs only three households had members who had a secure income. This then means that only eight households out of the 29 households represented in this study are economically secure. The findings of this research exposed the fact that 13 households had lost their source of secure income because of HIV/AIDS. These 13 households were made up of five households from the first FGDs, two households from the second FGD and six households from the IDIs. If it was not for AIDS, a total 21 households out of the 29 households in this study would have been economically secure. This is a sample which shows us the first economic impact of HIV/AIDS on the human security of households in Bulawayo.

Most of the households in this study now depend on donations and small income generating projects like selling vegetables. A summary of the information collected from the participants on the economic impact of HIV/AIDS is shown in the table below:

Table 10 Focus group economic challenges Table

Impact	First FGD	Second FGD	In-depth interview
Secure jobs	2 out of 7 participants were formally employed	3 out of 12 participants had secure jobs	3 out of 10 households had 6 people with secure jobs
Lost jobs because of AIDS	5 participants lost their jobs because of sickness	2 participants lost their formal employment on health grounds	6 people out of 10 in participating households had lost their job due to illness
Stay at home	1 participant was a stay at home mom	2 participants were stay at home mothers	Nil
Source of income	1 participant changed trade from sewing to doing laundry for people	2 households depended on donation from family members in the United Kingdom (UK),	2 households depending on donations
Survival strategies	Food and medical aid from Help Germany NGO	3 participants were self employed although not gainfully as they were in the buying and selling business.	3 households sold vegetables as an income generating project

4.4.3. Loss of income

This research found out that HIV/AIDS continues to impact negatively the economic security of households with people living with HIV/AIDS (PLWHA) in that it affects their health to the extent that they are no longer able to work properly, some would be off sick from work thereby temporarily reducing their households' income. As the disease develops the temporary reduction on the income of households develops into a permanent reduction of income, as some workers resign on medical grounds, some resign so that they can care for the sick and some salaries cease at the time of death. Participant 1 from the first FGD, a single mother of one, related how she lost income because of HIV/AIDS saying, *my health deteriorated drastically that I could no longer continue to work, Ngatshiya umsebenzo wami, kade ngisebenza ngeno receptionist meaning I left my job, I was working as a receptionist.* Her household finances were redirected towards her medication. The family was so supportive to the extent that her mother also left her job to care for her, thereby further reducing the income of her extended family. This is a clear sign of double loss of income in one family as both the daughter and her mother had to leave their jobs.

4.4.4. Medical expenses

This research also found out that HIV/AIDS also brought about increased expenses especially on medical expenses. Participant 1 from the first FGD shared on this issue saying, *it increased our medical expenses as we, (Her and husband) had to seek medical attention frequently especially for my husband. Our medical aid could not cover all the cost and the family had to pay 50% of the medical bills.* She went on to relate that they felt the economic challenges because her husband was the only breadwinner as she was a stay at home mother. Participant 1 from the second FGD contributed to the discussion of increased medical costs saying, *my economic security was impacted by the high cost of ARVs, I needed them because ngangi hlala ngigula (I was constantly sick). I could not start on ARVs medication because they were too expensive and the government free ARVs were not easily accessible.* She said she was left with no option other than to join the long government waiting list before she actually started treatment. Participant 3 in the first FGD added that the medical expenses were a major economic challenge for her household because she had to frequently visit the hospital as *they demanded that after every seven days the patients would have to pay another consultation fee which was way out of reach for most of us, especially now that we have to pay in foreign currency.*

Table 11 Participants contributions on medical impacts

Participant	Contributions
Part 1 FGD 1	She could not afford ARVs had to join the government waiting list
Part 2 FGD 1	She and her husband frequently visited the doctors, high consultation fees that were paid in forex while they were having reduced income, they could not afford ARV's
Part 3 FGD 1	Could not afford ARVs had to seek after the government free ARV's
Part 4 FGD 1	ARV's were too expensive, she had to join the government ARV provision program, she is also on TB treatment
Part 5 FGD 1	Complained about the medical expenses in Foreign currency
Part 6 FGD 1	Could not afford the ARV had to join the Government program
Part 7 FGD 1	She did not contribute but she is one government ARV program also
Part 2 FGD 2	She wasted a lot of money changing doctors and some times went to witch doctors seeking help, before she knew she was HIV positive
Part 1 FGD 2	He spoke on the need to get tested before wasting money seeking wrong medications

4.4.5. Transport fees

Another common economic impact of HIV/AIDS on households in this study was that it increases the expenditure in terms of transport fees as patients have to travel frequently seeking medical attention, counselling and food aid. Participant 5 in the first FGD said her major economic challenges had to do with transport fees to go for her ARVs medication. As a person who had lost her job which was her only source of income, She and mom had to improvise when it came to transport needs. They resorted to walking long distances to go to hospital. As she got weaker she said, *saba le plan yekuhamba siye lala kogogo eMzilikazi eduzane le sibehlela* meaning *we resorted to a plan of walking smaller distance and sleeping at a relative's house near the hospital then proceed with their journey the following morning*. The other participant also concurred on the transport fee challenge saying, *Saba lenginga yemali yemtshova ngenxa yokuti ngangifanele ukuti ngigade kabili kuze ngiyofika eCentral*, meaning *I had to commute twice for me to get to Central hospital*. She was one of the five that were receiving her counselling; medication and food aid at Central hospital which is on the far eastern end of Bulawayo. The nearby Mpilo hospital and local municipal clinics could not take her in for the ARV'S program because they could not meet the demand in the high density suburbs. Participant 7 from the second FGD noted that walking long distance that most AIDS patients were forced to by circumstances is not good for their health. He said, walking long distances causes his legs to swell and this causes him not to go to some places where he really has to be such as being at church (*inyau zami ziyavuvuka ngingahamba kakhulu, ngiya qina ngingahamabi lapho ngifane kona ukhuti ngifike kona njenge ukubuya echichi la*). Five of the participants were receiving their medication from distance Hospital that meant that they were supposed to pay R20 for a single hospital visit in transport fees. Participant 9 in the second focus group expressed the point that sometimes it is difficult to raise even R5 for a one way transport this was support by the amount of the participant that have walked long distances, some even walked and slept at relatives' houses near the hospitals because they could not afford R5 for one way transport fee.

Participant 4 in the first FGD also had challenges with transport money as her only source of financial support was her son who is not gainfully employed, (a *Hwindi*) meaning, a commuter omnibus tout, one who calls people (advertise) to get into a particular omni-bus and acts as a conductor in the omni-bus/kombi . She needed the transport money to attend counselling sessions for four weeks before she started was enrolled on the ARVs program as well as to continue to go for her monthly ARV's which sometimes they do not get. The same happens also with the food stuff they receive from Help Germany one of the two NGO HIV/AIDS support organisations in Bulawayo

Participants 5 and 6 from the first FGD also were impacted by the increased need of transport fee that was brought about by the HIV/AIDS pandemic. Participant 5 needed the transport money to go and collect her medication while participant 6 needed it for her weekly counselling session as she was diagnosed at an advantaged stage of HIV. She related that, *I had to take up three month counselling before commencing the ARV drug program; this really strained her finances as a person who was already sick and did not have means of getting the money.* The facilitator probed to find out why she had to take so long before receiving treatment assuming that this was passive euthanasia as she was already in an advanced stage of HIV. The participants clarified that patients receive different dosages and those in the most advanced stage need more counselling as they are desperate to get medication and can misuse the medication. This was a huge challenge financially as it demanded that she visit the hospital every week. This strained her personally as a patient as well as her financial resources in terms of transport fees.

4.4.6. School fee expenses

This research also revealed that HIV/AIDS brought about a challenge of school fee especially on household that had lost the providers or breadwinners. Participant 1 in the first FGD told the group that her husband died of AIDS and left her with two children saying; *one of them was in form four: the crucial stage of education.* She expressed that this was a challenge as form four (ordinary level) results determine if their child would have a better or worst life as it is the gate way to employment and further education.

She expressed that sometimes she is not sure what to prioritize between food for the family or school need. Participants in the first FGD also expressed appreciation to their local church for the commitment to pay tuition fees for all the orphans including the HIV/AIDS orphans this has lessened the burden on the people living with HIV/AIDS in their church

Participant 5 in the second FGD She also alluded to the economic challenges they faced as a households in buying such foodstuff and pay bills using foreign currency (forex) as they did not have anyone who was gainfully employed or who had the means of getting the Rands and the US\$. She related how God came to their rescue by allowing her household to be a beneficiary of the GVT- NGO (World Vision and Help Germany) food aid. Most of the participants affirmed their appreciation to God so similar break-throughs. The researcher noted heads nodding and some vocalized the word “Amen” to God provision for these households through food donations. This showed how much the participants appreciated the food and ARV aid.

4.4.7. Funeral cost

The potential impacts of HIV/AIDS are not limited to urban life only as they cause rural people to switch to less labour-intensive crops because of lack of labour as some die from HIV related illnesses. Rural household resources are also diverted to help fund medication needs and funeral expenses even the medical need and funerals of people that live in the urban areas (Bollinger et al 1999:6). Participant 2 in the first FGD gave a practical illustration of this saying, *Ubabazala waye funa ukutengisa inkomo yake ukuze sithole imali eyo kubadala lapo umgami wami kade elatshwa kona, waye funa futi ukuti simuhambise azinyangeni* meaning *my father in law had offered to sell his beast at his rural home so that we would have money for my husband's medication at private hospitals as well as at traditional doctors.*

Funerals also consume valuable and productive time as people have a cultural obligation to identify with the mourning by being with them throughout the time of the funeral; this means people stay for days with the mourning family thereby losing productive time consuming the few resources that the mourning family may have left. This results in a household failing to provide enough food in the future as most of these families depend on their harvest and also sell surplus crops to supplement their other household needs such as soap, bills and other cash demanding needs in a household. This impacts most Bulawayo households in that they are dependent on rural households, just as the rural households are dependent on urban households in terms of inputs and financial resources

4.4.8. Food security

Household food security depended on the ability of a household to provide physical and economic access to food. Household food security is dependent on the household's economic security; economically insecure households are not able to afford enough food. Recent statistics reports that 33% of Zimbabwe's urban areas such as Bulawayo are food insecure (Zimbabwe food security 2009). The assessment of the human security situation in terms of food security in Zimbabwe affirmed that 7.1 million people were estimated to be in need of food aid in March 2009 (WFP/FAO 2009). Many of the households are now living on one or two meals, these meals are mainly carbohydrates in the form of Sadza the staple food and vegetables as a strategy of coping with the food insecurity situation (Zimbabwe food security update Feb 2009 and Waal and Whiteside 2003:1236).

The research finding revealed that 10 of the 16 of the in-depth interviews are living on two meals a day and these meals are concentrated on carbohydrates. The findings of this study in this regard concur with the February 2009 Zimbabwe food security update assessment which reported that, "consumption patterns were deteriorating in urban areas where most of the households were consuming one to two meals a day and dietary diversity was limited, with carbohydrates and vegetables constituting most of the meals" are Three households out of 16 have one meal per day while the other three households have three meals per day. This is a pure sign of food insecurity, this is caused by the economic situation in Zimbabwe but it is also exacerbated by the HIV/AIDS pandemic

Participant 1 in the second FGD responded to the question of the impact of HIV/AIDS on the food security of a household the research revealed that most households survived on food donation. This shows that most of these households are insecure in terms of food. The research also revealed that five of participants from the first FGD had been removed from the Government and Non-governmental food donation program. The donor organisation want to channel the same resources they were giving these people to new patients that are starting the ARV program, who have been on the waiting list for a long time. The expectation of the organisation is that they have gained weight and are now able to help themselves through the projects however they are not really able to survive without these food donations as most families, relatives and neighbours were actually benefiting from these donations indirectly. One participant related how her daughter would phone and ask for food because her husband is not employed and they are struggling financially. Now that the donations are no longer these people will really struggle.

Participant four from the second FGD responded to the question of the impact of HIV/AIDS on the food security of households in Bulawayo saying, *not all household are affected*. He asserted that rich households are not really affected because they have fully packed pantries however the poor households are greatly affected in that *Ukudla kuyaswelakala kwabangabayanga* (meaning food runs out in a poor household). He went ahead to assert that AIDS is a big challenge for the poor than the rich, went on to explore some survival skill which poor households can adopt to alleviate the effects of food insecurity. He suggested that patience would utilize available *recommended African foods for the HIV/AIDS patients which can be easily found cheaply likes of beans and vegetables*. Participant 6 in second FGD also added that *these vegetables can be kept in a multi-cropped garden, this also help the sick to exercise as you tend the garden without using a lot of strength which sick people do not have anyhow*.

Responding to the question posed by the facilitator on other impacts of HIV/AIDS on the human security of households in Bulawayo, Participant five in the first FGD highlighted that her household was are now selective when it comes to the food they eat. She narrated

the challenge saying, *Indaba yekudla yaaffected imhuli yami in that sasifanele sipheke ukudhla ukufanele mina isigulwani, sasingelayo imali yekuenza two separate meals* meaning, *the issue of food affected the whole household in that we were forced to prepare one meal which suits me as a patient and we did not have money to make two meals/multiple dishes*. She expressed how their food selection was difficult to meet in the time of food shortages in Zimbabwe as there was no choice at all in terms of food. People bought what was available even if it was not good for her health. She related how she had to eat super refined mealie-meal instead of roller meal which is rich and is recommended for HIV/AIDS patients. Super refined mealie-meal was the only meal-meal on the market and it was imported from Botswana and South Africa as Zimbabwe did not have enough maize for its people.

4.4.9. Health security

The Zimbabwe government health department is struggling to provide health for all. The battle that Zimbabwe health department had with the cholera disease which claimed 3 229 lives of the 63 000 reported cases shows how Zimbabwe's health system could not protect its citizens (HELP-Hilfe zur Selbsthilfe e.V. 2009). If it was not for the help from the international society more lives would have been claimed by the diseases. Participant 7 responded to the question on the health impact of HIV saying, *the escalation of HIV/AIDS results in the straining of government health resources such as drugs and manpower*. (Fourie and Schonteich n.d: 11) alluded to this when he said, "this forces some governments to commit euthanasia in the form of turning back patients without providing care and medication as they would not be able to cope with the growing number of people needing health assistance". This has left HIV/AIDS as the major killer especially in Sub-Saharan Africa where governments struggle to provide adequate health resources and personnel (Heinecken 2001:120). AIDS has killed more people than those killed in conflicts in Africa with the later having claimed 200000 lives while the former claimed over 2 million in one year only (Fourie and Schonteich n.d: 3)

The research revealed that 22 households were on NGO-GVT ARVs program at different government hospitals and municipal clinics. This initiative is helping to provide health security in the affected households. Five of them were receiving their medication from

far away hospitals and clinics, only two were at nearby municipal clinics. The clinic and hospitals in the high density suburbs are serving a lot of people and have long waiting list this forces them not enrol more than they can provide for. This agrees well with the information that says out of 570 000 who were in need of ARVs in Zimbabwe in 2007 only 98 000 were receiving the government sponsored ARVs drugs (UNGASS 2008). The hospitals located in the low density suburbs have fewer patrons as few people leave in the low density suburbs and most of them can afford to buy their own drugs hence their hospital can still take more patients.

4.4.10. Environmental security

The area of environmental security is generally the least explored and also has less empirical evidence, this has been seen in the fact that only two households contributed indirectly towards this issue. High prevalence rate of HIV/AIDS has been cited as one of the causes of environmental insecurity in that people living with HIV/AIDS tend to resort to natural resources as a survival strategy which results in over harvesting of natural resources such as firewood and wild fruits for use/consumption and for resale as well as environmental degradation as people resort activities like gold panning (Shoko n. d). The impact of HIV/AIDS then on the environmental human security is that it forces households to resort to cheaper forms of lifestyle that harm the members as well as the environment. One example that came out in the IDIs is that some households pick and sell firewood and plastics as means of income generation. They also use the same resources as their fuel; this has a probability of affecting them as HIV/AIDS patient can easily have T.B.

4.4.11. Personal security

Personal security seeks to protect people from violent crimes. This research revealed that HIV/AIDS affected personal security is by claiming the lives of the people that are supposed to protect household from different forms of threat. Many parents have died and left their children as orphans in a vulnerable position and many of these children have been victims of violence because HIV/AIDS claimed the lives of their protectors.

The research findings showed that three household from the first FGD, three households from the second FGDs and five households from the IDI had lost one of the parents, this means a total 11 households had lost one of the parents leaving the children with no source of personal security. Fourie and Schonteich (2001:1) alluded that, “in 2000, 90% of the 11 million HIV/AIDS orphans were living in Sub-Saharan Africa” Zimbabwe is part of this region, hence the issue of orphans is a real problem that needs to be dealt with well. The sample of the household who participated in this research revealed that 12 of the 16 households have orphans in their homes.

HIV/AIDS also impact household in that affected people find themselves in the midst of HIV/AIDS based violence as some people fight about who brought the disease in the household. Another way in which HIV/AIDS has affected households in Bulawayo is that HIV/AIDS has caused some people to think and some commit self inflicted violence such as suicide. Participant 3 in the first FGDs shared about how she thought of suicide at one time saying, I had problem in revealing her status because she was scared I would be rejected. I thought of taking pill to kill myself because I thought I am going to die anyway. Her friend was there for her and helped her reveal it to her household as she stood by her as a source of support while she was there supporting her. Her family supported her however there came a time for her supportive brother to get married and she could not look after the need of two household because of the economic challenges in Zimbabwe. For this participant HIV/AID did not affect her personal security.

Personal security in households was also impacted by HIV/AIDS in that it reduces life expectancy which had increased with 24 years on the African continent in the last four decades but has been wiped out by HIV/AIDS (Piot et al 2001:971). The World Bank source 2007 asserts that Zimbabwe had gained up to 62 years of life expectancy by 1985 but has however lost those gains because of HIV/AIDS, to the extent that by 2005, life expectancy was around 37 years.

4.4.12. Community security

Community security is normally derived from being a member of a particular group. Such communities like family have been impacted greatly by the HIV/AIDS pandemic in that it force many people to migration into and out of affected household (Naidu and Harris 2006). Thereby killing the sense of community and belonging.

This research found out that HIV/AIDS has caused disintegrated families as parents die and children move to stay with other relatives or live alone as orphans. A study in rural South Africa suggested that households in which an adult who has died from AIDS were four times more likely to dissolve than those in which no deaths had occurred. Much happens before this dissolution takes place. AIDS strips families of their assets and income earners, further impoverishing the poor leaving no option for such a household than to disintegrate (Pembrey, 2009:2) .The research revealed that 7 out of 10 households that participated in the IDI were extended families with member that came from some disintegrated families. This support and concurs with the definition of household that has been adopted in this research as “people who leave under one roof (be it a house or a shack) for more than 4 nights a week including the migrant workers these may not necessarily be immediate relatives/ family” (Naidu and Harris 2006: 417). Participant 3 in the first focus group explained how to move back into her paternal house when her husband died saying, *Ngasala ngedwa umgami esebubile, umama wazongitata ngabuyela enhlini lapho engizalelwa khona* meaning *I was left alone after my husband had died and my mother came to me so that I could return to my fathers house as I needed someone to care for me.*

HIV/AIDS also causes instability in nations where it or its effects are prevalent. HIV/AIDS is both a cause and an effect of poverty which had been cited as one of the causes of social instability and high crime rates (UNGASS 2008:2). Some of the people that commit these crimes are people that have been left in a vulnerable position because of HIV/AIDS, these are the likes of HIV/AIDS orphan who drop out of school and end up living on the streets.

4.4.13. Political security

The research did not find out any impact caused by HIV/AIDS on the political security of households in Bulawayo.

4.4.14. Other findings

The research found out that the participants were given a chance by the donor organisation to train in skills that could help them earn a living. However the participants did not benefit from such an endeavour because gardening skills were irrelevant skills for Bulawayo in that it is a city with water problems, gardening is prohibited unless one had a borehole and also because the training were done at the hospitals which were already far from their homes. They already had transport fee challenges to collect their food and ARV's going for skills training would be adding another trip that need financing.

4.4.15. Feminization of the epidemic

This research also found out that the HIV/AIDS pandemic was found mostly in women. Participants cited the following as causes of the feminisation of the epidemic, gender imbalances that exist in our society, culturally limitations on women it comes to issues of sex and using condoms. One participant had this to say on this issue, *women do not have a say on issues of sex, because men say they paid Lobola. Women are not free to even wear a female condom.* Participant 11 in the second FGD contributed that when young ladies start getting into relationships they go out with adult men who are experienced in issues of sex; this also contributes to the feminization the epidemic as these girls would be exposed to people that would have had multiple sex partner than their male age mates.

4.4.16. Remarriages

This research also found out that four of the households represented in the in-depth interviews had people that had remarried after their partners had died, despite their HIV status. Three of these were women were forced by circumstances to remarry because they had no survival skills, being marriage brought them economic security. The man who remarried did so because he needed someone who would care for him. He had to migrate to South Africa with that woman in search of better medication facilities. He left her son in the care of her elderly mother.

4.4.17. AIDS causalities

This research revealed that six of the 16 households which participated in the in-depth interviews have had casualties of HIV/AIDS. In two of these households both parents are died. Two of the households lost one parent and their youngest child. All of the people in these households came to know about their HIV/status after the death of their spouse or after continued sickness of a member in their household. Five of the discussion participants have children in school yet not even one of them highlighted the need for school fees; the researcher later noted that they get school fees assistance from their local church.

4.4.18. Orphans problems

The other research finding was that there is a common problem of orphans and it was a sensitive issue for participants in the second FGD, they had to spend more than 10 minutes discussing the issue of orphans in an emotional way. An elderly participant in the second FGD alluded that HIV/AIDS is impacting household in that it is killing young parents, leaving grandmothers with the responsibility of looking after *abazukulu* meaning grandchildren. She explored that instead of them resting (*retirement*) after long years of service *ngenge amakhiwa abaretaya* meaning like the whites that retire, they find themselves *bewacha izitshubo* meaning washing napkins. She shared on the community impact of HIV/AIDS that it leaves many children as orphans, some of whom are so unfortunate to lose both parent and have to live as child headed households.

These orphans can be grouped as maternal orphans, paternal orphans and double orphans. Some of these orphans are abused sexually, exploited as cheap labour, some get involved in crime and very few continue in school. Some of them struggle with having important documents like Birth certificate and identity documents. The elderly participant said if the economic situation was okay it would not be a big problem, people would look after the orphans however, the economic challenges in Zimbabwe forces relatives to neglect HIV/AIDS orphans as they themselves are already struggling economically.

4.4.19. Sharing the food donations

The research also found out that the infected households that were receiving food aid were also taken advantage of by relative and friends, as some now resort to asking them for some of the food stuffs they receive. Asked why they do not refuse to give those who ask them for food, participant 8 from second FGD responded saying, “*If I without what I have I will have no one to help me*”. She supported this decision with a Shona proverb saying, *vakuru vakati kandiro kanoenda kunobva kamwe* literary translated elders say, “a plate goes where another plate comes from” meaning that you give those that give unto you. In this she referred to the help she was getting from these people hence she saw the need to share with them her food stuffs to give also. Discussion was filled with moments of laughter especially when people were describing how people ask for help without necessarily saying, “Please help me” when they come for some help.

4.4.20. Dependence on food donations

Most of the households in the study are dependent on food donations from NGOs and relatives from overseas. More than half of these households and are in the business of buying and selling vegetable as a way of supplementing their sources of income. This type of business is plausible in that it does not need huge amounts of capital. In addition to that, the demand for vegetables is high especially in the high density suburbs where very few people can afford meat every day. This vegetable business does not demand a lot of labours also making it a viable business for people living with HIV/AIDS. This business does not have high returns; the income they get is not much and can be used to meet needs like transport, smaller bills and supplementary food.

15 of the in-depth interview participants have school going children. This shows that young adults are amongst those that fall sick and die of the pandemic. These young adults die or became terminally ill before their children have become adults. This concurs with the ages in which HIV/AIDS is prevalent in Zimbabwe, these being 14-49 years as reported in the Zimbabwe national HIV and AIDS conference report (2004:28) which asserted that, “An increasing number of new HIV infection in Zimbabwe are occurring in younger age groups” and also with (UNAIDS 2007a cited in The world bank 2008:12)

which reports that, “the vast majority of people living with HIV/AIDS in Africa are adults in their prime working and parenting lives.”

4.6. Conclusion

The findings of this research revealed different forms of impacts that are exerted on the human security of household by HIV/AIDS. These impacts were evidenced mainly in the form of economic challenges brought by the pandemic, these included reduced income and increased expenditure in affected households. Other impacts took the form of other six areas of threat to human security as they are presented in HDR 1994. These impacts were arrived at by means of primary data research conducted on a sample of HIV/AIDS infected households in Bulawayo. This work sought to gather data in this regard and to analyse it. The findings of this research revealed how HIV/AIDS affect the seven areas of human security. It also explored how the economic crisis in Zimbabwe has added to the impact of HIV/AIDS on the Human security of households.

Chapter V

5. CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

5.1. Introduction

The overall objective of this research was to examine the actual impact of HIV/AIDS on the human security of households in Bulawayo. Three specific aims were explored, these contributed towards fulfilling the overall objective. The first specific aim was to assess the human security conditions in Zimbabwe and the second specific aim was to identify the potential impacts of HIV/AIDS on human security. Secondary data was consulted to realize these two aims.

The third specific aim sought to examine the actual impact of HIV/AIDS on the human security of households in Bulawayo in a time of economic crisis and primary data was consulted for the purpose of realizing this aim. Primary data in this study was gathered in form of focus group discussions and in-depth interviews which involved a sample of 29 participants who represented 29 households. 19 of these participants were involved in the focus group discussions and 10 participated in the in-depth interviews. 6 participants were involved in both the focus group discussions and the in-depth interviews and were counted amongst the focus group discussion participants as way of reducing confusion in adding up the participants.

The literature review was arranged in a way that follows after the specific aims of this research. These specific aims were dealt with in details in chapter four.

5.2. Limitations

This study had several limitations which are discussed below under the categories of limitation of the methodology, time limitation and resources limitation.

5.2.1. Limitation of methodology

The qualitative method of focus group discussions has the potential of encouraging participation through observing peer participation and also in realizing similarities or differences of experiences. However FGDs can also make a participant not to be honest in their contributions as many people would not want to be the only one who thinks differently. In cases where a participant disagrees with the group some tend to keep quiet and some give superficial support to what they do not agree with, thus not being honest enough. I observed that participant seven in the first FGD did not speak out about her reservations in agreeing to the use of a video recorder in the FGD. She participated freely only when the video recorder was not recording. Collin (2000:177) concurred with this observation saying, “focus group discussion may intimidate other participants, leaving them with no option other than to lie so that they would not be seen as the odd one out”. This sometimes hinders people from participation in an honest way.

In addition to that another limitation of this research was that it mainly captured the contributions of Christians in the focus group discussion. This then means that views and inputs of people that are non-Christians and are not member of faith-based support groups were not captured. The researcher had wanted to involve non-Christians in the focus group discussion as the third focus group however the non-faith based support group could not allow me to have focus group discussion with them as they said their program was fully booked could not accommodate the research. The researcher purposed to capture the views of those who are not part of the faith-based support groups by involving them in the in-depth interviews (IDIs) that complimented the focus group discussions (FGDs). In light of the 70% people that claim to be Christian in Zimbabwe the chances of having a good representation of non-Christians in this study were slim.

5.2.2. Time limitation

This research was also limited in terms of time. It was done in one semester if it was done over a longer time period, the focus group discussion would have been done as panel focus groups that utilise the same focus group to build up on the same topic. This would have brought more input on the impact of the HIV/AIDS on the human security of households.

5.2.3. Resources limitation

The other limitation of this study was that the researchers as well as the participants were limited in terms of resources to ensure the success of the research. Some of the participants could not come for the focus group discussions because they did not have the transport fees. If the research was well funded it could have provided transport money as another way of reducing the limitation of this study

5.3. Summary of findings

This study found out that HIV/AIDS is a great threat to human security than it is ascribed. The sad part of that is that not many of us realise the extent of this threat because it is not a violent threat. It destroys human security bit by bit while many are not aware of the massive degree of its effects. Piot cited in Heineken (2001:120) concurred with this saying that “HIV/AIDS is proving to be tenfold more destabilizing than the wars that have been and are still being fought in Africa”. If I have to contextualise this to the context of Bulawayo, many people in Matabeleland live with horrific memories of the Gukurahundi in the early 80’s and classify that as the worst impact we have ever had on human security without realising that HIV/AIDS is even a greater threat, it has killed more lives than all the wars in the history of our nation.

This research revealed that the impact of HIV/AIDS on the human security of households in Bulawayo can be categorized in four main categories these being: financial, health, nutritional and societal impacts. The same can be expressed as economic, health, food and community impacts the latter being a combination of personal and community security impacts.

The research did not find impacts that are connected to areas that not directly connected to households; an example of this would be the connection between political security and impacts of HIV/AIDS on households.

Financial impacts

This study found out that 8 households still have a secure source of income but 13 households have since lost their source of secure income because of HIV/AIDS. This means that if it was not for AIDS 21 households would be having a regular income. This is the impact of HIV/AIDS on the sample of these households; it destroys economic security which is the major contribution to the human security of a household.

Another finding that stemmed out from this study is that HIV/AIDS increases household expenditure in the form of increased transport cost to hospitals, increased medical expenses in the form of consultation fees and hospital bedding, high funeral costs as funerals are now more frequent in families because of HIV/AIDS and in terms of medical cost as ARV are expensive. All the above stated impacts households' economic security, thereby reducing the human security of households. HIV/AIDS also causes households to reduce or loose income and to divert investment that were supposed to help the family in the future, such investments for us as African can be cattle in our rural homes.

5.4. Recommendations

An ideal situation is that a government that prioritise human security would implement recommendation as the ones below, so that its people may enjoy good human security conditions. However in the case of Zimbabwe were the former government was solely responsible for all the human insecurities from the high unemployment rate (economic security), food shortages (food security) cholera outbreak (health security), pre and post presidential elections violence (political security), multitudes of gold panning activities, poachers and over harvesting of forest for firewood (environment security), rape cases, robberies, prostitution and high volumes of street kids (Personal security), the list is endless. Such a government is unable to provide or prioritise human security. Even the newly formed Government of National Unity (GNU) will find difficult it to address these issues.

This study then proposes that the responsibility of implementing these recommendations fall under the individuals, families, societies and NGOs especially the FBOs. Zimbabwe is indeed in a extreme multifaceted war, not a violent one but a silent war that is killing more victims than the capacity of violent wars which use guns. Therefore we as a people in Zimbabwe, Bulawayo in particular should unity our effort against HIV/AIDS in the following manner.

ARV provision: Though the chief impact of HIV/AIDS on the human security is the economic/ financial impact the chief response should addresses the health impact because it is the major cause of the economic impact in that it is the health status that deteriorate then forces people out of their income generation project and job causing an economic impact. The recommendation therefore is that as people are already infected we need to provide them with ARVs. Oluwagbemiga (2007) held up the need to advocate for provision of adequate medical treatment as a way of reducing the impact of this pandemic on households. The study revealed that the current efforts on providing the ARVs are almost insignificant just as a drop in an ocean. There must be collective way of seeking ARVs, and being able to distribute them to those that need them. Families in the Diaspora (oversees) can also contribute directly to their families or collectively to people in Zimbabwe, as long as there is an awareness and drive for such an initiative. This also brings in the issue of decentralising the distribution location so as to reduce the transport cost which the participants were complaining about. The NGOs especially FBOs can play an important role in seeking donors and facilitating this process. This will reduce the impact of HIV/AIDS on the human security of households to the levels that it has on households in nations like Botswana and South Africa which have better access to ARVs. Piot et al (2001:970) enlighten us on the positive effects of empowerment with medical treatment by exploring how the antiretroviral therapy treatment has managed to reduce the impact of HIV/AIDS on households in Brazil.

Economic empowerment: it is recommended that once the ARVs process has started even before, that HIV/AIDS affected households be economically empowered with relevant income generating skills as these reduce the probability of an HIV/AIDS affected households to be pushed and trapped into poverty. This will serve as poverty alleviation strategy and will reduce the incidences of crime and prostitution as some of these are caused by poverty thus further reducing potential causes of HIV/AIDS. In nations that emphasize human security grants are given to those that are terminally ill to help them continue with a steady life. In our context, individuals, families, society and NGOs can explore different ways of economic empowerment such as resuscitation of former businesses that were run by these HIV/AIDS victims before they fell sick instead of training them irrelevant skills like gardening for a context like Bulawayo. This does not mean that HIV/AIDS affected household should not keep gardens for themselves. Society can form cooperatives that fit PLWH to keep them busy, productive and earning a secure income. This study as small as it was had about four women that had the skill for sewing, financing such a project will greatly reduce the impact of HIV/AIDS on affected households.

Food aid: it is recommended that the N. G. Os would not lay off the patients that are on their food aid program, instead they are supposed to continue to reach out to a lot more that are not yet on this program. This calls for specific focus on enlarging their current schemes through new project proposals to their current donors and new donors, they may even use these food aid as a way of income for the patients that can be directed to do some work that fits their health in the organisation or society. The likes of food for work projects were people go and work on some small tasks and get food aid, this has been some of the strategies that were used to construct, roads building and boreholes in the rural areas in Zimbabwe. Current activities maybe to clean up Bulawayo, instead depending on a hired company to do the cleaning and paying a lot of money for unprofessional service, NGOs can work with the municipality at such projects.

Orphan care: it is recommended that there be a collective approach to the problem of orphans. All stakeholders from government, NGO, civic and faith based organisations. Such as the proposed intergradation of orphans into existing healthy families so that they grow up with all the family values that would help them to be better citizens that they would if the grow up in supported child headed households or orphanages. The method that is being used by some organisations and churches of supporting families that adopt orphans was suggested by the participants as a model that can work to help orphans to grow in a family setting. Struggling relatives of the orphans should be given first preference to be the supported families. The need for extensive follow up on these children and families was emphasize and failure to look after these orphans should classified as a criminal case, this will make those that want to benefit from such a scheme not do it as contracts are suggested. This will eliminate the street kid problem as well as preventing a lot of violence and prostitution these orphans would have caused if it is not dealt with. The authorities are also encouraged to be sensitive to the plight of orphans of orphans who do not have important document and help them have them than make it difficult for them as this will force them into crime and prostitution as they would not be able to continue school or get jobs without these important documents. The faith based organisation especially the church which takes up the major role of counselling and caring for HIV/AIDS affected individuals and households should help the infected to prepare the future for their siblings. They can do this by making sure that their children have the necessary important document which can be stored at churches if need be.

Decentralise the counselling, ARV, skills training and food donations providing facilities: It is recommended that the government and NGO would decentralise the pre ARV treatment counselling, ARV, skills training and food donations providing facilities. This will go a long way in alleviating the impact of HIV/AIDS in the form of excessive transport cost that have forced many HIV/AIDS patients to walk long distances because they can not afford excessive transport costs.

Equipping affected household with survival strategies: it is recommended that affected households either with mortality or with a chronically ill member be equipped with relevant survival strategies. An example of this would be strategies such as having knowledge of wild foods and how to prepare them cultivating, cultivating smaller areas and abandoning more high input high output activities in favour of those that demand less labour have been suggested and the all the stakeholders must cooperate to help gather and publicise these survival strategies. (Waal and Whiteside 2003:1235). Another survival skill will be of having a multi-cropped garden that will provide basic supplementary needs for a household. This will not take much land, power and water. Another survival skill will be to help the sick who are professional or equipped in a specific business or skill to resuscitate their businesses by providing them with capital

Lobbying for good governance of contributions or privatise them: AIDS levy and NSSA contribution: it is recommended that NGOs, pressure groups and FBO lobby that the compulsory AIDS levy and NSSA that is deducted from worker be channelled towards alleviating the pandemic. Not much evidence has been seen of late of how this fund is used. It is not benefit the people suffering from HIV/AIDS. The Zimbabwe government (before the government of national unity GNU) was using such funds as they had no other income sources as the government was raising less revenue and the international world had stopped giving aid to the government. The government should make sure that people would benefit from their contributions; it must not divert these contributions to other government needs as they have been doing with national social security Authority (NSSA) and the AIDS levy. This is human security- protecting and preventing the interest of people instead of the government as they adopted and signed the UN Security Council resolution 1308 (Kristofferson 2000: 1).

Pension schemes revival and Medical aid: it is recommended that the government should revive the pension schemes and make them viable as these are supposed to be fall back strategies that are supposed to shield a household from massive economic impacts of HIV/Aids. The government can do this by passing a compulsory legislation that all people should have pension schemes. However for this to take place the government need to work at reviving the economy of Zimbabwe so that people may have secure job.

5.5. Concluding remarks

This research revealed that HIV/AIDS is causing catastrophic impacts on the human security of households in Bulawayo. It also showed that we need to re-evaluate the way we look at the HIV/AIDS pandemic as most people take it lightly while it is destroying lives, to the extent that we are now living primitive year's equivalent life expectancy. The need to give it our collective efforts from individuals, families, societies and NGOs has been emphasized in this study. Four major themes that emanated from this research in terms the impact of HIV/AIDS on the human security of households were the financial, health, nutritional and societal impacts. The over reliance on government has been shunned in this work because of the realisation that the government does not have the capacity to prioritise human security now hence the need for a collective approach of all stakeholders ranging from individuals, families, societies and NGOs especially the FBO on these impacts has been recommended in this work.

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APPENDIX 1

University Of KwaZulu-Natal

School of Economics & Finance

M Com Research Project

Researcher: Milton Gadina 888 567

Supervisor: Sylvia Kaye 27 31 260 1417

Research Office: Ms P Ximba 031-2603587

I, Milton Gadina, am an M.Com student in the School of Economics & Finance, at the University of KwaZulu-Natal. You are invited to participate in a research project entitled 'The impact of HIV/AIDS on human security in households in Bulawayo'.

The aim of this study is to examine the impact of HIV/AIDS on human security in households in Bulawayo

Through your participation in a focus group, I hope to understand how the human security of households with one or more members with HIV/AIDS is threatened, and how these households cope. The results of the focus group discussion, together with some interviews, are intended to contribute to this understanding.

Your participation in this project is voluntary. You may refuse to participate or withdraw from the project at any time with no negative consequence. There will be no monetary gain from participating in this focus group. Confidentiality and anonymity of records identifying you as a participant will be maintained by the School of Economics & Finance, UKZN. However, as this is a participation in a focus group, please be aware that I cannot assure that other focus group members will retain confidentiality.

If you have any questions or concerns about participating in this study, please contact me or my supervisor at the numbers listed above.

The focus group discussion should take you about one hour to complete. I hope you will take the time to participate in the focus group

Sincerely

Investigator's signature _____

Date _____

This page is to be retained by participant

APPENDIX 2

University Of KwaZulu-Natal

School of Economics & Finance

M Com Research Project

Researcher: Milton Gadina 888 567

Supervisor: Sylvia Kaye 27 31 260 1417

Research Office: Ms P Ximba 031-2603587

CONSENT

I _____ (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project. I understand that I am at liberty to withdraw from the project at any time, should I so desire.

Signature of Participant _____ Date _____

This page is to be retained by researcher

University of KwaZulu-Natal (U.K.Z.N)
Research: The Impact of HIV/AIDS on Human Security in Bulawayo

APPENDIX 3

- Method:** Focus group discussions
- Session:** One focus group session per group for up to an hour and a half
- Facilitator(s):** A non-contributing facilitator will direct the focus group discussion and select prospective candidates for the in-depth interviews
- Data collection:** Recording- audio/video and taking notes
- Focus groups:** Two focus groups of not few that 6 or more than 12 members each

Rational for the focus group:

I am undertaking a research on the impact of HIV/AIDS on human security, will present the consolidated data to UKZN as the dissertation part of my conflict resolution and peace studies (CRPS) Masters degree requirement on June 30, 2009 in Durban South Africa. A lot of focus has been given to things that cause HIV/AIDS of which poverty is one of them and not much has been done to look at the impact of HIV/AIDS on different areas especially on household level. The outcome of this research could be useful to policy makers especially Zimbabwe's policy makers because our nations HIV/AIDS prevalence rate is still high though it has reduced significantly in that past year six years especially in light of its long time impact on household which will continues to be felt amongst the infected and affected in our nation even way after the infected member dies.

Discussion Topic: What is the actual impact of HIV/AIDS impacts on human security of a sample of households in Bulawayo in a time of economic crisis?

Sub-focus areas: Propose focus on one each session

1. How has HIV/AIDS impact your household's economic status
2. How has HIV/AIDS impact your household's ability to provide adequate food
3. How did HIV/AIDS impact the health of your household
4. How did HIV/AIDS impact your household's relationships in the community/ in general you whole household lifestyle.

(PARTICIPANTS ARE NOT OBLIGED TO PARTAKE IN THIS FOCUS GROUP AND ARE FREE TO WITHDRAW THEIR PARTICIPATION AT ANY TIME, SHOULD THEY WISH TO DO SO).

Support group

Researcher's Use only

Date:

University of KwaZulu-Natal (U.K.Z.N)
Research: The Impact of HIV/AIDS on Human Security in Bulawayo

APPENDIX 4

In-Depth Interview Questionnaire

Name (optional) _____ Sex: _____

Marital status _____ City: _____

Support group _____ ARV provider: GVT/SELF/NGO/CHURCH/FAMILY

House hold size

- How many people live in your household (4nights a week+ migrant workers)? __
 Children (under 18 years) ____ and adults (over 18years) ____not from immediate
 family__
- How many people have a secure job in your household? _____
- How many people are infected with HIV/AIDS in your household? _____

Patient (# only e. g Patient 1/ 2 & age)	Still health	Sick here & there	Often sick

Economic security

- List sources of income for your household in the past month (salary/
 donations/ crop harvests/ sale of property/vending) _____

- List the major expenses for your household in the past month (e. g rent,
 medication, school fees, food, salary for care givers etc) _____

Food security

- **Food quantity**- How many meals per day did your household have in the last 48 hours (2 days)? _____

- **Food quality**- What kind of food did you eat in the last 48 hours (2 days)_____

General Human security

- What has been the most challenging /shocking event that you have faced in the past three months?

- If you would have everything you need (funds, time, strength) what aspects of your household's life would you change and why?

- How has HIV/AIDS hindering the livelihood of your household in terms of work, health, productivity and children's education etc? _____

- Any additional information that you think may help in this research that you may want to add_____

* *Some questions in this questioner were developed from the question structures of Kaschula, S's (PhD candidate) work on HIVAIDS, rural livelihoods and food security: an action research project*

APPENDIX 5

University Of KwaZulu-Natal

School of Economics & Finance

M Com Research Project

Researcher: Milton Gadina 888 567

Supervisor: Sylvia Kaye 27 31 260 1417

Research Office: Ms P Ximba 031-2603587

I, Milton Gadina, am an M.Com student in the School of Economics & Finance, at the University of KwaZulu-Natal. You are invited to participate in a research project entitled 'The impact of HIV/AIDS on human security in households in Bulawayo'.

The aim of this study is to examine the impact of HIV/AIDS on human security in households in Bulawayo

Through your participation in an interview, I hope to understand how the human security of households with one or more members with HIV/AIDS is threatened, and how these households cope. The results of the interview, together with some focus group discussions, are intended to contribute to this understanding.

Your participation in this project is voluntary. You may refuse to participate or withdraw from the project at any time with no negative consequence. There will be no monetary gain from participating in this focus group. Confidentiality and anonymity of records identifying you as a participant will be maintained by the School of Economics & Finance, UKZN.

If you have any questions or concerns about participating in this study, please contact me or my supervisor at the numbers listed above.

The interview should take about 20 minutes. I hope you will take the time to participate.

Sincerely

Investigator's signature _____

Date _____

This page is to be retained by participant

APPENDIX 6

University Of KwaZulu-Natal

School of Economics & Finance

M Com Research Project

Researcher: Milton Gadina 888 567

Supervisor: Sylvia Kaye 27 31 260 1417

Research Office: Ms P Ximba 031-2603587

CONSENT

I _____ (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project. I understand that I am at liberty to withdraw from the project at any time, should I so desire.

Signature of Participant _____ Date _____

This page is to be retained by researcher

APPENDIX 7



Brethren in Christ Church

BICC Lobengula
P. O Box 6
Magwegwe
Bulawayo
Zimbabwe
Tel: 09- 521 112

15 April 2009

Dear Pastor M. Gadina

Ref: Permission letter to use church premises for your research project

This letter serves to inform you that you have been granted to use Lobengula BIC church Premises for your Peace studies research project with our Support group, “Touch the hem” on the requested date. Pastor Zakhe and the support group coordinator will be there to help you with all that you need and so will be the care taker. Please inform us of any breakages that may happen while you are using the premises. I wish you all the best.

H. Sibanda

(Church Administrator)

APPENDIX 8

ESCAP-Endumisweni Support and Care Programme

Meeting the challenge of HIV and AIDS with God's love

32A Fort Street
Bulawayo
Tel: 263 9 64003
Email: escap@mweb.co.zw
escappawc@yahoo.com
gpenduka@gmail.com

P. O. Box 2591
Bulawayo

May 19 2009

Pastor Milton Gadina
Malindela Baptist Church
Bulawayo

Re: Authority granted to conduct research with Fellowship 6.2

You are hereby notified of the granting of permission to conduct your research at our support group called Fellowship 6.2. It is our hope that our contribution to your research will benefit Bulawayo and Zimbabwe.

However, I hasten to stress out that in Fellowship 6.2's values confidentiality is paramount. Therefore do stay within the limits you highlighted to the group in person and in the letter of consent in our possession. The Board of Escap will be interested in the findings of your research.

May God bless you.

Godfrey Penduka

Escap Coordinator

...because we care!

A Ministry of Praise and Worship Centre

