

**Effects of the Income Generating Activities Project
On the livelihood of Volunteer Care Givers
And on their service delivery to HIV/AIDS affected households;
A case of Sedze cluster in Chitsanza ward, Zimbabwe**



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Dedication

To my husband, my son Tanaka and my daughter Wadzanai and my parents
Love you.

Acknowledgements

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Acronyms and abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti retroviral Therapy
ARV	Antiretroviral
CERTC	Clinical Epidemiology Resources Training Centre
CHBC	Community Home Based Care
CHF	Canadian Hunger Foundation
CSO	Central Statistics Office
FACT	Family Aids Caring Trust
FGD	Focus Group Discussion
HBC	Home Based Care
HEARD	Health Economics and HIV/AIDS Research Division
HHD	Household
HIV	Human Immunodeficiency Virus
HND	Health and Development Networks
KGs	Kilograms
IGA	Income Generating Activity
IMF	International Monetary Fund
MoHCW	Ministry of Health and Child Welfare
NGO	Non Governmental Organization
OVC	Orphans and Vulnerable Children
PLWHA	People Living With HIV/AIDS
PRA	Participatory Rural Appraisal
SAfaids	The Southern Africa HIV/AIDS information Dissemination Service
SAFIRE	Southern Alliance for Indigenous Resources
UNAIDS	United Nations on HIV/AIDS programmes
USD	United States Dollar
VCG	Volunteer Care Giver

Abstract

Several studies conducted have revealed that volunteer care givers (VCGs) are the cornerstone of Community Home Based Care service delivery (CHBC). In recognition of the contribution of VCGs to CHBC, Southern Alliance for Indigenous Resources (SAFIRE) in collaboration with Family Aids Caring Trust (FACT) and Canadian Hunger Foundation (CHF) joint together in implementing a three year project targeting HIV/AIDS affected households and also including the VCGs. The project seeks to build resilience of people living with HIV/AIDS through building their capacity in income generating activities. One of SAFIRE's inputs in the project was building the capacity of the VCGs in Income generating Activities (IGAs). SAFIRE lacks sufficient information on how the IGAs have affected the livelihoods of the VCGs and CHBC service delivery. Therefore the study main areas of concern were twofold: analyse effect of IGAs on the livelihood of the VCGs and on CHBC service delivery. The study looked at both intended and unintended change brought by the IGAs.

A case study was conducted in Sedze cluster in Chitsanza ward of Nyanga district in, Zimbabwe. The VCGs are participating in an income generating project on peanut butter processing and Jatropha soap making for which they got training, machinery and raw materials to initiate the IGAs. Document review and qualitative research methods were used to have an in-depth understanding of the changes brought about by this project, changes for both the volunteers as well as for the PLWHA. The changes studied were livelihood capitals (financial, social, human, natural and physical) and CHBC service delivery that covered tasks performed and time allocation to CHBC activities. All in all 24 people (VCGs and key informants) participated in the study.

Findings from the study indicated that the IGAs contributed significantly to human and social capitals as compared to the other three capitals. Participation of VCGs in IGAs has enhanced their technical and planning skills. Prioritizing and planning ahead of time has enabled the VCGs to manage IGAs and CHBC activities as well as daily household activities. Findings from the study showed that the VCG social status in the community has improved since the time they were given the peanut butter processing machine. The community leadership appreciates the contribution of the peanut butter processing machine to the development of the ward. Before the IGA the community used to travel 18kms to get a machine that produce quality product

Although, according to the project indicators the IGAs were supposed to increase income levels and household assets for the VCGs but this was not achieved by all the VCGs as indicated by the respondents. Even though all the 15 respondents processed peanut butter as individuals, only five indicated that they marketed the peanut butter. With the income raised from selling peanut butter, one VCG bought household kitchen utensils and the other four used the money to pay school fees. Jatropha soap was produced by only two of the respondents and the soap was used by the households. Apart from marketing and consumption, the study found out that the VCGs also donated a fraction to PLWHA whom they are providing care and support.

Change in CHBC service delivery was noticed in the second year of VCGs participation in IGA whereby the weekly work load of the VCGs was reported by all the respondents to have been reduced by 90%. The change was not influenced by the IGAs but it was because of improved access to ART by PLWHAs. Findings from the study showed that the VCGs lack adequate knowledge to provide counselling to PLWHA on ART. This was found to be a gap area that to be urgently addressed by FACT.

Various challenges that include lack of capital to buy groundnuts and jatropha seed and droughts were faced by the VCGs. Despite these challenges the group has managed to remain in operation. However there is urgent need for SAFIRE to consider financing mechanisms such as micro finance in order to sustain the IGAs. In addition, exploring feasibility of nonfarm IGAs need to be considered as well as a way of diversify the income sources of the VCGs. The study has managed to offer new dimensions in the roles of VCGs and potential strategies for assisting VCGs to improve their livelihoods.

Chapter One: Introduction

UNAIDS 2008 statistics indicates that an estimated 22.4 million adults and children were living with HIV in sub Saharan Africa (UNAIDS, 2009). The same report also indicated that 1.3 million people in Zimbabwe were living with the HIV virus. The epidemic is having devastating impact on the social and economic development of the country (Muller, 2005). Since HIV was first recognized in Zimbabwe in 1985, the country has come up with several strategies in response to the epidemic. Among these strategies is the CHBC programme that is meant to reduce pressure on the capacities of the formal health and care systems (MoHCW, 2004). In response to the impacts of AIDS, some community members have offered to work as volunteers in the CHBC programmes that are targeting HIV/AIDS affected households. HIV/AIDS affected households have been defined for the purpose of this research as households with a member who is HIV positive, ill or has died of AIDS related diseases. Informal or secondary volunteers who are addressed as VCG in this study are a critical source of support for the majority of people living with HIV/AIDS (PLWHA) especially in Zimbabwe which is amongst countries in Southern Africa with some of the highest HIV/AIDS prevalence rate in the world (Akintola 2010).

There is wide agreement in literature that VCGs are not adequately compensated for the time spent doing CHBC work. The volunteers give the assistance voluntary and appreciate the reward in terms of acquisition of skills, self-esteem and recognition in the community which they get from doing the caring work, but the economic environment surrounding them does not facilitate their work (Akintola 2010). Most of the VCGs are living in poverty hence expect economic benefits from the social work they are doing. Studies conducted in Zimbabwe have indicated that not much has been done to improve the livelihood of the VCGs (SAfaids and HND, 2007). This is increasing the vulnerability of the VCGs to the impacts of AIDS. VCGs in Zimbabwe pay a major role in providing care to PLWHA but majority do not receive incentives that compensate time spent doing Community Home Based Care work (CHBC). SAfaids and HND study on nine Zimbabwean Home Based Care organizations reveals that incentives given to some VCG are materials to facilitate CHBC service delivery such as bicycles and uniforms which does not contribute much in improving the livelihood of the VCG. Akintola's (2010) study in South Africa (SA) reveals that many VCGs are neither remunerated nor receive financial rewards.

SAFIRE being a developmental nongovernmental organization (NGO) working in the rural communities that are most affected by the epidemic decided to mainstream HIV/AIDS in its entire rural community programmes. The organization focus on reducing vulnerability of households to the impacts of AIDS through assisting rural communities to diversify and enhance their livelihood. Majority of the households including the VCGs in these rural communities are living in poverty and the situation has been worsened by the impacts of AIDS. A livelihood assessment conducted in 2007 prior to this study in six selected rural communities indicated that VCGs are living in poverty because they are not included in food security and income generating projects. The question raised during the same assessment by the VCGs was "*who cares for the livelihood of VCG*" and a similar question was also raised in Jessica Ogden et al, (2006) paper entitled expanding the continuum for HIV/AIDS. According to Khogali, (2003), majority of CHBC programme are coordinated by HIV/AIDS organizations and these organizations only consider affected households as direct project beneficiaries for material support like food and agriculture inputs. Majority of programmes

designed to address HIV/AIDS in Zimbabwe have largely focused on medical care, awareness education and prevention and not geared to enhancing household food production and incomes of affected household (HHDs) and VCG. A few organizations that have tempted to support food production and IGAs have targeted only affected HHDs and this has contributed to reduced livelihood options for the VCGs. In as much as the VCGs would like to initiate own IGAs, they do not have starting capital either in form of cash or liquid assets to support such initiatives. Figure 1.1 shows how the limited livelihood option contributes to ineffective CHBC service delivery. Passion for care giving work is what is driving the VCGs to continue doing the work.

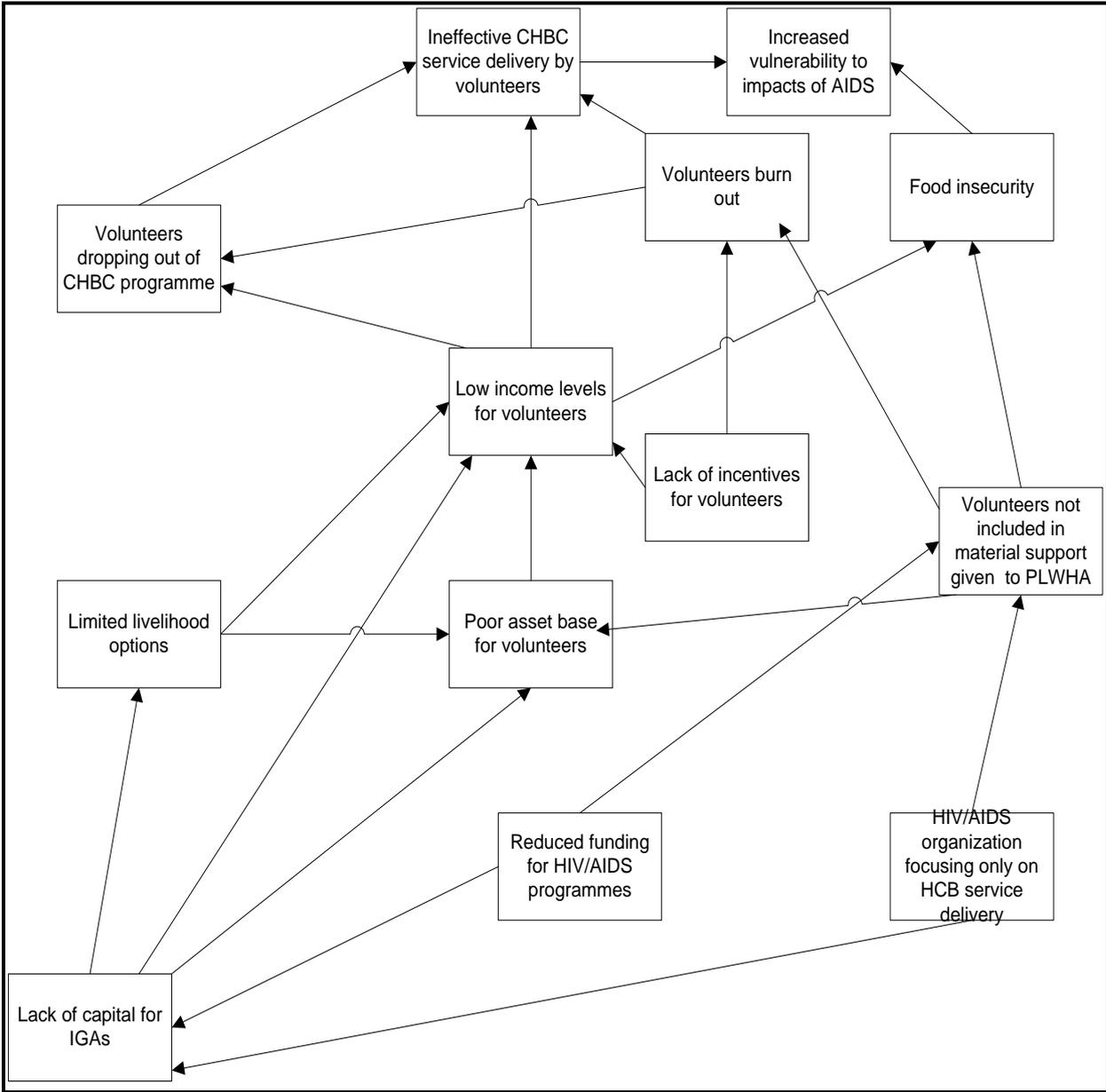


Figure 1.1: visual diagram of problems analysis

It is against this background that SAFIRE formed a partnership with Family Aids Caring Trust (FACT) and Canadian Hunger Foundation (CHF) in implementing a joint project targeting HIV/AIDS affected households and the volunteers. The project seeks to empower people living with HIV/AIDS to improve their livelihoods. In addition the project aimed at strengthening resilience of households and communities in fending for themselves through

sustainable livelihoods support. The project also recognized the effort of the VCGs by ensuring that they are included in income generating activities. Now the challenge with SAFIRE is how best they can contribute to the improvement of the livelihood of VCGs while not overburdening their capacity. This issue has been raised by Khogali, (2003) in his study on Community Home Based Care in Zimbabwe. SAFIRE's idea of assisting VCGs with IGAs is supported by many HIV/AIDS organizations that are against the idea of giving VCGs money as this is not sustainable (SAfaids & HND, 2007).

The current problem that SAFIRE is facing is lack of sufficient information on how the initiated IGAs have affected the livelihoods of the VCGs. Therefore for SAFIRE to continue assisting the VCGs there is need for sufficient information on how work done to date has affected the livelihood of VCGs and CHBC service delivery. There is therefore a need to have a critical analysis of the impact of the IGPs on the livelihoods of VCGs and HBC service delivery. The main objective of the research is to formulate recommendations for improving the existing programmes dealing with IGAs for VCGs in Sedze cluster located in Chitsanza ward, Zimbabwe. The study addressed the following research questions:

Main Research question

What is the impact of participation of VCGs in IGA on their livelihood (financial, physical, social, human and natural capitals) and on the service delivery to HIV/AIDS affected households in Sedze cluster in Chitsanza ward, Zimbabwe?

Sub questions

1. What are the characteristics of the project?
2. What are the characteristics of the volunteers?
3. What motivates the volunteers to do their work?
4. What kind of services has been provided by the volunteers?
5. What changes has occurred in CHBC service Delivery since the involvement of care givers in IGAs?
6. How has the IGAs changed the livelihood of the CHBC volunteers
7. How have the IGAs affected (hindered/ facilitated) CHBC volunteers work?
8. How can the IGAs be sustained?

The document has seven chapters including chapter one which is the introduction. Chapter two is literature review that covers concepts used in the study. Chapter three explains the methodology used including the tools used for data collection and analysis. Project context and background is covered in Chapter 4. Included in the chapter is the project model and the summary of the project implementation process. Chapter 5 gives the results followed by the discussion of the results in Chapter 6. The seventh chapter lays out the conclusion covering project achievements, challenges and recommendations

Chapter Two: Literature Review

This chapter mainly focuses on livelihood capitals and CHBC service delivery as these are key areas relevant to the research. As mentioned earlier in chapter one, the research was designed to measure impact of IGAs on the livelihood capitals of VCGs and on the service delivery. Issues on volunteering and VCGs motivational factors were also included as these have an effect on the CHBC service delivery.

2.1. Livelihood capitals

Literature has shown that several researchers have adapted the livelihood definition by Chambers and Conway (1992) whereby a livelihood is comprised of the capabilities or assets and activities required for a means of living. Ellis (2000) considers assets as the basic building blocks upon which households are able to engage in production, labour markets and participate in mutual exchange with other households. Ellis's definition of livelihood include access to and benefits derived from the state (Ellis 1998) The assets also known as capitals determine the options open to households and the strategies they adopt to attain a livelihood (Ellis, 2000). DFID (1999) distinguishes five categories of capitals (fig 2.1.) and these are commonly used by many researchers in analysing people's strengths and how they use available assets to earn a living. In 2007 DFID adapted the 5 capitals and added political capital that deals with access to political processes. For the purpose of this particular research the term asset was interchanged with capital.

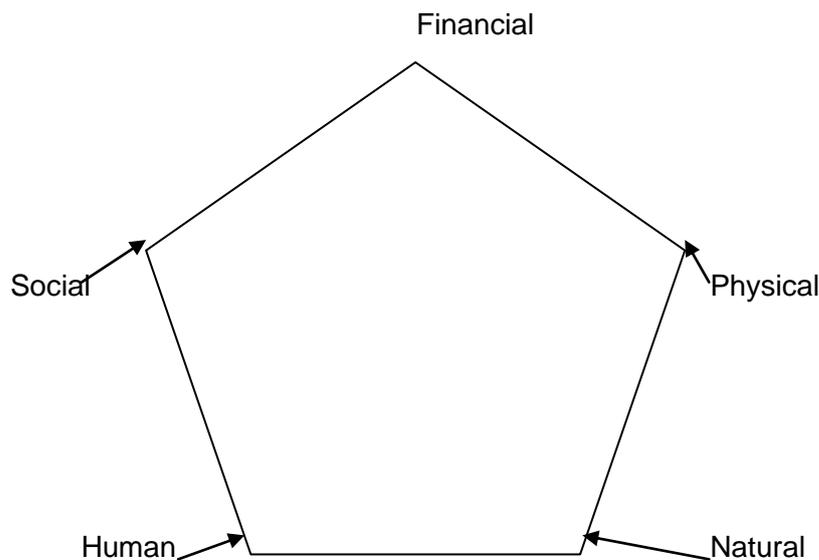


Fig 2.1: Asset pentagon (source: Ellis, 2000)

Figure 2.2 gives the dimensions of the 5 livelihood capitals. The livelihood capitals will be used for analysing the livelihoods of the VCGs before and after introduction of the IGAs. Five livelihood capitals will be used in this study and these are physical, social, human, natural and financial. Political asset was left because the IGAs promoted had not much to do directly with the politics.

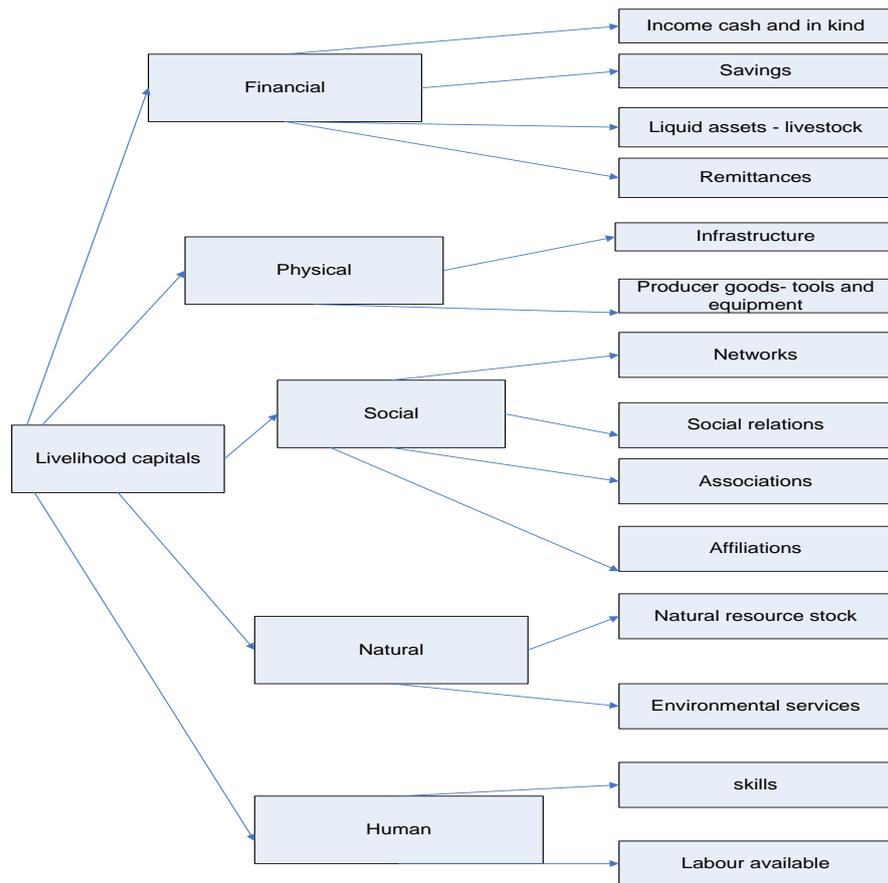


Fig 2.2: livelihood capitals dimensions. (source: adapted from Ellis 2000)

2.1.1. Physical capital

Ellis (2000) defines physical capital as the capital created by economic production processes. The physical capital is further divided into two categories: basic infrastructure (transport, buildings, water supply) and producer goods (tools, equipment (DFID, 2000)). The study put more emphasis on the producer goods as this can be easily measured at household level.

2.1.2. Financial capital

Financial capital refers to stocks of money in the form of savings, access to loans (Ellis, 2000). In addition financial resources are also bank deposits, liquid assets such as jewellery and livestock, pensions and remittances. For the purpose of this study all the financial resources will be considered as this will enable an in depth analysis on the actual financial contribution of the IGAs to the livelihood of the CHBC volunteers.

2.1.3. Social capital

Social capital encompasses social resources like networks and connectedness, membership to formalized groups and relationships to between individuals (DFID1999). In the context of the study, social capital will be taken as networks, social relations, associations and membership to formalized groups. The project used the group approach in supporting the IGAs; hence these social resources links very well with the project approach.

2.1.4. Human capital

According to DFID, (1999) and Scoones, (1998) human capital refers to the amount and quality of labour available. According to Carole and Lloyd-Jones, (2002) the labour resources available to households have both quantitative and qualitative dimensions. Quantitative refer to the number of household members and time available to engage in IGAs while qualitative refer to the level of education, skills and health status of HHD members. The VCGs' service delivery is influenced by the availability of both the quantity and quality of labour resources. As noted by Rakodi (1999), skills training enable people to take advantage of economic opportunities. Therefore the study considered both quality and amount of labour as they both have an effect on the performance of the volunteers on IGA and CHBC service delivery.

2.1.5. Natural Capital

Natural capital comprise of environmental resources that are utilize by people to generate means of survival (Ellis 2000). Scoones, 1998, categorize the environmental resources into two, the natural resource stock (soil, water, air, genetic resources) and environmental services such as environmental cycle and pollution sinks. The environment resources are further distinguished as renewable and non renewable (Ellis, 2000). Resources such as soil, water levels and stocks of trees for firewood falls under renewable resources while minerals and are non renewable. In rural areas most of the environmental resources are common pool resources with exceptional resources like land. The study focuses on how the land owned by individuals has been affected by the introduction of IGAs.

2.2. Income Generating Activities

IGAs offer alternative pathways out of poverty for households. Davis, Covarrubias, Stamoulis, winters, Carletto, Quinones, Zezza and Diguseppe, (2007) classified rural income under two major categories: agriculture and non agriculture whereas according to Ellis (2000) rural income is categorized into three categories namely farm, off- farm and non-farm (figure 2.2.). Farm income refers to income generated from own farming activities and this includes livestock and crop income. Off- farm income refers to income from wage or exchange labour on other farms as well as income from local environmental resources. Nonfarm income refers to non – agricultural income sources such as nonfarm rural wage, remittances, nonfarm self employment. For the purpose of this research agriculture income sources includes both on farm and nonfarm income sources. Non agriculture income sources are the off farm activities.

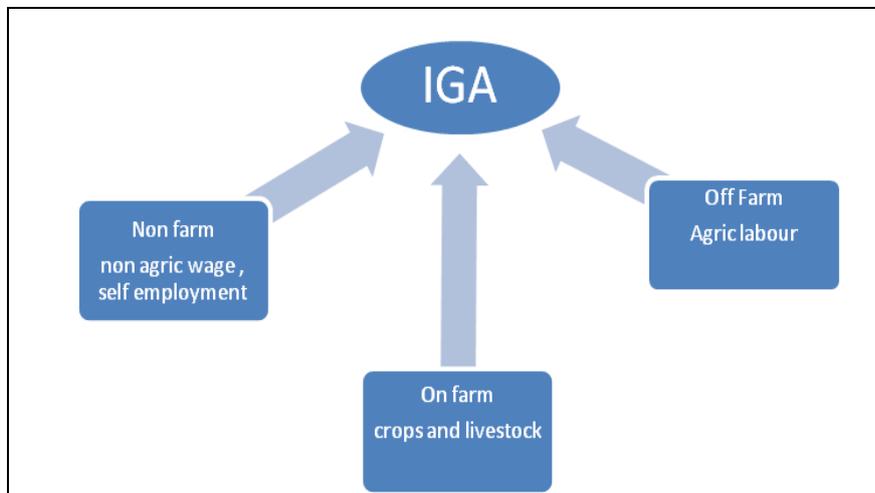


Figure 2.3: Categories and examples of sources of rural income. (source: adapted from Ellis 2000)

The IGAs were meant to address the livelihood improvement opportunities that the VCGs miss whilst doing care giving work. These opportunities may come through self-development or development programs in general supported by NGOs as well as government (Akintola, 2008). During the livelihoods assessment undertaken in 2007 by SAFIRE prior to implementation of IGAs, volunteers indicated that they spend much of their time trapped in caring work. At times sick people no longer wanted to be cared by their immediate family members. In some extreme cases sick people refused to be fed, bathed by family members, hence the VCG end up overdoing the voluntary work (Akintola, 2008) generally on farm activities are more important to rural communities in majority of African countries including Zimbabwe. This was noted by Davis et al, 2007 in a research work conducted in four continents that included Africa. In the study most of the rural IGAs were found to be building on existing agriculture activities.

2.3. Income generating projects for VCG

Studies on CHBC conducted in Zimbabwe have revealed that roles of VCGs are the same because all the organizations supporting CHBC implement the programme according to the country's HBC standards. In addition most of the organizations supporting CHBC programmes primarily focus on PLWHA and Orphans and Vulnerable Children (OVCs) leaving the VCGs. Findings from a research on Home Based Care in Zimbabwe conducted by SAfaids have shown that most organizations are supporting HIV/AIDS affected households with income generating activities leaving out the VCGs. The study reported some cases like Batsirai Home based care group whereby VCGs with the same need are grouped together and supported with suitable IGAs. Another case is Bekezele home based care that encourages VCGs to engage in IGAs without any material support to kick start the IGAs (SAfaids and HND, 2007). This has seen the VCGs failing to engage in IGAs with high returns. Literature has shown that IGAs with high returns requires startup capital if they are to succeed (Davis et al 2007).

Various studies have observed that current incentives given to VCGs are not attracting men to join (Akintola, 2008, SAfaids & HND, 2007). These findings are a true indication that the IGAs being done by the women have low returns. Some organizations like Dananai home based care in Zimbabwe differentiate the support they give to male and female volunteers. Despite the Dananai CHBC having started with female volunteers, only men are targeted for IGAs with high returns. The male VCGs supported by Dananai have been given peanut butter processing machines. In this organization male VCGs are regarded as bread winners even though some female volunteers like widows and single parents also fall in the same category of breadwinners.

Research conducted in Kenya by WHO recommended development of poverty alleviation programmes such as IGAs targeting HIV/AIDS affected households and VCGs as a strategy for effective implementation of Community Home Based Care (WHO, 2001). Some organization supporting CHBC are against the idea of giving VCGs money, the argument being that this not sustainable. However in countries like Swaziland, the government is giving VCGs a stipend through the global Fund grant (UNAIDS 2001). The Most preferred support by most of the organizations working with VCGs that seem to be sustainable is through IGAs (SAfaids and HND, 2008)

2.3. Community Home Based Care volunteerism

Various organizations and individuals have come up with different definitions for volunteering. Wilson, (2000) defines volunteering as an activity that produces goods and services at below market rate. The definition emphasise more on the product and is silent on the reasons for volunteering which are equally important in this study. Ellis and Campbell, 2007, consider the reason for volunteerism as recognition of a need with an attitude of social obligation. For the purpose of this study volunteerism is taken as offering resources (time and energy, materials) for the benefit of other people in a society without concern for monetary profit. Compensation given to VCGs differ with organization but literature has revealed that the VCGs work is not valued in economic terms, therefore what they are given either in form of money or materials is just to assist them (Ogden, Esim and Grown 2004). Narrowing volunteering down to volunteerism by VCGs' who are being focused in this study, VCG is a community member working with the community and HIV/AIDS affected families in providing care and support and the definition is according the (MOHCW, 2004). Smith (2000) came up with four dimensions of volunteer that are beneficiary, free will, rewards and organizational set up. In this research three out of the four dimensions of volunteer that are beneficiary, free will and rewards have been adapted as they all apply to the type of volunteer ship being practiced by the VCGs under study (figure 2.4.) In addition to the three the study included characteristics of the VCGs. and reasons for volunteering (Smith, 2000). Studies have shown that sex, age, household size and marital status affects performance of VCGs. Akintola's study in South Africa explored the burdens of HIV/AIDS faced by VCG, who are single mothers. Findings from his study showed that single mothers combine multiple caring roles because they have to care for themselves and also PLWAs without support from partner or husbands (Akintola, 2006).

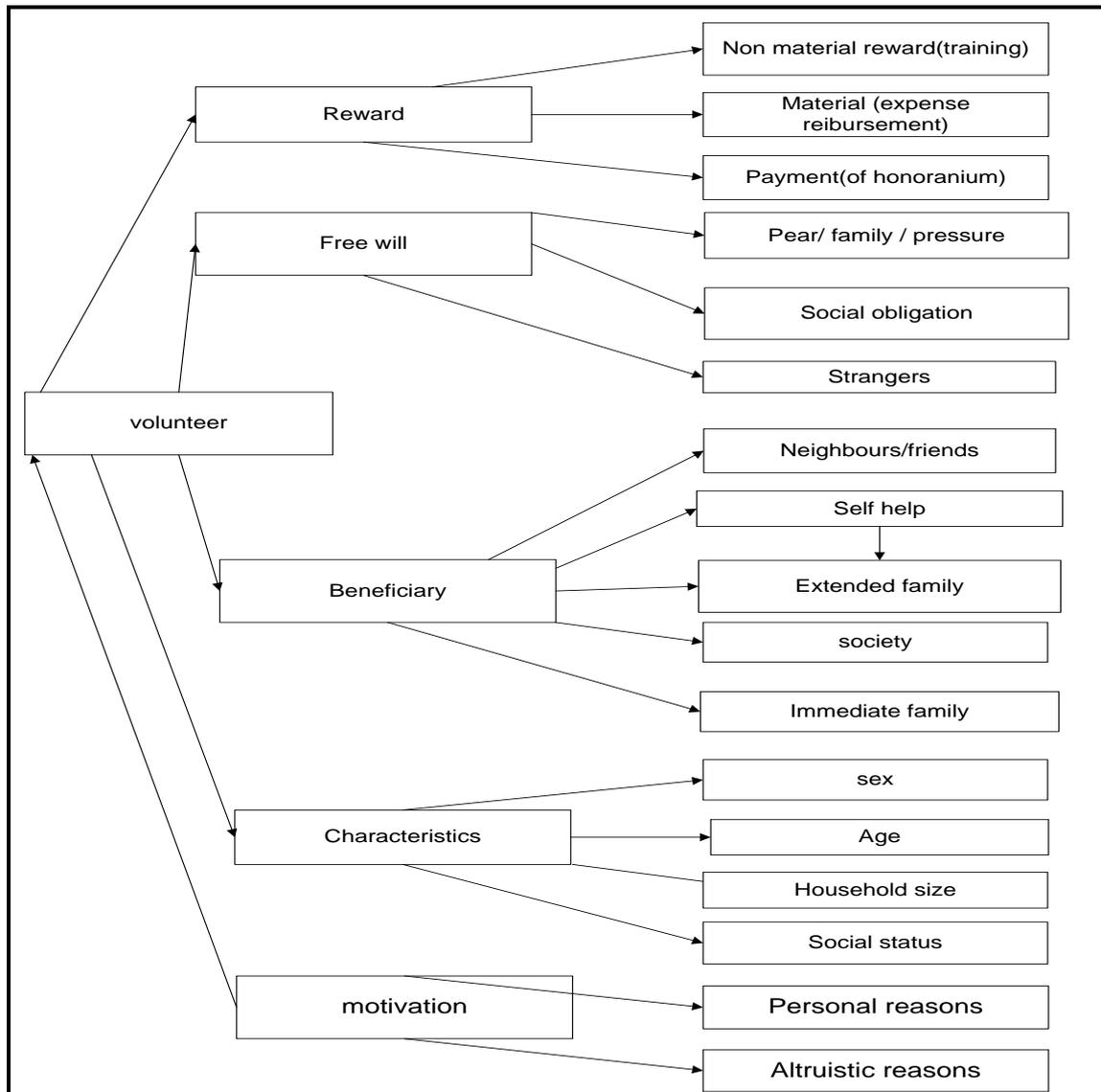


Fig 2.4. Volunteering dimensions

The operational definitions for the dimensions included in figure 2.3 being used in this research are reward, free will, beneficiary, motivation and volunteer characteristics.

2.3.1. Reward

The reward given to the volunteers varies with organizations. Depending on organizational policies and available funding, the reward can be in the form of incentives, compensation or stipend. Some organizations give money while other support VCGs with non-monetary materials such as uniforms, bicycle or in the form of training. A study conducted in Uganda and South Africa by Akintola revealed that although some organization gives incentives to volunteers these are not enough to meet basic needs. A suggestion made in the recommendations was providing support and material assistance to VCGs. (Akintola 2004). This study focuses on the non-monetary assistance given to VCGs as compensation for providing care and support to HIV/AIDS affected households (HHDs).

2.3.2 Free will (social obligation)

CHBC volunteers are acting in recognition of a need with an attitude of social responsibility (Ellis, 2007). After realizing the increased number of AIDs patients in need of care, health oriented NGOs initiated the CHBC programmes and the programme required people within communities who were prepared to offer their time for caring the sick people without given a salary.

2.3.3. Beneficiary

In this study the beneficiary is the society / community including the neighbours, extended family members and friends. However the volunteers operate within a specific area of jurisdiction called a ward. The ward is comprised of a number of villages and in this case there are 7 villages. Although other volunteering organizations like volunteering England, (2009) consider voluntary service to be given to someone whom the volunteers is not related to, but in this case service is offered to both relatives and non-relatives.

2.3.4. Characteristics of the VCG

The characteristics of the VCH have influence on CHBC service delivery. Generally, women have been reported to have disproportioned share of care giving activities for PLWHA (Akintola 2004). Despite the VCG being a male or female, social variables also have been found to have influence on the VCGs performance. The study focuses on the social and demographic characteristic that includes sex, household size, age and social status.

2.3.5. VCGs motivation

Altruistic and self-oriented reasons for volunteering have been observed in several studies. Altruistic is whereby people volunteer to help other without anticipating any form of reward while personal has to do with self-satisfaction reward by doing the work (Akintola 2010, Burns, Reid, Toncar, Fawcett, and Anderson, 2006). The reasons for volunteering differs with individuals and Anderson et al study found out that people may be driven to volunteer by both altruistic and personal reasons. The study also reveals that regardless of personal motivation possessed by an individual to volunteer, altruism plays a role. Narrowing down to VCGs reasons for volunteering, many studies have revealed common motivational factors which include burden of the disease, sympathy, skills enhancement and to get up keep. (Kiyange, 2007, Akintola, 2008a, SAfaids & HND, 2007) These reasons have been found to have two broad goals of either to help other or for self-oriented reasons. A study conducted in Zambia found that VCGs wanted incentives such as uniforms and bicycles to do a better job. In addition the VCGs also want training in skills to undertake IGAs. (RAPIDS, 2010). Akintola recent research South Africa found out that many volunteers when they joined CHBC pretended to have joined CHBC just to help PLWAs but had other underlying reasons such as acquisition of skills and knowledge. Some volunteers take CHBC as a stepping stone for paying better carriers (Akintola, 2008a). Nevertheless, motivations of becoming a VCG appear to be the same in most of these studies. In Zimbabwe, currently there are no concrete national standards for remunerating VCGs. However, organizations supporting CHBC are encouraged to include VCGs in livelihood programmes that they are asked to lead as a way of addressing VCG motivation problems (ZNASP, 2006). There is inconsistency in the support given to them by various organizations supporting CHBC programmes, hence quality of service differs form organization to organization. Recent research has revealed that low level of remuneration is amongst the factors contributing to poor retention of VCGs. This is because most of the VCGs are also vulnerable just like the HIV/AIDS affected families they are supporting (Akintola, 2010)

2.5. CHBC volunteer service delivery

The service offered by CHBC volunteers is centred on care and support that PLWHA receive in their homes through communities. According to Ncama (2005) report on models of community home based care HIV/AIDS has placed a large burden on the public health resulting in the shifting of the burden to the communities and family members. This care and support addresses the medical, nursing, emotional, spiritual, psychological, social and material needs of people living with HIV/AIDS (PLWHA) and their families (Nsutebu, Walley, Mataka and Simon 2001, Ncama 2005). The CHBC VCGs are expected to do nursing duties like monitoring drug intake by patients even though they are not formally trained practitioners MOH&CW (2004). With the increased coverage of Anti-Retroviral Treatment (ART), the VCG are also expected to monitor adherence to medication. A study conducted by Mohammed and Gikonyo, (2005) revealed that VCGs are not properly trained and supervised to monitor adherence to ARVs by PLWHAs. Fig 2.5 shows service delivery dimensions and the operational definitions.

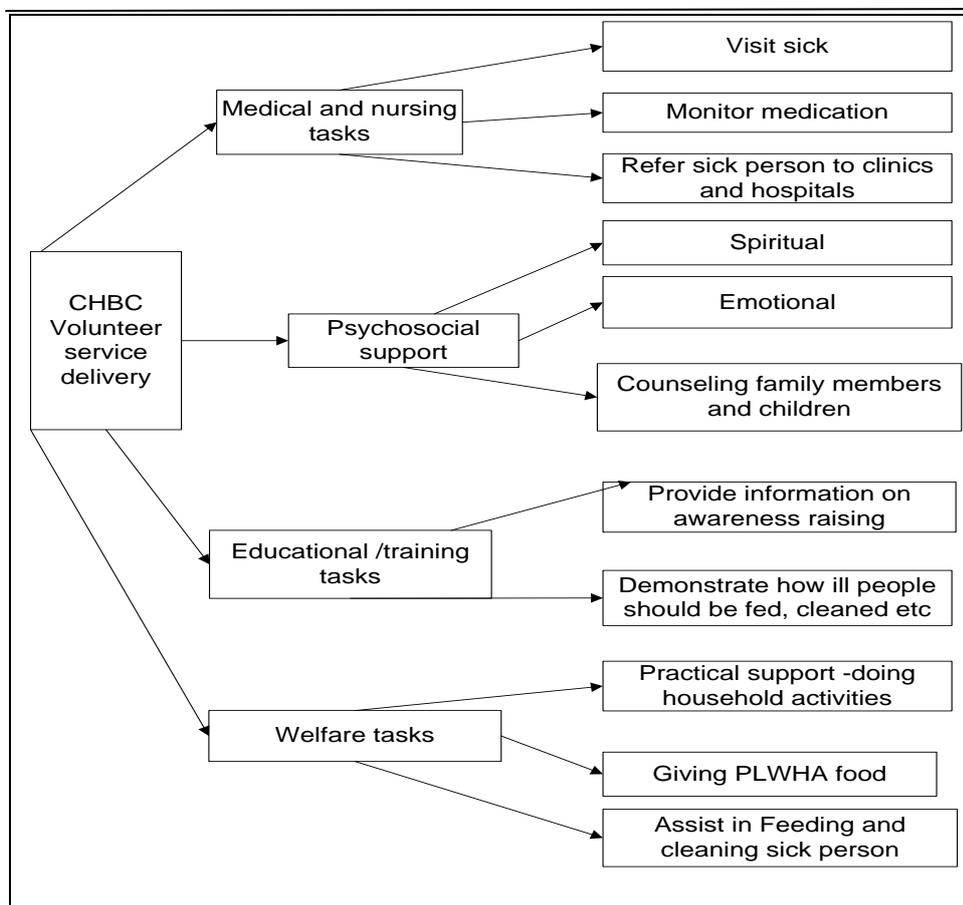


Fig 2.5: CHBC service delivery dimensions

In this research CHBC is taken as the provision of support (spiritual, medical, emotional and material) and the care, welfare, medical and nursing given to HIV/AIDS affected households. Most of the VCGs in Zimbabwe including the areas under study are doing these activities and its according to the Zimbabwean national HIV/AIDS 2006-2010 (ZNASP,2006) strategic plan. Delivering of these tasks makes up the work load of the VCGs.

Chapter Three: Methodology

A case study method in combination with desk study was used. A case study was used to get an in depth study on two main areas of concern which were two fold. The study explored the effect of participation of CHBC Volunteers in IGAs on their livelihood (financial, social, human natural and physical capitals). In addition the study also explored how the income generating activities affected community home based care service delivery to HIV/AIDS affected households. The research method used gives the researcher profound insight needed for coming up with recommendations for the improvement of the programme (Verschuren and Doreweerd, 1999). The study started by undertaking an intensive document review. This was followed by a Focus Group Discussion (FGD) and then interviews. Check lists (appendixes 1-5) were used to guide the discussion. Pretesting of the checklists was done with participants who were not part of the study. Although the checklists were written in English, I conducted the discussions in the vernacular language in order to accommodate all the participants with different literacy levels.

3.1. Document review

The approach used was meant to analyze changes brought about by the IGAs specifically on the livelihoods of VCGs and also on the HBC. The purpose of the literature review was to gather information regarding the project that already exists hence has an appreciation of the project. The literature reviewed included project documents (partnership agreement, implementation plan, monitoring plan, proposal, logical framework matrix, baseline reports, narrative reports and end of project report), literature on similar projects government reports and district profiles. Reviewing of project documents enabled the researcher to understand how the project was designed and implemented. During the process of the reviewing gaps in progress reports and proposal documents were noted.

In addition, the document review also looked at the various articles and books about livelihood capitals, projects that assist VCGs with IGAs and CHBC service delivery was. The literature was further used for the verification of the qualitative data collected during focus group discussion (FGD), key informant interviews and VCGs' interviews.

3.2. Sampling

Convenience sampling whereby the sample is selected because the people have potential to provide sufficient data on the research subject was done (Walonick, 1993). Considering the time allocated for data collection and also the expected in depth interviews answering the why and how questions, a total of 24 people participated in the study. Of the 24 participants 15 were VCGs, 3 PLWHAs and 6 were key informants. Majority of the people who participated in the study were VCGs because the study focus was on their livelihood and the service they deliver to HIV/AIDS affected households. Gender considerations were taken into account during the sampling process. Sampling of people to be interviewed was based on the information wanted, knowledge and experience in working in the CHBC programme. Criterion used for selecting volunteers to be interviewed was that the volunteer had worked before and after introduction of IGAs. In addition the volunteer was supposed to be working in Sedze cluster which is the research area. Table 3.3 gives the characteristics of the volunteers who participated in the study.

Table 3.2: Characteristics of VCGs who participated in the study

Item	
<u>Gender</u>	
Male	0
Female	15
<u>Age</u>	
30-40 years	1
41-50 years	7
51-60 years	4
+ 61 years	3
<u>Household characteristics</u>	
HHD size range	3-7 members
Average HHD size	5
HHDs with school going children	9
HHDs with elderly people	3
HHDs taking care of orphans	4
<u>Marital status</u>	
Married	9
Separated	1
Widowed	5
<u>HIV status</u>	
HIV positive	2
Status not known	13
<u>Treatment status</u>	
On ART	2
Caring for orphans	4
Caring sick family member	2

The ages of the volunteers interviewed ranges from 32-76 years and the majority are within 40-60 years. All except one of the VCGs who participated in the study joined CHBC in 1996. Therefore it is important to note that majority of these VCGs started HBC work 14 years back hence joined CHBC work at an age range of 25 -45 years. Unlike in other case where by CHBC work is regarded as responsibility for elderly people, in Sedze it was taken up by fairly young women. Majority of the VCGs are married. In addition to the VCGs three PLWHAs all females also participated in the study. Even though the study tried to give equal opportunities for men and women but the majority of the participants ended up being women. Reasons for this skewed results was beyond the researcher's influence for example of the 20 VCGs servicing Sedze cluster all but only one are women. At the time of the study the male volunteer was not available. Included in the study were also PLWHAs. The PLWHA who participated in the study were those who have worked with the VCGs before and after the introduction of the IGAs.

A total of 6 key informants comprising of SAFIRE project officers FACT project officer, District AIDS coordinator, Ward councillor and the chief were interviewed. Table 3.1 gives a breakdown of the key informants by gender. Selection of the key informants was based on experience of working with the volunteers in the HBC programme.

Table 3.2: Characteristics of key informants

People interviewed	Males	Females	Total
Southern Alliance for Indigenous resources (SAFIRE) staff who were responsible for the project implementation	1	1	2
Family AIDS (FACT) staff who were responsible for the project implementation	1	0	1
District Aids Coordinator	1	0	1
Ward councillor	1	0	1
Village head	1	0	1
Total	5	1	6

3.3. Data Collection Tools

Various tools were used for data collection. In selecting the tools the researcher considered time requirement, flexibility in their application and the intended results (IDRC, 2003). The selected data collection tools enabled a systematic collection of information. The tools used were observation, interviewing and FDG. PRA tools (activity calendar and timelines were used during the FDG .The observation technique was used during interviews and FDG and this was through observing the non-verbal communication and the surrounding at homesteads visited during the exercise.

3.3.1. Interviews

Face to face in depth interviews were conducted with respondents (volunteers and PLWHA) and key informants. The interview used loosely structured methods of asking questions as these allow continuous modification of questions during the course of the interviews. The tool was used to answer the questions why and how and according to Roche, (1999) semi structured interviews are most suited to answer such questions. Interviewing of various respondents was done in order to triangulate and validate information on HBC service delivery especially frequency and time spent during visits by the volunteers. Interviewing of the volunteers and the PLWHAs were conducted at each person’s residence. Visit to each homestead enabled the researcher to have an appreciation of the livelihood activities the volunteers are doing. Checklists were pretested with community members who were not part of the study. Detailed topics covered in the checklist contents are presented in appendix 1- 3.

3.3.2. Focus Group Discussion (FGD)

One FGD meeting was conducted with ten volunteers. The ten volunteers were randomly selected from the seven villages representing the cluster. The FGD allowed exploring of issues in depth as it brought together volunteers with different perspectives on the IGAs and HBC service delivery. (Roche, 1999). PRA tools that were used during the exercise included daily activity calendar time lines and ranking and scoring. A daily calendar was used to investigate if the care givers have labour conflicts / time constraints. The 24 hour calendar

was used to show how the VCGs allocate their time among different activities (productive, reproductive and community). The tool was also used at individual and group level, hence enabled triangulation of data obtained from FGD. Use of time lines helped in knowing in depth about individual and general community including the negative and positive impacts before and after the introduction of the IGAs to the VCGS in a non-threatening manner (Roche, 1999). In addition the times lines enabled critical analysis of important events that happened over the period under review that effected CHBC service delivery (SAFIRE, 2002). Ranking and scoring was used to assess opinions and judgments on income sources. A schematic approach adapted from Carney livelihood capital pentagon was used to compare asset status by plotting asset status before and after involvement of CHBC volunteers on the pentagon (Ellis, 2000). Check lists of issues to be dealt with were used to guide the discussion during the FGD and individual interviews. However, unexpected relevant issues that came up during the discussions were as well followed up with probing (PRA handbook, 2003). Detailed topics covered in the checklist contents are presented in appendix 4.

3.4. Data analysis

Data collected during the research was analyzed by writing summaries during discussions and observations. This was followed by listing the answers as they were provided by the respondents. Categorizing of similar responses and code with a key word was the next step that was done. Summarizing of the data using tables and matrixes was done in order to have an overview of the data collected. These steps helped with information processing for drawing conclusions. Literature from Varkevisser, Brownlee and Pathmanathan, (2003) and Seidel (1998) has shown that the process of data analysis is not sequential but iterative and progressive because it is a cycle that keeps repeating itself. The process involves noticing, collecting and thinking as shown in Figure 3.1 below. A clear distinction was made between descriptive and the researcher interpretation. Description deals with what the interview is all about and interpretation considers values, meaning, purpose and linkages. In addition the study dealt with cases that disconfirm or contradict the analysis (Varkevisser et al. 2003).

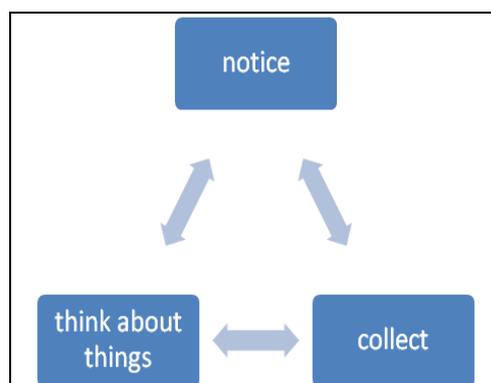


Figure: 3.1: Qualitative data analysis. (Source: Adapted from Seidel, 1998)

3.8. Ethical issues

All the interviewees were given a verbal guarantee that information will be kept confidential and that the participation is voluntary. It was fortunate that all the participants were interested to participants in the study.

3.9. Study limitations

The study failed to get the opinion of the male VCG because at the time of the research he was engaged in a contract work. Although Sedze cluster has only one male VCG but the opinion of the male VCG would have contributed much to reasons of volunteering and why there is low participation of male in CHBC work. In addition the study cannot be generalized to other clusters because of the differences in the support that were given to the clusters.

Chapter Four: Project context and background

4.1. Project context

Implementation of the project started during a period when Zimbabwe was undergoing a process of political and economic transformation. This period was characterized by hyperinflation and shortages of basic products that includes the soap and peanut butter that was promoted by the project. After the baseline study in 2007 the project implementation could not be start because of political instability experienced in the preparation of 2008 elections. All NGO activities were suspended for nine months in 2008. Formation of government of national unity led to the introduction of multi-currency in an attempt to stabilize inflation that had gone above 200 000 in 2008 (IMF, 2008).

4.2. Project background

In 2006, SAFIRE in partnership with FACT and CHF agreed to bring their experiences into a single programme that seeks to mitigate the impacts of AIDs in HIV/AIDS affected households. Recognition of the relationship between HIV/AIDS and food security by the development communities led to the designing of the project entitled HIV and Livelihoods improvement in Zimbabwe. In this collaborative effort FACT draw its experiences in from previous and on-going CHBC programme. According to the partnership document, FACT is a Christian- based organization working with various communities to provide HIV prevention programmes, training and caring for the whole person. The organization in its new strategy and direction has started working on income generating projects targeting PLWHA (FACT & SAFIRE 2006d).

SAFIRE contribution to the project was livelihood improvement through IGAs and food security initiatives while CHF contributed its experience in sustainable rural livelihoods, organizational development, social and gender analysis to the project team (SAFIRE & FACT, 2006b). The joint project seeks to ensure that affected households are able to provide for their needs with less support from HIV/AIDS support organizations.

FACT home based care programmes have VCGs who help to take care of patients, give support and source food. Volunteers come from churches and the majority are women. The volunteer care givers volunteer themselves and the local leadership and community at large give recommendations basing on the character of the person (SAFIRE & FACT 2006a). According to the selection criteria, a volunteer should be someone who is approachable and has a good record in the community. Involvement of the community leadership considered to be very important during the selection process and is also done in other countries such as South Africa (Akintola 2004). After the selection and approval process, the volunteers receive training in CHBC. The training covers basics on nursing, HIV/AIDS, psycho socio support as presented in box 4.1. After the training VCG were given HBC kit that comprised of disinfectants, gloves, bandages, cotton wool, swabs for dressing, plastic sheets, mild pain killers. In the past FACT used to replenish the CHBC kits but has since stopped due to financial constraints.

General Training (Chronic illness. Terminal illness, HIV/AIDS, Assist client with exercise)

Assessing vital signs (Temperature, pulse, respiration and blood pressure)

Nutrition (Food preparation, Feeding client, Assess hydration, Preparation of SSS)

General client hygiene (Bathing and dressing client, assisting client with oral care, assisting clients with toileting)

Providing a safe environment (Provide restful environment, Provide clean environment How and when to use disinfectants, Handle soiled linen)

Medication (Obtaining medication for client, giving medication to client)

Bereavement (What to do when an emergency arises, what to do if client dies, Counseling of relatives)

Psycho socio support (emotional and spiritual support)

Caregiver self-care (Prevention of cross infection, Getting rest and sleep, Exercise, Eating well, Exercise)

Psycho-social support (emotional, spiritual)

Box 4.1: CHBC Curriculum. Source: adapted from MOHCW,2004

Currently FACT volunteers are not getting monetary benefits, but gain training, networking skills and become link person for information sharing among stakeholders and the community (SAFIRE & FACT 2006a).

4.3. Project Description

According to the project logical frame work, the overall goal of the project was to improve capacity of the most vulnerable households in HIV/AIDS affected rural communities in Zimbabwe to sustain their livelihood (SAFIRE & FACT, 2006). The project had five key outputs contributing to the overall goal of improving the livelihood strategies and quality of life of the most vulnerable households in HIV/AIDS affected rural communities in Zimbabwe.

The focus of the study was on output one whereby the project was expected to build the capacity of CHBC VCGs to develop and sustain income generating initiatives. The project had three indicators for this output. These were

- I. Increased income
- II. Increased number of viable IG activities
- III. Increased accumulation of household assets.

According to Scoones, 1998, classification of capitals, the project focus was on two capitals- physical (household assets) and financial capital (cash). Apart from the two capitals, the study also looked at human capital (skills and health status of household members and social capital the training conducted and social networks created as a result of participating in the IGAs and also the natural capital. The project had the following activities meant to build the capacity of caregivers to develop and sustain income generating initiatives.

- Identification and feasibility studies of IGAs
- Business modelling and setting up of structures
- Capacity building in organizational and business management skills
- Business development, implementation and monitoring
- Facilitate business linkages between IGAs and markets and financiers

A livelihood assessment study conducted in Chitsanza ward in 2007 prior to IGAs implementation revealed that volunteers were amongst vulnerable households who were being targeted by the project (SAFIRE, 2007a). Unlike in some programmes implemented by HIV/AIDS organizations which exclude volunteers who are not PLWHAs for IGAs support, the project included all the VCGs in the IGAs. A total of three IGAs were identified by the volunteers during the Participatory Rural Appraisals (PRA) exercises done during the livelihood assessment prior to project implementation 2007. These were peanut butter processing, jatropha soap making and indigenous vegetables processing. However the project could only support two of the IGAs – jatropha soap making and peanut butter processing. The project promoted IGAs that could be easily supported by farming activities. Two groups of volunteers were formed to implement the IGAs. Jatropha group has 15 members all females while for the peanut butter processing has 20 volunteers all but only one are females. Initial support from the project included the peanut butter pressing and the jatropha soap making machines valued at 1 500USD. A feasibility study was conducted before implementation of the two IGAs. The peanut butter machine has a potential of producing 50kgs (100x 500g bottles). The project also supported the VCGs with packaging materials and groundnuts for testing the machine. The volunteers received training in business management (financial management, marketing), organizational development (group dynamics, leadership and constitution development). Organizational and business management training received by the VCG's from SAFIRE was meant to address the qualitative dimension of labour resources. The trained VCGs were supposed to assist affected HHDs in managing IGAs at the HHD level.

The model used by SAFIRE to achieve the objective of the project is presented below in Figure 4.1.

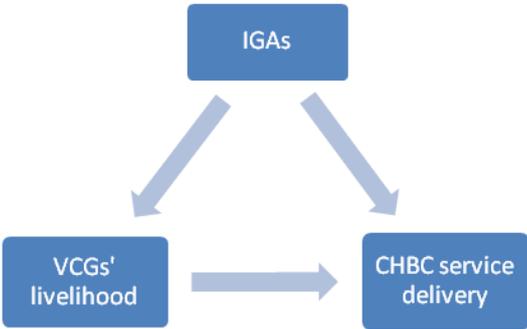


Figure 4.1: IGA model for the VCGs

According to the project design, the IGAs have a direct impact on both livelihood of the VCGs and CHBC and also the livelihood status of the VCG affect CHBC service delivery. The project expected that the IGAs, apart from building resilience of VCGs through improving their livelihood will also contribute to self-sustenance of the CHBC through donating 15% of the profit to CHBC. The volunteers stated the percentage contribution in their constitution.

4.4. Project Area

The project was implemented in six areas covering three districts of Manicaland province in Zimbabwe. The case study was conducted in Chitsanza ward of Nyanga district (figure 4.1). However, the study did not cover the whole ward but concentrated in Sedze cluster where the two IGAs being evaluated were taken up by the VCGs in the cluster. Although VCGs in Charamba cluster were supposed to benefit from the IGAs they decided to withdraw because the machines were stationed far away from the cluster. In addition, this particular site was selected basing on the support given to the IGAs by the project. One site was selected for the study.

Sedze cluster is located in Chitsanza ward in Nyanga district in the Eastern province of Zimbabwe (figure 4.1.). Appendix 7 gives a map showing demarcation of the wards in Nyanga district. According to Central Statistics Office (COS), 2002 census breakdown cited in SAFIRE (2007), the population for the ward is 3 681 (1 652 males/ 2 029 females). In 2002, the numbers of households' were 973 with an average household size is 3.9. (SAFIRE, 2007b). The area falls under natural region 11B that is characterized by annual rainfall of 600- 700 mm per annum. For the past three rain seasons (2007 – 2010) the area has experienced long dry spells and this could be attributed to the effects of climate change. The Chitsanza community is largely depended on subsistence agriculture which is currently vulnerable to poor market prices, lack of credit, high production costs and drought. To cope with these shocks and stresses people continuously seek other non-agriculture livelihood options which also include some of the IGAs supported by the project. Introducing IGAs was meant to diversify VCGs' households' income.

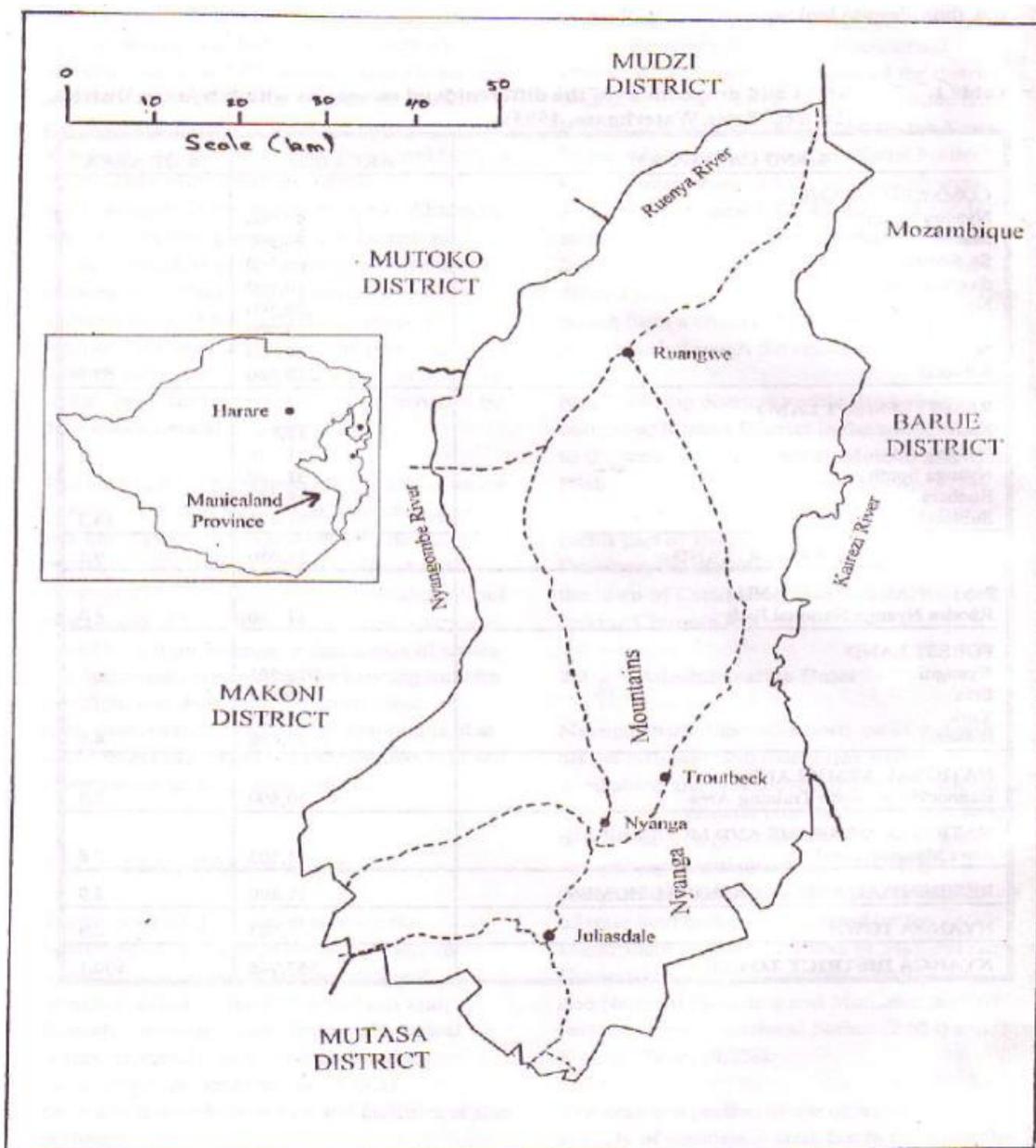


Fig 4.2: Map showing the location of Nyanga district. (Sources: SAFIRE, 2007a)

The project has been chosen for the study because the volunteers in this ward participated in the designing and implementation of the IGAs, hence have sufficient knowledge of the project.

Chapter Five: Results

5.1. CHBC volunteering

The general definition given by the VCGs was that volunteering is doing work for the community without getting payment in return. All the responses given by VCGs showed that all the VCGs are aware of voluntary work and were not anticipating direct payment from the work they are doing. In fact when they started the CHBC work in 1996 they were 54 and 39 dropped within two years after realizing that there was no payment attached to the CHBC work. Therefore those who remained understand what it means to be involved in voluntary work. However two of the VCGs who are widows pointed out that they would be very grateful if they are given any form of assistance on monthly basis. Currently the two widows are struggling to fend for their families. The low level of participation by men in voluntary work discussed earlier in chapter two was also noted in this study. The reason given by both FACT and the female VCGs are based on norms, sexuality and masculinity in traditional African society. As noted in other studies men are regarded as bread winners and would always want to fulfil that obligation (Akintola 2004). Therefore voluntary work especially care giving has been found to best suits women as it is regarded to be part of their responsibility. Men are motivated to join voluntary work where there is provision of meaningful incentives like in the case of Dananai Home Based Care in Zimbabwe that has a 50-50 ratio of male and female VCG (SAFAIDS & HDN, 2007).

5.1.1. Reasons for CHBC volunteering.

The study considered it important to have an understanding of VCGs' motivations for taking the social obligation of taking care of PLWHA. Various reasons were given by the volunteers for joining CHBC. These reasons were grouped according to Akintola (2008) two broad categories that are altruistic and personal. Altruistic is whereby people volunteer without anticipating any form of reward while personal has to do with self-satisfaction by doing the work.

5.1.2. Altruistic reasons

- **Social obligation**

All the VCGs who participated in the study indicated that they joined HBC after seeing the magnitude of HIV/AIDS problem due to failure by the government health delivery services to care for the AIDS patients. During the individual and focused group discussion the volunteers indicated that they have been and are still committed to do their work even if they are not given incentives. Their motivation comes from within and it's grounded on the Christian principles of loving one another and getting reward for the good work they are doing from God.

5.1.3 Personal reasons

VCGs gave different personal reasons for volunteering in CHBC and these were:

- **Build social capital**

Five VCGs amongst them two widows indicated that they joined CHBC voluntary work in order to strengthen social ties. Being in a group involved in caring work, they would also get support when they are sick. Two of the VCGs gave testimonies of the support they got from fellow VCGs when both their husbands were sick and bed ridden. Other VCGs assisted them and this relieved the burden of caring their husbands. The husband of one of the VCGs later

passed away and the affected VCG confessed that she was afraid to get tested but with the counselling and encouragement that she got from the other VCGs she was able to get tested. Presently she is on medication (ART) and is still getting moral and spiritual support from the other volunteers.

- **Hope for a future reward**

Although the VCGs joined HBC knowing that they would not get any incentives but also have underlying reasons for volunteering. Majority of the VCGs have the hope that NGOs and the government will in the long run appreciate their work by giving them incentives. During the interviews two VCGs (all elderly) openly said that they would appreciate if the organizations supporting CHBC programmes as well as the government give them assistance in the form of school fees, food or clothes.

FACT project officer indicated that the organization is aware of VCGs who have underlying reasons that includes incentives but as an organization they are failing to address such issues due to budgetary constraints. All the little resources that they have are channelled towards HIV/AIDS affected households. However the organization has partnered with donors who are interested in supporting the VCGs. The organization has observed that involvement of the VCGs in IGAs has boosted their morale, contributing to the effective service delivery. Since the VCGs started CHBC work in 1996 they had never benefited from IGAs specifically targeting them. Many times they have been asked to monitor IGAs for HIV/AIDS affected HHDs without direct benefit from the IGAs. The VCGs have been motivated by just being targeted in the IGAs even though they haven't benefited much in terms of cash from the IGAs.

- **Access to information about care and support and medication**

One of the two VCGs who are living with HIV expected that by volunteering she would have access to information about care and support and also easy access to treatment for opportunistic diseases and ART drugs. This worked for her and was able to access ART in 2003.

5.2. CHBC Service Delivery

The research looked at HBC service delivery by the volunteers before and after implementation of the IGAs.

5.2.1 Tasks performed by VCGs before and after participation in Income generating projects

The study indicated that VCGs provide various services (table 5.1.) to HIV/AIDS affected HHDs and all the services are in line with the recommended national CHBC tasks expected from the VCGs. Changes in the tasks performed before and after IGA were reported to have occurred in the second year of implementing IGAs as shown in table 5.1 below. The changes were said to have been influenced by improved access to ARVs by PLWHA and also involvement of PLWHA in IGAs supported by FACT. Accessibility of ART to majority of PLWAs enabled some bed bound patients to become mobile and being able to do much of the household activities that were earlier undertaken with the help of the volunteer.

Table 5.1: Changes in CHBC service delivery tasks

CHBC service delivery Dimension		Before IGA(1996-2007)	Year 1 of implementing IGA (2008)	Year 2 of implementing – to date (2009)
Medical and nursing	Visit PLWA	✓	✓	✓
	Monitor medication – antibiotics	✓	✓	x
	Monitor medication – ART	x	x	✓
	Refer sick to clinics	✓	✓	✓
Psycho socio support	Spiritual support	✓	✓	✓
	Emotional support	✓	✓	✓
	Counselling	✓	✓	✓
	Mobilizing PLWHA to form support groups	–	–	✓
Education/ Training	Demonstrate food preparation, feeding and caring sick person	✓	–	x
	Provide basic information on HIV prevention, transmission	✓	✓	✓
	Raise awareness on Voluntary Counselling and testing(VCT)	✓	✓	✓
	Monitoring PLWHA and OVCs projects-crop production and nutrition gardens	✓	✓	✓
	Monitoring PLWHA and OVCs IGAs projects	x	x	✓
Welfare/ caring	Assist feeding bed bound PLWHA	✓	✓	–
	Sourcing food items	✓	✓	–
	Donating food items	✓	✓	–
	Household chores (cleaning the house and washing dishes)	✓	✓	x

Key: X- Means they are not doing the activity, tick means the activity is done and the dash means the activity is partially done

Findings from the VCGs interviews and the trend analysis (appendix 7) indicate that VCGs are currently doing less of caring activities whereas psycho social support activities haven't changed. From 1996 to late 2008 most of the PLWHA supported by the VCGs were bed bound patients who demanded a lot of care and support. The tasks performed included assisting in feeding and bathing the sick person and also doing other domestic work like fetching water, cleaning dishes, fetching firewood. This was done in order to relieve the burden that caring had on PLWHA on affected families (Akintola, 2005). Extensive promotion of Voluntary Counselling and Testing (VCT) and improved access to life prolonging medication (antibiotics and ARVs) in 2009 resulted in the reduction of bed bound patients. Results from the study revealed that although the VCGs are monitoring ART adherence but they have inadequate knowledge to provide effective service on ART programme. PLWHAs

on ART interviewed said that they are getting much of the advice and counselling from the health centre.

5.2.2. Time spent on CHBC activities

The study showed that the total time spends on CHBC work depends on the frequency of visits, nature of the activity and number of people under the VCG care. However the number of days allocated to CHBC depends on the condition of the patient and support provided by the family members. As discussed earlier, changes in the frequency and time spent was influenced by the increased number of PLWHA accessing ARVS. The number of patients visited per VCG was reduced by half over the same period (table 5.2.) Reason to this decrease is due to the reduced demand for caring by PLWHA who are now mobile and can afford to do much of daily activities by themselves. Study results indicate that average time spent per week by VCGs on CHBC was reduced by 90%. The records of the VCGs also indicated that 90 % of the AIDS patients who were under CHBC in Sedze cluster before increased coverage of ART died. Not all the PLWHAs who were bed bound responded positively to the ART drugs. This contributes to the reduced number of people who need caring assistance from the VCGs.

Table 5.2. Time and days allocation for CHBC service delivery

Item	Before IGA implementation (1996 -2007)	First year of IGA implementation (2008)	Second year of IGA implementation 2009 to to-date
Average frequency of visits	3days / week (average)	3 days / week (average)	Once / week
Average time spent/patient /visit	2 hours / patient / visit	2 hours / patient / visit	1hour / patient/ visit
Average number of patients visited per week	5 patients (average)	5 patients(average)	3 patients
Average total time spend / week	30hrs	30hrs	3 hrs

In the past caring for affected HHDs took much of their time during visits. The number of visits per day depends on the condition of the sick person and also the care they received from the family members. According to the VCGSs nature of support given to the affected HHDs has shifted from caring to psycho social and spiritual support. This was said to demand less time if they compared with time required to give care to bed bound patients. This was supported by one of the PLWHA interviewed and had to say:

“If I do not disclose my status people will never know that I am living with HIV virus. Access to ARVs has changed my way of living. I am now able to do most of activities of daily living and also work in my garden. Now the support I need from the VCGs is spiritual and emotional because I am aware that ART drugs do not kill the HIV but just prolongs life”. (Personal communication)

Changes on the CHBC work load was noticed in the second year of VCGs participation in the IGAs. The study revealed that work load for the VCGs were reduces because of the improved access to ARVs by PLWHA. There are four explanations for the observed change in the service delivery:

- Majority of the PLWHV are now mobile and are able to do most of the caring activities which were in the past done the VCG
- PLWHA household members have reduced caring work load and can do much of the daily activities that were earlier undertaken with the help of the volunteer.
- Education about proper use of ARVs is currently done by health staff leaving the VCGs with less work load
- PLWHAs have form support groups were they meet and support each other emotionally and spiritually. Although the VCGs are involved in the mobilization of the PLWHAs but once the groups have been formed they are no longer needed. One of the PLWHA interviewed said that *“we do not need the VCGs in our support groups, we can support each other”*

5.2.3. Time allocation to daily activities by VCGS

The VCGs indicated that during the visits much of their time was spent caring for the sick person and demonstrating to the primary care givers (family members looking after the sick person) recommended hygienic practices and food preparation. The 24 hours -daily activity calendar (figure 5.1) produced by the VCGs during the focus group discussion gives a clear picture on how time was allocated for CHBC tasks, household activities(reproductive work) and IGAs (productive work). Information given by the VCGs on the tasks that they perform during visits was confirmed by both the PLWAs (Box 5.2) and the chief who was one of the key informants. Household (HHD) reproductive and productive work mentioned by the VCGs included:

- Productive: working in the field and the garden, looking after livestock, buying and selling commodities, piecework.
- Reproductive: bearing children, care giving, HHD chores(cooking, bathing children, cleaning the house, laundry)

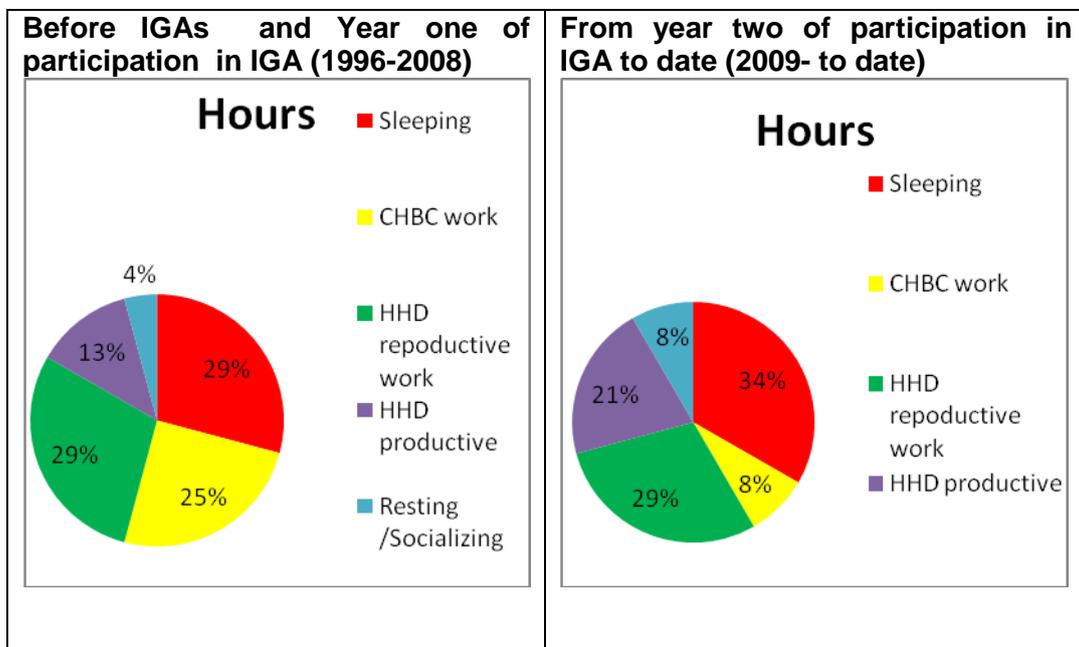


Figure 5.1: Time score

The results on table 5.2 shows a decrease of the time allocated to CHBC from 30hrs per week to 3 hours a week. Although figure 5.1. and figure 5.2 shows a decrease in the work load of the CHBC but the difference in the percentages it's because figure 5.1 results looked

at one day activity hence did not include the total number of days per week. In addition figure 5.1 looked at just one day activities whereas table 5.2 showed one week's activities.

The results showed that the time saved by the VCGs from doing CHBC work was used for productive activities, resting and socializing. The VCGs indicated that they managed to accommodate all the daily activities by adapting to the following coping strategies:

- Working up early (4am) and sleeping late (9pm) - VCGs with young school going children were the majority of VCGs who indicated that they work up early prepare food for their kids.
- Teaming up for visits and assist each other in cases where the patient does not have close relatives to assist. This reduced the time taken per patient
- Conduct CHBC work during weekends and sacred days. In Sedze every Wednesday is regarded as a sacred day and people are not allowed to work in the fields. During weekends, children would be available to help them.
- Planning of activities was done in advance.
- Volunteers with husbands share productive roles especially gardening activities as gardening is taken as female responsibility in the area. Widows indicated that they have much labour constraints as they do not have husbands to share with the responsibilities. As earlier discussed in the literature review, the widowed VCGs indicated that they have a burden of combining multiple caring roles. As noted by Akintola, (2006) They have to support both their family and HIV/AIDS affected households without support from partner or husbands.

One of the PLWHA said that she started working with volunteers in 1999 when her child was sick. Volunteers supported her with spiritual and moral support, food (own and mobilized from NGOs like FACT). At most the volunteers would visit her 3 times per week. Even though the child later passed away after 5 years but she appreciates the care and support she got from the volunteers during the time the child was sick. After the death of the child the volunteers continued supporting her because she became very weak. Through counseling by the volunteers she got tested and started ART programme in 2008. Since that time she is now strong and able to do her own work. She now is getting counseling on sexual behavior. As someone who is still young and sexual active she is being encouraged to have protected sex. Visits now reduce to once per fortnight Education on medication is done at the clinic but would prefer to get it from the volunteers. She has benefited from IGAs supported by FACT. She is doing poultry production and has managed to buy a goat, clothing and food from the money raised.

Box 5.1. Testimony by one of the PLWHA interviewed

5.3. Income Generating Activities

The research looked at the income sources before and after participation of volunteers in IGAs. Before the income generating project, income for the VCGs was from 8 sources and this increased to 9 after the introduction of the income generating activities. However on average each VCG is involved in at least three IGAs with the exception of one volunteer who has 8 sources of income (Figure 5.3.) As noted by Davis et al, 2007, on farm activities were indicated as the major income sources. Most the VCGs who participated in the study are

currently involved in field crops production, gardening and poultry production as presented in figure 5.2. The four respondents that indicated Peanut butter processing and marketing was reported by only 5 VCGs as one of their income sources.

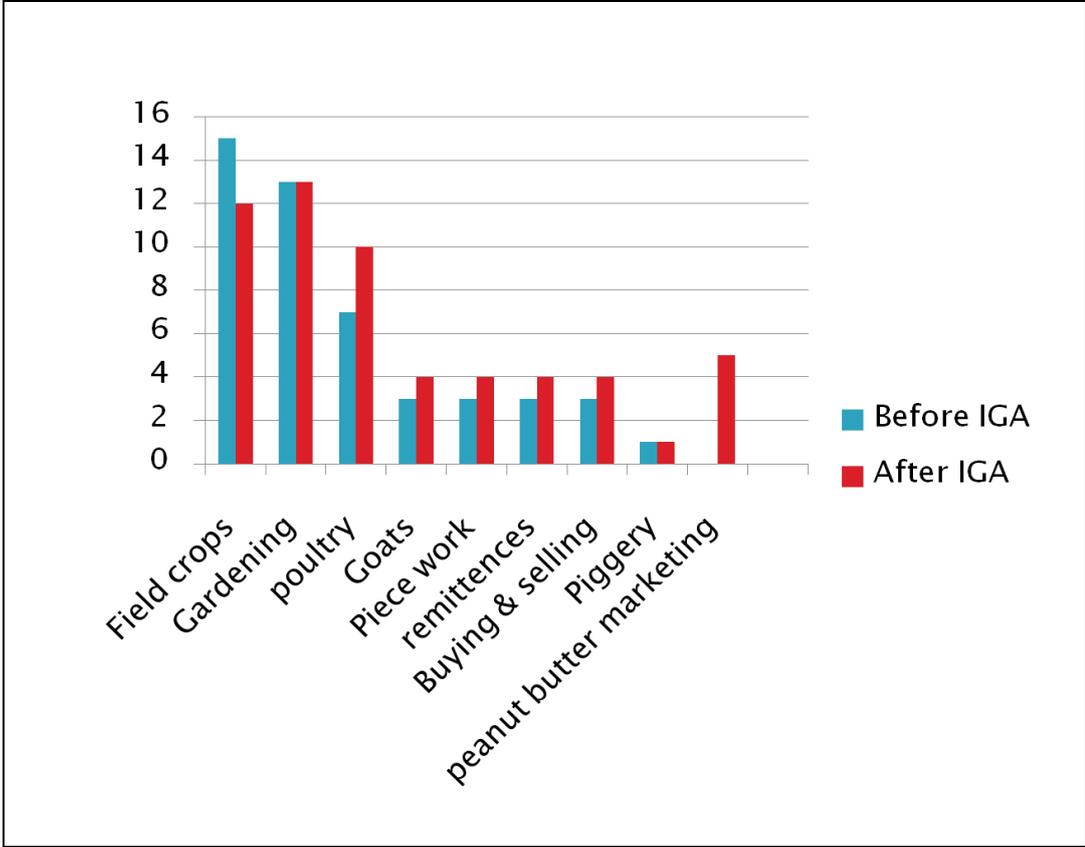


Figure 5.2: Income sources

Figure 5.2: Income sources

It was very difficult to get figures on the average money earned from the income sources because the VCGs do not have records and they also indicated that most of the transactions are through barter exchange. As reported earlier under the project context the multi foreign currency being used is not accessible to everyone. Most of the volunteers said that they use income from IGAs mainly for paying school fees as the majority of them have school going children (Appendix 8) In addition the money is used for purchasing food, clothes and crop inputs. HIV positive VCGs prioritize medication; hence use the money for bus fare when they go to the district health centre to collect ARVs and also medicines for opportunistic diseases.

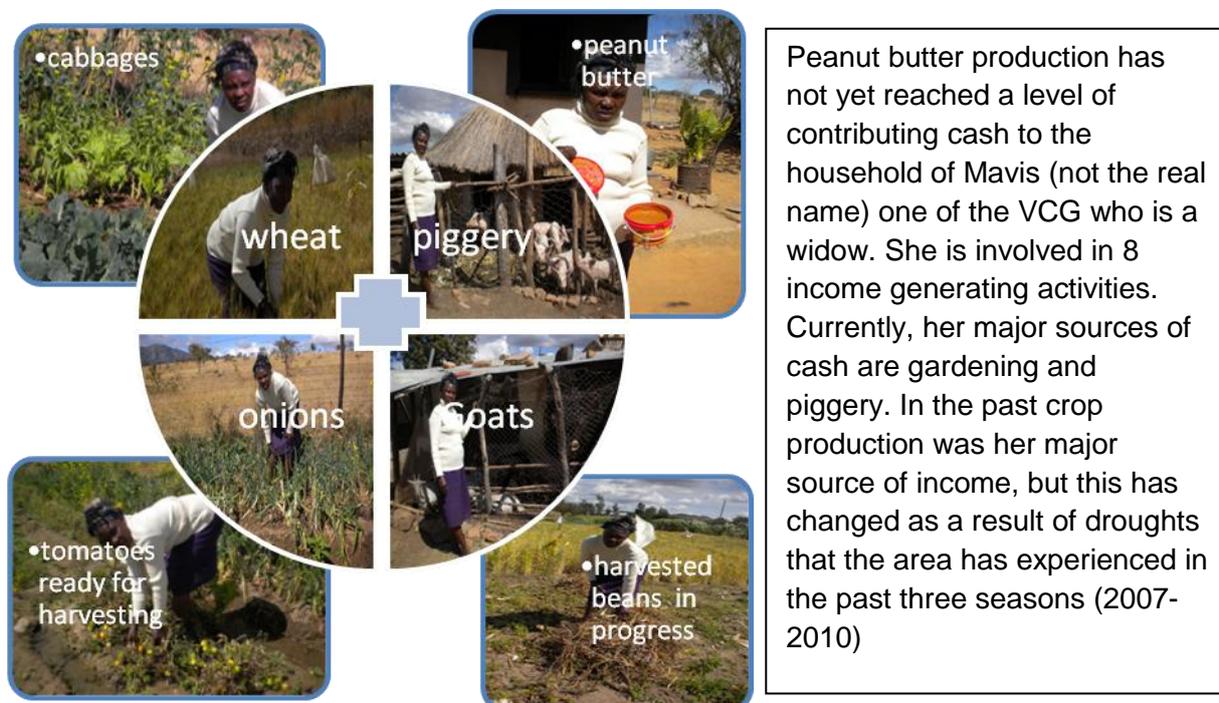


Figure 5.3: Example of VCG with various income sources

It is interesting to note that even though all the VCGs are producing peanut butter but only five have marketed. The majority are consuming the peanut butter and the reasons given vary with individuals as peanut butter is consumed in different forms. However, four of the five VCGs who sold the peanut butter used the money to pay school fees and the other one purchase kitchen utensils.

Table 5.3: Quantities of peanut butter processed and the number of VCGs involved

Item	Quantity processed (kgs)	No of VCGs involved
Consumed	99kgs	15
Donated	16kgs	14
Sold	25.5kgs	5
Barter trade	3	1
Total Produced	143.5kgs	

5.4. Performance of the IGAs

5.4.1. Peanut butter processing and marketing

According to the project design (SAFIRE, 2006b), VCGs were supposed to process peanut butter as a group, market and share the profits amongst themselves and also support CHBC. The VCGs were able to produce as a group in the first year of project implementation. Each VCG contribute 5kgs of shelled groundnuts to kick start the IGA. A total of 83Kgs were produced valued at 249USD. In order to continue producing as a group the VCGs were supposed to contribute again groundnuts so that they could raise more income to cover up operational costs and also buy groundnuts as a group. However this did not materialize because some of the VCGs no longer have groundnuts to contribute. The crop was affected by drought. Findings from the study indicated that all the volunteers who participated in the study produced peanut butter as individuals. However, the processing was not done for free but they had to pay for the service. This is how the IGA has managed to raise money for paying rent and electricity charges. The financial records of the group have shown that the money is just adequate to breakeven, thus they have never shared profits from the proceeds. Although during the time of the study they were planning to purchase groundnuts as a group, but it had not materialized. Most of the VCGs could not harvest their own groundnuts due to the drought that the area experienced this season.

5.4.2. Jatropha Soap making

Despite the group having a constitution that binds them to work together, but since the project was initiated they have never produced the soap as a group. The reasons given are that majority of the VCGs participating in the IGA does not have plantation of jatropha plants where they can get the raw material. Although neighbouring villages have abundant jatropha plants, but the VCGs do not have money to buy the seed. Only two VCGs have managed to produce a total of 59 bars and have used 46 for their own use and donated 13 bars to affected HHDs. In order to enable all the VCGs to participate in the Jatropha IGA, the VCGs have started establishing Jatropha cuttings and to date 10 volunteers have planted 254 plants of Jatropha.

5.5. Effect of the IGA on the livelihood capitals of the VCGs

The study explored the effect of IGAs on 5 livelihood capitals – social, human, health, natural and finance.

5.5.1. Social capital

- **Improved social status of the volunteers.**

The two machines that were given to the volunteers have made them to gain respect and recognition from the community and the leadership. CHBC work has been undervalued by the community and the volunteers had nothing tangible to show to the community as a benefit from CHBC work. One of the volunteers pointed out during FGD that since from the time they were given the machines people in the community have begun to value their work and some women are now interested to join.

- **Improved social networks**

Participation of the volunteers in IGAs has strengthened social ties amongst themselves and also with the community they are serving. The IGA has created an environment where the

VCGs share information on business related issues. In the past discussions were only focused on CHBC issues.

5.5.2. Human capital

The human capital of the VCGs was increased through enhancement of qualitative labour resources

- **Skills**

The study indicated that most of the VCGs acquired technical skill to operate and maintain the peanut butter pressing machine and planning skills that enabled them to accommodate important activities that need to be done. In addition most of the VCGs are now able to prioritize tasks and decide ahead of time. The volunteers develop duty roaster in order to accommodate all the activities that need to be done by individuals as shown in figure 5.4. One of the volunteers openly admitted that the IGA had made her to have first contact with an electric machine.

“Since I was born 51 years I have never used an electric machine. At first I was afraid even to go near the electricity plugs because I feared being electrified. Now I can operate the machine and also even teaching other how to use the machine.” (personal communication)

Business management was found to be an area of concern among the majority of VCGs as presented in figure 5.4. Reasons given were that the training sessions were done speedily and targeting only the management committee comprising of only 5 people. The trained people who were interviewed confessed that they did not acquire adequate knowledge to be in a position to train other VCGs and also HIV/AIDS affected HHDs. According to the project design, affected HHDs were also supposed to benefit from skills acquired by the VCGs. PLWHA interviewed indicated that they are not receiving training on business management from the volunteers but would like the VCGs to assist them in managing their IGAs which are supported by FACT. Figure 5.4 below shows skills and knowledge acquired by VCGs

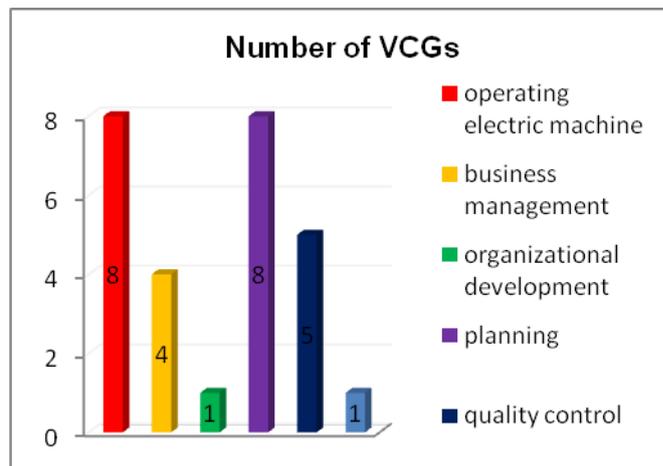


Figure 5.4: Competences acquired by the VCGs.

Figure 5.5 below shows an example of a duty roaster developed by the volunteers in order to accommodate IGAs in their CHBC work. The roaster consists of names and days each VCG is supposed to be operating the machine. The VCGs work in pairs and each pair is allocated 2 days per month to work on the machine. Progress review and planning for the next month is done once a month one week before the following month. The volunteer are able to plan their work in advance, hence avoiding labour conflicts.

Alvera Nthlanga	27/09/2010	01/10/2010	04/10/2010	07/10/2010
Agnes mbimbi	4/09/2010	03/09/2010	04/10/2010	07/10/2010
Maria Dzumwane				
Grace Mashenu				
Monica Sinyumare	6/09/2010	06/09/2010	06/10/2010	09/10/2010
Lelly Nyamhengura				
Loice Makombi	9/09/2010	09/09/2010	09/10/2010	09/10/2010
Clara Nyakapange				
Diane Sedze	8/09/2010	10/09/2010	11/10/2010	10/10/2010
Priso Chikungo				
Gladys Makombi	11/09/2010	09/09/2010	11/10/2010	12/10/2010
Febbie Kaduma				
Maria Chigwando	16/09/2010	15/09/2010	15/10/2010	15/10/2010
Maria Hondo				
Susan Gwagwa	19/09/2010	17/09/2010	19/10/2010	17/10/2010
Gyt Bure				
Samuel M...	21/09/2010	20/09/2010	20/10/2010	19/10/2010
Maria				
Abigail	23/09/2010	21/09/2010	22/10/2010	21/10/2010
Joyce				
Alu	25/09/2010	23/09/2010	25/10/2010	24/10/2010
	27/09/2010	25/09/2010	27/10/2010	26/10/2010
	30/09/2010	29/09/2010	29/10/2010	29/10/2010

Figure 5.5: Example of the duty roster developed by the VCGs

The picture below shows a 72 year old VCG operating the electric peanut butter pressing machine. She is the oldest in the group but she is amongst the 8 volunteers who indicated that they can operate the machine alone without assistance from other members. The VCGs received training in 2008 and since that time they have managed to operate and maintain the machine without external assistance.



Figure 5.6: VCG demonstrating how the peanut butter processing machine works.

- **Health**

Consumption of peanut butter is said to have contributed to the health of the volunteer's house hold members especially volunteers who are also PLWAs. From the total of 143.5 kgs of the peanut butter that was processed by individuals 99 kgs were consumed. Findings from the study indicated that some of the VCGs were not eating the peanut butter before participating in the peanut butter processing IGA because they could not afford to buy peanut

butter from the shops. With the machine the people can afford to process own groundnuts and pay for the fee for processing.

5.5.3. Natural capital

- **Increased area under groundnuts production**

Presence of the peanut butter in the area has made the volunteers and Sedze community members at large to increase their area for groundnuts production. Findings from the study showed that all the VCGs interviewed have increased area of groundnuts cultivation by more than 100% per VCG. The chief who participated in the study also indicated that he has observed the general increase in the area under groundnuts cultivation. One of the VCGs said that she used to grow just 1/8 of an acre but has increased to one acre. Findings from the study indicated that groundnuts did not replace other crops but the area under crop production was enlarged. Most households interviewed said they are not utilizing all their arable land due to lack of inputs.

“It’s unfortunate that this year we experienced drought I was expecting to harvest from one tonne from my one acre, but because of the long dry spell I only managed to harvest 0.2 tones” (personal communication)

5.5.4. Financial capitals

Only two VCGs were able to process and market their peanut butter. The money was used for paying school fees and also buying household assets which will be discussed in detail under physical capital. Table 5.3 gives a summary of the quantities and value of peanut butter processed by individual VCGs. However at the group level the VCGs have raised 249 USD and the money was used to cover operational costs that include rentals, electricity bills and repairs.

Table 5.4. Quantities and value of peanut butter processed

Item	Quantities (kgs)	Value (USD)
Sold	25.5	51
Consumed	99	198
Barter exchange	3	6
Donated	16	32
Total	143.5kgs	287

Apart from contributing to the health status of the HHDs, The VCGs also saved money.

5.5.5. Physical capital

Accumulation of the household assets was indicated by one VCG who bought kitchen utensils from income she got from selling peanut butter. The VCG processed 10kgs of peanut butter from groundnuts she produced from her field. At community level the peanut butter processing machine and jatropha soap making machine have added to the economic productive assets for the cluster. It is important to note that peanut butter processing machine is serving the community through provision of affordable quality service. Due to lack of capital to buy groundnuts, the business is surviving through processing peanut butter for community members.

5.6. Capital/ asset status for the VCGs

Asset status of the VCGs are summarized using Carney (1998), cited by Frank Ellis, schematic approach to compare assets. The pentagon has been used to describe the assets asset levels and it's according to the perception of the VCGs. The VCGs ranked the contribution of the IGA to their asset level. The ranking exercise was done in small groups during the FGD. The outer perimeter of the pentagon represents the maximum level and the center of the pentagon represents zero. Therefore the capitals status plotted in figure 2.6 represents the general overview of the findings on the contribution of IGAs to the HHD assets of the VCGs,

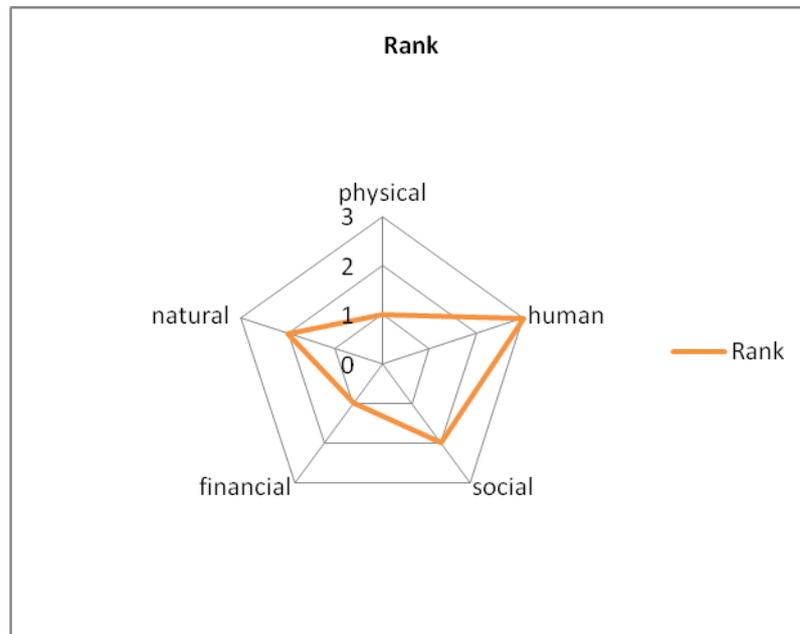


Figure 5.7. Capital status plotted on a pentagon (Source: Adapted from D Carney cited by Frank Ellis 2000)

The asset pentagon indicated the strong and the weak capitals, hence enabling identification of the contribution of the IGAs. Findings from the study show that the IGAs contributed significantly to human and social capital as compared to financial and physical despite the project objectives of increasing income and household assets for the VCGs.

Chapter Six: Discussion

6.1. Contribution of IGAs to the livelihood of the VCGs

As indicated earlier in chapter 5, significant change was indicated in the social and human capitals. However the other three capitals (physical, natural and finance) are equally important for the VCGs to sustain the income generating activities. At the household level the IGAs have contributed to the nutrition through consumption of peanut butter. Analysis of the data confirmed that all the VCGs who participated in the study consumed peanut butter that they processed and they have also increased the area under groundnuts production. Skills training enabled the VCGs to take advantage of economic opportunities as pointed out by Rakodi (1999). At the group level, enhancement of technical, planning and business management skills enabled the VCGs to provide service of processing peanut butter to community after failing to mobilize the groundnuts as a group. This has enabled them to raise money for paying rent, electricity and machine maintenance costs. Social networks of the VCGs have also been improved through integration with community when doing business with them. Discussion with the community members revealed that the community appreciates the service provided by the VCG. The project is benefiting the community through provision of a high quality service that is affordable. The VCGs are no longer identified only with PLWHAs but also as business people thereby raising their social status in the community.

6.2. Contribution of IGAs to CHBC service delivery

Findings from the research indicate that IGAs contribute to CHBC service delivery through building the social capital of the VCGs. In fact the IGAs facilitated the service delivery through boosting morale of the VCG. The IGAs were taken as recognition for their unwavering commitment, hence gave them the energy to continue volunteering. In addition the VCGs were able to donate peanut butter and jatropha soap to clients. Peanut butter is amongst the recommended foods for PLWHA and in the past FACT was providing the peanut butter. From the little that the VCGs managed to get from the IGAs they were able to share with affected families. My opinion is that if volunteers are well supported with IGAs this will result in self-managing CHBC. There is a guarantee that volunteers will continue supporting the CHBC because presently they are sacrificing even their own resources.

6.3. Results on the ground versus the project indicators

Analysis of the data indicates that the expected project indicators were not achieved. This was also supported by findings of a marketing and trade analysis for the ward conducted in December 2009 by SAFIRE staff whereby peanut butter processing and Jatropha soap making were ranked lowest in terms of realizable incomes. The community is aware of the IGAs run by VCGs but they were listed under potential major income sources for the ward. Table 6.1. Presents the changes identified by the study versus the project indicators

Table 6.1: Project Results

Output 1	Project Indicator	Impact / change / result
Vulnerable Households (VCGs) develop and sustain income generating initiatives	1. Increased Income (volume)	The project expected the VCGs to increase income levels through selling peanut butter and jatropha. As a group the VCGs have managed to raise money to breakeven. Only a few individuals (5 volunteers) have indicated selling peanut butter and the money was used for buying kitchen utensils and the other one paid school fees for her child. Majority of the VCG consumed instead of selling
	2. Increased number of viable income generating activities	VCGs did not come up with other IGA since they had not realized income from the initiated 2 IGAs. The idea was for the volunteers to initiate other IGAs using proceeds from the initial two IGAs supported by the project
	3. Increased accumulation of household assets	Purchase of kitchen utensils reported by one volunteer contributed to increased household assets-. According to the care giver it was achievement because she did not have good plates to use for visitors and also contributing towards community functions.

Apart from the results against stated project indicators, the study has revealed other results brought about by the IGAs.

- Skills enhancement- As reported earlier the female VCGs are now able to operate electric machine that they in the past regarded as a responsibility of males. Majority of the volunteers was their first experience with an electric machine. The technical skills gained and increased time for productive work enable the VCGs to take advantage of any other economic opportunities
- Improved social status – ownership of the machine by the VCGs has made the community to recognize the VCGs and giving them respect. Before the IGAs the volunteering was undervalued because there was nothing tangible that the volunteers could show the community as the reward for the work they doing
- Build self-esteem among the volunteers – VCGs have the feeling that their work is being appreciated and take the IGA as a reward for their unwavering commitment. Fact officer who work directly with the volunteers in the CHBC work has also noticed that the IGA increased the morale of the volunteers. FACT has managed to link up with other donors who are willing to support the VCGs with IGAs
- Improved planning skills – The VCGs are able to accommodate HBC, household tasks and the IGA activities. Contributed to improved household nutrition.
- Economic empowerment of women – As reported earlier all but only one are women. The volunteers indicated that they are economically empowered by having access and control

over a productive asset. They appreciate being able to make own choices and decisions with regards to the use of the peanut butter and jatropha soap making machine.

- Access to peanut butter processing machine by HIV/AIDS affected household- ownership of the machine by the VCGs' is making it easier for the PLWAs to process their groundnuts. However the study could not quantify processed peanut butter by affected households.
- Material support to affected HHDs by VCGs -Majority were able to share peanut butter with patients. In the past patients used to get peanut butter from FACT but it was stopped due to financial constraints. According to FACT project staff, donor have moved from supporting PLWA with food baskets but supports sustainable food security programmes like supporting agriculture production. In addition the two VCGs donated soap to some PLWHA.
- Change of attitude - Involvement in IGAs has transformed the way of thinking of some of the VCGs from anticipating an allowance to self-sustenance. This was also picked out during individual interviews with the volunteers. Majority of the volunteers indicated that they would like NGOs and the government to support them with IGAs. Others NGOs supporting CHBC like Action Aid have also taken up the initiative of supporting volunteers with IGAs instead of giving them money as reported by the FACT officer responsible for the CHBC programme.

6.4. Gaps in project design and implementation

The study identified two gaps in the project design and implementation. Firstly the project did not consider different needs by different VCGs households in the identification process of the IGAs. The project used a blanket approach. For example jatropha soap making was taken for granted that those without jatropha trees will contribute money to buy seeds from surrounding villages with abundant jatropha trees. This assumption did not materialize as evidenced by only the two volunteers who have jatropha plants being involved in the soap making. On the other hand most of the volunteers benefited from peanut butter processing because all were supported with groundnut seed by the main project. The second point is the failure by the project to provide adequate assistance on microfinance mechanisms to enable the VCGs to procure raw materials. The low production has been attributed to lack of capital to purchase raw materials. Failure by organizations to adequately support IGAs in the initial stages has been observed in other studies such as the case of Bekezela HBC in Bulawayo and FACT-Chiredzi HBC both in Zimbabwe whereby most of the IGAs initiated have stopped due to unavailability of raw materials (SAfaids and HND, 2007).

Chapter Seven: Conclusion and Recommendations

7.1. Conclusion

Findings from the study confirmed that the IGA had more impact on the livelihood on the livelihood of the volunteers as compared to CHBC service delivery. Through proper planning the VCGs were able to accommodate and manage both CHBC work and the IGA. The project had an impact on all the 5 livelihood capitals although more significant change was found to be more on the human and social capitals. Participation of the VCGs in IGA strengthened their social networks and also improved their social status in the community. Ownership of the machines made them to gain respect and recognition from the community. The human capital was increased through enhancement of technical and planning skills. This has enabled the VCGs to managed use and maintenance of the peanut butter processing machine since they obtained it in 2008. The IGA contributed to the health status of the VCGs through consumption of the processed peanut butter by individual VCGs.

The VCGs faced a number of challenges that contributed to failure of the project to achieve the expected results of increased level of income, increased household assets and increased number of viable income generating activities. The main challenge indicated was said lack of capital to buy raw materials, both groundnuts and Jatropha seeds. This is negatively affecting production hence failing to make profit as all the money raised from processing other people's groundnuts is just enough to cover rental and electricity bills and machine maintenance costs. With the low production the group is faced with high operational costs which if not urgently addressed may lead to the collapse of the business. Level of commitment to the IGAs is gradually going down as indicated by the VCGs during interviews. Because the VCGs expected to have processed and marketed enough to make profits but this has not yet materialized. The VCGs are also faced with the prevailing risky agriculture climate. The area has been hit by early and mid-season long dry spells in the past three agriculture seasons (2007- 2010) This has affected groundnuts production by individuals hence contributing to insufficient raw materials for peanut butter processing and marketing business. In addition, also failure by the VCGs to produce other crops affects total income level, thus failing to raise money to contribute towards purchase groundnuts and Jatropha seeds.

Despite all these challenges the IGAs has great potential to improve the income levels and household assets of the VCGs as shown by the innovativeness of the VCGs. Instead of just focusing on producing the peanut butter as group they offered a service to the community with a cost to enable them to cover operational costs. In addition, the contribution of the IGA to the livelihood capitals of the VCGs has empowered them hence have shifted from anticipating an allowance to self-sustenance.

7.3. Recommendations

The study offers new dimensions in the roles of VCGs. Findings from the study indicated that the VCGs have inadequate knowledge about ART. PLWHA said that they are getting information from health centre which is 18km away. On the basis of the findings from the research, ART makes that PLWHA have other needs that cannot be taken care of by the volunteers since they do not have the competencies as indicated by Mohammed and Gikonyo, (2005) that VCGs are not properly trained to monitor adherence to ARVs by PLWHAs.

Therefore there is urgent need to enhance the competences of VCGs in ART. SAFIRE need to advise MOHCW and NGOs supporting CHBC to look into the feasibility of training current VCGs in ART covering topics on adherence to medication, side effects and advantages and

disadvantages of poor adherence and how they can adapt the training contents to match the different literacy levels of the VCGs.

Findings from the study indicated that the majority of the income sources of the VCGs are from farming activities and with the prevailing risky agricultural climate, the VCGs may not benefit much from the current IGAs that depends on agriculture production. I would recommend SAFIRE exploring potential off farm and nonfarm activities as a way of diversifying the income sources. There is need for innovations and think outside agro based income generating activities. However there is need to undertake comprehensive feasibility studies before implementation. The challenges as observed by Ellis, 2000 are to use the limited resources in supporting agriculture related IGAs or support other non-agriculture IGAs.

The research findings have shown that although the VCGs were not able to contribute groundnuts to the group but all who participated in the study managed to process peanut butter at individual level. The explanation given by the VCG was that they are more interested in projects that have direct benefit unlike whereby they have to wait to share profits. I would recommend SAFIRE to consider in the future programmes having IGAs which can directly benefit individual households. With the different needs of individual households group projects may not benefit all the targeted households. The IGAs should have activities that maintain groups and at the same time assisting VCGs at individual household levels.

Findings from the study revealed that participation of VCGs in IGAs depended on asset base of the household. Therefore in order for all the VCGs to benefit from the IGAs there is need for SAFIRE to consider a targeted approach that is based on the vulnerability of households. This involves vulnerability analysis which includes risks faced by the different VCGs and the coping strategies being employed by the households. In addition the IGAs project should also consider less labor demanding IGAs in order to reduce workload of widowed VCGs who indicated that they have labor constraints.

Insufficient knowledge with regards to financing mechanisms was the major factor contributing to the low performance of the IGAs. This was identified as a gap area even though the activity was included in the project implementation strategy. Initial assistance given to the IGAs required the VCGs to contribute raw materials in order for the IGAs to be viable but with the poor groundnuts production the VCGs are in need of cash to buy the groundnuts from other areas. There is urgent need for SAFIRE to explore feasible financing mechanisms like micro finance to support the VCGs.

Although the study attempted to explore contribution of VCG household members to CHBC in reducing the work load of the VCGs, but further research can be done in this area. This will assist in the feasibility assessment of IGAs and in targeting VCGs for specific intervention.

References

- Akintola, O., 2010. Perception of rewards among volunteer caregivers of people living AIDS working in Faith Based Organizations in South Africa, *Journal of the international Aids society*, 13: 22
- Akintola, O., 2008a. Communities Responses to HIV/AIDS: The role of volunteers in HBC for people living with HIV/AIDS in South Africa
- Akintola, O., and 2008b. Towards Equal Sharing of AIDS caring responsibilities: learning from Africa, paper prepared for the United Nations Division for the Advancement of Women 'expert meeting' 6-9 October, 2008
- Akintola, O., 2006. Gendered Home-Based Care in South Africa: More trouble for the troubled, *African Journal of AIDS Research*, 5(3), p. 237-247
- Akintola, O., 2004. The gendered burden of home based care giving, HEARD
- Burns D. J., et al 2006. Motivation to volunteer: the role of altruism, *International Review on* `1234 Public and Non Profit Marketing (3), p 79-91
- Chambers, R and Conway, R.G., 1992. Sustainable rural livelihoods practical concepts for the 21st century. *IDS discussion paper, 296, Brighton.*
- Davis. B., et al, 2007. Rural Income generating activities: A cross country comparison, *Background paper for the world Development Report 2008.*
- DFID, 1999. Sustainable livelihoods guidelines, Department for International Development Available at www.eldis.org [accessed 2 July 2010].
- DFID, 2000. Sustainable livelihoods Guidance sheets Department for International Development.
- DFID, 2007. Livelihood Approaches in a nutshell: Module 2, Department for International Development.
- Ellis, J. S., 2007 and Campbell, K. H., *By the People a History of Americans as volunteers*
- Ellis, F., 2000. *Rural livelihoods and Diversity in Developing Countries*, Oxford university Press.
- Ellis, F., 1998. Household strategies and rural livelihood, *Journal of Development Studies*, 35 (1), 1-38
- IMF, 2008. World Economic and Financial surveys, International Monetary Fund, *Regional economic outlook, Sub Saharan Africa*
- Khogali, H., 2003. HIV/AIDS home based care in Zimbabwe, International Federation of The Red Cross and Red Crescent, 19, Available at: http://www.ifrc.org/cgi/pdf_pubs.pl?health/hivaids/hbc.pdf - 1k [Accessed 4/01/2010]
- Kiyange, F., 2007. Palliative Care in Africa, Making it real, 2nd African Palliative Care Association Regional Palliative Care Conference, Kenya 19th -21st September 2007

Mahommed, N and Gikonyo, J. Operational Challenges: Community Home Based Care(CHBC) for PLWHA in multi- country HIV/AIDS Programs(MAP) for Sub Saharan African Region, *Working Paper series No. 88*

Malcon A, and Caren P, 2000. Care in the home: Public responsibilities – Private roles, *Paper prepared for the dialogue on health reform.*

MOHCW, 2004. Ministry of Health and Child Welfare, Zimbabwe National community Home –Based care standards

Müller T, 2005. *HIV/AIDS and Human Development in sub-Saharan Africa: Impact Mitigation through Agricultural Interventions, An Overview and Annotated Bibliography.* African Women Leaders in Agriculture and the Environment (AWLAE) series No.3, Wageningen Academic Publishers.

Ncama, B, P., 2005. Models of community home based care for people living with HIV/AIDS in Southern Africa, *Science Direct*, 16(3), p. 33-40, Elsevier

Nsutebu, E.F. et al., Scaling- up HIV/AIDS and TB Home Based Care: lessons from Zambia, *Health Policy Planning*, 16 (3): 240-247

Ogden. J. et al. 2004. Expanding the continuum for HIV/AIDS: Bringing carers into focus, International centre for research for women.

Ogden. J. et al., 2006. Expanding the care continuum for care HIV/AIDS: bringing carers into focus, *Oxford university press in association with the London School of hygiene and tropical medicine* p 333-341

Rakodi, 1999. A capital assets framework for analyzing household livelihood, *Development Policy Review*, 17 (3) p. 315-338

RAPIDS, 2010. Reaching HIV/AIDS Affected People with Integrated Development and Support, RAPIDS evaluation Final Report 2005-2009 Key Findings.

Roche, C., 1999. Impact assessment for development agencies: Learning to value change, Oxfarm development guidelines

SAFAIDS and HDN, 2007. The Southern Africa HIV/AIDS information dissemination service and Health and development networks, Looking back, Mapping forward: Research Findings on Home Based Care in Zimbabwe,

SAFAIDS and HND 2008. The Southern Africa HIV/AIDS information dissemination service and Health and development networks, Caring from within: Key findings and policy recommendations on home based care.

SAFIRE, 2009. Southern Alliance for Indigenous Resources, HIV/AIDS and Livelihood project: End of project report.

SAFIRE, 2007a. Southern Alliance for Indigenous Resources , Chitsanza ward livelihood assessment report.

SAFIRE, 2007b. Southern Alliance for Indigenous Resources ,Nyanga district profile.

SAFIRE and FACT, 2006a. Minutes of the project design, Southern Alliance for Indigenous Resources and Family Aids Caring Trust

SAFIRE and FACT, 2006b. Southern Alliance for Indigenous Resources and Family Aids Caring Trust, Project Implementation Plan-2006-2009

SAFIRE, &FACT, 2006c. Project proposal, Southern Alliance for Indigenous Resources and Family Aids Caring Trust

SAFIRE, CHF &FACT, 2006d. Partnership paper between SAFIRE and FACT, Southern Alliance for Indigenous Resources and Family Aids Caring Trust

SAFIRE, 2003. Southern Alliance for indigenous resources, Participatory Natural Resources Management- PRA handbook,

Scoones, I. Rural Sustainable Livelihoods: A framework for analysis, *Institute of development studies Working Paper 72*

Seidel J.V. 1998, Qualitative data analysis Available at <ftp://ftp.qualisresearch.com/pub/qda.pdf> [accessed 28/06/2010]

UNAIDS, 2009. United Nations on HIV/AIDS programmes, Support women caregivers fight AIDS: The global Coalition on women and AIDS (Issue 5), HIV/AIDS in Southern Africa, *Science Direct*, 16(3), p. 33-40, Elsevier.

Varkevisser. C.M. et al., 2003. Designing and conducting health systems research projects – Data analysis and report writing, International Development Research.

WHO, 2001. World health organization, Community Home Based Care: caring for Family Members with HIV/AIDS and other chronic diseases, Action Research in Kenya.

WHO, 2001. World Health Organization, Community Home Based Care Programme, Action Research.

Walonick, D., 1993. StatPac Gold IV: Marketing Research and Survey Edition. Available at: <http://www.statpac.com/research-papers/research-process.htm>. [accessed 10 July 2010]

ZNASP, 2006. Zimbabwe National HIV/AIDS strategic plan :2006-2010

Appendixes

Appendix 1: Check list for project staff (SAFIRE and FACT)

Sub question	Dimensions and	Check list
What are the characteristics of the project?	Project description	Goals, objectives, results
	Rational	Why did the project include CHBC volunteers in the IGA?
	Roles	Role of SAFIRE in the project Role of FACT in the project Role of volunteers in the project
	Section criterion of CHBC volunteers	What were the criteria used for selecting the volunteers? Who was involved in the selection process?
	Expected impact	What did FACT expects from the CHBC volunteers with regards to CHBC programme? What did SAFIRE expects from the care givers with regards to IGAs? Can this be the best way / method to assist CHBC volunteers in situations with limited financial support resources? What changes has been brought by the project on the Livelihood of the CHBC volunteers What changes has been brought by the project on CHBC service delivery?

Appendix 2: Check list for CHBC volunteers

Sub question	Dimensions	Check lists
<p>Volunteership</p> <ul style="list-style-type: none"> ▪ What are the characteristics of the volunteers? 	Reward (non material, material expense reimbursement under characteristics?	<ul style="list-style-type: none"> ▪ What do the CHBC volunteers expect from the CHBC programme? ▪ What motivates the volunteers to do their work?
	Characteristics (Age, Sex Social status, Household size)	<ul style="list-style-type: none"> ▪ Description of the Home based care volunteers (age , sex, social status, household size
	Free will (social obligation)	<ul style="list-style-type: none"> ▪ What drives the CHBC volunteers to do their work?
	Beneficiaries Society Immediate family Neighbours friends Stranger	<ul style="list-style-type: none"> ▪ Beneficiaries assisted by CHBC volunteers before and after the IGAs
	Organizational (formally not for profit)	<ul style="list-style-type: none"> ▪ How are the volunteer organized
<p>How has the IGAs changed the livelihood of the CHBC volunteers</p> <p>Is everything you mentioned in the earlier section on livelihood and under the definition, included as dimension and topic in check list???</p>	Financial (Cash at hand, Cash in kind, Access to loan, Liquid assets – livestock)	<ul style="list-style-type: none"> ▪ Sources of income before IGAs (peanut butter processing, soap making and processing of vegetables) ▪ Income raised from before and after IGAs ▪ Forms of barter exchange before and after IGAs ▪ Loans secured (type and amounts) before and after IGAs
	Producer goods – tools and equipment)	<ul style="list-style-type: none"> ▪ Use of income –(Asset accumulation) before and after IGAs
	Social (Social networks Social relations Associations Affiliations	<ul style="list-style-type: none"> ▪ Association formed before and after IGAs ▪ Affiliations before and after IGAs
	Human (skills, Labour availability	<ul style="list-style-type: none"> ▪ Business competences acquired ▪ Labour requirements for (IGAs and CHBC tasks) ▪ Training received before and after IGAs ▪ Required competences to run the IGAs

<p>What kind of services has been provided by the volunteers?</p> <ul style="list-style-type: none"> ▪ What changes have occurred in CHBC service delivery to HIV/AIDS afflicted households since the involvement of volunteers in IGAs? ▪ How have the IGAs affected (hindered/ facilitated) CHBC volunteers work? ▪ What is the perception of CHBC volunteers towards IGA? 	<ul style="list-style-type: none"> ▪ Medical and nursing tasks (Visit sick, monitor medication and refer sick person to clinics and hospitals) ▪ Psychosocial support (Spiritual, Emotional) ▪ Educational training tasks (Provide information on HIV/AIDS and general health awareness raising, Demonstrate feeding and cleaning sick people) ▪ Welfare tasks (household chores, assist in cleaning and feeding sick people) 	<ul style="list-style-type: none"> ▪ Frequency of visits before and after IGAs ▪ Time spent for CHBC activities before and after IGAs ▪ Time spent with client before and after IGAs ▪ Tasks done during visits before and after ▪ Number of people being visited before and after IGAs ▪ Number of household and community training before and after IGAs

Appendix 3: Checklist for community key informants

Sub question	Dimensions and	Check lists
<p>What kind of services is provided by the volunteers?</p> <p>What changes has occurred in CHBC service Delivery since the involvement of care givers in IGAs?</p> <p>How have the IGAs affected (hindered/ facilitated) CHBC volunteers work?</p> <p>What is the perception of the community leaders towards involvement of volunteers in IGA?</p>	<p>Medical and nursing tasks (Visit sick, monitor medication and refer sick person to clinics and hospitals)</p> <p>Educational training tasks (Provide information on HIV/AIDS and general health awareness raising)</p> <p>Welfare tasks (household chores, assist in cleaning and feeding sick people)</p> <p>Psychosocial support (Spiritual, Emotional)</p>	<p>Basing on community leader observations:</p> <p>How has been the performance of the care givers?</p> <ul style="list-style-type: none"> • Frequency of visits before and after IGAs • Time spent for CHBC activities before and after IGAs • Time spent with client before and after IGAs • Number of people being visited before and after IGAs • Community training before and after IGAs

Appendix 4: Check list for PLWHA

Sub question	Dimensions and operational definitions	Check lists
<ul style="list-style-type: none"> ▪ What kind of services has been provided by the volunteers? ▪ What changes has occurred in CHBC service Delivery since the involvement of care givers in IGAs? ▪ How have the IGAs affected (hindered/ facilitated) CHBC volunteers work? ▪ What is the perception of the, PLWHA towards involvement of volunteers in IGA? 	<p style="text-align: center;">CHBC volunteers tasks</p> <ul style="list-style-type: none"> ▪ Medical and nursing tasks (Visit sick, monitor medication and refer sick person to clinics and hospitals) ▪ Psychosocial support (Spiritual, Emotional, counseling) ▪ Educational training tasks (Provide information on HIV/AIDS and general health awareness raising) ▪ Welfare tasks (household chores, assist in cleaning and feeding sick people, provision of food) 	<p style="text-align: center;">How has been the performance of the CHBC volunteers?</p> <ul style="list-style-type: none"> • Frequency of visits before and after IGAs • Time spent for per visit before and after IGAs • Training received before and after IGAs • Type of assistance(welfare tasks) before and after IGAs • Counseling sessions before and after IGAs

Appendix 5: Check list for Focus Group discussions

- a. Role of the care givers
- b. Contribution of IGAs to livelihoods of CHBC VCGs
- c. How have the IGAs affected (hindered/ facilitated) CHBCVCGs work?
- d. How can the IGAs be sustained

Appendix 6: Project Logical Framework Matrix

Project Title:	HIV/AIDS and Livelihoods Project		
Country/Region	Zimbabwe, Southern Africa		
Partner Organizations	CHF, SAFIRE, FACT		
Planned Duration:	3 years		
NARRATIVE SUMMARY	EXPECTED RESULTS	PERFORMANCE MEASUREMENTS	ASSUMPTIONS
<p>Project Goal:</p> <p>Improve the livelihood strategies and quality of life of the most vulnerable households in HIV/AIDS affected rural communities in Zimbabwe</p>	<p>Long-Term Effect/Impact:</p> <p>Improved livelihood capacity of the most vulnerable households in HIV/AIDS affected rural communities in Zimbabwe</p>	<ol style="list-style-type: none"> 1. Improve life expectancy of the most vulnerable 2. Reduced HIV/AIDS infection rates 3. Improved capacity of the most vulnerable households in HIV/AIDS affected rural communities in Zimbabwe to sustain their livelihood systems 	
<p>Project Purpose:</p> <p>To improve resilience and capacity of households and communities to fend for themselves through sustainable livelihoods support and HIV/AIDS mitigation (prevention, care and support)</p>	<p>Outcome:</p> <p>Households and communities with improved resilience and capacity to fend for themselves through sustainable livelihoods support and HIV/AIDS mitigation</p>	<ol style="list-style-type: none"> 1. Minimize periods of food deficit 2. Improved health 3. Reduced HIV prevalence rates 4. Improved exploitation of opportunities 	<ol style="list-style-type: none"> 1. Positive funding policies in donor organizations 2. Government ministries continue to support HIV/AIDS and livelihoods interventions
<p>Activity #1:</p> <p>Building the capacity of caregivers to develop and sustain income generating</p>	<p>Output #1:</p> <p>Vulnerable Households develop and</p>	<p>Performance Indicators:</p> <ol style="list-style-type: none"> 1. Increased Income 	<p>Assumptions:</p> <ol style="list-style-type: none"> 1. Increased income will translate into positive and

<p>initiatives</p> <ul style="list-style-type: none"> • Identification and feasibility studies of IGAs • Business modelling and setting up of structures • Capacity building in organizational and business management skills • Business development, implementation and monitoring • Facilitate business linkages between IGAs and markets and financiers 	<p>sustain income generating initiatives</p>	<p>(volume)</p> <p>2. Increased # of viable IG activities</p> <p>3. Increased accumulation of household assets</p>	<p>meaningful change for the most vulnerable households</p> <p>2. The economic environment stabilizes and improves</p>
<p><u>Activity #2:</u></p> <ol style="list-style-type: none"> 1. Promote diversification of food sources (short, mid and long term) 2. Promote production and use of natural products that provide nutrition for the most vulnerable in an environmentally sustainable manner 3. Promote the adoption of value added technologies at community level 4. Social protection and Food Aid 	<p><u>Output #2:</u></p> <p>Improved nutrition and food security of the most vulnerable households</p>	<p><u>Performance Indicators:</u></p> <ol style="list-style-type: none"> 1. Diversity of food 2. Decrease incidences of nutrition related diseases 3. Improved height/weight/age ratios 4. Surplus of food 	<p><u>Assumptions:</u></p> <ol style="list-style-type: none"> 1. Favourable weather conditions prevail 2. No major natural disasters affect communities

<p>Activity #3:</p> <ol style="list-style-type: none"> 1. Establish and/or strengthen community based care and support systems 2. Develop and promote models for effective behavioural change 3. Facilitate the development and implementation of community level development plans that integrate HIV/AIDS mitigation strategies 4. Support for volunteer caregivers for income generating activities 	<p>Output #3:</p> <p>Community is better able to mitigate the impacts of HIV/AIDS for the most vulnerable households</p>	<p><u>Performance Indicators:</u></p> <p>Everyone has 2100kcl/day</p> <p>Composition of diet (quantity and quality)</p> <p>School dropout rates decreased in vulnerable households</p> <p>Increased food purchases</p> <p>Reduced opportunistic infections</p> <p>Spread of initiatives (empowerment)</p>	<p><u>Assumptions:</u></p> <ol style="list-style-type: none"> 1. Increase in food purchases signifies an increase in capacity of household
<p>Activity #4:</p> <ol style="list-style-type: none"> 1. Strengthen local level rules and regulations that enhance livelihoods with special focus on most vulnerable 2. Lobby for appropriate policy change and implementation 3. Establish networks between key stakeholders and facilitate processes which integrates efforts towards HIV/AIDS mitigating strategies 4. Capacity building and Training for Transformation 	<p>Output #4:</p> <p>Local level institutions improve support for community based HIV/AIDS mitigation initiatives</p>	<p><u>Performance Indicators:</u></p> <p>HBC volunteers active/effective</p> <p>Appropriate active community initiatives effectively functioning</p> <p>Institutional issues hindering identified and acted upon</p>	<p><u>Assumptions:</u></p> <ol style="list-style-type: none"> 1. MOH&CW continues to support rural health centers and the HBC program 2. Minister of Education continues to support peer education HIV/AIDS in the school curriculum 3. Minister of Agriculture and Environment continues to support home based initiatives 4. The WAACs and VAACs and DAACs continue to support HIV/AIDS programs

<p>Activity #5:</p> <p>Technical coordination, preparation study, planning and reviews conducted.</p> <p>Administering, monitoring and reporting on the project.</p>	<p>Output #5:</p> <p>Participatory Results oriented planning and reporting operationalized and delivering data for CHF's monitoring and reporting to CIDA.</p>	<p><u>Performance Indicators:</u></p> <p>Plans and reports submitted and approved by CIDA.</p>	<p><u>Assumptions:</u></p> <p>Pre-Conditions</p> <p>1. Political stability will return to Zimbabwe.</p>
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Source: Adopted from SAFIRE & FACT project proposal document (SAFIRE& FACT, 2006c

Appendix 7: Map showing demarcations of Nyanga wards



Appendix 8: Time line analysis

Timelines

1996

CHBC introduced Many people joined received training in CHBC. 40% of the volunteers who anticipating rewards dropped after the training when they realizing that there was no remuneration. Majority of PLWHA were bed ridden. PLWA and OVCs being supported with food,

2006

Promotion of behavior change programmes
VCGs encouraging people to get tested
Mobile Voluntary Counseling and Testing services
People dying due to inaccessibility to medication

2007

Many people dying due to inaccessibility of medication
High inflation

Shortage of basic commodities
Poor crop production due to lack on inputs and inadequate rainfall

2008

Promotion of IGAs targeting VCGs by SAFIRE
Poor crop production due to lack on inputs and inadequate rainfall
Improved access to ARV
People getting tested and having access to medication (ART)

2009- To date

Majority of PLWHA are mobile patients
Household members can do much of household activities
VCGs spending less time with the PLWHAs
NGOs supporting PLWHA and OVC with income generating activities
VCGS monitoring the PLWHA and OVCs IGAs projects
PLWHA forming support groups

Appendix 9: Household size of the VCGs.

VCG HHDs	HHD size	Male				females			
		0-5	6-18yrs	18-40	40+	0-5	6-18yrs	19-40	40+
1	7	2	1	0	0	0	1	1	2
2	5	2	1	1	0	0	0	1	1
3	3	0	0	0	0	1	1	0	1
4	4	0	0	1	0	0	1	1	1
5	6	0	1	4	0	0	0	0	1
6	4	0	1	0	0	0	2	0	1
7	4	0	0	1	1	0	1	1	0
8	5	1	0	0	1	1	1	0	1
9	7	0	1	1	1	0	1	2	1
10	3	0	1	0	1	0	0	0	1
11	7	1	3	1	0	0	1	1	0
12	5	0	0	2		1	0	1	1
13	6	0	3	0	1	0	1	0	1
14	4	0	1	0	1	0	2	0	1
15	7	2	2	1	1	0	0	0	1

Used numbers for the households instead of real names have been used for anonymity reasons