

THE SOCIO-ECONOMIC CHALLENGES OF HIV AND AIDS ON WIDOWED  
WOMEN IN RURAL COMMUNITIES OF ZIMBABWE: A CASE OF  
MUKADZIWASHE VILLAGE IN GUTU CENTRAL DISTRICT.

By

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## DECLARATION

I declare that: **The socio-economic challenges of HIV and AIDS on widowed women in rural communities of Zimbabwe: A case of Mukadziwashe village in Gutu Central District**, is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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Beatha Mushangwe

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Date



## SUMMARY

### **The socio-economic challenges of HIV and AIDS on widowed women in rural communities of Zimbabwe: A case of Mukadziwashe village in Gutu Central District**

The study into the socio-economic challenges of HIV and AIDS on widowed women in rural communities of Zimbabwe was carried out in the village of Mukadziwashe. The main aim of the study was to find out the socio-economic challenges that are faced by HIV and AIDS widows. Of particular concern has been role played change agent since the dawn of the HIV and AIDS pandemic and its devastating socio-economic impact on families, especially widows.

The findings of this study are based on a sample of limited number (12) widows based in the village of Mukadziwashe in Gutu Central District, as well interviews of key informants who happen to be representatives of change agents in the main. In-depth interviews were the tool used to collect information from the research participants identified above.

The findings of the study revealed that widows still suffer from the serious social and economic challenges posed by HIV and AIDS such as cultural oppressions and prevention of women from inheriting their late husbands' wealth. The continued denial of women of their constitutionally enshrined rights is difficult to understand, because many studies have been conducted on this subject. It is reasonable to expect noticeable progress in promoting the rights of women, especially widows.

What is apparent in this sad story is the mute role of change agents, be they government, non-governmental or community based, in affirming widows' rights. Based on these observations, the study strongly recommends the design, implementation and constant monitoring of intervention programmes aimed at women empowerment in general.

**KEYWORDS:** socio-economic, HIV and AIDS, widowed, challenges, rural communities

# CHAPTER 1: INTRODUCTION AND BACKGROUND OF THE STUDY

## 1.1. Introduction

The title of the thesis is “the socio-economic challenges of HIV and AIDS on widowed women in rural communities of Zimbabwe: A case study of Mukadziwashe village in Gutu Central District”.

The location of the research study is a small rural village of Mukadziwashe which is the closest village to the growth point of Gutu. It has been noted in previous studies that there is high prevalence of HIV and AIDS in such communal lands (WHO, 2005). The high prevalence of HIV may suggest high numbers of orphans, widows and widowers as a direct result of HIV and AIDS-related deaths.

In most rural settings women face severe socio-economic challenges such as cultural oppression, poverty including the lack of control over their household financial resources, poor education and limited access to health services including sexual reproductive health. The onslaught of HIV and AIDS is most likely to exacerbate this already dire situation, especially where death of the husband or partner occurs.

Women have always been a marginalized group and once they become widowed the situation becomes worse through discrimination, limited or no access to resources among other things.

## 1.2. Problem statement

As Bird & Shepherd (2003) point out women in Zimbabwe do not traditionally inherit land or property. They generally access land for agricultural production through their fathers or husbands. If a woman is widowed, and she does not have an adult son who is in line of inheritance, she is in danger of losing land (and other assets) to her husband's family, and being forced to return to her father's house. The death of the male head of household has a significant impact on the household. It can reduce

crucial labour inputs making diversification impossible and shifting dependency ratios. It can also result in widows losing access to land and other assets.

Fleshman (2010) points out that in some Southern African countries adult women are still legally minors, and thus unable to own or inherit land and other property. This is a major contributory factor to the impoverishment of widows and orphans affected by HIV and AIDS, and underscore the urgent need for legislative reform and enforcement of women's legal rights. It can be argued that the injustices that are happening mainly in traditional societies and lack or limited access to relevant information exposes women to many risks and worsens the impacts of HIV and AIDS.

Anecdotal evidence suggests that most widows find it difficult to find their feet after the passing away of the husbands because they are not allowed to access the deceased financial benefits. In other cases some lack the general knowledge on how to access their inheritances. Women are denied access to the wealth of their husbands or partners which gets to be controlled by the deceased husband's relatives, mostly men.

Niehof, Rugalema & Gillespie (2010:74) point out that the problems associated with HIV and AIDS in Zimbabwe have been exacerbated by other challenges ranging from economic meltdown, high unemployment rates, poverty as a result of repeated droughts and political instability. Niehof et al (2010:79) further state that Zimbabwean communal areas have been undergoing rapid changes as a result of the land redistribution policies; this has resulted in the loss of employment and destabilization of communal area livelihoods and general uncertainty hence worsening the HIV and AIDS situation in which women are worst affected. High levels of poverty in these areas further exacerbate the already dire situation. In such circumstances, the position of women cannot be ignored because women require special attention in any situation because of their exceptional vulnerability.

It is against this background that this study sought to investigate the socio-economic challenges of HIV and AIDS on rural widowed women and in particular the types of intervention in place to address their plight, either by the Government of Zimbabwe, national and international NGOs or community based organizations.

It is important to track progress since the launch of multiple programmes in mitigating the negative impact of the HIV and AIDS epidemic on women. That is, since the advent of HIV and AIDS and above-highlighted challenges has the situation of women changed and what are women doing about their situation? What is the role of development agencies? What is the role of the Zimbabwean government? This study therefore attempted to explore these questions in details.

### **1.3. The Aim of the study**

The aim of this study is to investigate the extent to which social and material conditions of women in general but widows in particular have improved or otherwise in Zimbabwe since the discovery of the HIV and AIDS epidemic.

### **1.4. Objectives of the study**

The objectives of this study are to:

- Understand the prevalence of HIV and AIDS in Zimbabwe in general and Gutu Central District in particular.
- Investigate the social and economic challenges facing widows in Gutu Central District in the context of high prevalence of HIV and AIDS in Zimbabwe generally;
- Understand the kind of interventions and programs that have been put in place to assist these women to mitigate the challenges, and to
- Explore the possible options available to improve the situation of widows in Zimbabwe

## 1.5. Research questions

Specific questions pertinent to this study are:

1. What is the current socio-economic situation of widows affected by HIV and AIDS, with particular focus on changes to inheritance of their deceased husbands' estate?
2. What programmes have been put place to address the plight of widows affected by HIV and AIDS?
3. Who are the key role players, and what are their respective roles?
4. What are widows doing about their situation themselves?
5. What type of interventions are required, if any, to assist widows in Zimbabwe?

## 1.6. Method of Research Employed

### 1.6.1. Research Design

The study employed a qualitative research design. Thyer (2001:257) explains that 'a qualitative research aims at describing, making sense of, interpreting or reconstructing in terms of the meanings that the subjects express'. This research design is the most suitable method where data collected is in the form of stories of the respondents' experiences. A qualitative study was also appropriate for this investigation because it uses interviews. The choice of interviews is based on the vast advantages that they bear in social research. In-depth interviews allow greater spontaneity and adaptation of the interaction between the researcher and the study participant.

### 1.6.2. Research Population

Participants in the research included:

#### 1.6.2.1. Widows

Widows were the primary subjects of this research exercise. The research sought to understand their socio-economic situation since the introduction of various measures to address the adverse impacts of HIV and AIDS on them.

#### 1.6.2.2. Government Officials

The Government of Zimbabwe plays an indispensable role in addressing the situation of the vulnerable sections of the population in general, but especially widows. It was therefore important to interview personnel from responsible ministries

as key informants to understand the roles played by their respective departments in addressing the plight of widows.

#### **1.6.2.3. NGO and/CBO Representatives.**

Various national and international NGOs across Zimbabwe implement various programmes in various locations to support women in their fight against oppressive patriarchal system that is evidently dominant in Zimbabwe over many years. In some instances, CBOs have also been established to facilitate interventions at the local level. It is imperative to examine what each of these stakeholders are doing. Their representatives constitute key research informants.

#### **1.6.3. Sampling Technique Used**

Sampling is defined by Neuman (2007:141) as a small collection of units or cases from a much larger collection or population. For the purpose of this study, purposive sampling was used. Patton (1990) states that the main goal of purposive sampling is to focus on particular characteristics of a population that are of interest, which will best enable you to answer your research questions. In this study the researcher was interested in understanding the problems faced by widows in the context of widespread HIV and AIDS with devastating socio-economic repercussions.

More information on sampling is provided in Chapter 3. Since the aim of the study was to investigate the socio-economic situation of widows and the role played by various development agencies – including the Government of Zimbabwe, in the first place, widowed women residing in Mukadziwashe village were targeted. They were identified with the help of local leaders, Government officials, NGO staff and CBO representatives. Senior representatives of key Government Ministries as well as NGO and CBO were also targeted for this study.

#### **1.6.4. Data Collection Technique**

The method of data collection used in this study is interviews. The purpose of using interviews was to probe the ideas of the research participants about their living conditions, in the case of widows, and investigate the activities their respective programmes to address the plight of women, in the case of intervening agents – such as the Government of Zimbabwe through various Ministries, NGO and/or CBOs.

Interviews are particularly useful for getting the story behind a participant's experiences. The interviewer could pursue in-depth information around the topic (McNamara, 1999). Babbie (2010:270) points out that a qualitative research is especially appropriate to the study of those attitudes and behaviours best understood within their natural setting. It is for this reason that interviews were conducted in the widows' homes and programmes staffs' offices. Semi structured interview guides were used to facilitate the interviews.

#### **1.7. Ethical Considerations in the Study**

Ethical issues are an important aspect of social research that involves human subjects (Babbie, 2010:75). Ethical behaviour is a crucial foundation to a professional social research. The researcher took into consideration some ethical issues such as informed consent, voluntary participation, negotiation of access, privacy and confidentiality. Chapter 3 will elaborate further on these details.

#### **1.8. The Structure of the mini-dissertation**

This mini-dissertation comprised of five chapters. Chapter 1 provided an introduction to the study. Chapter 2 discussed the relevant literature pertaining to the study and the theoretical framework used for the study. Chapter 3 discussed the research methodology that was used in the investigation as well as the findings. Chapter 4 presented the research results. Chapter 5 provided an analysis of research findings as well as recommendations.

## CHAPTER 2: LITERATURE REVIEW

### 2.1. Introduction

The first section of this chapter discusses the HIV and AIDS situation in Zimbabwe. The second section discusses the interventions that have been instituted by government and NGOs. Thirdly, the chapter articulates the preferred theoretical framework. The fourth section concludes the chapter.

### 2.2. HIV and AIDS in Zimbabwe

The HIV and Aids pandemic is one of the deadly diseases that have hit the Southern African continent. In fact, it has become a world-wide concern such that world leaders are working together to fight the pandemic. WHO (2005) notes that

‘On account of its magnitude and rapid rate of growth, policy makers around the world are struggling to gain a deeper understanding of how to effectively combat the disease. While governments worldwide are rushing to formulate strategies to tackle the problem, nowhere is the urgency as great as in Africa, where three-quarters of all HIV and AIDS cases are to be found’.

UNAIDS (2005:12) further states that, the AIDS epidemic is seen as part of the wider crisis of African underdevelopment, and actions are taken by each nation – within relatively limited domestic and external resources. HIV, the virus that causes AIDS after lying quiet in an individual for seven to ten years, currently infects 42 million people worldwide. By the end of 2002, the disease had already killed 28 million people while an estimated 3 million now die from the disease each year Hunter (2003:21).

Zimbabwe is one of the countries that have been hardest-hit by the pandemic. However the situation in Zimbabwe has worsened over the years due to economic reasons aggravated by political crises that saw slow and inefficient response to the HIV situation when compared to other countries in the region. The slow response however can be generalised to the rest of Africa firstly because in the 80s, often government capacity was saturated by immediate economic concerns, war or



political crisis. Leach-Lemens (2010) states that, in Zimbabwe, the government was reluctant to admit to a generalised HIV and AIDS epidemic for fear of creating panic or discouraging tourism. Zimbabwean doctors were instructed not to mention AIDS on death certificates.

The first AIDS case in Zimbabwe was reported in 1983 and between 1983 and 2003, the prevalence of HIV peaked. Statistics released in December 2002 by the joint United Nations programme on HIV and AIDS and World Health Organization, WHO (2003) revealed that the National Adult HIV infection rate was 33,7%, the second highest in Africa only topped by Botswana which recorded 38,8%. A decrease was noted in 2011 where the prevalence rate in the same year was at 14,7%. This decline in the prevalence rate came 8 years later. There was an improvement in the behaviour of individuals as well as use of condoms which was advertised and intensified in the media as awareness. A marginal increase of 14,26% was recorded in 2012 (NAC, 2012). NAC (2013) further cited that the adult prevalence rate of HIV in 2013 was at 15%. Prevalence is high in urban areas but hot spots are border towns, mining areas, growth points and resettlement farms.

In 2006, the United Nations World Health Organization recorded that the life expectancy in Zimbabwe had dropped drastically in the past 20 years. Studies by *Medicins Sans Frontieres* (2009) and WHO (2006) revealed that life expectancy for women and men had dropped to 34 years and 37 years, respectively. It was also noted that one in five adults were infected with HIV. Factors driving the spread of the HIV are manifold and cut across socio-economic and cultural barriers. They may include: low levels of circumcision, multiple sexual partners, mobility, poverty and low social and economic status especially that of women; and low and incorrect condom usage, early marriages, spousal separation and low risk perception (NAC, 2011; 2012).

Heterosexual sex has been argued to be the primary cause of transmission though in other countries other forms of transmission can and do play a role. These include mother to child transmission (MTCT) (UNDP Report, 2010). In Zimbabwe, heterosexual contact is the main cause of the epidemic. Dirwai (2004:12) state that the major mode of transmission of HIV is heterosexual due to unsafe sex and multiple partners. Mother to child transmission can account for the deaths of infants

and neonates. A review of behaviour change approaches revealed that marriage alone is not a protective factor as extra-marital relationships are frequent, couple communication difficult and the disclosure of one's HIV status irregular. In addition condom use in marriage and with regular partners is low (ZNAPS, 2006). Access to treatment is improving. According to ZNASP (2013), the number of people living with HIV receiving ART were 665 299 and of those, 618 980 were adults.

### **2.3. HIV and AIDS in Gutu District**

Mavhundu (2012) states that Gutu as a district in Zimbabwe has a population of 31 715 People Living with HIV (PLHIV). Only 1 700 PLHIV were on ART, and the target was that by the end of 2013 a total of 12 000 people will be able to access ART in the district. Gutu is one of Zimbabwe's 59 districts. Before the 2012 census Gutu district had a population of 203 533 people. Kollie (2013) notes that The Ministry of Health and Child Welfare in Zimbabwe started HIV care and treatment in Gutu District in 2005.

Chimbari et al (2008) reported that at community level, it was shown that morbidity and mortality had increased in Gutu District with 53% of the households reportedly having a serious illness within the three months prior to their survey. On average, about 33% of the households reported having experienced an HIV-related death since 1999. However, the study revealed that the home-based care in the district could best be described as "progressed home-based dying" which is women centred. This was largely the case because carers did not have support in the form of transport and materials for use in the caring of AIDS. On the other hand, the sick persons did not have adequate food or treatment. However, women were reported as bearing the brunt of caring starting from youth (Chimbari et al, 2008).

In the district, 17 710 HIV positive patients needed ART by end of 2010. However the district had only one initiating site at Gutu Mission Hospital covering the whole District. All the services were being charged for and this forced PLHIV to travel long distances, furthest being 56km to Buhera looking for ART services (Mavhundu, 2012). PLHIV were travelling such long distances to collect ARVs, a fact that was indicated as discouraging others to be tested. PLHIV who accessed ARVs in Buhera

were also concerned about the ever flooding Nyazvidzi River especially in the rainy season.

In January 2011, MSF launched a project to support HIV/TB care and treatment in Gutu District using a “Mentoring Approach” concept for a period of 3 years. This approach primarily necessitates coaching or mentoring available qualified medical staff in the medical management of HIV and AIDS and TB patient. The objective of the mentoring approach was to increase access to HIV care and treatment as well as ensuring continuous monitoring of patients’ outcomes (Kollie, 2013). By May 2011, 600 PLHIV had been initiated on ARVs locally and 450 people who previously had to travel to Buhera to receive their medication had been transferred to the local clinics, (Kollie, 2013). By 2013, about 10 271 HIV positive eligible patients were initiated on ART in the district.

#### **2.4. Challenges faced by women**

As Niehof et al (2010:43) note that the epidemic disproportionately affects women. Young women aged 15-24 were found to be four times more likely than young men to be infected with HIV. According to Dhambuzha (2011) women accounted for more than 60% of the population of PLHIV in Zimbabwe in 2011. The prevalence rate of HIV and AIDS is highest among women in non-urban areas (Niehof et al, 2010:43). It is within this context that the rural village of Mukadziwashe was chosen for the study.

Women’s vulnerability to HIV infection is further increased by their low social and economic status. Genders dynamics deprive women of most (if not all) control over resources such as land, money and credit facilities and this reduces their ability to access justice and protect their rights. As Murungu (2012) notes, HIV positive women face stigma and discrimination, and often fail to inherit property because of such factors. Murungu (2012) further states that about 40% of Zimbabwean women whose property was grabbed by their husband’s families were HIV positive. Most women have lost property; they have been abandoned, discriminated and have had their financial support withdrawn. Married women have sometimes been abandoned by their husbands with no legal or economic recourse (Sandisi & Cherewo, 2005).

Being widowed, let alone through AIDS, leads to many women losing their property to their ex-husbands' relatives and finding themselves abandoned by their whole family. The challenges of single parenthood and having been abandoned by the family have led some women to turn to commercial sex work, or worse still, encourage their female children to take up commercial sex work. Widow inheritance, which is rampant in some ethnic groupings in Zimbabwe, has made women to suffer emotional stress by being married off to someone they do not love.

MSF (2011) noted that in HIV and AIDS situations, women become victims because they cannot make decisions concerning their own lives. Hence they become victims of their repressive fate. Inequality and power imbalances between women and men heighten the vulnerability of females to infection. Murungu (2012) notes that women lack protection under statutory and customary law. They lack education and are poorer which pre-disposes them to HIV infection. Moreover, other women who test HIV positive are also scared to have their children tested because should the children test positive, they will be divorced and will be accused of having brought the disease in the family.

MSF (2011) also pointed out that some women who have husbands working in other countries revealed that they are scared to negotiate condom use with their husbands when they come back home for holidays because they will again face divorce threats. This therefore shows that traditional laws as well as migration and movement patterns of people increase the risk and burden of HIV and AIDS on women more than in males. Women are also faced with the responsibility to make sure that their partners are also tested because men usually take the issue of HIV and AIDS seriously once they become seriously ill. Fleshman (2010) notes that there is a clear link between gender discrepancies in the disproportionate impact of HIV and AIDS on women and girls in six areas, including: prevention programmes education, violence, women's property and inheritance rights, home and community-based care giving as well as access to care and treatment.

ZNASP (2011) point out that stigma and discrimination remain a daunting challenge for PLHIV. Available evidence indicates that stigma is prevalent at a social, institutional and personal level. Its impact has compromised the development of an enabling environment. Some of the factors driving and sustaining stigma include lack

of knowledge and awareness, fear and cultural norms. The need to tackle this stigma cannot be overemphasized if there is a need to lessen the burden the women are facing in the era of HIV and AIDS. Mudavanhu (2008) notes that women in rural areas face competing demands with respect to crop production and care for family members suffering from AIDS-related illnesses. Traditionally, the burden of care for sick family members has always been reserved for women, who usually lack the resources and training to provide adequate home-based care. According to Izumi (2004) property grabbing from widows is not a new phenomenon. It existed prior to the HIV and AIDS pandemic. However, HIV and AIDS has contributed to the worsening of the situation due to the scale of infection rates, the stigma attached to HIV and AIDS and the social and economic vulnerability of these widows and their children.

HIV and AIDS exacerbate the vulnerability of widows who are suffering through material impoverishment, discrimination and marginalisation. Widows are faced with challenges of caring for their children on their own given the death of their husbands. The challenges of single parenthood are usually further exacerbated by the lack of all kinds of support from their marital homes. Zimbabwe like many of the countries in Africa practices tradition such as wife inheritance and property inheritance when a woman is widowed. Such traditional practices have negative impacts on the widows who face risks of contraction of HIV and re-infection with sexually transmitted infections and loss of property to which they would have been otherwise entitled.

UN Report (2013) points out that widows rights are violated through the following tactics: social exclusion; dispossession of property; land and inheritance rights; dispossession of children; rampant accusation of witchcraft and prostitution allegations; forced participation in inhuman, degrading and diabolic traditional rites; deliberate exclusion from social, economic, development and leadership processes; sexual abuse of young widows, and forced wife inheritance. All these conditions and many others contribute to the underdevelopment, marginalisation, abuse and discrimination of the rights of widows thus rendering them susceptible to gross levels of poverty.

Given this wide acceptance that HIV and AIDS poses serious threat to efforts to economically empower women in Zimbabwe, it is important whether this acceptance

has led to any improvement to the conditions of women, especially widowed women, many of whom have lost their husbands as a direct result of the epidemic.

## **2.5. Programmes and interventions to address HIV and the plight of women**

The epidemic and its devastating effects has called for different organisations, government bodies and Non-Governmental organisations to work together in a coordinated effort. Below we explore the role of these players in mitigating the impact of HIV and AIDS with particular focus on widows.

### **2.5.1. Government interventions programmes**

Various HIV and AIDS programmes have been implemented to address the multi-dimensional impacts of HIV and AIDS in the country. When HIV and AIDS first emerged in Zimbabwe, the government was slow to acknowledge the problem and take appropriate action. ZNASP (2006) states that the National AIDS coordination programme (NACP) was set up in 1987. The National Aids Council (NAC) was formed in 1999. After 1999, the government introduced an AIDS levy on all tax payers to fund the works of the NAC. The levy system is anchored in the national tax system. This commitment becomes crucial given the impact of the recent global economic crisis that has significantly reduced global funding for HIV and AIDS.

Zungura (2012) further notes that in 2002, the Zimbabwean government declared HIV and AIDS a National emergency. This allowed Zimbabwe to produce and purchase AIDS drugs locally under International law, thereby reducing costs. In 2005, the NAC recognised the importance of youths as “the window of hope” where HIV prevention programmes were mainly targeted at youths as the future of the country. While these measures have had a positive impact, the government’s response to HIV and AIDS has been compromised by numerous political and social crises that have dominated political attention and overshadowed the implementation of the national AIDS policy.

Added to that was poor organisation and lack of resources (ZNASP, 2006). National surveys which involve HIV-testing called Demographic and Health Surveys (DHS) are conducted every five years with the primary objective of providing current

information and statistics for policymakers, planners and researchers on population key health indicators such as fertility levels, sexual activity, mortality rates and HIV infection (Duri, Stray-Pederson and Muller, 2013).

According to NAC (2013), Prevention of Mother to Child Transmission pilot Programme was set up in 1999 at four sites to assist pregnant women with free testing and counselling provisions. By 2012, the programme expanded nation-wide while providing voluntary testing and drugs to pregnant women. This resulted in women decreasing their chances of transmitting the virus to their unborn babies. Drug provision rose from 6,6% in 2005, 52% in 2011, and by 2012, 82% of pregnant women were receiving therapy (Murungu, 2012).

The Zimbabwe National Aids Strategic Plan (ZNASP) was rolled out in 2006-2010 with the interventions of the Ministry of Health and child welfare, National AIDS Council and joint United Nations Programmes. The thrust of the Plan was on multi-sectorial fight against HIV and AIDS because with its devastating effects, HIV and AIDS called for consented and coordinated action to win the fight (ZNASP, 2006).

In the same year, that is 2006, the Ministry of Education, Sports and Culture in conjunction with UNICEF initiated an in-service training scheme of primary and secondary school teachers, wherein children were taught HIV related life skills and counseling as well as assistance to the families affected by and infected with HIV. HIV-testing and counseling sites offering “Provider Initiated Testing and Counseling” (PITC), increased from 35% in 2006 to 64% in 2010. Couple counseling also increased from 12% in 2007 to 25% in 2009 (ZNASP, 2011). By 2010, about 85% of people had tested and received results.

The ZNASP was revised in 2011 (ZNASP: 2011-2015), commonly known as Zimbabwe National HIV and AIDS Plan II, for five years as a multi sectorial framework developed to inform and guide the national response towards achieving zero new infections, zero discrimination and zero AIDS related deaths by the year 2015. The annual HIV incidence declined from a peak of 1,14% in 2006 to 0,85% in 2009. In the implementation of the Zimbabwe National HIV and AIDS Plan II (2011-2015), the guiding principle was ‘Three Ones’ principle. This principle implies that there will be one National multi-sectorial HIV and AIDS strategic plan, one

coordinating authority, and one national monitoring and evaluation system. Hence NGOs and other related bodies dealing with HIV and AIDS have to align themselves with the national principle.

ZNASP (2011) statistics indicate that Zimbabwe reduced annual deaths from 123 000 in 2006 to 71 299 in 2010. This was due to the provision of ART, management of TB/HIV co-infection and improved nutrition among others. Sustained provision of ART will not only help reduce death rates but also contribute to HIV prevention efforts (ZNASP, 2011). Zungura (2012) notes that by September 2000, where 189 heads of states set up 8 millennium development goals, the Zimbabwean government branded goals 1, 3 and 6 as their emergency priorities. These strove to eradicate poverty and hunger, promote gender equality and empowerment of women as well as to combat HIV and AIDS, malaria and other diseases by 2015. It is not certain if the government will be able to meet these goals because of other competing factors.

The decline in resources has had serious implications on the sustainability of strategic HIV and AIDS interventions including prevention of new infections and sustained provision of ART. The growing resource gap means that Zimbabwe will continue to face difficulties in financing the national response from domestic resources using existing strategies (Duri et al, 2013). Regarding widowhood through HIV, the government does not have many interventions to assist the usually marginalised group. A call to inspire communities to change their attitudes towards widows was made on the commemoration of International widows' Day in 2014 in Zimbabwe.

The National AIDS Council is the main government board that was formed to deal with HIV and AIDS. The Council also works at District level where it's known as the District AIDS Council (DAC). The council is responsible for the formation and implementation of HIV and AIDS policies. It also offers counselling and Home-Based Care (HBC) to those households with ailing patients. The DAC also assists widowers in the same situation.

Mudavanhu (2008) states that the provision of home based care services by the District AIDS council is of great help because most hospitals are referring patients for



home based care. This is due to the lack of medicine as well as the overwhelming numbers of ill patients. This training makes it easier for women to care well for themselves and for other family members because they are well equipped with the basic knowledge for taking care of HIV and AIDS patients.

The Zimbabwe Widows Association was formed in 1996, later to become the Zimbabwe Widows and Orphans Trust (ZWOT). It was established to assist grieved and poverty-stricken widows and orphans. The organisation assists with the legal, financial, medical, and material concerns of its members. ZWOT was created to assist the nearly one million widows and four million orphans currently living in Zimbabwe (World Bank, 2011). The organisation's primary mandate is to support widows and orphans in the areas of inheritance, income generation, health, and psychosocial support. Currently, ZWOT is working within a number of targeted communities that assist women and orphans on land and property inheritance disputes between customary and civil law.

As Laurel (2008) points out, orphaned children and widows are not in a good position to use either customary law or statutory law as a means of protecting or inheriting their parents' property or inheritance rights because they lack information, time, and the financial means to pay the logistical and legal costs. ZWOT has been successful in helping widows and orphans gain access to the complex legal systems. The challenge faced however is that ZWOT is currently working in Bulawayo and Harare towns only.

As in many countries, the Zimbabwean legal system provides for the issuing of peace orders (restraining orders) in situations of domestic or family disputes. These are designed for domestic issues as well as in family crises where inheritance disputes erupt. It is not difficult to get a peace order if the woman knows the procedures and has easy access to the legal system. Either way, even when issued, peace orders are largely ineffective. In short, state protection exists in theory, but in practice is very ineffective. It should be noted that women in rural areas do not have access to these kinds of services and the disparity between urban and rural dwellers is big.

## **2.5.2. NGO intervention programmes**

Apart from government efforts to fight HIV and AIDS, NGOs have also worked in different areas to mitigate the negative impacts of HIV and AIDS. NGOs use different means to convey prevention messages through leaflets, drama, television, radio programmes and community groups and support groups. For example Medicins Sans Frontieres (MSF) (2011) noted that in Tsholotsho District (Matebeleland North Province), a lot of awareness raising activities were carried out among chief elders and religious leaders who have powerful influence in the community's social and cultural issues. However, on the medical side, access to health facilities was still limited. For example, MSF (2011) observed that there was only one District Medical Officer in the Tsholotsho District in 2011 serving a population of 129 000 people. Moreover, a population of 198 536 had no medical doctor in Gutu District (NAC, 2007).

### **2.5.2.1. Medicins Sans Frontieres**

NGOs like MSF work in these rural areas where it helps the government hospitals and clinics especially through decentralizing the ARV treatment and prevention of mother to child transmission programmes.

A mobile legal Aid Clinic was also established in Harare and Bulawayo and it helps vulnerable women who are unable to pay legal fees (Zunguze, 1999). Through the clinic, women can learn about their entitlements, seek advice and learn critical skills such as registering a will. This, however, is only available in big cities and cannot be accessed by those women in rural areas.

### **2.5.2.2. Widows Empowerment Trust**

It was formed in Bulawayo to advocate and promote the empowerment of widows in Zimbabwe. The organisation is currently involved in four major programmes. These are:

1. The Strengthening Widows' Advocacy and Rights Mechanisms (SWARM);
2. The Sustainable Livelihoods Initiative for Development (SLID);
3. The Widows Rights Awareness Programme (WRAP); and
4. The Widows Counselling Programme, (Maphosa, 2013).

The programme operates in Bulawayo only and it covers a small portion of Matabeleland.

### **2.5.2.3. Batanai HIV and AIDS service organisation**

This NGO facilitates the formation, training and coordination of support groups who are empowered with skills in leadership, basic counselling, basic home based care and project planning and management (ZimVac, 2014). Trained community HIV and AIDS support agents assist and monitor other HIV positive people who are on ART. Behaviour change activities are carried out by support groups. Support groups in Zimbabwe are turning into advocacy groups with PLHIV successfully utilising advocacy methods in order to achieve better medical treatment and to reduce stigma in society. Success stories in Zimbabwe show the potential of HIV and AIDS related activism, linking local level activity with national campaigns. Women form a greater part of these support groups.

The gender and advocacy project helps people living with HIV and AIDS training them in human rights advocacy. Such training will equip them with skills that will enable them to advocate for their rights and services. Support group members from wards, district and provincial teams are successfully advocating for gender issues. In 2008, the Zimbabwean government interfered with the role of NGOs thereby worsening the HIV and AIDS situation in the country, in the process. Some NGOs never returned to full work after being banned while others continued but under heightened political environment.

NGOs have played a pivotal role in HIV and AIDS programmes by implementing government policies both in rural and urban areas of the country. Zungura (2012) points out that the lack of coordination of the functions between NGOs and government has derailed the national response as studies highlight concentration of HIV and AIDS programmes in some areas whilst other areas have no programmes at all.

#### **2.5.2.4. The Musasa Project**

It is one of the most prominent organisations which focuses on gender violence and has offices in Harare, Bulawayo, and Gweru. They offer counselling for victims and families, some legal assistance, and, in Harare, a temporary shelter (ZimVac, 2014). The intervention projects of this human rights organisation, which deals with gender violence, actually helped to transform the lives of a few commercial sex workers and the lives of a few courageous ordinary rural women from their subordinate positions to decision making positions.

The World Bank, (2011) highlights that the stories in gender tales from Zimbabwe show how the interventions by this organisation can help vulnerable and high risk groups. These groups can gradually change their behaviour and actually move away from being a high risk group dependent on men to become economically independent. Through workshops, the organisation teaches women issues on gender violence, sexual reproductive health and behaviour change.

Other NGOs include the Zimbabwe Women Lawyers Association which offers free legal assistance to women, regardless of the issues involved. Women's Action Group (WAG) offer free legal assistance to women covering everything from domestic abuse to inheritance and divorce cases. Finally, the Zimbabwe Girl Child Network provides shelter and assistance to girls affected by sexual and physical abuse.

#### **2.5.3. Interventions by women**

In rural communities, women are forming groups to support each other. For example 'Mother-to-Mother' increases awareness and promote acceptance of their situations through sharing experiences (MSF, 2011). Support groups in Zimbabwe are turning into advocacy groups with PLHIV successfully utilising advocacy methods in order to achieve better medical treatment and to reduce stigma in society. Murungu (2012) notes that success stories in Zimbabwe show the potential of HIV and AIDS related activism, linking local level activity with national campaigns. Women form a greater part of these support groups.

## 2.6. Theoretical Framework

According to Moira (2009), theory helps in ways by which research data can be interpreted and coded for future use, it helps in responding to new problems that have not been previously identified and prescribes solutions to research problems. For Moira (2009), theory influences research design; including decisions about what to research and the development of research questions. Theory underpins methodology and has implications for how data are analysed and interpreted.

This study will employ the gender and power theory as a theoretical framework. This theory addresses the wider social and environmental issues relating to women, such as gender based power imbalances. Connell (1987) argues that self-protection by women is often swayed by economic factors, abusive partnerships and the socialisation of women to be sexually passive or ignorant. Power imbalances and gender-based violence (GBV) have increasingly been cited as important determinants putting women at risk of HIV infections (Freeman, 2010). The theory of gender and power incorporates the structure of gender relations, societal definitions of masculinity and femininity and economic power. According to the theory, there are three major social structures that characterise the gendered relationships between men and women. These are:

1. The sexual division of labor
2. The sexual division of power
3. The structure of cathexis

On the sexual division of power, in intimate relationships, power is defined as dominance, control or influence over others. There is belief that the partner who is less dependent on the other in terms of meeting needs that partner will be less committed to the relationship, thereby posing sexual risks to the other (Rusbult, Agnew & Ariagga, 2012). Women in the African context are more dependent on their male partners to meet their needs, thereby exposing them to such risks. For example, a woman who is financially dependent upon her male partner may be less likely to negotiate condom use for fear that her partner will leave her, thus giving her male partner more power as regards condom use decision-making. Indeed, research on power in intimate relationships has shown that men have more power than women in influencing decisions regarding condom use (Sandasi & Cherewo, 2005).

Sandasi et al (2005) elaborate in the following terms “The unequal power balance between men and women translates into an unequal balance of power in heterosexual relations. That means that male pleasure is given priority over female pleasure and men have greater control than women over when and how sex takes place.” Moreover, in Zimbabwe, as is the case throughout Southern Africa, it is culturally acceptable that men can have multiple sexual partners - and women are not allowed.

The gender and power theories apply to the proposed study in that women are usually the most vulnerable in the HIV and AIDS situation in Zimbabwe. Men usually work in the urban areas or mining towns where they are away from their families while most women remain in the rural areas. The separation through such migration makes women more vulnerable as men engage in extra marital relationships. When they visit the rural areas, women become vulnerable to getting HIV infection.

Furthermore, it has been noted that women feel powerless over men when it comes to sexual issues. Therefore they will not insist on condom use. This stems from the nature of the societal values where women are expected to be more docile, humble and more tolerant than their male partners. Due to the patriarchal nature of Zimbabwean society, men are in control in all sexual and non-sexual relationships. Power underlies any sexual interaction, be it heterosexual or homosexual. This sexual power determines to a great extent women's vulnerability to infection. It determines how sexuality is expressed and experienced; whose pleasure is given priority and when; and how and with whom sex takes place (Sandasi et al, 2005). This theory will be explored in the proposed study which will tackle the vulnerability of women to HIV and AIDS in Gutu Central District.

On the sexual division of labour, women at some work places are normally paid less than men for comparable work. This probably stems from stereotypic notions that people hold regarding women. They view them as less powerful or on a lower level than men. This goes to show that discrimination still occurs at work places on the basis of gender, thus rendering women vulnerable in general.

Rusbult et al, (2012) state that the process of cathexis also affects women more than men because women are more vulnerable. They usually invest their mental and

psychological or even sexual energies in a person that they share the relationship with. This makes them more susceptible to contracting HIV and AIDS. They thus become too dependent on their partners. It can therefore be argued that the societal beliefs on the position of women in society create a gender imbalance in which women are mostly found vulnerable.

Traditional societies do not give equal opportunities to men and women it is thus, almost always seen that men are usually working or more educated while women are dependent on them for financial and emotional support. This makes women more vulnerable to all forms of abuse and places them at high risk of getting HIV. If women can be given equal opportunities they can stand up for themselves and reduce the impacts of HIV and AIDS. Inequities in traditional societies mean that women become less educated, lack adequate information and are usually taken advantage of by their partners and other members of the society. This continues after widowhood where they still find themselves as docile victims through the loss of their property or privileges that they would probably be legally entitled to.

In terms of culture (Kaufman, 1986), note that, women, like children, are considered unable to make intelligent, informed and rational decisions about their own lives. They are thus subjected to the paternal power dynamics. This mentality is carried out from a tender age of the woman's life and continues onto old age. The situation becomes worse and unbearable once women are widowed and decisions that have negative impact on them are made on their behalf.

## 2.7. Conclusion

Like the rest of the Sub-Saharan Africa, Zimbabwe faces the daunting challenge of high prevalence of HIV and AIDS and its devastating socio-economic impacts. Women and children constitute one of the most vulnerable sections of the population. The pandemic calls for joint operations among organisations and Government bodies so as to deal with its devastating effects with particular focus on the most vulnerable section of the population, women and children. Women in rural communities especially, are the main disadvantaged group. Ongoing research is required to monitor progress in mitigating the negative impacts of HIV and AIDS.

Certain cultural practices and socio-economic inequalities perpetuate the spread and impact of HIV and AIDS among women. The gender and power theory provides helpful lenses of viewing and understanding the interconnected web of relations between HIV and AIDS and other societal phenomenon; like the relationship between a man and woman and the spread of HIV and AIDS or the role of women in society and how the HIV and AIDS situation exacerbates the position of women.



## **CHAPTER 3: RESEARCH METHODOLOGY**

### **3.1. Introduction**

The aim of the study was to investigate the socio-economic impacts of HIV and AIDS on widows. It also aimed at examining the role of various interventions that have been put in place in Zimbabwe to improve the situation of women affected by HIV and AIDS, especially widows, and to understand widows' coping strategies. This chapter outlines the research method that was used in the investigation. The first section provides a brief contextual background to the study site. The second section discusses the research design. The study population and sampling techniques are discussed in section three. Section four discusses data gathering techniques used. Section five discusses the ethical considerations that were adhered to in the study. The challenges encountered during fieldwork are outlined in section six. A summary is provided in section seven.

### **3.2. Background to Zimbabwe**

#### **3.2.1. The Population of Zimbabwe**

According to Zimbabwe National Statistics Agency (ZNSA) (2013), the population of Zimbabwe was 13 million in 2012. Males constituted 6,2 Million while females accounted for the remaining 6,7 million. The majority of Zimbabweans live in rural areas. Sixty-seven percent of the population in 2012 was found in rural areas (ZNSA, 2013). Like the rest of the Africa, the population of Zimbabwe is fairly young. Forty-one per cent of the population was below the age of 15 while 4% was those above the age of 65 and 55 constituted the able bodied age majority of 15 to 64.

According to ZNSA (2013), 65% of the households in Zimbabwe were headed by males, the remaining percentage accounted for women-headed households, which include widows, single mothers and child-headed households. Black ethnic groups make up 98,5% of the population. The majority of the people are the Shona who comprise 70% of the population. Included among these are approximately 2 million descendants of migrant workers from Zambia, Malawi and Mozambique. The Ndebele speaking people constitute approximately 20% of the population (ZNSA, 2013).

### **3.2.2. The Economic Situation of Zimbabwe**

According to Monyau and Bandara (2014), Zimbabwe's economy remains in a fragile state with an unsustainably high external debt and massive deindustrialisation and informalisation. There is an economic slowdown which is a result of liquidity challenges like the lack of and high cost of capital and revenue underperformances, out-dated technologies, structural bottlenecks that include power shortages, infrastructure deficits and a fragile global financial environment. Much needs to be done in Zimbabwe to improve the business environment. Monyau & Bandara (2014) states that the country's GDP was estimated at 3,7% in 2013 and it was projected to increase slightly to 4% in 2014.

#### **3.2.2.1. Agriculture**

Agriculture is the mainstay of Zimbabwean economy. Since agriculture is largely dependent on rainfall, the economy is susceptible to weather and climate variations such as droughts and floods. Tobacco is largest foreign currency earner while cotton and sugarcane are the second major cash crops. Maize is the staple food and is widely grown by both commercial and communal farmers. According to Katsande (2013), agriculture contributed about 24% to the GDP in 2010, and in 2013, the sector's contribution to GDP declined to 13,1% (Monyau & Bandara, 2014).

#### **3.2.2.2. Mining**

The mining and manufacturing industries play a major role in the economy. According to Monyau & Bandara (2014), mining contributed 11% to the GDP in 2010 and contributed 10,1% to the GDP in 2013. In 2013, mining output for chrome, nickel and coal was on the increase. Diamond mining also contributes to a greater percentage of the mining sector. However, there has been several reports about the corruption in the mines such that their contribution to the national economy has been largely compromised (Zimstats, 2013). Presently, production is low and not viable in those sectors and this is because the recovering process has been slow since the 2008 crisis that was characterised by shortage of basic commodities such as fuel and foreign currency resulting in rampant parallel market (Duri et al, 2013).

### **3.2.2.3. Manufacturing**

According to Katsande (2013), the manufacturing sector, which includes industries, contributed 22% to the GDP in the year 2010 and this contribution dropped to 13,6 in 2013. A survey carried out in 2014 by the Confederation of Zimbabwean Industries revealed that the industries in the country were under serious threat. Deindustrialisation had reached catastrophic levels with dire consequences to the state of the economy.

### **3.2.2.4. Distribution and Tourism**

According to Katsande (2013), in 2010, it was reported that the sector contributed 14% to the GDP, however, its contribution to GDP dropped to 6,5% in 2014, (Monyau & Bandara, 2014).

### **3.2.2.5. Transport and Communication**

The country has adequate internal transportation and electrical power networks; however maintenance has been neglected over several years. Poorly paved roads link the major urban and industrial centres. The energy sector is heavily disrupted such and in turn affects other sectors interlinked with it. The sector contributed about 19% to the GDP in 2010 and a drop in contribution was noted in 2013, when it dropped to 12, 8% (Monyau & Bandara, 2014).

### **3.2.2.6. Finance and Insurance**

This section contributed 5% to the GDP in 2010 and its contribution increased to 11, 3% in 2013. As of December 2013, there were 21 operating banking institutions and 146 microfinance institutions. According to Monyau & Bandara (2014), activity on the Zimbabwe stock exchange remained subdued, as most investors adopted a cautious approach while concerns over the implementation of the indigenisation policy persisted.

### 3.2.2.7. Education

According to Katsande (2013), this sector contributed 5% to the GDP in 2010, it however collapsed to 3, 7% in 2013. The crisis in the country since 2000 has diminished the achievement in this sector of the economy mainly due to lack of resources and the exodus of teachers to other countries.

Zimstats (2013) states that the informal sector contributes around 19,5% of Zimbabwe's gross domestic product. From the total population of Zimbabwe, 7 million constitute the labour force. According to Monyau & Bandara (2014), in terms of the labour market, 60% of women work, compared to 74% of men. Nevertheless, women tend to work in agriculture and other low-productivity activities. Male dominated industries tend to have a higher contribution to the GDP.

According to Monyau & Bandara (2014) unemployment rate was estimated at 95% in 2013. Most unemployment is hidden by employment in the informal sector where cash incomes are extremely low. According to Zimstats (2013), a survey carried out in 2011, revealed that 84% of the population worked in the informal sector while 11% were in formal employment. The majority of households and people engaged in informal sector activities are in Manicaland province. In the capital city, Harare, more females than males are employed in the informal sector which is not the case in other provinces where males constitute 55% of the informal sector and females constitute 45% (Zimstats, 2013). A poverty assessment study showed that youths suffer the most from unemployment. The rate of unemployment for youths in Zimbabwe stood at 19% for females and 11% for males (Zimbabwe National Budget, 2014).

The country had to confront severe crises between the years 2000 and 2009, crises which created a delay in the response to HIV. UNAIDS (2005:32) highlighted that in an HIV and AIDS situation, agriculture and food security may be severely reduced, especially amongst the poorest rural populations as illness forces people to work less lowering the output of their subsistence farming. The number of people falling sick began increasing alongside a deepening economic crisis and recurring droughts that threatened livelihoods of those affected by HIV and AIDS (UNAIDS 2005: 32-38). In addition, wide gender disparities continue to characterise many aspects of development. This is reflected in the generally low status of women with respect to

access, control and ownership of economic resources and involvement in decision making (Monyau & Bandara, 2014).

### 3.2.3. Poverty Situation

According to a UN Report (2013), individual poverty prevalence was 84.3% in rural areas compared to 46.5% in urban areas, while extreme poverty was 30.3% in rural areas compared to only 5.6% in urban areas. Due to poor rainy seasons, the percentage of food-insecure rural households is projected to rise sharply, up to 32% for the period 2013-2014, reflecting Zimbabwe's reliance on rain-fed agriculture (UN Report, 2013).

According to UNAIDS (2005:38) Food and nutritional insecurity increases the mobility and migration patterns of individuals seeking food. Mobility and migration places people in risky situations and behaviours such as involvement in transactional and commercial sex. A common coping strategy for survival is for poor women and adolescent girls to exchange sex for money or gifts thereby increasing their risk of being infected. Socially marginalised and economically disadvantaged women also tend to stay in sexually abusive and violent relationships (ZNASP, 2011). This in turn increases their risk and vulnerability to HIV infection. In rural areas, low returns from informal sector like farming have been cited as another cause of the vulnerability in women. According to UNAIDS (2005:31), HIV and AIDS is reversing the progress in poverty reduction. It has been noted that AIDS tend to have more impact on the poor than on the rich due to the costs associated with treatment which the poor are less likely to afford.

The loss of productive labour in a household is another devastating impact of the epidemic. Many families are devastated by HIV and AIDS as they lose their primary income earners and the income of other family members is compromised because they are forced to stay at home and care for the sick which is also expensive (WHO, 2011). Rural communities are mainly impacted upon because of lack of basic information as well as the limited access to medical care.

Access to treatment of HIV is also a major concern that increases poverty levels. Chevo and Bhatasara (2012) note that women in rural areas find it difficult to obtain Ante retroviral drugs (ARVs) for income for rural households is usually low.

Moreover, the clinics that provide ARVs are scattered in such a manner that some people have to travel long distances to access the services. The other challenge associated with HIV is that it reduces the availability of able-bodied labour of both victims and those who have to take care of them for example farming which is done by women mostly (Feldman et al, 2002). In addition, it was also noted that HIV and AIDS consume family resources resulting from the costs of health care.

UNAIDS (2005) states that women in most of the cases are responsible for taking care of ill family members because ill people generally return to the communal areas where life is cheaper and also where the immediate extended family can provide care thereby increasing the burden of the epidemic's morbidity.

#### **3.2.4. Research site**

The investigation was carried out in the village of Mukadziwashe which is situated in Gutu Central District of Masvingo Province. Mukadziwashe village is the closest village to Mpandawana growth point which is the service point of Gutu District.

Gutu is the third largest district in Masvingo province after Chiredzi and Mwenezi districts. It is the northernmost district in the province (Wikipedia, 2013). See Map Below



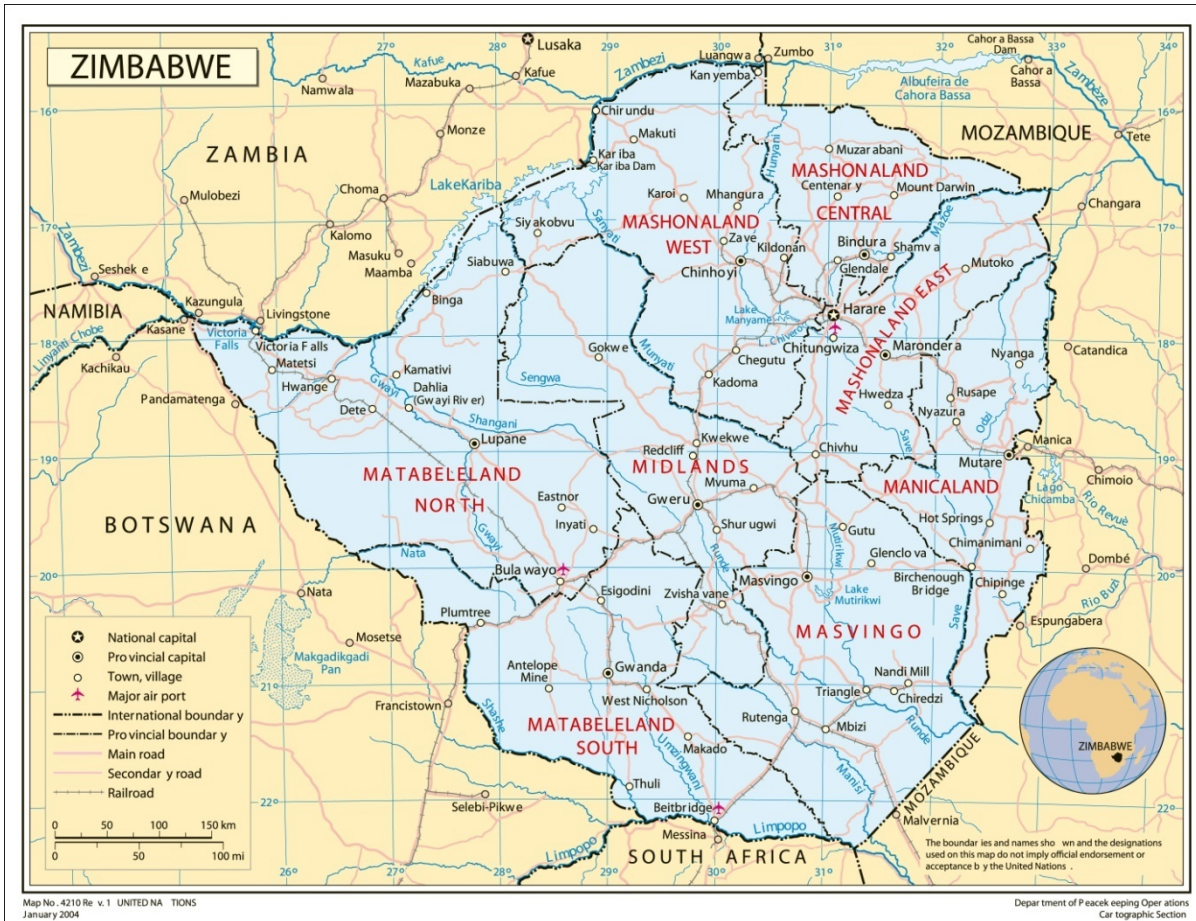


Figure 1: Map of Zimbabwe by Vidiani.com

**Note:** the specific village where the investigation was carried out does not show on the map but the District of Gutu shows.

Zimbabwe is divided into ten political provinces namely: Mashonaland East, Mashonaland West, Mashonaland Central, Harare, Matabeleland North, Matabeleland South, Bulawayo, Masvingo, Midlands and Manicaland. Each of the provinces is further divided into administrative districts which are also the service points. Each district is subdivided into wards. The rural districts are run by the rural district councils, which are composed of members elected from the wards in the district.

According to the Zimbabwe Election Support Network (ZESN, 2008), Masvingo is divided into 7 administrative districts. These are Bikita, Chivi, Zaka and Masvingo in the center of the province, Gutu in the north, and Mwenezi, and Chiredzi in the south and east respectively. All the seven districts have business centers referred to as growth points.

According to Zimbabwe National Statistic Agency (ZNSA) (2002), the population of Gutu District was 198 536 in 2002. This number rose to 203 533 in 2012. On the other hand, Gutu Central District had 6973 people in the same period (ZNSA, 2012). Mupandawana is the District's service center. It was designated as a "growth point" during the early years of independence and was only awarded a town status in 2013. Growth points are generally underdeveloped areas and receive additional resources and incentives from the government. This is to encourage their development into proper towns on their own (Poverty Assessment Study Survey, 2003). The long-term aim is to reduce rural-urban migration. Gutu Rural District Council is in charge of the day to day running of the district.

The employment opportunities in the small town are limited such that residents have to go and seek employment from other towns or in neighbouring countries given the current economic crisis and unemployment rates. Those residents who are working are mainly employed by the departments/ministries of education, health, police force, army, local businesses and the Gutu District Council. The area is also not doing well in terms of agriculture as it is located in the semi-arid geographical region (PASS Report, 2003). It is therefore difficult to say that people can entirely depend on crop production as a means of survival.

The livelihoods of the people include subsistence farming, market gardening, informal trading and formal sector employment. The army also employs a significant number of locals. The 4.2 Infantry battalion base is located in the town. Despite having banking services, retail shops and a hospital, Gutu is yet to grow into a proper town. There are ten wards in the district and ten ward councillors.

Like many other growth points, Gutu has hipe commercial sex activities. This inevitably brings along the dangers of HIV-infections into the area. Nilses et al (2002) reported that the prevalence rate of HIV for the district was 21.9% in 2002 and 20.7% in 2006 (DAC, 2007). Most of the commercial sex work is carried out at the very busy town, which services the community under study. There is hipe of activity in the town that is facilitated by an efficient public transport which links many parts of the country; this makes the new town one of the epicentres of HIV infection in the country (Chimbari et al, 2008).



The choice of this research location was informed primarily by high levels of HIV prevalence juxtaposed on ubiquitous poverty in this area. It is expected that widows residing in this area might face serious socio-economic challenges by virtue of their gender and marital status.

The situation described above made this site of research well suited to investigate the role of change agents in reversing the discriminatory practices that oppress women and further exposing them to poverty and exploitation. The researcher's familiarity with the area and her ability to speak the local Shona language influenced the choice of the study area as well.

### **3.3. Research Methodology**

#### **3.3.1. Research Design**

According to Denscombe (2004), there are two categories of research methods that are quantitative and qualitative methods. Quantitative data collection usually involves numbers, graphs and charts. The research findings in quantitative research can be illustrated in the form of tables, graphs and pie-charts. Data collection using some quantitative methods is relatively quick. For example, telephone interviews provide precise quantitative numerical data (Glassner & Moremo, 1989). Moreover, data analysis is relatively less time consuming. One of the disadvantages of quantitative research design is that knowledge produced might be too abstract and general for direct application to specific local situations, contexts and individuals (Denscombe, 2004).

On the other hand, qualitative research design refers to qualitative data collection methods that deals with feelings and other non-quantifiable elements. Research findings in qualitative studies are usually presented in analysis by only using words (Denscombe, 2004). According to Glassner & Moremo (1989), the advantage of the qualitative approach to research is its ability to get information directly from the source. Qualitative research methods such as interviews and focus groups allow researchers to understand the thought processes of the subjects. This allows them to incorporate the subjects' subjective analyses of the situations into the research analysis.

The strength of qualitative research is its ability to provide complex textual descriptions of how people experience a given research issue. It provides information about the “human” side of an issue – that is, the often contradictory behaviours, beliefs, opinions, emotions, and relationships of individuals. As Black (1999) notes, qualitative methods are typically more flexible than quantitative methods. They allow greater spontaneity and adaptation of the interaction between the researcher and the study participant. For example, qualitative methods ask mostly “open-ended” questions that are not necessarily worded in exactly the same way with each participant. With open-ended questions, participants are free to respond in their own words. These responses tend to be more complex than simply “yes” or “no.”

Monette et al (2005) state that with qualitative methods, the relationship between the researcher and the participant is often less formal than in quantitative research. In addition, Wilmot (2005) states that a qualitative design in research aims not to impose preordained concepts; hypotheses and theory are generated during the course of conducting the research as the meaning emerges from the data.

A major criticism of qualitative data is that it uses the researcher as the measuring tool. A human for the most part, will always have bias in his/her judgment. Patton (1990), notes that the volume of information is very large and may be difficult to transcribe and reduce it. Thus the volume of data makes the analysis and interpretation, a time consuming process (Glassner & Moremo, 1989). Critics of this design argue that research quality is heavily dependent on the individual skills of the researcher and more easily influenced by the researcher's personal biases and idiosyncrasies. The researcher's presence during data gathering, which is often unavoidable in qualitative research, can affect the subjects' responses (Monette et al, 2005).

A qualitative research design was employed in this study. Participants had the opportunity to respond elaborately and in greater detail because of the use of interviews. This feature of qualitative design enabled the researcher to gather detailed information because the participants were free to answer questions and a healthy rapport was developed.

### **3.3.2. Research Participants**

The study focused on selected widows residing in Gutu District. From the population, a sample of 15 widows was drawn. All the widows were Shona-speaking. The Government and NGO representatives constituted key informants. Interviews were conducted in both Shona and English languages.

### **3.3.3. Sampling Procedure**

A sample is defined by Neuman (2007:141) as a small collection of units or cases from a much larger collection. According to Chaturvedi (2003), sampling is the act, process, or technique of selecting a suitable sample, or a representative part of a population for the purpose of determining parameters or characteristics of the whole population.

Commonly used sampling methods include probability sampling. This encompasses simple random sampling, systematic sampling, stratified random sampling, cluster sampling and panel sampling (De Vos et al, 2005). Non probability sampling entails methods of sampling whereby the odds of selecting a particular individual are not known because the researcher does not know the population size or the members of the population (Marshal, 1996). Examples of non-probability sampling include accidental, purposive, quota, dimensional, snowball and spatial sampling, (Patton, 1990).

According to Wilmot (2005), qualitative research uses non-probability sampling as it does not aim to produce a statistically representative sample or draw statistical inference. Indeed, a phenomenon need only appear once in the sample. In addition, purposive sampling is one technique often employed in qualitative investigation. With a purposive non-random sample, the number of people interviewed is less important than the criteria used to select them. The characteristics of individuals are used as the basis of selection. Most often the sample is chosen to reflect the diversity and breadth of the sample population (Wilmot, 2005), because usually a qualitative study involves a small sample.

A sample criterion is also another important aspect of a qualitative research design. According to Wilmot (2005), a decision will be required as to the sample selection criteria. That is, the characteristics that will be needed to be reflected in the sample

population to address the research question. The criteria used may be based on demographic characteristics or behaviours or attitudes, and will need to be prioritised if purposive sampling is to be employed.

In this study, purposive sampling was used to select research participants. Purposive sampling is also known as judgemental, selective or subjective sampling, since it relies on the judgement of the researcher when it comes to selecting the units that are to be studied. Chaturvedi (2003) states that in purposive sampling, the researcher chooses the sample based on who they think would be appropriate for the study. Marshal (1996) adds that, in purposive sampling, the researcher actively select the productive sample to answer the research question. This can involve developing a framework of variables that might influence individual's contribution and will be based on the researcher's practical knowledge of the research area, the available literature and evidence from the study itself. This is used primarily when there is a limited number of people that have expertise in the area being researched. The main goal of purposive sampling is to focus on particular characteristics of a population that are of interest and in this study; the characteristic was 'widows'.

#### **3.3.4. Sample size**

According to Wilmot (2005), the issues that should be considered in determining the sample size for qualitative investigation are dependent on the heterogeneous or homogeneous nature of the sample population, or requirements of the data collection methods employed. Another feature of qualitative sampling is the small number of cases sampled. Furthermore, because qualitative investigation aims for depth as well as breadth, the analysis of large numbers of in-depth interviews would simply be unmanageable because of a researcher's ability to effectively analyse large quantities of qualitative data (Wilmot, 2005).

As explained above, widows were identified with the help of community leaders, Government, NGO and CBO representatives in the area. The first set of widows was identified with the help of Batanai HIV and AIDS Support Organisation and the others with the help of the ward councillor and the headmen for the specific ward. Additional

participants (widows) were identified with the help of Government and NGO officials. In total, twelve widows took part in the study.

In addition, senior representatives from three Government Ministries were also interviewed as key informants. Three NGO representatives were interviewed from Batanai HIV and AIDS Support Organisation (BHASO), Mediciens Sans Frontieres (MSF) and Gutu Development Forum respectively. Six key informants took part in this study.

**Table 1: List of key informants interviewed**

<b>Institution</b>	<b>No of respondents</b>
BHASO	1
Mediciens Sans Frontieres	1
Gutu Development Forum	1
Ministry of Public Service Labour and Social Welfare	1
Ministry of Health and Child Welfare	1
District Administration	1
<b>Total</b>	<b>6</b>

The reason for interviewing key informants from different NGOs and Government officials was to get answers from them as service providers on how they are helping widows.

### **3.4. Negotiating access to the research site**

In negotiating access to the research site, the first move was made with Batanai HIV and AIDS Support Organisation (BHASO) – the organisation that is doing some HIV and AIDS related work and the intentions the research explained. Arrangement was made that on the next visit, BHASO staff will help with the identification of widows registered with them and receiving different kinds of help from the organisation. A volunteer was assigned to the researcher during the identification process. This was an added advantaged in that the volunteer was familiar with the households while the widows knew the volunteer. This made access and entry into some households easier.

Contact was also made with the Gutu district Council where the ward councillor for Mukadziwashe was met. The permission to conduct the study was duly granted by the councillor. An access letter was signed by the councillor and the researcher. A copy of the access letter is attached in Appendix A.

The councillor thereafter introduced the researcher to the village headman. Together, they helped the researcher to identify the widows in the village. The headmen usually have all the information about their village including the vulnerable individuals or families. The main challenge with interviewing widows is that they mistook the study for relief work. With the help of the councillor and NGO staff, the researcher explained the purpose of the research to the participants. They continued to participate in the study and completed the informed consent forms without duress.

### **3.5. The Method of Data Collection Employed**

The major methods of collecting data in a qualitative study are individual interviews, focus groups, observations and action research. Interviews are usually structured, semi-structured and unstructured. They are also particularly appropriate for exploring sensitive topics, where participants may not want to talk about such issues in a group environment (Gill et al, 2008).

The advantages of using interviews in a study as mentioned by Gill et al (2008) are that they yield the richest data, details and new insights. Moreover, interviews permit face to face contact with respondents which in turn afford the researcher to explain and clarify questions thereby increasing the likelihood of useful responses.

However, other scholars criticise the use of interviews in a research. Bernard (2000) states that interviews are time consuming, costly and the volume of data gathered might be difficult to transcribe and reduce. Moreover, the interviewee might distort information through recall error, selective perceptions and desire to please interviewer.

The method of data collection used in this study was in-depth interviews. The purpose of the interviews is to probe the ideas of the interviewee about the phenomenon of interest. Interviews were particularly useful for getting the story behind a participant's experiences (McNamara, 1999). Interviews were facilitated via

a semi-structured interview guide – attached in Appendix B. The interviewing method was open and allowed for new ideas to be brought up during the interview. Therefore respondents went to lengths describing their experiences without feeling limited in answering. Open-ended questions were appropriate as they gave the respondent the freedom to answer the questions using their own words and in a diverse manner.

A household information sheet was also used to collect information about the demographic and biographic details of the widows and their households' situations. The household information sheet is attached in Appendix B.

The interviews were carried out in the widow's homes and took about 1 hour to 1 hour 15 minutes per widow. Conducting the interviews in their homes was an added advantage because most of them would feel comfortable in a familial environment. This is supported by Gill et al (2008), wherever possible, interviews should be conducted in areas free from distractions and at times and locations that are most suitable for participants. Whilst researchers may have less control over the home environment; familiarity may help the respondent to relax and result in a more productive interview. Consent forms were signed by those individuals who took part in the study – a sample of a consent form is attached in Appendix C. Comprehensive notes were taken during the interviews and supplemented by tape recording of the discussions.

Interviews with NGO and Government officials were conducted at their respective offices. A sample of the interview guide for NGO and Government officials is attached in Appendix D.

### **3.6. Data Analysis**

Bernard (2000) mentions six approaches of analysing data which are grounded theory analysis, discourse, narrative, content, cross-cultural and interpretive analysis. According to Kulich (2004), the ways to analyse data should stem from a combination of factors including the research questions being asked, the theoretical foundation of the study and the appropriateness of the technique for making sense of the data. Analysing qualitative data involves immersing oneself in the data to become familiar with it, then looking for patterns and themes, searching for various

relationships between data (Kulich, 2004). Le Compete and Schensul (1999) describe data analysis as the process used to reduce data to a story and its interpretation. Patton (1987), states that three things are important in analysis; data is organised, reduced through summarisation and categorisation and patterns and themes in the data are identified and linked.

Narrative analysis was used to analyse the data. According to Kawulich (2004), the focus of narrative analysis is to discover repeated similarities in people's stories. This method involves reading through the data to understand it, breaking it down into categories and building it again for the purposes of interpreting it.

The researcher started by reading through the data that was gathered in a process of trying to understand it. Data was then organised based on emerging themes of the research. Coding later followed where the data was broken into meaningful pieces. When the data was broken into meaningful pieces, topics were created which proved to be the major issues that came about in the course of the investigation. The data was later interpreted through analysis and comparison of the answers that came about in each of the different topics.

### **3.6.1. Credibility of the study**

Credibility involves establishing that the results of the research are believable. Bouma & Atkinson (1995: 20) maintain that, it is a classic example of quality not quantity, it is about the richness of the information gathered. The trustworthiness of qualitative research generally is often questioned by positivists, perhaps because their concepts of validity and reliability cannot be addressed in the same way in naturalistic work (Shenton, 2004). Lincoln & Guba (1985) mentions that credibility in a social study can be obtained through prolonged engagement, persistent observation, triangulation, peer debriefing, negative case analysis, referential adequacy and member checking. In this study, prolonged engagement that is building a rapport with the population under investigation was used before the study got underway.

Persistent observation was also utilised through constant checking of facts that were highlighted by widows as compared to data information that had been gathered about widows in general and the research area. This is described by Lincoln et al



(1985) as a process where the researcher needs to become oriented with the situation so that context can be understood. This was observed through a background study of the area and the population.

### 3.6.2. Validity

The term has been described by Babbie (2010:127) as the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration. Neuman (2007:120) describes validity as truthful; it refers to the bridge between construct and the data. Validity in qualitative research is defined as whether the data is plausible, credible and reliable, and can be defended when challenged. Maxwell (1992) mentions three types of validity that should be given attention to in a qualitative research.

These are descriptive validity which entails that the information that is reported is the actual truth of what was said and heard during the interview; interpretive which entails accuracy in how the researcher interpreted the interviewee's thoughts and feelings even if they were not said. Thirdly, theoretical validity entails that the theoretical explanations are congruent with the data gathered. Benz and Newman (1998) explain external validity as the extent to which the findings of the study may be generalised to another setting or another group of people. They believe that generalisation is not important and is not compatible with a qualitative study. Instead, they came up with, applicability, context dependant and replicability to explain how the findings can be generalised.

In this study, validity was ensured by comparing observational data with interview data. It was also ensured by checking available documented information and comparing it to the answers given during interviews. Participants were encouraged to be frank from the onset during the contact making phase when they signed consent forms. This was aimed at establishing a rapport in the opening moments and indicating that there are no right or wrong answers and that the respondents should feel free to express themselves.

The validity of the data collected can also be assured by the fact that, the data collected has been supplemented by the other current information that the researcher got from the internet, journals and other texts.

### **3.6.3. Objectivity**

The idea of objectivity assumes that a truth or independent reality exists outside of any investigation or observation. The researcher's task is to uncover this reality without contaminating it in any way (Lincoln & Guba, 1985). Objectivity is described by Neuman (2007:65) as following established rules or procedures that some people created without considering who they represent and how they created the rules. Babbie (2010:461) notes that social research can never be totally objective since researchers are humanly subjective.

However, it should be noted that objectivity is an important aspect in research. In the study, the researcher remained objective, impartial throughout the study and impartial to the outcome of the investigation through acknowledging preconceptions, avoidance of bias and value judgement. There was no influence of personal feelings throughout the interview processes in order to ensure that the data gathered were not biased, affected or contaminated in any way. Though many scholars like Babbie (2010: 461) doubt objectivity as a subject in social research, the researcher always strive to obtain objective information as guided by the ethics and to ensure that data gathered is rich and true in content.

## **3.7. Ethical Considerations**

Ethical issues are an important aspect of social research since it involves human subjects (Babbie, 2010:75). Ethical behaviour is a crucial foundation to a professional social research. The following considerations are very crucial in maintaining ethical conduct in social science research.

### **3.7.1. Voluntary participation**

This implies that participants should be informed that their participation in the study is voluntary and that failure to participate in the study or withdrawal of consent will not result in any penalty or loss of benefits to which the participants are otherwise entitled (Babbie, 2004:63) In this research, the researcher explained to the respondents that they were not forced to participate in the study. The contents and purpose of the investigation was explained to the participants beforehand.

### **3.7.2. Confidentiality and Avoidance of Harm**

The participants were informed that their information or whatever was going to be discussed in the interview remained confidential. The participants were assured that their real names will not be used in the study, but pseudonyms instead, in order to maintain confidentiality. This helped the participants to take part in the study freely knowing that their identities and information would not be revealed to whosoever.

Participants were assured that all the notes and the recordings that the researcher was taking during the interviews were only meant for the purpose of the investigation and would be kept in a safe place where access is strictly controlled.

### **3.7.3. Informed consent**

According to De Vos et al (2005:78), the term “informed consent” implies that all possible or adequate information on the goal of the investigation procedure, disadvantages, dangers, that the participants might meet are well explained to the subjects. According to Bless and Higson (2006:106), participants have the right to know what the research is about, how it will affect them, the risks and benefits of participation and the fact that they have the right to decline to participate if they choose to do so. The respondents only filled in the consent forms once the purpose, procedure, possible dangers and disadvantages of taking part in the study were explained to them.

## **3.8. Limitations of the study**

The challenges encountered were that respondents confused the study with donor intervention. As a result, any outsider in their village is easily be mistaken for relief work. During the contact making phase, the researcher together with the BHASO volunteer explained to the respondents that the purpose of the study was solely academic and that the participants were not to expect any sort of payment afterwards.

The subject at hand was a difficult one and sensitive one. As a result most of the widows broke down as they related their heart-breaking stories of how they suffered from the time their husband was sick to the time of death and the aftermath. This also lengthened the time that the interview took. This required the researcher to be

patient enough and in control, had to be empathetic and had to listen more instead of asking questions. However, the possible dangers of the study were explained to the respondents beforehand and were somewhat prepared for possible emotional breakdowns.

The ward councillor was helpful in identification of widows. However, the councillors also needed to make sure that the researcher had no political influence to the respondents. All assurance was provided that is purely for academic research purpose with possible contribution to policy debates in Zimbabwe and no political motive. Contact details of the UNISA research committee as well as the thesis supervisor were provided to both the councillors and government officials.

Some of the widows that were firstly identified by BHASO and even by the councillor did not meet the selection criteria of the study and convincing them why they could not be part of the investigation was difficult as they also wanted to be part of the interviews.

Scheduling appointments with a few of those respondents that were employed as well as with the Government officials was very difficult and consumed a lot of study time.

### **3.9. Conclusion**

The investigation was carried out in Mukadziwashe, a village in Gutu Central District. The village was chosen because of the high rates of HIV and AIDS and poverty. The study used a qualitative design. Widows and other key informants were purposely selected for the interviews with the help of the ward councillor and BHASO. In total, 12 respondents were interviewed for the study. In-depth Interviews were used in collecting data. Interpretive data analysis was used through comparison of responses. A number of challenges were encountered during the study. Firstly, respondents were not available for interviews. Secondly, difficulties were faced in convincing participants and councillor about the purpose of the study. The research had to adhere to a number of ethical issues including confidentiality, avoidance of harm and informed consent.

## **CHAPTER 4: RESEARCH RESULTS**

### **4.1. Introduction**

This chapter discusses the findings of the study on the socio-economic challenges faced by widows infected by HIV and AIDS in a rural Gutu Central District of Zimbabwe. The research is set in remote rural communities of Zimbabwe that are adversely affected by the HIV and AIDS epidemic. This chapter presents the research findings. The first section provides a profile of the respondents. The second section describes the widows' situation as informed by the research. The third section looks at the role of change agents in supporting widows. The fourth section highlights the limitations of the study. Conclusion is provided in section five.

### **4.2. Biographical profiles of widows interviewed**

Biographic details about the respondents are provided below. As explained in Chapter 3, pseudonyms have been used throughout this study to protect the identities of the respondents. This is in line with the undertaking made with respondents during data collection exercise that their identities will not be revealed to avoid possible unintended repercussions. It was further pointed out in Chapter 3 that 12 widows took part in the study. Table 2 summarises the profile of participants.

**Table 2: Profile of research participants**

<b>Widow</b>	<b>Age</b>	<b>Total Number of own children</b>	<b>Total Number of household members</b>	<b>Employment status</b>
Wongai	36	4	7	Employed
Tendai	47	4	8	Not employed
Gladys	29	2	10	Employed
Sarudzai	48	6	8	Employed
Ponesai	52	7	9	Not employed
Selina	34	4	6	Not employed
Berita	37	0	2	Not employed
Zorodzai	44	3	4	Not employed
Lucia	40	4	8	Employed
Semeni	37	3	4	Not employed
Machivei	50	6	9	Not employed
Sheila	52	4	11	Not employed

#### **4.2.1. Age of respondents**

Overall respondents were of middle age. The youngest participant was 29 years old and the oldest was aged 52 years. The mean/average age was 42 years, while the median age was 42 years.

#### **4.2.2. Household size**

The smallest household size comprised of 2 members and the largest household had 11 members, while the average for the households was 7 members.

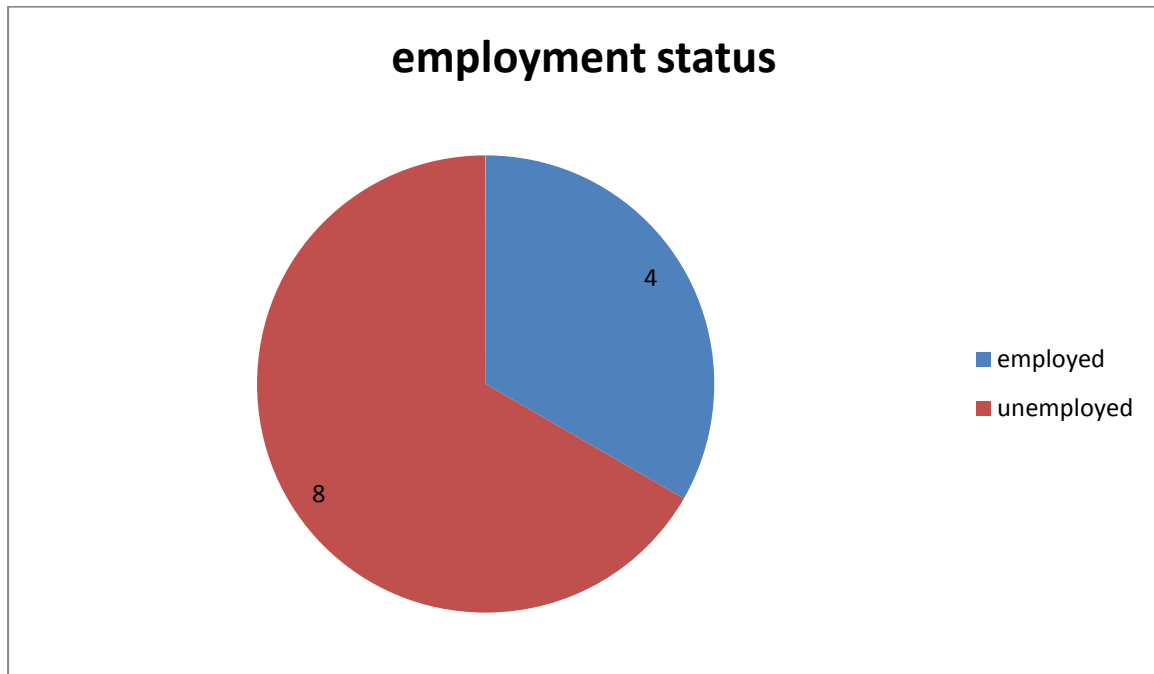
#### **4.2.3. Number of children born by a particular widow**

When it comes to the number of children each participant had, the participant who had the highest number of children had 7 and with one participant not having a child of her own.

#### 4.2.4. Employment status

Most of the widows were unemployed. As illustrated in Figure 1, eight out of twelve widows had no jobs.

Figure 2: Employment status of respondents



### 4.3. Challenges Experienced by Widows

Throughout the study widows described their most difficult problems regarding their coping strategies. Most of the widows related the challenges that they face from the time of sickness of the husband, their death and post-death. Throughout the interviews, the widows narrated problems and challenges that they are faced with collectively. These included poverty, lack of support, stigma, lack of access to resources, physical constraints due to illness, and fear of infection or re-infection. Below we discuss each area of problem identified.

#### 4.3.1. Poverty

As pointed out above, eight (8/12) of the participants were not employed. There is a cyclical relationship between poverty and unemployment. Unemployed people are likely to face severe levels of poverty. For research participants, their unemployed status made their situation worse because they reported that they were struggling to

provide for all those that they cared for. All the eight unemployed widows reported that they struggled to pay the school fees of their children even for those in primary schools. One widow, Machivei mentioned that her children were returned home from the school because they could not afford to pay school fees. Most of the households are living in poverty. They reported that they cannot access the US Dollar that is used as the main trading currency in Zimbabwe. One widow, Selina recounted:

*This US dollar is causing us a big problem, we just hear about it, but to have it in the pocket is so difficult. I need to look after the children and grandchildren and to make sure that they eat, but I cannot cope because I do not have access to that money. (Interview conducted on 23/12/2013)*

Food security is also one the major problem confronting most widows. Gutu District is characterised by low rainfalls, poor-quality soils and low economic activity. As a result, the constituency is left with mainly the young and the old, especially, women due to the low economic activity (ZimVac, 2010). The livelihoods of most of the participants basically include subsistence farming, market gardening and informal trading.

The produce from subsistence farming is not always enough to provide for the family. Seven of the participants spoke about the rainfall patterns that seem to have changed in the recent past and the impact on agricultural activities. This results in small produce and in turn leads to hunger. This is noted by Ponesai who recounted that:

*We depend mostly on ploughing as a means of survival but the rainfall patterns have changed. We don't know what to do at what time. There have been a number of repeated droughts because the rain always comes late and in other cases the rain is too much and our crops are drenched in the water and hence we get little or no harvest. (Interview conducted on 23/12/2013)*

All the participants mentioned that their hopes for living are shuttered because waking up every day is a challenge as they have to think of what the children and grandchildren would eat. Three of the participants who are also looking after their grandchildren mentioned that raising small children in this economic climate is a



battle because their needs and demands are more than what they can afford. One participant, Zorodzai recounted thus:

*My grandchildren still need to go to school, they need school fees and uniform, and from where I am standing, I do not have any money and I do not know what to do. Since last year, I have been begging my child in form 3 to drop out so that she can lessen the burden on my shoulders but she refuses.*  
(Interview conducted on 26/12/2013)

The participants mentioned that they struggle to look after their children because they are unemployed and do not have means to cope with the ever-rising prices of commodities.

The employed participants complained about the money not being enough to cater for their families. Lucia explained in the following terms:

*"I have to find other extra piece jobs and part time jobs to do on weekends and after work to top up my salary, if my husband was alive maybe things would be a lot much better"* (interview conducted on 06/01/2014).

In general, most of the participants complained a lot about poverty. Poverty was, indeed, evident in most of the houses.

#### **4.3.2. The lack of extended family support**

All the widows revealed that they felt as though they were carrying the burden of the whole world on their shoulders, because they do not have any support from family members.

*"It is so sad and difficult to accept, but I must accept that people do not want to be associated with someone with problems. I am alone in all of this. Family is no longer important to people in these modern days",* said Sarudzai  
(Interview conducted on 24/12/2013).

Most of the widows reported that they felt alone with no help from the time their husbands got sick till death because it was their sole responsibility to ensure that the sick partner was taken to hospital for treatment, that they were well-fed and looked after. Some of the widows revealed that they would turn to family members for

assistance but it was all in vain. For some families where the parents in law were available, it was difficult to consult them for help because some were either too old or had their own ailments. Hence expecting them to help would be too much to ask, this is supported by widow Lucia who said that

*“They want to help where they can, the problem is they are not feeling well and are not strong enough to help with finance, I have to make sure I remind them to drink their medications, they need me as well”.* (Interview conducted on 06/01/2014).

Most of them received help from their maiden families of origin and not from their marital families. Another challenge faced by widows was the lack of support from their own children. One of the widows, Tendai, indicated that she did not have any contact with one of her children who left for the big city. She wanted the child to help her fight for their assets that were left by her husband since he was the eldest son. Regrettably, she is worried because the son left her alone and yet he was the one in line to get the inheritance, *“he has been gone for years, and I keep praying and hoping that he will come back, it is scary”*, she sobbed. (Interview conducted on 02/1/2014).

#### **4.3.3. Stigma**

Another challenge revealed was that widows suffered a great deal of stigma and discrimination from their husbands' family members who accused them of not being good enough for their brother. One widow Semeni related how her brothers-in-law accused her of infecting their brother. These accusations created tensions in the family. The tensions started even before the husband died. The situation got worse after the death of her husband. His brothers took away all their assets. Semeni said that she was considering relocating to another area because, *“there is no happiness here anymore. I need to start afresh”* (interview conducted on 27/12/2013).

Widows revealed how hard it has been for them, to bury the partner and also having to face the psychological and emotional stress that is caused by the husband's family during the time of sickness, death and after death, *“Each morning revives sad memories and the reality of your losses and burdens, and to face the children and grandchildren is draining, recounted Lucia.”* (Interview conducted on 06/01/2014).

Widows revealed that stigma did not only stem from family members, but the community as well. It is generally known that HIV and AIDS have not been well accepted and understood in many societies. The stigma that is associated with HIV and AIDS comes in different forms; one being that the disease is associated with immoral behaviour. This therefore leads to discrimination from the community. The widows revealed that they suffered isolation and discrimination when they had to look after their husbands as people were not willing to help them in their dire predicaments.

All of the widows who are HIV positive also said that they feel unloved and that the community discriminated against them on account of their HIV status. They revealed that people in the community are not well informed about HIV and AIDS. Tendai related that even in church she feels the discrimination and very few people want to associate with her and that the stigma really makes her life complicated,

*“I feel as though everyone is talking about me, people are always staring at me, they need to gain information, so that they can understanding more about this kind of illness, maybe...??”* related one widow. (Interview conducted on 02/01/2014).

#### **4.3.4. Depletion of resources**

As pointed above, poverty is one of the major challenges that widows face. The problem is compounded by the depletion of resources in families and households affected by HIV and AIDS. There is lack of the basic resources needed to look after the sick partner or the family in general. The majority of the widows revealed that they struggle to get nutritional meals that are needed for their compromised bodies. The status quo persisted from the days the husbands were sick. The number of hours that the widows spend looking after their sick husbands meant that production in the field was reduced resulting in low food production, Machivei recounted;

*“ From March of that year, I did not managed to be in the field and even in October when others started tilling the land I was still looking after him, he was ill for a long time”*, she explained. (Interview conducted on 03/01/2014)

Other widows stated that they lost some of their household's assets like chickens, goats and in some instances cows because they had to sell them in order to raise

funds for medication for their sick husbands. This challenge persisted even after death of the partner because it is difficult to recover the assets due of the economic hardships in the country. One widow, Sheila recounted “*you see this homestead is quiet now; all my chickens and goats are gone*”. Worst affected are HIV-positive widows because they still need to look after their health.

*“The nurse told me that I have to eat all these fresh fruits and vegetables, and not the dried vegetables that we are used to, but how can I afford them, I am no more worried about myself, and I only want these children to have a better future.”* Semeni explained, (Interview conducted on 27/12/2013).

The question of stigma needs to be prioritised for the fight against HIV and AIDS in general to be won.

#### **4.3.5. Physical factors and constraints**

Most of the widows reported experiencing health problems. Three of the widows reported that they were HIV-positive and they also suffered from other related illnesses. As a result they were finding it difficult to work hard enough for their families. One widow, Tendai recounted

*“I am recovering from TB, I could not wake up to do my everyday chores, and my only prayer to God was that I should get better so that I can work for these children. I don’t know what will happen to them if I die.”* (Interview conducted on 02/01/2014)

Those who reported to be HIV-positive were also experiencing stress due to uncertainty about the future. One of the widows, Selina was worried because she has to look after her own health as well as to look after her last child who is also HIV positive. Selina said that she could not stop worrying as it is so hard for her to see her child’s health deteriorating every day, “*to watch her lying there breaks my heart, I wish I could do more to help her, this is so difficult for me as a mother*”, she related (interview conducted on 23/12/2014).

Other widows especially those above 40 years of age reported that they experienced body aches everywhere and they could not figure out what the problem was. Mostly they attributed these complications to hard labour in their gardens or fields. This was

elucidated by Sheila who said that her whole body ached, *“you cannot point out exactly where but when you sleep and try to rest you groan and moan (interview conducted on 05/01/2014).”*

These pains greatly reduced their ability to fend for themselves and their children, as most of the work in the rural areas is manual. This notion is highlighted by Peters and Peters (1998) who state that, women remain the chief producers of food stuffs and cash crops since they are the backbone of many rural economies of Africa. Of concern was that the widows were usually the only ones left in the families, with no, or very little, assistance from other family members. What seemed to emerge from the interviews was that widows were still expected to provide for their households.

#### **4.3.6. Infection concerns**

Regarding health, a number of the widows reported that they were not sure of their HIV status; they might have accepted and buried their partners due to HIV related illnesses but were scared about their own statuses. When they related about the sick period of their husbands, most of the widows explained how it affected them and how they are unsure of their own status. They reported that they were scared to undergo HIV tests themselves. *“It is very scary for me to think of getting tested, what will I do afterwards and who will look after me if I get sick?”* asked one widow. (Interview conducted on 28/12/2014).

Two of the widows also said that they might consider testing for HIV when they get seriously sick. The thought of having to find their HIV status scared them away from testing. One widow, Zorodzai argued; *“they told us that we have to wear gloves when looking after an ill member but how can I do that to my own husband, it’s as if I am shunning him”* (interview conducted on 06/01/2014).

This goes to show that the idea of wearing gloves as a safety measure was not understood and accepted within the rural settings. Therefore, some of the widows were uncertain of their situations and could not accept the importance of them being tested.

It is clear from above that the stigma associated with HIV and AIDS is having a negative impact on the fight against HIV and AIDS. One of the strategies to reduce

the spread and mitigate the impact of HIV and AIDS is through regular testing. The stigma attached to HIV and AIDS dissuades people from checking their status on a regular basis. And if test results are positive people hide their status from everyone around them, thus making early treatment difficult.

#### **4.3.7. Lack of knowledge of legal framework**

The study revealed that widows do not have enough information about some of their rights. They lack the knowledge of how and where they could access the estates of their deceased husbands. One of the widows, Selina reported that, she was not aware if her late husband had written a will or not. Others revealed that they were aware that there was a will but were not sure of the contents. Berita was caught up between fighting for the will as well as fighting with the late husband's family who were chasing her away from the family because she did not have children. She said

*"I could not wait anymore; I had to accept defeat, I eventually decided to leave my husband's land because I could not endure the harassment any more. No one could help me. Even the police took the side of my husband's relatives".*  
(Interview conducted on 05/01/2014).

This therefore demonstrates that many victims (widows not allowed to inherit their husband's property) are afraid to report their cases for fear of being judged and interrogated by authorities and the police.

Other widows also revealed that they knew the existence of a Will but it was kept under wraps with no lawyers involved. Hence, they had to accept whatever they were ultimately given by the husband's family as inheritance of which most of them got little to none.

A widow, Gladys revealed that she is still waiting for the pension pay-out from her late husband's employers. She does not know where to start or where to go because she initially thought that the employers would contact her but she thinks that a lot of time has lapsed and that she must take action but she does not know where to go. This lack of information plays a big role in disadvantaging the widows, thereby making their circumstances more difficult.

Other widows revealed that they fought with the husband's family in order to claim their inheritance. Realising that they could not win, they were further threatened to leave that family freely but never to return or take their children along as these belonged to the husband's family. Zorodzai related how she got scared when she was told to leave if she wanted to, but had to leave the children behind. *"It was an impossible choice to make; I could not leave my children behind no-matter what the circumstances were"* (interview conducted on 26/12/2013).

This therefore shows that most of the widows especially in rural areas are not fully aware of their rights as the surviving parent of the child. According to the Guardianship of Minors Act of Zimbabwe 1995 (5:08), the law will give legal guardianship or custody of a minor to the existing parent as long as the court has deemed that she is fit and proper to act as one. Children are also interviewed for opinion on such matters; hence the widows needed full information on such matters.

In the past, if the parents of the child were married in terms of customary law, the children belonged to the father and their custody was thus not discussed on the basis of what 'is in a child's best interest'. The decision had nothing to do with the particular child or children but with who owned that child; once that ownership was settled, everything else fell into place (Bhebhe, 2011). However, the law has since changed and it puts first preference to the widow as the legal guardian of the child. Therefore widows need to be informed about the adjustments in the law regarding custody and or guardianship of their children.

#### **4.3.8. Oppressive Cultural Practices**

Cultural practices and beliefs such as polygamy were also cited by some of the widows as a challenge that they face. A number of the widows reported that their husbands had extra marital relationships which were accepted by the families. With Berita, the husband had to marry a second wife, because she could not bear children. Berita related how difficult it was for her to accept the situation of being in a polygamous marriage and that the second wife was brought without her consent. This therefore shows that some of the participants have been affected by the cultural beliefs and practices wherein men are allowed to have extra marital affairs or to marry without even the consent of the first wife.

Most of the widows reported that these kinds of cultural practices and beliefs are putting most of the women at risk of being infected with HIV. The women would rather stay in marriages even though they were fully aware of their husbands' extra-marital affairs. This has affected them emotionally in a way because dealing with the after effects of a polygamous marriage such as death and sickness was too much to bear.

The other cultural belief relates to the expectation that a woman must bear children. Berita pointed out that she was chased out of her husband's home after the death of her husband because she could not bear children.

*"I had to go back to my family of origin because the pressure was mounting on me that I should have children and failure to have them, meant that I am not worth of being their daughter in law".* (Interview conducted on 05/01/2014).

Most of the widows revealed that cultural beliefs and practices that prevent women and the girl child to have a say in the family matters played a huge role in increasing the challenges faced by widows. They noted that the belief that a daughter in law cannot have a say in the family excluded them from major decisions that affected their lives ultimately. They do not have freedom of expression in their matrimonial homes and they suffer in silence.

'In terms of culture, women like children, are considered unable to make intelligent, informed and rational decisions about their own lives, they are subjected to the paternal power.... (Kaufman, 1986)'. Other widows said that they think that no-one cares about them as a group because the government and NGOs only think about helping with food but the legal issues are never a subject of debate, hence one widow said *"I have given up, there is no one who understands my problems and I have decided not to worry about it, it is God's will and he will find a way"* (interview conducted on 26/12/2013).

The practice of woman inheritance also played a major role. One widow, Wongai, also reported that she was forced to return to her family of origin when her husband died because the family wanted her to get married to her late husband's brother. She had to leave everything as she ran away from the forced marriage organised against her will. Chifamba (2013) notes that widows may be evicted from the land when



widowed, regardless of the years they spent in marriage. The multitudes that remain on the land do so at the goodwill of their in-laws or traditional leaders. Childless widows are often evicted, as are young widows who refuse to be physically 'inherited' by a male relative of their late husband.

#### **4.4. Government and Non-Governmental Organisations' Support and Intervention programmes**

In recognition of the challenges faced by widows, many governments and non-governmental organisations provide some support. The Government of Zimbabwe and various stakeholders play a major role in supporting widows. Some of the interventions are mentioned below.

##### **4.4.1. Non-governmental Organisations**

Three NGOs were found to be active in Gutu District. These were;

###### **4.4.1.1. Gutu Development Forum**

*Gutu Development Forum* started operating in Gutu in 2012. It was formed by Zimbabwean emigrants with origins from Gutu. Its goal is to attend to the nutritional needs of poverty stricken families. This is done by promoting and funding community gardening initiatives. The organisation runs a programme on nutritional gardens in five wards. Poor women and widows are provided with fence, boreholes, seed and technical advice from agricultural experts. They are also helped in the marketing of any produce. The aim of the programme is to economically empower widows so that they can support their families by sending their children to school, while having access to a balanced diet for them.

Most of the widows pointed out that they received help from this NGO. All the unemployed widows indicated that they were taking part in the nutritional garden project wherein they would meet, plough and grow crops to sell and take some of the foods from the garden to their families. They attested to the success of the project and maintained that it could still run even if there were no rains as the NGO provided them with boreholes and seeds. Most of the widows were happy and satisfied because not only was the garden providing nutritious food, but afforded them an opportunity to meet and share experiences. Semeni explained:

*“We meet every Wednesday at the mushandirapamwe garden. The project is running smoothly and the NGO has helped us a lot as there are boreholes such that even in dry summer days we still have fresh produce. This garden project awards us an opportunity to share ideas about our different social problem”* (interview conducted on 27/12/2013).

The chairman of the organisation’s board stated that the NGO has many programmes lined up for widows but the food gardening project has proved a success.

*“As an organisation, we can do more for this usually marginalised group and we are still in the process of planning other programmes and projects that can assist widows. We are satisfied that the gardening project got a lot of positive responses”,* he explained. (Interview conducted on 06/01/2014).

#### **4.4.1.2. Medicins Sans Frontieres**

The organisation started its operations in the country in 2000. Its main aim is to provide health care and assistance to the poor in Zimbabwe. Its major occupation has been the response to the HIV and AIDS epidemic in the country. However, as a relief organisation, the MSF provides assistance with any epidemic or endemic such as the cholera outbreak that hit the country in 2008 (MSF, 2009). In addition, it provides services such as TB diagnosis, treatment, care and supply of medical equipment.

In my interview with the project coordinator for MSF Belgium, it was revealed that the organisation only assists with medical care and treatment as well as counselling. The organisation works with the hospitals and clinics in the district in providing HIV and AIDS related care.

The MSF representative mentioned that they do not have any specific programmes for widows but hope that their interventions can reach out to widows.

*“It is unfortunate that our programmes are not directly intended for widows as a specific group. We aim at providing quality medical care to HIV and TB related patients. We hope that through our programme, we can also assist widows and their families.”* (Interview conducted on 05/01/2014).

The widows especially those who are taking medication for HIV and AIDS pointed out that Mediciens Sans Frontieres has been helping them with accessing free medicine, counselling as well as nutritional advice. Widows who are getting help from MSF noted that even though they wished that the organisation could help with poverty alleviation, they were still grateful on the quality of medical services they got from the organisation,

*“The staff is very professional, they know their job and most importantly I am getting the medication and advice for free”* said one widow who receives medical help from MSF (Interview conducted on 28/12/2013).

Even though MSF does not run specific programmes to assist widows directly, it is doing well to support widows indirectly.

#### **4.4.1.3. Batanai HIV and AIDS Support Organisation (BHASO)**

In 1992, 12 people living with HIV from different parts of Zimbabwe came together in Harare to discuss their plight as people living with HIV and AIDS. They decided to go back home and start HIV and AIDS support groups and the first support group to be formed was Batanai HIV and AIDS support group (Machinda, 2011). Its aim at the start was to have support groups for people living with HIV and AIDS. However, an external evaluation carried out in 2009 recommended that the name be changed to Batanai HIV and AIDS support Organisation to allow for more programmes. The organisation runs poverty alleviation and HIV and AIDS intervention programmes for vulnerable groups which include orphans, widows/widowers who are products of the HIV scourge and the elderly.

A number of complimentary activities and programmes exist in different parts of the intended province. Its work revolves around food security and livelihood, health and nutrition, support groups, orphans and vulnerable children, youth empowerment for behaviour change, children’s Anti Retro viral Therapy literacy and gender and advocacy.

Most of the widows spoke glowingly of the organisation regarding its roles in poverty alleviation and in HIV and AIDS intervention programmes. The widows revealed that the organisation has been helping them in establishing income generating projects.

Others were involved in internal loans' acquisition and savings while others took part in gardening and sewing projects. Though the programmes sometimes experienced challenges due to lack or minimal funds, the widows were hopeful that the projects will relieve them from dire poverty.

Support groups run by BHASO helps widows to share experiences and help each other with coping strategies as Zorodzai explained,

*"It is a relief to know that you are not the only one in such a predicament, talking and sharing moments with other widows is a relief and I treasure the moments".* (Interview conducted on 26/12/2013)

The widows mentioned that they wished that more organisations could come up with other poverty alleviation programmes.

The representative conceded that there are many challenges confronting the organisation particularly the ill-health of widows. As a result, most widows are not in a position to attend projects' activities as frequently due to their deteriorating health and related factors.

Another compelling challenge cited by the respondents was the dis-empowerment of widows due to dis-inheritance. Women are castigated for having caused the death of their husbands. In some extreme cases, they are thrown out of their matrimonial homes leaving them with no means of survival and poorer than before. The coordinator of BHASO mentioned that the organisation ran some gender and advocacy programmes where in people living with HIV and AIDS are trained in human rights and advocacy. This is meant to equip them with skills that will enable them to advocate for their rights and services.

The challenge however, is that the programme is not yet in Gutu District though reports indicate that it has been implemented successfully in other districts such as Chivi. The coordinator also disclosed that funding was a stumbling block to service delivery in most cases. He recounted *"Poor funding is a challenge to service delivery-often programmes prematurely come to an end when funds run dry"* (interview conducted on 07/01/2014). However, the representative noted that they worked cordially with other NGOs and with government bodies with view to mitigate such challenges.

## 4.4.2. Role of Government Bodies

The following Government bodies provide basic services to widows and other people infected or affected by HIV and AIDS:

### 4.4.2.1. The Ministry of Public Service, Labour and Social Welfare

According to ZimVac (2014), the major aim of the Ministry is to provide assistance and support to the vulnerable through the development and implementation of effective policies and legal instruments, professional social work and training in order to promote self-reliance and social security. It also aims to reduce poverty enhance self-reliance through the provision of social protection services to vulnerable and disadvantaged groups in society. Through the review of most of their work and documents, it was deduced that the Ministry does not pay sufficient attention to the plight of widows.

Basic services provided to widows include support with school fees payment. Two of the widows mentioned that the ministry helps them with school fees for their orphaned children or grandchildren. The ministry works together with the Ministry of Education in identifying vulnerable children and put them on, the Basic Education Assistance Module (BEAM). However, BEAM reaches only a small number of vulnerable families and children.

Zorodzai explained: *“BEAM has done a lot for my family because I never worry about school fees when they are in primary school, if only BEAM could help in secondary school as well.”* (Interview conducted on 26/12/2013).

An interview with District Head for this particular ministry showed that the ministry intends to do more for the widows, but their services have not reached other segments of the community. The representative explained:

*“our ministry has a provision to grant Assisted Medical Treatment Order to widows which enables them to get free treatment in all government hospitals and we also issue bus travel warrants to widows which enables them to travel to medical centres freely”* (09/01/2014)

Surprisingly none of the widows interviewed mentioned this service which could imply that they may have never heard of it. The ministry official mentioned that it

helped women in general by linking them with other role players in the field such as NGOs which provide different kinds of services to women and children. *“We make sure that we link them with other service providers if we cannot address the issue as a ministry”* (interview conducted on 09/01/2014)

#### **4.4.2.2. Ministry of Health and Child Welfare**

The overall purpose of the Health and Child Welfare is to promote the health and quality of life of the people of Zimbabwe. It also seeks to achieve equity in Health by targeting resources and programmes to the most vulnerable and needy in the society.

The District Medical Officer (DMO) of Gutu District, however, mentioned that intervention programmes are not necessarily targeted at widows:

*“We do not have specific programmes that are aimed at widows, there is a need for a widows’ bill which will compel society and arms of the government to take serious responsibilities on widows and their orphaned children”* (interview conducted on 07/01/2014).

This is however a weakness because the Ministry is failing to achieve its aims for it does not assist widows as a vulnerable group. During the interviews with the widows, there was no mention of this Ministry which goes to show that it does not have any programmes aimed at assisting widows specifically.

#### **4.4.2.3. The District AIDS Council (DAC)**

The District AIDS Council assists widows by offering counselling as well as provision of Home-Based Care (HBC) to those households with ailing patients. The DAC also provide assistance to widowers.

According to the participants, this is a much appreciated service since most hospitals are referring patients for HBC, owing to a lack of medicine as well as the overwhelming numbers of ill patients. One widow, Selina noted that, *“It is not easy to look after ill people hence DAC is assisting a lot with information and knowledge on how we should care for our loved ones when they get sick”* (interview conducted on 23/12/2013). However, only a few of these participants knew about it. Another widow Sarudzai, a community health care worker knew about the services because she

works in other communities distributing contraceptives. She recounted that “*the DAC has many useful programmes for the HIV and AIDS but most people in the village do not know too much about it*” (interview conducted on 24/12/2013).

#### **4.5. Limitations of the investigation**

The investigation only concentrated on a small sample of widows which might not be a representative of the whole population. The problems that were related by widows including the challenges met might not be representative of all the challenges that the widows encountered in rural communities. Nevertheless, the in-depth interviews conducted presented an opportunity to probe into the problems faced by the widows. The study could be criticised on grounds of gender bias because of its exclusive focus on widows. This is a legitimate concern. Whilst challenges faced by men may not compare to women’s or widows’ there is a need to also understand issues that they grapple with.

The study was carried out in a rural community that suffers more from the harsh economic climate due to limited job opportunities. This might worsen the socio-economic status of the widows in the area and might not be the case in widows who reside in towns or in other geographical locations. There is need to cover a larger geographical area of study, mix the sample and this might create more accurate results.

#### **4.6. Conclusion**

The study into the socio-economic challenges of HIV and AIDS faced by widowed women in Gutu Central District revealed that widows in general face a number of challenges.

Widows in Zimbabwe are vulnerable to poverty whose origins lie in the country's history but have been exacerbated by the HIV pandemic. Although previously discriminatory laws have been changed, widows remain marginalised because of their limited capacity to claim their new rights in the face of government’s lack of mechanisms to enforce the law.

Widows are expected to cope with these circumstances. They do not have enough support from extended families hence they have to face these all on their own.

The study also revealed that widows face stigma and discrimination and little is done in the community to deal with this stigma and to uplift the widows as a marginalised group.

Worth noting is the fact that there is inadequate support services to specifically meet the needs of such a population. Most NGOs and government bodies have programmes that assist women in general but not specifically widows.

In addition, poverty, illiteracy and lack of information undermine women's property inheritance rights and this has led to their impoverishment. Dependents of elderly widows are left in a vulnerable position if widows die without claiming their inheritance.

Other widows have been left in despair and have lost faith and hope for a better life. For those widows that are unemployed, life is even more difficult as they have to find means and ways to make ends meet, put food on the table and look after their health.

It can therefore be concluded that the intervention programmes as offered by NGOs and Governmental bodies did not help much in addressing the plight of the said group when it comes to inheritance issues. The interventions are mainly about poverty alleviation.

Government and NGO departments are clashing in terms of service delivery in some cases, because all they seek to achieve is poverty alleviation, and yet, legally, the widows need other kinds of help to fight the scourge.



## **Chapter 5: Research findings and Conclusion**

### **5.1. Introduction**

This chapter provides an analysis of findings as outlined in Chapter 4. In the first place, key emerging issues are addressed. Secondly, the role of theory in informing the research topic is highlighted. The third section provides recommendations for addressing key issues identified. The fifth section provides a brief reflection of the researcher on the research exercise. The last section provides recommendations.

### **5.2. Key emerging themes from the study**

Through the analysis of the research findings as presented in the Chapter 4, five themes emerged with respect to the challenges of HIV and AIDS on widows in Zimbabwe. These include: single parenthood, socio-economic hardships, harsh political environment, the eclipse of change agents and the intermittent NGOs funding.

#### **5.2.1. Single parenthood**

This study found that HIV and AIDS has serious negative impacts on the life of widows in Zimbabwe. This reality is highlighted by Lund (1989) who argued that becoming widowed is a difficult life transition for most, and for some, it is a devastating personal crisis. The death of a spouse is not only an emotional loss but also a social loss, and often entails major changes in life style and role performance.

The burden of raising children and taking care of the family on their own has proved to be a daunting task for widows. The problem is further exacerbated by lack or limited access to resources. Widows still have to take their children to school and make all the available means to ensure a better future for their children as well as settling down again after the death of their husbands. The thought of looking after the children until they become financially independent is a daunting task for a single parent. Financial resources are simultaneously considerably reduced. One widow recounted her experience indicating that her life and those of her children have been negatively affected by the death of her husband. She disclosed that she was unable to maintain the same standard of living for her children.

Throughout the study, widows spoke about the challenges that they faced in taking care of families on their own. Poverty was prevalent in most of the households. The situation was exacerbated by high levels of unemployment in the area under study. The situation could be attributed to the fact that women are mainly unemployed due to culture and traditional practices as compared to most of their deceased partners. Literature has shown that women often suffer from the dependency on their partners. Their challenges appear to be exacerbated upon the demise of their spouse.

### 5.2.2. Socio-economic hardships

Throughout the course of the investigation, it became apparent that widows suffer from stigma and discrimination that is often associated with HIV and AIDS. Family relationships are no longer intact as before. Family members are left with little or no support. In this study, widows revealed that their position is still perceived as low in society since the challenges they face are far worse than when their partners were still alive.

Even though some of the widows mentioned that they were mentally prepared for the death due to prolonged illness of their husband, the aftermath did not make things easier, as most of them suffered from traumatic grief and other physical constraints related to stress. Selina related when the researcher asked her how the situation was before and after the death of her husband, she said

*“He was ill for a long time and I knew that one day death was going to knock at my door, but when he passed away it was still very difficult to accept. I need someone to talk to and someone to share the problems with but who do I go to? There is no one to talk to and lift this burden from my shoulders”*  
(Interview conducted on 23/12/2013)

The fight for the liberation of widows is an international call. In his statement on the 2013 International Widows’ Day commemorations, United Nations Secretary-general Ban Ki-Moon noted that

*“Women can be exposed to extensive vulnerabilities when their husbands pass away. Far too many widows are shut out of any inheritance, land tenure, livelihood, social safety net, healthcare or education.”*

Many of the widows are infected with HIV or living with AIDS, and dispossession, harassment and eviction often take place when their economic and health conditions rapidly deteriorate. Consequently, such widows and their children are left without shelter or other means of livelihood or support.

Most of the widows cannot participate in community organisations activities because of the financial problems and fear of discrimination. Others are also socially withdrawn. Lucia gave an example of how going to church is now difficult for her, *“I cannot participate freely in church, it seems like everyone is staring at me and mainly it is because my husband died of AIDS, they expect me to be sick as well”* (interview conducted on 06/01/2014). On the same note another widow also explained,

*“I revealed my HIV status in church because I thought the church would help me, but instead it increased the stigma and discrimination against me. My late husband’s family had accused me of being a prostitute who had brought AIDS into the family and because of that I would leave with nothing because I could not kill their relative and benefit. But I had complained to them on several times about his promiscuous behaviour but they did nothing about it.”* (Interview conducted on 02/01/2014)

Therefore, society’s reaction to affected families, often results in social rejection, as the disease is linked to socially condemned behaviours such as promiscuity and prostitution. Hortensia and Raj’s (2009) findings also revealed that widowed women were less likely to attend social gatherings because of feelings of low self-esteem, lack of identity and financial powerlessness.

Economic hardships are other major challenge that worsens the burden of the disease on the widows. These economic hardships can be explained against the background of the educational attainment of women. Economic factors in the community create power imbalances between males and females. Generally, the women will be perceived as uneducated hence unsuitable to be employed.

There is a link between poverty and HIV and AIDS. Connell (1987) points out that living in poverty is an economic exposure that places largely poor women at risk of infection in a bid to survive these hardships. Meursing’s (1997) findings suggest that

even after patient(s) had died from AIDS, surviving family members experience difficulties in overcoming the economic downturn set in motion by the event.

Another economic impact of HIV and AIDS stems from the high costs of treatment and families may go out of their way in depleting resources in trying to save the patient's life. The economic situation will most likely deteriorate from then and it will be difficult for a widow to get back on her feet after death of the husband. Instead in most cases, the challenges escalate.

Financial inequality, authority and structure of social norms have a negative impact on widows and contribute immensely to the challenges they face. This financial crisis is a perennial in most single parent families. Widows find it difficult to meet the basic needs of children. These include food, clothing, school fees, maintaining the previous standard of living and meeting personal expense. Widows have to shoulder the responsibility of their husbands' and the transformation does not come easy on them and sometimes leads to depression.

### **5.2.3. Unfavourable Political environment**

It has been observed that the political environment in Zimbabwe constraints the activities of NGOs. NGOs are not able to operate freely for fear of victimisation by opposing political forces on either side of the spectrum. This kind of environment does not improve the situation of widows because the provision of services that can improve their situation is often disrupted on political grounds.

In 2008, the government of Zimbabwe banned a number of International NGOs due to political reasons Zungura (2012). This development had an adverse effect on the people who were suffering from droughts and needed food aid. This was also revealed by one widow, Wongai who said

*"I wish CARE International was still operating because that organisation was giving us food like beans, barley, maize....it stopped working in this area and I don't know how I will survive with these children because their food ration made a great difference in my family."* (Interview conducted on 03/01/2014).

Some of the widows reported that NGOs which were operating in their areas had stopped their operations due to constrained relationships with the government.

NGOs that used to provide food aid have stopped and this is impacting negatively on many households who cannot put food on the table for their families thus worsening the level of poverty in widows' families. Most of the widows revealed that there is always a conflict among members in the community and their ward councillors depending on which political party one belongs.

*“The distribution of food by other NGOs and the government depends on which party one belongs to, we are scared to openly express our stand when it comes to politics”* said Tendai in an interview on 02/01/2014.

The perceived politicisation of the role of NGO needs to be stopped if Zimbabwe were to reverse the negative impact of HIV and AIDS on her citizens, especially women.

#### **5.2.4. The role of change Agent**

In spite of the widely reported and acknowledged devastating socio-economic and psychological impact of HIV and AIDS on widows, very little has been done to improve their conditions and the statuses. Government interventions are limited while NGOs interventions have a limited reach due to resource constraints. This derails progress with regard to assisting widows in dire situations. The study revealed that the current government interventions are not enough to meet the needs of this marginalised group.

The patriarchal nature of the Zimbabwean society especially rural communities affects women as regards inheritance and distribution of wealth. These are the challenges that most widows related arguing that they had lost property after the death of the spouse. The change agents needs to put efforts on imparting basic knowledge on the widows and to protect them from the harsh norms. Change agents have a bigger role to play in Zimbabwe. Among others they can educate women about their rights. However, deducing from the study little is done in this regard. Widows feel powerless and are convinced that they are not being helped.

Cultural norms and custom practices in Zimbabwe impact negatively on the widows less equipped and lack knowledge on how to deal with recurrent social challenges. While the difficulties that the government encounters in attempting to incorporate

African customary law into the mainstream legal system should not be underestimated. These changes are necessary and overdue, especially when dealing with those aspects of customary law that discriminate women and contradict the constitutional right to equal treatment and equality before the law (Bhebhe, 2000). Women and their children remain largely unprotected. The fact that their position has not changed and nothing much is done by the government calls for their position to be improved. Throughout the interviews widows expressed their sorrows and how they wished someone could rescue them from their problems. Machivei said,

*“I do not know where my help is going to come from, I do not know who is going to even help me with these children in such difficult times, I did not get anything from the property that their father left, he just left me to suffer alone”*  
(Interview conducted on 03/01/2014).

Women’s social risk to the disease can be addressed through a variety of public health strategies that range from education to policy. Interventions for women are destined to be less than optimally effective if they ignore the social environment (Raj et al, 1999). There is a need to review the government strategies regarding women and the protection of widows. The government has an obligation to empower widows. The call for a change towards the plight of widows in line with a call at the 2013 UN International Women’s Day Conference where the Deputy Executive Director for UN Women Lakshmi Puri said:

*“Together we must erase the stigma of widowhood, the barriers widows face to resources and economic opportunities to survive and the high risk to widows of sexual abuse and exploitation.*

The focus by several change agents is on food security and yet the widows have plethora of problems that need to be addressed. These include legal knowledge, equipment of knowledge to the communities on HIV and AIDS and general knowledge to prevent discriminatory, derogatory and degrading practices on widows who are directly and indirectly affected by HIV and AIDS. Silence drives the stigma. The discrimination and criminality that widows face on a daily basis is driven by

people who perceive the widows as docile victims. Therefore a lot of work still needs to be done to improve the condition of women of which widows are part.

### 5.2.5. Intermittent NGO funding

The sustainability of NGO operations is threatened by funding situation in Zimbabwe as in many other countries facing similar challenges. NGOs depend on donor funding and the goodwill of other people. As a result, programmes in some cases come to an end prematurely when donors cease to fund or when aid or funds are redirected to other priorities. Programmes end before achieving the desired goals and without benefitting the befitting individuals. An example was given by the district coordinator for BHASO who mentioned that the lack of sustainability of projects that they run is usually a result of lack of funds. As a result, projects do not achieve their objectives. An official with the Gutu Development Forum also stated that their wish was to bring more projects that could assist widows despite the financial challenges associated with such an expansion. Said the official:

*“Our organisation can do a lot more for widows, we have a number of ideas on paper ,ideas which are difficult to implement because we do not have the funds to break through and realise our goals, fundraising is not making much progress to bring in capital” (interview conducted on 05/01/2014)*

Therefore, widows suffer as a result of this for they cannot forge any other links that could improve their situation. Most of the widows are not sufficiently informed about the reasons regarding NGOs continued operations or incapacity to exist. This lack of information also means that they do not know of where else to go for assistance. This goes back to the issue that women are generally ill-informed or not educated enough as society frowns on them to the extent that they become too dependent on people the government and other NGOs to meet their completing demands. However, as Matshalaga (2004) notes, one of the challenges most NGOs in rural areas face has been to strike a balance between assisting poor communities and at the same, time making them more self-sufficient, so that in the event of such NGOs withdrawing, the communities could continue with the development projects. On the other hand, poverty in these communities erodes efforts towards self-sufficiency.

### **5.3. Role of theory**

The gender and power theory was employed as analytical framework in the study. The theory raised the following issues that were relevant to this study:

#### **5.3.1. Socialisation**

Societal norms and upbringing entails that women are the caregivers responsible for children and the family. In general they still take on the role of rearing children after the death of their partner even without help from the family. This task is not easy. This is due to financial constraints and emotional instability arising from the burdens they meet. As Connell (1987) notes, the presence of these and other social mechanisms constrains women's daily lifestyle practices by producing gender-based inequities in women's economic potential, women's control of resources, and gender-based expectations of their role in society.

The structure of cathexis and social norms explains that women are vulnerable to societal norms and that what is expected of them from society is different from their partners. This includes accepting other social issues like polygamy. Throughout the study, widows revealed how societal norms affected them and how they suffered in silence with little or no help from society or other family members.

#### **5.3.2. Subjugation of women by men**

Discriminatory societal norms that are persistently perpetuated against women pose a number of challenges on women and when death occurs, the problems mount. The male-dominated nature of society limits women's ability to achieve economic independence and all the other kinds of freedom.

Men's domineering attitude is further entrenched by the fact that they are more educated and thus 'more enlightened' than women. Domination by men on matters of sexual relations meant that women have little or no control and are exposed to the risk of contracting HIV. This aspect is exemplified in widows' revelations that they could not talk their partners into practising safe sex. Most of them attributed their HIV infection to this state of affairs.

Connell (1987) further points out that, women's lack of power in heterosexual relationships often translates into constraints on their sexual behaviour. Most of them



have no capacity to refuse and that alone places them at risk of contracting HIV from their partners. Other widows pointed out that their economic dependency on their partners made them vulnerable to infection.

Sexual division of labour as a structure of the theory entails gendered roles or duties. As a result, the organisation and nature of women's work limits their economic potential and confines their career paths (Wingood & DiClement, 2000). This proved to have an adverse effect on the widows as most of them were not employed and were experiencing financial difficulties. Throughout the study, widows related heart-breaking stories regarding their suffering which was aggravated by economic hardships stemming from unemployment.

### 5.3.3. The role of culture

This culture theory addresses the wider social and environmental issues that affect women. The theory traces the genesis of gender power imbalances at the socialisation stage. This power imbalance expresses itself through puberty to adulthood. Therefore, widows who took part in the study were natural victims of the process. The socialisation process teaches young girls to be passive in many ways and their expected way of living is defined by society from a young age. Negative cultural attitudes towards key populations can create an environment which has been shown to increase the risk of HIV (Day & Malache, 2011).

According to UNICEF (2003), gender and cultural practices that marginalise women, account for high levels of poverty amongst households headed by women in Zimbabwe. Relatives of the deceased husband usually grab everything leaving the grieving widow with nothing. Most of the widows spoke about how their property and other assets were taken by their in-laws who claimed that everything belonged to them.

*“My in-laws grabbed all the cows and all the other big and useful items that their brother left for me and the children, and they even banished me from ever stepping on their grounds. (Interview conducted on 27/12/2013)*

Widows fall victim of such cultural beliefs and practices because they lack adequate knowledge. They are brought up and socialised to accept such notions and there is

little or no help for them. Other widows had to leave their marital homes after being threatened by relatives that their children will be taken from them. They also lost property that rightfully belonged to them because of the adverse effects of such societal norms.

These debates seem to resonate with the culture theory. Cultural theorists see a connection between traditional norms and violence against women. Cultural theories emphasize the power of tradition and norms within African culture as explaining the widespread incidence of violence against women in general and property stripping from widows in particular (Randall, 2003). The theory as used in this study explains the unlawful and unfair property grabbing of property including unfair treatment of widows on cultural basis. Day et al (2011) maintain that women's inability to inherit land for instance, results in an economic dependence on men and a power relationship in which women are unable to negotiate the terms of sex, including consent, fidelity and condom use. This, in essence increases their risk to HIV infection.

Traditional societies do not give equal opportunities to men and women. In most families, the deceased partner was employed while the widow was not. This makes widows more vulnerable because some of them are left with no capacity to be self-sustaining as they depended more on their deceased partner resulting in them being impoverished.

The Gender and Power theory provided useful conceptual analytical lenses that crystallise the unequal balance between male and females as embedded in the society. It also provides useful insight into how the plight of widows could be ameliorated-based on the observed reality.

## **5.4. Suggestions and Recommendations for future intervention strategies and future research**

Based on the research findings and interpretations, the following recommendations are suggested:

### **5.4.1. Widow empowerment through Training**

There is need to accelerate the training of widows so that they are capacitated with knowledge on gender issues, human rights, legal matters in relation to marriages, divorce and separation. Such knowledge will assist them to assert and access their human rights. Intense training is also required on the basics of HIV and AIDS. Widows need training so that they can understand key points about HIV and AIDS and the general societal behaviour. Society itself needs basic knowledge about HIV and AIDS especially rural communities, because most rural communities lack information dissemination. Awareness campaigns needs to be intensified. The trainings should also focus on the psychological aspect of HIV and AIDS. The recommendations will be forwarded to Government bodies and NGOs for consideration.

The psychological stresses and burdens caused by the epidemic are intense. Introducing and promoting gender sensitisation and training of all service providers engaged in the administration of justice, such as judicial officers, police, paralegals and lawyers is imperative. Gunda (2009) notes that through social widowhood education; men and women can be empowered collectively and individually to take full control over their lives and situations in order to overcome problems of irrational beliefs, superstition, ignorance, illiteracy and psychological suppression.

### **5.4.2. Improvement of legal structure**

Apart from education and economic empowerment, there is a need to improve legal systems so that widows can inherit the property of the deceased directly, instead of owning it through their sons.

Current programmes aimed at providing paralegal and legal aid services to women should be strengthened. This idea stems from Gunda's (2009) suggestions which entails that another empowerment approach is legal literacy, which aims at creating

awareness through human rights education among different stakeholders in the society.

### **5.4.3. Moral and Social Support**

Moral and social support from the extended family and the community at large will assist widows to cope with the impacts HIV and AIDS. Support groups will be beneficial to the widows as they will provide pristine conditions for women to share problems and experiences. Throughout the interviews, widows indicated that they got support from neither extended families nor the community at large. The support would assist them to effectively deal with their respective situation.

Support from others will lessen the burden of the disease on the widows. Support is vital not only to strengthen their capacity to continue as the sole bread-winners and caregivers of their children but also to ensure optimal functioning for the future of everyone in their care. Most of the widows suffer from physical constraints and psychological stresses of single parenting, hence such support could make a huge difference. Widows are regarded as a silent and excluded group in many cultures and countries (Maphosa, 2013). Therefore that perception can result in more women assessing moral and social support.

Grief and bereavement counselling would assist widows in their hour of need. Grief, according to UNICEF (2002), is a normal reaction to loss. It is experienced as feelings and emotions, while it also preoccupies the mind in the form of thoughts and worries. Some people may go to the extent of pondering the meaning of life and query existential issues at a spiritual level (UNICEF, 2002).

The aura of secrecy, stigma, and social ambiguity that surrounds AIDS deaths leaves no pathway for the grieving process to follow (Karim & Karim, 2005). Thus the immediate bereaved is left unsupported to confront the bewilderment of pain, sadness, and fear. Karim & Karim (2005), states that the bereaved are shunned very often by family and friends and by community or social networks, because of the generalised uncertainty and fear that accompany an HIV and AIDS-related death. Therefore, the provision of programmes that assist widows through the mourning and grieving period would lighten the burden of the reality of loss that they are faced with.

#### **5.4.4. Support with basic necessities**

Widows and their families need a support to meet the basic needs like food, NGOs and government departments play a huge role in this regard. Currently there is minimal support from government and NGOs. And where support exists, their provisions are not adequate to meet the needs of the widows and their children. School fees payments by the relevant government department only assist a small portion of the population.

Aid agencies need to extend their services to rural areas where service delivery is usually slow and poor. There is need to provide counselling to victims of HIV and AIDS. At present, such service is very limited yet it is direly needed. Identifying certain programmes is one thing but implementation to fruition and realisation of the objectives is another. Monitoring in terms of performance and potential is therefore essential (Ayieko, 2005). The government and private organisations have to help curb the wanton manipulation of inheritance laws that deprive widows of assets and entitlements on cultural, religious or social grounds.

All socialisation agents including families, churches and traditional structures should be involved in re-orienting members of their communities to help reduce the violation of widow's inheritance rights

#### **5.5. Reflections of my research journey**

The arrival at the decision to carry out an investigation into the socio-economic challenges of HIV and AIDS faced by widowed women in rural communities of Zimbabwe came about as a result of personal experience in my extended family. I saw how the pandemic was/is ravaging families and communities at large. I struggled to build the topic but with the help of a friend and my supervisor, I managed to put the topic together.

Undertaking the investigation journey, I overlooked some of the challenges that I was bound to meet and through the investigation new issues that needed consideration started to show face. Firstly, the contact with the gatekeepers was not easy because I had to thoroughly explain and convince them that my investigation into their community was only for academic purposes. The economic and political atmosphere

in Zimbabwe is not stable and the ward councillors needed to make sure that any new people or visitors into their wards are not there for political agendas.

Some of the respondents and their families initially mistook my visits for relief work. For a number of years now, Zimbabwe has been relying heavily on donor aid to sustain the needs of many households and communities. Hence any visitations to communities are always associated with donor funders' visits. This misconception also had an impact on some of the community members that were looking forward to food aid. Selection of the respondents was not an easy task because most of the widows were willing to participate in the study and when BHASO told them that they could not partake because of their geographical location, they were heartbroken.

The study also impacted heavily on me as an individual and a woman because it revealed heart-breaking stories of how widows suffer in silence with little or no support from families, the government and NGOs. Most of the widows broke down as they related their stories. Interacting with the widows during the interviews made me to realise that their wounds were still fresh and the interviews were also a reminder of the reality of their losses as well as the fears and uncertainties that they carried in their hearts. It was a touching and sad experience having to talk until they broke down into tears.

For most of the widows, however, their believe systems kept them going. They believed that the Lord knew about their predicaments and that he would vindicate them one of the days. It was hard to carry on with the interview questions as the research was in a way opening up old wounds and in a way traumatised them. In the end I had to try and comfort the widows but had to also gather as much data as I could. The whole purpose of the investigation demanded that I harvested context rich data. The process made me realise that social research is usually sensitive because one will be dealing with human subjects. The sensitivity of the matters that were discussed meant that interviews took longer than I had scheduled and anticipated.

However I appreciate that most of the widows welcomed me warmly into their homes, even though they knew that I would not offer anything to them as payment, willingly took part in the investigation and enriched my study. With the extent of

poverty in most of the families, the widows still put a smile on their faces with the hope that the investigation will one day change their lives. I am hugely indebted to their generosity and am awed by their audacity.

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## APPENDIX A: ACCESS LETTER

Gutu Rural District Council

P.O.Box 34

Gutu

I am a Masters student in Social Behavior Studies in HIV and AIDS at the University of South Africa. As a prerequisite to attaining the degree, I have to undertake a research project that will make a difference in the life of its participants, but that will also contribute knowledge to policy makers and programme staff, as well as the general public. I am interested in carrying out a research on HIV and AIDS in your area. The title of the research is “The socio-economic challenges of HIV and AIDS on widowed women in rural Communities of Zimbabwe: A case of Gutu Central District”. I am asking for your permission to talk to the widowed women in this area about this study, in particular gain and understand the challenges HIV and AIDS has on them.

I can assure you that no harm will be done to your area by conducting this research. I will also ensure that no intended harm will be done to those individuals who will participate in the research. No payment will be made. Participants are requested to willingly volunteer their information. UNISA Research Ethics Committee has approved the procedures of this study.

If you have any questions concerning this study, please contact the following people:

Beatha Mushangwe: the researcher on 0717794316 or email at [49134531@mylife.unisa.ac.za](mailto:49134531@mylife.unisa.ac.za)

Dr T. Tamasane: the research supervisor on 0114076490 or email at [t.tamasane@gmail.com](mailto:t.tamasane@gmail.com)

Should you wish to raise a query about the study with UNISA Research Committee you may contact them at: [ethics@unisa.edu.au](mailto:ethics@unisa.edu.au) or 0883023118

I..... (Full names), hereby agree that the research be carried out in my area. I confirm that I am well informed about the purpose of the study. I would also like to acknowledge that I have received a copy of this form.

Signature of councillor/ward chairman: .....

Signature of researcher: .....

Date:.....

Thank you for participating in this study

## APPENDIX B: INTERVIEW SCHEDULE FOR WIDOWS

### A. Biographic profile of participants

Name of the participant:

1. Age

2. Highest Educational qualification

3. Employment status

Employed	
Unemployed	

### B. Household Profile

1. Household Members. How many people reside in you the same household as you for at least five days a week?

Name	Age	
1.		
2.		
3.		
4.		
5.		
6.		
7.		

2. Monthly Household Income. How much does your household earn per month and what is the source of the income?

Source of income	Amounts
Source 1	
Source 2	
Source 3	
Source 4	
<b>Total</b>	

3. Monthly Expenditure

How much does your household spend per month and on what?

Type of Expenditure	Amounts
Type 1	
Type 2	
Type 3	
Type 4	
<b>Total</b>	

#### 4. Other household Assets

1.	
2.	
3.	
4.	

#### **C. The Experiences of Widows**

1. When did your husband/partner pass away?
2. And briefly explain how the family managed during the time of sickness
3. What support did you seek? And who provided that support?
4. How was the situation after his death? What support did you seek? And who provided that support?
5. What happened to his inheritance? Was there a will that safeguarded your position and that of the children?
6. How are you and your children (if you have any) being supported by your late husband's family?
7. Do you think widowed women face challenges in Zimbabwe because of certain cultural practices?
8. Yes, do you think enough is being done to address the plight of widowed women?

#### **D. Role of Intervention Programmes**

1. What interventions are place to assist widowed women?
2. What type of assistance or support are they offering?
3. What do you think about level and/or quality of service they provide?
4. What other services would have liked them to provide which they don't provide currently?
5. Is there anything else you would like to share with me?

THANK YOU!!

## APPENDIX C: INFORMED CONSENT FORM

I am a Masters student in Social Behavior Studies in HIV and AIDS at the University of South Africa. I am conducting a research study on “The socio-economic challenges of HIV and AIDS on widowed women in rural Communities of Zimbabwe: A case of Gutu Central District”. In the main, the purpose of the study is the partial fulfilment of a MA degree requirement. But it is also hoped that its findings will elevate the plight of women suffering under the yoke of HIV and AIDS to the relevant authorities, both local and nationally.

You will be asked to contribute in this research study by providing information as answers to questions asked in the interview session with the researcher. The information will be written down for reference purposes later on by the researcher. Any information gathered will be used solely for the purposes of the study.

I can assure you that no intended harm will be done to you as an individual by taking part in this research. There will not be any payments for your participation in the study and participation in the study is voluntary. There will be no negative implications for you if you refuse to participate in the study or if you choose to withdraw from taking part in the study mid-way through the interview. Your anonymity will be maintained throughout the research process. UNISA Research Ethics Committee has approved the procedures of this study.

If you have any questions concerning this study, please contact the following people:

Beatha Mushangwe: the researcher on +27 717794316 or email at [49134531@mylife.unisa.ac.za](mailto:49134531@mylife.unisa.ac.za)

Dr T. Tamasane: the research supervisor on 0114076490 or email at [t.tamasane@gmail.com](mailto:t.tamasane@gmail.com)

Should you wish to raise a query about the study with UNISA Research Committee you may contact them at: [ethics@unisa.edu.au](mailto:ethics@unisa.edu.au) or 0883023118

I..... (Full names), hereby agree to participate in the study. I confirm that I am well informed about the purpose of the study.

Signature of participant: .....

Signature of researcher: .....

Date:.....

Thank you for participating in this study

## **APPENDIX D: INTERVIEW SCHEDULE FOR KEY INFORMANTS**

### **A. Interview Guide for Ministry of Health and Child Welfare Officials**

1. Name of the official
2. Position of the official
3. What are the challenges facing widows in this area?
4. What is the Ministry doing to address the situation? That is, what programmes are being run to assist widows
5. In your opinion how successful has the programme been?
6. What are challenges confronting the programme implementation?
7. What can be done over these challenges – if any?
8. How is the working relationship between your department and other stakeholders, especially non-government ones?
9. What else would you like to share with me?

THANK YOU!!



## **APPENDIX E: INTERVIEW GUIDE FOR NGO REPRESENTATIVES**

1. Name of the organisation
2. The name of the representative
3. Position of the representative
4. When did you start your operations in this area?
5. What types of programmes are your organisations running for widowed women?
6. What are the aims of the programmes?
7. In your view how have these programmes changed the lives of widows?
8. What have been shortcomings of your interventions?
9. What types of challenges are you confronted with?
10. How would you describe your working relationship with government officials?  
What about traditional Leaders? What about local politicians?
11. What else can be done to improve the situation of widows?
12. What else would you like to share with us?

THANK YOU!!