HIV/AIDS Community Home Based Care Baseline Livelihood Assessment for Mwenezi District, Zimbabwe. CARE.

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CARE Zimbabwe Community Home Based Care Baseline Report for Mwenezi District

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1. INTRODUCTION

This report is the baseline evaluation of CARE Zimbabwe’s Community Home Based Care (CHBC) program in Mwenezi district of the Masvingo province in Southern Zimbabwe. CARE’s CHBC program is part of its comprehensive Protracted Relief Program (PRP) that currently operates in Mwenezi district.

The main objective of the community Home Based Care component is to introduce a holistic package that includes the provision of care, agricultural inputs, hygiene and medical articles, health, nutrition, hygiene education and HIV and AIDS awareness campaigns aimed at reducing stigma and discrimination.

This chapter outlines the purpose and methodology of the baseline. It also explains how impact of chronic illness is measured by using comparison data collected during the HLSA. Finally, it assesses the population in terms of targeting criteria established by CARE. As CHBC begins to scale up in the district, it may be necessary to verify new households to ensure proper targeting is maintained.

1.1 Purpose and Objectives

The purpose of the baseline is to assess the current health and livelihood situation of households with chronically ill members currently experiencing serious health problems. The households sampled represent the potential beneficiaries of CHBC. The objective of this report is to determine the social, economic and cultural processes associated with chronic illness that lead to a deterioration of household livelihood security. The report also evaluates current care giving activities in order to determine the steps that need to be taken to improve home based care. The goal of the analysis is assist CARE by providing recommendations in developing a comprehensive program to assist households caring for the chronically ill.

This analysis employs a livelihoods systems framework which approaches the household as a unit of production, consumption and exchange within its socio-economic context. Chronic illness is a shock to household livelihood security (see Figure 1.1). The capacity of households to care for the chronically ill depends on its resource base and productive capacity. The deteriorating effect of chronic illness on household livelihood demands that CHBC programming promote such activities as asset protection, income generation and agricultural production in addition to care giving, awareness raising and the provisioning of food and medical supplies.

1.2 Methodology

The baseline was conducted with 280 households affected by chronic illness in 8 wards of Mwenezi district: wards 3, 6, 7, 8, 9, 10, 11 and 12. The selected wards are those where CARE plans to implement its CHBC program. The exercise was carried out between March 22 and April 9, 2006 by the Mwenezi district office. The baseline was designed to capture information at the household and individual levels. For the household, data was collected on household composition, assets, livestock, agricultural production, income, expenditure and social support networks. Individual level data was collected for the chronically ill and their care givers. A copy of the questionnaire can be found in Annex C.

Households eligible to participate in the survey were already registered with the Zvishavane AIDS Trust Program. A sampling frame at the village level for all 8 wards was developed.
using their beneficiary list. The sampling design used was a random selection of eligible households using a cluster approach. It was determined that a sample of 35 households per ward would be sufficient to represent the ward as well as to generate a sample representative enough for statistical analysis. Villages were selected at random and all households on the list were included. Village selection was concluded when 35 households had been identified.

Figure 1.1 Understanding HIV/AIDS in a Livelihoods Systems Framework

1.3 Targeting
Targeting of households is based on the health status of individuals and the relative wealth of the household. The most important criteria for selection is if an individual is chronically ill. Besides health criteria, targeting should include households who are most vulnerable. The purpose of this section is to evaluate the sample as a potential beneficiary population.

Data was collected on assets and livestock to give some indication of household wealth. The set of criteria used to measure wealth are those suggested by the Zimbabwe Red Cross. These criteria have been adapted as best as possible to show the wealth class of households. The variables for rural wealth classes are ownership of key productive assets (plough or ox cart), ownership of cattle and per capita availability of cereal in the household.

Poorest households do not have any assets, cattle and their food security is 1 month or less. Poor households have no assets, or no cattle or their food security is between 1 and 2 months. Average households have at least 1 asset, have up to 2 cattle, or have a food security of between 2 and 4 months. Above average households have 2 assets, at least 2 cattle and a food security of more than 4 months.

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Figure 1.2 gives the distribution of wealth ranking for the CHBC population. Targeting of households succeeding in including the most vulnerable.

**Figure 1.2 Wealth Rank of Sampled Households**

Overall, the majority of households (66%) fall into the two most vulnerable categories – poor and poorest.

In addition to wealth criteria, targeting should also be evaluated according to the health status of individuals. The baseline gathered health related information that allows for an AIDS proxy variable to be used. The specifications for this variable come from WHO\(^2\) and are used for surveillance purposes when testing is not available.

Figure 1.3 gives the chronic illness status of the patient. The majority of patients (79%) are identified as AIDS cases and another 16 percent are seriously ill. Only five percent of households have a patient who has no major illnesses.

**Figure 1.3 Chronic Illness Status of Patients**

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\(^2\) WHO HIV/AIDS Case Definition. See Annex B
Figure 1.4 combines wealth ranking with health status to show the percent of patients that fall into each category of the table. The largest group of households falls into the poor and AIDS case category (28%). Only 3 percent of patients should be considered targeting error. This is a low targeting error, however, as CHBC begins to scale up in the district, it may be necessary to verify new households to ensure proper targeting is maintained.

**Figure 1.4 Wealth Rank by Illness Status**

<table>
<thead>
<tr>
<th></th>
<th>Not Seriously Ill</th>
<th>Seriously Ill</th>
<th>WHO AIDS Case</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorest</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Poor</td>
<td>2%</td>
<td>6%</td>
<td>28%</td>
<td>35%</td>
</tr>
<tr>
<td>Average</td>
<td>1%</td>
<td>3%</td>
<td>11%</td>
<td>15%</td>
</tr>
<tr>
<td>Above Average</td>
<td>0%</td>
<td>1%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3%</strong></td>
<td><strong>10%</strong></td>
<td><strong>45%</strong></td>
<td><strong>57%</strong></td>
</tr>
</tbody>
</table>

1.4 Focus Group Discussions

In addition to the baseline survey, focus group discussions was conducted to better understand the conditions of stigma and discrimination, livelihood and coping strategies as well as primary care giving to the ill. Data from the focus groups combined with quantitative survey data collected the week prior provides a rich dataset from which statistical descriptions and narrative discussions can be drawn to produce an accurate discussion of chronic illness at the local level.

Focus group discussions were conducted in sex disaggregated groups of chronically ill, care facilitators, primary care givers, youths and non beneficiaries. The objective is to build our understanding of the pandemic regarding issues such as livelihoods, coping strategies, stigma and discrimination and the quantity and quality of support needs. FGDs were conducted with the Ministry of Health & Child Welfare and the District AIDS Action Committee.