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**THE EFFECTS OF POVERTY ON HEALTH EQUITY IN ZIMBABWE: THE CASE
OF CHEGUTU URBAN DISTRICT**

By,

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ABSTRACT

This study employed a qualitative methodology to investigate the effects of poverty on health equity in Zimbabwe. The investigation was motivated by the fact that the effects of poverty on health in Chegutu District have not yet been examined systematically despite the fact that the focus on poverty and equity considerations dictates the opportunities for equal health for the marginalised people. The contemporary socioeconomic crisis in Zimbabwe has posed a serious challenge to the comprehensive and equitable health systems and wellbeing. There is mounting pressure globally to implement appropriate interventions that can contribute concretely to health institutions' efforts to tackle poverty and health inequities. In Zimbabwe, the extent to which poor people, households and social groups are accessing the resources to be healthy strongly determines their health potential. The study also examined the role of the non-governmental organisations and the town municipality in addressing poverty and promoting health equity in Chegutu. It was established that the focus on poverty entails the broader commitment of the local government and NGOs to the achievement of greater equity in health using a human rights framework to consider both poverty and equity. In practice, all systematic differences in Chegutu could be regarded as unfair and avoidable, and therefore regarded as inequities. The evidence points to the existence of extensive and widening social inequities in Chegutu District which have escalated the unequal distribution of diseases and survival in the district. The complexity of poverty as it relates to the distribution of health in Chegutu demands new ways of understanding the growing rich-poor gap. Thus to understand this complexity the Capability Approach and the Sustainable Livelihood Approach were used as the basis for critical appraisal of the variables under study. This study advances the

understanding of the urgent need to take action to reduce these inequities and their root causes. The study calls for new ways of thinking about the direction of policy and also calls for renewed vigilance in monitoring impacts, to make sure that no segment of the population is excluded. Their implementation is seen to be dependent on increasing the capacity and organisation of the poor to more strongly influence policy and resource distribution in the health sector. It is important that health services respond effectively to the major causes of preventable ill-health among the poor and disadvantaged so as to address these continuing inequalities.

Keywords: Health; Poverty; Equity, Social justice; Health services; Resource distribution

DECLARATION

I, the undersigned, hereby make a declaration that this dissertation entitled, “The effects of poverty on health equity in Zimbabwe: The case of Chegutu District” is the product of my own work. All the sources that I have quoted or used have been acknowledged or indicated by means of completed references. I also declare that this dissertation has not been submitted and will not be presented at any other institution.

.....

Signature

_____/_____/2016

Date

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DEDICATION

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LIST OF ACRONYMS

| | |
|------------|--|
| CSDH | Commission on the Social Determinants of Health |
| DFID | Department for International Development |
| ESAP | Economic Structural Adjustment Programmes |
| FAO | Food and Agriculture Organization |
| FTLRP | Fast Track Land Reform Programme |
| GMB | Grain Marketing Board |
| HDI | Human Development Index |
| HIV/AIDS | Human Immunodeficiency Virus Infection/ Acquired Immune Deficiency Syndrome |
| NGO | Non-Governmental Organisation |
| OECD | Organisation for Economic Co-operation and Development |
| PHC | Public Health Care |
| SDF | Social Development Fund |
| SL | Sustainable Livelihood |
| UNICEF | United Nations Children's Fund |
| USAID/DART | United States Agency for International Development /Disaster Assistance Response Team |
| WHO | World Health Organisation |
| WSSD | World Summit for Social Development |
| ZANU-PF | Zimbabwe African National Union Patriotic Front |
| ZIMASSET | Zimbabwe Agenda for Sustainable Social and Economic Transformation |
| ZIMPREST | Zimbabwe Programme of Economic and Social Transformation |

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Figure 1: Sustainable Livelihood Approach

CHAPTER ONE

BACKGROUND OF THE STUDY

1.1 Introduction and Background

The study seeks to explore the effects of poverty on health equity in Zimbabwe, with special reference to the town of Chegutu. In particular the study seeks to assess how poverty influences health equity. It also seeks to examine the role of the non-governmental organisations and the town municipality in addressing poverty and promoting health equity in the Chegutu urban municipality of Zimbabwe. The focus of the study is primarily based on the premise that the elimination of poverty, the promotion of health and equity are concepts central to the current global development discourse. As a result, it has become more difficult if not impossible to ignore the rich-poor schism.

Locally and globally the poverty levels seem to be on an increase despite various declarations to alleviate it as enshrined in the Millennium Development Goals (MDG) and other related drafts. While there is no commonality about the experiences of poverty there is consensus that the poor are suffering the most. Yet little action has been undertaken to capture their views and experiences about poverty and its impact on their health and wellbeing. This is despite the fact that the relationship between poverty and ill health has been witnessed globally and the World Health Organisation (WHO) has been vocal in advocating for an equity-oriented strategy for poverty and health as enshrined in Alma Ata Declaration of 1978 (WHO, 1986: 1). Blas and Kurup (2010: 6) argue that it is acknowledged in development literature, largely in the sphere of health, that if countries are to deal effectively with health challenges and to achieve the Millennium Development Goals related to health,

especially from an equity standpoint, there is need to address the upstream determinants of health and go beyond the traditional health interventions. In line with this study, this entails focussing on addressing poverty as it relates to the social and economic conditions that people live in. In the same manner, the World Bank has espoused growth with equity strategy as a vital economic constituent of development and is tremendously supportive of the notion of investing in the poor people as a strategy of inclusive development and the promotion of health for all (World Bank, 2000: 83).

The link between poverty and poor health is undeniable. However, the notion of whether poverty leads to disease or diseases causes poverty is a complex problem and an intricate chicken and egg equation. In the same vein, Anyangwe and Mtonga (2007: 94) argue that some African governments have even blamed all diseases plaguing the continent on poverty and some have even claimed that poverty itself is the true African disease. Interestingly, there is nowhere in the world where health challenges are more acute than in Sub-Saharan Africa. The region consists of only 13% of the global population. Nevertheless, Sub-Saharan Africa accounts for 24% of the worldwide disease burden (Anyangwe and Mtonga 2007: 94). The burden of diseases and frail public health system are rooted in a broader context of poverty and underdevelopment. Thus, there is need to assess poverty as it relates to health and livelihoods of the poor bearing in mind the fact that in Sub-Saharan Africa, health challenges or the burden of diseases in poverty stricken areas are alarmingly increasing at a time when the social and economic conditions in the region are drastically decreasing (Wiggins, 2005: 3).

In the same vein, the importance of analysing poverty in relation to health equity can be traced back to 1978 when the World Health Organization (WHO) member states acknowledged the importance of social, environmental and economic factors as the basis for national health policy (WHO, 1978), thus shifting the sight away from the biomedical approach to a paradigm that focuses on economic, social and political health determinants (Carpenter, 2000: 36). According to Braveman and Gruskin (2003: 254), the pursuit of health equity refers to the elimination of health differences that are closely linked with social or economic disadvantage. The sentiments echoed by Braveman and Gruskin (2003: 255) reflect that health disparities are prevalent among those groups of people who have systematically experienced greater social and economic problems. In this regard, health equity is the principle underlying a commitment to reduce and to alleviate poverty. Therefore, pursuing health equity entails striving for the highest possible standard of living for all people.

In the view of Hofritcher (2008: 18), health equity simply means social justice in health. This entails action on unjust conditions that are linked to poverty that affects the equitable health distribution. Drastic economic challenges in a number of countries had resulted in equity and pro-poor policies being neglected. This has had serious implications in the equitable distribution of health. However, there is a revived concern for the reduction of poverty as a panacea to achieve equity in health in the global development agenda. Interestingly, the major concern is whether this focus on the reduction of poverty as it relates to health disparities is reflected at the country level. Whitehead et al (2001: 834) established that policy choices affect the health of people. Thus policies that are committed to reduce inequalities in health should be explicitly highlighted in the national development policy documents.

Past and current experiences have established that without addressing problems of poverty and questions of resource distribution, human development is grossly affected. In its 2003 report, the World Health Organization highlighted that poverty is a crucial determinant in the development of public health and called for the regeneration of primary health care (WHO, 2008: 12). Kawachi et al (2002: 647) acknowledged that people who are entrenched in poverty usually experience high rates of illness and deaths. Therefore any efforts towards achieving equity in health should focus on the reduction of poverty and addressing the disadvantaged position of the poor.

Similarly, in Zimbabwe the reduction of poverty as it relates to equity in health is fast becoming an integral development goal for the public health. However, it should be noted that equity is interpreted differently by different people. Equity in health as highlighted by Whitehead (2007: 478) means that ideally every person could achieve their fullest possible health potential. More pragmatically it entails that none must be deprived of attaining such potential due to one's social position or any other socio-economically determined conditions. Thus, any plans to promote health equity in Zimbabwe should focus on addressing poverty, removing barriers and creating opportunities to help people to achieve their full health potential and to bringing health disparities to the lowest possible levels. Whitehead (2007: 479) further asserts that equity in health involves the fair resource distribution necessary for health, just and fair access to the available opportunities as well as fair support given to people when they get ill.

The WHO Commission on the Social Determinants of Health in 2005 acknowledged the importance of addressing poverty in the pursuit of equitable distribution of health.

The Commission on the Social Determinants of Health (CSDH) argues that it is fruitless to treat people and send them back to the same conditions that are responsible for creating illness (Marmot, 2004: 82). This assertion poses a strong challenge to global public health systems especially in Zimbabwe, not only to acknowledge the prevalence of both rural and urban poverty as a serious pathway to poor health and health inequities, but to urgently address this as a critical public health concern affecting a significant global population (Raphael, 2011: 221). Thus, the focus on the relief of poverty and the pursuit of equity in health as a development issue has become central to the planning of development activities. It needs to be acknowledged that the Alma-Ata goal of worldwide health for all had somehow lost its significance in Zimbabwean health discourse over the past years.

The notion of poverty and inequalities as it relates to development priorities in Zimbabwe can be traced back to years before and after independence. Mentan (2010: 37) posits that the ushering in of a new political dispensation in Zimbabwe created a lot of expectations, especially among previously disadvantaged groups who looked forward to the reversal of the inequalities of the colonial past with respect to access to social services and resources. Indeed, in the 1980s, Zimbabwe made creditable progress in redressing these disparities. The country indeed committed itself to redressing the historic legacy of the colonial era and to promote the welfare of the previously disadvantaged groups in the country (Bautista, 2002: 28). Thus the concept of equity occupied the centre stage in Zimbabwean development policies. However, the need for equity in the distribution of health has re-emerged in the Zimbabwean public health as new evidence suggests that some segments of the population are still lagging behind in terms of their health status. This brings again to

the fore, the importance of analysing the impact of poverty as it relates current inequities in health.

The linkages between poverty and health have been noted for centuries. However, the considerable growing health disparities have led scholars to question the way pro-poor health programmes and poverty reduction programmes are actually designed. The CSDH (2008: 2) argues that the existence and perpetuation of inequities is closely related to the direct influence of health public policies, as well as the benefits and opportunities that these policies offer citizens so that they can enjoy their maximum health potential. Raphael (2009: 1) identified poverty and its facets of material deprivation as major factors determining health outcomes of poor households and described them as serious concerns in the public health discourse. It is an excruciating fact in Zimbabwe that the burden of illness is severe among the socially disadvantaged populations who have limited access to the resources and conditions that support health (Patrick, 2011: 14).

The 1978 Alma-Ata Declaration was an important breakthrough in the field of public health in the 20th century as it recognised the importance of tackling poverty for the realization of health for all. However, thirty seven years after the signing of the declaration, Zimbabwe's public health profile is showing no signs of improvement, instead it is declining (Chevo and Bhatasara, 2012: 10). The country is now witnessing very high rates of mortality as compared to statistics of the 1990s despite the fact Zimbabwe is a signatory to the Alma Ata Declaration (Mlambo, 2014: 54). However, it is important to note that the decline in the quality of population health is simultaneously taking place at a time when every aspect of Zimbabwean social and

economic life is in ruins. This brings to the fore the significance of exploring the impact of poverty as it relates to population health.

Cognisant of the fact that Zimbabwe's health system, only a decade ago, was among the best in Sub-Saharan Africa, it becomes mind-boggling to note that The Zimbabwe National Statistical Agency (2009: 5) established that many Zimbabweans are being affected by a heavy burden of disease dominated by preventable diseases such as HIV/AIDS, tuberculosis, malaria, diarrhoeal diseases and other vaccine-preventable diseases. However, the fact that The Zimbabwe National Statistical Agency (2009: 1) also pointed out that in the last five years, the country's' poorest have suffered the most raises suspicion over the relationship between poverty and poor health.

It should be noted that despite the attempts that have been made to make health care accessible to all the people in Zimbabwe, the poor remain the most disadvantaged in the general measures of health, such as life expectancy, disease patterns and mortality rates (Patrick, 2011: 17). Malnutrition, for instance, is higher in the most remote parts of the country, and in the poorer communities within the urban areas. Generally, health inequities in Zimbabwe are increasingly worsening despite the fact that the government adopted a number of macro policies and programs with clear pro-equity goals and objectives. Mazingi and Kamidza (2011: 323) are of the view that the health profile in Zimbabwe predominantly reveals a society whereby the more affluent segments of the population have the potential to enjoy health to the fullest while the economically disadvantaged groups continue to be affected by pathologies such as increased rates of infectious and chronic diseases. Thus, according to Sanders and Chopra (2006: 73) any reasonable explanation for poor

performance in health requires a disaggregation of these inequities and an interrogation of their underlying causes.

Mazingi and Kamidza (2011: 326) argue that despite achievements in the health sector in the post-independence era, inequities in health have persisted in Zimbabwe and in some cases have even widened. Fong (2010: 23) further argues that a lot of marginalised and deprived citizens in Zimbabwe have failed to improve their achievements in health. This brings to the fore the importance of addressing poverty as it relates to the distribution of health. This is grounded on the reality that poverty has stood to be a real challenge to the majority of Zimbabwean citizens despite the commitment of the government to pursue pro-poor health policies and interventions vigorously (Fong, 2010: 23)

In actual fact, the vision of an egalitarian Zimbabwean society as envisaged after the attainment of independence has been blurred due to the failure of development policies and programmes to effectively deal with poverty and inequalities in the distribution of resources, especially in the country's rural and peri-urban communities. This scenario has necessitated the marginalisation of the poor segments of the population in Zimbabwe in development efforts making it difficult if not impossible to achieve health equity in a society perceived to be guided by principles of distributive justice as enshrined in its development policies. To this effect, this paper seeks to explore the poverty conditions which have affected the implementation of inclusive development strategies which are congruent to the Zimbabwean egalitarian vision and to the promotion of health for all. This study thus offers an opportune moment to examine the effects of poverty on health equity in Chegutu urban municipality of Zimbabwe.

1.2 Problem statement

Poverty remains a serious problem in Zimbabwe despite the national achievements made in the post-independence era and a number of pro-equity policies adopted by the government to promote people's livelihood, wellbeing and health. UNDP (2014: 1) indicates that about 72.3 percent of the population in Zimbabwe is still languishing in poverty. Consequently, 62.6 percent of households in Zimbabwe are poor and as a result they continue to experience the worst health due to inequities stemming from the impoverished conditions that they live in.

Likewise, poverty remains a major predictor of health and mortality in Zimbabwe and is associated with undermining a range of significant human attributes. Subsequently, poor health hampers human capital, thus perpetuating a vicious poverty cycle and poor health. Thus, the low capabilities of poor households entail that ill-health shocks often dwell cheek and jowl with them. This has led to an increase in rich-poor gap. The conditions of the poor are not by any means natural, they are a reflection of the toxic combination of poor social policies and programmes, unfair economic arrangements, and political injustices. This situation is greatly affecting the livelihood opportunities of poor people and likewise threatening health systems as evidenced by high rates of avoidable deaths and diseases like HIV/AIDS, cholera and typhoid among poor households in Zimbabwe.

More so, poverty and inequalities have far reaching consequences for outcomes that are intrinsically important to poor people's health. The inequalities in health conditions can create further social, economic and political problems in the country and can further strain people's health and health service delivery. Consequently, it is the poor who are most vulnerable to diseases caused by the inequitable distribution

of health resources. This poses a real challenge and need to understand the inequitable distribution of health in Zimbabwe as well the processes that shape these patterns and find explanation for the trends that emerge. Against this backdrop, the question arises as to what are the effects of poverty on equitable distribution of health and how the poor perceive their vulnerability.

1.3 Aim and Objectives of the Study

The main aim of the study is to explore the effects of poverty on health equity in Zimbabwe. The sub objectives are to

- assess the effects of poverty on health distribution among poor households in Chegutu urban municipality,
- examine the role of the local municipality and non-governmental organisations in addressing the poverty and promoting health equity,
- identify a way forward for equitable inclusive health distribution for development.

1.4 Significance of the Study

Limited data on the impact of poverty on health equity has necessitated this study. There is very little data that has been streamlined to focus on the disparities in the social distribution of resources, the social and economic conditions that poor people live in and the overall implications of these factors on population health. Yet these conceptions are very important to understand the poor's own perspectives for the purposes of finding entry points for equity in health and capacitating the poor. Most studies done in Zimbabwean health domain, for example, "*What is the way forward for health in Zimbabwe?*" by, Ray, Madzimbamuto and Sanders (2010), have mostly

focused on health care and health care services utilization, while studies that have dealt with poverty have failed to factor in the implications of poverty as it relates to equity in health from the perspective of the poor themselves.

Thus it is the absence of comprehensive studies that examine the impact of inequitable social distribution of resources and services that support health on poor households in Zimbabwe that has given impetus to undertaking this study. This is based on the reality that it is only after the understanding of the conceptions of the poor that policymakers can begin to talk about the need for equity as a point of departure in health. Therefore, this study seeks to fill this knowledge gap by examining the link between poverty and the increased risk of ill health among poor households from the lens of the poor. This will help to better understand the reasons why poor households are vulnerable to diseases, illness and poor health.

Much of the health data, for example HIV/AIDS statistics, mortality rates and many of the existing health literature in Zimbabwe , fails to take a multilevel perspective that links social system characteristics with individual health outcomes. There is no research that has been done in Zimbabwe to view health outcomes in terms of the interacting processes of marginalisation, social exclusion and social stratification. Thus, this study will demonstrate the pathways by which poverty affects health outcomes and makes clear the linkages between poverty and health inequities as experienced by the poor and the vulnerable segments of the population. This study will capture the importance of poverty as a determinant of health outcomes.

Thus, the study can contribute valuable, unique and concrete guidance for actions of local, national and international organizations concerned with health and development related issues. The discussions made in this study will lead to greater

awareness of the need to accelerate progress in reducing health inequities and to establish a way forward for equitable inclusive health distribution for development.

1.5 Delimitation of the study

This study will only focus on Chegutu urban municipality since it is one of the areas that have been experiencing deepening poverty levels and consequently rendering the area vulnerable to serious challenges and disease outbreaks. This study focuses only on poverty and health equity issues that are linked to poverty, social exclusion, social and economic conditions. Issues of poverty and equity that relate to gender, sexual orientation, and geographical location are not the focus of this study.

1.6 Chapter Outline

Chapter One

This chapter provides the background of the study, problem statement, aims and objectives of the study. It also provides the significance of the study as well as the delimitation of the study.

Chapter Two

This chapter provides the theoretical framework of the study. A detailed discussion of the Capability approach and the Sustainable Livelihood approach and their implications to poverty and health equity will be given.

Chapter Three

The third chapter focuses on the study area. It discusses the history of poverty in Zimbabwe and how the government has attempted to address it focusing on the policies and poverty intervention strategies and how these have dealt with the issues of equity.

Chapter Four

The fourth chapter deals with research methodology and provides the research design, data collection techniques, sampling procedures, population of study, methods of data analysis and ethical issues. The chapter also provide a presentation of research findings.

Chapter five

Chapter five provides the interpretation, analysis and presentation of the research findings.

Chapter Six

Lastly, chapter six provides the conclusion to the whole study as well as the way forward.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The measurements and approaches to poverty are diverse. They vary from conventional approaches to poverty based on income and alternative approaches that take cognisance of social and economic indicators as well as participatory assessments of poverty. Recently, the concern over the deepening poverty and health challenges in developing countries have resulted in critical thinking and advanced research in epidemiological discourse (Marmort, 2004: 82). This complexity of poverty as it relates to the distribution of health has called for new ways of understanding the growing rich-poor gap. The importance of understanding poverty intervention mechanisms with respect to health is embodied in the Ottawa Charter that called for and promoted new forms of public health interventions guided by core values of empowerment and participation (WHO, 1986: 1). Thus a sound theoretical framework that is challenging and thought-provoking in action on poverty and inequality is very critical at this juncture.

Like poverty, health equity is a complex issue that can be approached from different perspectives. However, over the years, there has been a tendency, in global health agendas, of relying on narrowly defined, bio-medical approaches of public health interventions (WHO, 2008: 12). There is a growing need for a health to be taken as a social phenomenon. Consequently, this calls for new and more complex methods of inter-sectoral policy action, which is somehow linked to a broader agenda of social justice and the reduction of poverty. To understand the complexity of poverty as it relates to the distribution of health, the Capability Approach and the Sustainable

Livelihood Approach were used as the basis for critical appraisal of these variables under study. These theories enhance the understanding of poverty and health equity in Zimbabwe and help to inform the formulation of policies as well as to illuminate entry points for policy interventions and action.

2.2 The Capability Approach

The capability approach is one of the most predominant paradigms for policy debate and conceptualising development. The notions of development and human well-being have been extensively emphasised by Amartya Sen in his writings. Clark, (2002: 5) argues that the ideas of Amartya Sen mainly consist of a critique of conventional notions of development and the establishment of an alternative framework for conceptualising wellbeing, with particular emphasis on the human capabilities and the freedoms that people have reason to value. Thus, Amartya Sen challenged the supremacy in the income definition of poverty and advocated instead a definition of poverty grounded on the capacity of the poor people to improve their condition (Gwatkin, 2003: 541).

Interestingly, the ideas of Amartya Sen have also gained immense support from institutions like the United Nations Development Programme (UNDP) that measures poverty in terms of a human development index which includes health status alongside income and education. The concepts of poverty and health are complex and interlinked and it can be logically deduced that health is wealth. Therefore, if welfare is broadly measured not only in conventional terms of income, then poor health alone is a form of deprivation that is encompassed in poverty. In line with this thinking, Sen (2000: 21) characterized poverty as deprivation of capability. This inference refers to instances where people lack the freedoms that they need to lead

the kind of life they have reason to value (Sen, 2000: 18). This notion has been incorporated in the UNDP measure of well-being, Human Development Index (HDI) that gives emphasis on the achievements in the basic human capabilities (UNDP, 1990).

Wolff and De-Shalit (2007: 26) highlighted the view that the capability approach can be used as a normative framework that aides or guides the design and evaluation of policies and institutions. More so, Robeyns (2005: 93) defended this perspective by arguing that the approach articulates a broad framework and moral basis for people's entitlement to health capability. More often, in addressing development hitches such as poverty or economic development, practitioners and researchers have built upon ideas raised by Sen in the Capability Approach (Alkire, 2005: 116). Hence, the Capability Approach can be harnessed as a useful tool for understanding the growing rich-poor schism between and among different groups of people globally and particularly in Zimbabwe, especially as it relates to the distribution of health. To that end, Venkatapuram (2009: 224) asserted that disparities in mortality and ill health in poor countries have been conceptually brought together under the umbrella term of public health inequity. It is then that focus on equity that saw the emergence of the capability approach in the development discourse as one of the leading frameworks for thinking and conceptualising poverty, public health, inequality and human development in general (Clark, 2002: 5). Clearly, the approach views poverty and inequity as a result of deprivation or failure to achieve certain functionings (Alkire, 2005:134).

Furthermore, the capability approach has increasingly become relevant in academia and policy making; the core reason being the fact that the approach assesses well-being and judgements about equality, or development of a community not primarily

focusing on resources but on the opportunities that people have to lead the lives they have reason to value (Alkire 2002:11). However, the challenge has been on how to ensure that the vulnerable populations or the poor achieve their potential to lead a life they have reason to value (McIntyre and Rondeau, 2013: 1). The reality has been that the poor people have less access to conditions necessary for health and well-being. Therefore, the capability approach offers an intervention mechanism which ensures that the poor have access to resources necessary for their health and that they exercise control over their own development initiatives.

Coast et al (2008: 668) argue that perhaps, the capability approach is the recent approach to be harnessed towards the conceptualisation of equity in public health. Its prominence is grounded on the premise that the capability approach can offer a new basis for thinking or perceiving poverty and health equity. Sen, (2005: 156) clearly states that the capability approach focuses on the evaluation of programmes and actions on the basis of the degree to which a person is able to function in a certain way, whether or not he or she chooses to do so. Thus this approach is useful in providing insight as to whether the poor have poor health on the basis that they choose to do so or as a result of deprivation of certain capabilities. Nussbaum (2006: 48) highlighted that, for decades, approaches to poverty in the global development and policy making world were obtuse in human terms for they advocated economic growth as the basic and sole goal of development, focusing specifically on GNP per capita. Therefore the capability approach offers a new multidimensional way of conceptualising poverty and offers the basis for intervention justified by health equity considerations.

Most importantly, it should be noted that the income measurement of development did of course not take into account issues of distribution and thus such approaches

were utterly useless in countries with high rates of poverty and inequality (Sen, 2005: 154). Nussbaum (2006: 50) argues that unlike the capability approach, neo liberal approaches to poverty reduction are actually worse than useless in the sense that they gave high marks to nations that contained huge inequalities, instilling a mind-set that such countries are actually doing good. South Africa is a good example of a country that has done outstandingly good in terms of economic growth while breeding huge inequalities (Ozler, 2007: 487). It is no wonder then that in South Africa, there are high levels of inequality in socio economic status between and among various groups of people (CSDH, 2008: 2). This has helped to exacerbate inequalities in health and in most cases the poor are the victims. The realisation of this blurriness of the conventional approaches to development have thus given impetus to new approaches to development with the capability approach being the newest approach to be explored especially towards achieving equity in public health.

The capability approach has provided for new working tools for thinking about poverty, equity and fairness in the distribution of health (Sen, 2009: 2). Thus the work of Sen has developed and defended a framework that is concerned directly with social justice, human freedoms and capability (Sen, 2005: 153). In that regard, Sen (1999: 3) and Marmot (2004: 82) assert that unequal social distribution of resources, power and status impact on the freedom of people to lead valuable lives and to participate in the decisions that affect their lives and to take control of their lives. These are undoubtedly the same issues that are at the centre of any public health initiative. Hence this approach is useful in examining the extent to which poverty and health programs have advanced in addressing the challenges that limit human development. This is critical taking cognisance of the fact that UNDP continues to challenge the world to look at poverty from a human development

standpoint. A human development perspective looks at poverty as a denial of opportunities for people to lead a life they have reason to value.

In addition, Hick (2012: 291) asserts that a poverty analysis framework must reflect economic shocks and societal change in human terms. Basically, this entails that there is need for the right concepts and measures of social exclusion and deprivation, for it is in deprivation that poverty manifests itself (Venkatapuram, 2010: 119). The Capability approach has been used to show how poverty in the form of deprivation tragically shortened the lives of many in Sierra Leone where access to water, nutrition and medical care have been a challenge. Ideally, if the approach was useful in conceptualising poverty in Sierra Leone, then it can be of mammoth importance in understanding poverty in Zimbabwe. More so, the approach takes cognisance of the fact that it is denial of choices and opportunities crucial to the notion of human development that limits people to have healthy lives and to enjoy a valuable living standard (UNDP, 2014: 1) Therefore, the capability approach provides a framework to reflect the many ways in which human lives can be blighted, and which thus offers some promise for poverty analysis. WHO (2011: 16) argues that poverty is a key determinant of equity and justice and as such it determines the capabilities of people to live healthily and to partake and benefit from development initiatives.

Sen (1992: 2) justifies the importance of the capability approach when he articulates that this approach is people centred. This argument is grounded on the fact that it focuses on what people are able to do and be. This refers to capabilities and opportunities. Sen (1992: 4) critically argues that when analysing the concept of well-being, focus should be shifted to the actual opportunities a person has and not just focussing on the means of living such as income. This paradigm shift focuses much

on the functionings and capabilities of people (Sen, 2009: 4). Hick, (2012: 299) highlighted that the fundamental importance of the capability approach is the emphasis on real or substantive freedoms, since opportunities and capabilities are that one could exercise them if so desired or have the choice to do so. This notion is grounded on the reality that the purpose of development is to advance human lives by expanding the range of things that enable one to be healthy and well-nourished and to participate in the community. Taking it from this view, development is about eliminating the barriers that limit what a person can do in life such as lack of people's access to resources, illiteracy and lack of freedoms (Sen, 2000: 19). It then becomes more realistic to conclude that a variety of social factors that affects health equity are rooted in social deprivation and marginalisation. Hence, the capability approach becomes necessary in conceptualising the variables under study.

The capability approach's fundamental strength is the clarity about the objective of poverty reduction strategies. This understanding is based on the argument that the capability approach views the expansion of the freedom that deprived people have to enjoy 'valuable beings and doings' as the major objective of both poverty reduction and justice (Alkire, 2005: 123). The approach argues that poor people should have access to the resources necessary for their wellbeing, and that they should be in a position to make choices and decisions that are of concern to them. The other crucial point to note is that the capability approach does not only criticise the income or conventional approach to poverty, rather it provides alternative space in which to conceptualize and understand issues of poverty reduction and justice (Sen, 2000: 17). In the lens of this approach, this space involves multiple freedoms and functionings. The capability approach is thus a paradigm shift and an alternative way of evaluating and identifying intermediary actions which includes but is not limited to

social investment, growth and participation that might contribute to the expansion of valuable capabilities (Alkire, 2005: 125).

Given the close relationship between poverty and health, a commitment to equity in public health automatically implies a commitment to the reduction of poverty, and the multiple social disadvantages associated with material deprivation. In addition, WHO, (2008) argues that poverty and sickness often interact to create a vicious cycle. This vicious cycle means that health shocks keep households into poverty and vice versa. In India, for example, a child born in the poorest 20 per cent of the households is more than three times likely to die before the fifth year compared to one born in a rich family. For many poor people, the damaging effects of economic poverty on health constitute inequalities and deprivation. Hence it is that focus on deprivation that gave the capability approach a cutting-edge in this study.

The capability approach emphasises the importance of equity as an ethical concept enshrined in the principle of distributive justice. Thus the concern about health equity implies the concern to the reduction of unequal health opportunities. Braveman and Gruskin (2003: 254) argue that in operational terms, the pursuit of health equity means eliminating those health determinants that are systematically linked with underlying disadvantaged position of the poor and marginalization. Thus a framework for equity systematically centres attention on the marginalised and socially disadvantaged people and groups within and between countries. Therefore, the capability approach offers the basis for understanding the disadvantaged position of the poor and to find pathways to equity in health distribution.

More so, the Ottawa Charter of 1986 concluded that health promotion involves the process of enabling people to improve and increase control over their health (WHO,

1986: 1). The Charter was, in essence, referring to empowerment which is both the outcome and process whereby communities or people increase control over the decisions that concern their lives, which is therefore critical to building equity in health which is central to the capability approach. Therefore, the significance of the capability approach is grounded on the reality that it proposes for social actions and programmes that aim to develop people's capabilities and freedom to promote their choices to enjoy healthy lives

2.2.1 Capability Approach and the Functionings

Proponents of the capability approach would undoubtedly agree that development is all about ensuring that people live the lives they choose and value. To this end, functionings are critical to the conceptualisation of human development. In the same manner, Sen (2009: 3) argues that capability is a reflection of the freedom that people have to achieve valuable functionings in life. Functionings can best be understood as what people are able to be and do and have reason to value (Ruger, 2010: 41). The proposed definition of functionings can tell that functionings are valuable both objectively and to the conceptualisation of poverty. However, as much as functionings are valuable, that does not necessarily mean that they can be automatically reduced to a single concept. This therefore entails that poverty alleviation strategies or development projects should aim to expand human capabilities not to maximise utility or income per se.

It should also be borne in mind that the capability approach rather acknowledges the various kinds of human achievements solely because no permanent priority can be related with them. Sen therefore refers to a functioning as what people manage to do or be (Saith, 2001: 11). It is also argued that achieving a functioning depends on a

wide range of social and personal factors (Alkire, 2002: 13). Sen (2009: 4) refers to these aspects as functioning vectors and these vectors depend on the societal opportunities for their realisation. Therefore, this implies that wellbeing and health are determined by the use a person makes of the commodities and opportunities at his or her command. Thus, a person's well-being should be considered in the space of functionings and capability (Nussbaum, 2011: 3).

One of the reasons why it the quality of life and wellbeing measure involves some achieved functionings is linked to equality or inclusion in terms of opportunities for human development. What matters most is whether people have the same opportunities to achieve these functionings (being healthy) or are deprived of them. Robeyns et al (2007: 26) assert that usually people differ systematically in their levels of achieved functioning, that is, their health status. This underscores the fact that people do not have access to the same capabilities, lest there are credible explanations as to why they would systematically choose not to be healthy. Therefore development or poverty reduction strategies should ensure that people are able to achieve these valuable functionings for a healthy well-being.

The capability approach has thus gained strength in the sense that it encompasses all achievements of intrinsic importance rather than focussing on material functionings, or the subjective states. The assumption is that any achievement a person attains is directly important to one's living standard. Thus it is important at this juncture to acknowledge that the capability approach does not categorically exclude any intrinsically valued achievements per se. Instead, the approach embraces a focus on social justice, inequality, living standards and human rights.

Likewise, it is important to note what the health capability set looks like. Usually what people have reason to value in terms of health is often related to nutrition, morbidity and mortality. Capabilities for health would then include the set of vectors which resource inputs and conversion factors would allow, and thus health functionings would refer to the particular capability chosen to be of value. It is also significant to consider the possible difference between functionings more broadly and achieved functionings, which can be readily observed and measured. Perfect examples of achieved functionings include being free from illness and being well-nourished and this have a high likelihood of reflecting valued states of being (Osmani and Sen, 2003: 105).

2.2.2 Poverty, Health and Capability Deprivation

Alkire (2002: 21) posits that functionings alone cannot give a clear picture of the analysis of human development. Therefore, there is need to incorporate capabilities in human development conceptualisation. Sen (2001: 55) argues that the basis of development is the expansion of human capabilities. The main concern of poverty reduction or the concern for equity in health is the concern for people who lack the freedom to lead lives they value. Thus, the notion of capability as highlighted by Amartya Sen (2005: 159) refers to the various combinations of functionings that a person can achieve. Capability therefore reflects the person's freedom to lead one type of life or another or to choose from possible livings (Sen, 1992: 3). More so, Sen (2009: 4) highlighted that each of the capability set represents the real opportunity that people have to accomplish what they value. Thus, the notion of capability does not only capture achievements but also unchosen alternatives. Simply, it scans the horizon to notice roads not taken. Thus in thinking about development and poverty reduction, the capability approach focuses on the multi-

dimensional nature of poverty and offers a new way of understanding it (Sen, 1999: 4).

The approach by Sen looks at poverty as deprivation of the capabilities to lead a life that people have reason to value and this cannot be limited to economic terms (Burger and Christen, 2011: 787). In the lens of Sen's approach, poverty and ill-health are characterised by deprivation of capabilities and lack of opportunities (Sen, 2009: 3) This broadening conceptualisation of poverty and ill-health to include aspects such as access to economic, social, political opportunities, freedoms and capability dimensions has resulted in an increased questioning of the association between poverty and health distribution and a paradigm shift on the role of poverty reduction in promoting wellbeing and health equity.

Alkire (2002: 25) points out that Sen does not subscribe to a fixed list of capabilities. Instead Sen (2005: 151) argues that the weighting and selection of capabilities depend on personal value judgements. Clark (2002: 5) argues that even though Sen sometimes makes reference to intrinsically valuable capabilities such as the ability to live long, be well nourished, to escape avoidable morbidity and so forth, he did not endorse a unique capability list as objectively correct for strategic and practical reasons. Nussbaum (2000: 220) has therefore criticised Sen for failing to provide a list of important capabilities. However, in as much as Sen failed to provide a list of capabilities, what is clear is the fact that any wellbeing measure will include certain capabilities and exclude others in a given context. Thus if one is to take health equity for instance, the capabilities that one needs to be healthy varies from one society to another. Therefore, it is clear from the expositions of Amartya Sen that there is no

capabilities list that is uniquely valid though Nussbaum (2007: 21) has provided her own version of capability theory and has come up with a capability list.

The fact that Sen did not provide a list of capabilities made it possible for every person to draw his own set of functionings (Clark, 2005: 1344). Thus, the capability approach can be applied in different contexts depending on the place and situation, purpose of the measure and more so the kind of analyses that the measure will inform and the institutions that it will guide (Alkire and Deneulin, 2009: 8). Here, it is important to point out that the fundamental strengths of the capability approach is grounded in its flexibility and the fact that it exhibits a considerable degree of internal pluralism, which allows scholars to develop and apply it in many different settings (Sen, 2005: 151).

Similarly, Alkire (2002: 17) indicates that the purpose of the application provides the necessary definition and limitations to the set of relevant capabilities. For this reason, the capability approach represents a major contribution to poverty analysis since it offers a framework for defining poverty in the context of the lives people lead and the freedoms they enjoy (Sen, 1999: 5). In the same vein, Sen (2005: 152) argues that the choice of capability as a framework for poverty alleviation still allows considerable diversity in terms of what measures can be pursued. The capability approach can thus be used to inform measures of extreme poverty and deprivation because of its conceptual breadth. The flexibility of the approach allows one to investigate situations of affluence and well-being and to probe inequalities in different contexts.

It should be noted that health is a significant capability that is important in the achievement of other capabilities. Therefore, the unfair distribution of health

capabilities may affect social justice in many ways (Sen, 2000: 20). Osmani and Sen (2003: 105) concluded that (based on evidence from South Asia) deprivation of nutrition and health attainment has serious consequences on society's wellbeing. Health capabilities thus have both an instrumental and intrinsic role in the enhancement of human well-being. Deprivation in health can possibly cause deprivations in other dimensions, such as employment and education. Therefore, lack of health can therefore be at the heart of inter-locking deprivations. Thus it is clear that, for those living in contexts of poverty; poor health is not just suffering from illness. It pushes people towards losses in incomes assets, productivity and education further entrenching the cycle of poverty. Thus, it is important that public policy should emphasize the significance of preventive health measures so that people are protected from the types of multi-faceted deprivations that could threaten their overall well-being.

2.2.3 Capability as Freedoms

The capability approach puts strong emphasis on the advancement of human freedoms as crucial to the development process. Sen (1999: 4) views people as active agents that direct their own lives and promote larger social goals. Thus the concepts of practical reason and freedom are notions central to the capability approach. United Nations (2005) indicates that the linkages between poverty, human rights and equity in relation to health are many and profound. Thus, according to the capability approach, both human rights principles and equity advocate for equal opportunities (freedoms) for health for the historically discriminated or socially marginalized groups of people.

CSDH (2008: 2) highlighted that after the Alma-Ata Declaration there was an increased call and justification for alleviating poverty as necessary to achieve health for all. Such an approach clearly portrays that health equity is a fundamental human right and a social goal crucial to the development process. Therefore ensuring human freedoms is equally important in the process of development and poverty reduction. Hence, at this juncture, it is worth noting that achieving the equal health opportunities entails not only guarding against the effects of marginalisation and poverty, rather it entails expanding the opportunities and freedoms that people have as the primary end in enriching human well-being. Thus, the capability approach looks at ill-health and inequality as deprivation of freedoms. Therefore efforts to address poverty, poor health and inequality should focus on the advancement of human freedoms.

Sen (1999: 6) emphasized the fact that a country does not necessarily need to be rich for it to be healthy, nor is economic development enough to achieve improvements in health. While the rich communities tend to be healthier, the link is not spontaneous. What is important are the freedoms and opportunities that a country offers to its citizens, and the control citizens have over their lives as well as how a society organizes itself or chooses to deploy its resources. The capability approach urges governments to be responsible for setting targets and benchmarks towards progressive achievement and full realization of human freedoms. In line with this, poverty itself is not a violation of human rights or freedoms per se. However, government inaction or action resulting in poverty, or failure of the government to adequately respond to the conditions that create and perpetuate poverty and marginalization is closely linked to human rights violations and denial of freedoms (Sen 1999: 4).

The capability approach or the notion of freedoms, to be more precise, argues that without a systematic focus on how discrimination, marginalization and the denial of freedoms creates and perpetuate poverty, it is very likely that efforts to reduce the impact of poverty and deprivation on health will be fruitless. For instance, without active outreach and support for poor people, despite their need, may make the improvement of the financial and geographical accessibility to preventive health services not to address inequalities in their utilisation. Thus the notion of freedoms in its practical sense entails that when designing and implementing policies and programmes, institutions should systematically consider how their actions may directly or indirectly influence social disadvantage, marginalization, vulnerability and discrimination especially of poor people (Alkire and Deneulin, 2009: 5).

The notion of freedoms, the pursuit of equity and justice require determination and overcoming of obstacles that keep disadvantaged groups, the poor in particular, from equitably receiving the full benefits of poverty reduction programmes and health initiatives (Sen, 1999: 9). While it is true that many poverty reduction programmes and policies that aim to improve the health of the poor do sometimes take this into consideration and usually include these concerns in their programmes, research has shown that many do not (CSDH, 2008: 5). Therefore, the adoption of the capability approach with its focus on of freedoms (human rights) ensures that particular focus is paid to systematic social disadvantage as well as marginalisation in poverty and health related programmes and policies.

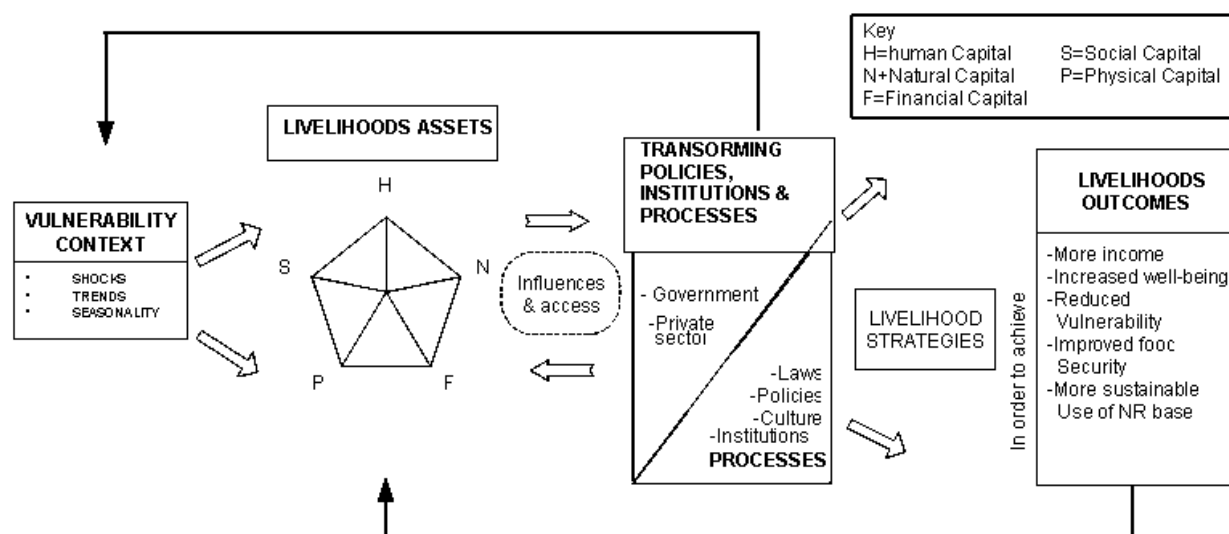
The focus on human freedoms therefore provides a universal basis for identifying inequitable conditions, which are usually subject to dispute. For instance, human rights norms give optimum preference to living standards that are fundamental for

the best possible health. Thus, the focus on freedoms and human rights entails that there is no discrimination based on the economic or social position. Without this particular focus disadvantaged groups will remain excluded from decision-making processes. Furthermore, the notion of freedoms advocates for legal accountability and universally accepted human rights mechanisms to be applied in the poverty reduction strategies and health initiatives to provide platforms for engagement and to suggest concrete approaches to alleviate poverty as a panacea to equity in health. Thus the centrism of freedoms in the capability approach not only offers a conceptual framework but also a legal obligation for sound policies towards achieving equal opportunity necessary to be healthy, and an obligation that requires the consideration of poverty as a social disadvantage or rather as a denial of freedoms as Sen (2000: 19) painstakingly puts it. More so, it should be borne in mind that the focus on freedoms that people have can be very significant in strengthening poverty alleviation and in ensuring equity and social justice.

2.3 The Sustainable Livelihood Approach

The capability approach has provided a conceptualisation of poverty and well-being in the context of capabilities, functionings and freedoms. However, poverty as it relates to health equity is also intrinsically and inextricably linked to people's livelihoods. Hence, the sustainable livelihood approach is another useful theoretical framework to understand equity considerations, to guide action on poverty reduction and to improve public health outcomes.

Figure 1



The Sustainable Livelihoods Approach (SLA) is a holistic approach that attempts to encapsulate and present a way of understanding the livelihoods of poor people without narrowing the attention to a few factors. Morse and McNamara (2013: 23) argue that this approach is founded upon the notion that intervention must be based upon an appreciation of what underpins livelihoods. According to Leonard (2006: 126), the development of a strong public health requires just but livelihood development.

The Sustainable Livelihoods Approach provides a way of thinking about interconnectedness between poverty and vulnerability. It looks at how people pursue their livelihood in certain vulnerability context, set of opportunities and constraints and combination of assets. The Sustainable Livelihoods Approach is thus a useful framework to understand the nexus between poverty and equity concerns in public health in Zimbabwe. Livelihood is defined by Chambers and Conway (1992: 7) as a means of living, and the assets, capabilities and activities needed for it. According to

Krantz (2001:9), a livelihood comprises of income, and gender relations, social institutions and property rights necessary to sustain a certain standard of living. Livelihoods also encompass issues of benefits and access to public as well as social services provided by the state. Taking a leaf from Morse and McNamara (2013:19), a livelihood is considered sustainable when it is capable to manage, to cope with, as well as recover from shocks and stress and uphold or improve its assets and capabilities in the present day as well as in the future, at the same time not compromising the needs of the future generations.

The Sustainable Livelihoods Approach to poverty and development is a framework that is based on a commitment to the elimination of poverty, achieving sustainability and strengthening local capacity. More so, Baumann, (2002: 7) makes the claim that the Sustainable Livelihood approach is a framework to help in the understanding of more dynamic and complex livelihood systems. Toner (2004: 11) argues that the Sustainable Livelihood Approach has gained prominence since the mid-1990s, and has been adopted by numerous organizations such as the United Nations Development Program (UNDP), the Department for International Development (DfID), Oxfam and CARE as a new way of thinking about poverty reduction more holistically.

Most of the available literature on poverty and public health, as published by WHO and the CSDH, has generated an almost international consensus that poverty is having adverse health effects on those countries whose overall livelihoods standards are poor. McIntyre et al (2006) argue that these challenges are not only affecting individuals and families; rather they are also decelerating economic growth significantly and worsening the conditions of poverty and inequities between and within countries. It is also crystal clear that health has become a major development

goal almost in every society and many governments especially in Europe have boldly declared that universal and equitable good quality health be a priority for their citizens. In doing so, they have strengthened the focus on alleviating poverty and the obstacles that limit human development (DFID, 2009: 6). Nevertheless, UNDP (2006: 3) argues that health equity has been a difficult goal to achieve in many countries especially in Sub-Saharan Africa due to limited livelihood opportunities. Hence, strategies for poverty-reduction and the promotion of equity in health should focus on promoting sustainable livelihoods.

The Sustainable livelihood approach becomes a very important theoretical basis for understanding poverty and public health challenges faced by the poor in Zimbabwe. Its significance is grounded on the reality that it puts poor people at the heart of development programmes and initiatives and highlights their strengths instead of their needs (Farrington, 2001: 6). Moreover, Sustainable Livelihood approach provides a platform for coherent livelihoods analysis, as well as the vulnerability and poverty analysis. It also provides for the design of people-oriented development and poverty reduction projects, programmes and policies mainly for the poor who are most vulnerable to health challenges (DFID, 2009: 6). This approach is very flexible and can be applied to address specific needs of poor people in Zimbabwe. Therefore, it is envisaged that the Sustainable Livelihoods Approach will make ground breaking contribution to the analysis of poverty as it relates to equity in health distribution in Zimbabwe based on the fact that the Sustainable Livelihoods Approach focuses more on specific aspects of equity in public health without losing sight of the wider scope of poverty.

The Ottawa Charter for Health Promotion in 1986 set the challenge for a move towards sustainable livelihood approach by identifying the fundamentals for health as peace, shelter, education, food, income, social justice, sustainable resources, a stable ecosystem and equity (WHO, 2011: 3). The progressive realisation of these fundamentals entails efforts to eliminate poverty and vulnerability and the promotion of good health. It is also worth noting that these fundamentals are very important as pathways to equity in health distribution amid the revelation that health follows a social gradient. In essence this entails that the better the socio economic position, the better the health. Therefore the Sustainable Livelihoods Approach offers the platform for identifying entry points for pro-poor transformation, and the development of activities in such a way as to reduce the risk of appropriation of benefits and resources by privileged local elites (Kasi, 2015: 98)

In addition, the Sustainable livelihood framework places poor people, their resources and livelihood assets at the heart of a web of interconnected influences that determine how people build valuable livelihoods. In 2008, the Ouagadougou Declaration on health recommended equity of access to essential services and resources, with a focus on the needs of the poor and vulnerable as key to the equitable distribution of health. In line with this, DFID (1999: 7) argues that the extent of peoples' access to resources is strongly determined by their vulnerability context and the existing social, economic, political, institutional and environmental factors which affect the livelihood strategies of people and their prospects of being healthy.

Ashley and Carney (1999: 37) stipulate that DFID understands the notion of sustainable livelihoods tool of analysis that is made up of a set of core principles entrenched within an overall theoretical framework. However, it is also important to

point out that to date the Sustainable Livelihood Approach has been used with strong biases towards rural areas. In the same vein, the interest in applying SL approach to urban settings is gaining momentum (UNFPA, 2007: 13). Thus the approach can make ground breaking contribution to the analysis of poverty and the distribution of health in Chegutu urban municipality, which is an urban setting. The adoption of the Sustainable Livelihoods Approach to urban settings may be attributed to the fact that recently, development practitioners and scholars are conceptualising poverty as being multidimensional thus denoting the lack of the capabilities. This entails lack of basic, or minimally essential human capabilities, which are ends in themselves and are needed to lift one from poverty and to sustain strong human development (OECD, 2008: 48), therefore it cannot be limited to rural areas alone. It is crucial then to point out that the multidimensionality of poverty is important, not only because it informs efforts to analyse and understand poverty, but also in the development and operationalization of interventions to promote sustainable development and reduce poverty in both rural and urban settings as an equity measure (Slater, 2011: 250).

The Sustainable Livelihood Approach recognises the interconnectedness of the micro-cosmos of the livelihoods of people with the larger social, political and economic context at the meso as well as macro levels. Barkley (2002: 11:) argues that mushrooming literature from the developing world highlights that high rates of mortality and diseases are intrinsically linked to the lower social and economic status. More so, Fisher and Baum (2010: 1057) confirmed the interconnectedness of health environmental, social and economic domains and the current importance of sustainability and equity. Thus the Sustainable Livelihood Approaches help to reconcile the operational need for focused development interventions with a holistic perception of sustainable livelihood (Sanderson, 2002: 162). According to Ludi and

Slater (2011: 251) this framework gives access to the complexity of livelihood and poverty while acknowledging the need to minimise this complexity in a responsible way for designing programmes, projects and drafting policies.

Moreover, the Sustainable livelihoods approach is grounded on the belief that the ultimate aim of development interventions is to facilitate people on a path to their own improved development. The use of Sustainable Livelihoods Approach to the study of poverty and health equity is rooted in the fact that a lot of development efforts in the past failed to include equity considerations in poverty reduction strategies. WHO (2010: 6) argues that the focus on income and averages to understand poverty obscure large pockets of poor people's challenges and disadvantages, thus masking the reality of the lives of poor people. The fact that poverty and health equity are intrinsically and inextricably linked to people's livelihoods, gives the Sustainable Livelihood Approach a cutting-edge over conventional approaches in the understanding of poverty and to guide action to improve public health outcomes (WHO, 2011: 12). Therefore, the pervasive and strong linkages between equity and poverty entail that a commitment to health equity automatically entails a commitment to the poverty reduction, that is, alleviating deprivation as well as other various social disadvantages that people face.

Barnett and Whiteside (2002: 15) assert that while acknowledging that the poor are always the major victims of poverty, the nature development challenges, like those in Zimbabwe, especially in the health and education sector, truly reflect the underlying economic, political and social problems of the society. It also goes without saying that some dimensions of inequality and poverty can compromise poor people's coping strategies and livelihoods and this increases the risk of illness and exposure to diseases among the poor. Nolte, McKee and Gilmore (2005: 153) assert that the

challenges of increasing mortality faced in Eastern Europe, especially in Estonia, Latvia and Lithuania, after the collapse of the Soviet Union are linked to the socio-economic challenges that followed the demise of this bloc. This assertion helps to support the idea that the outcomes of people's health are heavily linked to the livelihood opportunities that people have at their disposal.

The report by WHO (2011: 5), reveals the importance of sustainable livelihoods to health outcomes. The report revealed that the Zimbabwe catastrophic cholera outbreak was due to poor livelihood conditions including high unemployment and reduced household incomes, food insecurity, transport failures, and progressive dilapidation of infrastructure including lack of access to water and sanitation given the prevailing national systemic constraints and poverty context. The existing gap between the poor and the rich therefore implies that action to improve health outcomes must constitute action to improve sustainability and the livelihoods of the people. Action to reduce poverty is important as it will automatically lead to improvements in overall health for all globally and within countries.

Within the present context of widening inequalities globally, the Sustainable Livelihood Approach would argue that sustainable livelihood and equity in health cannot be achieved unless action is taken to ensure that poor people gain access to facets of livelihoods such as social capital, financial capital, policies and institutions that help to improve livelihoods of the people. Hofritcher (2008: 16) argues that the notion of equity in public health discourse and its relationship to the socio economic living conditions is now the mainstream of public health thinking. Thus it is now completely impossible to overlook, the nexus between the vulnerability of people who live on the periphery and the importance of addressing such inequities.

Sustainable Livelihoods Approach takes precedence over conventional methods of poverty analysis on the basis that conventional development has failed to produce desirable effects. Dibua (2006: 33) argues that in Africa for instance, significant strides on limited aspects of the economy failed to improve the overall poverty conditions and the welfare of people. Thus, the work of Chambers and Conway (1991: 7) becomes critical in laying the foundations of broader thinking about poverty and development. In actual fact, the conventional methods of development failed to take a holistic approach to poverty (Sen, 2000: 17). Conventional approaches to poverty reduction were found to be too shallow as they paid attention to particular aspects of poverty, for example income, and failed to take into consideration other vital facets of poverty such as social exclusion and vulnerability.

Carr (2004: 25) observes that nearly three decades after the adoption of the Alma-Ata Declaration, the reduction of poverty and health for all still remains elusive goals in Zimbabwe and in the developing world at large. Gostin (2008: 571) argues that on average, those living in the world's poorest continents like in Africa, Asia and Latin America are prone to premature death. The poverty reduction strategies of the past failed to make an impact in improving the public health situation in developing countries. Thus the Sustainable Livelihood Approach is an attempt to think about poverty alleviation beyond the conventional concepts and approaches but also from the lens of the poor themselves taking cognisance of other dimensions of poverty and vulnerability contexts of the poor.

WHO (2011: 7) is of the view that many factors need to be considered if the causes of poverty and poor health are to be understood better. These include population dynamics, issues of urban governance, natural and built in environments, the economic atmosphere and issues pertaining to access to services. This

conceptualisation helped to shape the contemporary global development discourse by introducing the notion of sustainable livelihood in poverty and public health debates. Likewise there is currently a revived attention in the global health discourse for attention to be centred on the different processes and factors that work either to enhance or to hinder the abilities of poor people to enjoy their fullest possible health. Generally, it is established that millions of people prematurely die from preventable diseases. Growing evidence therefore confirms the strong relationship that exists between poverty reduction, economic growth and health thus confirming the notion that health is wealth and vice versa. Therefore, it is legitimate to conclude that the Sustainable Livelihoods Approach provides the basis for integrated and coherent approach to understand and to respond to poverty from the lens of the poor.

Moreover, Krantz (2001: 9) confirms the significant relationship between various poverty dimensions. Krantz (2001: 9) states that the improvement in one dimension has positive impacts on the other, for example, raising the educational level of people may yield positive results on their health standards, which in turn may help to increase their production capacity. Therefore, minimising the vulnerability of poor people in terms of exposure to risk may improve their propensity to engage in more productive economic and social activities (Clark, 2005: 1339). Thus the Sustainable Livelihoods Approach provides for the transformation of political and economic structures that sustain poverty, marginalisation and vulnerability and paves the way for the tackling of poverty, poor health and inequities. Therefore, the Sustainable livelihood Approach is very significant as a tool for understanding poverty and the prospect for encouraging sustainable and inclusive development. More so, it offers a suitable framework for assessing the social and economic impacts of poverty alleviation programmes.

The Sustainable Livelihoods Approach views the household's livelihood outcomes as being determined by the interaction between the dimensions of the vulnerability context, livelihood assets, livelihood strategies and transforming processes and structures (Morse and McNamara, 2013: 23). Thus the Sustainable Livelihood Approach is cognisant of the fact that poor people understand their needs and their situation better and therefore must participate in the design of programmes and policies envisioned to better their lot. It advocates that the people themselves especially the poor be given a say in policy design to enhance their commitment to implementation. The Sustainable Livelihoods Approach offers a holistic perspective of livelihood analysis and helps to identify strategic areas of intervention for effective poverty reduction either at the local level or at the policy level (Morse and McNamara, 2013: 23).

2.3.1 The Core Concepts of the Sustainable livelihood Approach

Alkire (2003: 3) highlighted that the Sustainable Livelihood Approach is a comprehensive people-centred framework. (Mercer and Kelman (2009: 214) postulate that this approach is centred upon the active involvement of people meant to be helped by change as well as their local knowledge. This notion was also supported by Moser et al (2002: 19) who argue that the Sustainable Livelihoods Approach pays priority concern on people rather than resources they use. Thus according to FAO, (2000: 16) the Sustainable Livelihoods Approach is a people-centred approach on the basis that sustainable poverty alleviation strategies will succeed only if development practitioners develop a close working relationship with the communities or people they engage with in accordance with their existing capabilities and livelihood strategies. Practically, this entails a continuous detailed introspection of the livelihoods of the poor. To that end, rethinking approaches to

poverty reduction, public health and development places attention and priority on the health needs and wellbeing of poor people. Likewise there is need to pay particular focus on vulnerability of marginalised populations. This would ensure popular participation of the population, a pursuit of an end to structural inequity and poverty, and to overcome non-sustainable ways of development and poverty reduction (Baumann, 2002: 26).

Moreover, the Sustainable Livelihoods Approach takes a holistic view of the livelihoods of people. This approach is cognisant of the holism of the society and seeks to understand the livelihoods of people as a whole, with all its facets. According to DFID (1999), the Sustainable Livelihoods Approach takes a holistic approach to the things that poor people might be vulnerable to, the resources and assets that help them to survive, as well as the institutions and policies that have an influence on their livelihoods. However, Baumann (2002: 19) argues that it should be noted that the holistic view of the Sustainable Livelihoods Approach does not serve as an accurate picture of the way the world is. Nevertheless, it provides a practicable approach to identify the most pressing challenges people face regardless of where they occur, be it in any sector or geographical space.

In the same vein, the Sustainable Livelihood Approach recognises that people's strategies for livelihood depend on a number of capabilities and assets and the way they interact as well as the circumstances in which they are entrenched (Carney, 2003: 26). Hence, taking a holistic livelihood approach to poverty alleviation and the promotion of health for all enables opening up more traditional sectoral approaches. This means that the Sustainable Livelihood Approach allows the examination of risks and vulnerability and of processes and structures at different levels to help

understand strategies open to the poor and to help illuminate likely impacts that different policies have on people living in poverty (Krantz, 2001: 10). This is grounded in the fact that Sustainable Livelihood Approach acknowledges the multiple influences poverty has on people.

Carney (2003: 28) outlines the dynamism aspect as one of the key principles of the Sustainable Livelihood Approach. To that end, Moser et al (2002) argue that people's livelihoods are not static rather they are dynamic even as the institutions that shape them are also dynamic. This aspect offers a new and dynamic way of viewing poverty and the livelihoods of people so as to learn from the changes and help counter the harmful impacts, whilst supporting the positive effects. The Sustainable Livelihoods Approach recognises the inherent potential of people in overcoming their challenges and in the realisation of their potentials. More so, many development activities tend to focus either on the micro or the macro level. However, the Sustainable Livelihoods framework attempts to close this gap by acknowledging the linkages between the micro and macro levels as people are always affected by macro level policy decisions and vice-versa (Krantz, 2001: 10).

In a nutshell, the Sustainable Livelihoods Approach is founded upon the notion that intervention must be based upon an appreciation of what underpins livelihoods (Morse and McNamara, 2013). Thus according to Tao and Wall (2009: 138), the Sustainable Livelihoods Approach provides a framework for analysis leading to concrete suggestions for intervention. This approach has been applied in many situations especially in poorer countries in the planning stage of an intervention by means of a policy, a development programme or as the basis for comprehensive research. Thus the Sustainable Livelihoods Approach is an exploration of peoples'

livelihood and an analysis for what is required for livelihood enhancement and it is very critical in circumventing the inappropriate interventions (Chambers and Conway, 2008: 10).

2.3.2 Sustainable Livelihood Capitals

The Sustainable Livelihoods Approach emphasizes the importance of human, physical, financial, social and natural assets and activities required to gain and maintain a living under conditions of vulnerability Moser (2008: 43). These assets are very crucial in the sustenance of equitable distribution of health among the population. To that end, access is the most fundamental issue for sustainable and healthy well-being. Masanjala (2007: 1032) for example, highlighted that researches that applied the Sustainable Livelihood Approach to study HIV/AIDS and malaria demonstrate a number of difficulties that people face in accessing assets that impede their strategies to cope with diseases and illness. Masanjala (2007: 1033) further asserts that mobilization is a critical factor influencing the livelihoods of people and health in as much as the possession of household and community assets is.

Emerging literature from livelihoods in rural African communities demonstrates the significance of assets in anchoring livelihoods and population health. Ellis and Freeman, (2004: 3) argue that the Sustainable Livelihood Approach emphasizes that people's health depends mainly on their access to household and community livelihood assets. Therefore, this approach demonstrates that the challenges that people face in accessing livelihood assets are hindering their ability to enjoy their full health potential. Thus the prevalence of diseases is much higher among the socially disadvantaged populations (Friel et al. 2007: 1241). In other words, lack of access to livelihood assets is a significant factor affecting people's access to health related

services. In Zimbabwe, many people are living in poverty due to limited livelihood opportunities evidenced by the lack of ability to meet proper basic needs like food, shelter, water and sanitation.

Furthermore, it can be deduced that the Sustainable Livelihood Approach is a capital oriented approach where sustainability of livelihood is considered in terms of availability and access to capitals. These are human capital, natural capital, social capital, financial capital and physical capital (Chambers and Conway, 1992: 8). It is then necessary to have an assessment of the vulnerability context in which these aforementioned capitals exist. Capital is therefore the basis by which people engage meaningfully and fruitfully with the world and most importantly the capability to change the world. Thus these capitals offer the basis for power to act and ultimately to bring about change in society (Moser, 2008). Rakodi (2002: 4) attests to the fact that when making an analysis of assets that individuals or households use, it should not be assumed that all these assets fetch the same value.

2.3.3 Human Capital and Livelihood

The concept of Human capital is used to refer to healthy, well-nourished, educated, and skilled individuals. Krantz (2001: 9) refers to human capital as the knowledge, ability to labour, skills, good health and physical capability important for overall improved conditions of human beings that can result in a productive labour force (human asset) in any country. Dao (2008: 294) argues that factors with a capacity to provide future returns such as nutrition, education and health that an individual embodies, are all aspects of human capital. Other capitals such as the financial one, in terms of access to employment and earnings are highly reliant on sufficient human capital. To that end, human capital also relies on adequate health, nutrition, education and safe environmental conditions. Barrett (2014: 461) argues that human

capital has a decreasing effect on the possibility of being poor among all rural households whether they participate in non-farm activities or farm activities. Resource-poor people normally have poor access to health enhancing factors. In essence, human capital determines individual and community capabilities to meaningfully participate and benefit from social and economic development. Thus lack of access or control over human capital impacts heavily on the health of the most vulnerable populations and this reduces their freedom to lead the kind of lives that they have reason to value.

2.3.4 Natural Capital and Livelihood

Ellis (2000: 8) and Norberg (1999: 23) argue that natural capital refers to environmental assets and natural resources such as land, water and biodiversity. These natural resources are important in that they are generally used to support livelihood strategies for many people especially in rural areas where the main source of livelihood is farming. Equally, all human beings cannot be divorced from their environmental context. Ellis (2000: 8) argues that natural capital is utilised by people to generate a means of survival. Natural capital is of mammoth importance to the majority of poor urban dwellers who live in the periphery of medium or small sized towns. Recent research has shown that the livelihoods of the poor are vulnerable to rapid growth of cities as the scramble for land use is also increasing. Ultimately, the vulnerability of the poor to natural capital or their lack of it thereof constrains their ability to lead and maintain healthy lives. However, the promotion of sustainable livelihoods to benefit the poor in urban or peri urban areas requires specific approaches as shown in peri urban villages of Hubli-Dharwad in India (Allen 2006: 30). Hence the Sustainable Livelihoods Approach becomes significant in the study of poverty and health equity. There are very broad disparities in the control and

access over natural resources amongst people of diverse socio economic backgrounds. These differences in access to natural capital also account for poverty and the inequitable distribution of health across the population.

2.3.5 Social Capital and Livelihood

Like the other capitals, social capital is a fundamental asset for both urban and rural and poor. Social capital usually refers to networks of mutual support that exist within and between families and communities which can be mobilized by people to access livelihood assets (Krantz, 2001: 9). The World Bank (2000: 93) argues that social capital is a critical resource for poor people especially in the times of catastrophes and during changes in social and economic milieu. The existence of informal social networks helps to minimise the possibility of resource populations perceiving their households' social and economic conditions as insecure (Moser, 2008: 44). Nevertheless, although social capital is a crucial asset for the poor, it should also be understood that processes of migration and urbanization may weaken social networks and this usually affects the poor people.

The striking question in the developing countries today, especially in Zimbabwe, where there are high incidences of poverty is; does social capital contribute to poverty reduction and if so, to what extent? Verily, answers or explanations to these questions will largely help in strengthening the institutional capital to complement the provision of infrastructure and to intensify the development of human capital and to empower the poor and the most vulnerable. Grootaert (1999: 2148) observes that the world is fast recognising the importance of social capital in affecting the livelihoods and wellbeing of people at all levels of the society. The World Bank

(2000: 91) highlighted that the appreciation of social capital as a fundamental input in the production function of people can bring about improved livelihoods. It proposes that social capital or institutional capital must supplement physical and human capitals before deriving the full benefits of any development programme.

2.3.6 Physical Capital and Livelihood

Ogwuche (2012: 1) is of the opinion that the quality and quantity of, and access to, physical capital are crucial factors for sustainable urban poverty reduction. A new global poverty reduction initiative focusing on the socio-economic and environmental factors has evolved since the World Summit for Social Development (WSSD) of 1995. The WSSD acknowledged that the continuous decline of the quality of life and poor health in developing countries is associated with the deterioration in the physical environment and that makes the need for a sustainable strategy for poverty reduction more important and mandatory for all development stakeholders.

In the same way, if poverty is to be measured and defined in the context of the Zimbabwean health system, the analysis of environmental and physical deprivations becomes imperative for equity reasons. For example, Schelzig (2005: 24) indicated that poverty in the Philippines includes the problems to access to water, sanitation and infrastructure issues which of course lead to poverty and health challenges. To that end, Moser (2008) points out that physical capital comprises assets like shelter, equipment and tools that people own or use. It also denotes access and use of public infrastructure. These assets determine the prospect of one living a healthy life or not. Hence an interrogation of people's access to physical capital is imperative for equity development and poverty reduction outcomes.

2.3.7 Financial Capital and Livelihood

Ashley and Maxwell (2001: 396) highlighted that credit is an essential asset for the poor people who lack resources. Many individuals and households have challenges in accessing credit and in South Asian countries, for instance, this is the general trend (Hunt and Kasynathan, 2001: 4). Thus, while financial capital is very crucial in many circumstances, it is usually far from poor people's reach. In Zimbabwe, the need to break the vicious poverty cycle and ill health is a critical concern for equitable social and economic development. However, the question remains whether the financial investments being made to reduce poverty are enough to bring positive health outcomes for the poor as an integral element of equity development. Considering the overall public health picture in Zimbabwe, pro-poor approach to health entails reaching out to the most vulnerable groups, designing equitable and sustainable health financing mechanisms and developing effective partnerships with the private sector.

Generally, it has been widely acknowledged in health literature that without meaningfully increased financing, the poorest segments of the population will remain entranced in the quagmire of poverty and ill health as is the case in Ecuador (Lopez, 2003: 24). This is a grave concern in Zimbabwe where the long period of political and economic crisis has weakened the capacity to implement a pro-poor development approaches. Thus the Sustainable Livelihoods Approach calls for an urgent action to increase financial investments amongst the poor and to mobilise additional resources necessary for the promotion of good and quality health for all.

In the same manner, a pro-poor framework offers preference to the protection, promotion, and the improvement of the poor people's health. This entails the provision of quality public health services, with equitable financing mechanisms

which are very important in the improvement of population health and the prevention of the cycle of poverty and ill health (WHO, 2008). Studies have shown that lack of financial capital can constrain the ability to sustain good livelihoods. Studies done in the United Kingdom, prior to the establishment of the National Health System reforms in the 2000s, revealed that income was key determinant of access to resources and healthcare services. In line with the above, Kawachi et al. (2002: 647) observe that income inequality leads to high rates of mortality via disinvestment in social capital. He noted that at the individual level, the relationship between health, income and social capital and health has been studied and it was established that social capital is intrinsically linked with material deprivation.

2.4 Poverty and the Vulnerability Context

The Sustainable Livelihood Approach emphasises the importance of understanding the vulnerability context of the people affected by poverty in all its facets. The World Bank (2000: 74) argues that everywhere people face the risks and vulnerabilities but surprisingly poor people face them more than their rich counterparts. This is a true reflection of the situation in Sub-Saharan Africa. Wiggins (2005: 3) deduced that market failure, harvest failure, conflict, and health shocks are some common vulnerabilities and risks that create and sustain poverty in the Sub-Saharan part of Africa. There is no doubt that poverty remains an unresolved burden for many poor households. This has serious negative implications for health and well-being as this limits the capacity and ability of poor households to escape the poverty trap and to live healthy lives.

Masanjala (2007: 1032) is of the view that poverty increases the vulnerability of household towards the impacts of shocks and stresses such as HIV/AIDS and other

communicable diseases to which poor households are exposed. Nonetheless, some households and families can succeed in escaping the trap of poverty even in face of shocks and stresses, while others, especially the poor cannot. This led to the thinking that livelihoods aspects such as the use of the local natural environment, social connections and engagement in off-farm livelihood strategies have positive implications for well-being and health.

More so, it should be noted that the household and community factors which promote or constrain household resilience and the ability to ascend out of poverty in Zimbabwe are interactive, complex, and remain poorly understood. They include among others, income, access to social services and employment. Above all, they are embedded in the broader context of social and economic conditions in the country. Thus a deeper understanding of household livelihoods in Zimbabwe is very essential for informing programmes and policies designed to reduce poverty and to promote equitable health distribution and social development in transitioning poor communities that face multiple shocks and stresses. A study by CSDH (2008: 26) targeting the poorest people in the world in poor countries establishes that many people who are impoverished die every year of conditions that can be prevented or treated. The fact is that these deaths are tragic and the enormous and pervasive economic as well as social implications associated with them reflect the fact that lifesaving systems are out of reach to the majority of the poor. WHO (2011: 12) has stated that without extending these pro-poor intervention strategies, it is very much likely that poverty and health challenges will be passed on to the future generations.

The findings of the CSDH (2008: 29) on the impacts of socio-economic conditions on health equity call for epidemiological studies to go beyond the biomedical factors to the analysis of the vulnerability context of the poor. It is also worth mentioning that

the vulnerability context and the sustainability of livelihood outcomes that the households face depend on institutions and policies at macro and meso levels as well as institutions at local level. This means that institutional and policy environment in conjunction with household assets and the implied vulnerability context determine the livelihood strategies that households adopt. This in essence calls for the transformation of underlying socio-economic processes and structures. Thus the level of participation from the state, private sector and the civil society should be reflected in transforming these structures. To that end, Chambers and Conway (1992: 7) argue that the different activities that people do in the context of generating their livelihood underpin their livelihood strategies. Hence, access to assets or lack thereof determines the well-being and health of population in context.

The vulnerability context of people, inequality and limited livelihood opportunities combine to keep many poor people in poverty. Thus an organised and determined effort to reverse these and other contributors of poverty is therefore required. Going beyond that, poverty reduction strategies and development initiatives that are pro-poor are necessary to provide all people with the capacity to enhance their lives, and to reduce inequalities and vulnerability to risk. This needs commitment of leaders, sound policy formulation and implementation, the rule of law and other governance reforms (World Bank, 2000: 18)

2.5 Applications of the Sustainable Livelihoods Approach

The application and the potential of the Sustainable Livelihood Approach are multifarious and thus cannot be limited only to the thinking about livelihood. In essence; the Sustainable Livelihood Approach encompasses other ideas of theoretical methodologies. The openness and flexibility of the Sustainable Livelihood

Approach makes it applicable to various settings where it can be useful to different development research levels and project objectives (Nicol, 2000: 5).

The Sustainable Livelihood Approach can function as an analytical tool prior to any development activity for the identification of new activities and development priorities. A study conducted by Ellis (2000: 9) in the villages of Tanzania emphasises the significance of a livelihood analysis for effective development cooperation in the country. In the region well known for producing coffee, a detailed analysis of livelihoods was effective in demonstrating that the production of coffee forms only one percent of household income. This is a striking element that can be easily ignored without a comprehensive livelihood analysis. Carlow et al (2001: 13) generated similar findings when they analysed water supply systems in Ethiopia, for which conventional inquiries had highlighted paucity in the availability of water as the most obstructing factor. Carlow et al (2001: 12) used a different but broader approach to establish which people have access and how much water do they use and how these aspects change household.

Moreover, the Sustainable Livelihood Approach, as a framework for livelihood analysis can be used to evaluate development strategies and their influence on poor people's livelihoods; at the same time, the Sustainable Livelihood Approach might be useful as a means or checklist for structuring ideas. To that end, Ashley (2000: 11) explored how rural livelihoods in Kenya and Namibia are influenced by natural resource management enterprises and what this entails for these programs. Thus the SLA has the potential for the reshaping of programmes to enhance their fit with livelihoods of the poor for participatory planning with communities as well as a focus for impact assessment. Similarly, SLA framework can be used to improve the focus of monitoring and evaluation systems. Nicol (2000: 6) used Sustainable Livelihood

approach to monitor, analyse and evaluate the efficiency of water projects in Kenya and Ethiopia.

In conclusion, the Sustainable Livelihood Approach has many uses which are diverse and can be used flexibly in many settings. However, this does not mean that this approach is a magic tool for the alleviation of poverty or a completely revolutionary idea for development and research. It is however, a tool to structure and guide research and development with the potential to increase the efficiency of development projects. The Sustainable Livelihoods Approach produces a more holistic view on what resources, or combination of resources, are crucial to the poor since it casts its focus on the multiplicity of assets that people make use of when constructing their livelihoods. By focusing on the wide range of factors, at different levels, that indirectly or directly determines or constrains poor people's access to resources of different kinds; the framework guides the understanding of the underlying causes of poverty. To conclude, the framework provides a more convincing multidimensional framework for assessing livelihood and poverty.

2.6 Conclusion

The importance of a sound theoretical framework as basis for intervention, conceptualisation poverty and health equity concerns cannot be underestimated. Scholars and researchers in the contemporary global development discourse have attested to the fact that the biggest enemy of equity in health especially in developing countries like Zimbabwe is poverty. The relationship between poverty and poor health can no longer be underestimated. Hence different approaches have been proposed as an endeavour to understand poverty as it is experienced by the poor themselves especially in marginalised communities. This study has elaborated much

on the Capability Approach as an evaluative tool for the assessment of well-being and as a framework to aid the design of policies and programmes about social change and social arrangements. The study has paid particular attention on the key elements of the Capability approach particularly its focus on functionings, freedoms and capabilities. The chapter has provided a moral justification for the adoption of the Capability Approach grounded on the notions of distributive justice which are critical tools for appraisal of poverty reduction programmes and health interventions in Zimbabwe.

The chapter has provided a discussion on the Sustainable Livelihood Approach and the justifications for its adoption which lie in the fact that this approach was born out of a desire to ensure that progress in human well-being is lasting. This is deemed crucial in the study of poverty and health equity since there is need to understand the complexity of societies in order to make interventions on livelihoods optimally effective. Thus the people centeredness of the Sustainable livelihood approach allows it to be applied to both rural and urban settings. More importantly, the notion of sustainability ensures what is done now does not impede or limit the livelihood choices of future generations. Thus the notion of Sustainability, one of the defining words in the 21st century development agenda, was incorporated with the capability approach to help in the conceptualisation of poverty as it relates to equity in the distribution of health in Zimbabwe. At this juncture it is worth mentioning that the next chapter will give a synopsis of the history of poverty in Zimbabwe and the intervention strategies that have been adopted to deal with it. The chapter will show how these intervention mechanisms have dealt with the issue of equity, and the variable impact of these interventions on the poor.

CHAPTER THREE

HISTORICAL ANALYSIS OF POVERTY IN ZIMBABWE

3.1 Introduction

This chapter provides a historical analysis of poverty in Zimbabwe. In addition, the chapter discusses the intervention strategies and policies that have been adopted by the Zimbabwean government to address poverty as a conduit to equity in health. Particular focus is on how these intervention strategies and policies have dealt with the issue of equity and how they have impacted on poor peoples' health. This is critical in order to capture a clear picture of the poverty landscape in Zimbabwe.

The focus on the poor is grounded on the premise that it is among the poor that poverty and inequality remain stubborn adversaries. Thus it becomes imperative to look at key institutional policies that might have worked for and against poverty reduction efforts. The fact that the majority of people in the country live below the poverty line (UNDP, 2014: 1), makes it impossible to detach the history of poverty in Zimbabwe from the dynamics of development. The interconnectedness of resource distribution and wellbeing makes the need to understand the history as well as efforts to dismantle the vistas of underdevelopment and to push away the frontiers of poverty in Zimbabwe more pertinent for equity concerns in health.

3.2 Poverty in Zimbabwe

Poverty in Zimbabwe is as complex as is the social and political situation in the country. Alwang et al (2002) highlighted that growing poverty, increasing imbalances in the distribution of resources and the widening gaps in health status are reflections of poverty in Zimbabwe. Bird and Shepherd (2003: 592) assert that there can be no

doubt that poverty has been the number one enemy of development in Zimbabwe for years. This has posed a serious challenge to the poor whose limited livelihood opportunities and capabilities have meant that they endure all the burden of economic and social injustices. This usually results in poor health. Thus, the history and evolution of poverty is important to understand the development challenges in Zimbabwe especially as it relates to equity in health.

Definitely, for a country like Zimbabwe, the history of poverty is undeniably an unimaginable legacy for a country that was once celebrated as a vibrant and strong economy, a giant and bread basket of Africa. It is mind-boggling then to note that Zimbabwe is now a shadow of its former self. The majority of people are still languishing in poverty with only a few living conditions of opulence. Hence many questions are bound to arise as to what went wrong in Zimbabwe and how the country became the perfect caricature of a failed African state. Therefore, an attempt to understand why the majority of people in Zimbabwe are in grinding poverty, requires an analysis of events that have been taking place in Zimbabwe and how they have impacted on the livelihoods of the ordinary people including their health.

To begin with, it is important to note that the CSDH (2008: 31) establishes that the need for equity in health cannot be separated from the social and economic conditions that people live in which determine their exposure to illness. Thus poverty and health challenges in Zimbabwe are encapsulated in the socio-economic typologies. In reference to the post millennium period, Clemens and Moss (2005: 20) argue that the dawn of the third millennium has been very difficult for the majority of Zimbabweans who are still languishing in poverty and misery. These sentiments underline the notion that the social, economic and political situation in Zimbabwe has not been favourable as is the health situation in the country.

Likewise, Tibaijuka (2005: 8) highlighted that the frequency and brutality of poverty in Zimbabwe drastically increased in the past two decades due to the political and economic crises. This situation greatly affected the social fabric of the country. Similarly, the country's health system was no exception. Mlambo and Raftopoulos (2010: 3) argue that years of political instability, ruthless economic meltdown, misgovernment and lawlessness transformed the once leading Southern African giant nation into the proverbial basket case and an international pariah as poverty levels in Zimbabwe reached unprecedented levels. Thus, the decaying socio-economic situation in Zimbabwe and the collapse of the social service sector led to the deterioration of health infrastructure and a drastic decline in the quality of health services available for the population.

Furthermore, poverty in Zimbabwe cannot be separated from the country's colonial history. At independence, the country inherited a completely unequal society whereby the political, social and economic environment tended to favour the white minority as opposed to the black majority (Chinake, 2007: 39) Thus, Mazingi and Kamidza (2011: 322) argue that it cannot be disputed that the majority of black Zimbabweans were settled on small poor pieces of land while the white minority had large fertile lands. While this may be a historical fact that marked the inception of a deliberate systematic process of impoverishing black people, it does not justify the continuing crippling poverty and deprivation in post 1980 Zimbabwe. Cooper (2003: 7) argues that the ruling party has to be held liable for the debilitating state of affairs in the country, for 35 years is too long a time to still blame history and absolve the culprits while the majority of Zimbabweans are still languishing in poverty.

It should be noted that the socialist agenda that the Zimbabwean government adopted in response to the disparities inherited at independence was not fruitful in

addressing these gaps (Moyo, 2001: 311). Although it is legitimate to conclude that the inequalities and poverty that continue to ravage the livelihoods of poor people in Zimbabwe cannot be divorced from the discriminatory policies of the colonial era (Mazingi and Kamidza, 2011: 324). It also needs to be noted that these inequalities can neither be divorced from the policies and actions of the current government that has been responsible for re-inventing and perpetuating poverty and inequality.

Thus the development discourse in Zimbabwe has presented a dilemma in terms of understanding the root causes of the development hitches the country is facing. This is based on the reality that it becomes illogical, as aforementioned, to totally blame colonialism for the drawbacks in Zimbabwe, more than three decades after independence. Doing so is misleading considering the fact that the government has flooded the country with dozens of economic blueprints. In actual fact, national policies resulted in severe economic collapse and ultimately a serious failure of the national health system. A series of failed monetary policies, corruption, currency devaluations and land seizure policies resulted in hyper-inflation at approximately 231 million percent and an economic crash that left 80% of the population unemployed (Moore, Kriger, and Raftopoulos, 2013 :86)

As highlighted above, in the wake of growing poverty and inequalities, the socialist policies adopted by the government of Zimbabwe, although they resulted in the expansion of social services like education and health, failed to improve the livelihoods for the majority of Zimbabwean people. In fact, as is the argument of the opponents of the Basic Needs Approach, the government spending on the social services sector had negative effects on economic growth and it also led to debt crisis and the declining terms of trade (Brett, 2008: 339). No wonder then that the

government was forced to abandon its socialist rhetoric and adopt Economic Structural Adjustment Programmes (ESAP).

Generally, many scholars concerned with the development discourse in Zimbabwe would agree that the ESAP agenda in fact did more harm than good to the majority of Zimbabweans. Alwang et al (2002: 21) argue that the ESAPs advocated for market economic systems which further marginalized the poor and the most disadvantaged populations. During the ESAP era, the cost of living was high, the social services were falling, income reduced and unemployment became rampant. Mhone (1995: 18) states that:

“.....by 1992 it was estimated that about 25,000 employees had been retrenched. the number of school leavers looking for work stood at about 300,000 per year when only about 10,000 new jobs per year were being created; and unemployment rates were 48 per cent for the 15 - 19 year age group, 37 per cent for the 20 - 24 year age group, and about 9 per cent for the 25 - 29 year age group; and no appreciable foreign investment was forthcoming”

It is critical then to note that ESAP failed to consider the importance of social planning in the development process. There was a shift in emphasis in the redesign of the state's social programs, away from a concern with issues of equity and access (Moyo, 2007: 344). The negative social and economic consequences of this shift were abundantly and immediately clear for ordinary Zimbabweans. Of particular note was the rapid deterioration in the country's acclaimed education and health sectors. Consequently, there was a decline in public expenditure on health leading to reduced spending preventative health services and other components of quality

health care (Clemens and Moss, 2005: 20). Likewise, the government's stricter enforcement of a user fees on health care erected barriers to the way of the poor who were, typically, most in need of health services.

Therefore, the growth of poverty in Zimbabwe cannot be separated from the history of ESAPs. Hence, it is legitimate to conclude that the growth of poverty in Zimbabwe is linked to the policies that were adopted by the government which in fact did more harm than good to the majority of people in Zimbabwe. In fact, Du Pisani (2002: 86) blamed the government of Zimbabwe for the economic and political crisis now confronting the country. Broadly speaking, the present-day crisis in Zimbabwe has its roots in poor fiscal policies and rampant government spending, among many other issues.

Likewise, the history of poverty in Zimbabwe cannot be separated from the major shocks and natural calamities that the country faced such as droughts and disease epidemics that put further strain on the social and economic systems in the country. Bird and Shepherd (2003: 591) point out that these natural hazards increased the vulnerability of people thereby increasing their impoverishment. The drought of 1992 had repercussions on the socio-economic wellbeing of the people of Zimbabwe (Hoddinott, 2006: 301). Droughts led to price increases and shortages of basic goods in the shops. This situation increased the burden on the health of the poor. These shocks and hazards were, however, not proportionally distributed as exposure to risk depends primarily on the individual's ability to cope with the situation at hand. Therefore, it was again the poor that were most affected. Therefore, any debate about poverty and health distribution in Zimbabwe cannot be separated from the economic and social challenges in the country. In essence, incidences of malnutrition, hunger and diseases increased along the socio-economic axis.

Furthermore, the history of poverty in Zimbabwe especially in the early 2000s and beyond cannot be divorced from the withdrawal of donor aid from Zimbabwe and its isolation from the international community (Clemens and Moss, 2005: 20). Donors have for long played an integral part in the development initiatives in Zimbabwe especially in the health sector. Hence, the withdrawal of their assistance after the politically motivated land invasions of 2000 can be a plausible argument to explain the deepening crisis in Zimbabwe. Clemens and Moss (2005:4), for example, indicate that between 1994 and 2003, international aid to the health sector declined by almost \$43 million dollars. Thus, the withdrawal of donor aid had some implications on the development efforts in the country especially in the health sector.

In the same vein, Addison and Laakso (2003: 460) traced the challenges of poverty in Zimbabwe back to 1997 when, after considerable pressure from the war veterans demanding compensation for their sacrifices during the liberation war, President Mugabe awarded over 60 000 war veterans with a Z\$50 000 one-time payment and Z\$2000 monthly allowance. This was an addition to the already increasing fiscal deficit. Furthermore, between 1998 and 2002, Zimbabwe participated in the war in the Democratic Republic of Congo (DRC) the costs of which were very high. By 2000, the government had spent about US\$200 million in this war (BBC, 31 August 2000). Zimbabwe's involvement in the war in DRC and the untimely compensation awarded to liberation war veterans laid the basis for inflation in the country which is responsible for the on-going crisis and poverty which has become unbearable to the majority of poor people in Zimbabwe.

In line with the above, Addison and Laakso (2003: 457) state that the fiscal deficits together with currency depreciation caused inflation increase which led to rising unemployment. Since the government's involvement in the DRC war and the

untimely compensation of war veterans, inflation continued to rise and in 2008 it reached its zenith. It was then that the government was forced to suspend its own currency. However, the dollarization of the economy has just but made it more difficult for ordinary citizens to cope with their livelihoods and to do business (Cooper, 2003: 7).

Clemens and Moss (2005) assert that Zimbabwe, the once vibrant and dynamic society, witnessed its economy virtually collapsing. High rates of inflation, shortages of fuel, food, pharmaceuticals and an increasing unemployment are aspects that depict the situation in Zimbabwe after 2000. To that end, Kairiza, (2009: 10) indicates that between 2003 and 2010 there was a rapid increase in prices of basic commodities and in that wave of political crisis evidenced by election violence, oppression, lawlessness, corruption and government mismanagement and other related economic crises, the majority of Zimbabweans failed to escape widespread poverty. It was the poor people that were most vulnerable to these crises. The rich were somehow spared because the growing corruption in the country allows them to accumulate resources at the expense of the general populace (Braun, 2004: 79).

Similarly, the Zimbabwean socio-economic landscape cannot be complete without mentioning the severe fuel shortages and other innumerable problems that the country experiences. Notably, in delivering the Mid-Term Fiscal Policy Review in 2006, the then Finance Minister noted corruption, rising inflation, declining savings and investment, inadequate foreign exchange, erratic fuel supplies, interruptions of electricity supply (Government of Zimbabwe, 2006:1) as having devastating effects on the living standards of people.

The main struggle for the majority of Zimbabweans is the one for survival. The struggle is taking place at a time when businesses are closing down and the confidence of investors has dropped (Cooper, 2003: 7). To make matters worse, donors have frozen aid, foreign investment has largely disappeared and Zimbabwe's trading position with traditional local partners has become more difficult (Mlambo, 2006: 54). Obviously, this has led to a severe decrease in the welfare standards for the people particularly the poor people. The economy, already weakened by mismanagement and corruption, frightens foreign investors resulting in large sums of capital being repatriated out of the country at alarming rates.

Consequently, the worsening health, education and income indicators portray the vulnerability of people in face of socio-economic quagmire (Mlambo and Raftopoulos, 2010: 3). Meanwhile, the international non-governmental organisations like World Vision that are currently operating in the country addressing food aid, nutrition, agricultural recovery, HIV/AIDS, water and sanitation are operating amid rather a complex political environment. More so, linked to the complex political environment is the deepening governance and human rights crisis in the country (Mlambo and Raftopoulos, 2010: 3).

Likewise, the destruction of urban shelters during the politically motivated Operation Murambatsvina in 2005 worsened the marginalization of people as many were made homeless after government demolished their structures. This was indeed the hallmark of the country's governance crisis (Tibaijuka, 2005: 10). The most affected were the poor who could not afford alternate housing and livelihoods. Hence they were made to bear the harsh realities of the socio-economic and governance crisis in Zimbabwe. Thus the efforts to promote equity in health cannot be successful without

addressing the underlying causes of poverty and vulnerability which are rooted in political pragmatism.

From the above discussion, it is legitimate to conclude that issues of bad governance and land seizure policies greatly impacted on the development initiatives in Zimbabwe and the consequences cannot be underemphasised. In line with this thinking, the following section will give a synopsis of the strategies that have been developed to deal with poverty and issues of equity as it relates to health.

3.3 Poverty Alleviation Strategies and Health in Zimbabwe

Many anti-poverty initiatives have been designed and implemented to ensure better life for all in Zimbabwe. Emerging literature has shown that concerns about poverty reduction and equity in health reflects the organised efforts of a society to improve the overall wellbeing of its population by reducing inequalities and by enhancing the underlying determinants of health which are embedded in the social and economic conditions (Beaglehole and Bonita, 2004: 1). Likewise, if health can be understood as a social good as enshrined in the Ottawa Charter for Health Promotion (WHO, 2008), then the notion of health in Zimbabwe can be best understood by exploring the development strategies adopted in the country. Similarly, it is important to assess how the development goals and modalities have advanced equity concerns and the elimination of poverty for inclusive and equitable health development

Since the democratic dispensation in 1980, the agricultural sector has undergone significant reforms. In essence, agricultural development was seen as key to poverty reduction in the country. Hence, in carrying out the mandate of agricultural development the land question was to be addressed first (Moyo and Yeros, 2005: 8). The land issue has for long been at the heart of economic performance of Zimbabwe

and has been at the centre of all struggles and revolutions in the country in both political and economic terms. Before independence, uneven distribution of land was to the detriment of the majority of Zimbabwean people (Chinake, 2007: 43). Hence policy measures were required in order to correct this anomaly and to redress the unequal distribution of land and to enhance production potential of communal farmers. This was critical in the sense that this had the potential to yield positive impacts on well-being and livelihoods of the people.

To that end, Raftopoulos and Mlambo (2008: 16) argue that since 1980, the government has embarked on a rapid transformation of the small scale farming sector as a pro-equity measure. This was mainly done through the provision of inputs and open access to the market through various marketing boards like Grain Marketing Board (GMB) and other extension services to the small scale farmers who comprised much of the poor. It is important to note that the government supported the resuscitation of agriculture bearing in mind the fact that in Zimbabwe the majority of the poor primarily depend on agriculture for survival. Hence, these measures had the potential to bring the majority of people out of absolute poverty and to capacitate them with resources necessary for wellbeing and health. However, many small-scale farmers are still facing serious challenges in terms of enhancing their production capacity. Chimhowu and Hulme (2006: 728) pointed out that the strategy failed to address the broader scope of inequality of opportunity and poverty of exclusion for example in the access to technology and credit. Therefore, poverty and poor health continue to characterise their welfare standards of many people in Zimbabwe.

In the same vein, the government embarked on the radical Fast Track Land Reform Programme (FTLRP) in 2000. However, up to date, critical questions still arise

pertaining to the inclusiveness and distribution criteria of the programme bearing in mind that the majority of people are still landless even after the so called successful FTLRP in certain political circles. It is argued that the orientation of the FTLRP towards the poor was marred by political interference. In fact the majority of Zimbabweans are still landless both in rural and urban settings. Thus, poverty and inequalities still haunt many across the country and the need to address poverty and inequalities remains an issue of critical concern to date.

Chimhowu and Hulme (2006) argue that due, in large part to chaotic FTLRP pursued by the government, the agricultural sector was badly disrupted and the country's economic woes were later accompanied by serious food shortages. This also culminated in a resource crisis, leaving much of the country without food, welfare or the ability to afford health care. Likewise, the widespread exodus of medical personnel from the country, the near universal poverty and failure of sanitation infrastructure fuelled an increase in mortality and disease. This crisis culminated in the cholera epidemic of 2008 which left approximately 4 200 dead and 96 700 gravely ill (Moore et al, 2013:86). Moore et al (2013: 86) blamed the government's diversion of resources away from basic health as the cause of the cholera epidemic.

It is also critical to note that the post 1980 government has inundated the country with a number of blue prints for poverty alleviation since the inception of independence, yet the majority of Zimbabweans are still trapped in grinding poverty. The Growth with Equity policy of 1981 targeted the equitable distribution of economic growth. More so, the Economic Structural Adjustment Programme was introduced to implement market based economic reforms in many sectors of the government (Chinake, 2007: 40). Much can also be said about the Zimbabwe Programme of Economic and Social Transformation (ZIMPREST). Currently, the focus is on the

Indigenisation and Economic Empowerment Policy and the Zimbabwe Agenda for Sustainable Social and Economic Transformation (ZIMASSET). Other policies implemented included the National Development Plan, Vision 2020, Millennium Economic Reform Plan, 2003 National Economic Revival Plan, and National Economic Development Priority Programme, among many others. However, many of the policies were great as mere promises that failed to transform the lives of ordinary Zimbabweans. Mounting evidence points to the fact that these policies suffered mostly on the implementation front.

It should be noted that the Indigenisation and Economic Empowerment policy which has generated heated debate in the development discourse of Zimbabwe states that every business that is foreign owned must cede 51% of the shares or interests therein to indigenous Zimbabweans (IMF, 2014). Ideally, the policy targets local people who were disadvantaged by the discriminatory policies of the past. Matyszak (2010: 11) argues that the policy is concerned about empowering the previously disadvantaged Zimbabweans by increasing their participation in mainstream economy in an effort to eradicate poverty, to create wealth and to build a self-sustaining economy in which all can attain better standards of living.

Magure (2012: 13) is of the view that the Indigenisation and Economic Empowerment (IEE) policy has undermined the prospects of business expansion in Zimbabwe and affected job creation or and pro-growth improvements that once made Zimbabwe the pride of Africa (Magure, 2012: 14). The costs of this policy to the majority of Zimbabweans are staggeringly high as many have lost their jobs. In actual fact the policy has failed to create a conducive environment for foreign investments and private sector expansion. Consequently, despite the policy being a pro-poor and an affirmative action policy in principle, it has not changed the

livelihood trajectories of the poor who continue to dwell cheek and jowl with poverty, deprivation and vulnerability.

However, in many instances, the ruling elite, which is the government, has given a blind eye to the flaws in the policy based on the premise that the deliberate negative costs of this policy are endured by the ordinary citizens. Basically, it is clear that the challenges facing Zimbabwe's prospects for development continue to be self-inflicted policies that are affecting investor and business confidence. This is grounded on the fact that political objectives lie at the heart of most if not all policy decisions in Zimbabwe and generally these actions cannot be explained in purely economic terms (Dashwood, 2000: 15). Therefore, poverty and inequities in Zimbabwe continue to be a thorn in the flesh for many policymakers whilst the country is on an accelerated trajectory of self-destruction. In actual fact, the poor continue to bear the burden of policy flaws and burden caused by the current economic crisis in the country.

The policy landscape of Zimbabwe cannot be complete without mentioning the Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIMASSET) which is a five-year policy framework implemented by the government in 2013 (IMF, 2014: 3) aimed at addressing the socio-economic deficiencies in the country. Bonga (2014: 33) states that the policy is purposed to transform Zimbabwe into an empowered society and a growing economy. More so, it envisaged that ZIMASSET will achieve sustainable development in Zimbabwe as well as social equity anchored on empowerment, indigenisation, and employment creation. According to this policy, this transformation will be supported by human capital and natural resource exploitation. However, there are concerns over whether the policy has enhanced the opportunities for the poor.

While the ZIMASSET agenda is now in the implementation stage, the question is whether the blueprint will manage to address the twin enemies of development in the country, poverty and inequities. The Reserve Bank of Zimbabwe (2014) pointed out in 2014 that the success of the policy requires funding of about US\$27 billion. In addition to that, robust and prudent monetary and fiscal policies are needed to create investor-friendly environment to attract foreign capital investment. Considering the political and economic landscape in Zimbabwe, it is highly unlikely that the country will raise such a figure to support the policy or to create optimum conditions necessary for the success of ZIMASSET.

Magure (2014) argues that the biggest threat to the success of ZIMASSET in addressing poverty and inequities in Zimbabwe is the fact that the policy itself was more of a self-serving propaganda that the ruling party, ZANU PF used for electoral advantage. The elections having come and gone, there is no food on the table for the majority of Zimbabweans. In actual fact, nothing has changed in Zimbabwe since the inception of ZIMASSET. Rather life for ordinary citizens has gone from bad to worse. The policy has not yet opened new economic opportunities. The economy is continuously shrinking thereby making it very difficult for the poor to be part of the mainstream economy.

There is a great deal of ambivalence that has been noted with respect to ZIMASSET as a policy. This is based on the fact that it is very difficult to ascertain whether the blueprint was a party campaign manifesto or a national policy document. For instance, the inclusion of the Presidential Inputs Support Scheme in the ZIMASSET is questionable. Mangongera (2013: 13) argues that the fact that a national policy document now contains a partisan presidential programme can never be morally justified. This is based on the fact that if national resources are being allocated to

agriculture, why then should they be part of a partisan programme that in reality benefits only members and supporters of ZANU PF.

Secondly, if the inputs for the programme are privately sourced, why do they need to be contained in national policy agenda that is meant to benefit all people regardless of political affiliations (Zimbabwe Independent, December, 6: 2013). Thus, ZIMASSET as a policy is very much limited in terms of creating mass scale equal opportunities for the vulnerable citizens, including, and through agricultural development. The policy is flawed in multiple ways and is biased towards partisan orientation and therefore cannot be trusted as a blueprint to alleviate poverty and bring about equitable and sustainable socio-economic development. With a few years remaining before the expiration of the ZIMASSET in 2018, the government indeed has a lot of homework to do if the blueprint is to effectively address the growing poverty and inequalities in the country.

3.4 Social Welfare and Poverty Reduction

The growing poverty and inequalities in Zimbabwe after independence implied that the new government had a serious task of coming up with strategies to minimise the impacts especially on the poor. At that time social safety nets were a necessary prerogative to cushion the poor from the harsh shocks of the adjustment programmes (Hoddinott, 2006: 304). To that end, a number of social welfare and safety net programmes such as the Social Development Fund (SDF), Public Assistance Programme of 1999, Drought Relief Programmes, Child Supplementary Feeding Programmes, the Agricultural Recovery Programmes, Basic Education Assistance Module and Cash Transfers have been adopted in Zimbabwe since

independence specifically for the purposes of minimising the effects of poverty and natural hazards on the poor.

In this regard, it is necessary to point out that safety nets were important in the wake of growing unemployment, retrenchment, inflation, and drought (Mutangadura and Makaudze, 2000: 14). Nonetheless, Slater (2011: 255) questioned the transparency and efficiency of the delivery systems. Therefore, it is legitimate to conclude that although these pro-poor programmes were very crucial in addressing the vulnerability of the poor, the lack of a clear cut framework of who benefits and how, rendered these policies unfruitful in alleviating poverty and in minimising inequalities. Thus, mechanisms for self-targeting coupled with widespread availability must form the mainstay of an effective safety net programme in Zimbabwe. Moreover, to ensure continued poverty reduction and human development in the country, Zimbabwe needs to return to the basic principles of social welfare that shaped its early successes and to ensure that the poor and the most vulnerable people have enough access to basic social services.

More so the question of sustainability was raised with regard to these intervention mechanisms. Critical concerns of whether these safety nets and cash transfer programs could effectively address poverty over time were also raised. The question of transparency and efficiency of the delivery systems raised by Slater (2011: 253) haunted the Social Development Fund (SDF) that was created in 1991. Through this fund, the government sought to provide welfare support to its people to minimise the social impact of ESAP (Mutangadura, 2000: 10). Mutangadura (2000: 9) argues that the design, implementation and funding of the scheme was poor and therefore rendered ineffective. These same questions of sustainability and effectiveness were also raised in the food distribution programmes that were introduced in 1995. The

same concerns were raised regarding other schemes such as the Child Supplementary Feeding Programme (CSFP), the Enhanced Social Protection Project (ESPP), the National Action Plan for Orphans and Other Vulnerable Children, Basic Education Assistance Module (BEAM). Many questions have been raised over the eligibility of the beneficiaries (Mutangadura and Makaudze, 2000: 13).

In summation, while safety nets and social welfare programmes to livelihoods in Zimbabwe have made some contribution, serious concerns remained regarding the effectiveness of these programmes in addressing poverty and inequality. These concerns have been supported by mounting evidence pointing to the fact that social safety failed to address the root problems of poverty and inequality in Zimbabwe which lie in the huge imbalances in the distribution of resources and wealth. Having understood the ideal picture of poverty in Zimbabwe, it is imperative at this juncture to narrow the focus down to the situation in Chegutu. In that regard, a description of the study area and poverty is given in the following section.

3.5 Overview of the Study Area

The study focusses on Chegutu, an urban municipality in Mashonaland West Province of Zimbabwe. It is a town that lies 105 kilometres from Harare to Bulawayo highway. The urban district is comprised of the residential area, industrial area and the central business district. The Parliament of Zimbabwe Research Department, (2011: 1) reported that population in the town is about 60,000. Chegutu is primarily a farming and mining district which is located along the mineral-rich Great Dyke of Zimbabwe. It is also important to note that the town is surrounded by once productive commercial farms and mines making it hub for various economic activities (Magure, 2014). However, the situation dramatically changed since early 2000 and

currently many livelihoods are greatly compromised and there is dramatic increase in poverty levels in the district.

3.5.1 Housing Problems

Housing is a serious challenge in Chegutu as evidenced by inadequate housing programmes which mainly affect the poor. The majority of people in Chegutu are living in environments that are overcrowded and many have resorted to shanties which do not have proper sanitary facilities. The housing problem, especially amongst the poor, has been attributed to lack of access to land, which has seen the increase in the demand for stands. The *Newsday* newspaper of September 25, 2011 quoted the town mayor saying that there are over 9 300 people on the council's housing waiting list, a figure that overwhelmed the cash-strapped local authority. The United Nations Healthcare Report (2008) argues that housing affects health in many diverse ways. It states that poor housing can affect the provision of basic needs of water and sanitation, and can allow the spread of communicable diseases.

The establishment of mining operations saw people flocking to the town to seek employment leading to a dramatic increase in the population. This led to vast problems associated with urbanisation including overcrowding, illegal buildings in town and in the peri-urban zones, frequent burst pipes and sewer outflows. Pfulajena is one of the residential areas that have seen an increase in illegal buildings as landlords tried to cash in on the housing problems in the town. The housing challenge in Chegutu increased after Operation Murambatsvina, a clean-up campaign that saw the destruction of many houses that were deemed illegal (Tibajuka, 2005: 1).

3.5.2 Food security

In spite of some remarkable improvements in the food situation in the country and in surrounding farms, chronic food insecurity continues to manifest amongst many households in Chegutu. Many families and the district at large had for long been dependent on white commercial production for food security in the district (Magure, 2014). However, the situation made a dramatic change following the controversial land reform process. Many families who were employed in white commercial farms and were receiving food parcels in addition to their wages had their livelihoods affected. White commercial farms used to provide the town with cheap agricultural produce. Those farms are now lying idle in the hands of newly resettled farmers and as a result the consumption levels in Chegutu have been affected. However, the rich agricultural soils made it possible for people to continue to survive on agriculture, albeit on a smaller scale, in both rural and urban areas. Nevertheless, these opportunities failed to stem the growing poverty and unemployment in the district.

3.5.3 Unemployment and income

There are high rates of unemployment in Chegutu. Unemployment is both a cause and a manifestation of poverty in Chegutu. Magure, (2014) highlighted that the David Whitehead textile firm used to employ about 3500 people. However, the textile giant collapsed two years ago and up to now it is operating below capacity. To make matters worse, mines such as Pickstone and Falcon have been closed as are many other industries in Chegutu leaving thousands jobless and stranded (The Parliament of Zimbabwe Research Department, 2011: 1). The Cotton Marketing Board has now been privatised and the Grain Marketing Board is operating below capacity. These industries used to accommodate a significant number of workers in Chegutu. Their

closure meant retrenchment, loss of employment, loss of the sources of income; hence youths and adults alike do not have jobs. People depend on the informal sector for survival as there is a serious shortage of formal jobs.

Many people used to derive employment from the white commercial farms. However, farmers who have been allocated land in surrounding areas are failing to create employment since they are operating at very small scale. Many have thus resorted to gold panning, “*chikorokoza*” as a way of earning a living. There is also an increase in vending and hawking in Chegutu as people are trying to make a living through selling airtime, belts, and other commodities at taxi ranks and at one of the marketing places famously known as “*Mudurall*”. Lack of employment has led to social problems like prostitution as young girls have resorted to selling their bodies for survival.

3.5.4 Water, Sanitation and Solid Waste Management

Chegutu has serious water supply challenges and the Newsday, 2014 reported that the town had gone more than five years without running water. The situation is caused by the town’s out-dated reticulation system. This has seen people resorting to using unprotected wells. United States Agency for International Development (USAID) (2009: 1) believes that water challenges alongside poor sanitation, and hygiene practices led to the outbreak of cholera in 2008. It was also reported that there was contamination of the main water supply in high-density urban areas. There is also a danger of cross-contamination of the town sewage and water lines due to poor sewage systems taking into consideration that the most sources of water are unprotected shallow wells. In high density suburbs where the majority of the poor are staying, there are no functioning boreholes or other sources of safe water. More so,

there is a lot of uncollected garbage piling up in high density suburbs and in the CBD. Health experts have often made calls that the city is sitting on a health and disease time bomb (USAID, 2009: 2).

3.5.5 Health Profile

There has been instability of health trends in Chegutu. The town has been a hot spot of cases of typhoid and cholera. Major causes of morbidity and mortality in the area are malaria, malnutrition, HIV/AIDS, Tuberculosis and diarrhoea. The district was also affected by the exodus of doctors and nurses out of the country. At health facilities where substantial losses occurred, this compromised the quality and quantity of services provided. Charges levied by some health institutions reduced access to services by marginalised groups.

3.6 Conclusion

The history of poverty and equality in Zimbabwe is a complex phenomenon. It is rooted in the legacy of historic injustices and the self-inflicted conditions especially after the year 2000 and the policies adopted. In this regard, it is fundamental to note that Zimbabwe has never experienced a dearth of policies whether social or economic, for over a dozen of policies have been implemented in the past three decades. However, there has been continued debate on the objectives, relevance, implementation and effectiveness of these policies.

Many scholars would agree that the blueprints in Zimbabwe were sacrificed on the altar of political expediency, thus they dismally failed to add any value to the livelihood of expectant citizens. Years of economic decline and political instability have led to the collapse of the public health system in Zimbabwe. Reduction in

health-care budgets, for example, affected provision at all levels across the country. The overall burden of the failure of government policies and the current economic crisis has been shouldered by the poor.

Generally, poverty remains number one enemy of development in Zimbabwe as many poor people continue to suffer and to be exposed to preventable diseases such as HIV/AIDS, tuberculosis, malaria and other vaccine-preventable diseases whose origins are deeply rooted in the social and economic conditions that poor people live in. Thus, there is a great need for a thorough investigation of the relationship between poverty as it relates to equity in public health. To that end, the following chapter will provide research findings, methodology and ethical considerations.

CHAPTER FOUR

METHODOLOGY AND PRESENTATION OF RESEARCH FINDINGS

4.1 Introduction

The aim of the study is to investigate the effects of poverty on health equity in Zimbabwe. In line with this thinking, this chapter gives a discussion of how data about poverty and its implications on health distribution was obtained, organised and analysed. A discussion of the methodology, which includes research design, sampling, population and data collection techniques, is conducted. The chapter provides a synopsis of secondary method of data collection as well as data analysis. It will give a description of demographics and the perceptions of local people about poverty and health equity. Finally this chapter presents a detailed record of the views of research participants concerning the questions under study as empirical research findings.

4.2 Methodology

Methodology is the heartbeat of any scientific research and should be accorded maximum attention before going into the field. Polit and Hungler (2004:233) define methodology as a way of obtaining, organising well as analysing data. Usually methodology decisions are influenced by the type of research questions. This study was concerned with getting the perceptions of local people concerning poverty and its impact on the distribution of health. To that end, this study utilised the qualitative research methodology. Burns and Grove (2003:19) point out that qualitative research methodology is a subjective and systematic approach used to describe life experiences and to attach meaning to them. Thus this allowed the residents of

Chegutú to go at length in describing their experiences in their own way and this helped to get a clear picture of how different people in different settings interpret vulnerability. In the same vein, Burns and Grove (2003: 19) argue that methodology involves issues like research design, sampling, techniques for data collecting and analysis. It is fundamental to note that qualitative research endeavours to understand some elements of social life and its methods generate words and themes for analysis not numbers. This was very instrumental in Chegutú, an area that represents nothing short of a complex social life.

Generally, research methodology is all about how the study was done and its logical sequence. Therefore, the appropriateness of the qualitative research methodology to this study is grounded on the fact that it takes cognisance of the view that research participants have a better understanding of their own situations and predicaments as they are shaped and determined by their own experiences of poverty and the distribution of health unlike quantitative methods that cannot actively analyse the social context and perspectives of people in their natural settings. Creswell (2009: 9) argues that qualitative approach studies people within the context of their natural social settings unlike the quantitative approach that uses mathematical, numerical or statistical data to study the social phenomena.

Denzin and Lincoln (2003: 5) assert that this approach appreciates the diversity of the perspectives of people under study and tries to understand people in terms of their beliefs, diversity and their behaviour and the meanings that people attach to situations. Thus, the significance of the qualitative approach to this public health research is grounded in the argument that it is suitable for studying most of the contemporary questions emerging in public health literature. Quantitative methods in

this study were only limited to quantifying study samples. This is evidenced by the use of numerical and statistical data in quantifying study samples.

4.2.1 Research Design

This study employed a case study method of enquiry as it allows a more contextualised study of people in their natural social settings. Yin (2003: 11) argues that a case study research design is suitable for poverty and health studies in terms of developing theory, developing interventions and evaluating programs as well as exploring individuals and organizations because of its flexibility and rigor. This method is useful in answering the why and how type of questions, taking into consideration the fact that poverty in the post independent Zimbabwe is a complex phenomenon that has taken precedence in health discourse. Thus an understanding of this intricate phenomenon requires an exploration of the social, economic and political contexts that health inequity manifests itself in as well as the perceptions of people about their situations. Thus a case study method of inquiry provides a tremendous opportunity to gain an excellent insight to poverty and health issues in Zimbabwe as well as studying most of the new questions emerging in development discourse as pointed out by Myers (2009: 7). Additionally, the pressing need for new strategies in poverty reduction and health promotion in Zimbabwe requires contextualized and individually based knowledge. Hence, the flexibility of case study design was useful in exploring poverty information in order to come up with accurate results.

4.2.2 Sampling and Study population

Burns and Grove (2005: 40) highlighted that a population includes those elements that meet the criteria for inclusion in a research. A sample is thus a population segment that is selected to represent the population as a whole. Ideally, a sample

should be representative enough to enable the researcher to come up with accurate results that are representative of the whole population (Denzin and Lincoln, 1994: 230). Decisions were made on who should be included in the research and the type of information required from the chosen participants. More so, decisions were made concerning sample size that is, deciding on how many people were to be included in the study.

In this study purposive sampling was used. Purposive sampling relies on the judgement of the researcher in selecting the units that are to be studied (Burns and Grove, 2009: 703). The main aim of purposive sampling is to focus on specific characteristics of a population that are of interest to the researcher and which best enable one to answer research questions (Burns and Grove, 2009: 703). This sampling technique was used strategically to identify the local municipality and the specific departments therein that were relevant to the variables under study and to select the non-governmental organisations that were interviewed for the purposes of this study. The purposive sampling technique was useful in this study because it helped to identify relevant research participants suitable for this study. The researcher used purposive sampling to strategically identify a total of 25 participants from Hintonville, Pfulujena, Heroes, Kaguvi Phase 1 and Kaguvi Phase 2. The participants were derived from these residential areas since these are the areas where there majority of people live and it was easy to identify participants for the purposes of this study.

Table 1: Summary of Demographic Information

| Participant | Age | Gender | Marital Status | Education | Occupation | Dependents |
|--------------------|------------|---------------|-----------------------|------------------|-------------------|-------------------|
| 1 | 25 | Female | Single | Secondary | Unemployed | 2 |
| 2 | 34 | Female | Married | Secondary | Self employed | 4 |
| 3 | 29 | Male | Married | Primary | Unemployed | 3 |
| 4 | 48 | Male | Divorced | Secondary | Employed | 6 |
| 5 | 38 | Female | Single | Tertiary | Employed | 3 |
| 6 | 28 | Male | Single | Secondary | Unemployed | 3 |
| 7 | 31 | Female | Single | Secondary | Unemployed | 5 |
| 8 | 43 | Female | Widow | Primary | Unemployed | 6 |
| 9 | 45 | Male | Married | Secondary | Employed | 5 |
| 10 | 47 | Female | Widow | Secondary | Unemployed | 2 |
| 11 | 39 | Male | Married | Secondary | Self employed | 5 |
| 12 | 32 | Female | Divorced | Primary | Unemployed | 1 |
| 13 | 42 | Male | Married | Secondary | Unemployed | 5 |
| 14 | 31 | Male | Single | Secondary | Self employed | 6 |
| 15 | 33 | Female | Single | Secondary | Self employed | 4 |
| 16 | 28 | Male | Married | Secondary | Unemployed | 3 |

| | | | | | | |
|----|----|--------|---------|-----------|---------------|---|
| 17 | 36 | Female | Single | Secondary | Unemployed | 5 |
| 18 | 31 | Male | Single | Primary | Self employed | 5 |
| 19 | 43 | Female | Married | Secondary | Unemployed | 7 |
| 20 | 32 | Female | Single | Tertiary | Employed | 1 |
| 21 | 41 | Female | Married | Secondary | Unemployed | 6 |
| 22 | 33 | Female | Single | Secondary | Unemployed | 4 |
| 23 | 27 | Male | Single | Secondary | Self employed | 3 |
| 24 | 44 | Female | Married | Secondary | Self employed | 6 |
| 25 | 47 | Male | Married | Tertiary | Employed | 5 |

4.2.3 Demographics

From the above table, it is evident that 25 local people participated in this study. Below is a detailed demographic description of the participants in terms of their age, gender, household composition, education and income. The demographic data is presented in table form and explained. Demographic information is very significant in the sense that it influences the responses of the participants, which is critical to the conceptualisation of variables under study.

Table 2: Age

| Age Range | Number of Participants (Out of 25) |
|-----------|------------------------------------|
| 18-30 | 6 |
| 31-40 | 11 |

| | |
|-------|---|
| 41-50 | 7 |
| 50+ | 1 |

Of the twenty five participants six (24%) fall in the 18-30 age range, 11 (44%) of them were in the 30-40 age range while seven (28%) were in the 40-50 age range. One participant (4%) was above fifty years of age. It was clear from the demographic data that poverty is distributed across all age ranges in Chegutu.

Table 3: Gender

| Gender | Number of Participants(Out of 25) |
|---------------|--|
| Female | 14 |
| Male | 11 |

The majority of the participants were females. Of the twenty five participants, 14 (56%) were females. Males were only 11 constituting 44 percent of the participants. This indicates that women were more willing to open up than men. More so this is a reflection of the fact that most women in Chegutu spend much of their time home compared to men.

Table 4: Household size and composition

| Household Size Range | Number Of Participants (Out of 25) |
|-----------------------------|---|
| 1-3 | 8 |
| 4-6 | 16 |

| | |
|----|---|
| 7+ | 1 |
|----|---|

Participants interviewed were coming from families of different sizes. The average family size was five, a slightly big number considering the average income of these families which falls far below the poverty datum line. An understanding of this variable was also crucial because it helps to explain the vulnerability of these families. This variable was distinguished into four categories, which range from 1-7+. 8 (32%) participants indicate a household size of 1-3, while 16 (64%) indicated a family size of 4-6. One (4%) indicated a household size of 7. It has been observed that many of the household members in poor households in Chegutu are extended family members.

Table 5: Occupation

| Employment Status | Number of Participants (Out of 25) |
|--------------------------|---|
| Employed | 5 |
| Self Employed | 7 |
| Unemployed | 13 |

Poverty and unemployment are closely correlated. The study established that five (20 percent) of the participants were employed in farming and in non-farming activities. Seven (35 percent) were self-employed with unreliable sources of income. Hence, their households were characterised by a lack of reliable wage income. Those who were unemployed were 13 constituting 65 percent of the total participants. Most of them survive by involving themselves in part time low-paying menial jobs. Generally, participants indicated that they typically rely on multiple sources of income, which helps in meeting some of their daily basics though it

remains far from being enough. Due to the fact that income is one of the largest determinants of health and wellbeing, lower incomes that are associated with the poor accounts much to the rates of higher morbidity and mortality. In essence, income accounted for a significant proportion of the widening gaps in people's health.

Table 6: Level of Education

| Education Level | Number Of Participants(Out of 25) |
|------------------------|--|
| Primary | 6 |
| Ordinary | 16 |
| Tertiary | 3 |

The participants who were investigated in the study were requested to indicate their level of education. This has been significant for the study because education determines the level of decision making, thus helping the participants to understand the questions under study. This is very critical considering that Lee et al (2006: 532) argue that education offers the main route out of the sea of poverty and empowers people in both financial and political terms. Three categories were used to distinguish the levels of education namely, primary, secondary and tertiary. From this study it emerged that most of the participants acquired secondary level of education and lacked the opportunity to advance to tertiary education. From the sampled households, most responses show that they acquired secondary education and this represents 64 percent of the participants. Only 3 (12 %) of the participants indicated

that they had obtained tertiary education and (6) 24 percent ended at the primary level.

Table 7: Key informants

| Organization | Number of Informants (Out of 25) |
|---------------------|---|
| NGO A | 3 |
| NGO B | 3 |
| NGO C | 3 |
| NGO D | 3 |
| Local Municipality | 3 |

Table 7 above shows that four NGOs were selected for inclusion in this study. NGOs selected were the ones that are active in poverty reduction and health related issues. These were specifically included in the study to gather in-depth information about their view of poverty as well as their intervention programs in the District. This was done to help give the best possible insight about poverty in Chegut. Twelve officials from the selected non-governmental organizations and three officials from the local municipality were interviewed to get detailed and relevant information about the linkages between poverty and population health.

4.2.4 Data Collection Techniques

Burns and Grove (2003:373) posit that data collection process is a precise and systematic way of gathering information pertinent to research objectives. Usually

interviews, observations and focus group discussions are used to gather information. To that end, interviews were used to collect data. Interviews were held with the officials from the Chegutu municipality and from the selected NGOs. This was done in order to get detailed information of the socio-economic challenges that households in Chegutu are facing, and more importantly, to get information about programmes and action that have been taken to address poverty as it relates to equity in the distribution of health in the district. Moreover interviews were conducted on the selected participants to get their perceptions of poverty and its impact on the distribution of health. Interviews proved very crucial in getting the perceptions and views of people towards poverty and the institutional programmatic interventions.

The importance of using interviews in the study of poverty and health was also echoed by De Vos et al (2011: 137) who highlighted the advantages of using interviews to gather data. De Vos et al (2011: 136) stated that interviews are a flexible technique that enables the researcher to obtain information that cannot be obtained using other techniques. This technique explores greater depths and allows the researcher to elicit more information using his or her interpersonal skills. It was established that the rate of responses was due to the fact that interviews allow for a complete description of the phenomenon under study by research participants. This helped to obtain comprehensive data concerning the socio and economic challenges that limit poor households from enjoying their full health potential.

4.2.5 Secondary data

This study employed a historical approach to get an understanding of the Zimbabwean situation as well as the current socio-economic challenges in Chegutu District. The purpose of utilising secondary data is to ensure that past events are captured and analysed to give background information on why the poor continue to

be vulnerable to multiple shocks that usually work to impede their wellbeing and livelihood (Kumar, 2002: 20). Much of secondary data was utilised in chapters one, two and three. Information was collected from various secondary sources of data which included research documents, published reports, papers and journals and published books. The historical approach was very important in the sense that it helped to compliment the understanding of poverty and its implications on health in Zimbabwe and to reconcile the views and perspectives of different people about poverty in Chegutu and in Zimbabwe. The historical approach helped to show how poverty has manifested itself and how it was dealt with in the past and over time. Likewise, the historical approach helped to deduce some policy weaknesses and weak links which can be used to inform future policy decisions, recommendations and the way forward in the fight against poverty and vulnerability. The historical approach helped to show how poverty has evolved and how most of the challenges witnessed today are rooted in past events (Kumar, 2002).

4.2.6 Data analysis

Data analysis is very important in research. Coffey and Atkinson (1996: 10) argue that data analysis in qualitative research should be conducted with care and rigor. Coffey and Atkinson (1996: 10) further argue that when analysing data, researchers should become immersed in the data. Qualitative data analysis is very important in that it preserves the uniqueness of participants' experiences at the same time allowing a compressive understanding of the phenomenon under study. To that end Burns and Grove (2003: 20) assert that data analysis goes beyond mere description as data is extended and transformed.

This study is qualitative in nature and hence it used the qualitative method of data analysis. Information that was obtained from local people, NGOs and the local municipality was rearranged and essential features were identified and the interrelations among them described and analysed. Themes were derived from the collected data and presented in a logical manner. This approach of data analysis was also supported by Creswell (2009: 8) who echoed that qualitative data analysis involves the process of identification, examination, as well as the interpretation of themes and patterns in textual data and determines how these themes and patterns can help to answer the research questions. Welman and Kruger (1992: 5) are of the view that it is imperative to note that qualitative method of data analysis is a cyclical, fluid as well as an on-going process that occurs throughout the stage of data collection of research and proceeds over to the stages of data entry and presentation. Within the process of analysis, the researcher had some guiding questions in mind that helped to reflect on the study's aim, objectives and research questions.

4.2.7 Ethical Considerations

Graham, Lewis and Nicholas (2006: 19) assert that ethics is a moral issue that deals with what is right and what is wrong. It involves the professional adhering to the standards of conducting a scientific research (Best and Kahn, 2006: 13). Further, De Vos et al (2005:57) indicate that the fact that human beings are the centre of study in the social sciences brings unique ethical problems to the fore which would never be relevant in the pure, clinical laboratory setting of the natural sciences. Therefore, ethical considerations are norms and values that are generally accepted, and which offer rules and expectations about the most correct conduct towards research

participants. These ethical issues are critical to any research and this study was cognisant of these ethical issues and remained within the ethical boundaries.

Informed consent is a serious issue in research. No one should participate in any research without freely consenting to it. Thus there is need to guard against coercion and pressurising participants into participating in the research without freely consenting. Therefore participants should be well informed about what their participation implies. In the event that a written consent cannot be obtained, a verbal consent should at least be obtained. Thus during the course of this study the researcher provided the participants with adequate information that helped them to make informed decisions whether to agree to participate in the study or not. This included informing them about the purpose of the study, the procedures and the right of the participant to refuse participation or to withdraw from the research at any point. Permission was also sought from local authorities in Chegutu to conduct the study.

Upholding confidentiality and privacy is another crucial ethical aspect for protecting the research participants especially in this health related study. Usually it is difficult to measure the dangers of a certain context to individuals or a given population. Thus this study has tried by all means to protect the identity of participants. Participants' identity should be protected at all times (Sieber 1992: 117). Steps were taken to ensure that their names will not appear in the research.

This study also adhered to the University of Fort Hare ethical protocol. Hence permission was sought from the University Ethical Committee to conduct this study. Moreover, according to Bowling (1997: 12), it is the ethical responsibility of the researcher to protect the participants from any physical or emotional harm. Therefore, this study ensured that no participants were harmed by this study or by

participating in this study and that no negative emotions in the participants were evoked by this study.

4.3 Survival Strategies in Chegutu

4.3.1 Informal trading

The study established that most residents have resorted to informal activities like hair dressing at their residences with some renting places at shops of which they bemoaned high rentals. Most of the participants stated that they are involved in this activity to get instant cash to buy food for the family and other basics. It was also established that vending and hawking have become major activities in the city especially among the poor. These people are engaged in selling airtime, fruits and drinks at bus terminuses, in front of major shops and other busy areas. Others have resorted to selling tomatoes, vegetables and other smaller products along busy roads and at the shops.

However, the challenge is that they have to go to nearby farms to get the products and have to incur transport costs and at the end of the day the money they get is not enough. They sell to survive. Others, especially men and male youths, are involved in transporting peoples' goods using two wheeled carts (*zvingoro*) which require a lot on labour. Since many people are involved in this business and the fact that people's purchasing power has decreased greatly affected their industry. They make an average of \$10 dollars a day according to one participant.

The participants expressed that informal trading is their only option to overcome socio-economic challenges and to survive. It can also be said that informal trading was found to be helping in the upkeep of many families. Thus the informal trading is helping families and households to generate income that is crucial in their

sustenance and to overcome health challenges associated with the socio-economic position. Thus many indicated that the lack of support to this sector and the recent actions of the government outlawing vending is a grave injustice to the health prospects of poor people who depend on it for a living.

4.3.2 Gold Panning

In the face of social and economic hardships in Chegutu, the local residents expressed that gold panning has become part of their livelihood. Most of the poor people are involved in gold panning in surrounding areas like Gadzema and Chakari. This is an illegal activity but the participants mentioned that they do not have any alternative options. Although the participants acknowledged this activity is having serious consequences on their physical health, they argue that they need to work in order to help feed and cater for their families. In actual fact, they are concerned with helping their families cope with the socio-economic challenges.

They revealed that the police are always running after them. Moreover, they indicated that they are facing challenges in boosting gold panning as a survival strategy that can lift them from the poverty trap. The challenges mentioned include lack of working capital, mining equipment such as compressors and milling plants and explosives. Ironically, the gold panners boasted that they are actually the ones keeping Chegutu alive. One participant boasted, *“We are the industry here in Chegutu, the community rely on us. Those in flea markets, bottle stores and shops rely on us more than they rely on other professions for the survival of their businesses because we have better purchasing power”*. Although many people expressed that this activity was illegal and dangerous, it emerged that many local people actually rely on such mining activity to sustain their livelihoods.

In actual fact, gold panning was found to be helping citizens economically and in reducing absolute levels of poverty. This is based on the fact that many of the panners can afford to have decent meals and send their children to school. Their families rely on their income to access health care, pay bills and to buy food which, at least, helps to increase their general health potential as well as the livelihoods of their families.

4.3.3 Small Scale Urban Farming

Most of the people interviewed expressed the threat of hunger and malnutrition that they are facing due to poverty. It was established that many households are struggling to feed their families. Thus many residents argued that they have resorted to urban farming albeit on a smaller scale especially on the outskirts of the town and in vacant pieces of land in town. Those who are privileged to own a house or a stand highlighted that they farm within the confines of their premises. Residents expressed that they usually plant maize and vegetables. It was found that this urban farming is helping residents to have access to garden food which helps them to meet their dietary needs. In fact urban farming was found to be helping to address nutritional inequalities and diet-related health inequities.

It was expressed that farming, though on a small scale, is helping to complement food security and public health programmes of non-governmental organisations and governments among marginalized populations. However, many respondents stated that urban farming is illegal and many at times are always in constant fear of having their plants chopped down by municipal police. The respondents indicated that if they do not farm and plant, they will starve and die as they have limited opportunities for survival. In actual fact, urban agriculture in Chegutu is helping the poor to overcome unreliable, inadequate and irregular access to food and thus helping to

increase the nutrition basket of these families thereby increasing their chances for better health.

4.3.4 Offering Labour for Hiring (Selling Labour)

The study deduced that land reform and deindustrialisation meant that a lot of workers lost their jobs. However, in face of all odds, the participants argued that they are taking up various employments though these are vulnerable activities. Residents interviewed highlighted that they usually engage in on farm and non-agricultural farm activities as income generating activities. They indicated that they usually work in surrounding farms on casual basis, usually as part time seasonally and throughout the year. Labourers are usually picked at certain pick-up points and returned at the end of each working day.

However, the amount of wages for them is typically small as compared to labour invested. To make matters worse, these activities are increasingly becoming scarce as production in surrounding farms is decreasing. Participants expressed that this activity is playing a crucial role in sustaining them and their families though concerns were raised that these kinds of activities are labour intensive and might have long term effects especially on the physical health of people.

4.3.5 Energy use

The study established that there is a serious challenge of electricity in the district of Chegut. As a result almost all participants concurred on the electricity challenges and that they have resorted to using wood and paraffin for cooking and warming purposes. Very few residents interviewed owned generators and some privileged use gas for cooking purposes. Many women highlighted that they find themselves having to carry firewood an average of five kilometres every day. It was highlighted

that lack of energy, especially electricity, compromised health care facilities in their neighbourhoods. Respondents highlighted the need for government agencies and non-governmental organizations (NGOs) to implement programs that enhance energy services for the poor. Generally, power cuts and power shortages were mentioned by participants as major problems in Chegutu which continuously adds strain to an already unbearable situation.

4.4 People's Perceptions of Poverty and Health in Chegutu

A significant number of residents in Chegutu were interviewed to capture their perception of poverty and how it is affecting their health. The motive was to get a clear understanding of the vulnerability of the poor to poverty as the basis for understanding of the possible reasons behind the differences in the distribution of health in Chegutu. The views of residents interviewed show the multidimensional nature of poverty in Chegutu and the different interpretations that poor people give to poverty and poor health and what they perceive as priority areas of action. Therefore, the subsequent section presents the themes as they arise from the findings of this study.

4.4.1 Poor infrastructure services

In terms of the people's perception and experience of poverty, the study deduced that the majority of the poor in Chegutu felt that their poverty and vulnerability is a reflection of poor infrastructure development. They highlighted that their potential for a better standard of living is being hindered by the declining infrastructure and government institutions alike. The lack of access to clean water was highlighted by many as a major challenge in town. The study established that the highly populated residential areas of Pfupajena, Kaguvi Phase 2 and Kaguvi Phase 3 have not

received running water for years as is the situation in Hintonville. This is despite the fact that unequal access to water and sanitation accounts much to health inequalities in Chegutu.

Yet today, proper sewerage connections and piped water are the privilege of a minority. The situation in Chegutu reflects a health bomb that the town is sitting on. The study reveals that the water situation is so dire that women and children spend much of their prime time queuing up for water at the few boreholes in lucky areas. It was also established that the water challenge has also led residents to resort to unprotected wells, which is a serious health threat. In addition to water and sanitary woes, most of the roads in Chegutu are in a deplorable state. It was highlighted that it is even difficult to reach a health centre if roads are impassable during especially the rainy season. On the other hand, the study revealed that the town council blames the infrastructural problem on urban sprawl which they argue has led to an increase in urban poverty. The municipality seems to have no mechanism at the moment to control overcrowding which is a serious threat in terms of providing decent housing and in terms of providing health supporting services and infrastructure. This overcrowding amplifies the effects of inadequate water and sanitation.

The challenge of housing in Chegutu has also created other problems that pertain to sewerage reticulation. Participants indicated that sewages are always flowing all over the streets. The study also established that the challenge of infrastructure extends to water infrastructure as it emerged that some water pipes that were installed during the colonial period have up to now not been replaced. The other challenge revealed by the study was garbage collection and disposal. The town was hit hard by cholera in 2008 and some participants attributed this pandemic to the lack of infrastructure for basic sanitation, health and hygiene. It was expressed by many

residents that if proper sanitation is not practiced people will continue getting sick. Poor sanitation emerged to be linked to health challenges like typhoid, cholera and other communicable diseases which are endangering the health of the entire community. In essence, it was found that good sanitary practices are difficult to maintain if the conditions of sanitation and water supply are poor.

4.4.2 Social Exclusion and Lack of Participation

The study also reveals that many of the poor in Chegutu identify their vulnerability with social exclusion and lack of participation. It emerged that this is a form of poverty closely associated with lack of income and community participation in development projects and activities alike. Participants argued that lack of income limits their ability to participate in the mainstream society. This form of poverty depicts the importance of the social dimension of participation which takes cognisance of the importance of social capital in human wellbeing and development. It emerged that the poor are not involved in planning and on action on the social determinants that affect wellbeing and health. Participants indicated that they are restricted from participating in mainstream society politics and economics and from benefiting from its associated resources and opportunities. The study established that there are clubs and cooperatives that were being implemented and funded by the local municipality which the poor were not even aware of. It emerged that the level of participation in development projects is very low. *"They don't need us, we are only called upon when our labour is required for free and that's all"*, fumed one of the participants.

This is the kind of social alienation that is keeping the poor trapped in the poverty quagmire with only limited prospects for better health potential. It was indicated that participation in poverty alleviation and health promotion should actually focus on the

redistribution of resources and power so as to advance issues of equity. The study also established that the level of poor people's participation in voluntary projects is limited. In essence, lack of participation impedes the creation of sustainable environments and healthy public policies. Community participation helps to reduce disparities in resource and service distribution. Thus, lack of public participation constraints opportunities to develop individual capacity and limits the choice of people to act in their own best interests leading to inequities in the distribution of resources. Thus, without active focus on processes of change and transformation there can be no health improvements in terms of equity.

In the same way, most of the participants argue that they are financially deprived. They indicated that their deprivation encompasses lack of material possessions inclusive of housing as well as health supporting services and resources. In actual fact, it was discovered that the poor lack the capacity to pay their bills. Thus, they are kept in a vicious cycle of poverty and poor health. Thus their experience of poverty and poor health is embedded in social exclusion which subjects them to additional deprivations and social alienation alike. In actual fact, social exclusion explains why the poor may be more at risk of poverty and associated health inequities. It was found that the poor are more exposed to adverse living conditions that result in health inequities, greater burden of mortality and disease.

4.4.3 Lack of Information

The study managed to establish that information is one of the missing components that subject the poor to a cycle of poverty and poor health. Most of the participants interviewed expressed that their poverty is due to lack of information that is vital in the enhancement of their wellbeing. In most instances information is disseminated through forms of media like televisions, radios, newspapers that are not accessible

and understandable to the poor. As a result they lack information on appropriate health-promoting practices which leave them vulnerable to diseases and illness.

Although some participants indicated that they do get some information, for example, on health education and other development projects or services (especially by the government), many of them (the poor) do not get the information in time. The study found that there are many awareness programmes for water, sanitation and hygiene practices as well as HIV/AIDS programmes that the poor do not know about. Generally, participants indicated that they are poor because they don't have information. This obstacle, they argued, subjects them to vulnerability and poor health due to lack of knowledge about available resources, activities and channels to access to basic needs and health supporting services.

Moreover, the study established that in as much as some of the services are provided by the government institutions, NGOs, clinics and hospitals, the poor often do not access them because of the mere fact that they lack the knowledge that such services exist. Participants highlighted that poor health and growing poverty is a reflection of lack of information among them. The majority of poor people who are in need of services and resources do not get them mainly because they lack the relevant information required to obtain them. This exposition underlines the fact that poverty in many parts of Chegutu is a reflection of insufficient information or lack of it altogether. This emerged as a challenge affecting the livelihood prospects for many in Chegutu.

Generally, it was established that the poor lack health information, information about how their government works and about the relevant institutions that should be assisting them. Many of the respondents felt that they do not have enough information about opportunities for income generating projects within their localities.

They believe that if they can be equipped with information of the associated development programmes, they can make ground breaking contributions in addressing their vulnerability status.

4.4.4 Inadequate access to social services

The study found a serious manifestation of poverty that pertains to limited access to social services. The study found that poverty among the poor in Chegutu results from various interlocking aspects that interplay to trap the poor in poverty. The majority of people interviewed bemoaned lack of access to basic services as a sign of poverty. They pointed out that their poverty was due to the lack of education which they highlighted is affecting their children very much. In this respect, basic health services, including education, water, sanitation and food were highlighted as necessary determinants of good health which are inaccessible to the poor. Some participants indicated that it is crucial to address the complexity of access to basic social services so as to contribute to better and healthy lives for the poor.

Many of the participants (especially the widowed women) expressed that they cannot afford to send their children to school for financial reasons. These children are forced to drop off and form a strong part of the labour force needed to work in surrounding farms to help their families. In their view, lack of education has led to early marriages and for girls it had forced them to give birth at a very young age thereby perpetuating the cycle of poverty which makes them vulnerable to poor health. In essence, poverty in Chegutu is connected to lack of opportunity to lead a healthy life.

Furthermore, the people interviewed highlighted lack of access to health care services as a strong challenge affecting the wellbeing of their households. Many bemoaned the fact that they cannot afford to pay for health user fees in clinics and

hospitals and have resorted to staying at home using traditional means which they deemed cheaper. These challenges, they argued, have led to high rates of mortality, malnutrition and HIV/AIDS in Chegutu.

They argued that the situation has been worsened by the fact that they do not have access to clean water and proper sanitation because the town council have not provided them with such. Generally, there was consensus amongst the participants that poor access to social services, poor housing conditions and poverty in general are critical aspects of their vulnerability to poor health. Hence, investments in public services such as health and education are of particular importance in promoting the health of the poor.

4.4.5 Lack of resources and low asset base

The respondents interviewed spoke a lot about lack of assets and a low asset base as a critical concern. Many of them lamented the fact that they do not have access to resources needed for their wellbeing. Some who are involved in small scale urban farming for example, bemoaned the lack of access to land and this was also raised by municipal officials as a critical concern. In the same vein, almost all respondents argue that they lack working capital to buy the goods, especially food items that they need on a daily basis. It was also found that the poor lack capital to invest in small projects which they believe could lift them from the rut of poverty and to diversify their activities for a better wellbeing. Participants indicated that most of the poor lack assets with a market value (income earning assets).

Of critical concern was the fact that many of them do not own anything that can be sold in case a family member got ill. It appears that most of the resources of poor households tend to be redirected to survival needs and this is to the detriment of

longer term investments with implications for a household's future wellbeing. In actual fact, there were concerns about the health effects of this low income and low asset base especially in terms of health care and service utilisation.

It was highlighted that many have been forced to sell the little they have to pay rentals and to purchase grain and food for the family in the face of chronic economic and food crisis in Zimbabwe. The stress of low asset base put a further strain on the poor who live already in poor conditions. In essence, the low asset base stretches the poor households to breaking point.

4.4.6 Decline of Support Systems

Some respondents lamented the lack of a secure support base. The research established that in many instances women were found to be the breadwinners in their families and are the primary sources of income. These women are involved in low paying manual jobs. Some are left widows; some have been left by husbands who joined gold panning (*chikorokoza*) and are failing to remember the families they left behind. As a result poverty continues to ravage such families. Thus the prospects for better health for these households are highly minimal.

Another issue is that of the lack of support from children. There are parents with children who are not supporting them. Some of these children are presumed to be employed as farm labourers and some are gold panners whose earnings are not enough to support their parents and siblings. These families have limited support from NGOs who are also facing financial constraints to cater for the growing population of the needy. As a result some families depend on single mothers and the elderly for survival which is very much unsustainable.

4.4.7 Lack of capacity building

A significant number of participants lamented the fact that they are not being provided with the skills, resources and opportunities needed for them to survive, adapt, and cope with the effects of poverty. Some of them expressed that they have a great deal of knowledge about their needs and have the zeal to see themselves out of poverty but they are not being capacitated or given space to advance their own capacities. It was established that there are no programmes to ensure that the poor are also participating in the processes that involve them especially when it comes to programmes that affect their lives and their health.

The research unearthed that there are no proper training programmes or skills development programmes that enable the poor to champion their own development. This was happening despite the fact that capacity building is important especially in terms of effective health promotion. It was indicated by participants that capacity building might address poverty and health problems, and in particular, problems that emerge out of social exclusion.

Although capacity building is being promoted across some government institutions and NGOs as an instrument for addressing inequities and building healthy communities, the participants showed minimum and overall lack of knowledge about the government activities and even some of the NGO activities. Many of them failed to show an understanding of where they can fit in with respect to the alleviation of poverty for the betterment of their health potentials. However, there are those who showed signs of willingness to participate in the development process if equipped properly with the expertise and capacity to participate in mainstream society and economy and in decision-making.

4.4.8 Cost of health care

Participants raised concern over the impact of the costs of health care on their households. Most of the participants indicated that they are usually unable to afford these services, resulting in low utilization of these services by the poor in both council and government clinics. Some of the participants indicated that they use these services but use a large share of their income to pay for these health services leaving their household susceptible to falling again into the poverty trap. As a result, the participants indicated that though they have the desire to ensure that health improvements occur, they are afraid that doing so will lead to an excessive decline in the living standards of the household. People in the poorest quintals are less likely to use basic health services such as immunization, maternity care, and family planning. For many Zimbabweans especially the most vulnerable, user fees act as a barrier to healthcare services. The information obtained from the participants in Chegutu clearly indicates that the poor are suffering the most due to the low utilisation of health care services in the District.

4.4.9 Food Insecurity

The threats of hunger and food insecurity were raised as critical concerns by many participants. This was found to be more acute amongst the unemployed and those who lack productive land or other income-earning assets. It was indicated that meeting most of the basic needs for food is a daily struggle for poor families. One participant said, *"In the morning we eat sadza, in the evening we eat sadza, at lunch we always go without"*. This is a clear indication of the presence of hunger amongst poor households. The few monotonous and primarily starch-based meals that poor families take per day and nutritionally inadequate diets are a sign of poverty and hunger.

The health effects of malnutrition are noticeable in these families. Some of the poor equate poverty with the inability to work (especially in the labour intensive farms) because of the effects of malnourishment. It was revealed that poor people have inadequate food supply and usually rely upon charity but in most instances they are forced to eat whatever they are able to find. This is a serious challenge because even if the government might scale up HIV/AIDS treatment programmes (as has happened already in some areas) which might help to reduce the prevalence of the disease, the programmes will only be effective when people are receiving sufficient nutrition. In some instances, HIV/AIDS sufferers in Chegutu District are said to be selling their medication to buy food.

4.4.10 Restrictive Economic environment

The study established that many of the poor in Chegutu are vulnerable to social ills inclusive of poverty and poor health due to the restrictive economic environment that they are exposed to. It emerged that due to the closure of many industries like GMB, David Whitehead and the surrounding mines and the prevalence of other related economic challenges, the employment base drastically contracted, leaving many outside the bracket. Consequently, people no longer afford a decent standard of living. Participants were emphatic that their vulnerability is an outcome of lack of opportunities posed also by the multicurrency system which has produced devastating effects on their wellbeing. They argued that the economic environment has contracted due to the dollarization of the economy and their purchasing power has declined dramatically.

Some participants highlighted that the high cost of living associated with the restrictive economic environment has perpetuated their impoverishment. They lamented the fact that the high cost of living was happening at a time when real

value of labour is decreasing. Some highlighted that they can no longer actively engage in the informal sector since they do not have the means to boost their business activities and that people no longer have the buying power they had before the crisis invaded their once vibrant town. Consequently, the respondents highlighted that feeding their families and clothing them has become more difficult as is the ability to send children to school. Hence the prospects of improved livelihoods and better health have been greatly compromised.

4.5 Municipality's Perception of Poverty and Health

The study found out that that the district municipality officials understands poverty and vulnerability as deeply rooted in deprivation and exclusion of local people especially the poor from benefiting from local development initiatives. They believe that poverty sets in when development benefits do not reach the most deserving areas and people especially the poor who are in need of basic amenities like water and sanitation. This scenario exposes the poor to diseases like cholera, typhoid and diarrhoea, among others. They indicated that they have engaged and will continue to engage with ward councillors to ensure that the needy people and their needs are identified at ward level.

It also emerged that municipality officials also viewed poverty as lack of access to infrastructure such as roads, drainage systems and transport. They expressed that infrastructural challenge is a major setback in Chegut. They stated that this observation has made them to focus their current activities on improving access to infrastructure services especially water and sanitation as lack of these services puts a further strain on the poor and makes them vulnerable to health challenges. They indicated that they had procured some water pipes for Kaguvi Phase 2 and Kaguvi Phase 3 that were ready for installation. They indicated that they will look into the

possibility of issuing out tenders to private companies to speed up the process of infrastructure development. The local municipality believed that infrastructural development is important in terms of integrating the marginalised poor, who are usually at the periphery of the society in its entirety, into the urban mainstream economy and in terms of addressing their health needs.

Municipality officials who were interviewed were of the view that poverty and vulnerability were the main cause of the deterioration in the living standards in the town of Chegutu. They stated that people whose access to infrastructure is limited are forced to compete for inadequate facilities in extremely hazardous conditions which subject them to poor health. More so, the local municipality expressed concern over health hazards that are in broader environmental contexts which call for urgent action in terms of mitigating the impacts bearing in mind that these environmental challenges accounted much to the 2008 cholera epidemic. The municipality expressed positivity in terms of their efforts to addressing the living conditions of the poor. However, they were uncertain in terms of time frames needed to address the status quo in Chegutu.

These officials also perceived poverty in terms of the growing rate of unemployment in the district. They reiterated the notion that the district is facing economic downturn and as a result employment opportunities have greatly contracted. They believed that this calls for urgent action to promote local economic development to boost employment opportunities for poverty alleviation and better health for all. Above all they highlighted that local economic development has to include employment creation and opening up opportunities for income generation projects for people living in poverty. It was indicated the municipality is making inroads in terms of looking in to the prospects of promoting the informal sector to ease employment

challenges. In addition, they stated that they are developing partnerships with external organisations including the private sector, that would enable the municipality to access skills and resources which are not available to them. However, the situation on the ground does not compliment such kind of development thinking.

Lastly, the study established that the critical health consideration for municipality officials that the increased migration into town has led to the critical challenge of housing in Chegutu. This in turn has had a fair share in increasing the level of poverty. However they highlighted that migration is not really a challenge in itself but the challenge is how to accommodate everyone sustainably into the mainstream society and to adequately provide for them with the necessary services for better human development and equal health opportunities. It emerged that accommodation problems are likely to persist since municipality is prioritising the overhaul of the ageing water and sewer reticulation system. However, the municipality envisages cutting the housing challenges by way of roping in other partners who would service stands before they are allocated to beneficiaries.

4.6 District Municipality and Poverty Alleviation

Poverty in Chegutu is multidimensional requiring a breadth of responses. The town officials interviewed expressed that their role is to organise and steer local development in Chegutu. This, they argue would ultimately lead to equal opportunities for health for all. The study established that the local municipality has many departments, for example, housing, public health, water and public works but it has a common goal of implementing pro-equity policies and planning. The town officials expressed that they have a duty to stimulate social, political and economic development which is very critical in health promotion. It was also established that a

number of challenges (as will be discussed in subsequent sections) are impeding the effectiveness of the municipality in addressing poverty and promoting health.

4.6.1 Infrastructure Development and Social Service delivery

Making services available to local residents is one of the main duties of the local municipality. The officials expressed that they have a mandate from the Ministry of Local Government, Public Works and Urban Development in terms of the Urban Councils Act (Chapter 29:15) to promote and undertake local development initiatives and to promote a safe and healthy environment in Chegutu.

The municipality officials acknowledge that they have the prime responsibility of ensuring the provision of basic level of sanitation and waste management which entails a systematic collection of refuse, the provision of clean water, among other related services. However, in some areas waste and garbage go for months without being collected, thus posing a health hazard. The reason is lack of transport to ferry garbage and waste to the designated dumping sites since they have insufficient fuel and vehicles for this purpose. When garbage goes for a long time without being disposed of, it poses serious health risks to residents who may end up contracting such diseases as cholera and malaria.

The participants (local people) expressed time and again that there is no adequate and reliable water supply in many suburbs especially in Pfupajena, Hintonville, Kaguvi Phase 2 and Kaguvi Phase 3. In some of these suburbs there is no running water at all. This, they admitted, is a critical health issue that continues to give them sleepless nights especially that the town fell victim of the cholera pandemic in 2008. They also expressed that due to lack of financial resources it is difficult for them to

deliver adequate services and resources to meet the demands of local people although they acknowledged the importance of pro-poor service delivery.

4.6.2 Local Municipality and Economic Opportunities

The study established that steering local economic development is one of the roles of the local municipality. In pursuit of this goal, the town council expressed that they are doing everything in their capacity to ensure that they create employment opportunities in the informal sector and through their development programmes. They indicate that when they carry out public work programmes like installation of pipes, they employ local people to do most of the work like digging trenches, garbage collection and street cleaning. Usually these programmes only absorb a tiny fraction of the unemployed.

It was expressed by the municipality officials that in its different structures and organs, the municipality has employed a significant number of men and women. They also argue that they are in the process of implementing Recycling Projects which will employ a significant number of locals. Currently there was one being run by the Department of Housing, Water and Sanitation. Women Clubs aimed at livelihood development are said to be implemented in every suburb especially targeting the poor.

These are programmes that are designed to reduce poverty through employment creation. The municipality officials highlighted that they have platforms for business management skills and training programs to improve the skills of the poor. However, it emerged that some of the needy people are not aware of such activities.

The municipality officials expressed that they are engaging in enterprise development that will help to stimulate the potential of SMMEs in the Chegutu. In so

doing they assist the local people in ensuring that they have the right platform to do their entrepreneurial activities. They have designed places like “Mudurall” to accommodate local traders especially the local poor. Some of them have received funding from the municipality officials to start poverty alleviation projects that will see them escaping the web of unemployment. Although it can be concluded that not much has been done to curb the growing poverty in the district in the municipality mainly due to the harsh economic trends in the country, the officials at the municipality indicated that at least they are doing something. It was stated by many participants that the information on what the municipality claims to be doing for them is not reaching them. This raises serious questions as to who then is benefiting from these initiatives.

4.7 Challenges for Poverty Alleviation and Health Promotion

The challenges that the Municipality of Chegutu is facing are many and profound. The major challenge is weak human and financial capacities that have contributed to poor performance and mistrust of the local municipality as a state institution. It was established that there is lack of accountable and transparent management within the district municipality. The study managed to establish that the top management of the town council has been awarding itself some lucrative salaries at a time when service delivery is deteriorating. This has led to a continued cycle of poverty and poor health. It was also established that the council owes its workers a lot of money in outstanding salaries and this has greatly affected its human resource capacity. Residents expressed that there is need to investigate cases of corruption, financial imprudence and mismanagement in the district municipality as a matter of urgency as this is affecting service delivery.

Most importantly, the study established that the lack of human resources is affecting the efforts of the municipality to maximise their coverage. It was also revealed that there are no proper management systems to raise revenue and to mobilise local resources and to ensure transparent and accountable delivery of services to the needy citizens. Local residents lamented that the town council has failed them in all aspects of service delivery. The residents accused the municipality officials of looting resources for personal gains. Over and above, it was established that these challenges can be attributed to the lack of systematic monitoring and evaluation.

The town officials highlighted that they are failing to do so because they lack the financial capacity to undertake such periodic assessments. As a result, the trust of citizens in the local municipality has declined resulting in many of them defaulting in payment of rates and water bills. It is however worth noting that many especially the poor are defaulting mainly because of lack of income or money to pay their bills. Consequently the local municipality is financially constrained. As a result there have been challenges in procuring spares for refuse trucks leading to uncollected garbage lying idle in town and posing a health time bomb. The municipality is depending on the cash strapped central government for financial assistance to fund their programmes and activities. The timely grants that they used to receive from the government have since stopped thus putting a further strain on their already overstretched budget.

The negative consequences imposed by the limited financial resources available for health and poverty programmes are so dire that even if the municipality is committed to redirect resources to the poor or to transform spending on the poor, in reality, they only meet a fraction of the actual needs of people. Thus as a pro-equity measure, health policy should be guided by explicit consideration of how best to finance and

cover the poor and the most vulnerable. Poor financing of health supporting services is an exacerbating factor in the challenges of health inequity, unequal access, poor quality and expensive health care services. Thus a long-term commitment is required in order to achieve long term changes in the social determinants of health and health equity.

There is also a problem of political interference in local institutions' decision making. This has made other relevant stakeholders to negate efforts to influence decisions, thus adopting a wait-and-see approach thereby undermining the legitimacy of statutory structures. It also emerged that the council refused an offer by Zimplats to construct roads in Chegutu. One town official said, *"If truth be told, politicians and MPs want to run this town council. They forget that they must work together with us because we know what is happening in our wards"* fumed one of the town officials. It was established that there are top politicians who have on many occasions vowed to fire top municipal managers and replace them with those who can aid them to deliver their electoral promises.

It emerged from the study that there is no coordination and working partnerships with NGOs. In actual fact NGOs are there to fill the gaps left by the state. It was established that there is poor involvement of non-state actors in the development processes of Chegutu. Non-state actors have developed a wait and see attitude and this has affected participatory and inclusive decision making. Residents are of the view that if the local government and NGOs can coordinate in local development processes they would not be complaining of service delivery to date.

4.8 Non-Governmental Organisations (NGOs) in Chegutu

The study deduced that Chegutu has witnessed an influx of both local and international NGOs in the post millennium period. International NGOs operating in the district include UNICEF, USAID, IRF, Concern and Goal Zimbabwe, among many others. Like any other NGOs in Zimbabwe, NGOs in Chegutu are actively participating in the advancement of human well-being and the alleviation of poverty. The study established that most of NGOs identified themselves as working for the poor in the district. A number of local and international organisations operating in the district are providing humanitarian and philanthropic services as well as emergency relief services. Generally, the majority of the NGOs are concerned with improving the living standards of people. The NGOs articulated their view of poverty and their involvement in the fight against poverty and how their programmes are impacting in the distribution of health in Chegutu.

4.9 NGOs' Perception of Poverty and Health

Most of the NGOs interviewed expressed that poverty in Chegutu is multidimensional and so are its indicators and consequences. They believed that the social and economic aspects of poverty, including material deprivation (of shelter, food, safe drinking water and sanitation), lack of formal education, social exclusion, low income and unemployment, which, reinforcing each other to perpetuate vulnerability, limit choices, reduce opportunities, and undermine access, and as a result, threaten the health of the residents of Chegutu especially the poor.

The officials at NGOs interviewed believed that poverty in Chegutu is the poverty of policy. The NGOs expressed the feeling that the actions of the government implies that it (the government) has not considered the poor in its decision making and in the

implementation of development programmes and projects. It was conveyed that policies and programmes that are implemented in Chegutu towards poverty alleviation have not addressed the needs of the poor and the vulnerable populations as the poor continue to lack access to basic services which are important for health promotion. The NGOs were of the view that corruption, lack of accountability and transparency in government institutions has affected the implementation of pro-poor policies and programmes for poverty reduction in Chegutu.

These NGOs expressed that the poor have no access to basic services like water, sanitation and food. Hence the reason why USAID is funding water, sanitation and hygiene (WASH) activities targeting areas prone to disease, particularly high-density suburbs of Chegutu. The lack of access has increased the vulnerability of the poor to diseases especially in areas like Pfulajena that are predominantly poor. They also believed that it is lack of access that has led to increase of hunger and malnutrition in Chegutu. It was also concurred by NGOs that poverty in Chegutu is poverty of information that has hindered the poor from accessing certain services. The NGOs revealed that in all their experience and engagement with the poor, they have realised that the most vulnerable populations have no access to information. They believed that poverty of information is so dire in the sense that it undermines the capacity of households to engage meaningfully and to benefit from programmes and activities meant to improve their livelihoods.

Furthermore, NGOs expressed that poverty in Chegutu is linked to a higher prevalence of diseases such as HIV/AIDS, tuberculosis and other chronic diseases that are pervasive in Chegutu. NGO officials believed that health afflictions of poverty tend to disproportionately affect the poor. They were of the view that the poor often need health (public) services the most and, on that basis, health programs and

policies need to account for the poverty dimensions and address specific challenges and needs of the poor.

It was the view of these key informants that the development of health policy should include an analysis of the poor people's access to and use of services to ensure that policies support poverty reduction efforts and contribute equity in health. It emerged from the discussions with NGO officials that program and policy monitoring is important to ensure that poverty interventions targeting the poor have the intended effects and lead to improved health outcomes.

Moreover, it was raised that in addressing poverty and health inequities there is need to quantify and understand the root causes of health inequalities and scrutinize health financing policies and systems to ensure they support equitable access to services. Likewise, officials highlighted that the poor need to actively engage in policy development processes and implementation to ensure issues of equity are incorporated in the policy agenda, programs and services that respond to the needs of the poor.

4.10 The Roles and Programmes of NGOs in Chegutu

The study established that a number of non-governmental organisations are operating in the town of Chegutu. These organisations are providing philanthropic, humanitarian as well as relief services to the marginalised poor who are usually the victims of poverty and poor health. Their programmes and services include the provision of basic social services, mainstreaming pro-poor development, capacity building and advocacy among many other services.

4.10.1 Provision of basic social services

Most of the NGOs interviewed expressed that they are working towards the reduction of poverty, deprivation and vulnerability in Chegutu through the provision of basic social services to the needy poor people in Chegutu. They indicated that they have programmes (installation of boreholes and building toilets) aimed at combating sanitation and water challenges in certain areas of the district. It was established that USAID and United Nations Children's Fund (UNICEF) are actively involved in water, sanitation, and hygiene (WASH) services at district level. NGOs believed that health and well-being of local people is anchored on access to social services. Generally, it was established that some NGO programmes in Chegutu are aimed at providing access to and maximising access to food and nutrition (through food aid programmes), environmental protection, housing and safe water. The officials indicated that they are tirelessly working to ensure that their poverty reduction efforts address the totality of human development. Thus, although some of their programmes do not directly centre on health care, they contribute in one way or another to advancing the health prospects of the poor. Thus the efforts of NGOs in education and health service provision in predominantly poor areas and to the most vulnerable populations in Chegutu cannot be underestimated.

4.10.2 Mainstreaming and Pro-Poor Development

It emerged from this study that some NGO programmes are aimed at mainstreaming poverty reduction to ensure that policies are pro-poor and that they address the health of the poor. NGOs in Chegutu are advocating for the reorientation of local and government policies in a manner that they target the challenges affecting the poor. These policies that NGOs champion are geared towards the redistribution of

development to the poor and the marginalised. In reality, NGO programmes were found to be grounded in a bottom up approach whereby they want the views of the poor to be loud and directly influencing policies, decisions and programmes. It was highlighted that mainstreaming is aimed at overcoming many strategic flaws in defining and identifying the neediest population in order to reach them with health and development services. These efforts are aimed at overcoming many unjust inequalities in health that emerged as a result of the failure of development programmes, including health services, to reach the poorest members of the population. Mainstreaming has also begun to take root within some municipalities as a method of responding to the effects of poverty and diseases especially HIV/AIDS.

4.10.3 Encouraging Participation and Empowering the Poor

It was established that the work of many NGOs in Chegutu is anchored upon empowering the vulnerable populations and promoting poor people's participation. Some of the projects and programmes (community based projects) of these NGOs have an orientation towards increasing the participation of the poor in the mainstream economy and development of Chegutu. NGOs believed that it is only by increasing participation of poor people that people might be able to assess and act on issues that concern the broader notion of their human development inclusive of health promotion. They reiterated that their engagement with the vulnerable communities is a commitment dedicated to ensure that people are active in dismantling the frontiers of poverty and in creating the living standards that are optimum for the promotion of good health. They indicated that they have mechanisms (strategies for targeting and mainstreaming) in place to ensure that resources reach the poor. Over and above, NGOs expressed that their role in the

poverty reduction process is to create a conducive atmosphere for the poor to have control over the social and economic arrangements that determine their livelihoods, health and wellbeing.

4.10.4 Capacity Building, Education and Training

NGOs expressed their engagement with the poor in terms of helping them to break the vicious cycle of poverty and deprivation anchored on capacity building. They believed that this would help to improve the overall human wellbeing. The NGOs highlighted their commitment to capacity building as an end itself not a means to an end. They highlighted that they are concerned in ensuring that the poor have the ability to undertake new development roles that can sustainably change their livelihood trajectories. This is evidenced by programs that they have implemented across the district. They highlighted that capacitating the poor will help them to address their vulnerability in a sustainable manner. NGOs believed that capacity building (training and supporting the poor to be engaged in the policy process and community programmes) can help the poor to identify their own needs, eliminate barriers to participation and enable equitable access to services. This will help to address the conditions that breed vulnerability, diseases and poor health.

NGOs detailed their involvement in educational programmes and training through consultative meetings with the public and workshops with community leadership (in some instances they involve everyone) for capacity development purposes. In their view, these programmes are aimed at empowering local communities to be in charge of their livelihoods and development. It was revealed that NGOs are not only involved in the provision of financial and material resources but they are actually

bankers in the development process in that they invest in the capacities of the poor and the vulnerable in the process of combating poverty and pursuit of social justice.

4.10.5 Advocacy, awareness raising and information dissemination

The NGOs interviewed expressed that their engagement with local people is embedded in advocacy. USAID and GOAL Zimbabwe indicated that some of their programmes are centred on public sensitization and awareness raising programmes on HIV/AIDS, water, sanitation and hygiene (WASH), cholera risk and transmission awareness programs, and home-based water treatment.

They believed that if they continue with their awareness raising they will change some aspects of the status quo that is helping to perpetuate poverty and vulnerability of local people. They stated that the purpose of these programmes is to ensure that the voice of the poor is heard especially in instances where bureaucracy and political interference in service delivery is the order of the day. They also indicated that they engage local and government institutions to ensure that public policies are responsive to the needs of the poor and that these institutions are harnessing and channelling resources towards the poor for equity purposes. Above all, officials expressed that they will continue to advocate for the integration of health equity goals into national development and poverty reduction plans.

4.10.6 Mobilizing resources for the poor

NGOs expressed their involvement in the poverty reduction process as a pathway to the promotion of health. They indicated that they are active in the mobilisation of resources for the poor and the vulnerable in Chegutu. They mobilise resources within its vicinity and beyond to help the poor in cases of emergencies such as the 2008 cholera outbreak. Both local and international NGOs echoed the sentiments

that they lobby with donors for resource and finance (resource pooling). They pride themselves in their ability to obtain and manage both external and local resources for the benefit of the local poor though at times the resources they get are not enough to address people's multiplicity of needs.

They believed that mobilising and availing resources to the poor will help decrease the levels of poverty in Chegutu and can contribute to local employment creation. Some NGOs reiterated the fact that the direct impacts of their resource mobilisation can be minimal but they are catalytic in that they will propel the advancement of the overall human development inclusive of health through addressing water, sanitation, nutrition and other basic needs of the poor in Chegutu.

4.11 Factors affecting NGOs' Poverty Alleviation efforts and Health Equity

The study established that non-governmental organisations in Chegutu are working tirelessly to ensure that the frontiers of poverty and the vistas of underdevelopment are dismantled. However, they are facing a number of challenges that, at times, impedes the effectiveness of their work. These challenges are a combination of both internal and external factors. The officials interviewed expressed that they are working to overcome these identified challenges.

4.11.1 Financial Challenges

Lack of adequate funding was expressed by NGO officials as a challenge impeding their activities. It was established that the funding that NGOs receive is not adequate to meet the multiple livelihood needs of people they serve. It was stated that some donors are once off funders that target specific projects. Yet NGOs do not have the capacity to generate alternative income to complement their operating needs. They are over reliant on external funders and this makes them financially dependent and

vulnerable. Due to financial challenges, at times there is no assurance of projects or programmes continuity. As a result, residents who are beneficiaries have no assurance of continued support. This poses further threat in terms of connecting equity considerations with the distribution of access and outcomes and a burden in terms of distributing of finance.

This is a serious challenge considering the fact that health equity can only be achieved through securing enough access by all citizens to appropriate promotive, preventive and curative services. Thus the financial challenges are impeding the successful provision of health and health supporting services. More so, the financial challenges have meant that most of the NGOs in Chegutu have their programmes focusing on specific health initiatives, diseases or interventions rather than the broader issues affecting population health. Thus due to financial limitations they are unable to address the multiplicity of challenges that the poor are facing although residents interviewed expressed that it is better that these NGOs address their multiplicity of needs.

4.11.2 Lack of Public Participation

Many times NGOs are unable to ensure public participation due to a number of factors beyond their control. It was revealed that NGOs have long been associated with opposition politics in Zimbabwe and as such people are afraid to participate in their activities out of fear of being associated with opposition politics.

It was also established that people are sometimes not dedicated to NGO activities because most NGOs do not have bases in the local communities (lack of decentralization) they serve. Most of these NGOs have their offices in Harare and as such they fail to win the hearts of people they serve in terms of ensuring their

participation. There is generally a poor attitude among other local organisations in terms of supporting each other's activities and ensuring public participation.

4.11.3 Lack of Coordination

One major challenge established by this study is the lack of partnerships among NGOs themselves which has led to duplication of services and concentration of services in certain areas, making it difficult for other areas or groups of people to access the services they provide.

The challenges that were said to be emanating from lack of coordination include duplication of services and overlapping. It was also revealed that there is no coordination between NGOs activities and government activities both at local and national level. Yet without coordination between NGOs and government stakeholders in service delivery underpinned by a common purpose, it is difficult to improve the connections between services in order to improve outcomes. Similarly, without proper coordination, the poor people's wellbeing will likely continue to be negatively affected by their lack of access to basic health supporting services, care and support. Officials interviewed indicated that they are working to engage, collaborate and mobilise the private sector (businesses) to act on principles of corporate social responsibility to address health inequity issues. Likewise, they highlighted that they are partnering with organizations and agencies representing the marginalized people, mainly the poor, to adopt pro-poor policies for health equity goals.

4.11.4 Political Interference

It was established that district of Chegutu is a politically contested area and this has led to too much political interference in NGO activities. It was expressed that

politicians interfere with beneficiary selection with a strong bias towards partisan lines. The NGOs interviewed expressed that politicians from national, provincial and local level are interfering in their activities thereby undermining the effectiveness of their poverty alleviation projects. It was also established that residents who are affiliated to opposition parties are systematically and forcibly barred from benefiting from NGO programmes. Thus, it can be deduced that political interference in the functioning of NGOs makes it difficult for food aid and other health supporting services to reach the most deserving people. Some district authorities present unnecessary bureaucracy which leads to unnecessary delays in aid reaching the vulnerable groups. This limited access makes the poor to remain vulnerable to poor health.

4.12 Conclusion

The chapter has provided a discussion of the methodology, which includes research design, sampling, population and data collection techniques. A synopsis of secondary method of data collection as well as data analysis was also given. It has captured a detailed description of demographics and the perceptions of local people about poverty and health equity. The chapter articulated much on the people's views and perceptions of poverty in Chegutu and how it makes them vulnerable to poor health. In general, people's perceptions and experience of poverty can be summarised as lack of secure resource base, social exclusion, lack of capacity building and poor infrastructure development.

The chapter also discussed poverty and vulnerability as understood by municipality officials. In a nut shell, the district municipality officials understands poverty and vulnerability as deeply rooted in deprivation and exclusion of local people especially

the poor from benefiting from local development initiatives. The same can be said of officials from non-governmental organisations who believed that the social and economic aspects of poverty in Chegutu are reinforcing each other to perpetuate vulnerability of the poor in Chegutu.

Generally, NGOs and the local municipality's understanding of poverty is based on their priority areas and programmes. However, a lot of challenges were deduced to be impeding efforts of the institutions in combating poverty and vulnerability in the district. The following chapter will provide an analysis of these findings showing the effect of poverty on health equity considerations.

CHAPTER FIVE

INTERPRETATION, ANALYSIS AND PRESENTATION OF RESEARCH FINDINGS

5.1 Introduction

This chapter provides interpretation, analysis and presentation of research findings. The study sought to explore the effects of the poverty on health among poor households in Chegutu urban municipality with respect to the issues of equity in distribution. While the previous chapter gave primacy to the vulnerability of the poor in Chegutu to poverty and poor health as well as the dynamics and challenges in combating poverty, this chapter gives insights for equity considerations and policy developments using the sustainable livelihoods approach and the capability approach as tools of analysis. Part of this chapter will focus on analysis of institutional policy and programmatic interventions in ensuring equal health distribution considering the fact that the study also sought to examine the role of the local municipality and non-governmental organisations in poverty alleviation and in promoting equity in health.

5.2 Poverty and Health Equity in Chegutu

The findings of the study deduced that the vulnerability of the poor to poverty accounts much for the poor health among the poor in Chegutu. This notion concurs with the analysis made by Boutayeb and Boutayeb (2005: 2) that health occurs along the socio-economic axes of social stratification in which the poor always experience the worst health. In essence, it is clear from the findings of the study that health determinants, including those relating to income, housing, water and sanitation, and food security account much for the inequalities in distribution of health in Chegutu.

The inequalities in distribution of health in Chegutu are both avoidable and unfair in the view of Whitehead (1992: 3) argument that health inequalities are unfair when they stem from factors that society can do something about. Likewise there is something that the government, through its institutions, and NGOs can do to address unequal access to resources such as education, clean water, safe housing, transportation, and health care services. To a large extent, the vulnerability of the poor to poor health problems in Chegutu is avoidable and unfair as it reflects the inequalities in the socio-economic opportunities rather than different individual choices.

In essence, the likely differences in the distribution of health in Chegutu are a reflection of the lack of sustainability of livelihoods underpinned by deteriorating socio-economic conditions of people in the district. The connection between ill-health and poverty in Chegutu is a complex, bi-directional and multi-faceted one as the study established that poverty perpetuates poor health outcomes and in turn ill-health can be a catalyst for poverty spirals. Thus, achieving health equity in Chegutu means eliminating avoidable differences in one or more aspects of health across socially, economically and geographically defined population groups.

It is clear that a broad set of social, economic, and political conditions influence the level and distribution of health within Chegutu. Thus addressing these structural factors which constitute the social determinants of health is important as a pro-equity measure as some of health inequalities are likely to result from the unjust distribution of social goods, power and resources. In actual fact redressing inequities in health needs to be prioritised as a primary goal of public policies in Zimbabwe with health systems having a specific and special role in achieving equity in the distribution of health.

Moreover, the systematic social patterning of health outcomes in Chegutu reflects that there is something about the living conditions that lays the basis for differences in health. These differences highlight the idea raised by Raphael (2009: 3) that health inequalities are by and large not explained by biomedical differences alone, which means that they can be avoided mainly by judicious societal level action. Over and above, these differences are unfair and unjust (Marmot et al. 2008: 1661) on the basis that only the poor people are the ones suffering from such a multiplicity of deprivation that translates into high levels of ill-health. This articulation points to the fact that in the long term pursuit for equity in health is imperative to reduce the magnitude of socio-economic inequality in Zimbabwe, since it is the driving force behind inequities in health outcomes as evidenced in Chegutu. Likewise it implies the need to break the linkage between people's socio-economic position and health outcomes.

The study identifies that the poor have the highest level of health needs in terms of both health status and economic factors and are at increased risk of ill health. High poverty levels and poor services utilisation by poor households' means that improved equity depends on improving public infrastructure and access to basic social services by the poor. Thus there is need for resource redistribution towards health needs, including a shift in the budget allocation towards expansion of infrastructures and increased coverage of primary health care. The socio-economically disadvantaged position of the poor implies that measures to address the continuing health inequalities in Chegutu will depend largely on increasing the capacity and organisation of the poor to strongly influence policy and resource distribution.

Shortfalls in public service provision and utilisation by the poor have consequences in terms of increased mortality, illness and reduced life opportunities. Thus, the

research reveal a critical development concern in Chegutu both in terms of equity considerations in health as explained by the capability approach and the sustainable livelihood approach. The understanding of health equity in Chegutu is thus based on the understanding of the reciprocal relationship between urban social conditions and the people's wellbeing which in reality reflects a negative correlation. The fact that the poor or the disadvantaged were found to be living in deprived conditions is of grave concern considering that shortfalls in the provision of services like water and sanitation are associated with outbreaks and high prevalence of preventable diseases.

It is evident from the findings of the study that economic inequality affects access to key inputs to health, like improved incomes, nutrition and the uptake of health services. Wide differences in access to safe water and sanitation, food poverty and nutritional levels in Chegutu continue to be strongly linked to the socio-economic conditions. The fact that poverty levels continue to determine the health outcomes among the poor implies that the analysis of inequities in health should seek to better understand and address the social distribution of health and of the services that support health. Thus, the unequal distribution of diseases and survival in Zimbabwe can, in many instances, be explained by the extent to which people, households and social groups are accessing the resources to be healthy.

Thus the poverty state of the majority of the poor in Chegutu and the lack of sustainable livelihoods thereof reflect likely magnitude of health inequalities. Thus the findings of this study make it plausible to conclude that intervening on the socio-economic level will likely improve the people's health and often lessen their exposures to the deteriorating socio-economic conditions. By reducing people's exposure to poverty, it is possible to also improve people's health outcomes and

alleviate some aspects that exacerbate and perpetuate poor health and ultimately factors that affect equity (Marmot, 2004: 82).

The situation in Chegutu concurs with the findings of Hunter (2008: 37) who investigated the relationship between exclusion and poverty in Pakistan and established that poor health outcomes among social groups were actually being aggravated by multiple processes of social exclusion. In actual fact, the situation in Chegutu provides an illustration of equity challenges as embedded in the differences in the living standards of people as well as the low levels of protection provided to the disadvantaged by both the local municipality and NGOs. In this regard, government health programmes such as HIV/AIDS and Tuberculosis Treatment Programmes and Cholera programmes will remain ineffective if people are treated and then sent back to the poverty conditions that made them sick (or perpetuate sickness) in the first place.

The CSDH (2008: 26) advocated for the centrality of equity in health issues implying the need to go beyond contemporary concentration on the proximate causes of poor health to the fundamental structures of social hierarchy as well as the socially determined conditions in societies. The fact that the poor continue to be lagging behind in terms of participation and capacity building puts pressure on the government and other development agencies to quickly recognise sustainable poverty reduction as a fundamental factor for equity and health improvements.

The situation in Chegutu gives a clear picture of a people whose capabilities and opportunities for better lives are greatly compromised. In fact equity considerations in health in Chegutu implies that people need to have control over their lives, have political voice and participate actively in decision making processes as these are

critical factors in achieving a just distribution of power which ultimately results in the empowerment of residents for equity considerations in health and other related development activities. This notion is the reason why Sen (2000: 20) characterized poverty as deprivation of capability. Thus he placed these issues at the heart of the capability approach.

The lack of people's participation and empowerment in Chegutu reflects a vacuum in development efforts. This is grounded on the reality that the supremacy of and the recognition of the importance of participation and empowerment was confirmed by the Alma Ata meeting in 1978 and the United Nations Children's Fund (UNICEF) when primary healthcare (PHC) was endorsed as the health policy guiding its member states which Zimbabwe is part of. It is very surprising then that participation is still a missing link at grassroots level in Zimbabwe as established by this study. Thus, the critical challenge in advancing the health of the poor in Chegutu for equity reasons lies in capability deprivation of the poor. It needs to be underlined that although the health inequalities is a worldwide occurrence, seen in all countries, such articulation should not blindfold the fact that health inequities in Zimbabwe is an indication of the plight of the poor who are at the periphery of the society in its entirety.

The findings of this study also underscore the fact that the distribution of health in Chegutu is embedded in a wider context than disease problems. It is actually rooted in the social, political and economic environments that the poor live in, which limits their access to health supporting services and even the efficient and effective health system that the rich have (Wagstaff, 2001: 262). When these services are available, they are inaccessible and too expensive for the poor to afford because of their limited livelihood opportunities.

The same findings were reached by Rashid (2009: 574) who concludes that in Bangladesh, the broader social, economic and political conditions seriously compromise the ability of the poor to improve their health outcomes. Surprisingly, resource allocation and health policy concerns in Chegutu and in Zimbabwe at large remain rooted in a biomedical model of health that views health as the absence of diseases. This kind of articulation fails to take into consideration the plight of the poor and the implications of their poverty status on health. In essence, the living conditions of the poor in Chegutu account much for the health trajectories of the poor that are affecting equity issues.

Disinvestments in social services or the lack of access thereto greatly influence the health of the poor. People's lack of access to social services as the study has established, means that the livelihoods are susceptible to diseases and poor health. This obviously affects the household ability to lead sustainable livelihoods that they have reason to value. This poses a challenge to the government to quickly invest in the provision of services that address the needs of the poor in order to close the equity gap with respect to the distribution of health in Chegutu. This is a serious development challenge considering the fact that Sen (2000: 22) argues that the unequal distribution of resources affects the freedom of people to lead lives they have reason to value, which subsequently has a powerful influence on health distribution.

The findings of this study also indicate that equitable access to health care services could reduce the poor-rich differences in terms of the severity and vulnerability to diseases. Thus, improved access or exposure to preventative health measures could help reduce the occurrence of disease among the poor. Poor people are prone to plunge into progressive spiral of sickness and poor health due to lack of equal

opportunities for the poor who experience poverty and vulnerability to escape the trap or the vicious cycle of poverty and poor health. In fact, the poor are suffering appallingly and they are likely to experience poor health as a result of poverty that affects the equitable distribution of health across the socio-economic gradient.

The vulnerability of the poor in Chegutu is thus a complex and intricate combination of low capabilities especially for those living in slum and hazardous environments. This works to ensure that health shocks always haunt their already miserable lives. Sen (1999: 4) argues that deprivation and oppression are outcomes of lack of opportunities to develop individual capacity. Thus the poor people's lack of freedom restricts their choices to act in their best interests and to lead meaningful lives. Their low capabilities also entail that they take time to recover from health setbacks. Their lack of voice in civil and political decisions further exacerbates their disadvantage and vulnerability.

It is apparent from this study that the poor have not been empowered to guard against and to cope with vulnerability. The poor are not in a position to guard their household economies against shocks. This means that they are vulnerable to long term welfare losses. This is the same conclusion that Pryer et al (2003: 6) reached in a study in Dhaka, Bangladesh. In actual fact, the poor in Chegutu do not have the capacity for self-protection, a direct contradiction of Sen's (2000) argument that development arises from a wide range of choices which enable people to realize their full potential. Thus the disenfranchisement of the poor from the mainstream of public services and public participation implies that their exposure to poor health continues to be high. There can be no doubt therefore that poor health in Chegutu is a poverty phenomenon. This is so despite the fact that the Sustainable livelihoods approach argues that any equity centred development should consider the

importance of people as experts in championing their own development. It appears that the government as represented by the local municipality is paying lip service to issues of equity and poor people's participation.

Woolf (2007: 523) highlighted that income is a major determinant of health. Thus low incomes and lack of assets of many poor people in Chegutu entail reduced expenditures and diminished service utilisation. This is also exacerbated by the costs of accessing health care. This is a real challenge taking cognisance of the fact that ill health, poverty and low income and low or lack of asset base are intertwined and more so that the subsequent ill-health is associated with high health care costs. It is clear that poverty in all its aspects undermines a whole range of capabilities and opportunities for health. Marmot (2006: 2081) argues that poverty as it is reflected in the structures and characteristics of a society attest much to the differences in health and not just differences in health care. Therefore, the vulnerability of the people to poor health in Chegutu is a reflection of people's lack of power to command, mobilise and utilise resources in order to attain the foundation for better health.

5.3 Institutional Interventions and Health Equity

It is important at this juncture to go a step further in the analysis of the findings in order to get a clear picture of whether the institutional policies and programmes of NGOs and the local municipality are making an impact in addressing the poverty and promoting health equity. This is very important considering the fact that people's access to the resources for health and the promotion of equitable health systems are both increasingly influenced by policies and institutions at local, national and global levels. It is imperative to note that the responses of the municipality and NGOs in relation to the issues of health equity and social justice in Chegutu should be judged

at two levels, that is, on operational terms through actions that address specific socio-economic indicators (for example unemployment, hunger, infrastructure, water and sanitation) to a more philosophical level that relates to a humanistic concept of policy.

To begin with, policy and programmes cannot be intelligently comprehended without an understanding of mechanisms of governance. Thus the importance of paying attention to institutional responses found expression in the ideas of Bambas and Casas (2001: 12) who highlighted that the pursuit of equity is in many ways linked to governance issues and how institutions respond to people's vulnerability. Issues of accountability, transparency and decision making procedures are questionable in the Chegutu municipality.

The impacts of lack of accountability are mostly felt among the poor who have little space or possibility for manoeuvre to ensure that their concerns are taken aboard. In fact, lack of accountability of the municipal officials and politicians has meant that poverty alleviation and services delivery has become simply another line of political and economic patronage. There is, for the venal, power and wealth to be siphoned out of poverty alleviation and service delivery at the expense of the poor. This has helped to exacerbate the vulnerability of the poor to poverty and poor health through limited access to resources and services. Thus increasing accountability mechanisms is essential to addressing the deep political constraints that promote inequitable policies.

Sanders and Chopra (2006: 73) argue that South Africa offers an exciting example of what promises to be a perfect model of good governance as demonstrated by its pro-equity policies and programmes as well as a progressive constitution, which

encourage participation and effective partnerships. Hence Zimbabwe can take a leaf from that. In actual fact, the study found that ensuring the meaningful participation of the poor in decision-making and monitoring processes and holding institutions accountable is important for the fulfilment of the right to health.

It can be argued that the effectiveness of institutions, especially the local municipality in making inroads towards equity in health, is being marred by the absence of clear mechanisms for transparency and accountability in decisions that concern resource allocation and distribution. This implies that poverty alleviation efforts and the pursuit for equitable health distribution remain illusory in Zimbabwe. When such critical governance issues were raised, people especially the poor, confirmed that they are not in a position to influence the political sphere to allow a broader representation which is critical in the expansion of public health choices by all. This explains why many are still trapped in abject poverty making very slim the prospects of equal and inclusive health distribution.

Due to high levels of poverty and vulnerability in Chegutu, as highlighted in the previous chapter, the chances for equal health distribution are very slim at the moment. The interventions of the municipality have not succeeded in addressing extreme difficulties that the poorest people experience in accessing services. It appears that most intervention programmes have not yet prioritised the health of the poor and poorest in society as economically and ethically justifiable for wellbeing of the population. The devastating impacts on poverty and vulnerability on individuals and households in Chegutu require programmes to embrace the notion of social justice. However, policy and programmatic responses seem to have not addressed the denial of health supporting services, especially amongst the poor, such as socio-economic, political and human rights. Thus, decision makers have the onus to pay

attention to the social and economic drivers of development for equitable health distribution.

There is no doubt that programmatic and policy responses for eliminating health inequities are a matter of justice in terms of the distribution of resources, wealth opportunities, and privileges as expounded by Rawl (2009: 33). The delivery of social services in Chegutu reveals a polarised system in which the poor and some segments of the population are deprived of access and opportunities to participate fully in the mainstream society. This has made it very difficult for various institutional and stakeholder responses to create, enhance and sustain optimum conditions necessary for health equity or rather to overcome barriers associated with inequitable distribution of health. It then becomes important for stakeholders in local governance, poverty reduction and population health care to include the broader concept of social justice in addressing the social determinants of health across their areas of jurisdiction.

In the same vein, it is crystal clear that programmatic and policy responses in Chegutu still have a long way to go as far as the achievement of health equity is concerned. It appears that the district municipality has not yet explored the differing perspectives of poverty and vulnerability that are vital in explaining health inequities. The poor highlighted various perspectives concerning their vulnerability which appear not to have been accounted for in policy and programmatic interventions of the municipality. Although, NGOs are doing their best to respond to the real needs of the poor, it is clear that without local government support and initiative, their efforts will not be enough to ensure equal health opportunities for everyone. The lack of programmes that speak to participation, capacity building and empowerment implies

that the municipality is far from addressing the root causes of social and economic vulnerability of the poor as priority action for equal health distribution.

Poverty alleviation and health promotion programmes of the municipality and NGOs in Chegutu need to speak to empowerment and equity in the form of distributive justice, and social justice. This is very critical considering the fact that health is underpinned by community participation and empowerment (Laverack and Labonte, 2008: 114). In the same vein, Levy and Sedel (2006: 1) articulated that issues of equity should be viewed in the context of who controls access to opportunities and resources. Thus it is critical that institutional responses and interventions set the ground for people to access opportunities, resources and services necessary for equal distribution of health across the population. Similarly, the programmatic interventions of the municipality have not ensured that the poor, the vulnerable and the powerless have fair and equitable access to opportunities and resources. They have not ensured that the poor have the capacity to compete in the mainstream society. Thus, the contribution of the local government plans in providing services and conditions necessary for equal health distribution remains very minimal among the poorest segments of the population.

It was established that, ideally, the municipality is more positioned to lead the process of creating optimum conditions for equal health distribution considering the influence they have over land use, housing, water sanitation and infrastructure. However, their sector programmes and poverty alleviation programmes and policies are failing to ensure sustainable livelihoods in which people can improve their health.

The critical aspect that the study deduced with respect to institutional policy and programmatic interventions pertains to the lack of broad approach to health

improvements in Chegut. There is no coordination between NGO and municipality programmes and policies are leading to (for example) duplication in the distribution of services. It is critical for the district to focus on institutional transformation by designing a new vision for poverty reduction and health supported by new models of implementation based on the bottom-up approach and multi-stakeholder coordination. However, institutional transformation and strengthening should not be an end in itself, but rather it should be a means to achieve sustainable development for equal health distribution. It becomes critical then to incorporate health indicators across all functions and sectors of local governance. Zooming down to the municipality, it is critical that every department and sector, including environmental health, urban planning and housing should have an orientation towards achieving better health for all citizens inclusive of the poor anchored by active civic and citizen participation.

Even though all the challenges of local governance in terms of the delivery of services, poverty reduction and opening up of opportunities point to the need of renewing health (public) governance, it should also be noted that urban governance is not the sole domain of government. Civic society and private sector organisations do participate in advancing local, social and economic development and have proved the best of their prowess in this endeavour. However, the local government has the sole responsibility, which it must stand up to, of taking the lead in coordinating all sectors and stakeholders to work on health determinants in a coordinated fashion. This role appears to be missing from local government programmes and sector development initiatives.

More so, it appears that the challenges in local governance especially as it relates to the distribution of recourses, services and opportunities arise as a result of lack of

coherence between national policies and local implementation. The study deduced that stakeholders have not prioritised their issues quite reasonably as well as their interventions and monitoring outcomes to ensure that they align to the national policies which speak to affirmative action, empowerment and socio-economic transformation. The fruits of the national policies need to be seen at grassroots level, clearly reflecting in programmes for poverty reduction. The challenges highlighted by the residents make it clear that there is a lack of coherence between national policies and the programmes being implemented. Maybe it confirms the common view that national policies are just but mere rhetoric. On this account, there is need to develop poverty reduction action plans which can be synchronised with national development plans for the systematic graduation out of poverty.

Consequently, this makes the need to promote local ownership for sustainability of interventions more pertinent. This is critical considering the fact that much of the programmes are being marred by the lack of broader agenda for community development underpinned by empowerment. Therefore, it is critical that the municipality reorient its programmes towards addressing local needs as pathway linking poverty reduction efforts with improved health outcomes

Further, it is critical to note that most of the activities of the local government have not opened enough space to enable strategic and critical debates and engagements with citizens and the civil society. This is evidenced by differing views and perspectives on poverty and the gaps in the implementation of programmes and policies for poverty alleviation between and among different stakeholders. Thus the opening up of platforms for engagement is critical in order to inform the implementation of demand responsive policies and programmes which are fundamental in offering opportunities and the springboard to address inequities and

other related development bottlenecks through exchange of information, increased civic and community participation.

In essence community participation is equally important in the delivery of local sustainable development as enshrined in Agenda 21 of the United Nations Conference on Environment and Development. In fact what is critical for health equity in Chegutu to be realised is to re-craft the public health framework in a manner that locates communities as active champions and managers of their own health. Based on this argument, it is imperative that all stakeholders promote a bottom-up approach and listen to and learn from the people themselves through discussing and making decisions together (Macfarlane, 2000: 6). This will help to create an enabling environment necessary for the poor to have equal chance for good health.

5.4 Conclusion

The chapter has provided an analysis of poverty in relation to equity in health distribution in Chegutu. The chapter also provided a critical analysis of institutional programmatic and policy interventions as it relates to health distribution in Chegutu. Significant effects of institutional programmatic and policy interventions for poverty reduction and health equity considerations were detailed. In essence, the logic of the chapter revolves around the idea that health inequities in Zimbabwe especially in Chegutu flow from the systematic and unequal distribution of power and resources and the relative position in the society.

Generally, the chapter concludes that a broad set of social, economic, and political conditions influence the level and distribution of health within Chegutu. Thus addressing these structural factors which constitute the social determinants of health

is important as a pro-equity measure. In actual fact redressing inequities in health needs to be prioritised as a primary goal of public policies in Zimbabwe with health systems having a specific and special role in achieving equity in the distribution of health. It is legitimate then to declare that the time for action is now, not just merely because improved health makes more economic sense, but solely because it is right and just. Therefore, the next chapter will give a conclusion to the whole study and provide a way forward.

CHAPTER SIX

SUMMARY AND WAY FORWARD

6.1 Introduction

This chapter provides a summary of major points raised in the dissertation with a central focus of showing how the dissertation responded to the concerns raised in the problem statement and to achieve the set objectives of the study. This chapter also suggests the way forward in which the study proposes areas that need to be considered for further research and the reasons for that as well as actions that are needed to address some of the problems discussed in this dissertation.

6.2 Summary

Poverty has significant effects on the inequitable distribution of health. In fact, poverty in Zimbabwe is rooted in poor socio economic arrangements. In many instances it is the poor who are most affected. To that end, poverty is one of the core variables that impact on the distribution of health. In actual fact, the social and economic resources are actual determinants of individual and population health. The poor tend to have limited access to health supporting services and resources on the basis of their vulnerability. Thus the contribution of poverty as a proximate determinant depends partly on its distribution across socio-economic groups.

It can be concluded that the poor in Zimbabwe have no equal opportunities for positive health outcomes. Many of these drawbacks are attributed to the failure of intervention programmes to identify and conceptualise the manifestations and perspectives of poverty as they are experienced by the poor themselves. The study therefore concluded that the pursuit for equity in health is value-based commitment

to tackle poverty. It is very unfortunate that the programmes and policies on poverty have done very little in addressing health inequalities. Thus, it can be deduced that new ways of reaching the poor in terms of enhancing access to opportunities, resources and services for equal health distribution are more critical than ever before.

The focus on poverty entails the broader commitment to the achievement of greater equity in health using a human rights framework to consider both poverty and equity. It can also be concluded that the importance of local government and NGOs should not be underestimated in the alleviation of poverty in Zimbabwe. It is surprising then to note that sector programmes are failing to reach the poor despite their need. This has been exacerbated by the fact that the poor are unable to participate in the mainstream society because of skewed social and political arrangements that have closed the gap and opportunities for them, that have disfranchised them, that have disempowered them.

The research thus found the importance of the perspective of social justice in the design, implementation of policies and programmes for poverty alleviation. Social justice, through empowerment and capacity building, is critical in tackling social marginalization, disadvantage, vulnerability and discrimination on the basis of socio-economic status. Although some sector programmes have considered the importance of social justice as evidenced by some NGO programmes orientation to poverty reduction and health promotion, unfortunately the local government is still lagging behind. Therefore it can be deduced that paying systematic attention to the root causes of social disadvantage, vulnerability and discrimination with respect to access of and opportunities is vital for equal health distribution.

6.3 Way forward

The need for new strategies for poverty alleviation and development in Chegutu underpinned by equity considerations is very pertinent than ever for achieving equal health opportunities for all. The serious problems of poverty and vulnerability in Chegutu and their effects on the inequitable distribution of health make the need for new ways of influencing policy and action more critical. Over and above, the failure of current strategies to effectively address and alleviate poverty or rather to open equal opportunities for the people gives impetus to the need for new models of development tailored to address the development bottlenecks as highlighted in this dissertation. To that end, the study proposes various ways to address the challenges of poverty and inequitable distribution of health in Chegutu District.

This study proposes need to promote sustainable development as crucial to the alleviation of poverty and reduction of inequalities in the distribution of health in Chegutu. This will require corresponding change in the traditional concept of politics. It is imperative to alter the business-as-usual kind of mind-set to a new mind-set geared to work towards poverty alleviation for equal health distribution. For this reason, mind-sets need to change at both the macro level and micro level in order to achieve equity and justice. In the same vein, it is important to underline the fact that the onus of poverty alleviation and health promotion cannot necessarily be placed on governments alone. The onus rests increasingly with civil society and the community-based constituencies that are active in advocating for increased government responsiveness when it comes to equitable outcomes in health and development.

Sustaining and widening efforts to achieve universal coverage of key services based on delivery of universal entitlements will need to be funded through mandatory pre-payment financing, such as by taking forward the policy proposals in Zimbabwe Agenda for Sustainable Socio-Economic Transformation (ZIMASSET) to improve progressive tax funding, including from earmarking VAT and excise taxes, with measures to ensure equity, efficiency, transparency and accountability in their management. Needs based resource allocation would need to apply to new resources, so that no district receives reduced funds. Measures need to be applied to strengthen monitoring of service gaps and to build capacities to absorb and use funds effectively. A dialogue with the private health sector to co-ordinate a partnership aligned with national goals will need to be based on better information and public domain reporting, including on costs and performance.

The fact that determinants of improved health equity lie outside the health sector implies that priority areas include identifying specific measures and targets for improving employment and income security as well as addressing the vulnerability associated with the socio-economic conditions of people. It also entails investing in rehabilitation of public urban water supplies and active promotion of improved sanitation. Thus inter-sectoral processes are critical in improving health equity and advance health in all policies to address the underlying determinants of poor health outcomes.

Different government and civil society systems and processes need to identify health inequities and address them in all aspects of policy formulation, implementation, monitoring and evaluation. This requires policymakers, implementers, managers, and service providers who are accountable to achieving health equity goals starting

with the equitable allocation of relevant resources based on vulnerability and poverty.

The study noted that the most marginalized communities and poorest are often forgotten and not systematically assessed when national development plans are laid down and resources allocated. As a result, they do not have a voice in global and national and local decision-making platforms. Thus there is need to disaggregate national data in order to identify the affected groups and assess the factors that exclude them as critical to scheming equitable solutions to health and development.

In pursuit of sustainable development for equal health distribution, there is need for proper coordination between donors themselves, government and local authorities to ensure maximisation of available resources. This is based on the premise that currently there is no interdisciplinary political and social analysis of poverty in Chegut. This has led to lack of linkage between poverty analysis with planning and policy between and among different stakeholders. Subsequently, this has affected the distribution of health across the population spectrum. Thus an integrated and coordinated approach to development and the alleviation of poverty has the potential to ensure that the resources and services reach the marginalised populations.

With respect to coordinated efforts, Hasegawa (2007: 1) highlighted that sustainable development includes issues and notions of poverty reduction, human rights, security, gender empowerment and good governance. Therefore, the integrated efforts of different stakeholders have the potential to achieve equitable development within sustainable means. This can be achieved by pooling resources together and maximising the distribution thereof. This will help also to avoid duplication of efforts. Thus, it is critical to incorporate and integrate multi-stakeholder participation in the

sustainable human development agenda as this will empower local stakeholders in issues of local development to the end that issues of deprivation and marginalisation will be addressed. Multi-stakeholder coordination and participation has the potential to bring about sustainable human development for equal health distribution.

Moreover, poverty alleviation should be a key policy at both local and national level. It is suggested therefore that the need for sustainable development should be a priority of intermediate actors inclusive of research institutions, NGOs, local government and service ministries. Likewise, it is proposed that the local government sphere stand up to its position as the melting pot in which service delivery takes place and also as an oasis that can ignite stakeholder cooperation for equitable service delivery and poverty reduction. This has the potential to address the root causes of inequalities for equitable development and for equal health distribution.

Further, there is need for proper community involvement to improve targeting. In view of achieving equity in the distribution of health as anchored by poverty reduction efforts, it can be further proposed that institutions and actors involved in local development be responsive and accountable to the needs of all citizens especially the poor who are victims of poor social and economic arrangements. Thus in addressing the development hitches, the community including the poor should be involved at all levels of decision-making to ensure that they are not disadvantaged or excluded from making decisions that affect their lives. This is significant in order to ensure that local investments match the needs of the poor who are usually the victims of inequitable distribution of health mirroring severe inequalities in the distribution of health supporting resources and services.

It is advisable for institutions that cooperate in poverty alleviation to adopt the sustainable development approach which endorses the empowerment paradigm as a core principle to give impetus to all citizens including the poor to be active in the development agenda. This is based on the assumption that the active participation of people and the wide and robust representation at all levels and platforms of policy and decision making are key to sustainable development. In any case, it should be borne in mind that development that cannot be sustained is not genuine human development. Thus the need to sustain human development speaks to the need for empowerment and should be embraced as prerequisite for healthy wellbeing. Therefore, it is critical that actions for sustainable development provide the springboard for poverty reduction through the provision of demand-responsive local and public investments in human resources, social and economic infrastructure. It is further suggested that sustainable development should be anchored by improvements in the efficiency, responsiveness and transparency of delivery systems for local development. This is very critical as it will stimulate transparency and accountability in local planning, budgeting, and implementation of poverty reduction projects. This will promote transparent local institutional transformation for development.

In turning the tide on both poverty and inequality reduction, it is critical to ignite strategic debates on how to link institutional policies, social policies with economic policy which underpins the defeat of poverty and the reduction of the rich-poor schism. Thus the need of expanding the economic base becomes important through the active involvement of more people and multi-stakeholders in the fight against poverty as this will lead to the equitable distribution of the benefits to all people.

As a pro-equity measure, the government needs to support the notion that higher spending in social welfare per capita leads to lower level of socio-economic determinants of poor health and mortality. Over and above, issues of sustainable development health and equity need to be addressed together since they are both part of social justice. This is very critical considering the fact that policy at the local, national and the international levels can have huge impacts on the kind of lives that people are able to lead, and hence influence health and health equity and development.

This study therefore suggests the need for greater citizen participation and empowerment, access to and influence on public affairs, inclusive decentralization, and creation of institutional space for interaction between the public and the local state. In so doing, there is need to create new spaces and avenues for the community and people to fully participate in decision-making processes and to influence local politics as foundational to the creation of sustainable and equitable society. It is further recommended that local economic and social development and institutional transformation must be steered in a consultative, systematic and strategic manner. This will ensure that barriers to local transformation as reflected in the devastating effects of inadequate access to clean water, health care and education for the majority of the poorest are kept at minimum. This will also entail that people's choice to lead a healthy and long life and to achieve a decent standard of living are expanded as well as the ability to influence decision making.

There is need for capacity-building as a necessary step for empowerment for both individual improvement and for making sure those issues of health inequities are identified and addressed. It also enables the poor to influence decisions to gain skills and knowledge to engage and take an active role in a process developing their own

livelihoods. Equally important is monitoring and evaluation. Monitoring and evaluation are important in that they will enable the removal of local barriers and discriminations that perpetuate polarisation with respect to access of resources and services necessary to lead a healthy life.

It is also important not to lose sight of the reality that health is one of the most compelling indicators of the progress of a society as a whole. Thus the current investment strategies for achieving equity in health should focus on eradicating obstacles to service provision for the marginalized poor. This calls for urgent need to promote equity within the policy process by assessing, monitoring, and evaluating the implications of policies, strategies, resource allocation, and programs on the poor and marginalized communities. Likewise there is need to actively engage the poor and other vulnerable groups in policymaking, implementation, and monitoring so that all policies, strategies, plans, programs, and financing interventions reflect the realities of the poor and other marginalized groups and respond to their needs as defined by them. There can be no doubt that equity based strategies can accelerate progress to address the inequitable distribution of resources and services for better health outcomes. Above all, policymakers must continue to pursue practical solutions to overcome the entrenched barriers by persistently addressing the central question: What obstacles continue to keep the poor in poverty and from utilizing and accessing health supporting services and resources?

6.4 Implications for future research, policy and action

The challenges of poverty as detailed in this study and the proposed way forward have significant impact on future research, policy and action. To begin with, the pursuit for equitable health distribution implies that there is greater need to review

the numerous actions and interventions that have been undertaken so far to address the needs of vulnerable populations and the development bottlenecks in the district. It seems at the moment that there is lack of research output evaluating such actions. Evaluation of this progress will inform the basis for future action to reduce inequities in a sustainable manner. This will require implementation of research focusing on measurable outcomes.

Above all, it calls for research to inform the basis for policy and action. Research policy and action should endeavour to support investments in social and human capital as foundational for equitable and sustainable societies. In essence, principles of social and redistributive justice should occupy space in the collective societal consciousness and should find expression in both local and national policies bearing in mind the fact that equitable distribution of health determinants is the pathway to equity in health.

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APPENDIX 1



University of Fort Hare
Together in Excellence

FACULTY OF MANAGEMENT AND COMMERCE

DEPARTMENT OF DEVELOPMENT STUDIES

INTERVIEW GUIDE FOR CHEGUTU MUNICIPALITY AND NON GOVERNMENTAL ORGANISATIONS

I, Joseph Budzi (201013880), a Masters of Social Science in Development Studies student, am hereby carrying out a study on the effects of poverty on health equity in Zimbabwe. I therefore kindly request you to assist with information that will help in the analysis of poverty and its implications of health status of the poor. The data collected will be strictly for academic purposes and will be treated with confidentiality.

1. What do you think are the major causes of poverty in Chegutu District?
2. In what way do you think poverty is affecting people's health in Chegutu?
3. In your opinion, do you think poverty reduction and the equitable health distribution objectives are achievable in Chegutu?
4. What is your organisation doing to address poverty for the equitable distribution of health in Chegutu?
5. How do you ensure that your poverty reduction programmes advance the health outcomes for all people in Chegutu?

6. Do you have a multifocal policy framework that guides your poverty reduction programmes for health reasons?
7. Do you think your intervention strategies are addressing the real causes of vulnerability and the multiple health needs of the poor?
8. Do you think health promotion programmes in Chegutu also takes into consideration the importance of poverty reduction for equitable health distribution?
9. What other areas do you think need to be addressed to effectively deal with poverty and to address imbalances in the distribution of health?
10. How do you see the poverty and health profile of Chegutu in the next five years?
11. What challenges are you facing in your efforts to reduce poverty for the promotion of health in Chegutu District?
12. What do you think can be done to improve your capacity or government capacity for sustainable and equitable distribution of health resources and services?
13. Is there anything that you want to share with me in relation with what we have been discussing?

APPENDIX 2



University of Fort Hare
Together in Excellence

FACULTY OF MANAGEMENT AND COMMERCE

DEPARTMENT OF DEVELOPMENT STUDIES

INTERVIEW GUIDE FOR LOCAL PEOPLE IN CHEGUTU

I, Joseph Budzi (201013880), a Masters of Social Science in Development Studies student, am hereby carrying out a study on the effects of poverty on health equity in Zimbabwe. I therefore kindly request you to assist with information that will help in the analysis of poverty and its implications of health status of the poor. The data collected will be strictly for academic purposes and will be treated with confidentiality.

1) Demographics

a) Sex

| | | | |
|------|--|--------|--|
| Male | | Female | |
|------|--|--------|--|

b) Family size

| | | | | |
|-----|-----|-----|-----|----|
| 1-3 | 3-5 | 5-7 | 7-9 | 9+ |
|-----|-----|-----|-----|----|

c) Age Range

| | | | | |
|--------|-------|-------|-------|-----|
| 18 -24 | 24-30 | 30-36 | 36-42 | 48+ |
|--------|-------|-------|-------|-----|

d) Monthly Income (US\$)

| | | | | |
|------|-------|--------|---------|------|
| 1-30 | 30-60 | 60-100 | 100-200 | 300+ |
|------|-------|--------|---------|------|

e) Education

| | | | |
|---------|-----------|----------|------|
| Primary | Secondary | Tertiary | None |
|---------|-----------|----------|------|

2) Employment

- a) What is your main occupation?
- b) How long have you been working or unemployed?
- c) Do you have other sources of income?
- d) What kind of assets do you own?

3) Housing

- a) Do you own a house or you rent?
- b) Are your housing standards conducive for your household's wellbeing?
- c) What do you think contribute to the housing challenges in Chegutu?

4) Water and Sanitation

- a) What are the causes of water shortages in your area?
- b) How do you cope with water shortages in your area?
- c) What can you say about your household sanitation facilities?
- d) How do you manage solid waste?

5) Food Security

- a) What kind of food do you normally eat and how many meals a day?
- b) What are the causes of food challenges in your household?
- c) How do you cope with food challenges in your household?
- d) Any record of hunger and malnutrition in your family?

6) Health information

- a) To what extent is your household exposed to diseases?
- b) What kinds of disease are common in your area?
- c) What the preventative measures that you have taken to reduce your exposure to diseases?
- d) Do you have enough access to health care services?
- e) How many hospitals and clinics are in your area and how accessible are they?
- f) Do you afford medical treatment when ill?
- g) In your opinion how does poverty affect health and health care?

7) Energy use

- a) Do you have access to electricity? If not what kind of energy do you use
- b) What are the challenges that you face in relation to energy access?
- c) How do you think the challenges you mentioned are affecting your health outcomes?

8) Perceptions about Poverty

- a) How do you understand by poverty?
- b) What do you think is contributing to the high rates of poverty in your area?
- c) In your opinion, how is poverty manifested and how does poverty affect the poor?
- d) What do you think needs to be done to reduce the level of poverty for better health outcomes?

9) NON GOVERNMENTAL ORGANISATIONS

- a) What kind of poverty reduction programmes and health promotion activities are being provided by NGOs operating in your area?

- b) Are you consulted in the design and implementation of their programmes?
- c) What can you say about their overall poverty reduction programmes and their health promotion programmes?
- d) What do you think can be done to improve their work so that you can also benefit from their programmes?

10) DISTRICT MUNICIPALITY

- a) Are there any poverty reduction programmes being done by the municipality?
- b) Do you think their programmes are promoting the health of all people especially of the poor?
- c) Do you participate in the design and implementation of the municipality's poverty reduction programmes and health promotion programmes?
- d) What challenges do you think they are facing in alleviating poverty and promoting the health of all people in Chegutu?
- e) What do you think can be done to improve their work so that everyone can benefit from their poverty reduction programmes as well as health promotion programmes?

11) General information

- a) How do you see your living conditions and health in the next five years?
- b) What else do you want to tell me in line with what we have been discussing?