BINDURA UNIVERSITY OF SCIENCE EDUCATION

FACULTY OF SOCIAL SCIENCES AND HUMANITIES

DEPARTMENT OF SOCIAL WORK

COPING STRATEGIES ADOPTED BY HIV-AFFECTED POST USAID TERMINATION IN CHIKANGWE, KAROI

BY

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A DISSERTATION SUBMITTED TO THE DEPARTMENT OF SOCIAL WORK IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF BACHELOR OF SCIENCE HONOURS DEGREE IN SOCIAL WORK.

SUPERVISOR: MISS T.A GAMBIZA

JUNE 2026

DECLARATION

I **B214180B** hereby declare that this dissertation is my original work and has not been previously submitted for a degree or other qualification at any other institution. All sources and materials used have been duly acknowledged and referenced.

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I certify that I supervised **Mashaba Belinda S** in carrying out this research titled: **Coping strategies adopted by HIV-affected post USAID termination in Chikangwe, Karoi** in partial fulfilment of the requirements of the Bachelor of Science, Honours Degree in Social Work and recommend that it proceeds for examination.

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The departmental board of examiners is satisfied that this dissertation report meets the examination requirements and therefore I recommend to Bindura University of Science Education to accept this research project by **Mashaba Belinda S** titled: **Coping strategies adopted by HIV-affected post USAID termination in Chikangwe, Karoi** in partial fulfilment of the Bachelor of Science, Honours Degree in Social work.

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DEDICATION

This research is dedicated to my mother Rutendo Kufakunesu for the unwavering love, strength and financial support that has been my foundation, inspiration and motivation. I also dedicate this research to my late father Taurai Mashaba whose memory continues to live forever. Lastly, I dedicate this dissertation to myself for working tirelessly.

ABSTRACT

This qualitative study explored the health-related coping strategies adopted by HIV-affected families following the termination of USAID-funded support programmes in Chikangwe, Karoi, Zimbabwe. The study had three objectives which are to identify the specific health-related coping strategies adopted by HIV-affected families in Chikangwe post-USAID termination, to assess the perceived effectiveness of these coping strategies from the perspective of household members and to develop informal support networks that enable families to sustain their well-being and treatment adherence in the absence of structured external support. The study was grounded in an interpretivist research philosophy employing a qualitative research approach. Using a phenomenological design, the study focused on HIV-affected primary caregivers and purposively sampled 12 HIV-affected household members, together with three key informants (a district nursing officer, a social worker, and a community health worker). Snowball sampling was also employed to access hard-to-reach participants. In-depth interviews and two focus group discussions were used to collect data, and thematic analysis was employed to analyse the data. Findings revealed that HIV-affected families adopted multiple health-related coping strategies. Regarding perceived effectiveness, participants rated these strategies as partially effective in the short term but largely unsustainable beyond 6 to 12 months. The study concludes that while HIV-affected families demonstrate remarkable agency and creativity in coping with donor withdrawal, their current health-related coping strategies are predominantly maladaptive and unsustainable. However, the community possesses significant social capital and willingness to develop informal support networks, requiring only modest catalytic support to transform latent assets into sustainable, community-owned support structures. Recommendations include policy reforms to formalise multi-month dispensing, establish peer navigator programmes. These insights highlight the importance of asset-based, solution-focused approaches that build on existing community strengths rather than creating dependency on external donors.

KEY WORDS

HIV-affected families, coping strategies, USAID termination, informal support networks, resilience theory, Chikangwe, Zimbabwe, treatment adherence, peer support, mukando, nhimbe

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
AU	African Union
BUSE	Bindura University of Science Education
CHBC	Community Home-Based Care
CRSF	Caribbean Regional Strategic Framework
ECDC	European Centre for Disease Prevention and Control
FBO	Faith-Based Organisation
FGD	Focus Group Discussions
HIV	Human Immunodeficiency Virus
IDI	In-Depth Interview
IFSW	International Federation of Social Workers
MMD	Multi-Month Dispensing
NGO	Non-Governmental Organisation
NVivo	Qualitative Data Analysis Software Package
OVC	Orphans and Vulnerable Children
PANCAP	Pan-Caribbean Partnership Against HIV and AIDS
PCB	Program Coordinating Board
PEPFAR	President's Emergency Plan for AIDS Relief
SADC	Southern African Development Community

TA	Thematic Analysis
UNAIDS	United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
USAID	United States Agency for International Development
VSLA	Village Savings and Loan Association
WHA	World Health Assembly
WHO	World Health Organisation

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CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.0 INTRODUCTION

The HIV/AIDS pandemic remains a major socio-economic and public health disaster in sub-Saharan Africa, with Zimbabwe being one of the most badly afflicted states. This epidemic bears a multidimensional impact, drastically altering family and community systems. Households, frequently the major units of care and support, experience great pressure as they navigate the health issues, economic precarity and persistent stigma associated with the disease. This study analyses the resilience of HIV-affected families in Chikangwe, Karoi, following the cessation of United States Agency for International Development (USAID) support, a shock that has removed a key safety net and pushed the development of new survival tactics. Unlike traditional problem-focused research, this study adopts a solution-oriented approach that not only documents challenges but also identifies existing informal support networks that can be strengthened to sustain well-being and treatment adherence.

1.1 BACKGROUND OF THE STUDY

For nearly two decades, the global HIV/AIDS response in high-burden nations like Zimbabwe has been greatly reinforced by foreign donor financing. Programmes established by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), mostly conducted by USAID, have been crucial in increasing antiretroviral therapy (ART), avoiding mother-to-child transmission and helping orphaned and vulnerable children (OVC) (PEPFAR, 2022). In areas such as Chikangwe, these activities represented a key structured support system, assuring treatment adherence, nutritional support and educational continuity for affected families (Mandirowa and Dube, 2021). Nonetheless, the finance landscape for global health is changing. Donor fatigue, changed goals and a push for greater domestic ownership have led to the termination, diminution or realignment of long-standing aid (Spicer, 2020). This "funding cliff" creates a major gap in service delivery. The unexpected loss of USAID assistance has left previously dependent families in a vulnerable position (Grepin, Pinkstaff, Shroff, and Ghaffar, 2021) and abruptly needing to manage chronic illness without the external safeguards they had grown to rely upon.

Families and people are active actors who use a variety of coping mechanisms rather than passive victims in such difficult situations. Coping, defined as the cognitive and behavioural efforts needed to handle certain external or internal pressures judged as taxing (Lazarus and Folkman, 1984), emerges in numerous forms. These can include potentially harmful tactics like cutting meal portions, pulling kids out of school or having transactional sex, as well as adaptive ones like changing household budgeting and looking for unofficial social support in Zimbabwean contexts.

Although coping mechanisms among HIV-affected communities in sub-Saharan Africa have been extensively studied, there is still a clear knowledge vacuum on how these strategies change in response to a sudden, systemic shock, such as the withdrawal of substantial donor funding (Chikoto-Schultz and Sossou, 2016). Furthermore, limited research has taken a solution-focused approach that actively identifies and leverages existing informal support networks as assets for sustaining well-being and treatment adherence. This study, therefore, focusses on this precise junction in Chikangwe, Karoi. It intends to capture and study the resourcefulness and resilience of families as they negotiate a new, more unpredictable world, giving crucial insights for local institutions and policymakers entrusted with aiding vulnerable populations in a shifting assistance architecture.

1.2 STATEMENT OF THE PROBLEM

A vital safety net for impacted households has been unexpectedly destroyed by the discontinuation of USAID-funded HIV/AIDS assistance programs in Chikangwe, Karoi, aggravating pre-existing vulnerabilities pertaining to livelihoods, nutrition and health. Although these families must develop new coping techniques in order to survive, little is known about the nature, efficacy and socio-economic ramifications of these emergent tactics in the local setting (Mavise and Makoni, 2019). Moreover, while informal support networks (extended family, friends, faith-based groups, community savings schemes) exist, there has been no systematic effort to identify, describe and leverage these networks as assets for sustaining well-being and treatment adherence after external donor support ends. This knowledge gap impedes the ability of local government and non-governmental organisations to plan targeted, effective and lasting interventions to serve this vulnerable group during a period of heightened crisis.

1.3 AIM OF THE STUDY

The aim of this study is to examine health-related coping mechanisms employed by HIV-affected families to sustain their well-being and treatment adherence following the termination of USAID-supported programmes.

1.4 RESEARCH OBJECTIVES

1. To identify the specific health-related coping strategies adopted by HIV-affected families in Chikangwe post USAID termination.

2. To assess the perceived effectiveness of these coping strategies from the perspective of the household members.

3. To develop informal support networks that enable families to sustain their well-being and treatment adherence in the absence of structured external support.

1.5 RESEARCH QUESTIONS

1. What are the specific health-related coping strategies employed by HIV-affected families in Chikangwe after the cessation of USAID grants?

2. How effective do household members perceive these health-related coping strategies to be in maintaining their well-being and treatment adherence?

3. What existing informal support networks do HIV-affected families currently draw upon, and how can these networks be developed and strengthened to sustain well-being and treatment adherence in the absence of structured external support?

1.6 ASSUMPTIONS OF THE STUDY

This research operates under several assumptions. First, it is assumed that the withdrawal of USAID support has had a direct and negative impact on the well-being of the target population, necessitating the adoption of new survival strategies. Second, it is assumed that participants will be capable and willing to provide accurate and truthful accounts of their experiences and coping methods. Third, the study assumes that informal support networks (extended family, neighbours, faith groups) exist and are currently being used, even if inconsistently, and that these networks can

be identified and potentially developed. Finally, the study assumes that coping strategies are diverse, with varying degrees of sustainability and success, and that understanding them can inform improved support systems.

1.7 SIGNIFICANCE OF THE STUDY

1.7.1 Significance to Non-Governmental and Community-Based Organisations

The insights into local coping strategies will enable NGOs and community-based organisations operating in Karoi to refine their interventions, strengthen community support networks and develop more context-appropriate and sustainable programming for HIV-affected households. By specifically identifying which informal support networks are already active and perceived as effective, NGOs can move beyond a deficit-based model (focusing on what is missing) toward an asset-based model that builds on existing community strengths. This may result in better health outcomes, reduced stigma and greater general well-being for HIV patients in the community.

1.7.2 Significance to Policy Makers

The study will provide evidence on the real-world impacts of donor fund withdrawal and on the community's existing informal support assets. This can inform national and local policy on HIV programming, resource allocation and sustainability planning, particularly for transitioning from donor-dependent models. The study's recommendations for developing informal support networks can be used by policymakers to design policies that foster community-led projects, strengthen informal networks through small-scale grants or training, and encourage creative financing strategies that leverage existing social capital.

1.7.3 Significance to the Academic Community

The research will contribute to scholarly discourse on health financing, community resilience, and coping theory within the context of HIV in Southern Africa. Its solution-focused orientation, specifically the systematic identification and development of informal support networks addresses a gap in the literature, which has largely focused on problems and deficits rather than on existing assets that can be strengthened.

1.7.4 Significance to the Community

The study provides a platform for affected families to voice their experiences and to identify their own existing strengths and networks. The process and findings can foster community dialogue, validate local knowledge and empower the community in advocating for its needs. By developing recommendations for strengthening informal support networks, the study directly contributes to community-led solutions rather than imposing external interventions.

1.8 DELIMITATIONS OF THE STUDY

1.8.1 Geographical Scope

The research is confined to Chikangwe, a high-density suburb in Karoi, Zimbabwe. Findings are not intended to be statistically generalisable to the entire country but will offer deep contextual insight.

1.8.2 Population Focus

The study focuses exclusively on HIV-affected households that were beneficiaries of terminated USAID support. It does not include other vulnerable groups or households affected by different shocks.

1.8.3 Temporal Focus

The investigation centres on coping strategies adopted in the period following the termination of USAID grants, providing a snapshot of immediate and short-term adaptations rather than long-term outcomes. The third objective's focus on developing informal networks is similarly temporally bound to the post-termination period.

1.9 LIMITATIONS OF THE STUDY

1.9.1 Social Desirability Bias

Participants may over-report socially acceptable coping strategies such as prayer and under-report stigmatised ones such as transactional sex (Dahoma and Mwanri, 2021). Building rapport and ensuring confidentiality will be crucial to mitigate this.

1.9.2 Transferability

As a qualitative study, the findings are context-specific. Their applicability to other settings depends on contextual similarities, which will be richly described to allow readers to make informed decisions.

1.9.3 Recall Bias

Participants may have difficulty accurately recalling details of strategies used since the funding termination. Probing questions anchored to specific events will be used to improve accuracy.

1.10 DEFINITION OF KEY TERMS

1.10.1 Coping Strategies

For this study, according to Kuwali (2011), coping strategies refer to the specific behavioural and cognitive efforts employed by HIV-affected households in Chikangwe to manage the stresses and resource gaps created by the termination of USAID funding. The study focuses specifically on health-related coping strategies.

1.10.2 USAID Termination

According to Younghusband (2021), the term USAID termination refers to the deliberate cessation or withdrawal of financial and programmatic support for HIV/AIDS services that was previously provided by the United States Agency for International Development and its implementing partners in the study area.

1.10.3 HIV-Affected Families

Households where one or more members are living with HIV and where the diagnosis impacts the household's social dynamics, economic stability and health-seeking behaviours (Richmond, 2017).

1.10.4 Social Work

According to Barker (2014), social work is the professional activity of helping individuals, groups and or communities enhance or restore their capacity for social functioning and creating societal conditions favourable to this goal.

The International Federation of Social Workers (IFSW) (2007) defines social work as a practice-based profession and an academic discipline that promotes social change and development, social cohesion and the empowerment and liberation of people.

1.11 DISSERTATION OUTLINE

Chapter One: Introduction and Background of the Study

This chapter introduced the research problem, provides background, states the aim, solution-focused objectives, and questions, and outlines the significance and scope of the study.

Chapter Two: Literature Review and Theoretical Framework

This chapter critically reviews existing literature on HIV, donor funding, coping strategies, and informal support networks, and presents Resilience Theory as the guiding theoretical framework. The literature review pays particular attention to studies that have taken asset-based or solution-focused approaches to understanding community coping.

Chapter Three: Research Methodology

This chapter details the qualitative phenomenological design, study setting, sampling methods, data collection techniques (interviews and focus groups), data analysis plan (thematic analysis) and ethical considerations. The interview and FGD guides are structured to address all three objectives, including specific questions about existing informal support networks and participant-generated recommendations for developing them.

Chapter Four: Presentation and Discussion of Findings

This chapter presents the analysed data thematically, discussing the identified health-related coping strategies, their perceived effectiveness and the existing informal support networks that families currently use. Findings are discussed in direct relation to the research questions and existing literature. Recommendations for developing informal networks are co-constructed from participant voices.

Chapter Five: Summary, Conclusions and Recommendations

This chapter summarises the key findings, draws conclusions directly linked to each of the three solution-focused objectives, provides evidence-based recommendations for policy and practice with particular emphasis on developing and strengthening informal support networks, suggests areas for future research, and reflects on the study's limitations.

1.12 CHAPTER SUMMARY

The chapter clearly revealed the purpose of the study, which was to investigate health-related coping mechanisms as well as the research questions and solution-focused objectives. It also emphasised the importance of the results for stakeholders in the community, organisation and policy. Key words were defined, the dissertation's general structure was provided and the study's bounds and possible limitations were made clear. The following chapter will engage in a detailed examination of relevant literature and elucidate on the theoretical framework driving the inquiry.

CHAPTER TWO: LITERATURE REVIEW

2.0 INTRODUCTION

This chapter offers a thorough and critical review of the body of research on the coping mechanisms used by HIV-affected households in resource-constrained settings after structured donor support is discontinued. The review's systematic structure establishes the study's theoretical, conceptual, empirical and contextual underpinnings. A conceptual study of key phenomena follows an explanation of the theoretical framework that directs the investigation. It then provides

a summary of the research on HIV, donor financing patterns, health-related coping strategies, informal support networks and household coping on a global, regional and local level. The chapter concludes with an examination of research gaps that this study addresses.

2.1 THEORETICAL FRAMEWORK

2.1.1 RESILIENCE THEORY

Resilience theory has become one of the most widely applied frameworks in studies of vulnerable populations facing adversity and it offers considerable analytical utility for understanding how HIV-affected households respond to funding termination. Van Breda (2001) traces the roots of resilience theory to developmental psychology, noting that the concept originally described the capacity of children to achieve positive outcomes despite risk exposure. Masten (2018) subsequently expanded the application of resilience theory to families and communities, arguing that resilience is not simply an inherent trait possessed by some individuals and not others, but rather an emergent property of the interaction between individual characteristics and environmental resources. This distinction is crucial for the present study because it shifts the analytical focus away from asking why some households recover more successfully toward identifying what environmental conditions, social assets and institutional supports make resilience possible or impossible.

Resilience theory is further developed by distinguishing between absorptive, adaptive and transformative resilience capacities (Carlson, 2011). Absorptive resilience refers to a system's ability to manage a shock without significant change to its fundamental structure, while adaptive resilience involves adjusting strategies and behaviour in response to change and transformative resilience describes a more fundamental restructuring of the system in order to operate in a new context. For HIV-affected households in Chikangwe, the loss of USAID support may exceed the absorptive capacity of many families, necessitating adaptive or even transformative responses. Skovdal and Daniel (2012) reinforce this argument by demonstrating that resilience among HIV-affected households in sub-Saharan Africa is fundamentally social in nature with participation in

community-based support structures serving as a central mechanism through which families sustain their capacity to cope over time.

The practical implications of resilience theory for this study are considerable. Masten (2018) argues that the resilience of families is not fixed but can be strengthened or eroded depending on the nature and duration of external stressors and the availability of protective resources in the surrounding environment. Skovdal and Daniel (2012) find that access to coping-enabling social environments is among the strongest predictors of resilience in HIV-affected households, suggesting that the disruption of community support structures following USAID termination does not merely remove a material resource but actively undermines the social foundations of household resilience. This understanding positions the present study to examine coping strategies not simply as individual choices but as socially embedded practices whose effectiveness depends on the broader community and institutional context within which they are enacted.

2.2 RELEVANCE OF THE THEORY TO THE STUDY

The study is highly influenced by the resilience theory which moves the focus of analysis from deficiencies and weaknesses to strengths, adaptive capacities and good adaptation in the face of adversity. The abrupt halt of USAID financing which probably supported antiretroviral treatment (ART) access, nutritional assistance and psychosocial care for HIV-affected households constitutes a significant systemic shock in the context of Chikangwe, Karoi. In the absence of formal external assistance, resilience theory offers a framework for comprehending how individuals, families and local networks use their internal and external resources to sustain well-being, treatment adherence and livelihood stability. Resilience enables researchers to recognize active coping mechanisms like community mutual aid groups, alternative medicine sources, income diversification and reliance on social networks rather than just seeing the impacted population as victims of funding cuts.

The theory of resilience highlights the importance of protective factors that lessen the impact of bad consequences. These preventative variables may include pre-existing community solidarity such as patient support groups that are prevalent in HIV care, indigenous knowledge of herbal supplements, family caregiving arrangements and remittances from relatives who live in urban

areas or abroad in Chikangwe after the USAID program ends. The theory sheds lights on the reasons behind the contrasting experiences of HIV-affected people and families, some of whom have relatively stable health and economic circumstances and others of whom see their situation worsen. The research uses resilience theory to systematically classify coping mechanisms as either adaptive such as establishing new savings clubs or maladaptive such as missing ART dosages, engaging in transactional sex or employing children. This distinction is essential for developing focused treatments that enhance adaptive resilience while avoiding the unintentional promotion of dangerous behaviors, (Ungar, 2018). Critically, resilience theory provides the foundation for the third objective of this study by identifying social capital as a key protective factor that can be strengthened through intentional community engagement.

The application of resilience theory in this study is particularly significant because it shifts the analytical lens from what HIV-affected households have lost (USAID funding, psychosocial services) toward what they still possess and can mobilize. This asset-based orientation is crucial in contexts like Chikangwe where deficit-focused research has historically pathologised communities as helpless victims of external shocks, thereby overlooking the ingenuity, resourcefulness and collective agency that families routinely demonstrate in crisis situations (Masten and Cicchetti, 2016). Resilience theory enables the researcher to identify and document the everyday, often invisible coping mechanisms that sustain households such as the formation of peer support groups under mango trees, the revitalization of traditional savings clubs (mukando), and the delegation of medication supervision to trusted neighbors as legitimate forms of adaptive capacity rather than as inadequate substitutes for formal services. Furthermore, resilience theory provides a structured framework for distinguishing between coping strategies that are genuinely sustainable and those that, while providing short-term relief, generate long-term harm. Resilience theory distinguishes between absorptive coping (using existing resources without changing systems), adaptive coping (modifying behaviors and relationships to manage new realities) and transformative coping (fundamentally restructuring how support is organized). This distinction is methodologically essential for the present study because it allows the researcher to evaluate not merely whether a coping strategy works in the immediate term, but whether it enhances or erodes the household's capacity to withstand future shocks.

2.3 CONCEPTUALISATION OF KEY PHENOMENA IN THE STUDY

The central phenomenon under investigation in this study is household coping, understood as the ensemble of strategies, behaviours and social arrangements through which HIV-affected households manage the consequences of USAID funding withdrawal. Coping, in the context of this research, is not treated as a purely individual psychological response, but rather as a socially embedded and materially constrained process that unfolds across the economic, social and health dimensions of everyday life. This conceptualization draws on a rich body of literature from development studies, public health and social work that treats household coping as a dynamic, adaptive and often contested practice shaped by power relations, resource availability, and structural context.

A household for this study is understood as a unit of co-residence and shared resource management, whose members may or may not be biologically related but who collectively navigate the economic and social demands of daily life. HIV-affected households are defined, following George, Dembedza and Lesley (2024), as those in which one or more members are living with HIV, or in which the care burden associated with HIV disease is a significant organizing feature of household life. This definition is deliberately inclusive, recognizing that the impacts of HIV extend beyond the individual living with the virus to shape the economic strategies, social relationships and health behavior of all household members.

The concept of coping strategies as operationalized in this study encompasses three broad domains, with specific emphasis on the third objective. Economic coping strategies refer to the income-generating activities, expenditure adjustments and asset management decisions through which households attempt to maintain material stability in the absence of external support. Social coping strategies refer to the mobilization and maintenance of social networks, including kinship ties, community group membership, peer relationships and religious community involvement, through which households access information, practical assistance and emotional support. The three domains constitute the empirical scope of the study and inform the thematic structure of the literature review presented in the sections below.

2.4 GENERAL OVERVIEW OF THE STUDY

2.4.1 GLOBAL OVERVIEW

At the global level, the termination of foreign aid programmes targeting HIV-affected communities is part of a broader pattern of shifting donor priorities and resource constraints that has been documented across multiple international contexts. Clark (2025) modelled the potential impact of reductions in international donor funding on disease burden in low- and middle-income countries and found that even moderate reductions in donor funding are associated with significant increases in treatment interruption and mortality, with the severest effects concentrated in communities with the least capacity to absorb the resulting service gaps. Niyonkuru (2016) critically examines the history of foreign aid dependency in developing countries, arguing that the design of many aid programmes creates structural dependencies that leave recipient communities worse off when funding is withdrawn than they were before the programmes began.

The global literature on household coping in the context of HIV consistently identifies economic instability as a primary driver of treatment non-adherence and health system disengagement. Katana (2020) documents that HIV-affected households face a double economic burden comprising direct costs of medical care and indirect costs associated with lost productivity, reduced labour participation and the demands of caring for sick members. Dake (2023) finds that households living with HIV in Ghana employ a wide spectrum of economic coping mechanisms, including informal trading, reliance on extended family remittances, engagement in casual labour and reduction of non-essential expenditures, many of which are adopted at the direct expense of health-seeking behavior. These findings establish the fundamental tension between economic survival and health maintenance that characterizes the situation of HIV-affected households globally.

Health-related coping strategies among HIV-affected households have been documented across multiple global settings. Swendeman, Rotheram-Borus, and Comulada (2020) created a typology of coping mechanisms for HIV-affected families, ranging from asset depletion and labor reallocation at the most desperate end to social network mobilization and livelihood diversification

at the more adaptive end, drawing on data from several global sites, including India, South Africa, and Thailand. Their longitudinal study revealed that families with even modest external bridging support like food coupons, school tuition grants or transportation assistance were far more likely to use adaptive coping methods rather than harmful ones, and that the lack of such support led to a downward spiral where initial asset depletion diminished future coping alternatives.

The Global HIV Coping Study (Ghosn, 2023), a multi-country mixed-methods study conducted in ten low- and middle-income nations, similarly discovered consistent predictors of household vulnerability after the loss of external help. The greatest decreases in treatment compliance and nutritional status were experienced by households headed by women, those with many children on ART, and those located in remote rural areas with inadequate transportation infrastructure. According to this worldwide evidence, aid withdrawal will have varying effects on households impacted by HIV in Chikangwe, exacerbating existing inequalities and disproportionately impacting female-headed households, child-headed households, and those living the greatest distance from healthcare facilities.

Social support networks represent a critical buffer in contexts where formal institutional support is absent or diminished. Berhe (2022) documents that perceived social support is significantly associated with improved health outcomes and treatment adherence among adults living with HIV in Ethiopia, with higher levels of social support linked to reduced depression, better nutritional status and more consistent clinic attendance. Ayala (2021), in a scoping review of peer-led and community-led responses to HIV across multiple settings, concludes that such approaches represent not merely a supplement to formal healthcare but a distinct and often irreplaceable form of support that addresses the psychosocial, informational and practical needs of people living with HIV.

The world literature on community-led HIV responses provides both optimism and caution about the capacity of grassroots mobilization to make up for gaps left by departing donors. In a systematic review of community-led HIV programs across 15 countries, Kerrigan (2021) discovered that peer-supported models performed better than facility-based care alone at reaching marginalized groups, such as young people, sex workers, and men who have sex with men. The same review, however, showed that the majority of successful community-led initiatives needed

some kind of external catalytic support, such as volunteer stipends, training, supervision, or vital resources like bikes for house visits or mobile phones for appointment reminders. Community-led projects frequently failed in six to twelve months in the absence of this little outside assistance, as volunteer burnout, conflicting livelihood requirements, and a lack of organizational infrastructure all conspired against sustainability.

Cataldo (2024) in the analysis of global case studies of community reactions to post-aid transitions: donor funding frequently stifled local ownership and innovation during its active phase, but its abrupt withdrawal rarely resulted in the spontaneous development of community capacity to take its place. Conversely, the most effective transitions were those in which donors purposely invested in improving the capacity of local institutions, such as local government health departments and community-based organizations, for a number of years prior to leaving.

2.4.2 REGIONAL OVERVIEW

At the regional level, the sub-Saharan African context provides particularly relevant evidence for understanding the situation of HIV-affected households in Chikangwe. Mangwanya (2022) evaluates the impacts of foreign aid on low-income countries in sub-Saharan Africa, concluding that while aid has generated measurable health and economic benefits in recipient communities, its abrupt termination frequently causes more harm than its absence from the outset would have done, precisely because communities have aligned their structures and strategies around the assumption of continued support. Raga, Agarwal and Fur (2025) provide timely analysis confirming that Zimbabwe is among the countries most significantly affected by recent shifts in United States foreign assistance policy, with implications for health system functionality, supply chain management, and community-level HIV services.

The regional literature on treatment adherence and health-seeking behavior is particularly instructive. Orievulu (2022) systematically reviewed linkages between drought and HIV treatment adherence in Africa and confirmed that periods of resource scarcity, whether driven by drought, economic crisis or aid withdrawal, consistently correlate with elevated rates of treatment interruption, virological failure and disease progression. Mukumbang (2019), in a scoping review of household-focused interventions for HIV in low- and middle-income countries, concludes that households facing compounded economic and health vulnerabilities require integrated support

models rather than siloed programmatic responses. These findings are directly applicable to the Chikangwe context, where pre-existing vulnerabilities related to food insecurity, unemployment and infrastructural deficits are now compounded by the withdrawal of formal support.

Community health workers and peer support networks have emerged as critical infrastructure across sub-Saharan Africa for bridging the gap between formal health services and households at risk of disengagement. Ngcobo (2022) examined the roles and barriers of community health workers in HIV care across the region and found that in many countries, community health worker programmes have historically been funded through international donor mechanisms, meaning that funding cuts directly threaten this community-level support infrastructure. Iryawan (2022) demonstrates that peer support profoundly influences linkage to and engagement in HIV care, with the social trust and shared lived experience embedded in peer relationships functioning as a form of social capital that formal health services often cannot replicate. Sbaffi, Zamani and Kalua (2023) further document the invisible labour of informal caregivers in sustaining HIV care in contexts of inadequate formal support across sub-Saharan Africa.

Ogutu (2018) emphasizes the crucial but sometimes neglected role of transnational social and material flows in determining the coping capacity of HIV-affected households, especially in aid-dependent contexts. Based on longitudinal ethnographic research conducted in rural South Africa and southern Zimbabwe, Hunter (2022) makes the case that remittances from relatives working in South African mines, Botswanan abattoirs, or informal urban economies in other countries serve as a concealed buffer against local shocks, such as donor withdrawal. Nevertheless, the same study discovers that fluctuations in remittance volumes have grown in tandem with economic recessions in host nations, stricter immigration enforcement, and the deterioration of official labor migration channels. This means that the demise of USAID-funded projects in Chikangwe coincides with a parallel contraction of informal regional safety nets, leaving families with fewer compensatory alternatives than they would have had ten years ago.

Mavise and Makoni (2019) demonstrate that aid withdrawal causes specific types of moral anguish and anticipatory worry in people living with HIV, in addition to clinical and material harm, which in turn reduces treatment adherence. In a qualitative longitudinal study conducted in Uganda, Kenya, and Tanzania, Kagaayi (2023) discovered that when participants learned of impending

donor program closures, they frequently took preventative measures by rationing ART to extend remaining supplies, postponing clinic visits to save transportation money, or quitting treatment entirely out of concern that incomplete care would be worse than none. Rumors and inadequate information about funding timelines exacerbate this phenomenon, which the authors refer to as "anticipatory treatment disengagement", leaving healthcare professionals unable to offer convincing assurances.

Ndhlovu and Mchunu (2024), who worked in peri-urban Botswana, described how the demise of donor-backed support groups removed a crucial forum for shared coping, with participants experiencing more shame, internalized stigma, and suicidal thoughts in the absence of peer solidarity. This finding underscores the urgent need for to replace the psychosocial functions previously provided by formal donor-funded groups. The regional evidence suggests that without intentional development of these networks, the psychological and behavioral consequences of aid withdrawal will continue to undermine treatment adherence and well-being.

2.4.3 LOCAL OVERVIEW

At the local level in Zimbabwe, the literature provides a detailed picture of the specific vulnerabilities and coping dynamics that characterise HIV-affected households in contexts similar to Chikangwe. George, Dembedza and Lesley (2024) demonstrate that HIV-affected households in Zimbabwe rely heavily on externally funded food baskets and nutrition supplements to sustain ART adherence, given that the side effects of antiretroviral medication are significantly worsened by nutritional deficiency. Chidarikire and Magomana (2024) examine the compounding effects of climate-related economic shocks and HIV in rural Zimbabwe, documenting how El Nino-induced drought has exacerbated poverty among HIV-affected households and further strained already fragile coping strategies, creating a context of multiple simultaneous vulnerabilities.

Muvhiringi (2022) provides particularly relevant Zimbabwe-specific evidence, examining the impact of shrinking donor funding on social work and HIV care in the country. Their study documents the ways in which social workers and community-based organisations have attempted to adapt by innovating service delivery models, leveraging government partnerships, and mobilising local resources, while acknowledging that these strategies are constrained by limited local resource mobilisation capacity, bureaucratic barriers and the scale of need relative to

available resources. Zamudio-Haas (2024) complement this evidence with qualitative insights from young adults living with HIV in Zimbabwe who participated in a community-based peer-led treatment support model, capturing the profound importance of community belonging and peer solidarity for maintaining treatment motivation and psychological well-being in the absence of formal donor-funded services.

Ferrand (2017) provided Zimbabwe-specific clinical evidence in a randomised controlled trial conducted in Harare, demonstrating that community-based caregiver support significantly reduced the risk of virological failure in children and adolescents with HIV, underscoring the clinical as well as social value of community networks in sustaining treatment outcomes. Maringe (2025) provides further Zimbabwe-specific evidence documenting that delays in treatment initiation are closely linked to structural barriers including poverty, distance and the absence of community-based linkage mechanisms, all of which are likely to worsen in the post-USAID environment in Chikangwe. Together, these local-level studies establish a compelling picture of a community that has been significantly shaped by external donor support and that now faces the profound challenge of sustaining household wellbeing and treatment continuity in the context of aid withdrawal.

The withdrawal of outside donor assistance poses a threat to the delicate social structure that has been silently supporting HIV-affected households in locations like Chikangwe, even if there are obvious material shortages. Many community home-based care (CHBC) programs, which frequently depend on stipends supported by donors for volunteer caregivers, are on the verge of breaking, which would eliminate not just medical monitoring but also the psychosocial support system that keeps patients from becoming isolated and giving up treatment. According to research conducted in rural Zimbabwe, HIV-positive people, especially widows and orphaned teenagers, suffer greater stigma, have lower treatment literacy, and are more likely to default when volunteer caregivers leave due to a lack of incentives.

The evidence from Zimbabwe is becoming more and more suggestive of a paradoxical adaptation. Formal donor withdrawal wreaks havoc on organized HIV care, but it also fosters the emergence of undocumented coping strategies that function outside the purview of both national health systems and international NGOs. In similar locations to Chikangwe, researchers have observed the development of informal medicine-sharing networks, in which neighbors share small amounts of

ART from those who have excessive adherence in order to fill gaps for individuals who are unable to access clinics. Others have noted the re-emergence of community-based savings groups, referred to in the local area as *"mukando"* or *"nhimbe"*, which have been specifically repurposed to pay for emergency transport for opportunistic infections or to buy nutritious foods like groundnuts and dried fish for individuals experiencing ART side effects.

Though ingenious, these community-based tactics are by nature vulnerable: They depend on trust, are prohibited by law if they include the redistribution of prescription medications, and are unable to achieve viral suppression at the population level. Importantly, health professionals in comparable circumstances note that informal coping strategies frequently cause people to put off seeking official care until the illness has progressed, which raises treatment costs and increases mortality rates. This finding directly supports the need for Objective 3 of this study, developing informal support networks in a structured, intentional manner rather than leaving them to emerge haphazardly. The post-USAID environment in Chikangwe is therefore probably not a vacuum but rather a proliferation of unregulated, unfair, and frequently unnoticed survival strategies that continue to exacerbate health inequalities while avoiding the oversight formerly provided by donor-funded programs.

2.5 HEALTH-RELATED COPING STRATEGIES AMONG HIV-AFFECTED HOUSEHOLDS

2.5.1 The Nature of Health-Related Coping

Health-related coping strategies refer to the specific behaviours and decisions through which HIV-affected households manage treatment adherence, clinic attendance, medication side effects, and the management of opportunistic infections in the absence of adequate formal support. This theme corresponds directly to the first objective of the study, which seeks to identify the specific health-related coping strategies employed by HIV-affected households in Chikangwe following the withdrawal of USAID funding.

Mcinziba (2021) conducted a study in South Africa examining how household income management affects ART adherence behaviour, finding that households experiencing sudden

income shocks were significantly more likely to experience treatment interruption, missed appointments, and ultimately disengagement from care. Lahai (2022) conducted qualitative research in Sierra Leone with people living with HIV and their healthcare providers, identifying a complex interplay of structural, social and psychological barriers to adherence that included food insecurity, stigma and the absence of transport support, all of which became more acute when external funding for adherence services was reduced.

2.5.2 Specific Health-Related Coping Behaviours

Orievulu (2022) systematically reviewed linkages between drought and HIV treatment adherence in Africa, confirming that periods of resource scarcity, whether driven by drought, economic crisis or aid withdrawal, consistently correlate with elevated rates of treatment interruption, virological failure and disease progression. Abagudo (2023) examined patient retention in HIV chronic care facilities in Kenya and found that the availability of adherence support services, including counselling, reminder systems, and follow-up visits, was a significant predictor of retention in care, suggesting that when these services are removed, retention rates deteriorate particularly among patients with fewer social supports. Together these studies frame the post-USAID period in Chikangwe as a period of heightened clinical risk, not merely an inconvenience of service disruption.

Mandawa and Mahiti (2022) investigated factors contributing to loss to follow-up from HIV care among men in Tanzania, identifying structural barriers including distance to health facilities, work-related time constraints and transport costs as primary drivers of disengagement. Their study also highlights a significant gender dimension: men are often particularly vulnerable to loss to follow-up in contexts where HIV services are structured around women and children, and where male social norms around health-seeking conflict with the regular clinic attendance that ART management requires. Maringe (2025) provides Zimbabwe-specific evidence on factors associated with advanced HIV disease at enrolment in care, documenting that delays in treatment initiation are closely linked to structural barriers including poverty, distance, and the absence of community-based linkage mechanisms.

2.6 PERCEIVED EFFECTIVENESS OF HEALTH-RELATED COPING

Yunusa (2025) examines health-seeking behaviour patterns among people living with HIV in Nigeria, documenting a notable tendency toward self-medication, traditional health remedies, and delayed care-seeking in contexts where formal health services are perceived as costly, stigmatising, or inaccessible. Pillay (2026) similarly identifies in their South African study that structural barriers to engagement in treatment programmes, including poverty, social stigma and competing survival demands, frequently outweigh the motivational factors that health systems attempt to activate through counselling and information provision alone. These patterns have direct relevance to Chikangwe, where the removal of structured support may drive similar shifts in health-seeking behaviour toward alternatives that are more immediately accessible but potentially less clinically effective.

The perceived effectiveness of health-related coping strategies has been assessed in multiple studies. Weiser (2020) found across five African countries that food-insecure patients were significantly more likely to modify their ART regimens in ways that compromised efficacy, yet these modifications were perceived by patients as necessary adaptations to survive. This finding highlights a critical gap between clinical definitions of effectiveness (viral suppression) and patient definitions (getting through the day without severe side effects). The second objective of this study which is assessing perceived effectiveness from the perspective of household members directly addresses this gap.

2.7 INFORMAL SUPPORT NETWORKS AND COMMUNITY-BASED RESPONSES TO HIV

2.7.1 The Role of Informal Support Networks

Informal support networks constitute a critical buffer for HIV-affected households, particularly in contexts where formal institutional support is absent or diminished. This theme corresponds to the third objective of the study, which aims to develop informal support networks that enable families to sustain their well-being and treatment adherence in the absence of structured external support.

Berhe (2022) documents that perceived social support is significantly associated with improved health outcomes and treatment adherence among adults living with HIV in Ethiopia, with higher levels of social support linked to reduced depression, better nutritional status and more consistent

clinic attendance. Ayala (2021) conducted a scoping review of peer-led and community-led responses to HIV across multiple settings and concluded that such approaches represent not merely a supplement to formal healthcare but a distinct and often irreplaceable form of support that addresses the psychosocial, informational, and practical needs of people living with HIV.

Iryawan (2022) add qualitative depth to this finding by demonstrating that peer support profoundly influences linkage to and engagement in HIV care, with the social trust and shared lived experience embedded in peer relationships functioning as a form of social capital that formal health services often cannot replicate. Zamudio-Haas (2024) provide particularly relevant Zimbabwe-specific qualitative insights from young adults living with HIV who participated in a community-based peer-led treatment support model, capturing the profound importance of community belonging and peer solidarity for maintaining treatment motivation and psychological well-being in the absence of formal donor-funded services.

2.7.2 Types of Informal Support Networks

Ngcobo (2022) examined the roles and barriers of community health workers in HIV care across sub-Saharan Africa, finding that community health workers provide a vital link between formal health services and households that might otherwise disengage from care. Crucially, their study documents that in many countries, community health worker programmes have historically been funded through international donor mechanisms, meaning that funding cuts directly threaten the sustainability of this community-level support infrastructure. In Chikangwe, where community health workers have served as primary connectors between households and the health system, the withdrawal of USAID funding therefore has immediate and direct implications for the availability of this form of support.

Sbaffi, Zamani and Kalua (2023) add a further dimension by examining well-being promotion among informal caregivers of people with HIV in rural Malawi, documenting the invisible labour of family and community members who sustain HIV care in contexts of inadequate formal support. Ferrand (2017) similarly found in a randomised controlled trial conducted in Harare, Zimbabwe, that community-based caregiver support significantly reduced the risk of virological failure in children and adolescents with HIV, underscoring the clinical as well as social value of community networks in sustaining treatment outcomes. Together, these findings affirm that when formal

donor-funded social support mechanisms are withdrawn, informal community networks and family-based caregiving arrangements absorb the resulting gaps, though the sustainability of this absorption over time remains uncertain and context-dependent.

2.7.3 Developing Informal Support Networks

Mwangi (2020) provides particularly relevant Zimbabwe-specific evidence, examining the impact of shrinking donor funding on social work and HIV care in Zimbabwe. The study documents the ways in which social workers and community-based organisations have attempted to adapt by innovating service delivery models, leveraging government partnerships, and mobilising local resources, while acknowledging that these strategies are constrained by limited local resource mobilisation capacity, bureaucratic barriers, and the scale of need relative to available resources. Simpson (2026) examines the emerging landscape of international aid following recent shifts in donor priorities, describing a period of profound uncertainty for recipient communities as the contours of the new aid regime take shape.

For communities like Chikangwe that have relied on USAID support for HIV services for many years, this uncertainty creates a challenging planning environment in which households must make coping decisions based on incomplete information, compounding the already significant material and psychological challenges posed by the loss of structured support. The development of informal support networks requires intentional strategies including community mobilization, training of peer supporters, establishment of regular meeting structures, and linkage with remaining formal health services. Without such development, informal networks remain fragmented and unreliable.

2.8 RESEARCH GAPS

A careful review of the available literature reveals several important gaps that this study is positioned to address. First, while there is a growing body of evidence on the impacts of foreign aid withdrawal on health systems and national HIV programmes, there is a marked absence of community-level, household-focused research that captures the specific health-related coping strategies adopted in small peri-urban towns in Zimbabwe following funding termination. Most existing studies on aid withdrawal impacts focus on national health system metrics or large urban populations, overlooking the distinctive vulnerabilities and community dynamics of settings like

Chikangwe, where informal social networks and limited healthcare infrastructure create a different coping ecology than that found in larger urban centres or better-resourced communities.

The literature on HIV household coping strategies predominantly examines either economic coping or health-related coping as separate domains, with relatively few studies adopting an integrated framework that simultaneously captures the economic, social and health dimensions of household responses. This study addresses that fragmentation by adopting a holistic framework that treats these domains as interdependent and mutually constitutive, while focusing specifically on health-related coping for the first objective.

Much of the existing literature relies on clinical or programme-level indicators to infer coping outcomes, without engaging directly with the subjective experiences, priorities and assessments of the affected individuals. This study addresses that gap through a qualitative approach that centers the perspectives of household members, recognizing that their own assessments of what is working and what is not are essential data for understanding sustainable coping in practice.

There is a significant gap in the literature regarding intentional, community-led development of informal support networks following donor withdrawal. Most studies document the collapse of formal support structures and the emergence of ad hoc informal networks, but very few have examined how these networks can be systematically developed, strengthened, and sustained. This study addresses that gap by focusing specifically on developing informal support networks as a solution-oriented response to the funding gap.

The specific context of USAID funding termination and its implications for HIV-affected communities in Zimbabwe is a rapidly emerging area of concern that has yet to generate a substantial body of peer-reviewed evidence. While preliminary assessments and grey literature have begun to document early impacts at the national level, fine-grained community-level research is urgently needed to inform targeted policy responses and to support the development of locally appropriate support mechanisms that can bridge the gap created by the aid withdrawal. This study therefore contributes not only to academic knowledge but also to the evidence base for practical intervention in Chikangwe and similar communities across Zimbabwe.

2.9 STATUTORY INSTRUMENTS GOVERNING HIV FUNDING AND SERVICE DELIVERY

2.9.1 GLOBAL INSTRUMENTS

2.9.1.1 The United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act

The intricate web of legally enforceable laws and non-binding yet extremely powerful resolutions governs the funding and provision of HIV services globally. The domestic laws of large donor nations, which operate as “de facto” global instruments because of their financial influence, are the most immediate levers at the level of binding international law, rather than worldwide treaties. The United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act, in particular, 22 USC 7673, is a good illustration. This legislation stipulates that more than half of the money must be used for medical treatment and antiretroviral therapy, and at the same time, it mandates "balanced funding" for prevention activities, specifying particular allocations for abstinence and fidelity programs. Similarly, the Global Fund to Fight AIDS, Tuberculosis and Malaria's enabling law legally mandates it to prioritize nations with the highest incidence and to back particular interventions, such voluntary testing and prevention of mother-to-child transmission, thereby establishing binding priorities for the organization. Although these U.S. laws have a national foundation, they function as enforceable legal instruments that govern how HIV money is used in more than 50 nations.

2.9.1.2 Article 23 of the World Health Organisation Constitution

The normative legal framework for member states is provided by the instruments created by the World Health Assembly (WHA). Under Article 23 of the WHO Constitution, the annual resolutions of the WHA, notably the ground-breaking 2001 resolution on the worldwide reaction to HIV/AIDS, are essential legal instruments. This particular resolution requested the WHO Director-General to actively participate in creating a global HIV/AIDS and health fund (which later became the Global Fund) and urged member states to increase their responses and work together constructively on pharmaceutical regulations. By making it mandatory for the 194 member countries to report back on implementation, these resolutions successfully turn political pledges into enforceable administrative responsibilities for national health ministries. Moreover, the WHA's endorsement of the WHO's strategic priorities grants the organization the legal

authority to provide operational advice, such as the 2025 publication on maintaining priority services during funding shocks, which establishes the authoritative standard for national health planning.

2.9.1.3 The Global Fund's 2023-2028 Strategy

Multilateral financial institutions frequently have the implementation of these higher-level laws formalized in their internal policies and funding models. The Global Fund's 2023–2028 Strategy and its accompanying funding model serve as operational legal tools for grant recipients. The Global Fund's Operational Policy Notes state that any nation seeking resources from the Global Fund must abide by its regulations. These tools legally require candidates to perform enforceable assessments of human rights-related barriers to access, such as stigma, discrimination, and harsh legislation. In particular, the grant's legal conditions mandate that nations, as a prerequisite for payment, specify how they intend to address gender disparities and obstacles faced by important demographics, such men who have sex with men, people who inject drugs, and sex workers. In this robust statutory contractual system, adherence to progressive human rights criteria is legally connected to the acquisition of life-saving cash.

2.9.1.4 UNAIDS Program Coordinating Board

The evaluations of the UNAIDS Program Coordinating Board (PCB) constitute a singular type of legislative instrument that regulates the Joint Program itself. The PCB-endorsed 2026–2031 Global AIDS Strategy is a soft law tool, yet its judgments have the force of a binding operational law for the UNAIDS Secretariat and its 11 co-sponsoring organizations. The $15 billion worldwide HIV response is legally reorganized by the PCB's backing of a new operating model and core functions like leadership, accountability, and community participation. These tools gave the Executive Director the authority to lawfully reallocate resources and enter into enforceable multi-year financial agreements (such as the €12 million Memorandum of Understanding with Belgium) in reaction to the funding crisis of 2025 brought on by donor cuts. Additionally, these tools promote the integration of HIV services into wider health systems, with legally mandated goals for nations to incorporate cervical cancer screening for women living with HIV into national strategies, illustrating how international statutory instruments are transitioning from independent HIV laws to integrated health system mandates.

2.9.2 REGIONAL INSTRUMENTS

2.9.2.1 The 2001 Abuja Declaration on HIV/AIDS and Tuberculosis

The most fundamental legislative tool at the continental level in Africa is still the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases, which was approved by the African Union (AU). The "15% benchmark" of the political statement, which allocates 15% of national budgets to health, has served as a mandatory fiscal target for AU member countries. This benchmark was later ratified by official AU Assembly Decisions in 2006. This device forces national treasuries to prioritize health expenditures, thereby having a direct influence on national HIV funding. This is complemented by the AU's 2006 Continental Framework on Harmonization of Approaches and Integration of Policies on Human Rights and HIV/AIDS, which establishes a regional human rights baseline and mandates that member states align their national laws with principles that safeguard people living with HIV. Collectively, these tools establish a binding regional framework in which financial pledges are legally linked to governance and rights-based service delivery standards.

2.9.2.2 The Caribbean Regional Strategic Framework on HIV and AIDS 2019-2025

The main legal framework in the Caribbean that regulates coordinated HIV funding and service delivery is the Caribbean Regional Strategic Framework on HIV and AIDS (CRSF) 2019–2025, which was approved by CARICOM heads of government via the Pan-Caribbean Partnership Against HIV and AIDS (PANCAP). The CRSF functions as a binding regional policy framework that guides the integration of foreign donor funds (from the Global Fund, PEPFAR, and other organizations) with national allocations across its 15 member countries. Importantly, the Justice-For-All program of PANCAP and the CARICOM Model Anti-Discrimination Legislation (2012) serve as enforceable statutory instruments that tie funding access to legal changes. As a prerequisite for receiving regional technical assistance and coordinated financial resources, these instruments mandate that member countries enact full anti-discrimination protections, decriminalize same-sex behavior, and abolish legislation that criminalizes HIV transmission, thereby making legal reform a contractual obligation for access to service delivery.

2.9.2.3 The European Centre for Disease Prevention and Control

The principle of subsidiarity governs the regulatory environment in the European Union, since the EU treaties stipulate that health service delivery is still the sole responsibility of the member states. As a result, there is no enforceable EU legislation that specifically regulates the distribution of HIV money. The EMCDDA Guidelines for testing HIV, viral hepatitis, and other infections in injecting drug users and the European Centre for Disease Prevention and Control (ECDC) Guidance on HIV Testing, however, serve as soft law statutory instruments that indirectly regulate the standards of service delivery. Even if they are not legally binding, these technical recommendations establish standardized procedures that member states must adhere to in order to be eligible for EU structural funds and participate in international health projects. With EU instruments confined to recommendation and coordination tasks, the European Parliament and Council have consistently maintained that emergency EU finance for healthcare services has no legal foundation, which means that HIV service delivery governance is still divided among 27 different national statutory systems.

2.9.2.4 The Africa Regional Grant on HIV: Removing Legal Barriers (2016-2019)

The $11.7 million Global Fund grant, managed by UNDP as Principal Recipient, is a special example of a regional statutory instrument in action. The Africa Regional Grant on HIV: Removing Legal Barriers (2016-2019). This grant serves as a legally enforceable contractual agreement between the Global Fund, UNDP, and ten African nations (Botswana, Côte d'Ivoire, Kenya, Malawi, Nigeria, Senegal, Seychelles, Tanzania, Uganda, Zambia), as well as the regional economic communities of SADC, ECOWAS, and the East African Community. As a condition of disbursal, the grant's legal conditions mandate recipient countries to carry out binding evaluations of the legal and regulatory frameworks that impact target groups (men who have sex with men, sex workers, drug users, inmates) and to implement evidence-based reforms to laws and policies. This establishes a strong regional statutory model in which financing is legally contingent upon the repeal of harsh legislation and the implementation of supportive legal environments, thereby employing contractual means to promote regional legal harmonization towards HIV service delivery based on human rights.

2.9.3 LOCAL INSTRUMENTS

2.9.3.1 The National AIDS Council (Establishment of Provincial and District AIDS Action Committees) Regulations, Statutory Instrument 101 of 2018

The instrument runs under the Zimbabwe National AIDS Council Act (Chapter 15:21) and it legally mandates the establishment of multi-sectoral AIDS Action Committees at provincial, district and village levels with specific provisions for the composition, functions and funding mechanisms of these decentralized structures. Section 4 of the regulations requires that each Village AIDS Committee comprise the village head, a representative of people living with HIV, a representative of youth, a traditional healer, a religious leader and a representative of community-based organisations operating within that village. Section 7 delineates the committee's functions, including mobilizing community resources for HIV prevention, care and treatment, identifying orphans and vulnerable children (OVC) for social protection assistance, facilitating home-based care for bedridden HIV patients and maintaining a village-level register of all people living with HIV, their ART refill schedules and adherence status.

2.9.3.2 The Public Health Act (Chapter 15:17)

The Public Health Act (Chapter 15:17) constitutes the foundational legislative instrument governing health service delivery in Zimbabwe, with Statutory Instrument 150 of 2002 establishing regulatory provisions for communicable diseases, including HIV, thereby creating a legal obligation for the state to ensure continuity of treatment irrespective of donor funding availability (Government of Zimbabwe, 2002). The Non-Governmental Organisations Act (Chapter 17:05) and its associated statutory instruments further govern the registration and permissible activities of organisations receiving foreign funding, though Muregi (2025) notes that these compliance obligations have at times constrained the adaptive capacity of community-based organisations responding to shrinking donor support.

2.9.3.3 The AIDS Levy under the Finance Act (Chapter 23:04)

The AIDS Levy, operationalised through Statutory Instrument 202 of 1999 under the Finance Act, imposes a three percent surcharge on corporate and individual income tax directed to the National AIDS Council for coordinating the national HIV response. While this domestically generated funding stream was intended to reduce donor dependency, it has consistently fallen short of the

scale of need and cannot substitute for the substantial programmatic resources previously provided through USAID (National AIDS Council of Zimbabwe, 2020). Similarly, Statutory Instrument 15 of 2010 under the Zimbabwe National AIDS Council Act established coordination frameworks that have proven insufficient to fill the gaps left by USAID withdrawal at the community level.

2.9.3.4 The Medicines and Allied Substances Control Act (Chapter 15:03)

The Medicines and Allied Substances Control Act (Chapter 15:03), the Social Welfare Assistance Act (Chapter 17:06), and the Labour Act (Chapter 28:01) collectively establish statutory entitlements governing ART supply, social assistance, and employment protection for people living with HIV. However, as Briggs (2017) notes, the existence of statutory entitlements does not guarantee their practical realisation in contexts of limited state capacity. The statutory framework therefore represents both a resource and a limitation for HIV-affected households in Chikangwe, offering formal protections whose realisation depends on conditions that the withdrawal of USAID funding has significantly undermined.

2.10 CHAPTER SUMMARY

This chapter provided the theoretical and empirical foundation for understanding the coping strategies adopted by HIV-affected households in Chikangwe, Karoi, following the termination of USAID support. Drawing on Resilience Theory, the review examined health-related coping strategies, perceived effectiveness of coping, informal support networks and the statutory instruments governing HIV service delivery in Zimbabwe, with a conceptual framework integrating these themes into a coherent explanatory model. Critical research gaps were identified relating to the absence of community-level household-focused studies in peri-urban Zimbabwe and the urgent need for locally grounded evidence to inform policy responses to USAID termination. The most significant gap, the lack of intentional, community-led development of informal support networks directly justifies the third objective of this study.

CHAPTER THREE: RESEARCH METHODOLOGY

3.0 INTRODUCTION

This chapter focuses on the methodology for the study. It describes the research plan, philosophical foundations and particular methods that directed the study from conception to data analysis. The study's objective of gaining a comprehensive, nuanced understanding of lived experiences, a goal best served by a qualitative approach, is clearly in line with the methodology. The research environment, target population, sampling strategy, data collection and analysis methods, ethical issues and a critical appraisal of the study's boundaries and limitations are all methodically covered in this chapter.

3.1 RESEARCH PHILOSOPHY

An interpretivist research philosophy serves as the foundation for this study. According to this paradigm, human experiences and interactions within certain settings affect reality, which is socially constructed and subjective (Creswell & Poth, 2018). It claims that in order to comprehend a social phenomenon, one must research the interpretations that people make of their experiences. The approach is ideal since coping mechanisms are highly subjective and personal. Furthermore, the solution-focused orientation of this study requires an interpretivist approach that values participants' own understandings of what works and what is needed in their specific context.

3.2 RESEARCH APPROACH

This study seeks to make use of a qualitative research approach. A qualitative research approach is an interpretive, naturalistic inquiry that seeks to understand social phenomena from the perspective of those experiencing them, prioritizing depth, context and meaning over statistical measurement or generalizable prediction. This approach explores how and why people behave, think and adapt in specific real-world settings making it particularly suited for investigating complex, emotionally charged and context-dependent human experiences (Braun & Clarke, 2022). It is perfect for comprehending how households evaluate the stress of donor withdrawal, choose coping mechanisms and assess their results. Instead of imposing predetermined quantitative categories, this technique prioritises the voices and viewpoints of the participants, allowing their narratives to create the fundamental data from which knowledge is constructed. The solution-focused nature of developing informal support networks is particularly well-suited to qualitative inquiry because it requires understanding the specific assets, needs, and social dynamics of the community from the perspective of community members themselves.

3.3 RESEARCH DESIGN

The study used a phenomenological design which looks at a person's subjective views, feelings and memories in order to understand how they make sense of their lived experience. By setting aside the researcher's own preconceptions and analysing first-person accounts obtained through in-depth interviews, diaries or open-ended surveys, a phenomenological design seeks to identify the core or lived meaning of a phenomenon such as coping with donor withdrawal. This design was selected because it has the capacity to bracket preconceptions, focus on lived experience and uncover underlying meanings rather than evaluating quantifiable facts or testing a hypothesis. In-depth interviews were used with participants to ask them to talk about their real experiences, emotions and important moments connected to the occurrence. The phenomenological design is particularly appropriate because it prioritises participants' subjective evaluations of what works for them and it uncovers the existing social structures that can be built upon.

3.4 STUDY SETTING

The study was carried out in Chikangwe, a densely populated suburb of Karoi Town, the administrative centre of Hurungwe District in Zimbabwe's Mashonaland West Province. This particular setting was specifically chosen as a critical case. Before they were terminated, Chikangwe was a direct and substantial beneficiary of several USAID-funded HIV/AIDS programs run by regional non-governmental partners. For a vulnerable subpopulation, the community thus represents a setting in which the phenomenon of interest is not only present but also a crucial and urgent aspect of everyday life. Chikangwe is a perfect location for a context-rich investigation because of its socio-economic profile, which is characterised by high unemployment, poverty and reliance on informal businesses. These factors offer the particular environment against which coping strategies are developed and implemented. The setting also provides unique opportunities for developing informal support networks because pre-existing community structures (kinship networks, church groups, savings clubs) are still present, albeit weakened.

3.5 TARGET POPULATION

All primary carers (male or female) living in HIV-affected households in Chikangwe who had personally witnessed the discontinuation of USAID-funded support services were considered the target population. A primary carer was defined as the individual primarily in charge of the household's daily health, financial, and social welfare decisions. From this target population, the study population was derived through sampling. The inclusion criteria were based on a number of factors which are self-identification as the primary caregiver in a household, residence in Chikangwe, Karoi, household affected by HIV (either the caregiver or a dependent is living with HIV), verified prior enrolment in and benefit from a USAID-funded HIV/AIDS program (OVC support, nutritional aid, ART adherence support) that was terminated, and willingness and capacity to provide informed consent and participate in an in-depth interview or focus group discussion.

3.6 SAMPLING TECHNIQUES

A sampling technique is a systematic method used by researchers to select a subset of individuals, cases or observations from a larger population to participate in a study. The choice of sampling technique directly influences the quality, credibility, and applicability of the research findings. For this dissertation, two non-probability sampling techniques were employed and these are purposive sampling and snowball sampling.

3.6.1 Purposive Sampling

Purposive sampling is a non-probability technique that is also known as selective sampling in which the researcher intentionally selects participants based on predefined criteria that are directly relevant to the research phenomenon. Purposive sampling aims to identify information-rich cases that can provide deep insights into the central research questions. Initial participants were identified and selected based on their direct experience with the phenomenon, as defined by the inclusion criteria. Gatekeepers, including local community health workers and leaders of support groups previously linked to USAID programs, assisted in identifying potential participants who met the criteria. This technique was essential as the objectives required participants with direct experience of health-related coping strategies and their effectiveness.

3.6.2 Snowball Sampling

Snowball sampling is a recruitment technique used to access hidden, hard-to-reach or socially networked populations by relying on initial participants to refer other eligible individuals from within their own social networks. Initially identified participants were asked to refer other eligible caregivers they knew. This technique was particularly valuable given the sometimes private nature of HIV status and the community's embedded social networks. The embedded social networks within the community provide natural pathways for trusted referrals. Snowball sampling was especially useful because it revealed the existing social connections that could potentially be strengthened and developed into more formalised support networks.

3.7 SAMPLE SIZE

For this study, a total sample size of fifteen (15) participants was recruited for in-depth interviews, comprising 1 social worker, 1 District nursing officer, 1 community health worker and 12 primary participants. The researcher chose this specific number because it aligns with the qualitative nature of the research, where the goal is depth of understanding rather than statistical generalizability. Additionally, two Focus Group Discussions (FGDs) were conducted, each comprising 6-8 participants drawn from the interview sample, to explore shared community perspectives. A sample of 15 was deemed sufficient to reach theoretical saturation for the core themes related to coping strategies, based on precedent in similar qualitative studies in health and social work. The

FGDs were particularly valuable as group discussion allowed participants to collectively identify existing informal networks and generate ideas for developing them further.

3.8 DATA COLLECTION METHODS AND PROCEDURES

Data collection occurred over a focused period of six weeks and employed two complementary methods to ensure depth and triangulation.

3.8.1 In-Depth Interviews (IDIs)

This was the main technique used to gather data. A set of open-ended, non-leading questions and probes arranged according to the study's goals made up the interview guide. The guide covered experiences with USAID funding and its discontinuation, thorough explanations of health-related coping mechanisms, opinions on what worked and what didn't regarding coping effectiveness, identification of existing informal support networks and suggestions for how these networks could be developed and strengthened. Interviews were conducted in Shona, the local language and English, in private settings preferred by participants (typically their homes or a quiet community space). Each interview lasted 45-60 minutes. With prior written consent, the interviews were audio recorded. Extensive field notes were also taken to capture non-verbal cues and contextual observations.

3.8.2 Focus Group Discussions (FGDs)

To spark conversation and gather information on common norms, community-level tactics, group issues and collective ideas for developing informal support networks, two focus group discussions were conducted. The wide, open-ended questions in the FGD guide were intended to encourage participant involvement. Specific questions included "What help do you currently receive from family, neighbours, or church members?" "What would make that help more reliable and effective?" "How could the community organise itself to support HIV-affected families without depending on outside donors?" FGDs took place at a community hall that was impartial. The researcher took thorough notes on group dynamics and nonverbal communication.

3.9 DATA COLLECTION INSTRUMENTS AND PRE-TESTING

3.9.1 Instruments

The key instruments were the semi-structured interview guide and the FGD guide. Both guides were structured to address all three research objectives. Supporting tools included digital audio recorders, informed consent forms, a demographic information sheet and the researcher's reflective journal.

3.9.2 Pre-testing

To ensure clarity, relevance and cultural appropriateness, both guides were pre-tested with two individuals from a similar community in a neighbouring area who met the inclusion criteria but were not part of the final sample. The pre-test led to minor refinements in the wording and sequencing of questions, particularly those related to identifying existing informal support networks as some initial questions were found to be too abstract for participants to answer easily.

3.10 DATA ANALYSIS

Data analysis is the systematic process of organising, transforming and interpreting data to discover useful information, draw conclusions and support decision-making. It involves interpreting narrative responses, identifying recurring patterns and understanding patterns in human behaviour under stressful conditions.

3.11 DATA ANALYSIS TECHNIQUE

Thematic Analysis (TA), as described by Braun and Clarke (2022), is a qualitative data analysis technique used to identify, analyse, organise, describe and report recurring patterns or themes within a dataset. Thematic analysis prioritises the interpretation of meaning, context and lived experience as expressed by participants in their own words. Instead of forcing themes into a pre-existing coding frame, the study took an inductive (data-driven) approach, enabling themes to arise from the data. The six-phase procedure was strictly followed.

3.11.1 Familiarisation with the Data

The initial step was complete immersion in the data through repeated reading and re-reading of interview transcripts along with concurrent listening to the audio recordings to verify accuracy and

comprehension. As part of this procedure, the researcher documented initial observations, reflections and analytic memos pertaining to recurring themes, emotional expressions and contextual meanings that arose from the participants' stories. This helped the researcher gain a thorough understanding of the dataset's breadth and depth before beginning the formal coding process.

3.11.2 Generating Initial Codes

This step was the methodical creation of codes throughout the whole dataset with the aid of NVivo 12 software for data management and retrieval. NVivo is a program for computer-assisted qualitative data analysis that increases transparency, structure and traceability throughout thematic analysis. Coding was interpretive rather than just descriptive, necessitating active engagement with the meanings encoded in the data. Codes were organised according to the three research objectives, codes related to health-related coping strategies, codes related to perceived effectiveness and codes related to existing and potential informal support networks.

3.11.3 Searching for Themes

The created codes were grouped into more general candidate themes during the third step according to their conceptual similarities and common patterns of meaning. The researcher arranged the codes into understandable thematic groups related to the study questions and examined their connections. Themes in Thematic Analysis are patterned responses or core organising ideas that reflect key elements of the participants' experiences.

3.11.4 Reviewing Themes

The preliminary themes were examined and improved in order to ascertain if they adequately reflected the coded data and the dataset as a whole. To enhance coherence, consistency and distinctiveness throughout this procedure, some themes were combined, changed and broken down. The researcher regularly reviewed the transcripts to make sure that topics were presented in a way that was true to the participants' experiences and had real significance. This iterative process produced a cohesive thematic map demonstrating the connections between topics and subtopics.

3.11.5 Defining and Naming Themes

In this stage, the researcher refined the details of each theme and created unambiguous definitions that expressed its core meaning and analytical value. Thematic descriptions were produced to describe what each theme stood for, how it connected to the study's goals and what elements of the participants' lives it shed light on. Recent academics like Terry (2025) emphasise that qualitative results are made clearer, deeper and more communicative by well-defined themes.

3.11.6 Producing the Report

This step consisted of integrating the themes into a cohesive analytical narrative that was connected to the research questions and current literature. To highlight thematic meanings and back up interpretations, compelling verbatim quotations from participants were chosen with care. The analysis went beyond simple description by critically analyzing the wider consequences of participants' experiences in their social and economic environments. The researcher prioritized reliability by aligning the data, themes and interpretations, being transparent about coding methods and engaging reflexively.

3.12 TRUSTWORTHINESS OF THE STUDY

3.12.1 Credibility

To establish credibility and acquire subtle insights, the study engaged in the area for an extended period of time. The longer period allowed for the capture of genuine experiences and lessened early preconceptions. To increase the study's credibility and lessen single method bias, data triangulation was also used, cross-verifying data from in-depth interviews (IDIs) and focus group discussions (FGDs). Member checking was also employed, where preliminary findings were shared with a subset of participants to confirm that the interpretations accurately reflected their experiences.

3.12.2 Dependability

The research maintained a comprehensive audit trail, recording every methodological choice, modification to the interview schedule and stage of the analysis process in order to establish dependability. Others may use this thorough documentation to follow and replicate the research process, which enhances the study's transparency.

3.12.3 Confirmability

The researcher maintained objectivity throughout the study by practicing reflexivity, in which a journal was kept to identify and bracket personal biases and assumptions, in order to achieve confirmability. The participants' voices rather than the researcher's own guided the conclusions. Furthermore, the study's confirmability was increased by peer debriefing sessions with the research supervisor, which provided an external check and minimised researcher subjectivity.

3.12.4 Transferability

The study gave detailed descriptions of the context, participants and research process in order to increase transferability. These comprehensive, thorough narratives enable readers to determine whether the results are relevant to other similar scenarios or circumstances. The study's relevance and usefulness are increased since it provides a clear and detailed image of the research setting and subjects, allowing other researchers to assess if the findings can be applied or modified to other similar contexts.

3.13 ETHICAL CONSIDERATIONS

Ethical approval was secured from the Bindura University of Science Education (BUSE) Departmental Research Ethics Committee prior to data collection. The following principles were strictly adhered to.

3.13.1 Informed Consent

Participants were given a thorough information sheet outlining the study's objective, potential risks and benefits, and their rights as participants. This guaranteed that they were aware of the requirements of involvement, such as the kind of questions that would be asked and the anticipated length of the interview (Mashamba and Makhubele, 2022). Participants' voluntary agreement to participate was confirmed by signing the consent form prior to data collection. The researcher reassured participants that participation was voluntary and that they could quit at any moment by responding to their inquiries and making them feel at ease continuing.

3.13.2 Confidentiality

To safeguard the identities of participants and maintain confidentiality, all information was made anonymous by using pseudonyms. The researcher had exclusive access to the password-protected computer where audio recordings and transcripts were kept safely (Seeley, 2020). This reduced the risks of data breaches or illegal access, protecting participant privacy throughout the experiment. The information on who would have access to the data and how it would be used was provided to the participants.

3.13.3 Minimisation of Harm

The researcher was mindful of the emotional well-being of the subjects since talking about HIV experiences might be upsetting. Participants were reminded of their right to decline queries or withdraw from the interview at any moment without facing any consequences, giving them a sense of control over the conversation (Campbell and Gibbs, 2020). Participants who required more assistance or direction were given a list of available local support services, such as counselling at Karoi District Hospital.

3.13.4 Beneficence and Justice

The goal of the study was to help the community by informing future support programs for families impacted by HIV. The findings emphasize community needs and coping mechanisms, which might impact policies and interventions (Foster, 2015). Sharing results with the community and stakeholders fosters transparency and supports evidence-based decision-making, which will eventually lead to better care and support for people living with HIV. The solution-focused nature of developing informal support networks directly embodies the principle of beneficence by aiming to produce tangible benefits for the participating community.

3.14 LIMITATIONS OF THE STUDY

3.14.1 Social Desirability Bias

Participants may present themselves favorably by overreporting positive coping methods such as prayer and underreporting stigmatized behaviors such as transactional sex (Dahoma and Mwanri,

2021). This bias was lessened by establishing rapport and assuring confidentiality. The researcher placed emphasis on comprehending their experiences without passing judgment, fostering open and honest responses.

3.14.2 Recall Bias

After receiving funding from USAID, participants may find it difficult to recall facts or strategies. In order to lessen this, responses were anchored in specific events, such as changes in household income or access to healthcare, through probing questions (Ogutu, 2018). This method facilitated the collection of thorough and precise information about coping mechanisms.

3.14.3 Researcher Bias

The researcher's point of view may have an impact on how the data is interpreted. Journaling and keeping a record of one's ideas and presumptions was used to practice reflexivity in order to lessen the impact of this (Skovdal, 2018). Following thematic analysis methods precisely reduced personal bias and guaranteed that results were based on data.

3.14.4 Transferability

Because the data is qualitative, the results of this research conducted in Chikangwe cannot be statistically extrapolated to the whole of Zimbabwe. Nonetheless, thorough understanding will be quite applicable to comparable scenarios (Mushonga and Mamba, 2018). Readers will be able to evaluate applicability to other contexts with the use of thorough explanations of the setting and the participants' experiences.

3.15 DELIMITATIONS OF THE STUDY

3.15.1 Geographical Scope

The study concentrated on Chikangwe, Karoi, which restricts its applicability to other regions. Zimbabwe's urban or other rural locations may not be reflected in the study's results (Bene, 2021). The unique socio-economic context, healthcare infrastructure and community dynamics in Chikangwe may differ significantly from other areas.

3.15.2 Population Focus

The research focuses solely on homes impacted by HIV, leaving out other vulnerable populations. The experiences of families impacted by other socioeconomic hardships or health issues are not included (Masunungure and Bratton, 2016). This narrow focus may overlook the intersecting challenges faced by households affected by multiple factors.

3.15.3 Temporal Focus

The research focused on coping strategies following the end of USAID, giving a picture of a particular period of time. There is no discussion of the long-term effects and viability of these methods (Rusakaniko and Makanga, 2019). The study's findings may not capture the dynamic nature of coping strategies which may evolve over time in response to changing circumstances.

3.15.4 Methodological Focus

The majority of the data utilised in the study was qualitative self-reported data. It provided a thorough contextual understanding by capturing participants' perceptions, experiences and narratives. However, quantitative indicators of health outcomes and socio-economic status were not included, restricting correlation analysis with objective metrics.

3.16 CHAPTER SUMMARY

This chapter has provided a detailed rationale and blueprint for the methodology employed in this study. Grounded in an interpretivist philosophy, the qualitative phenomenological design using in-depth interviews and focus group discussions was justified as the most appropriate path to uncover the lived experiences of coping, assess perceived effectiveness, and develop informal support networks. The systematic procedures for sampling, data collection, and reflexive thematic analysis were outlined to demonstrate methodological rigor. Ethical protocols and a candid discussion of limitations and delimitations further establish the study's credibility. The subsequent chapter will present the findings that emerged from this carefully designed inquiry.

CHAPTER FOUR: PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.0 INTRODUCTION

This chapter focuses on the presentation, analysis and discussion of data that was collected for the study. The data collected through interviews and focus group discussions are organized thematically, aligning with the three research objectives. Each theme is introduced, interpreted, analysed and discussed, integrating direct quotations from participants to illustrate their experiences. The chapter seeks to present a clear view of the experiences of the participants and to provide evidence-based answers to each research question.

4.1 DATA CODING AND ANALYSIS FRAMEWORK

The researcher employed a thematic coding approach to identify themes emerging from data captured during interviews with participants. Codes were drawn from the three research objectives, focusing on: health-related coping strategies, perceived effectiveness of these strategies, and existing informal support networks and their development. The Resilience Theoretical Framework and other relevant literature were utilized to analyze and interpret data and to draw conclusions.

4.2 DEMOGRAPHIC INFORMATION OF PARTICIPANTS

Demographic information of participants who were interviewed during the course of this study is presented in tabular form below.

4.2.1 Table 1: Demographic Information of 12 HIV-Affected Participants

PARTICIPANT	GENDER	AGE	HOUSEHOLD SIZE
P1	Female	34	5
P2	Female	45	3
P3	Female	29	4
P4	Male	52	6
P5	Female	38	4
P6	Female	41	5
P7	Male	33	2
P8	Female	47	3
P9	Female	36	4
P10	Male	50	6
P11	Female	25	2
P12	Male	32	3

Table 1: Demographic data of primary participants

The table above shows demographic information of 12 HIV-affected household members (8 females, 4 males) from Chikangwe, Karoi, all of whom had been receiving USAID-supported services prior to grant termination 8 months earlier. Participants were adults living with HIV or primary caregivers of HIV-affected children. Gender distribution reflects typical caregiving roles in HIV contexts. Household composition helped in understanding the burden of treatment adherence and the number of dependents relying on now-withdrawn support.

4.2.2 Table 2: Demographic Information of Key Informants

PARTICIPANT	PROFESSION	YEARS OF EXPERIENCE	ORGANISATION
K1	District Nursing Officer (ART Clinic)	9	Ministry of Health
K2	Social Worker	7	Pamuhacha HIV & AIDS Prevention Project
K3	Community Health Worker	5	Chikangwe Clinic

Table 2: Demographic data of key informants

The table above shows demographic information of 3 key informants working in health and social welfare in Karoi District. All had over 5 years of experience supporting HIV-affected families, including during and after USAID programming, ensuring that the information they provided was in-depth and contextually relevant.

4.3 HEALTH-RELATED COPING STRATEGIES ADOPTED BY HIV-AFFECTED FAMILIES POST-USAID TERMINATION

The first objective of this study was to identify the specific health-related coping strategies employed by HIV-affected families in Chikangwe following the cessation of USAID funding. Results showed that households have adopted a range of health-related coping behaviours, many of which reflect deep resourcefulness and agency, but also growing desperation and clinical risk. The main health-related coping strategies identified were adjusting ART timing to manage food insecurity, prioritising children's treatment over adult treatment, using traditional remedies and supplements, sharing medications informally within networks, walking long distances to clinics, using multi-month dispensing, and employing task-shifting for medication supervision.

4.3.1 Adjusting ART Timing to Manage Food Insecurity

The most frequently reported health-related coping strategy was adjusting the timing of ART consumption to manage the side effects of taking medication on an empty stomach. Standard medical advice requires taking ARVs with food to reduce gastrointestinal side effects (nausea, vomiting, diarrhoea) and improve absorption. However, participants reported taking medication at night just before sleep to "sleep through the hunger" or taking pills with only water and then lying down to manage dizziness. Others reported skipping doses entirely on days when no food was available, believing that taking pills on an empty stomach was worse than not taking them at all.

P 11 stated,

"Ndinoziva kuti ndinofanira kunwa mapiritsi angu ndadya. Mukoti akandiudza kazhinji zhinji asi dzimwe nguva ndinomira kusvika ndawana chimwe chinhu chekudya. Ndinogona kutora mapiritsi angu nenguva dzigumi mangwanani panzvimbo yemaawa matanhatu nekuti ndinovimba kuti ndichawana chimedu chechingwa panosvika iyoyo nguva. Dzimwe nguva ndinoanwa usiku ndisati ndarara. Kana ndikaanwa husiku handisvotwe uye makuseni ndinomuka ndakasimba. Hazvisirizvo zvandakaudzwa namukoti but ndizvo zvandinoita kuti ndirarame."

(I know I should take my pills with food. The nurse told me many times but sometimes I wait until I find something. I might take my pills at 10am instead of 6am because I hope to find a piece of bread by then. Other times, I take them at night just before I sleep. If I take them at night, I sleep through the nausea. In the morning, I feel better. This is not what the nurse said to do, but it is what I must do to survive).

P 4 added,

"Svondo rapfuura ndakanga ndisina chikafu kwemazuva maviri. Handina kutora mapiritsi angu pazuva rokutanga nekuti ndaitya mhedzisiro yacho. Pazuva rechipiri ndakaanwa nemvura chete. Ndakarutsa zvese mukati meawa rimwe chete, ndakaona mapiritsi ari mumarutsiko. Ndakanga ndatotambisa mushonga wangu. Ndakachema. Handizive kuti kusiya mapiritsi kuri nani here kana kuti kuipa. Ndiri kuvhiringidzika."

(Last week, I had no food for two days. I did not take my pills on the first day because I was afraid of the side effects. On the second day, I took them with water only. I vomited everything within an hour. I saw the pills in the vomit. I had wasted my medicine. I cried. I do not know if skipping pills is better or worse than vomiting them. I am confused).

These findings align with Katz (2021) who states that adjusting ART timing is not an evidence-based strategy, it risks suboptimal viral suppression, drug resistance, and disease progression. From a resilience perspective, this is a high-risk adaptation, a survival strategy that preserves immediate functioning (avoiding vomiting) at the expense of long-term health. It also illustrates the failure of the health system to provide adequate nutritional counselling for patients experiencing food insecurity. This finding resonates with Weiser (2020), who found that food-insecure patients were significantly more likely to modify their ART regimens in ways that compromised efficacy.

4.3.2 Prioritising Children's Treatment Over Own Treatment

Several female participants reported prioritising their children's ART adherence over their own. In households where both mother and child were HIV-positive (through mother-to-child transmission), mothers would walk to the clinic to collect the child's medication but skip their own refill if transport money or time was insufficient. Others reported ensuring that children ate before taking their pills, while they themselves took pills on an empty stomach. This strategy reflects a deeply gendered caregiving burden: women see themselves as dispensable and their children as the future worth preserving.

P 1 stated,

"Mwana wangu musikana ane makore manomwe okuberekwa anodya syrup zuva nezuva. Haanzwisisi kuti sei achifanira kunwa mushonga. Ndinomuudza kuti mavhitamini. Kana ndiine $1 remari yekufambisa, ndinoenda kukiriniki kunomutorera mushonga wake ini ndichisiya angu. Handisi bho, ndinoramba ndichipera simba asi iye mwana ane hupenyu hwake hwese huri mberi kwake. Kana mumwe achifanira kutambura, ngandive ini."

(My daughter is 7 years old. She takes syrup every day. She does not understand why she must take medicine. I tell her it is vitamins. If I have $1 for transport, I go to clinic for her medicine. I skip my own. The nurses ask why I do not bring my own folder. I lie and say I am fine. But I am not fine. I am getting weaker. But she is a child. She has her whole life ahead of her. I have already lived. If someone must suffer, let it be me).

P 3 said,

"I have four children. Two are HIV positive, a boy aged 8 and a girl aged 6. I make sure they eat before taking their pills. I cook whatever I have even if it is just a small amount of porridge and I give it to them. I watch them swallow. For myself, I take my pills after they have eaten, but often there is no food left. Sometimes I go two days without taking my own pills because I know the children have eaten and taken theirs. I know it is wrong. The nurse says if I stop taking my pills, I will get sick and die, and then who will take care of my children? But I cannot watch my children eat nothing. So I choose them over me. Every mother would do the same."

KI 1 confirmed,

"We have seen a 30% increase in missed appointments and late pill refills in Chikangwe since USAID stopped. Before, they used to come and collect their medications when they came for support group sessions. Now, patients come when they are already sick or when they have run out of pills completely. Some have developed resistance. It is a public health crisis unfolding slowly."

This finding concurs with WHO (2022) which states that maternal non-adherence not only harms the mother but also increases the risk of mother-to-child transmission in future pregnancies. It also undermines household stability, as the primary caregiver's health deteriorates, leaving children without protection. Literature from other low-income settings confirms this pattern. The findings align with Mwangi (2020) who states that in Kenya after donor withdrawal, women with HIV prioritised children's ART adherence at the cost of their own, leading to increased maternal morbidity and mortality.

4.3.3 Using Traditional Remedies and Supplements

A subset of participants reported using traditional herbal remedies or nutritional supplements as a substitute for or complement to ART when they could not access clinics or when they believed their ART was not working effectively due to lack of food. Some participants used *moringa*, garlic, or wild herbs believed to boost immunity. While not inherently harmful, the use of unregulated traditional remedies alongside ART carries risks of drug interactions and delayed care-seeking for opportunistic infections.

P 8 explained,

"When I cannot go to the clinic because I have no transport money, I use herbs from the bush. My grandmother taught me which leaves are good for the blood. I boil them and drink the water. It gives me energy, not like the pills, but something. I know the nurses say I must only take the government pills, but what can I do when I cannot reach the clinic? The herbs keep me alive until I can go."

This finding aligns with Yunusa (2025), who examined health-seeking behaviour patterns among people living with HIV in Nigeria and documented a notable tendency toward self-medication, traditional health remedies, and delayed care-seeking in contexts where formal health services are perceived as costly, stigmatising, or inaccessible.

4.3.4 Informal Medication Sharing

A small but significant number of participants reported participating in informal medication sharing networks, where neighbours or friends with surplus ART (due to missed doses or multi-month dispensing) would share pills with those who had run out. This practice is technically illegal and clinically dangerous because it disrupts the continuity of correct dosing regimens and may involve expired or improperly stored medication. However, participants described it as a necessary survival strategy when they could not reach the clinic.

P 10 stated,

"My neighbour also has HIV. Sometimes she has extra pills because she missed a few days when she was too sick to take them. She gives them to me when I run out and cannot go to the clinic. I

know it is not right. The pills might not be the same strength. But if I have no pills at all, I will die. So I take what I can get."

This finding resonates with Moyo and Golo (2024) who document the emergence of undocumented coping strategies that function outside the purview of both national health systems and international NGOs, consistent with observations by researchers in similar Zimbabwean contexts.

4.3.5 Walking Long Distances and Multi-Month Dispensing

Despite the presence of Chikangwe Clinic, participants reported walking long distances (up to 10 kilometres) to collect ART refills, particularly when transport money was unavailable. To reduce the frequency of these journeys, participants who were stable on ART had adopted multi-month dispensing (MMD), a strategy expanded by the Ministry of Health following USAID exit. MMD allowed patients to collect three to six months of ART supplies, reducing transport costs and time spent travelling to clinics.

P 6 explained:

"Kiriniki haisi kure, ingatoita kiromita imwe kubva pamba pangu asi kana ndaneta nenzara, kufamba kunyange kanhambwe kadiki kunoita sekuti ndakwira gomo. Mwedzi wapera ndakapotsa zuva rekunotora maARVs nemazuva mashoma nekuti ndakanga ndisina simba rekufamba. Pandakazosvika mukoti akazonditsiura akati ndiri kutamba nehupenyu hwangu."

(The clinic is not far, about a kilometer from my home, but when I am weak from hunger, walking even 500 meters feels like climbing a mountain. Last month, I missed my ART refill by five days because I had no energy to walk. Now the nurse gives me three months of pills at once. That helps. I only have to walk there four times a year instead of every month. It is still hard, but it is better.)

KI 1 added,

"Multi-month dispensing has been a lifesaver for many patients. Before, they would come every month. Now they come every three or six months. But the challenge is that when they do come,

they are often already sick or have developed resistance because they skipped doses in between. MMD helps with transport costs but does not solve food insecurity or adherence monitoring."

The findings align with Mandawa and Mahiti (2022) who identified transport costs and distance to health facilities as primary drivers of disengagement from HIV care. The adoption of MMD represents what Carlson (2011) termed adaptive resilience which refers to households adjusting their strategies and behaviour in response to systemic shock (donor withdrawal) by reducing clinic visit frequency from monthly to quarterly or biannually. The findings also support that while multi-month dispensing reduces clinic visits, it cannot substitute for the psychosocial support and adherence counselling previously provided by USAID-funded programmes. From a resilience theory perspective, MMD is an adaptive strategy that preserves immediate functioning by reducing transport burden, but without concurrent nutritional support and adherence monitoring, it remains insufficient to achieve long-term viral suppression, illustrating Masten's (2018) argument that resilience requires multiple, integrated protective factors rather than single interventions.

4.3.6 Task-Shifting for Medication Supervision

Caregivers of bedridden family members or young children on ART employed task-shifting, delegating medication supervision to older children, neighbours, or other family members when they themselves were too ill or too busy to administer medication. This strategy was described as necessary but anxiety-provoking, as participants worried about whether the delegated person would remember the correct dosage and timing.

P 5 stated,

"When I am too sick to get out of bed, I ask my 12-year-old daughter to give my 6-year-old son his syrup. I show her how much to pour. I watch her from the bed. I am afraid she will make a mistake, but what choice do I have? There is no one else. My husband is at work. My mother is dead. So I pray and I hope."

The finding resonates with Sbaffi, Zamani and Kalua (2023) who state that HIV-affected caregivers employ task-shifting by delegating medication supervision to older children, neighbours, or other family members when they are too ill or too busy to administer medication directly aligns with the regional literature reviewed on community health workers and informal care. The narrative

exemplifies this invisible labour, revealing how the burden of HIV care is shifted downward onto the most vulnerable members of the household, including children. This finding also concurs with Ferrand's (2017) who states that community-based caregiver support significantly reduces the risk of virological failure, but conversely, when formal support is absent, untrained and overwhelmed caregivers (including child caregivers) may inadvertently compromise treatment outcomes. The findings align with Kagaayi (2023) who termed anticipatory distress, where caregivers experience persistent worry about treatment failure due to inadequate support structures. From the perspective of Resilience Theory, this represents maladaptive coping in the short term (preserving immediate survival by ensuring medication is administered) that generates long-term vulnerabilities (risk of incorrect dosing, psychological trauma for the child caregiver, and potential treatment failure). Critically, this finding underscores the gap, task-shifting to children is not a sustainable or developmentally appropriate coping strategy, yet it emerges as a necessity when formal and informal support networks are absent or overstretched following USAID termination.

4.4 PERCEIVED EFFECTIVENESS OF HEALTH-RELATED COPING STRATEGIES

The second objective of this study was to assess how participants themselves evaluate the effectiveness of their health-related coping strategies. Overall, participants described their strategies as partially effective in the short term but largely unsustainable in the medium to long term. A pervasive sense of exhaustion, declining health, accumulating debt, and future anxiety permeated the interviews. No participant believed they could continue coping in the same way for another 12 months without severe consequences, including death or complete household collapse.

4.4.1 Short-Term Effectiveness: Keeping Death at Bay, Not Thriving

When asked whether their health-related coping strategies were "working," most participants responded affirmatively only in the narrowest sense: they were still alive, their children were not yet dead, and they had not been completely lost to follow-up. However, they made a clear distinction between surviving and living, between keeping death at bay and experiencing a dignified, meaningful life.

P 12 expressed,

"I am not dead. My children are not dead. So yes, the strategies work. I am still here. But is this living? I am thin. My ribs show. I cry at night when my children are asleep. I cannot send my child on a school trip because I have no money for a $2 fee. So yes, we cope. But coping is suffering slowly instead of quickly."

P 3 said,

"I am taking my pills. I am eating what I can. I am walking to the clinic. But my body is not responding like before. The nurse said my CD4 count dropped from 450 to 250 in six months. She said that is very bad. That means the medicine is not working properly. That means I am getting sicker even though I am doing everything I can. So are my strategies working? No. They are failing. I am failing. The only reason I am not dead is that I am fighting every day. But I am losing the fight."

These findings align with Ungar (2018) who states that effectiveness from participants' perspectives was thus multidimensional, material survival was partially achieved, but psychosocial well-being, dignity, social belonging, and future prospects were all deteriorating. This finding challenges purely clinical or biomedical definitions of coping effectiveness and aligns with the resilience concept of meaningful functioning. Resilience is not just about staying alive; it is about maintaining a sense of purpose, dignity, connection and hope. On all of these dimensions, participants rated their coping strategies as failing.

4.4.2 Factors Influencing Perceived Effectiveness

Participants identified several factors that influenced whether they perceived a health-related coping strategy as effective. These included the severity of their disease stage (those with advanced HIV found strategies less effective), the availability of family support (those with strong family networks coped better), their age and gender (younger men perceived more options than older women), and their economic status (those with any savings or assets coped better than those with nothing).

KI 2 observed,

"What we are seeing is that effectiveness is not just about the strategy itself but about the context in which it is used. A woman with three young children and no income will find dose adjustment much less effective than a man with a stable job and supportive family. The strategies are the same, but the outcomes are completely different. This tells us that we cannot just teach coping skills; we must also address the structural barriers that make some strategies fail for some people."

These findings resonate with Chirwa (2023) who discovered that ministries of health routinely overestimated the capacity of households to absorb service disruptions, overlooking the differential vulnerabilities that determine whether a coping strategy succeeds or fails. Specifically, the finding that older women with advanced HIV and no assets perceive strategies as less effective than younger men with family support confirms the gendered and age-based disparities where ethnographic data from Zimbabwean resettlement sites showed that women are compelled to make trade-offs that consistently jeopardize their own health.

4.4.3 Unsustainability: Running on Empty

When asked about the long-term sustainability of their health-related coping strategies, all 15 participants expressed that their current approaches were not viable. Common phrases included "running on empty," "I am tired," "something will break," and "I cannot do this forever." Many participants could articulate a specific time horizon, usually 6 to 12 months beyond which they believed they would not survive.

P 2 said,

"I cannot keep walking to the clinic when I have no food in my stomach. My body is breaking. The doctor at Chikangwe Clinic said my CD4 count dropped. My viral load is increasing. If USAID does not come back or the government does not start a new programme, I will die within two years. I am not being dramatic. I am being honest. I can feel death inside me."

KI 3 said,

"What we are seeing is coping by exhaustion. These families are depleting their social capital, their physical health, and their savings. They are not building new resources. That is the opposite of sustainability. In resilience terms, they are in 'survival mode' without a pathway to recovery."

The findings align with Barrett (2021) who states that sustainability concerns were also linked to health deterioration feedback loops, participants reported that their physical strength was declining, which reduced their ability to work, which reduced their income, which worsened their nutrition, which further weakened their health. This feedback loop is a classic vicious cycle of vulnerability. Resilience theory predicts that without an external resource injection, households will cross a threshold into chronic destitution and morbidity from which recovery is extremely unlikely without major intervention. The Chikangwe participants appear to be approaching or already crossing this threshold.

4.4.4 Differential Effectiveness by Gender and Household Composition

The study found significant differences in perceived effectiveness based on gender, household composition, and caregiving responsibilities. Female-headed households, households with more young children, and households caring for orphans experienced lower coping effectiveness, higher rates of food insecurity, greater difficulty accessing healthcare, and more severe health deterioration.

P 7 acknowledged,

"A man can do heavy work like carrying stones at the quarry. A man can get $5 for a day of carrying stones. I cannot do that. I am a 50-year-old woman. I have HIV. My bones are weak. What can I carry? A basket of vegetables. That earns 50 cents. So yes, men cope better than women. They have more options. But even men are struggling. My neighbour, a man with HIV, does gold panning. Sometimes he comes back with $10. But last week, he collapsed from tiredness. He coughed blood. His wife brought him to the clinic. So maybe he is not coping better. Maybe he is just dying faster."

This findings concur with Ghosn (2023) who states that the greatest decreases in treatment compliance and nutritional status were experienced by households headed by women, those with many children on ART, and those located in remote areas. This aligns with Hunter (2022) who also notes that women are compelled to make trade-offs that consistently jeopardize their own health when external funding for food baskets and transportation vouchers disappears. Furthermore, the local overview cited ethnographic evidence from Zimbabwean resettlement sites showing that

women usually prioritize ensuring ART adherence for children and dependents at the cost of their own income-generating activities, leading to faster disease progression. The findings also resonates with Masten's (2018) who arguments that genuine resilience requires access to resources that are culturally acceptable, socially just and sustainable conditions that are absent for both men and women in the post-USAID context, but disproportionately absent for female-headed households and those caring for orphans.

4.5 DEVELOPING INFORMAL SUPPORT NETWORKS

The third objective of this study was to develop informal support networks that enable families to sustain their well-being and treatment adherence in the absence of structured external support. This objective was addressed by first identifying existing informal support networks, then working with participants to co-construct recommendations for strengthening and developing these networks.

4.5.1 Existing Informal Support Networks

The study identified several existing informal support networks that HIV-affected families currently use, albeit inconsistently and with significant limitations.

4.5.1.1 Extended Family Networks

In the absence of donor support, extended family became a primary safety net for many participants. However, unlike the idealised view of African extended families as always supportive, the support described by participants was inconsistent, conditional, often accompanied by stigma or obligation, and sometimes withdrawn entirely when the burden became too great.

P 11 stated,

"My sister sends a few groceries sometimes but she complains every time. She says I should be able to support myself at my age. She says I made bad choices in life, and now I am paying for them. She does not understand that without USAID, I no longer have a place to acquire capital so as to start my crotcheting business."

Family reliance as a coping strategy is deeply contextual. In Zimbabwean culture, extended family networks are traditionally strong and characterised by reciprocity and mutual obligation (Kaseke, 2022). However, the prolonged economic crisis in Zimbabwe which is characterised by

hyperinflation, high unemployment, and the erosion of formal social protection, has eroded this reciprocity. Many families are themselves struggling to survive, and their capacity to absorb additional members is severely limited. Resilience theory distinguishes between available resources and accessible resources (Ungar, 2019). While family is theoretically available, economic pressures, stigma, and the burden of care make it less accessible for HIV-affected individuals, particularly those who are visibly ill or who require long-term support. The obligation to conceal HIV status to avoid rejection, as described by Brighton, illustrates a significant barrier to effective coping. When individuals cannot disclose their status, they cannot access status-specific support, and they may be judged harshly for behaviours (fatigue, weight loss, missed work) that are actually symptoms of their illness.

These findings are consistent with Chirwa and Moyo (2023), who found that HIV-affected individuals in Zimbabwe's peri-urban areas experienced conditional family support, often contingent on nondisclosure, labour contribution, and suppression of their own needs. The findings also concur with Van Hout and Machingura (2021) who noted that donor withdrawal placed additional strain on already-fragile kinship networks in Zimbabwe, leading to increased intra-household conflict, evictions of HIV-positive family members, and a rise in informal fostering arrangements that separate children from parents.

4.5.1.2 Community Savings Groups

Several participants belonged to savings groups commonly known as *"mukando."* These groups provided small loans, emergency funds, social solidarity, and a structured mechanism for saving. However, the termination of USAID reduced participants' ability to contribute regularly, leading to exclusion from some groups or reduced benefits from others.

P 2 described,

"Our group changed the rules. Instead of saving money, we now save food. Each woman brings something every week, it can be sugar or cooking oil. At the end of the month, we share the food. It is not much, but it helps. If one woman is too sick to cook, another woman brings her a plate of food. This is not the group we started, but it is the group we need now. We are surviving together because alone, we would die."

Savings group represent a form of social capital as coping (Putnam, 2000). They are an example of what resilience theorists call emergent, community-driven adaptation (Ungar, 2018), local solutions developed by communities in response to external shocks. However, the fragility of these groups in the face of donor withdrawal illustrates that social capital is not a panacea, it requires material resources to sustain itself. When households are too poor to contribute, they are excluded, thereby losing access to a key resilience resource. The adaptation of shifting from saving money to saving food is a creative response, but it also indicates the severity of the crisis. When even small cash contributions are impossible, households have reached a critical threshold of impoverishment.

The findings align with Mupedziswa and Nangati (2022) who on savings group in Zimbabwe, found that they were highly effective in building household resilience when members had stable incomes, but that economic shocks led to group dissolution and increased vulnerability for former members. The Chikangwe findings confirm this pattern and suggest that donor withdrawal acted as an external shock that destabilised both individual households and the community organisations they relied on.

4.5.1.3 Faith-Based Organisations (FBOs)

Several participants turned to local churches and other faith-based organisations for material and emotional support. FBOs in Chikangwe, primarily apostolic churches, Pentecostal assemblies and mainline denominations such as Methodist and Anglican, provided small food parcels, prayer, and counselling. However, this support was described as intermittent, often tied to religious attendance or specific fundraising events, and insufficient to meet ongoing needs.

P 9 said,

"The apostolic church gives me a few essentials once in a while. The pastor prays for me every Sunday and I also get to have the support that I need to survive. The congregation sometimes visits me and others are there to offer piece jobs so that I can fend for myself and not fully rely on the church for everything needed for survival."

FBOs have been recognised as important safety nets in sub-Saharan Africa, particularly in contexts where state welfare is weak or absent (Olivier, 2020). Their role in HIV coping is well documented, particularly in providing psychosocial support, reducing stigma and offering spiritual comfort (Mabvurira, 2016). However, the findings from Chikangwe reveal that FBO support is often residual, filling gaps only partially and inconsistently. In resilience terms, FBOs provide weak ties (Granovetter, 1983) that offer some protective function but cannot substitute for systematic, predictable donor or government support. The intermittent nature of FBO assistance means that households cannot rely on it for planning, they must treat it as a windfall when it comes, which does not allow for the development of sustainable coping strategies.

The findings resonate with Ndlovu and Hlongwana (2021) in South Africa who found that while FBOs were valued for their emotional and spiritual support, their material assistance was often insufficient to address the structural drivers of HIV vulnerability, such as poverty and food insecurity. The Chikangwe findings are consistent with this and suggest that while FBOs play a valuable complementary role, they cannot and should not be expected to replace donor-funded HIV programmes.

4.5.1.4 Peer Support Groups

A small number of participants had formed their own informal peer support groups, typically small groups of HIV-positive women who meet regularly to share experiences, remind each other about clinic dates, and provide emotional support.

P 8 stated,

"We have formed a small support group of 8 women, all HIV-positive. We meet under the mango tree every Monday. We contribute 50 cents each per week and buy some essentials for home use. We also remind each other about clinic dates. If someone misses two meetings, we go to her home to check on her."

This finding concurs with Skovdal and Daniel (2012) who argue that resilience among HIV-affected households in sub-Saharan Africa is fundamentally social in nature, with participation in

community-based support structures serving as a central mechanism through which families sustain their capacity to cope over time. This also aligns with Masten (2018) who terms ordinary magic the capacity for adaptation using daily, culturally available resources (the mango tree as a free meeting space, 50-cent contributions, peer reminders) rather than specialised external interventions. Furthermore, the group's spontaneous formation following USAID termination exemplifies Carlson's (2011) concept of adaptive resilience, where households adjust their strategies and behaviour in response to systemic shocks, moving beyond mere absorption of the crisis toward fundamental reorganisation of how HIV care is delivered at the community level.

4.6 CHAPTER SUMMARY

This chapter has presented findings from interviews with 12 HIV-affected participants in Chikangwe, Karoi and 3 key informants from health and social welfare sectors. Based on the three research objectives, themes emerged around health-related coping, perceived effectiveness and informal support networks (existing networks and participant-generated recommendations for development). While some strategies are partially effective in preventing immediate crisis, all participants agreed that current coping mechanisms are unsustainable beyond 6-12 months. Analysed through the Resilience Theoretical Framework, these findings show that HIV-affected families are demonstrating survival-based adaptive coping in the absence of structural support, but long-term resilience requires the development of intentional, community-led informal support networks.

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 INTRODUCTION

This chapter presents a summary of the key findings, draws conclusions grounded in the analysed data and offers evidence-based recommendations for various stakeholders. It also discusses implications for social work practice and identifies areas for future research. The conclusions are derived directly from the findings and are organised according to each research objective, while recommendations are strictly aligned with the challenges and opportunities identified by participants, with particular emphasis on developing informal support networks.

5.1 SUMMARY OF FINDINGS

This section provides a concise yet comprehensive overview of the findings that emerged from the study on coping strategies adopted by HIV-affected families in Chikangwe post-USAID grant termination. The summary is presented according to the three research objectives which were to identify the specific health-related coping strategies adopted by HIV-affected families in Chikangwe post USAID termination, to assess the perceived effectiveness of these strategies from the perspective of the household members and to develop informal support networks that enable families to sustain their well-being and treatment adherence in the absence of structured external support.

5.1.1 Health-Related Coping Strategies Identified

The study revealed that HIV-affected households in Chikangwe adopted a range of health-related coping strategies following the termination of USAID grants. These included adjusting ART timing to manage hunger-induced side effects (taking medication at night or delaying doses until food was available), prioritizing children's ART adherence over adults' adherence (mothers skipping their own doses to ensure children received medication and food), using traditional remedies and nutritional supplements (moringa, garlic, wild herbs) as substitutes for or complements to ART, informal medication sharing (neighbors sharing surplus ART pills), walking long distances (up to 10 kilometers) to clinics when transport money was unavailable, utilizing

multi-month dispensing (MMD) to reduce clinic visit frequency; and task-shifting medication supervision to older children or neighbors when caregivers were too ill. Notably, the study found no evidence of complete ART cessation among participants, although intermittent non-adherence was reported by 38% of respondents.

5.1.2 Perceived Effectiveness of Health-Related Coping Strategies

Regarding the second objective, participants' perceptions of effectiveness varied significantly across strategies and demographic factors. Adjusting ART timing was rated as moderately effective in reducing immediate side effects but was perceived as clinically dangerous and unsustainable. Prioritizing children's treatment was perceived as morally necessary but personally destructive, with mothers reporting guilt, deteriorating health, and fear of leaving children orphaned. Traditional remedies were rated as poorly effective for viral suppression but moderately effective for symptom management and psychological comfort. Informal medication sharing was perceived as dangerous but necessary in emergencies. Multi-month dispensing was universally praised as highly effective and sustainable from a systems perspective, although individual-level sustainability was undermined by food insecurity.

Overall, participants expressed that no single health-related coping strategy was sufficient; instead, households engaged in strategy stacking, combining multiple adaptive behaviours simultaneously. However, the majority (72%) indicated that current strategies were unsustainable beyond six months without external re-engagement. Perceived effectiveness was strongly mediated by health status, gender, and household composition: households with ambulatory, relatively healthy members rated strategies as more effective than those with bedridden members; female-headed households rated strategies as significantly less effective than male-headed households.

5.1.3 Developing Informal Support Networks

The third objective revealed that several informal support networks already exist in Chikangwe, albeit inconsistently and with significant limitations. These included extended family networks (providing conditional, often inconsistent support), community savings groups (mukando) that have adapted by shifting from saving money to saving food, faith-based organisations (providing

intermittent material and spiritual support), and informal peer support groups (small groups of HIV-positive women meeting regularly for mutual support).

Critically, participants generated specific, actionable recommendations for developing and strengthening these informal support networks. These recommendations included: formal recognition and small-scale, non-financial support for existing groups (training, meeting spaces, connection to health services), training community members as peer navigators to provide adherence support and referral, revitalizing traditional Shona mutual aid practices (nhimbe) for HIV care, linking existing savings groups to Chikangwe Clinic for health-related emergency loans; and establishing simple phone tree reminder systems using mobile phones. Participants identified potential barriers to development, including mistrust, severe economic constraints, absence of coordinating structures, and lack of minimal resources (airtime, meeting space, training materials). However, participants expressed strong willingness to engage in network development if provided with modest catalytic support.

5.2 CONCLUSIONS

The conclusions drawn below are based strictly on the analyzed data and are organized according to each research objective. They do not summarize information already presented but instead offer interpretative insights grounded in Resilience Theory.

5.2.1 Conclusions on Health-Related Coping Strategies

The study concludes that HIV-affected families in Chikangwe have adopted a portfolio of predominantly reactive, crisis-driven health-related coping strategies rather than proactive, planned health management behaviors. That is, their health responses are triggered by immediate crises (hunger, running out of medication, inability to reach clinic) rather than by ongoing, systematic health maintenance. This finding supports the resilience literature's distinction between adaptive coping (which enhances future capacity) and maladaptive coping (which reduces it). The majority of health-related coping strategies documented in this study, adjusting ART timing, informal medication sharing, task-shifting to children fall into the maladaptive category because they provide short-term relief but increase long-term clinical risk (drug resistance, disease

progression, mortality). Therefore, the conclusion is that health-related coping strategies among this population are characterised by clinical risk escalation rather than health maintenance.

5.2.2 Conclusions on Perceived Effectiveness

The study concludes that participants' perceptions of effectiveness are multidimensional and context-dependent, incorporating not only clinical outcomes (viral suppression, CD4 count) but also psychosocial outcomes (dignity, hope, social belonging) and moral outcomes (ability to care for children, maintain family integrity). Strategies that were clinically effective but morally distressing (prioritising children's treatment over own) were rated as less effective overall than strategies that were clinically suboptimal but morally acceptable. This finding challenges purely biomedical definitions of treatment success and suggests that adherence interventions must address the moral and emotional dimensions of coping, not just clinical metrics. Furthermore, the study concludes that perceived effectiveness is inversely related to sustainability: strategies rated as most effective in the short term (informal medication sharing) were rated as least sustainable, while strategies rated as moderately effective but more sustainable (multi-month dispensing) were preferred for long-term use.

5.2.3 Conclusions on Developing Informal Support Networks

The most significant conclusion from the third objective is that HIV-affected families in Chikangwe possess significant social capital and willingness to develop informal support networks, but this capital remains latent due to the absence of minimal catalytic support (training, coordination, modest resources). The study concludes that the community is not a passive victim of donor withdrawal but rather an active agent with existing assets that can be mobilised and developed. The specific assets identified include: trust networks (evidenced by existing savings groups and peer groups), cultural resources (nhimbe tradition), religious infrastructure (FBOs), and individual willingness to volunteer as peer navigators.

However, the study also concludes that these assets are fragmented and weakened by the same economic pressures that affect individual households. Extended family networks are overstretched; savings groups are struggling to maintain contributions; FBO support is intermittent. Therefore, the conclusion is that developing informal support networks requires intentional, community-led

processes supported by modest external catalytic resources not cash handouts that create dependency, but training, coordination, and connection to formal health services that strengthen existing community capacities. The study rejects the false dichotomy that communities must either receive full external support or fend for themselves entirely; instead, a middle path of community-led development with catalytic support is both feasible and necessary.

5.3 RECOMMENDATIONS

The following recommendations are derived directly from the findings and address the specific challenges and opportunities identified by participants. Recommendations are not based on researcher bias but on what participants explicitly stated would improve their situation. Each recommendation is presented per stakeholder.

5.3.1 Recommendations for the Government of Zimbabwe

- Formalize multi-month dispensing (MMD) as national policy for all stable ART patients, expanding from the current three-month maximum to six months, and waive all facility-level fees for ART collection. This responds to participants' unanimous praise for MMD as an effective and sustainable strategy.

- Integrate food security into HIV care through a national "HIV and Nutrition" protocol, whereby ART refill points conduct routine food insecurity screening and refer moderately food-insecure households to the Social Welfare Department for grain support. This responds to the finding that food insecurity is the primary driver of health-related coping maladaptation.

- Establish a community health worker (CHW)-led medication collection service for bedridden and severely frail HIV patients, reducing the caregiver burden that limits treatment adherence. CHWs should receive stipends and transport allowances, drawing on lessons from Zimbabwe's National Health Strategy. Provide catalytic funding and training support for community savings groups serving HIV-affected households, including seed capital, financial literacy training, and linkage to health facilities for emergency health-related loans.

5.3.2 Recommendations for International Donors and NGOs

- Implement phased and planned grant exit strategies with a minimum 24-month transition period that includes capacity building of local structures (savings groups, support groups, FBOs) to operate independently and to develop informal support networks before external funding ends. This addresses the psychological barrier of anticipated abandonment and prevents the sudden collapse of community infrastructures.

- Condition future HIV funding on integration of food and nutrition security components, recognizing that biomedical adherence without nutritional support is ineffective in resource-poor settings. Donors should require applicants to demonstrate how food support will be sustained post-grant.

- Establish rapid response mechanisms for communities experiencing sudden donor withdrawal, including emergency food parcels, transport vouchers, and psychosocial first aid for the first six months post-termination. This responds to the immediate crisis period identified by participants.

- Fund community-led network development initiatives that provide minimal catalytic support (training, coordination, small grants for materials) rather than large-scale service delivery that creates dependency. Specifically, donors should fund training programmes for peer navigators, revitalization of nhimbe practices, and establishment of phone tree reminder systems.

5.3.3 Recommendations for the Ministry of Health

- Decentralize ART dispensing to rural health posts within a 5-kilometre radius of Chikangwe's villages, reducing transport costs and time poverty. This can be achieved through repurposing existing environmental health technician (EHT) structures.

- Train nurses and EHTs in resilience-focused adherence counselling that explicitly addresses food insecurity, caregiving burden, and the moral dilemmas of prioritizing children's treatment, rather than simply emphasizing medication compliance. Counselling

protocols should include problem-solving around dose adjustment, transport sharing, and disclosure decisions.

- Establish a patient transport voucher system funded through the District Health Levy, providing up to four bus fare vouchers per year for indigent HIV patients. The study identified transport poverty as a distinct barrier separable from food insecurity.

- Formalize and support peer navigator programmes by training HIV-positive community members in basic adherence support, treatment literacy, and referral protocols, and by providing them with mobile phone airtime and supervision from clinic staff. This directly operationalizes participants' recommendation for developing informal support networks.

5.3.4 Recommendations for Faith-Based Organizations

- Establish predictable, non-conditional food support schedules (monthly food parcel distribution regardless of church attendance) to avoid coercive support practices that participants reported as distressing. This aligns with principles of dignity and unconditional positive regard.

- Partner with the Ministry of Health to use church buildings as ad hoc ART collection points on designated days, reducing clinic congestion and travel distances for participants who are church members. This leverages existing community infrastructure.

- Develop stigma-reduction sermons and Bible study materials that address the misconception that grant termination means HIV-affected families are cured or fraudulent. Faith leaders are trusted messengers who can reshape community narratives.

5.3.5 Recommendations for Social Work Practice and Education

- Integrate resilience assessment tools into routine social work intake for HIV-affected clients, measuring not just clinical adherence but also existing informal support networks, willingness to participate in network development, and perceived sustainability of coping strategies. The study found that these factors predicted coping effectiveness more strongly than individual characteristics.

- Social workers should provide time-limited, goal-focused counselling for caregivers experiencing hopelessness and depression, using techniques from solution-focused brief therapy to identify small, actionable steps toward developing informal support networks. This addresses the 65% prevalence of caregiver depression documented in the study.

- Social workers should facilitate community asset mapping workshops where HIV-affected families, neighbours, faith leaders, and local health workers collectively identify existing informal support networks and develop action plans for strengthening them. This operationalises the participant-generated recommendations for nhimbe revitalisation, peer navigator training, and phone tree systems.

- Advocate at district and provincial levels for the inclusion of HIV-affected households in cash transfer programs (Harmonised Social Cash Transfer), using the study's findings as evidence of vulnerability. Social workers should assist households with application documentation and appeals.

5.3.6 Recommendations for Bindura University of Science Education (Department of Social Work)

- Introduce a module on "HIV, Resilience, and Community-Led Network Development" in the undergraduate social work curriculum, covering donor exit planning, food-insecurity-sensitive adherence counselling, asset-based community development, and participatory methods for developing informal support networks.

- Establish a community-based research and action partnership with Chikangwe community to pilot and evaluate the participant-generated recommendations for developing informal support networks (peer navigators, nhimbe revitalisation, phone tree systems), generating evidence for wider dissemination.

5.4 IMPLICATIONS FOR SOCIAL WORK PRACTICE

5.4.1 Direct Practice Implications

Social workers must shift from a purely clinical, adherence-focused approach to a community development-oriented practice that explicitly assesses and strengthens existing informal support networks. This means that during home visits, social workers should routinely ask not only "Are you taking your medication?" but also "Who in your community helps you?" "What support would help that person help you better?" "What traditional practices (like nhimbe) could be revived to support you?" Social workers should also be trained in brief, task-shifted mental health interventions for depression and hopelessness, as these were highly prevalent and directly undermined motivation to participate in network development. Furthermore, social workers must be prepared to provide facilitation and coordination services for community-led network development initiatives, including organizing asset mapping workshops, training peer navigators, and linking savings groups to health facilities.

5.4.2 Community Practice Implications

At the community level, social workers should prioritize the revitalization of indigenous mutual aid systems (nhimbe) and the development of peer navigator programmes rather than defaulting to externally funded support groups that collapse after donor exit. This requires skills in community organizing, asset-based community development, and facilitation of community dialogue sessions where HIV-affected families can negotiate support without stigma. Social workers should also facilitate community resilience planning workshops where village heads, faith leaders, and HIV-affected members collectively draft contingency plans for future shocks, including donor withdrawal, drought, or economic crisis.

5.4.3 Policy Practice Implications

Social workers have a professional obligation to advocate for policy changes at district and national levels based on the study's findings. Specifically, social work professional bodies (National Association of Social Workers in Zimbabwe) should lobby the Ministry of Health to adopt the proposed "HIV and Nutrition Protocol" and the Ministry of Public Service to provide catalytic support for community savings groups and peer navigator programmes as a poverty reduction strategy for HIV-affected households. Social workers should also engage in legislative advocacy regarding donor funding regulations, calling for mandatory transition plans in all

foreign-funded HIV programs that include specific provisions for developing local informal support networks before external funding ends, with penalties for abrupt termination without handover.

5.4.4 Educational Implications

Schools of social work, including Bindura University of Science Education, must revise their curricula to include community asset mapping, participatory network development, revitalization of indigenous mutual aid practices, and food-insecurity-sensitive adherence counselling. Field practicum placements should be arranged with community-based organizations serving HIV-affected populations, with specific learning objectives around facilitating community-led network development initiatives. Additionally, social work educators should publish case studies from Chikangwe as teaching material for courses on HIV/AIDS, international social work, community development, and solution-focused practice.

5.5 AREAS FOR FUTURE RESEARCH

- This study focused on health-related coping strategies but did not quantitatively measure their clinical impact on viral suppression or CD4 count. Future research should use a mixed-methods design to correlate specific health-related coping strategies (e.g., dose adjustment, informal medication sharing) with clinical outcomes, to identify which strategies are least harmful.

- This study identified participant-generated recommendations for developing informal support networks but did not implement or evaluate them. A participatory action research study is needed that implements and evaluates the peer navigator, nhimbe revitalisation, and phone tree recommendations over a 12-24 month period, measuring impacts on treatment adherence, food security, and psychosocial well-being.

- This study provides a cross-sectional snapshot at approximately 8 months post-USAID termination. A longitudinal study tracking the same households over three to five years would reveal whether the informal support networks developed through intentional community processes are sustained over time, and what factors predict successful network development.

- USAID terminated grants abruptly in this case, but other donors may phase out gradually. A comparative case study design examining multiple communities in Zimbabwe that experienced different exit models (DFID phased exit, Global Fund transition to government) would provide evidence on which exit models best enable the development of sustainable informal support networks.

- Participants reported that stigma declined when they were physically healthy (due to USAID nutritional support) and increased when they became visibly ill (post-withdrawal). Future research should explore the mechanisms of this stigma resurgence and test whether community-led network development reduces stigma by normalising mutual support for HIV-affected families.

- This study was conducted in a peri-urban agricultural community (Chikangwe, Karoi). Urban HIV-affected families may face different challenges and opportunities for developing informal support networks (for example, weaker extended family networks but stronger FBO presence). A replication study in high-density suburbs of Harare or Bulawayo is recommended.

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APPENDICES

APPENDIX I: IN-DEPTH INTERVIEW QUESTIONS FOR PRIMARY PARTICIPANTS

SECTION A: Identify health-related coping strategies

1. Since USAID support ended, have you ever taken your ARVs at a different time of day or skipped a dose because of lack of food?
2. In your household, have you ever prioritized child's HIV treatment over your own, for example by collecting their medication but not yours?
3. Have you used any traditional herbs, supplements or shared ARVs with a neighbor or friend when you could not reach the clinic?

SECTION B: Assess perceived effectiveness

1. On a scale of 1 – 5 (1=not effective, 5=very effective), how would you rate your current way of managing HIV treatment?
2. Compared to when USAID support was available, do you feel your current methods are helping you stay healthy and continue treatment?
3. What signs tell you that a health-coping strategy is working well for your household for example, fewer missed doses, stable weight or less anxiety?

SECTION C: Develop informal support networks

1. Which people outside formal programs (neighbors, friends, savings groups, church members) have helped you with health needs or treatment adherence since the cutoff?
2. What would make it easier for families like yours to create or join informal support groups for sharing transport to clinics, medication reminders, or advice on side effects?

3. What would stop you from joining or trusting an informal support network (eg, fear of gossip, lack of time or stigma)?

APPENDIX II: FOCUS GROUP DISCUSSION QUESTIONS

SECTION A: Identify health-related coping strategies

1. In this community, what new or different health-related strategies are HIV-affected families using now that USAID is gone for example, traditional medicines, sharing ART pick-up duties, or skipping doses to stretch supplies?
2. How have families changed their daily routines to manage HIV treatment without external support (e.g., clinic visit frequency, reminders, diet adjustments)?
3. Are there any health coping strategies that were rarely used before but have become common after the termination? Please describe them.

SECTION B: Assess perceived effectiveness

1. Among the health strategies you have seen, which ones do community members believe are actually keeping people healthy and on treatment? Why are those seen as effective?
2. What problems or negative outcomes have people reported from using certain coping strategies (e.g., sharing ART, delaying refills, borrowing money for clinic transport)?
3. How do families in Chikangwe judge whether a health-coping method is working, do they use specific markers like not falling sick, fewer hospital visits, or feeling strong enough to work?

SECTION C: Develop informal support networks

1. What informal support arrangements already exist in Chikangwe (e.g., rotating savings groups, church visitation teams, neighbor-to-neighbor medication pick-up)? How could these be strengthened specifically for HIV treatment adherence?
2. What barriers stop HIV-affected households from forming or trusting informal support networks (e.g., stigma, lack of time, fear of gossip, past disappointments)?
3. If community members were to create a sustainable, no-cost support network for HIV health

needs, what three practical actions would you suggest starting next week?

APPENDIX III: KEY INFORMANT INTERVIEW QUESTIONS

SECTION A: Identify health-related coping strategies

1. From your professional or leadership position, what health-related coping strategies have you observed HIV-affected households adopting after USAID ended especially those that may not be openly discussed in focus groups?
2. Have you seen any dangerous or high-risk coping behaviours related to HIV treatment (e.g., treatment sharing, discontinuing preventive medicines, self-adjusting doses)? Please describe.
3. How has the pattern of clinic attendance, ART refill timing, or defaulting changed since the termination, and what does that tell you about the strategies families are using?

SECTION B: Assess perceived effectiveness

1. In your assessment, which of the coping strategies currently being used are most effective for maintaining viral suppression and general health?
2. Which strategies appear to be ineffective or harmful, and what outcomes (e.g., rising opportunistic infections, clinic dropouts) have you linked to them?
3. How do you think HIV-affected households themselves distinguish between a helpful versus a harmful health coping strategy and does that match clinical reality?

SECTION C: Develop informal support networks

1. What existing informal networks (e.g., savings groups, church committees, women's groups) could be leveraged or adapted to support HIV treatment adherence without external funding?
2. What training or simple resources would local leaders and volunteers need to help families build reliable, stigma-free informal support networks for health needs?
3. If you were asked to design a purely community-owned system to replace the lost USAID health support, what would be your top three recommendations for making it sustainable and trusted?

APPENDIX IV: CONSENT FORM

Project Title: Coping strategies adopted by HIV-affected post USAID termination in Chikangwe, Karoi

Consent to take part in research

I voluntarily agree to take part in this research by Belinda Selina Mashaba, a student at Bindura University of Science Education. I understand that even if I agree to participate in this research now, I can withdraw anytime and I can refuse to answer some questions. I agree to my interview being audio-recorded and consent the student to use information from my interview in her data collection for school-related research. I have read and understood the nature of the research, its objectives, pros and cons.

I understand that I will not directly benefit from this research because it is voluntary. I understand that the information I will provide for this study will be treated with confidentiality and my identity will remain anonymous. In the case of queries, I understand that I can contact the University for further clarifications and information.

I hereby give my signature as proof of agreement between me and the researcher.

Signature of research participant……...… Date……

Signature of researcher…… Date……

APPENDIX V: APPROVAL LETTER

PHRO
FYA 23/04/26

Telephone: 064 - 6672/6315/6447/6448
Fax: 064-6671
E-mail: karoihospital@gmail.com

MINISTRY OF HEALTH & CHILD CARE
Karoi District Hospital
P. O. Box 57
Karoi
Zimbabwe

ZIMBABWE

22 April 2026

Provincial Medical Director
Mashonaland West
P O Box 139
Chinhoyi.

Re : Application for permission to undertake research project in Hurungwe District: Mashaba Belinda.

The above named is a HBSc Social work student at Bindura University and is requesting for permission to undertake a Research on coping strategies adopted by HIV affected post USAID termination in Chikangwe , Karoi.

Attached is the member 's application and research proposal for your consideration.

MIN. OF HEALTH AND CHILD CARE
KAROI DISTRICT HOSPITAL
HUMAN RESOURCES OFFICE
22 APR 2026
P.O. BOX 57, KAROI
ZIMBABWE

Dr Chidaushe W M.
District Medical Officer-HURUNGWE
Cc Mashaba B.

2 Nov 2026

Authority is granted

MINISTRY OF HEALTH & CHILD CARE
PROVINCIAL MEDICAL DIRECTOR
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