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Morbidity and mortality in Zimbabwe's urban areas: policy implications for social protection

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ABSTRACT

In times of tightening national budgets as a result of structural adjustment requirements, the need to make choices in a country's publicly-funded social protection programme is heightened. A greater understanding of the patterns and causes of morbidity and mortality in Zimbabwe's urban areas forms an important basis for designing an effective social protection policy and programmes that may have a positive impact on the welfare of the urban poor. This study assesses the prevalence of morbidity and mortality in some low-income suburbs of Zimbabwe. Results indicate that the reported leading causes of long illness and death were predominantly AIDS related. This calls for social policies and programmes to integrate HIV/AIDS prevention and improve access to treatment for the poor. The study revealed that households are heavily dependent on informal forms of support to help them cope with adult morbidity and mortality. Policies aimed at strengthening these informal sources of support can help foster the well-being of poor families. Lower-income households are less likely to make use of nation-wide public support programmes. The resultant policy implication is that public social support schemes such as health and education support and employment guarantee schemes should be intensified and expanded to generate substantial positive welfare effects by complementing informal resources.

Introduction

IN A COUNTRY where resources are scarce, information on the prevalence and cause of morbidity and mortality can serve as a guide in making

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social protection policies that target the major social protection needs and can help in deciding which interventions could yield the best social welfare benefits. In most cases this task requires a consideration of multiple objectives such as economic efficiency and equity. Information on the relative importance of various causes of death and chronic illnesses and the household coping responses adopted allows policymakers to select objective health and social support priorities and allocate scarce resources to yield optimal benefits to society. Unfortunately information on mortality and morbidity at the level of the household is very scarce. To date relatively little empirical work has been done in Zimbabwe to find out how prevalent morbidity and mortality is in low-income urban household settings and how households can be strengthened to cope with the impacts of morbidity and mortality.

The aim of this study was to find out the prevalence of morbidity and mortality in a randomly selected sample of households in low-income residential suburbs, identify household coping mechanisms and the formal and informal social support mechanisms currently utilized by households to help cope with adult morbidity and mortality and identify the emerging social protection policies that can be recommended to help households cope with adult morbidity and mortality. The aim is to contribute to more effective policy formulation required to support the existing support mechanisms through identifying new types of public social support interventions and policy reforms which are expected to have a significant positive impact on the welfare of the urban poor.

The first section presents the background information, the second section reviews the data and methods, the third section presents the results, the fourth section presents a discussion of the results and their policy implications. Conclusions are presented in the last section.

Background

SINCE 1991 THE government has been implementing macroeconomic reforms. Throughout the country these reforms have resulted in very high inflation which has eroded the real incomes of low wage earners and the poor in general and severely crippled their purchasing power.

Gross domestic product (GDP) growth has not kept up with population growth and the performance of GDP per capita has been poor. Economic growth rates have been on the decline from 8.2 percent in 1996 to 3.7 percent in 1997, 1.5 percent in 1998 and 1.2 percent in 1999 (Central Statistical Office 2000). The annual increase in formal employment has been very small. Massive retrenchment in the civil service resulted in many people losing their source of regular income. As part of the macroeconomic reforms health and education fees were increased and enforced, thus lowering the affordability of these services by low-income households (Bassett *et al.* 1997). The general decline in the economy has resulted in increased poverty and the poor performance of the health sector with some health indicators declining to below 1980 levels (Mutangadura 1998). In both urban and rural areas households are facing rising prices of basic food because of inflation. In 1995 62% of the national population lived below the national total consumption poverty line of Z\$2132.33 per person per annum and about 46% of the population were living below the national food poverty line, indicating that these households are unable to meet their basic nutritional needs (Ministry of Public Service, Labour and Social Welfare and United Nations Children Fund 1997).

Against this backdrop of an economic downturn has come the unparalleled crisis of HIV/AIDS that is now threatening the productive sector and seriously affecting the health of women and children. Zimbabwe has one of the highest AIDS infection rates in the world, with the adult HIV rate estimated to be 25.8% (Joint United Nations Programme on HIV/AIDS (UNAIDS) 2000). At least 700 people die from AIDS every week (National AIDS Co-ordinating Programme (NACP) 1999). Zimbabwe's last sentinel surveillance survey was undertaken in 1997. The reported adult HIV percentage rates among antenatal women in rural areas ranged from 28% in Harare to a high of 37.7% in Mutare. The data also show a typical upward trend in the sero-prevalence in all areas over the years covered by the surveillance study. Anti-retroviral therapy costs more than Z\$20 000 per month, which is more than the average formal wage earned by an average civil servant professional with tertiary training; hence it is beyond the reach of many. HIV/AIDS has already reversed

hard-won national health gains and continues to threaten the major health indicators. Life expectancy, which had improved to 62 years by 1994, had fallen to 49 in 1997. Discounting the AIDS epidemic, adult deaths in the age range 15–50 in Africa is very low – about six deaths per 1000 persons aged 15–50 per year (Over 1995, Adetunji 1997). But including the AIDS epidemic the total death rate in Zimbabwe, which had fallen to 9 per 1000 in 1994, rose to 13 per 1000 in 1997 (UNAIDS 1999).

Recent research indicates that HIV/AIDS-related morbidity and mortality has the greatest impact at household level (Kwaramba 1998, World Bank 1997). The household is forced to bear the costs of medication, funerals, loss of income, loss of labour and management skills as well as severe emotional and psychological costs. Theoretical insights into the socio-economic impact of AIDS on households suggest that the premature death of an adult results in direct and indirect costs (Barnett and Blaikie 1992, World Bank 1997, Tibajuka 1997) where direct costs are the medical costs prior to death and the costs of the funeral and indirect costs are costs related to the income lost due to death of the adult and the impact on other welfare measures such as household food security status, child schooling, and loss of assets. The degree of vulnerability of households to the impact of the death of an adult and the subsequent risk management strategy adopted by a household depends on

- the household's socio-economic setting (internal factors peculiar to the household, such as the asset base, the household's access to resources, household size and demographic composition),
- the availability and accessibility of informal social support mechanisms,
- the availability and accessibility of formal social support mechanisms (Moser 1998, Webb *et al.* 1992, Barnett *et al.* 1992).

The ability of the household to manage the impact of the loss of an adult female in the household depends on its economic asset base.

The availability and accessibility of informal social support mechanisms is crucial for successful recovery from a death of an adult female in the household. Informal social support mechanisms refer to the inter-household relationships between the household and community

members, friends, relatives and neighbours. In times of stress, households usually resort to these relationships for help on the basis of trust and reciprocity. The role of communities in mitigating the impact of adult illness and death depends on the socio-economic status of the community and the stage of the epidemic. The poorer the community and the more advanced the stage of the AIDS epidemic, the less likely the community is to be able to cope with the increase in the number of deaths (McKerrow 1998). Urbanization and the economic and social hardship resulting from structural adjustment programmes and HIV/AIDS are weakening community and family support structures (Ledward 1997).

With this background, the thrust of this study was to find out the prevalence of adult morbidity and mortality in a randomly selected sample of households in low-income residential suburbs, identify the main causes of adult morbidity and mortality, identify household coping mechanisms and the formal and informal social support mechanisms currently utilized by households and identify the emerging social protection policies.

Data and Methods

THE STUDY WAS conducted in three low-income suburbs of three major cities; Harare, Bulawayo and Mutare. A total sample of 598 households was selected (Harare (n=200), Bulawayo (n=200) and Mutare (n=198)). Cities have a high incidence of poverty with the percentage of poor and very poor people estimated to be 35%, 37% and 50% for Harare, Bulawayo and Mutare respectively (MPSLSW and UNICEF 1997). The adult HIV prevalence is also high in cities. According to the 1997 sentinel surveillance study, the HIV prevalence rate was estimated to be 28%, 30%, and 38% in Harare, Bulawayo and Mutare respectively (NACP, 1998). In all the three cities the oldest low-income residential suburb was selected (Mbare in Harare, Mzilikazi in Bulawayo, and Sakubva in Mutare). With the exception of Mzilikazi the residential suburbs are located close to a centre of informal trade and the travel centre (Mbare *musika* [market] in Harare and Sakubva *musika* in Mutare). In some parts of Mbare and Sakubva some people live in wood and plastic cabins and have poor access to clean water sanitation and health facilities. In

Table I. Demographic characteristics of sampled households by site

	Harare (n=200)	Bulawayo (n=198)	Mutare	All areas (n=598)
Sex of head of household (% households)				
Male	86	71	69	75
Female	15	29	31	25
Marital status of head of household (% households)				
Married	75	59	64	66
Deceased	8	30	18	19
Single	10	7	13	9
Divorced	8	4	6	6
Average age of head of household				
	38	49	42	43
Average household size				
	6	5	5	5

some areas of Sakubva and Mbare, households share common toilets, water collection and laundry facilities. Unlike Sakubva and Mbare, most of the people in Mzilikazi have access to better facilities (water, health and accommodation).

The study used two sampling procedures, cluster sampling and systematic sampling. Both qualitative and quantitative research methods were used. The former involved three focus group discussions with communities in each site. The latter methods involved administering a household questionnaire on the randomly selected sample.

Results

The socio-economic characteristics of sampled households

THE SOCIO-ECONOMIC characteristics of households in the different sites are presented in Table I. The Mutare and Bulawayo samples have higher proportion of female-headed households. The marital status of the sample differed across the three sites. In Harare married household heads dominated whereas in Bulawayo a large number of household heads

had a deceased spouse. In Mutare, although married household heads dominated, there was a higher proportions of household heads with deceased spouse and those who were single. The average household size was five, which conforms to the national mean of 4.6, but is higher than the urban average of 4.1.

On average households had low average monthly incomes. Fifty-two percent (311 households) of the households indicated monthly incomes of the head of household of less than Z\$2000. The main source of income was higher from formal sources (53%, 317 households), followed by informal sources (42%, 251 households), pensions (3%, 18 households), and gifts and transfers (2%, 12 households). The forms of household head's formal employment were permanent formal job, casual or temporary and self-employed. The main informal business activities include food, urban agriculture and clothes vending, knitting and sewing. The 1995 poverty datum line, calculated as Z\$2132.33 per person per year, translates to Z\$817 per household per month using a national average household size of 4.6 persons (Raftopolous *et al.* 1998).

Adjusting for inflation, which averaged 21%, 19%, 32% and 57% in 1996, 1997, 1998, and 1999 respectively, these results indicate that more than half of the households sampled live below the inflation-adjusted national total consumption poverty line. Recent studies of poverty in two low-income suburbs of Harare also revealed a high incidence of households whose average monthly income is below the national total consumption poverty line (Matshalaga 1997a and b).

Long illness and death in households and households: coping and preventive strategies

THE PREVALENCE OF households with chronically ill patients in the sample was 24 percent (see Table II). This figure is higher than a morbidity of 12% found by the author in a similar study in Zambia's low-income suburb of Kafue town (Mutangadura *et al.* 1999). The definition of a chronically ill patient (CIP) in both surveys was "ill for the last 30 days". The difference may be because of the difference in the stages of the epidemic that the two countries are experiencing, where Zimbabwe has now a higher HIV rate than Zambia. The prevalence of CIPs was higher

in Harare and Bulawayo than in Mutare. The breakdown of CIPs by gender revealed that in Harare and Bulawayo, more than half the CIPs were female whereas in Mutare more CIPs were male than female. The most common type of relationship of the CIP to the head of household was a son or daughter, spouse and household head.

More than fifty per cent of the CIPs have been ill for more than three months, indicating that affected households had experienced an income shock for an equivalent length of time. The overall mean age of a CIP for males was 33.9, for females it was 34.7. A salient feature that comes out of the age distribution of the CIP by gender is that female morbidity was higher in the economically active age group when compared with male morbidity, which was higher at the younger and older ages. The leading causes of morbidity in order of importance were: high blood pressure, coughing or TB and diabetes. Other common types of illness were fever, malaria, sores, wasting, cancer, witchcraft, diarrhea, STD/HIV and mental illness. The conditions were self-reported with no medical diagnosis as confirmation.

The health facility most frequently utilized by chronically ill patients was the clinic or hospital, followed by private clinic or doctor. In Mutare clinics and hospitals were the main health facilities utilized, followed by modern faith healers. Overall, 12 CIPs indicated that they did not use any health facility. The main reasons for this were reported to be lack of funds and religious reasons. The average total medical costs per illness episode were Z\$865 for the clinic and hospital, Z\$2858 for the private clinic or doctor, Z\$474 for the traditional healer and Z\$681 for the modern faith healer. As expected, the costs were highest for the private clinic or doctor. The main sources of money to meet medical costs included wage earnings, relatives, savings and the Ministry of Public Service, Labour and Social Welfare's Social Dimensions Fund (SDF) (see Table III). This shows that long illness is indeed a form of an income shock that diverts wage income and depletes household savings. Relatives and the SDF formed the major social support mechanisms to help households meet medical costs. The main insurance support adopted by households was medical aid. However, high membership costs makes this mechanism inaccessible to poor households.

Table II. Profile of chronically ill patients

	Harare	Bulawayo	Mutare	All areas
	n=200	n=200	n=198	n=598
% Households without a CIP	67	67	86	76
% Households with a CIP	33	33	14	24
Number of CIPs	65	66	27	158
% of male CIPs	35	32	59	42
% of female CIPs	65	68	41	58
Relation of CIP to head of household (% households)				
	(n=65)	(n=66)	(n=27)	(n=158)
Household head	21	36	27	28
Spouse	35	22	0	24
Son/daughter	23	32	50	32
Parent of head	0	2	8	2
Other relation	21	9	15	14
Total (%)	100	100	100	100
Length of illness (% of CIPs)				
	(n=65)	(n=66)	(n=27)	(n=158)
1-2 months	51	26	7	33
2-3 months	11	14	8	12
>3 months	38	60	85	55
Total (%)	100	100	100	100

Coping with illness-related decrease in income

AFFECTED HOUSEHOLDS were asked whether the illness had affected household income. Seventy percent of the 158 households with CIPs indicated that they had experienced a decrease in income as a result of the ill adult not being able to perform normal income-generating activities. In order to cope with the decline in income, households adopted different strategies. The main strategies adopted were remittance from relatives (27%, 30 households), use of savings (19%, 21 households), informal borrowing (16%, 18 households) and informal business activi-

Table III. The main source of money to pay for medical costs (% households)

	Harare n=65	Bulawayo n=66	Mutare n=27	All areas n=158
Formal Sources				
Wage earnings	32	25	23	27
Medical aid	4	7	4	5
SDF	7	15	12	12
Informal Sources				
Relatives	16	13	23	15
Savings	18	13	15	14
Sold assets	4	0	4	2
Borrowed	7	3	4	5
Proceeds from own business	0	10	8	6
Not reporting	14	14	8	14

ties (11%, 12 households). Other household coping strategies reported included the sale of assets, subletting, taking on a second job and borrowing from a bank. These household coping strategies are similar those found in other studies, Kwaramba in rural Zimbabwe and Rugalema in Tanzania.

Prevalence of death in the sample households

TWENTY ONE percent of the households reported a death within the previous 12 months. There were a total of 126 deaths from the total of 598 households. About 15 households experienced more than one death. Some points stand out. Seventy four percent or 93 of all the deaths were of adults aged 19 to 50 years. The most common death to occur overall was that of the household head or spouse. Also noticeable was the fact that the vast majority of deaths (over 70 per cent) were of the immediate nuclear family (the head, spouse, the son, daughter and the parent of head or spouse) possibly indicating that each death is likely to have a

Table IV. Profile of deceased persons and household's coping responses to a death

	Harare (n=200)	Bulawayo (n=200)	Mutare (n=198)	All areas (n=598)
Number of deaths	36	49	41	126
% of male deaths	50	53	46	50
% of female deaths	50	47	54	50
Deceased's relation to head of household (% households)				
	(n=36)	(n=49)	(n=47)	(n=126)
Household head	0	2	21	7
Spouse	28	44	3	28
Son/daughter	22	15	46	26
Parent of head/spouse	16	13	9	13
Other relation	34	24	21	26

greater overall impact on the welfare of the household. In addition, the low average age at death of 35 indicates that those who died were likely to be productive and involved in supporting other household members. The reported cause of death was dominated by coughing/TB (32%, 40 of the deaths), followed by hypertension (13%, 16 of the deaths), boils (8%, 10 of the deaths), HIV/AIDS (8%, 10 of the deaths), sores (7%, 9 of the deaths) and witchcraft (6%, 8 of the deaths). Other reported causes of death were malaria, meningitis, accident, cancer and old age. In general the mortality profile was similar to the morbidity profile.

The coping strategies adopted by households in response to a household death also follow closely those adopted for morbidity. Households rely heavily on support from family members, utilization of savings and borrowing from informal networks. The main coping responses adopted by households included remittances from family members (30%, 37 of the deaths), use of savings (26%, 33 of the deaths), borrowing from informal institutions (16%, 20 of the deaths), informal business activities (11%, 14 of the deaths), subletting (9%, 11 of the deaths), sale of assets (4%, 5 of the deaths) and government transfers (3%, 4 of the

deaths). The most commonly sold assets were furniture, cattle, radio, televisions, goats, beds and bicycles. In Zimbabwe's rural areas, Kwaramba (1998) found that households sold agricultural implements such as hoes and ploughs and livestock. The majority of the household coping strategies adopted are reversible, indicating that households had not yet reached the point of destitution.

The existing local informal social support mechanisms

THE MAIN INFORMAL support mechanisms cited by the surveyed households and focus group discussions include burial societies, savings club, church clubs, women groups, informal borrowing and *chimbadzwa* (high interest loan clubs). The informal mechanisms where the households have been receiving benefits for a long time include burial societies, church, women's group and *chimbadzwa*. The benefits of the latter accrue mostly in the form of funeral assistance, food support, clothing, counselling and spiritual support. The inadequacy of benefits was cited as the most severe type of constraint in all types of informal social support mechanisms. Burial society and savings clubs were ranked the most effective type of informal support mechanisms by affected households. Other support mechanisms perceived as highly effective are women's groups and church organizations.

The existing formal social support mechanisms

THE MAIN PUBLIC social support mechanisms include the Social Development Fund for Fees, Social Development Fund for Health, Department of Social Welfare public assistance and medical aid. Only four households reported that they had benefited from the education and health assistance programmes. The main constraint experienced in accessing the public mechanisms was the inadequacy of the benefits and the long vetting procedure. Other constraints identified include ill-defined selection criteria, bureaucracy and corruption. Affected households also reported receiving support from non governmental organizations such as Plan International, FACT and the Red Cross in the form of micro-credit, boreholes, food and school fees.

The main private social support mechanisms on the other hand include financial insurance and funeral insurance. For private social support mechanisms, "membership" and "joining fee" were identified as the main criteria needed by the household before benefits could be accessed. The lack of collateral, high interest rates and prohibitive joining fees were the main constraints cited by households to accessing support from micro-credit schemes. Funeral insurance and financial services were rated to be the most effective formal support mechanisms. With the current economic hardships the country is experiencing it is very difficult to get a loan and be able to repay it due to very high interest rates. A general observation is that the public formal support mechanisms are less effective than private formal support mechanisms.

Discussion and emerging social protection policy implications

IN THIS STUDY WE SOUGHT to expand our understanding of the prevalence of morbidity and mortality in a randomly selected sample of households in low-income residential suburbs, identify household coping mechanisms and the formal and informal social support mechanisms currently utilized by households to help cope with adult morbidity and mortality and identify the emerging social protection policy implications. The study revealed the prevalence of households experiencing adult morbidity to be 24% and households experiencing adult mortality to be 21%. The leading causes of long illness and death were reportedly similar, dominated by coughing or TB followed by hypertension, diabetes, fever, boils, sores and witchcraft. Coughing or TB, boils, fever and diarrhea are the primary manifestations of AIDS, while meningitis and malaria mortality can be AIDS related also. These findings suggest that the leading cause of long illness and death in adults in these low-income urban areas is AIDS related. This calls for the government to promote strategies that can help prevent the spread of HIV/AIDS and improve access to treatment for those who are ill. In terms of social protection, HIV/AIDS prevention and mitigation programmes should be integrated with the social assistance programmes in order to prevent future illnesses, deaths and increased poverty. This means that some

programmes can include prevention messages. Certain mitigation strategies, such as micro-credit, can be specifically targeted at women and youths, who appear to be the worst affected by the epidemic, yet typically have limited access to productive resources and employment opportunities.

Findings on what households do to cope with morbidity and mortality revealed that they have become increasingly dependent on family support and informal sources of income to cope with the morbidity and mortality-related loss of income. One of the mechanisms adopted by households was informal business activity. There is need to explore ways of strengthening informal activities that have been reported to be most frequently used by households such as vending, agriculture, crafts and sewing and knitting. Increased informal sector activity can be a major route to fostering the informal mutual assistance schemes found in the communities. The level of output and earnings in the informal sector can be increased by enhancing its supply potential through policies aimed at improving access to financing, supportive regulatory policies, supportive infrastructure, the removal of prohibitive by-laws hindering the operations of this informal sector and training and disseminating information about appropriate technologies (Raftopolous *et al.* 1998; Kanji and Jazdowska 1993).

The main form of income or food transfer was from extended families and informal networks. This dense network of exchange does help a household overcome the impacts of the long illness or death of an adult member. However, during an economic crisis it is more difficult to ask for help from anyone as they are also experiencing a decline in income and the poorer the community, the less the support and the greater the need for outside intervention. It is therefore necessary that public assistance programmes play a more active role in sustaining the livelihood of the poorest families. This calls for the improved allocation of funds to social welfare and the improved targeting of the transfers to needy households. In sub Saharan African countries public transfers are often not well targeted and fail to reduce income inequality (Moser 1998, Castro-Leal *et al.* 1999). Improvements in the targeting of social assistance to the poor not only involves rearranging the flow of the public

transfers but also addressing the constraints that prevent the poor from accessing these services, such as improved access to health, education and sanitation services and the way that the transfer is administered. How can targeting government transfers from the SDF be improved in the urban areas? Should the SDF change its targeting mechanism from means testing (where programme eligibility is determined by household income)? According to Baker and Grosh (1994), means testing, used in combination with geographical targeting greatly improves the efficiency of a transfer programme. It is important that the SDF explores means of incorporating geographical targeting in their programmes, using the high-density suburbs as units of analysis. As shown in the study, more than half of the households in the randomly selected sample earn an income that is lower than the inflation-adjusted poverty datum line. Thus primarily targeting transfers to low-income suburbs can improve targeting of social assistance. However, given that there are many low-income suburbs, targeted suburbs should be prioritized using other indicators such as the availability of clean water, sanitation, health and education services.

Improvement in the management and administration of the social protection programmes can greatly improve the efficiency of what might be small social safety nets. Such improvements can be achieved through tackling the major constraints raised by the communities, which include minimizing bureaucracy and political influence and eliminating corruption. The process of getting exemptions for school and health fees has been reported in one study to be difficult (Bassett *et al.* 1997). It is therefore important that the Social Development Fund improves the handling of beneficiary applications so as to avoid any unnecessary decline in human welfare development. This can be achieved through the decentralization of activities and sub-contacting activities to local-level organizations such as municipalities. Such schemes have the advantage of low administration costs and encourage the local participation of communities in project design and implementation.

Burial societies were reported in this study to be an effective informal mechanism helping to cushion households against death-related income shock. It is important that the government formulate policies

and incentives that strengthen this informal institution and promote it in areas where it is non-existent. There is a need for policymakers to explore how similar voluntary societies such as burial societies can operate to help cushion the impact of long illness-related income shock. Such a social support mechanism at community level could be a health-fees insurance club or a prepayment scheme. There is a growing body of literature on voluntary community health insurance and prepayment schemes in which such schemes have been reviewed and evaluated (Atim 1999, Ron 1999, Bloom *et al.* 1999, McPake *et al.* 1993, Noterman *et al.* 1995, Sauerborn *et al.* 1996). One of the major findings of these reviews is that community initiatives to generate funds to meet health costs through risk-sharing schemes proved efficient in protecting the community from the negative effects of fees and is a promising tool in shouldering the economic burden of income shock. This helps the poor beat the high joining fees and membership subscriptions often required by formal medical organizations (Atim 1999). However the schemes should be strongly based on community participation, accountability and autonomy. Such schemes can also benefit from government or NGO assistance in their design and monitoring (Ron 1999).

All in all, although policies that strengthen household's coping strategies should be encouraged, such policies should be seen as a complement to and not a substitute for efficient and equitable macroeconomic policies and sustained growth in the formal sector of the economy. It is important that macroeconomic policies securely embeds the need to sustain the welfare of the most vulnerable in society, by addressing inflation and ensuring that expenditure on social capital does not fall. It is important that the government prioritize the welfare of the poor and allocate resources towards it if progress in the country's human development is to be achieved. Social protection strategies can be successful only where the macroeconomic policies support the social policies (Raftopolous *et al.* 1998). High nominal and real interest rates and stagnant per capita incomes have created a hostile environment in which the new small-scale enterprises have to operate (Raftopolous *et al.* 1998). The study has shown that inflation is weakening the informal support network, the main form of support to

households. The macro-economic policies that are required include those that foster economic growth and price stability, create an environment that promotes savings, investment and employment creation, improve the purchasing power of the poor, reduce unproductive spending (such as military spending) and promote efficient spending on the social sectors; health and education.

Conclusion

THIS STUDY HAS revealed that low-income households have been under severe stress from adult morbidity and mortality. Social services budget cuts, real decline in wages, massive retrenchments, real increases in food and other non-food items, health cost recovery and increases in HIV/AIDS and other epidemics have seemed to have worked against the poor. The study's findings suggest that households and communities have adopted innovative strategies to try and cope with the income loss-related morbidity and mortality. It revealed that households are heavily dependent on informal forms of support ranging from informal borrowing, remittance from family members to informal business activities. Policies aimed at strengthening these informal sources of support can help foster the well being of poor families and reduce the burden of the negative impact of morbidity and mortality. If informal employment or self-employment is to be a viable development strategy, the necessary innovative enabling environment must be created. Policies such as improving the regulatory framework of the informal business activities, technical training, technology promotion and financing can help ensure that poor households have a reliable source of income to help them maintain consumption when they experience an income shock.

The study has suggested that the SDF needs to improve the targeting of public assistance by localizing the administration of the fund. Granting financial grants to local area administration or grassroots organizations involved in education, housing, health and sanitation can help ease the costs of administering the programme at the same time as ensuring that the transfers reach the people who are most in need. If the aim of national economic development is not simply to increase output but also to improve human welfare, government must redirect its policy

towards meeting this goal. What is needed is improvement in government resource allocation to social services and employment generation; a modified cost recovery mechanism, intensified HIV/AIDS prevention and mitigation strategies and targeted social assistance for the vulnerable, in order to protect the poor from falling deeper into poverty.

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