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ABSTRACT
Living in social contexts characterised by poverty and inequality, street young people have limited access to healthcare, water sanitation and hygiene services; exacerbating effects of ill health, infections, lack of nutrition and substance abuse that undermine their wellbeing. In Harare, Zimbabwe, they are also excluded from Social Protection Programmes (SPPs) which potentially assist other impoverished Zimbabweans, two-thirds of whom live below the poverty line (WFP 2019. Zimbabwe Annual Country Report 2019. World Food Programme). In this paper, we propose a reassessment of SPPs, in particular the Assisted Medical Treatment Order (AMTO), identifying barriers to access, and benefits for extending access to street young people. Drawing on secondary analysis of data from Growing up on the Streets, this paper re-conceptualises Ingrid Robeyns’ (2005. “The Capability Approach: A Theoretical Survey.” Journal of Human Development 6 (1): 93–117. https://doi.org/10.1080/146498805200034266) model of capabilities and applies it to the reversal of street youth exclusion and the application of government-targeted initiatives which have failed to reach those in the most vulnerable situations. In so doing, we propose an adapted model which recognises how the capabilities of street young people are enhanced when they are integrated into SPPs. This adapted model can be replicated and applied to relevant interventions for other groups of marginalised people in across contexts.

KEYWORDS
Capability approach; street young people; social protection programmes; Accessing healthcare; Wellbeing; Assisted Medical Treatment Order (AMTO); Zimbabwe

Introduction
Social Protection Programmes (SPPs) emerged in lower-income countries in the 1990s as a method of targeted accountable fund transfers from states to individuals.
Since 2000, impetus from development agencies in promoting SPPs as a focus of global public policy (Hickey and Seekings 2017). Unlike social welfare or security models in higher income countries, SPPs are rapidly adaptable to political and financial need, providing financial safety nets for recipients and incentivising socially targeted policies, such as school attendance for children in low-income families. SPPs are targeted at households, excluding homeless populations (Hebo 2013). Both home- and household-less, street young people are excluded from SPPs, exacerbated by age and lack of advocacy.

As SPPs rose in popularity, the sociology of childhood literature (see James and Prout 1997) simultaneously recognised young people’s agency and rights, including capabilities of street young people (Shand 2014). Subsequent literature has mapped SPP development (Townsend 2009), but with a dearth of academic studies researching experiences of marginalised children and youth located outside the household. Yet there is a fundamental disconnect between policy targeted at the most vulnerable and their ability to access it. This is due to street young people’s presence outside households as an identifiable social unit, uncertainties and disagreements about definitions, and measurability of interventions (Poretti et al. 2014).

This paper seeks to explore this disconnect, joining up recognition of street young people as having rights to access SPPs and identifying gaps between policy and implementation realities. It does so by examining one SPP, the Assisted Medical Treatment Order (AMTO) in one context (Zimbabwe), using a theoretical model of the capability “functionings” of street young people.

There are several reasons why marginalised Zimbabwean’s such as street young people are excluded from provisions of SPPs. Governmental policy priorities are a key challenge in provisioning social protection. For example, the Zimbabwe African National Union Patriotic Front (ZANUPF) government (1980–2008), emphasised an agrarian approach towards poverty reduction through land reform at the expense of poverty-reducing cash transfers (Chinyoka and Seekings 2016). During the Government of National Unity, a coalition between ZANUPF and the Movement for Democratic Change (MDC) (2009–2013; Chagonda 2019), MDC ministers succeeded in channeling resources towards SPPs such as Harmonised Social Cash Transfers (Arruda 2018), National Action Plan for Orphans and Other Vulnerable Children (Saito et al. 2007), among others (Chinyoka and Seekings 2016).

This localised investment sat within a global context in which the Sustainable Development Goals (SDGs) were set out and ratified by all United Nations (UN) member states (UN 2015). The SDGs intended to address poverty and inequality across 17 areas by 2030, including the most marginalised such as street young people (Consortium for Street Children [CSC] 2019), but are behind target (UN 2022). SDGs highlight the acute nature of street young people’s marginalisation (CSC 2019) and impacts of both structural and contingent risks upon their lives, which further constrains their capabilities. Since
ZANUPF returned to majority power in 2013, Zimbabwe’s economic difficulties have continued, meaning SPPs only reach a tiny proportion of those in need (Dafuleya 2022). Structural risks include intersectional situations of vulnerability and poverty where discrimination and marginalisation impact people’s rights and capabilities (Sabates-Wheeler, Devereux, and Hodges 2009). In Harare, street young people face discrimination, being referred to as magunduru (of no fixed abode, societal deviants). Their social exclusion, lack of status and agency is exacerbated by a politicised and authoritarian state context (Mare 2020) exposing them to contingent risks such as inflation, shortages of foreign currencies, poor salaries, weak child protection policies, and a paucity of investment in public service by the Government of Zimbabwe (GoZ) (Sabates-Wheeler, Devereux, and Hodges 2009). Due to intersectional challenges, street young people are unable to access their most basic rights including the right to an identity and health services at government hospitals and clinics (Growing up on the Streets 2016).

Against this background, this paper explores SPPs’ development and place in Zimbabwean society, focusing on AMTO. It provides an overview of the conceptual background to the capability approach and explores Robeyns’ (2005) theoretical survey, before demonstrating how her model (Figure 1) can be adapted to emphasise SPPs’ role as a commodity contributing to choices for street young people in their capability functionings (Figure 2). Using secondary analysis of Growing up on the Streets research project data, we demonstrate how a paucity of state and institutional support in Zimbabwe deprives street young people of a key input into their capabilities and their means to achieve, impacting on their capability set and freedom to achieve. Finally, we suggest how the design and delivery of SPPs, particularly AMTO, could be amended to incorporate delivery to this group and the implications for SPP implementation to marginalised groups in other contexts.

**SPPs Reaching Target Populations: Excluding the Most Needy**

SPPs are formal and non-formal measures that help recipients to sustainably meet basic needs or build resilience to risks (Seekings 2019). They have been critiqued as a neo-liberal mechanism for contractually obligating impoverished recipients and promulgating individualism and stigma (Hickey et al. 2020; Ulriksen and Plagerson 2014). Across Africa this criticism extends to lack of buy-in, political commitment, short-term pilot projects and narrow scope (Merrien 2013). Implemented effectively, they provide income and mitigate risks for poor households, enhancing opportunities for a better future. Formal SPPs are organised in their delivery but restrict eligibility (Hickey et al. 2020), using donor-driven models imported from high income countries, potentially inappropriate when applied in African contexts (Devereux and Kapingidze 2020).
Some Latin American countries implemented SPPs conditional on work using income transfer; effective for economic and human development objectives and to assist the chronically poor (Barrientos 2011). Several African governments have invested in SPPs at varying levels including cash transfer programmes and as social assistance (Seekings 2019). For example, in South Africa, SPPs form part of a constitutional social contract supported by civil society organisations (Devereux, McGregor, and Sabates-Wheeler 2011). In Ghana, as a livelihood empowerment against poverty programme, and health-related SPPs in Ethiopia and Guinea (Hickey et al. 2020; Mussa 2021).

In Zimbabwe, SPPs are defined in the National Social Protection Policy Framework (GoZ 2016), based on principles of social support, care, livelihood strategies, labour market interventions, social insurance and assistance. SPPs
include AMTO (UNDP 2019) and the Harmonised Social Cash Transfer Programme (Arruda 2018). The majority are run by GoZ with support from development partners including bilateral donors and UN agencies (Devereux and Kapingidze 2020).

AMTO is a non-monetary SPP, part of the GoZ Social Protection strategy (GoZ 2016; World Bank/GoZ 2016). AMTO was designed to provide free-at-the-point-of-use medical health services for pregnant women, children under 5 and citizens over 65 (GoZ 2016). However, access to AMTO is through individual means testing, a “lengthy” process which often takes place inside potential beneficiaries’ homes (Buzuzi 2016, 34). Despite being one of the most marginalised groups in Zimbabwean society (Gunhidzirai and Tanga 2021) and defined as “children in need of care” (GoZ 2001) SPPs such as AMTO remain inaccessible to street young people due to the intersectional nature of their marginalisation. They lack identity documents such as birth certificates and, being homeless, an address. Their homeless existence makes them a hard-to-reach group both physically and due to discrimination and the structural and contingent risks to which they are exposed, seeking a living through the informal economy (Shand, van Blerk, and Hunter 2016) including, gambling, illegal work and transactional sex (Stoebenau et al. 2016; van Blerk 2016) with limited access to food, water, sanitation and hygiene services (UNICEF 2017). These multiple intersecting challenges make accessing even basic rights such as healthcare difficult.

The disconnect between policy, its implementation and accessibility by target beneficiaries goes beyond the policy implementation gap to issues of discrimination and exclusion which are visible in the daily lives of street young people described above. Providing evidence of both the deficit of implementation and the potential benefits requires a fresh approach. By applying a model which considers street young people’s capabilities and their experiences of accessing health care, this paper adopts a novel approach to demonstrate impacts of the absence of state care which could be replicable in other contexts. AMTO is used here to demonstrate the impact of SPPs’ inaccessibility for street young people, as lack of access to healthcare impacts upon their ability to live a dignified life and reach their potential; a violation of their human rights, as enshrined in national and international legislation (Bhaiseni 2016; African Union (AU) 1999; UN 1989). AMTO has been associated with challenges such as means-testing and lack of funding (Gunhidzirai and Tanga 2021). Delivery is in the form of a health voucher only accepted in government-run hospitals and pharmacies, precluding treatment from private hospitals. Public health services in Zimbabwe, once exemplary, have declined through neglect, mismanagement, and corruption, with shortages of essential drugs and frequent strikes by healthcare staff (Kidia 2018; World Health Organisation [WHO] 2016).

In the next section, we introduce the concept of capabilities and Robeyns’ capability model, which situates individual capabilities within their context
We then adapt Robeyns’ model to identify the potential benefits that improved access to AMTO could make to the health and life chances of street young people. Using evidence from the Growing up on the Streets project (see Methodology) shows the barriers to healthcare for street young people; the role of social, cultural, and legal institutions and norms; and potential impacts of AMTO. The model’s capability framework provides a useful tool to explore the interactions between young people’s street lives; their constrained choices, coping strategies and impact on health; the socio-cultural context in which they live; the boundaries and barriers of street existences, and their influence on capability functionings. We explain how recasting the capability framework is useful in identifying the gulf between lived experiences of street young people and their unmet healthcare needs; illustrated through data analysis in Section 5. Towards the end of this paper, we return to the model to identify how AMTO and other SPPs could be adapted to reach this neglected cohort.

Recasting the Capability Framework

Amartya Sen defined the capabilities concept to examine human wellbeing beyond welfare economics (Barreda, Robertson-Preidler J, and Bedregal García 2019; Sen 1999; Shand 2014). Freedoms, or capabilities, deliver individual achievements, or “achieved functionings”; “their effective opportunities to undertake the actions and activities that they want to engage in, and be whom they want to be” (Robeyns 2005, 95). There are inherent individual and structural delimitations to capabilities and functionings; constrained opportunities limit individual autonomy; similarly, opportunities may flourish as young people grow up and their capabilities and functionings grow with them (Ben-Arieh 2014).

Sen argues that human beings should not be seen as consumers, rather as agents who can “think, assess, evaluate, resolve, inspire, agitate, and, through these means, reshape the world” (2013, 7). For street young people, capabilities are affected by lack of access to, or deprivation of, resources. A social environment characterised by poverty and inequalities inhibits capability functioning and increases susceptibility to health challenges.

Crystallising the capability approach as a framework of social justice, Nussbaum (2003, 2011) introduced the concept of dignity as a critical indicator of capabilities, arguing that the purpose of any policy or development inter/nationally “is to enable people to live full and creative lives, developing their potential and fashioning a meaningful existence commensurate with their equal human dignity” (Nussbaum 2011, 185). From Nussbaum’s social justice perspective, the capabilities of street young people are constrained by a social environment that deprives them of the normative expectations of childhood, such as play or education.
For street young people, the fundamental problem is not only limited availability of services, but exclusion resulting from homelessness. Lack of household, address and identity documents renders it impossible to convert available resources into real opportunities and promote their capabilities and development. Exclusion from resources, including SPPs, compromises their development and constrains their capabilities and functioning.

In acknowledging the interdisciplinary nature of the capability approach and its scope and application across policy, Robeyns (2005) created a model which she described as “a stylised non-dynamic representation of a person’s capability set and her social and personal context” (2005, 98). As Figure 1 shows, she explains an individual’s achieved functionings depend not only on the means and freedom to achieve, but each functioning is “an act of choice”; a choice taken subject to “the influence of societal structures and constraints” (Ibid, 108).

Starting with Robeyns’ model, we examine the constrained functionings of street young people in Harare, where their social context affects their capability set, which according to Robeyns’ model, is characterised by social institutions. These could be defined as tangible and intangible societal structures of governance, including social norms and other’s behaviour; potentially including assistance, stigma and discrimination. Environmental factors include patterns of urban occupation, such as informal housing, which impacts the make-up of street-based networks, and livelihood opportunities. This social context influences negative attitudes and perceptions towards street young people in Zimbabwe, within which they are viewed as criminals, drug addicts and magunduru. By positioning street young people as outside the social norm, this facilitates societal and political reluctance from Government and other agencies to include such young people in the provision of SPPs.

With this context in mind, this paper explores the usefulness of developing this model and its applicability for street young people, and its potential to extrapolate to other contexts of marginalised young people. Robeyns’ model (Figure 1) requires enhancements to apply to the specific conditions experienced by street young people and to highlight the potential value of AMTO to them. This paper therefore recasts Robeyns’ model to provide greater clarity of the terms used and the applicability to street young people’s lives.

Figure 2 highlights the changes applied to the model, now segmented laterally into pillars 1–4 and horizontally showing the flow of inputs to explore their interaction, and where the interjection of SPPs can play a role. Laterally, the pillar headings summarise the elements contributing at a macro level to individual achievements; the pillar footers summarise personal micro-level elements and indicate both interrelationships and the flow of influence and cumulative impact on achievement.

Looking at Figure 2 laterally, the first pillar, “Inputs”, shows the “social context and barriers” as well as “capability inputs” that make up the “means...
to achieve” for street young people. Robeyns’ economic terminology defined the tangible and intangible inputs as “goods and services” (renamed “material and non-material circumstances” in the second pillar). Public policy approaches form part of the social context, as they can act both as a barrier and facilitator to improved access to healthcare. These fluctuate dependent on political will and policy goals. The addition of the SPPs here is key; they act as a “capability input”, enhancing means to achieve alongside production, income and transfers-in-kind, which represent the informal and formal strategies for support used by street young people. Other capability inputs could be injected here, such as skills, to apply the model to different contexts. As a visualisation of possible inputs, the model indicates impacts of adding and removing interventions; by showing the flow from left to right across the revised model, we now see the dynamic connection between the means to achieve or capability inputs; the flow of influence of structures and constraints combined with personal factors, towards the freedom to achieve, and ultimately achievements.

The second pillar illustrates the “influence” of socio-cultural structures and barriers that interact to create the “material and non-material circumstances”, in turn interacting with “personal conversion factors” and “personal history and psychology”. As an example of personal conversion factors, Robeyns (2005, 99) uses the analogy of a bicycle: where usefulness is dependent on an individual’s ability to cycle. A more useful analogy for street young people is to replace the commodity with AMTO and the personal skills required to survive in street settings. We have moved into this pillar personal history and psychology; this influences a person’s conversion factors as well as their choices of functionings. Here the flows of influence are explicit from the social, cultural, and legal institutions and norms, amalgamated within “social context and barriers”, and their influence on the personal conversion factors and the personal history and psychology, which now sit adjacent to the material and non-material circumstances.

The third pillar, the “role of capabilities”, highlights individual capabilities that lead to individual “choice”. Choice is determined by the role of capabilities; in turn influenced by social context and barriers. The individual’s capability set also directly influences choice, which in turn was influenced by personal conversion factors, material and non-material circumstances, and capability inputs. Choice bridges this and the fourth pillar, “individual achievements”, and is the culmination of the freedom to achieve. The result of choice is the “achieved functionings” of the individual, in the fourth and final pillars, “individual achievements”.

In Robeyns’ model (Figure 1), the social and environmental context can include an infinite number of factors; coupled with commodities which in the adapted model (Figure 2, pillar 1) highlights SPPs as part of capability inputs. The adapted model shows how the macro- and micro-scale can combine to influence achieved functionings; the items in the first pillar
influence and feed the subsequent pillars. The model imposes no value nor indicates scale of influence, but by adding SPPs as one of Robeyns’ “many, many more” (2005, 99) social and environmental factor capability inputs, the role of SPP access in improving street young people’s lives can be visualised. SPPs as an intervention at this key point influences how subsequent factors, such as material and non-material circumstances, lead to personal conversion factors; to personal psychology; to the capability set; and, ultimately, choice and achieved functionings.

Following an outline of methodology, this paper moves on to explore the applicability of the adapted model for street young people in Harare, by demonstrating how a deficit of state support typified by AMTO impacts on their lives.

**Methodology**

This paper uses secondary analysis of data drawn from Growing up on the Streets, a longitudinal ethnographic research project which took place in three African cities (Accra, Bukavu and Harare; 2012–2016), involving street young people as participants and researchers (Growing up on the Streets 2013; 2014). Ethical approval was gained from the University of Dundee. In a pilot phase, young participants identified 10 capabilities they saw as key to their lives, including health and wellbeing. Training took place for potential participants in 2012 and 2013 and in each city six street youth researchers were selected from volunteers to undertake ethnographic research for 3 years and facilitate focus groups on each capability. To ensure accuracy (Lincoln and Guba 1985), recording and transcribing were completed by local street workers, close to the data and fluent in local languages. Street youth researchers and focus group participants were paid in recompense for their time. This peer network (229 participants by 2016) participated in 198 quarterly focus groups across the three cities, one on each capability and an additional set on rights as part of a UN consultation (UNOHCHR 2017). Six Harare health and wellbeing focus groups were analysed and the data applied to this paper. The project sought to involve both young women and men; in Harare the number of female participants reflected the gender makeup and dynamics of the street.

SPPs were not a focus of the original research, but the reflections of focus group participants on health describe the impact of lack of access to healthcare and related state support for street young people. To explore this, a sub-set of data was anonymised for secondary analysis, drawn from six focus groups on the health and wellbeing capability, in Harare in May 2013. Lincoln and Guba (1985) provide trustworthiness criteria for data collection which suggests that credibility comes from multiple sources of data. Analysis for this paper was across 6 groups capturing the views of 57 participants (53 young men and 4 young women) with an average age of 16 years among the 38 participants who gave their ages, ranging from 12 to 20. While a limitation of this paper
is the focus on one city, findings corresponded with those shared in a comparative briefing paper of health and wellbeing across the three cities (Growing up on the Streets 2016). Of the 57 participants, 29 (55%) were part of the peer network and 33 had taken part in other focus groups. All were self-selected participants who had heard about the project through peers and local NGO collaborator; several had taken part in training run by Growing up on the Streets. The street youth researchers’ pseudonyms are used below: Brighton, Dai, Goodwill, Nhamo, Nixon and Taurai.

While the primary data used a participatory approach, the secondary data analysis engaged a thematic content analysis for this paper. This process was undertaken by Chikoko and reviewed by the other authors. Themes and sub-themes that emerged were discussed and grouped under key health themes. Their interaction with the adapted model is explored below.

**Realising Capabilities for Street Young People: Inputs, Influences, Capabilities and Achievements**

Having examined how the model could be adapted to explore potential impacts of SPPs; this section identifies how a paucity of inputs effects the health of street young people. Focus group discussions sought to understand the impact of health on aspects of their lives, such as sleep and livelihoods; how they access treatment, and in the absence of treatment, what alternatives are available; the impact of coping strategies such as drugs and alcohol; and how they protect themselves from sexually transmitted infections (STIs); and their mental wellbeing.

Six key health themes (Table 1) emerged from secondary data analysis and the cumulative impacts for young people of absence of inputs is shown at the intersection of these themes as the adapted model’s four pillars are traversed. Each is illustrated with a quote from a focus group member, which were recorded anonymously with only their gender indicated.

**Social Context and Barriers, Capability Inputs and Means to Achieve (Pillar 1)**

Pillar 1 of the adapted model (Figure 2) highlights the broad environmental and social contexts and barriers for street young people that impact their means to achieve.

**Key Health Theme: Limited Access to Healthcare Services**

The data illustrated how few capability inputs, yet many social, cultural and environmental barriers limited access to healthcare services, affected young peoples’ means to achieve, a paucity impacting on subsequent elements in the adapted model and ultimately individual achievements. The empirical data illustrates this lack of input through individuals’ experiences:
When we fall ill on the streets there is no one we really look to in order to help us; [...] in truth there is no one to count on for helping us. (Goodwill’s group)

There are neither the structural nor social supports necessary to gain access to treatment or maintain sustenance when ill, leaving young people fending for themselves and potentially serious transmissible conditions (e.g. tuberculosis, STIs) untreated without access to AMTO.

**Key Health Theme: Water, Sanitation and Hygiene Issues**

The lack of access to clean water exacerbates health issues. A young woman revealed that water for drinking, cooking and washing comes from the Mukuvisi river that runs across the city:

The water that we drink; one may be bathing upstream in Mukuvisi while I am drinking water; one may be messing [going to the toilet] in the water and it flows to where I am; and I drink the water. (Nhamo’s group)

Lack of clean water is symptomatic of poverty; infectious diseases, including cholera, are a rare, but substantive risk (WHO 2018).

**Influence of Societal Structures and Constraints (Pillar 2)**

Pillar 2 shows the influence of societal structures and constraints. Young people’s material circumstances include savings, possessions, or any form of shelter or food; non-material circumstances include skills and support from friends. Their personal conversion factors and personal history and psychology interact here with each other, with pervading influence from their social context and barriers.

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**Table 1.** Key health themes emerging from the Growing up on the Streets secondary data analysis, mapped to elements of the adapted model (Figure 2).

<table>
<thead>
<tr>
<th>#</th>
<th>Key health theme</th>
<th>Experiences of street young people</th>
<th>Mapped to elements of the model</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Limited access to healthcare services</td>
<td>Unable to access healthcare services due to lack of money</td>
<td>Pillar 1 Inputs → Means to Achieve</td>
</tr>
<tr>
<td>2</td>
<td>Water, sanitation and hygiene issues</td>
<td>Inability to keep clean leads to infections, exacerbates issues of self-esteem and further marginalises young people</td>
<td>Pillar 1 Inputs → Means to Achieve</td>
</tr>
<tr>
<td>3</td>
<td>Limited access to food</td>
<td>Poor diet inhibits mental and physical development and hunger exacerbates substance abuse</td>
<td>Pillar 2 Influence of societal structures and constraints → Personal circumstances</td>
</tr>
<tr>
<td>4</td>
<td>Sexual relationships and STIs</td>
<td>Concurrent sexual relationships, transactional sex, unprotected sex. STIs include gonorrhoea, syphilis, HIV and AIDS</td>
<td>Pillar 3 Role of capabilities → Freedom to achieve</td>
</tr>
<tr>
<td>5</td>
<td>Substance abuse</td>
<td>Most participants abuse substances including alcohol, “bhirongo” (cough syrup), “mbanje” (cannabis), and glue</td>
<td>Choice: Role of capabilities/ Individual Achievements</td>
</tr>
<tr>
<td>6</td>
<td>Violence</td>
<td>Physical and sexual violence are experienced by young men and women. Perpetrators include other young people, non-street adults, and those in authority</td>
<td>Pillar 4 Individual Achievements → Achievement</td>
</tr>
</tbody>
</table>

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**Key Health Theme: Limited Access to Food**

Difficulty in finding food also impacts on health, many participants were struggling to find or buy enough food, leading to hunger and desperation. A young man in Taurai’s group explained how he “gets ill because of hunger not having anything to eat”. A common resource is scavenging for food from rubbish bins by city centre flats, fast-food outlets and supermarkets, as another young man describes:

> Because I have spent the day hungry, I just get there and separate the food from Pampers and I eat; those are some of the things that cause us to get ill. (Dai’s group)

While poverty is a driver to risk-associated strategies, those most at risk cannot seek assistance to avoid or treat resulting conditions.

Reflecting the importance of personal history, participants explained the influence of past experiences on their current lives. As a female participant in Nhamo’s group explained:

> I take [drugs] because my parents are no longer there, and so I will be thinking, where will my life end? ID, birth certificate I do not have …

Feeling a powerlessness in the face of institutional structures that mean without ID she cannot hope to change her situation, this young woman’s personal history means there is no parental support or evidence of her birth.

**Role of Capabilities in the Freedom to Achieve (Pillar 3)**

The third pillar shows how an individual’s capability set, summarised by Robeyns’ (2005, 95) as the “opportunity set of achievable functionings”, combines with preference formation mechanisms and social influences on decision-making to influence the freedom to achieve.

**Key Health Theme: Sexual Relationships and STIs**

Street young people engage in sexual relationships both as an expression of freedom to achieve and as economic enhancement to their capability set. Transitory and cyclical concurrent relationships are a common pattern of street relationships, exposing them to STIs. For example:

> Say today I have my girlfriend and I sleep with her for two- or three-days using protection and on the fifth day I will say she is now my wife … and on the eighth day we fight and argue, and she is taken by that one. He will repeat the same thing and she will be taken next by that one and she will be on the same position … (Goodwill’s group)

Young women and young men engage in transactional sex, or trade sex for subsistence, in the form of a meal, for as little as £0.25 (USD$0.34):

> you just buy her food for 5rand and go sleep with her, and you then get HIV or STI … (Dai’s group)
A female group member provides a young woman’s perspective:

the boys in town are cruel to us [...] they will take you to a base where he will buy you sadza and during the evening he will come wanting to have sex. That is cruelty because he did not tell me that on buying me sadza he will want to sleep with me; I had no choice as I had already eaten the sadza so I give in. (Nhamo’s group)

The interrelationship between limited access to food, highlighted in the first pillar, exacerbated by the social context with further gendered constraints, has a direct impact on health. The situation is worsened as street young people do not have access to treatment if they fall sick.

**Choice**

In the adapted model, “choice” sits between Pillars 3 and 4, and is directly influenced by personal history and psychology, preference formation and influences on decision-making. For street young people, choices are constrained by a paucity of positive inputs, negative impacts of state and societal stigma and discrimination, the influences of social structures and constraints combined with personal circumstances, and an inhibited capability set. All such factors lead to choices that are often incrementally detrimental to young people’s health.

**Key Health Theme: Substance Abuse**

It must be recognised that the choices that young people make are within limited frames. This is supported by a conversation between a young woman and a young man, who complains, “sometimes you do not get money to buy soap”, but his female colleague disputes this, saying:

That is a lie, they like drugs very much [...] they would have money, but they consider drugs and “makasa” (card gambling). (Taurai’s group)

According to the young woman, her male peers make a choice between soap and drugs, or money to gamble. While not everyone “chooses” to take drugs, substance abuse is widespread: Another young woman stated:

We are now addicted to drugs; we cannot live our lives without drugs. (Nhamo’s group)

This expression of lack of choice highlights the intersection between key health themes. The lack of food my drive young people to use drugs; sex is traded for food or drugs and may result in STIs. This young woman underlines this later by stating: “you cannot live when sober …”. While the cumulative effects of Pillars 1–3 form her lack of means to achieve, her personal conversion factors, influenced by social norms; combined with her personal history, preference formation, and social influences may all influence this young woman’s drug use. In her opinion it is not an active choice, but a necessity of survival.
For other participants, substance abuse magnifies problems and inhibits food intake:

most of the time the drugs increase your problems and you get hungry; that is when
you will end up going to pick food from bins … (Taurai’s group)

A young man in Nixon’s group describes how a strong “home”-brewed beer
can act as a replacement to food, probably because its strength dulls hunger
pains. As well as missing out on nutrition there are health risks associated
with this:

Most of us are ill because of ngoma (beer); they now see ngoma as food; they no
longer eat […]. If you drink ngoma your intestine will be glued together

**Individual achievements (Pillar 4)**

Beyond “choice”, the final pillar “individual achievements”, includes achieved
functionings, which Robeyns summarises as “what people are effectively able
to do and to be” (2005, 94), implying both current action and future aspiration.
These young people have demonstrated that day-to-day survival is an achieve-
ment. However, a chronic lack of inputs results in negative behaviour in the
form of being both perpetrators and recipients of violence.

**Key Health Theme: Violence**

We saw above how a female participant’s personal history, lack of ID, experi-
ence of peer abuse, and drug use have impacted her life. She continues:

Plus also being traumatised by older boys, the police if they want to sleep with you by
force, because there is nowhere you can go to report; with the soldiers, it is the same,
they abuse us the girls who stay in town; even if you are beaten up and report, that you
are a street kid, they will do nothing. (Nhamo’s group)

Feeling powerless in the face of institutional structures mean without ID she
cannot hope to change her situation, and when subjected to sexual violence by
men in authority, there is nowhere to turn. With no inputs in the form of state
recognition, access to SPPs, or state help when a victim of crime, the material
and non-material circumstances for this young woman are critically depleted.
Her response is to seek solace in drugs, which cost money, and given limited
material circumstances, she may be forced into sex work as a means of
earning money.

The societal structures and constraints expose street young people to beha-
viours that impact on their health and wellbeing, as they seek livelihoods and
coping strategies, such as transactional sex and substance abuse. Cumulative
impacts of lack of access to state inputs, including AMTO medical vouchers,
effect their material and non-material circumstances and the necessity of indi-
viduals fending for themselves puts them at risk of harm. Combined with
personal conversion factors, history and psychological issues can lead to a negative cycle that directly impacts on health, as a young man describes:

These things affect even the way you think, because [...] the side-effects of injection, pills, and glue, they kill your health; and when having sex, you will forget to wear condom because you will be drunk. (Dai’s group)

This is a rather pessimistic outlook on potential achievements. Expanding freedom and choice is the key to the capability approach (Robeyns 2005). However, in response to the lack of capability inputs (pillar 1) the individual achievements (pillar 4) available to street young people are the result of such constrained “choices” that substance abuse, unprotected sex and violence is the culmination of “what people are effectively able to do and to be” in these contexts (Ibid., 94).

These six themes, mapped across the pillars of the adapted model (Figure 2, Table 1) demonstrate how street young people are marginalised and their subsequent survival strategies, behaviours and appearance lead to additional stigmatisation. From the perspective of policy makers and medical practitioners, this in turn diminishes their position as “deserving” assistance.

Discussion and Conclusion

The Introduction explored the global and local contexts, including gaps in policy implementation the SDGs across Africa. Political and economic uncertainties have resulted in continuing extensive situations of acute poverty in Zimbabwe (e.g. Dafuleya 2022), meaning street young people are further marginalised. We have shown using their testimonies the impact upon their health through key health themes, including limited access to healthcare services, water, sanitation, and hygiene issues, limited access to food, sexual relationships and STIs, substance abuse and violence.

Implementing policies and reaching all potential beneficiaries is challenging. In the case of street young people, their social status as magunduru means they are exposed to structural and contingent risks in a context where the neediest do not receive the social assistance to which they are entitled. Rather than give up on this group, in this paper we show that by adopting a capability framework, and adapting Robeyns (2005) model, this tool can be applied across different contexts to problematise structural and individual challenges. In Section 5, young people’s personal experiences of structural failure to implement social protection and subsequent impacts upon their capabilities were shown. Policies and approaches that hinder rather than assist them to reach their potential impact their means to achieve (pillar 1, Figure 2) are inhibited, and the cumulative impact of this absence is felt at every stage of young people’s lives.

This paper has made the link between experience and reality for the application of the capability approach to street young people’s lives. The ability to
pursue life goals are central to the capability approach; the ill-health and ill-being of street young people limits their ability to pursue such goals. As Robeyns makes clear, the capability approach as outlined by Sen (1999) and Nussbaum (2003) is not a theory of justice (Robeyns 2005, 96), but seeks to “evaluate policies according to their impact on people’s capabilities” (Ibid., 95) and asks if people are:

healthy, and whether the means or resources necessary for this capability are present, such as clean water, access to doctors, protection from infections and diseases, and basic knowledge on health issues. It asks whether people are well-nourished, and whether the conditions for this capability, such as having sufficient food supplies and food entitlements, are being met. (Ibid., 96)

For street young people, these “entitlements” are consistently unmet. Health is a central human capability (Nussbaum 2003); in a situation where street young people do not have access to health services, it becomes an issue of social injustice that their human capabilities are compromised, for example rendering them vulnerable to sexual violence in exchange for food.

While the capability approach has been critiqued as placing emphasis on the individual (Nussbaum 2011), the adapted model positions individual choice and achievement within wider macro-level societal contexts, showing the material impacts of lack of social and state inputs upon personal circumstances. Thus the adapted model and data assists in visualising the impact not of inputs, but their absences on young people’s lives. By mapping individual experiences drawn from data, we have demonstrated the ongoing relevance of the capability approach in the lives of street young people and the usefulness of Robeyns’ model, adapted and employed to address a specific issue. This has highlighted where a paucity of inputs has tangible effects on both individual lives and society. Street young people have the same human rights as their peers with homes and deserve equitable opportunities to achieve their capabilities and pursue life opportunities that they value.

There is an urgent need to rethink the delivery of SPPs which currently fail to meet basic needs of the most socially excluded. Properly designed, targeted and managed, SPPs such as AMTO would enable street young people the same basic rights to healthcare as others in need and enhance their freedom to achieve. Considering the testimonies of the young people showing this absence of inputs, using the adapted model, it’s possible to visualise their achieved functionings with access to AMTO and the positive impacts on their achieved functionings. AMTO would enable access to basic healthcare services, potentially lowering disease transmission, improving quality of life and enabling their achieved functionings to become more akin to that of young people in mainstream Zimbabwean society. Access to AMTO would not resolve all their health issues; as we have seen, basic needs such as food may remain a challenge and they may still engage in risky livelihood strategies to raise money for
survival. The absence of inputs into street young people’s wellbeing from duty bearers such as GoZ is symbolised by their lack of identity documentation. Without this they are unable to access SPPs or gain formal employment offering greater security and remuneration, expanding their material circumstances and enhancing their personal conversion factors. The social structures to administer SPPs exist, but a flexible implementation approach is required to expand access for the most marginalised. Reconfiguring of SPPs in Zimbabwe must ensure that programme beneficiaries are not limited to those with identity documentation or an address. Simplifying the process of application and referral, to include organisations working with street young people on their behalf, could allow access to SPPs such as AMTO by impoverished groups. Such a flexible approach could be applied to others in vulnerable situations in Zimbabwean society and to street young people globally.

By drawing on a data excerpt, we have demonstrated that the absence of access to healthcare negatively affects street young people’s capabilities and achievements. Yet his paper seeks to go beyond our empirical example to suggest that this adapted model can be applied in different contexts and to different problems, where individual capabilities are set within contexts and a capability framework. Our unique recast application of Robeyns’ model can provide a powerful tool which is adaptable across different contexts. We envision that the model can be thus adapted by policy makers, academics and third sector teams to demonstrate where a paucity of service provision has impacts across individual capabilities, causing cumulative societal harm. Thus the adapted model has the potential to achieve transferability across many geopolitical areas to be part of a problem-solving toolkit for service providers in their funding applications or retrospectively in status reports. For policy makers, demonstrating rigour and achieving policy implementation is a challenge, yet the adaptation of Robeyns’ model is both a useful tool and a verified qualitative source. As such, this paper provides important evidence of its use and applicability.

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