

**FARM COMMUNITY TRUST OF
ZIMBABWE (FCTZ)**



**REPORT OF THE FCTZ INFORMATION SHARING
WORKSHOP ON HIV AND AIDS AND FARM
COMMUNITIES**

HELD AT ST LUCIA PARK HARARE

3-4 MARCH 2005

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MARCH 2005

Executive summary

Zimbabwe has one of the highest HIV infections rates in the world. It is estimated that 24, 6% of the adult population is infected by the virus¹. Since HIV/ AIDS was identified in the country over 20 years ago, several response initiatives have been put in place at various levels throughout the country, yet the problem remains. The situation is worse in former large-scale farms and rural informal settlements where there have been limited response initiatives. Former large-scale commercial farms were over the years considered private properties and as a result they were left out of mainstream development for many years.

FCTZ is committed to the prevention and mitigation of HIV and AIDS and care for the infected and affected in former large-scale commercial farming areas and rural informal settlements. In its contribution to fight against the virus and the disease, FCTZ implements the following programmes under the Health and HIV/AIDS Programme: Training of farm health workers and community volunteers in Home Based Care; Establishment of Youth Drop In Centres, Peer Education and Networking with other organizations. FCTZ is contributing to the national HIV and AIDS agenda by enhancing access to HIV and AIDS prevention, mitigation and care programmes by vulnerable communities in former large-scale commercial farming areas.

It is estimated that the spread of HIV and AIDS is higher in former large-scale commercial farming areas and mines than any other sections of the Zimbabwean population. National HIV and AIDS statistics show that 34.9% of the people infected are people staying in farms or mines compared to 28,1% and 20.9 % of people living in towns and rural areas respectively². The HIV and AIDS situation of commercial farming communities is characterized by the following:

- Development initiatives by pass these areas despite the burden of the disease.
- Poor distribution of health care centers (and other social services) to respond to the health demands
- Low levels of income and limited livelihood opportunities that lead farm workers to resort to negative coping strategies.
- Low levels of education and limited access to information about the virus and diseases exposes the communities to more infections everyday

It is against this background that FCTZ held a workshop on HIV and AIDS and Farm Communities to bring together stakeholders operating in farm communities to discuss HIV and AIDS and come up with a holistic plan on HIV and AIDS for farm communities.

One of the major issues raised during the workshop was that there was need to put in place effective, standardized and locally accepted structures to fight HIV and AIDS in farm communities. The workshop observed that there were few players who were

¹ MoHCW, Zimbabwe National HIV and AIDS Estimates 2003

² MoHCW, Zimbabwe National HIV and AIDS Estimates 2003

implementing HIV and AIDS programmes in farm communities. It was noted that national HIV programmes were not reaching commercial farming communities due to a perceived “migrant” nature of communities in former large-scale commercial farms. The subdivision of former large-scale commercial farms after the fast-track resettlement programme is said to have created a heavy work load for the National AIDS Council (NAC) which highlighted that it was failing to effectively implement programmes in these areas. There were calls to involve People Living with HIV and AIDS (PLWHAs) in programmes that affect them in their areas.

The workshop noted that players implementing HIV and AIDS programmes in farm communities were not well coordinated. For example players are not clear what a Home Based Care (HBC) kit should comprise of.

It was highlighted that a sectoral policy on HIV and AIDS for the agriculture industry which was being developed by GAPWUZ should be prepared with the involvement of all stakeholders in the agriculture industry. One of the gaps identified was that stakeholders were generally not aware of the roles and responsibility of NAC and hence implementation of some programmes suffered.

It was pointed out about 95% of farm children are not registered.

The workshop recommended the formation of a Working Group (WG) on HIV and AIDS for farm communities. The WG, which would meet quarterly to discuss HIV and AIDS in farm communities, would comprise all the organisations which attended the workshop.

The WG should perform some of the following tasks:

- To come up with terms of reference for the WG
- To identify gaps in current HIV and AIDS interventions in the operational areas
- To liaise with the Ministry of Health and Child Welfare, National AIDS Council (NAC) and other organisations to fight against HIV and AIDS in farms
- To work with NAC to review the National Policy on HIV and AIDS
- To facilitate the process of post-test counselling in former large-scale commercial farms and rural informal settlements
- To sensitise relevant authorities, ministries through working with NAC on the need to carry out research on HIV and AIDS in former large-scale commercial farms and informal settlements.

It was therefore generally agreed that the government, private sector and NGOs must cooperate to improve the quality of life of people, especially vulnerable groups.

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AIAS	African Institute of Agrarian Studies
ALB	Agriculture Labour Bureau
ART	Anti Retroviral Treatment
ARV	Anti-retroviral
ASRH	Adolescence Sexual Reproductive Health
BEAM	Basic Education Assistance Module
CBD	Community Based Distributor
CPS	Child Protection Society
CSO	Civil Society Organisation
DAAC	District Aids Action Committee
DFID	Department for International Development
DSW	Department of Social Welfare
ECEC	Early Childhood Education and Care
EPI	Expanded Immunization Programme
FAO	Food and Agriculture Organisation
FCTZ	Farm Community Trust of Zimbabwe
FHW	Farm Health Worker
FOST	Farm Orphan Support Trust
FP	Family Planning
FKP	Federation of Kushanda Pre-Schools
GAPWUZ	General Plantation Workers' Union of Zimbabwe
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
ID	Identity document
IEC	Information, education and communication
IDS	Institute of Development Studies
IOM	International Office of Migration
LAMA	Legal Age of Majority Act
MOH&CW	Ministry of Health and Child Welfare
NAC	National Aids Council
NS	New Start
NGO	Non-governmental Organisation
NEC	National Employment Council
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PAAC	Provincial AIDS Action Committee
PAC	Pos Abortion Care
PLWHAS	People Living with HIV and AIDS
PMTCT	Prevention of mother to child transmission
PSI	Population Services International
PSS	Psycho Social Support
SAFAIDS	Southern Africa HIV and AIDS Information Dissemination Service
RDC	Rural District Council

RG	Registrar General
RH	Reproductive Health
STI	Sexually Transmitted Disease
TB	Tuberculosis
TCE	Total Control of the Epidemic (TCE)
VAAC	Village AIDS Action Committee
VCT	Voluntary Testing and Counseling
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Fund
WAAC	Ward AIDS Action Committee
WASN	Women and AIDS Support Network (WASN),
WG	Working Group
ZAPSO	Zimbabwe AIDS Prevention Support Organisation
ZBH TV	Zimbabwe Broadcasting Holdings Television
ZNFPC	Zimbabwe National Family Planning Council

1.0 Background

Farm Community Trust of Zimbabwe (FCTZ) is a local non-governmental organization whose major objective is to improve the quality of life of vulnerable groups in former large-scale commercial farms and rural informal settlements. FCTZ promotes the livelihoods of those living in commercial farms through facilitation of community development and communication, advocacy and lobbying of all those who can facilitate change within the commercial farming communities. To help achieve this goal, FCTZ implements several programmes including: Research, Advocacy and Lobby; Food Security and Sustainable Livelihoods; Early Childhood and Education Care (ECEC); Health; HIV and AIDS; Basic Education, Gender and Credit and Savings Programme.

2.0 Introduction

FCTZ held the Information Sharing Workshop on HIV and AIDS and Farm Communities to allow farmer, farm worker, HIV and AIDS organizations, government sector ministries and other partners to come up with a holistic approach in dealing with HIV and AIDS in farm communities. The aim of the workshop was to give stakeholders in former large-scale commercial farms and rural informal settlements an opportunity to share plans and experiences on HIV and AIDS and to shape future interventions.

The workshop was attended by 50 participants and representatives from farmer, farm worker, HIV and AIDS organisations, Ministry of Health and Child Welfare, donor agencies, members of the media, people living with HIV and AIDS, organisations from farm communities and FCTZ staff.

3.0 Workshop methodology

The workshop was participatory with paper presentations and plenary sessions during the two and half days set aside for the activity. Twelve (12) papers were presented during the workshop (including the official opening and a presentation by FCTZ). Recommendations were produced through plenary discussions.

The workshop began with FCTZ Provincial Manager for Mashonaland East, Mr. Clifford Mpande leading participants into introductions before inviting FCTZ Deputy Director, Mrs. Mercy Kaviza to present the objectives of the workshop. The AIDS and TB Coordinator for the Ministry of Health and Child Welfare, Dr. O Mugurungi opened the workshop.

4.0 Workshop objectives

The workshop sought to achieve the following objectives:

- To lobby farm and farm worker organisations to strengthen their activities/programmes to promote prevention, care and awareness on HIV and AIDS

- To lobby HIV and AIDS organisations and other NGOS to strengthen their programmes in former large-scale commercial farms and rural informal settlements into their programmes
- To lobby government to allocate more resources towards prevention, care, mitigation and awareness for communities in former large-scale commercial farming areas and rural informal settlements
- To bring out and address HIV and AIDS gaps with particular focus on former large-scale commercial farming and rural informal settlements
- To share plans among participants
- To come up with a holistic approach on HIV and AIDS for farm communities and the way forward.

5.0 Opening remarks

FCTZ Deputy, Director, Mrs. Mercy Kaviza

Using a metaphoric story of “**Joshua and the garden of stone**” to describe the situation of HIV and AIDS in farm communities, Mrs. Kaviza challenged the government, NGOs, farmer and farm worker organisations, donors and other partners to take the workshop seriously and come up with programmes and work together to deal with the “garden of stone”. In the story of Joshua, a young boy symbolized the deaths of his parents, brothers and sisters who had died of AIDS by drawing an ever growing “barren garden of stone”. The following is the story of Joshua as presented by Mrs. Kaviza:

Joshua’s Story

Joshua was a boy of 11 who lived in Zhombe. Joshua was refusing to go to school and play with other children. His teachers got worried and tried to find out what problems he was facing. Joshua would not say anything.

Then, one day somebody noticed that Joshua always drew something on the ground or on a piece of paper. What Joshua always drew was a big garden with rolls and rolls of stone. So when he was asked what he was drawing Joshua said he drew his garden of stone.

Now people tried to find out why Joshua seemed so obsessed with his garden of stone. The reason Joshua was refusing to go to school was that the garden he was drawing was growing so fast and expanding so much. He was afraid if he went to school and came back home he would not be able to identify where his mother was, where his father was and all his other brothers and sisters would be.

Now the question was, what had happened to traumatize Joshua so much that he now began to symbolise his family in the form of a dry arid garden where only stone grew. We then learnt and found out that Joshua had lost his parents and also lost almost his entire family. The garden of stone to him symbolised the graves in which his entire family lay.

The morale of the story is what are we going to do about a child like Joshua who only associates life with an arid garden of stone? Are we going to help and raise the hopes of a child like Joshua by making sure that we arrest the expansion of the gardens of stone? Joshua is a victim like many other children we refer to now as Orphans and Vulnerable

Children (OVCs). He has lost his family to the HIV and AIDS scourge. What are we doing to address the lives of children like Joshua?

6.0 Official opening

Dr Mugurungi, AIDS AND TB Coordinator, Ministry of Health and Child Welfare

Dr Mugurungi noted that because agriculture is the back bone of Zimbabwe's economy, it was important to put in place urgent measures to address HIV and AIDS issues. He challenged participants to take advantage of the workshop to map the way forward with regards to the prevention and mitigation of the epidemic and care for the affected in the agriculture sector. He reiterated that the workshop was timely in that it sought to bring together all the stakeholders working in former large-scale commercial farms to try and find strategies to address the epidemic within one of the worst affected areas.

He noted that the government has the mandate and responsibility for overall implementation and coordination of our national response to the epidemic. However, given the size of the problem and resources required to address it, government has recognized and welcomed the initiatives by other stakeholders to complement its efforts.

7.0 HIV and AIDS situation in former large-scale and rural informal settlements. Role of NAC, DAACs, WAACs and VAACs in the fight against HIV and AIDS in these areas and challenges (including access to ARVs- Mr. Mundida, NAC Advocacy Coordinator

Mr. Mundida presented the general situation of HIV and AIDS in the country as follows:

- HIV prevalence is 24.6% of the 15 – 49 age groups.
- An estimated 1.8 million Zimbabweans are living with HIV.
- 90% of the infected are not aware of their status.
- 600 000 of those carrying the HIV virus have the signs and symptoms of AIDS and require varying degrees of care and support.
- Girls in the 15 – 19 age groups are most vulnerable to HIV infection.

It was noted the mandate of NAC is to mobilise, coordinate and monitor an expanded national multisectoral response to HIV and AIDS, as well as ensure maximum transparency and accountability in the management and utilisation of resources raised. NAC's goal therefore, is to empower communities to reduce HIV transmission and minimise the impact of the AIDS epidemic on individuals, families and society.

Situation on HIV and AIDS in farms

Information derived from sentinel sites has shown that prevalence of HIV and AIDS is high in farming communities. NAC noted that the migrant labour force makes it difficult for the workers to benefit from the existing programmes. Long term programmes are difficult to implement with the migrant community. The rise in the number of orphans

and lack of extended family structure further worsens the situation. There is a greater likelihood of child abuse especially girls.

HIV and AIDS programmes farms

Structures are not well defined in some districts and this makes it difficult to follow the usual procedures in accessing NAC funds. The workshop was informed that the “mobile nature” (migrant workers) of farm communities made it difficult for NAC to effectively plan and implement its programmes in former large-scale commercial farms. Mr. Mundida noted that the number of structures to work with in former large-scale commercial farms had increased following the resettlement exercise, for example the number of villages had increased following the subdivision of farms.

There has been a rise in the number of terminally people who need services and facilities are not able to cope with the demand especially HBC. The HBC programme is not well developed in former large scale farms.

ARVs are being piloted in Central, Mission and Provincial hospitals which make it difficult for farm worker communities to benefit since most of these sites are either in urban areas or in communal areas.

7.0 Regional Perspective on HIV and AIDS- SAFAIDS- Tsitsi Singizi

The presentation by SAFAIDS focused on the global perspective and in particular the current situation in Southern Africa. Globally, the number of people living with HIV has reached its highest level. The number rose from 36.6 million in 2002 to an estimated 39.4 million. It has been noted that HIV and AIDS IS an “African problem”- Africans account for approximately 25.4 million (65%). Sub Saharan Africa is by far the worst affected region in the world. The continent accounts for 25.4 million (65%) of the people living with HIV and AIDS in the world.

The region prevalence rates range from 15% to 35%. One in 5 people in Southern Africa is HIV positive. HIV and AIDS are exacerbated by poverty and vice versa. In any given country 10 to 20% of positive people need treatment

The majority of HIV infected in Africa lack adequate medical treatment for opportunistic infections. Less than 1% of positive people are on life prolonging ARV drugs. AIDS is the number one cause of death in southern Africa. In the year 2003, 2.3 million people died...6500 people die everyday and 3.2 million were newly infected. The life expectancy in sub-Saharan is 47 years; without HIV/AIDS it will be 62.

HIV and Agriculture

Since 1987, 7 million agriculture workers have died from AIDS. According to FAO 25% of the Agriculture labour force will die by 2020. More than two thirds of the population affected live in rural areas.

HIV and AIDS threaten both subsistent and commercial agriculture. Rural communities are subject to high levels of stress due to HIV infections. Because there is limited access of information and lack of health facilities in rural areas and farming communities, agriculture workers often do not know how to protect themselves against HIV infection.

The severe hunger catastrophe in several Southern Africa countries during 2002 is closely interwoven with the HIV crisis. It was found that in the region cash crops are grown at the expense of crops for own consumption. Care for the sick relatives and orphans take up time which is then no longer available for agriculture work. Investments such as irrigation and soil improvement projects are reduced. Older people die before they pass on knowledge to the younger generation. Increasing amounts of grain are grown, which is less labour intensive but of less nutritional value. Animals are slaughtered in order to feed the sick and pay expenses. Diminishing revenues lead to a loss of purchasing power within the overall social context.

Discussion

Farm worker access to HIV and AIDS facilities

It was pointed out that the argument that farm communities were difficult to access did not hold water. As the existence of farm villages should make it easier for NAC to access farm communities.

GAPWUZ noted that while farm workers were contributing to the AIDS levy, most of them were not benefiting from the AIDS levy. NAC pointed out that the distribution of the AIDS levy was different from the Medical AID Levy- it did not mean that only those who contribute to the AIDS Levy would benefit. The money is put in a national basket and is accessed by everyone through prioritization. It was suggested farm workers should identify structures within their communities for them to access HIV and AIDS services. GAPWUZ also suggested NAC should implement its programmes through employer structures in farm communities to enable farm workers to access NAC services.

It was suggested that farm worker communities should be represented in structures which implemented HIV and AIDS programmes, e.g. DAACS, WAACs and VAACs to make sure the voice of farm workers is heard and that they are included in these programmes.

It was noted Zimbabwe has a huge deficit in terms of HIV and AIDS funding. Out of about 600 000 infected with the disease, only three (3%) percent are said to be accessing ARVs in the country. The situation is worse in former large-scale commercial farms. NAC noted that in areas where there are no public health facilities, NAC identifies players already providing services in farm communities and they are provided with resources to run HIV and AIDS programmes. It was observed that there are very limited VCT facilities for farm worker communities .

The major challenge identified was how to work with highly mobile populations visa vis implementing long term programmes. The workshop was challenged to find the way

forward on the “the migrant workers” to make sure they are not left out in terms of accessing HIV and AIDS programmes.

The workshop agreed that organisations implementing HIV and AIDS programmes in farm communities should utilize the existing structures to reach vulnerable groups.

HBC kits and incentives for care givers

NAC noted that it is cheaper to procure drugs and sundries used in the HBC programme from NATPHARM. It was noted the HBC programme is difficult to implement because care givers were now traveling long distances from farm to farm as opposed to visiting one farm because farms had been sub divided. It was suggested that there was need to provide incentives to HBC care givers to encourage them to work.

8.0 Access to VCTs by former large-scale commercial farming areas and rural informal settlements- Population Services International- Mr. Roy Dhlamini

PSI new Start Network has 20 operational sites countrywide. Two sites are located directly in commercial farming areas (Triangle and Concession). Fifteen sites are involved in mobile outreach activities while 10 of these cover continuing and former large-scale commercial farming areas. About 78% of all VCT clients in Zimbabwe went through New Start Network in 2004. A total of 163 928 VCT clients were seen in 2004 including those from commercial farming areas. About 24% (39 342) of total number of clients were seen through mobile VCT outreach, a large number were said to be coming from commercial farming areas.

Challenges

Maintaining growth and quality in current operating environment was seen as one of the challenges facing PSI. Other challenges included consolidating and incorporating the VCT/PMPTC programme, staff burnout, establishment of linkages with more post test service providers on outreach, community mobilization for outreach and issuance of written results to clients tested HIV positive to improve their access to care and treatment.

Way forward on VCTs

The following were suggested by Mr. Dhlamini as PSI’s way forward on VCTs:

- Greater number of clients with continued emphasis on quality
- Greater access for clients in commercial farming , rural areas and small towns not presently served by a static VCT center
- Focus on targeting of high impact groups
- Enhance capacity of existing NS sites
- Broaden outreach activities to cover every district in Zimbabwe

- Establish linkages with PMTCT, OI, clinics, ART, TB diagnostic and treatment services
- Improve community mobilization strategies
- Facilitate the establishment of post test services in commercial farming areas where these do not exist

Discussion

A concern was raised that the information provided as the individuals personal history prior to taking the HIV/AIDS test would influence the out come of the tests. The perception of some members of the public is that once you say that you have had many sexual partners, your results will be positive. PSI explained that the questions asked about personal details are part of the risk assessment procedures to inform Health Education and counseling. The drawing of blood and testing are independent procedures that are not influenced by risk assessment verbal discussions.

Another issue brought up was that of allegations that the equipment used for testing cannot differentiate viruses such that a person who is TB + ve may be tested as +ve for HIV while they are in actual fact HIV –ve. In response, PSI indicated that Zimbabwe has one of the strictest methodologies compared to other countries. They run two different tests which give independent results. If the two tests do not agree then a tie breaker (which is a third and different test) is used.

A major area of concern was that of psychosocial support for infected or affected children under the age of 16. It was noted that current policy does not allow for children under the age of 16 to undergo HIV/AIDS tests. At present psychosocial support is targeted at those aged 16 years and above. However, it has been realized that there are some children below the age of 16 who are mature enough to go through the counseling process. As a result the policy is placing constraints on implementation as minors can not consent to testing although they would benefit from it. However the National AIDS policy is going to be reviewed during the year and some of these concerns might be addressed.

It was noted that a significant number of people are now being referred to VTC by HBC programmes especially after introduction of ART's and its publicity. A challenge has arisen in that most of those referred from HBC are not mentally alert to go through the process. It has to be recognized that VTC should be voluntary and therefore the patient and not the family should make the decision to seek voluntary testing and counseling.

9.0 ZNFPC HIV and AIDS programmes in Farm Communities- Deputy Director, ZNFPC, Mrs. Butau

Mrs. Butau pointed out her organisation did not have specific programmes in farm communities. Their services are integrated countrywide. ZNFPC is a parastatal mandated to coordinate and implement family planning (FP) programmes and related components. Its activities include procurement and distribution of contraceptives for the public sector, Provision of Family Planning services-including integration of STI/HIV and AIDS,

fertility, cervical cancer screening and PAC. ZNFPC also provides training programmes on family planning. It also produces information, education and communication (IEC) materials and carries out sexual reproductive health programmes for adolescents and youth.

ZNFPC works with other organisations in implementing its programmes, for example the depot holder programme. ZNFPC works hand in hand with FCTZ in providing depot holder training programmes Community based distributors (CBD) programmes in former large-scale commercial farms. The ZNFPC CBD programmes are also implemented in urban and communal areas.

She identified strong networks, technical competence, wide geographical spread and infrastructure as the strengths of ZNFPC. The challenges were listed as inadequate capacity to scale up the expanded CBD programme, lack of resources, funds and equipment. There are also some hard to reach areas, such as newly resettled farmers and large commercial farming areas.

The opportunities identified are strong government support, integration of Family planning and HIV, ASRH Expansion, Smart partnerships with NGOs, project- delivery of commodities to service delivery points (clinics and CBDs)

Discussion

Concern was raised on the reduction of numbers of CBD's. This was because ZNFPC has not been able to replace those that have left because of lack of funds. It takes 6 weeks to train a CBD and they are also provided with uniforms.

The question of standardized training for peer educators was discussed and it was noted that ZNFPC had produced a manual on training of peer educators. This manual can be accessed through the IEC department of the ZNFPC.

A major concern raised was the sustainability of a strategy based on the use of volunteers. It was noted that there were three categories of volunteers in the promotion of public health in the country. The village health worker/farm health worker who is the direct responsibility of MOH/CW, the HBC care giver who is the direct responsibility of NAC and the depot holder who is the direct responsibility of ZNFPC. The different incentives (or lack of incentives) offered to the different categories at times caused tension. It was noted that most volunteers want to be trained as depot holders. This is because the depot holders are paid a commission for the contraceptives they have sold and the other volunteers argue that they do same amount of work as the depot holders but are not rewarded for their services.

It was suggested that an in depth analysis of the sustainability of the volunteers commitment be carried out. However it was noted that incentive giving had its own implications in terms of resource mobilisation. There is a need to come up with a common position on voluntary workers.

10.0 GAPWUZ HIV and AIDS Programmes- GAPWUZ Secretary General Gertrude Hambira

She reiterated the point that HIV and AIDS had affected agriculture as productive age groups were hit hard by the pandemic more than any other age groups. The disease has also affected families as many workers are out of employment leaving children and other dependents to fend for themselves.

There are problems of discrimination and stigmatization as a result of HIV and AIDS. It was noted that workers suspected to be HIV positive or suffering of AIDS were at risk of having their contracts terminated, transferred harassed or treated unfairly by their superiors. They also receive the same harsh treatment from family members and community members.

Child labour, early marriages and child headed families were singled out as some of the challenges facing farm communities. These are directly linked to HIV and AIDS.

Discussion

Mrs. Hambira pointed out that the organisation mainstreamed HIV and AIDS in all its programmes i.e. the organisation distributes condoms and HIV and AIDS pamphlets from other organisations during the implementation of all its programmes.

She said GAPWUZ in conjunction with farmers representatives and the agriculture employment council were in the process of developing an HIV and AIDS Sectoral Policy (HIV and AIDS Policy for the Agriculture Sector). Three workshops have been held to discuss a draft policy document..

It was highlighted that farm workers minimum wages at \$170 000 were below the poverty datum line then at Z\$2 million and that many cannot afford basic health services. Mrs. Hambira said many farm workers were not accessing HIV and AIDS programmes including ART

11. 0 FCTZ HIV and AIDS programmes- FCTZ Health Advisor, Taurayi Malunga

FCTZ implements the HIV and AIDS programmes in four provinces in Mashonaland Central , East and West and Manicaland and in former large-scale commercial farms and rural informal settlements. The objective of the FCTZ HIV and AIDS programme is to prevent, mitigate and care for the affected and infected in FCTZ operational areas. The FCTZ HIV and AIDS programme includes the following components:

- Home based Care
- Peer Education
- Youth Drop in Centers
- HIV/AIDS mainstreaming

- Advocacy
- Condom promotion
- Promotion of VCT provision

Home Based Care

The FCTZ HBC programme seeks to care and support patients and families of those who are terminally ill. The programme focuses on training of the care givers including refresher courses, supervision and monitoring of the caregivers in conjunction with MOH&CW, provision of HBC kits and their replenishment. Training has so far taken place in Chiparahwe clinic catchments area and Glen Forest area in Goromonzi District, Kanyaga and Umboe clinic catchments areas in Makonde District and Centenary farm Health Scheme area (St Albert's area) in Muzarabani District.

Peer Education

FCTZ facilitates training of peer educators and the formation of peer groups. To date peer educators have been trained in Centenary and Bindura in Mashonaland Central; Raffingora, Banket and Makonde in Mashonaland West; Macheke, Manyame and Goromonzi in Mashonaland East and Mutare, Mutasa and Makoni in Manicaland.

The organisation also involved in social mobilization and community capacity building on HIV and AIDS issues (especially Youth Friendly Services) Community based management, socio-psycho support)

FCTZ is involved in awareness campaigns and advocacy and works closely with other organizations and government sector ministries – Education, Home Affairs, and Gender Employment Creation.

HIV and AIDS mainstreaming

There is deliberate targeting of affected/infected with HIV and AIDS e.g. targeting households with a member(s) who are terminally ill, those supporting orphans, orphan headed households as well as female headed households.

The organization also has a HIV and AIDS workplace policy for staff.

Condom promotion

This is done through partner organizations e.g. ZNFPC (depot holders), PSI (peer education) and MOHCW EPI support services.

Promotion of VCTs

This is done through:-

- depot holders referrals
- PSI mobile services referrals
- Peer educators referrals

Youth Drop in Centres

The organization is spearheading the peer education programme in Macheke (Craig Lea) and Mutasa (Nyatso in Old Mutare).

Challenges

The challenges faced are as follows:

1. Limited coverage capacity- too many districts
2. Few other players available
3. Working in commercial farms has always been a challenge, .i.e. accessing the farms remains problematic- It requires a lot of investment in time to access commercial farms

Discussion

FCTZ geographical coverage

Given the paucity of organizations working in former large scale commercial farming areas. Concerns were raised as to why FCTZ was not operational in southern provinces such as Matabeleland, Midlands and Masvingo. Participants were advised FCTZ had decided to work only in four provinces based on the farm worker population density in these areas. When FCTZ was launched in 1996, it focused specifically in large-scale commercial farming areas in one province and later moved to other provinces. FCTZ's original focus was farm workers and it chose the northern provinces because about 80% of farm workers were in the northern region.

Low uptake of condoms

Concerns were also raised as to why there was a low uptake of condoms distributed in farms- was it an issue of affordability or lack of awareness? There were suggestions that there was need to carry out research on why there was a low uptake of condoms in farms.

Food security and HIV and AIDS

It was highlighted the FCTZ Sustainable Livelihood Programme targeted households with terminally ill persons to help them achieve food security.

12.0 HIV and AIDS and vulnerable children in farms- Child Protection Society- Mr. Rueben Masarandega

Mr. Musarandega noted the following:

Dimensions of the Spread of HIV to Children

1. Internal migration which heightened in the farming areas due to the fast-track land reform exercise 2000-2002

2. Early Marriage

AIDS induced orphanhood causes economic hardships that compel children to marry early. Girls enter marriages arranged by parents as a means to secure the family economically. Early marriages frequently break up and young people remarry. This is a common HIV transmission path. There are high domestic violence risks, and sexual relationship webs (multiple sexual partnerships). Children marrying early risk marrying adults who are probably already infected.

3. Sexual Abuse

There is coercive sex with no chance to negotiate for protection

There is susceptibility to rape by close relatives because of accommodation conditions. Because of the myth of sex with a virgin as a cure for AIDS, children are sexually abused by infected people. Economic hardships (orphaned or not) are forcing some children to enter relationships with adult partners for material or financial reward, exposing themselves to sexual abuse.

More than 50% of sexual abuses culminate in HIV infection for the child.

4. Casual and Commercial Sex

Economic hardships prompted by low incomes, and orphanhood are forcing children to indulge in casual sexual relationships for material and financial gain as well as engaging in commercial sex.

The high marriage failure is causing children to grow up with single parents who sometimes are of indecent sexual behaviour. Children emulate such sexual behaviour and expose themselves to HIV at an early age. Some mothers in the commercial sex trade recruit their children to augment household income.

HIV and AIDS' Impact on Children...link with Rights

1. Multiple Bereavements

Children are robbed of the right to live in a family, right to love, right to protection from harm and abuse. Children suffer trauma and psychological effects, loss of esteem and loss of hope for the future

Children face hopelessness which leads to loss of vision and motive to develop into self-reliance. They become vulnerable to manipulation, sexual abuse and sexual exploitation. Children enter into marriage early, where they have a weak position and risk being subjected to domestic violence, multiple sexual relationships and polygamy.

2. Economic Vulnerability

There is loss of right to decent life and basic rights like food, clothing, shelter, good health, education and others. Children are dropping out of school and are being trapped in the poverty cycle. They have to rely on employment in menial jobs for survival.

They enter into sexual relationships with adults for support or become commercial sex workers. They marry early for economic security and there is high exposure to infection with HIV.

2. Right to Education

Economic hardships induced by the effect of HIV and AIDS in the household lead to failure by the family to raise school fees for children or remove the family's attention to the education of their children.

The state, through its social protection programmes should extensively subsidize education for orphaned and vulnerable children, however due to their growing number, this demand cannot be met. This year BEAM is projected to support only 25% of deserving children, up from 7 % in 2004.

Capacity of the extended family members is overstretched. Many children therefore fail to proceed with education and fall in the poverty trap, and become vulnerable to HIV.

4. Birth Registration

Due to citizenship issues, many children in farm communities do not have birth certificates. Research has revealed a non-registration rate of up to 95%. Generally non-registration of children in Zimbabwe is high, estimated at 30%. High level non-registration of children is not so much because of failure on the part of the Registrar General's office but a system that is not responsive to circumstances under which children are found nowadays.

The absence of both parents (in most cases) having died of AIDS, poor relationships between in-laws because of AIDS deaths, overwhelming number of orphans for surviving relatives are some of the factors that inhibit orphaned children from acquiring birth certificates.

A strong link between HIV and AIDS and birth registration has been observed. Without a birth certificate, a child cannot take an identity document (ID), write public examinations, open a bank account, be employed formerly, etc.

A host of other rights are denied and children are eventually trapped in the poverty cycle which causes vulnerability to HIV. In the event of sexual abuse or statutory rape, the age of the child cannot be legally determined without a birth certificate and access to justice is denied in that case.

Way forward on Children and HIV and AIDS

Mr. Musarandega made the following recommendations as the way forward on children and HIV and AIDS:

1. To redefine the value of the child at family, community and national level... and strengthen community mechanisms for child care and protection through educating families and communities about the rights of children and better quality of care for them.
2. To educate children about their rights, to prevent child sexual abuse and HIV transmission to them. The school and church should be used as platforms for that initiative.
3. To scale up interventions strengthening family and community self-support capacity, in order to minimise the impact of HIV and AIDS on children
 - Mobilising the private sector to make social investment in society for the vulnerable households
 - Setting up community structures such as day care centers for children
 - Training families and youths and assisting them to set up agro-based income-generating projects,
4. Direct assistance for children should be holistic. Rather than addressing food security alone, it is necessary to address education, health, shelter, custody, water and sanitation, and protection from sexual abuse. Resources would not permit one organisation to focus on all these areas but synergies are the solution where a team of organisations work in an area to address different needs and provide a holistic package.
5. All organisations should strive to have advocacy programmes for a multisectoral effort to promote the rights of children.
6. In advocacy, partnership with government departments should be utilised like what PSI is doing. Areas in which CSOs can support government institutions in their advocacy lobby for more resources to certain government departments through the national budget and providing baseline information to parliamentary portfolio committees.

Discussion

Commercial sex and farm children

Participants noted that children engaged on commercial sex as a survival strategy. It was also pointed out that not only girl children were prone to sexual abuse but both girl and boy children were affected.

Registration

It was suggested there was need to lobby for the reduction in requirements on birth registration to register children. It was noted many organizations such as CPS, FCTZ and UNICEF have been lobbying the relevant authorities to address the problem of birth registration and efforts continue to hit a brick wall as the Registrar's Office has been reluctant to cooperate.

Beneficiary burnout/ community and volunteer fatigue

While emphasizing the need for up to date accurate and reliable data. Concerns were raised that some NGOs faced problems of beneficiary/ community and volunteer fatigue when they carry out programme evaluation/monitoring. A shared responsibility approach was suggested- where all stakeholders would be involved in the planning and implementation of HIV and AIDS programmes.

13.0 Women, Girls and HIV and AIDS- WASN Advocacy Manager- E Gunduza

Prevalence of HIV among women and girls

The presentation highlighted the fact that women are disproportionately affected by HIV and AIDS epidemic than men due to patriarchy beliefs. In Zimbabwe, women are about 1.35 times more likely to be infected than men (MOHCW & NAC 2004). The following statistics were given:

- People living with HIV and AIDS are 1 820 000. Of this number 870 000 are women.
- In Zimbabwe, women are the hardest hit with 1 in every 3 pregnant women testing positive and it is up to 70% in some districts such as Chiredzi.
The prevalence is greater in stable relationships mainly because there is no condom use.
- In the age groups 14 -19: the infection ratio is 6 girls to 1 boy (NAC 2002). The number of girls compared to boys shows that girls become sexually active at an early age. Analysis has revealed that these girls engage in sexual activities with older men whose sexual history could be a disaster.

Zimbabwe is highly patriarchal and this forms the foundation upon which our culture is framed and this has created a system of structured inequality – gender power relations, access and control of resources and decision making. The socialization of men and women is guided by this ideology.

Factors that continue to predispose women to HIV infection.

- Patriarchy creates unequal gender power relations. Men have greater control than women over when and how sex takes place. As men usually determine the circumstances of sexual intercourse they often refuse to protect themselves and their partners. The use of condoms is limited in stable relationships. Women are

not empowered to negotiate for safe sex. The public campaigns on the use of condoms concomitant with the advent of HIV and AIDS gave the impression that condom use was for those who engaged in extra marital sex or for use by commercial sex workers. The result was that the condom use was associated with promiscuity and that stigmatized condom use in marriages. Women cannot demand that their husbands use condoms.

- There are limited female controlled devices currently available to prevent the transmission of HIV and other STIs. This disadvantages women who may want to use the condom. This asymmetrical power balance is also reflected in how male pleasure is given priority over female pleasure. In effort to please men, some women may use herbs or other agents to dry and tighten the vagina because it is believed that men prefer dry sex. The substances used may erode the vaginal mucous membranes and cause inflammation, which may facilitate HIV transmission.
- Still on the issue of power balance, the stereotypes of masculinity and what it means to be a real man encourage male dominance over women, leading to risk taking through promiscuous sex.
- Then there is the whole issue of cultural sexism that blames the spread of STIs on women (*chirwere chevakadzi*) whereas a man suffering from the same infection brags about the infection in terms of it representing a Bull's Scar of battle (*bhuru rinowonekwa nemavanga aro*)
- A culture of silence surrounds the issue of sexual abuse, makes it difficult to identify and address. Sexual abuse may be sanctioned by some cultural traditions (e.g. Muzukuru mukadzi, kutamba chiramu,
- Some cultural practices predispose women and girls to HIV infection. For example, virginity testing by the father in-law on the first night of the couple's marriage is a high risk cultural practice in some parts of Matebeleland. Wife cleansing and inheritance are equally high risk cultural practices.
- Women often have less access to information either because of lower literacy skills or insufficient time and opportunity to acquire it. The lack of useful information and alternatives to condom use that are female controlled puts women in a compromised position when it comes to HIV prevention.
- Deepening poverty and limited opportunities for education and limited access to employment and capital leave women with few options. They are often obliged to exchange sex for money. (Sugar daddies, commercial sex.)
- The importance of bearing children leads to unsafe sex. Culturally children do not belong to women so decisions on child bearing lies with the men.
- Married women find it difficult to refuse sex from their husbands because of the lobola issue.
- Women are sexually active at a young age. Gender power differential is compounded by age differences. Women typically have sex with older men. Men that increasingly seek younger women because they believe these will be free from infection are a menace. The immaturity of the genital system of young girls puts them at high risk of infection.

- Biologically women are 2 to 4 times more likely than men to be infected by the HIV virus during heterosexual intercourse without a condom. They are more exposed to the virus during sex because of the large mucousal surface in the vagina. Semen which has a higher concentration of the virus than vaginal fluids stays in the vagina a relatively long time. In addition, women are more likely to have symptomatic sexually transmitted infections. As a consequence, women may have sexually transmitted infection for a long time before receiving treatment.

Other factors that contribute to early sexual encounters for women

- Rape and coercion
- The thought of minors as “AIDS free generation”
- Curiosity
- Expression of physiological and emotional feelings which are normal
- Peer pressure

Burden of care

The burden of care squarely rests upon women. No one can dispute the fact that the HBC program has a woman's face. Male involvement is very low because HBC is unpaid work. The question is: ***who cares for unpaid work?***

Often the girl child is pulled out of school to look after a sick parent, denying the child the joy of childhood.

Discussion

Behavior change

A concern raised was that although communities were becoming more aware of the gender disparities between men, women, girls and boys with regards to HIV and AIDS nothing seemed to change. It was agreed there is need for information sharing and change of perceptions among rural and farming communities. It was suggested there was need to dialogue with community leaders and to use them as agents of change for there to be a paradigm shift from patriarchy to something that suits both men and women.

WASN and farm communities

WASN has no direct programmes in farm communities. It uses platforms such as workshops and meetings organized by partners operating in farm communities to reach farm communities.

Female condom not fully supported

It was noted the female condom which is supposed to give women control in matters to do with sex, is not popular and that not many people wanted to use it due to the following reasons:

- It was not properly marketed
- It is not readily available
- It is expensive to manufacture and therefore more expensive than the male condom
- It requires training of health workers to use the female condom
- Women do not use the female condom because they want men to be in control of the sex act
- Service providers have a negative attitude towards the female condom
- There is limited literature on female condom and plenty of it on the male condom

There were suggestions that all stakeholders should work together in promoting the female condom, in particular service providers should market it more and produce more literature to help women fight HIV and AIDS. It was noted service providers should change their attitude towards the female condom so they can market it well.

Women in farms and HIV and AIDS

It was noted women on farms were the worst affected in terms of HIV and AIDS compared to other women in urban and rural areas in Zimbabwe. Recent studies by FOST indicate that about 64% of farm worker women during a recent study tested HIV positive. Women in farms were the hardest hit because of economic vulnerability, many enter into multiple marriage like relationships as they move from farm to farm.

It was alleged that traditional dances such as “Zvigure” exposed women to multiple sex partners while practices such as “Chinamwari”- girls are forced into traditional sex rituals.

It was noted the greatest hindrance for women with regards to HIV and AIDS was socio-orientation/ culture. There were suggestions that there was need to find interventions to deal with the problem of burden of care which had become a problem for women and girls only.

14.0 How orphans are accessing HIV and AIDS programmes? FOST HIV and AIDS programmes- Mrs. Lynn Walker, FOST Executive Director

FOST is a child focused AIDS service organisation and, hence, its programmers are linked to responding to the HIV and AIDS pandemic. The organisation aims to develop a “holistic” programmatic intervention that builds the capacity of the community to respond in sustainable ways.

Situation of Orphaned and Vulnerable Children in Farm Communities

FOST defines an “orphan” as any child, below the age of 18 who has lost one or both parents. A “vulnerable” child in this context is a child who has been negatively affected by HIV and AIDS. This would include children who are living with a terminally ill

parent/caregiver or sibling, who are infected with HIV and who are living in a household which has absorbed sick or orphaned relatives.

It has been estimated that there are approximately 1.2 million orphaned children in Zimbabwe. If we assume that around 10% of all children live on existing or former commercial farms this gives us a figure of approximately 120,000 OVC in farm communities.

Research by FOST since 1995 has shown that the number of children being made vulnerable by HIV and AIDS in farm communities has increased exponentially over the past 10 years. In 1997 there was an average of 1 orphaned child per farm community. This figure had risen to over 25 by the end of 2004.

In December 2004 the proportion of children in farm schools in Manicaland and Mashonaland Central who had lost one or both parents was 27% and about one quarter of orphaned children were not attending school. It was also estimated that approximately 12% of farm households were “vulnerable” to the effects of HIV and that 13% of all OVC who started school in 2004 dropped out during the year. Many who managed to remain at school reported having their education seriously disrupted due to the impact of HIV on the household.

Main areas of impact of HIV and AIDS noted by FOST include:

- Reduction of household income because breadwinner(s) are sick
- Large proportion of household income and assets being spent on care of sick members
- Children undertaking nursing and home-based care activities
- Children/ young people needed for income generating activities and domestic duties
- Trauma caused by losing a loved one or seeing them sick
- Stigma and discrimination

How are OVCs in farm communities accessing HIV and AIDS programmes?

The community

Because of a lack of traditional structures in farm communities, high mobility, breakdown of extended family networks over many generations and isolation, children in farms do not tend to receive the same level of community-based support and care as their counterparts in rural communities and, even, in urban areas.

According to Mrs. Walker, it is humbling to note the number of community members who are prepared to become volunteers in the FOST programme despite the current economic and social difficulties being experienced is encouraging. FOST is working to build on this commitment and to enhance capacity at community level.

Access to Education

OVCs in farm communities are less likely to attend school and are vulnerable to drop out of school for a number of reasons. This is significant because school is one of the most important, if not the most important, source of information and education for children on HIV and AIDS and plays a vital role in the protection of children from abuse and exploitation. Schools also serve as effective mechanisms for the monitoring of children's welfare and identifying those at risk.

Access to health care

OVC in farm communities also experience poor access to health care. This is partly a product of poor provision within the former farming areas, but also the breakdown of the existing systems which were provided by RDCs. Vulnerable households are not in a position to afford even the smallest of user charges for health care, nor to pay the high transport costs to reach these facilities. In addition, it is very difficult for children to "self-refer" or to gain access to services for members of their household. This means that OVC in farms are less likely to access preventative services and treatment for HIV and AIDS -related illnesses for themselves or their households.

In addition, non-governmental health related programmes do not tend to incorporate farm communities which means they have less opportunity to access voluntary counseling and testing (VCT) and treatment such as ARVs and are less likely to be included in nutrition and feeding programmes.

Access to Social Welfare

Historically the level of support being given to OVC in farm communities by mainstream support mechanisms such as the Department of Social Welfare (DSW) has been low. This is due to a number of factors including difficulties in finding transport to visit the farms, lack of traditional structures in farm communities to identify and refer vulnerable children, lack of awareness in farm communities of availability of services as well as lack of capacity within the department to respond. FOST is working hard to address these issues and support the DSW in their activities.

Access to Other Agencies

Generally, AIDS service organisations have not, in the past, extended their activities to farm communities for a number of reasons. This is partly a product of their inaccessibility and also due to the inaccurate perceptions held about farm communities

In its effort to fight HIV and AIDS, FOST implements the following child centered programmes:

- Support networks in communities
- Access to education
- Home-based care (HBC)
- Development of "Kids Clubs"
- Alternative livelihood skills

- Child-Headed Households

Support networks in communities

FOST is attempting to strengthen support networks for households and children affected by HIV through the development of peer support networks. This includes working with over 350 community-based volunteers and training them in psychosocial support skills, HIV and AIDS, children's heritage, wills and inheritance, LAMA, child rights and child protection.

In addition, FOST is working closely with agencies such as the Department of Social Welfare and other sector ministries to support and enhance mainstream provision at community level. The organisation still believes that the only effective way to mitigate the effects of HIV and AIDS on children is to strengthen community capacity, both socially and economically.

Access to education

FOST is supporting access to education through the provision of block grants to farm schools in return for free education for OVC. FOST also provides basic uniform and stationery for the beneficiary children. In addition, psychosocial support awareness and training is given to teachers, SDC members and community volunteers in an attempt to create a caring and nurturing environment for all children in the farm communities.

Currently over 6000 primary school children and 500 secondary pupils are being supported in partnership with 108 farm primary schools in two provinces. Over 58% of the direct beneficiaries of the programme are girls.

Home-based care (HBC)

FOST believes that the best way to mitigate orphanhood is to keep the caregivers alive and healthy. As a result the organisation has piloted two HBC projects in farm communities in Manicaland. This has involved identifying and training over 80 HBC volunteers who now support primary caregivers in over 450 households where there is a sick person who is either bed-bound or house-bound.

In addition FOST has found the HBC programme particularly effective at identifying vulnerable children prior to their orphanhood and has incorporated PSS for children from the HBC households into the programme activities to equip them with coping skills and to build peer support mechanisms.

Development of "Kids Clubs"

FOST has developed a programme where young people aged between 16 and 24 years old are running "Kids Clubs" for younger children in their community. Currently there are over 50 "Kids Clubs" located in farm communities offering recreation, cultural and

educational activities to over 1500 children. The youth leaders have been trained in various skills and are able to support children in their community and act as a safety net for the most vulnerable children.

The young people involved in the programme are volunteers but in return for their involvement have been offered training in psychosocial support, leadership skills, HIV and AIDS, nutrition and vocational skills which will hopefully make them more employable in the future. Involvement in this programme has built their confidence, personal skills and self-esteem which, is hoped, will make them less vulnerable to the risk of HIV infection and other negative influences.

Alternative livelihood skills

There is increasing evidence that the best way to mitigate the effects of HIV on children is to focus interventions at household or community level rather than at individual children³. A FOST study of Effects of HIV and AIDS on very young children noted that by building the economic and social capacity of households, all children within the household become less vulnerable to school drop out, abuse and exploitation and at community level there is a reduction of stigma and discrimination and greater peer support.

FOST is working to develop a “livelihoods” aspect to all interventions. For example, as well as the facilitation of recreation activities in the “Kids Club” project, the youth leaders have identified people in their community who have a skill that could be used for income generation. They have then arranged for that person to share their skills with themselves and the children in the community. Skills covered to date have been:

- Raising small livestock
- Fence making
- Gardening: medicinal herbs and kitchen gardens
- Shoe repairs
- Bee-keeping: honey, wax for vaseline and shoe polish etc

FOST has supported these activities with basic inputs such as seeds and additional training and is currently developing a programme of short vocational skills training courses held in the community covering skills such as shoe repairs, radio repairs, metal work, bicycle repairs and furniture repairs.

Child-Headed Households

FOST also offers specific support to households without an adult caregiver. This involves identifying support systems within the community as well as provision of material and psychosocial support for the household members. Children from these households are prioritised for education assistance and/ or vocational and life-skills training. Currently over 50 such households are being supported.

³ FOST study of Effects of HIV and AIDS on very young children. July 2004

FOST way forward and recommendations

Farm communities, by their nature, have always been susceptible to the effects of HIV and AIDS and the recent upheavals in farm communities are affecting the ability of communities to mitigate the impact of the pandemic. As a result increasing numbers of children are becoming vulnerable. FOST believes that the most effective way to enhance community capacity to protect children from HIV and AIDS is to build community capacity, both social and economic. The development of meaningful livelihoods, keeping parents alive and healthy, enhancing psychosocial support systems and building the resilience of the children themselves are more sustainable interventions than pure material support.

Discussion

Child rights, education, livelihood, labour

Concerns were raised as to how FOST balanced between child rights to education, labour and livelihood when it engages children in its programmes. It was highlighted that the reality in farms was that most schools were far and FOST assists mainly drop out children. As concerns relating to child labour, children participate in work for them to survive and pay for school fees. As long it is not exploitative they require a livelihood for example if they are orphans they should be assisted with skills to protect them from more abuse. It was suggested that there was also need to assist children who are not at school. This means that children at all levels should be assisted.

Child decision making

It was highlighted children who participated in FOST programmes were not mere participants but are consulted and make decisions on what type of programmes they wanted implemented in their areas to address certain societal challenges, eg FOST has identified volunteer children within the communities who are trained on how to run clubs.

Openness

It was suggested there was need to come up with programmes which encouraged HIV infected person to open up to their children to assist children accept the reality of HIV and AIDS.

FOST and other organisations

It was noted FOST also works in conjunction with the Ministry of Health and Child Welfare and organisations such as UNICEF, NAC and FCTZ when it implements its programmes.

FOST grass root proposals

It was observed organisations' proposals for funding should be prepared from the grassroots level for them to be credible. For example FOST involved the grassroots when it applied for HIV and AIDS funding to NAC and proposals were accepted.

15.0 Testimonies of persons living with HIV and AIDS

Michael Machaya, Bindura

He is 29 years old and has been living with HIV since 1994. Mr. Machaya is gainfully employed in Bindura and came out open about his status. He encouraged professionals infected with HIV to be open and those who did not know their status should be tested for them to plan for their lives in an informed position. Mr. Machaya is the provincial chairperson for the Provincial AIDS Action Committee (PAAC).

He said PLWHA's faced discrimination and stigmatization for example the food rations distributed for all sick people by organisations such as the Red Cross is labeled as food for HIV and AIDS people. He urged organisations implementing HIV and AIDS programmes to involve PLWHA's to fight against the pandemic, for example the PLWHA's should be involved in implementing HBC programmes because they are more compassionate than merely trained Hob's. He said PLWHA's should also be involved at planning stages.

He appealed to those who provide food for PLWHA's to distribute prescribed food types to people with HIV and AIDS. He noted some PLWHA's received the wrong food rations.

DAAC's and WAACS

He noted that WAAC's programmes were malfunctioning in his area because of what he called "red tape" and staff shortages at DAAC level. WAAC's submitted proposals to DAAC's and no proposal had been approved. This means many infected people in his area are not benefiting from the NAC funds.

Mrs. Chipso Chibodo, Burma Valley, Mutare

She is 28 years and a widow with four children. She has been living with the HIV virus since 2003. A seasonal farm worker who earns about \$130 000 per month, said she is struggling to look after her children who are between the ages of 2 and 11 years. She appealed to well wishers to help her in cash or kind to raise her children.

Access to HIV and AIDS programmes in farms

Mrs. Chibodo has not been tested to check if her status required ARVs because there are no such services in her area.

There are many people in farming areas who are in the same situation as Mrs. Chibodo's. There is an appalling dearth of health services in commercial farms and hence the few

people who have been tested HIV positive merely become national statistics as they receive no follow up services. Many others do not know their status or are ill but cannot access health services.

16.0 Workshop recommendations

The workshop made the following recommendations:

1. Formation of an HIV and AIDS working group comprising participants who attended the workshop. The working group should do the following:
 - To come up with terms of reference for the working group
 - Identify gaps in current HIV and AIDS interventions
 - To meet quarterly to review recommendations/ progress
 - To involve both affected and infected people with HIV and AIDS
 - Working group should liaise with Ministry of Health and Child Welfare, National AIDS Council (NAC) and HOSPAZ Association (an organisation that specialises in looking after the terminally ill)
 - Working group to sensitise relevant authorities, ministries through working with NAC on the need to carry out research on HIV and AIDS in former large-scale commercial farms and informal settlements.
 - Working group to work with NAC on review of National Policy on HIV and AIDS
 - Working group to facilitate the process of post- counseling in former large-scale commercial farms and rural informal settlements
 - Identify organisations that can effectively lobby for issues identified in the recommendations
 - Share work plans and hold reviews
2. There is need to come up with a standardised Home Based Care (HBC) programme
 - This includes standardization of activities and allocation of incentives and kit
3. Lobby for the involvement of PLWAS (People Living With AIDS) in HIV and AIDS programmes
4. Come up with lobby material for birth registration.
5. Improve team work and networking
6. Publication and wide dissemination of workshop report

17.0 Closing remarks- FCTZ Director, G Magaramombe

He thanked all participants for attending the workshop. He encouraged participants to lead by example to make efforts to know their HIV status. He alluded to the fact that there were few players in farm communities and there was need for more resources to fight HIV and AIDS in these areas.

He said the formation of the WG should not be seen as duplicating already existing structures but should be used as a holistic approach by stakeholders in farm communities to fight HIV and AIDS in farm communities. He thanked FCTZ staff for organising the workshop.