DETERMINANTS OF HIV & AIDS infection among Farm Workers in Goromonzi, Zimbabwe: THE PRE-2015 PICTURE

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Dedication

This research is dedicated to my beloved husband Tegwe Soko, my brother Biggie Joe James, my young sister Susan Muzika and my children, Charlotte Soko and Tafadzwa Soko who patiently endured my absence when I was pursuing my studies.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
FAO	Food and Agriculture Organization
FCTZ	Farm Community Trust of Zimbabwe
FGD	Focus Group Discussion
FOST	Farm Orphan Support Trust
GDP	Gross Domestic Product
HIV	Human Immune Virus
IBBS	Integrated Biological and Behavioural Study
IOM	International Organisation of Migration
JICA	Japan International Cooperation Agency
KII	Key Informant Interview
MoHCW	Ministry of Health and Child Welfare
MTCT	Mother to Child Transmission
NAC	National AIDS Council
NBCSPH	National Behavioural Change Strategy for Prevention of Sexual Transmission of HIV
NCFH	National Centre for Farm Worker Health
NGO	Non-Governmental Organisation
RA	Research Assistant
SARD	Southern African Rural Development
STIs	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
ZHDR	Zimbabwe Human Development Report

Foreword

HIV&AIDS remains one of the most pressing global health challenges, significantly affecting the lives of millions worldwide. The epidemic's complex interplay with socio-economic factors, such as poverty, education, and access to healthcare, continues to shape its trajectory. The note reflects on the progress made, the ongoing challenges, and the future directions in the fight against HIV&AIDS, particularly among marginalised communities such as farm workers in Zimbabwe.

Globally, 2023 marked a critical year in the epidemiology of HIV&AIDS. An estimated 39.9 million people were living with HIV, a figure that underscores the persistent burden of the disease. In the same year, 1.3 million individuals became newly infected, highlighting the ongoing need for robust prevention strategies. The death toll from AIDS-related illnesses reached 630,000, a stark reminder of the fatal consequences of the disease when untreated. However, there were significant advancements in treatment, with 30.7 million people accessing antiretroviral therapy (ART), a lifesaving intervention that has transformed HIV from a fatal diagnosis to a manageable chronic condition.

Since the beginning of the epidemic, an estimated 88.4 million people have been infected with HIV, and 42.3 million have died from AIDS-related illnesses. These statistics reflect the scale and impact of the epidemic over the past four decades. In 2023, women and girls accounted for 44% of all new HIV infections globally, with this figure rising to 62% in sub-Saharan Africa. This region remains the hardest hit, with over 68% of the global HIV burden. Every week, 4,000 adolescent girls and young women aged 15-24 years were newly infected with HIV globally, with 3,100 of these infections occurring in sub-Saharan Africa. These figures highlight the urgent need for targeted interventions addressing the specific vulnerabilities of women and girls in this region.

In Zimbabwe, the national HIV incidence has seen a remarkable decline by over 50% in the past decade. In 2022, the incidence rate stood at 0.17%, with new infections declining across all age groups. Between 2021 and 2022, new HIV infections among adults decreased by 7%, and among children by 9%. New infections among people aged 10-19 years and 15-24 years also saw reductions of 6% and 7%, respectively. Adult HIV prevalence (ages 15-49) fell from its peak of 26.5% in 1997 to 11% in 2021. As of 2022, an estimated 1,310,438 people were living with HIV in Zimbabwe. Despite these positive trends, the prevalence remains higher among women (14.7%) compared to men (8.7%), underscoring

gender disparities in HIV burden and the need for gender-responsive interventions.

The intersection of HIV&AIDS with socio-economic factors is particularly evident in the agricultural sector, which is the backbone of Zimbabwe's economy. Agriculture not only provides food and income for most of the population but also significantly contributes to the national GDP. However, farm workers, who are essential to this sector, remain one of the most vulnerable and underserved groups. Their remote working conditions, poor access to healthcare, and high levels of poverty and illiteracy place them at increased risk of HIV infection.

Farm workers in Zimbabwe face unique challenges that exacerbate their vulnerability to HIV. They often live in isolated rural areas with limited access to health services and HIV-related information. This isolation, coupled with high mobility and migratory labour patterns, increases their risk of contracting and transmitting HIV. Moreover, socio-economic factors such as poverty, lack of education, and inadequate access to healthcare services further compound their risk.

Despite the significant contribution of the agricultural sector to Zimbabwe's economy, the impact of HIV&AIDS on this sector has been largely overlooked. The loss of agricultural productivity due to HIV-related morbidity and mortality has profound implications for food security and economic stability. Recognizing this, there has been an increased focus on the role of the agricultural sector in HIV prevention and mitigation. Policies and interventions have been scaled up to address the specific needs of farm workers, including the provision of mobile health clinics, targeted education programmes, and improved access to ART.

Efforts to curb the spread of HIV in farming communities have included the development of behavioural interventions tailored to these populations. Comprehensive sexual education, the distribution of condoms, and campaigns to reduce HIV-related stigma are crucial components of these interventions. Additionally, advances in HIV treatment, such as long-acting injectable ART and pre-exposure prophylaxis (PrEP), offer new avenues for prevention and management among high-risk groups like farm workers.

NGOs and government bodies have played a pivotal role in implementing HIV&AIDS programmes in farming communities. Overcoming challenges related to remote locations and resource limitations, these organizations have strengthened their efforts to provide essential services and support. The integration of HIV&AIDS services into broader health and development programmes has been a key strategy in reaching underserved populations.

Despite these efforts, comprehensive research on the determinants of HIV infection among farm workers in Zimbabwe remains limited. Studies have explored various aspects of HIV risk among marginalised groups, but specific research targeting farm workers is scarce. This gap underscores the need for focused research to identify the root causes of HIV infection in this community and develop targeted interventions.

The present study aims to fill this gap by exploring the determinants of HIV infection among farm workers at Rattray Arnold Research Farm in Goromonzi District. Situated 35 kilometres east of Harare, this farm represents a microcosm of the challenges faced by farm workers across the country. The study's broad objective is to assess the levels of HIV infection among farm workers, understand their knowledge, attitudes, perceptions, and sexual practices related to HIV&AIDS, and examine the impact of HIV on the agricultural sector's viability.

By employing a cross-sectional research design that triangulates both qualitative and quantitative data collection methods, the study provides a comprehensive analysis of the factors driving HIV infection among farm workers. Surveys, focus group discussions, key informant interviews, and in-depth interviews are used to gather data on various aspects of HIV risk and impact. The findings will inform policy recommendations aimed at addressing the determinants of HIV infection in this vulnerable population.

In conclusion, the fight against HIV&AIDS in Zimbabwe has made significant strides, but challenges remain, particularly among marginalised groups such as farm workers. By focusing on the specific needs and circumstances of these communities, we can develop targeted interventions that address the root causes of HIV infection and promote better health outcomes. This study represents a critical step towards understanding and mitigating the impact of HIV&AIDS among farm workers, contributing to broader efforts to combat the epidemic and improve the lives of those affected.

CHAPTER 1:
HIV&AIDS among farm workers in Zimbabwe: An Overview

INTRODUCTION

HIV&AIDS among farm workers in Zimbabwe is a serious cause for concern. Currently, HIV prevalence rate is 13.7% in Zimbabwe (Ministry of Health and Child Welfare, 2009). In Zimbabwe, very few studies have endeavoured to research on the determinants of HIV infections among farm workers. The reason could be that farm workers are a marginalised group because their living and working conditions often place them at risk (National AIDS Council, 2004). They are the most underserviced workers due to their remote location of work (Heideman, 2010). According to Heideman (2010), farm workers suffer from poor access to health care and health related information, high incidence of poverty and low levels of education, hence, the need to carry out a study of this nature. This study seeks to explore the determinants of HIV infection among farm workers at Rattray Arnold Research Farm that is situated in Goromonzi District, about 35 kilometres east of Harare.

BACKGROUND

Globally, 33.3 million individuals were estimated to be living with HIV&AIDS (UNAIDS, 2011). Sub-Saharan Africa is the hardest hit region in the world, with 1.8 million people who became newly infected with HIV in 2010 alone, bringing the total number of people living with HIV to 22.9 million in the region (UNAIDS, 2011). While the rate of new HIV infection in Sub-Saharan Africa has slowly declined, the number of people living with HIV in Sub-Saharan Africa has also declined from 24.5 million in 2006 to 22.9 million in 2010.

National surveys in Zimbabwe revealed that the prevalence of HIV declined from 25% in 2003 to 16% in 2007 (Ministry of Health and Child Welfare, 2009). Currently, adult HIV prevalence stands at 13.7%. Clearly, the foregoing statistics of the HIV situation in Africa and particularly in Zimbabwe, call for broad based interventions especially in commercial farms. Farm Community Trust of Zimbabwe (FCTZ, 2005) estimated that the spread of HIV&AIDS is 35% higher in farming and mining areas, compared to 28.1% and 20% of infected people living in towns and rural areas respectively.

Levels of HIV infection is very high among farm workers as revealed by various studies that were carried out on HIV&AIDS among farm workers globally. The National Centre for Farm Worker Health (NCFH, 2009) carried out a survey among farm workers in the United States on the prevalence rate and found out

that infection rates ranged from as low as 2.6% to as high as 13%. WHO (2005) asserts that in Zimbabwe the average HIV prevalence rate in large-scale commercial farms and mines was about 35% in 2003. The study also revealed that farm workers were perceived to be at high risk of HIV infection as they were having unprotected sex. In Zimbabwe Siziya *et al.* (1999) carried out a study in 1999 on risk awareness of HIV&AIDS among commercial farm workers. Their findings revealed that 57.6% and 64.6% of female and male respondents respectively reported that they had no chance of acquiring the HIV infection because they only had sex with their spouses.

Despite several studies on HIV&AIDS done among farm workers globally, regionally and nationally, comprehensive research about the determinants of HIV infection among farm workers is still lacking. Thus, it is against this background that the root causes of HIV infection among farm workers need to be established because most of the labour force is employed in agriculture (Rukuni, 2006). They depend on agriculture for food, income and employment. In Zimbabwe, the agricultural sector is the major contributor to the economy of Zimbabwe contributing about 18.5% of the Gross Domestic Product (GDP). It also provides over 60% of raw materials required for the manufacturing sector (Ministry of Agriculture and FAO, 2006). A FAO (2006) report, concluded that HIV&AIDS is perceived as a health sector issue alone, leaving out agriculture and other sectors. Its impact-on agriculture and food security has been neglected for many years (Ministry of Agriculture and FAO, 2006). Therefore, the potential role of the agricultural sector to assist in the prevention and mitigation of the disease is not recognised especially in farms.

The agricultural sector is the back-bone of the Zimbabwean economy. According to the World Bank Development Indicators (The World Bank Group, 2022a), the value added by agriculture, forestry, and fishing has averaged around 8.5% of the gross domestic product (GDP) over the past decade. Although the contribution of these sectors to the GDP has been declining over time, Zimbabwe possesses highly productive arable land, offering the potential to boost economic growth through agricultural production. If these resources are utilised efficiently to enhance agricultural output, it could significantly impact economic growth (Mhaka & Runganga, 2022). The economic rebound in 2021 was primarily driven by the recovery in agriculture and industry, with GDP estimated to have grown by 5.8% in 2021 after a contraction of 6.2% in 2020 (The World Bank Group, 2022b). Most of the population depends on agriculture for food, income and employment, yet the impact of HIV&AIDS on agriculture and food security have been neglected for many years. HIV&AIDS has negatively affected productivity and food security in the agricultural sector. Given that agriculture is the primary livelihood for most people affected by HIV& AIDS, and with food

security becoming an increasing concern as the impacts of the epidemic intensify, it is essential for the agricultural sector to adopt a proactive approach in addressing these challenges (Gillespie, 2006). The government and Non-Governmental Organisations (NGOs) have largely neglected the farming community with regards to HIV&AIDS as they have not implemented relevant policies and programmes that target the agricultural sector. The absence of properly enforced HIV&AIDS policy with regards to farming communities has created problems that have worsened the plight of farm workers. Furthermore, the problem of HIV&AIDS in the agricultural sector in Zimbabwe is not adequately addressed and the research done on the area of addressing the pandemic among farm workers is minimal.

Currently, efforts to address HIV&AIDS among farm workers in Zimbabwe have yielded little results as the development of behavioural interventions are lacking in farming communities (Ministry of Agriculture and FAO, 2006). Efforts to curb the spread of HIV tend to focus on urban areas leaving out the farming community. Basset & Mhloyi (1991), Mhloyi & Mhloyi (1996), Lower (1997), Mutungadura, Mukuraziva & Jackson (1999), Siziya, Rusakaniko, Tshimanga & Marufu (1999), UNESCO (1999), Chiororo, Mashu & Muhwava (2002), Wekwete & Madzinga (2006), WHO (2005), Gunda (2008) and IOM (2010) carried out studies on HIV&AIDS in Zimbabwe. Though the studies where on the determinants, they did not target the farming community. Basset & Mhloyi (1991), Mhloyi & Mhloyi (1996),) targeted the Private sector in Zimbabwe, Mutungadura *et al.* (1999) targeted rural areas in Zimbabwe and Wekwete & Madzinga (2006) targeted adolescents in Murehwa district. UNESCO (1999) and WHO (2005) targeted other aspects of HIV&AIDS. These studies were carried out in areas near urban areas, hence the need to carry out research on the determinants of HIV infection among farm workers in Rattray Arnold Research Farm in Goromonzi District.

Furthermore, there is lack of HIV&AIDS campaigns in the farming communities in Zimbabwe. NAC (2004) highlighted that it was failing to effectively implement HIV&AIDS programmes in the farming communities due to the subdivision of former large-scale commercial farms. Therefore, this study will educate the residents of Rattray Arnold Research Farm on the determinants of HIV infection and their impact to reproductive health. Conversely, carrying out research in this part of Zimbabwe will be critical in developing a starting point for planners and policy makers to map the way forward for farming communities such as Rattray Arnold Research Farm.

The broad objective is to explore the determinants of HIV infection among farmworkers at Rattray Arnold Research Farm.

Sub objectives are to:

1. Assess the levels of HIV infection among farm workers at Rattray Arnold Research Farm.
2. Assess the knowledge, attitudes, perceptions, and sexual practices on HIV&AIDS among farm workers.
3. Establish the effects of HIV&AIDS infections among farm workers on the viability of the agricultural sector.
4. Make policy recommendations on the determinants of HIV infection among farm workers.

The study was cross-sectional in nature. It triangulated both qualitative and quantitative data collection methods. Quantitative data were collected using the survey method (using a questionnaire as a tool). Questionnaires were used to quantify the magnitude of the knowledge, attitudes, perceptions and practices towards HIV&AIDS. Focus Group Discussions (FGDs), Key Informant Interviews and In-depth interviews were used to collect qualitative data.

The study consists of five chapters. Chapter One covers the introduction, background to the study, statement of the problem, justification, objectives of the study and brief methodology. Chapter two reviews literature related to the study. Chapter 3 covers the theoretical framework and the methodology. The methodology consists of the geographic location of the study, target population, research design, data collection methods, data management and data analysis. Chapter 4 covers the research findings while chapter 5 presents the summary, discussions, conclusions and recommendations of the study.

CHAPTER 2:
Perceptions, Knowledge, Attitudes, Practices among Farm Workers Regards HIV&AIDS: A Review

HIV&AIDS is predominantly a sexually transmitted disease (Barnett & White, 2006). It causes illness and death among people. The greatest people at risk are between 15 and 50 years of age and these are often described as the sexually active and most productive people in society (FAO, 2006). This section reviews literature concerning levels of HIV infection, knowledge, perceptions, attitudes, practices among farm workers, and the impact of HIV&AIDS has on the agricultural sector.

Globally, it is estimated that 33.3 million people were living with HIV&AIDS in 2009 (UNAIDS, 2011). Approximately, 2.6 million new HIV infections occur each year (UNAIDS, 2011) (Table 2.1.1). A cumulative total of 1.8 million people has died from AIDS between 2001 and 2009 (UNAIDS, 2011) (Table 2.1.1). Worldwide, the HIV adult prevalence rate (15-49) is 0.8% (UNAIDS, 2011) (Table 2.1.1). However, the global estimates given are not sector specific. They are general estimates that do not specify estimates for people living with HIV&AIDS in farm communities globally.

Table 2.1.1: Global HIV&AIDS Estimates, end of 2009 (*UNAIDS Report, 2011)*

	Estimate	Range
People living with HIV&AIDS in 2009	33.3 million	31.4-35.3 million
Adults living with HIV and IDS in 2009	30.8 million	29.2-32.6 million
Women living with HIV&AIDS in 2009	15.9 million	14.8-17.2 million
Children living with HIV&AIDS in 2009	2.5 million	1.6-3.4 million
People newly infected with HIV in 2009	2.6 million	2.3-2.8 million
Adults newly infected with HIV in 2009	2.2 million	2.0-2.4 million
AIDS deaths in 2009	1.8 million	1.6-2.1 million
Orphans (0-17) due to AIDS in 2009	16.6 million	14.4-18.8 million
Prevalence rate in 2009	0.8	0.7-0.8

The epidemic in Sub-Saharan Africa varies considerably with Southern Africa still being the most severely affected by HIV&AIDS (Table 2.2.1) (UNAIDS, 2011). About 68% of people living with HIV are found in sub-Saharan Africa, a region with only 12% of the global population (UNAIDS, 2011). People living with HIV&AIDS in Sub-Saharan Africa in 2009 were 22.5 million while newly infected people were 1.8 million (Table 2.2.1). People living with HIV in the Southern

Africa in 2009 were nearly a third of the global total. People who died of HIV illness in Sub-Saharan Africa in 2010 comprised 72% of the global total of 1.8 million (UNAIDS, 2011). Prevalence varies widely by regions, with the highest levels in Sub-Saharan region of 5.0% and lowest levels in East Asia of 0.1% (Table 2.2.1). However, Sub-Saharan region carries the greatest burden of the global HIV epidemic. Although there was a notable decline in the regional rate of new infections, the epidemic continues to be most severe in Southern Africa. Almost half of the deaths from AIDS-related illness in 2010 occurred in Southern Africa. Epidemics in Asia have remained relatively stable and are still largely concentrated among high-risk groups such as sex workers, drug abusers and to a lesser extent men who have sex with men. Conversely, the number of people living with HIV in Eastern and Central Asia has almost tripled since 2000 from 760 000 to 1.4 million (UNAIDS, 2011) (Table 2.2.1). The regional overview shows the general HIV&AIDS estimates for 2009 regionally. However, the estimates are not sector specific. Thus, they do not specify the regional agricultural estimates.

Table 2.2.1 Regional HIV&AIDS estimates, end of 2009 (*UNAIDS Report, 2011)*

Region	Adults & children living with HIV&AIDS	Adults & children newly infected	Adult prevalence*	AIDS-related deaths in adults & children
Sub-Saharan Africa	22.5 million	1.8 million	5.0%	1.3 million
North Africa & Middle East	460,000	75,000	0.2%	24,000
South and South-East Asia	4.1 million	270,000	0.3%	260,000
East Asia	770,000	82,000	<0.1%	36,000
Oceania	57,000	4,500	0.3%	1,400
Central & South America	1.4 million	92,000	0.5%	58,000
Caribbean	240,000	17,000	1.0%	12,000
Eastern Europe & Central Asia	1.4 million	130,000	0.8%	76,000
North America	1.5 million	70,000	0.5%	26,000
Western & Central Europe	820,000	31,000	0.2%	8,500
Global Total	**33.3 million**	**2.6 million**	**0.8%**	**1.8 million**

For the past two decades, FAO (1995; 2002; 2006), IOM (2010) and SAFAIDS (2000) carried out studies on HIV&AIDS regionally. The studies concentrated on the need to reduce the spread of HIV, the prevalence of HIV&AIDS, impact of

HIV&AIDS and vulnerability to HIV&AIDS. It should be argued that very few studies have concentrated on the factors underlying to HIV&AIDS transmission among farm workers, hence, scarcity of data on the levels of HIV infection among farm workers. There is also limited understanding on the dynamics of the HIV&AIDS in the agricultural sector, hence, the need to carry out a study of this nature.

The first case of HIV&AIDS was positively identified in Zimbabwe in 1985. While Zimbabwe has experienced some of the highest levels of HIV infection rates, prevalence rates have been declining. Downward trends were witnessed from 24.6% in 2004 among adults aged 15-49 years to 20.1% in 2005, 15.3%% in 2007 and further to 13.6 in 2010 (USAID, 2010) (Figure 2.1). The decline in the prevalence rate is attributed to many factors among them being the increase in condom use and reduction of sexual partners (Zimbabwe HIV&AIDS Estimates, 2010; UNAIDS, 2011; USAID, 2010). Although the incidence rates have declined, Zimbabwe still needs to continue reducing the prevalence rate (Zimbabwe HIV&AIDS Estimates, 2010).

Given that Zimbabwe has a young population where most of the people are sexually active and where homosexuality is culturally prohibited, heterosexual intercourse which accounts for 92%, becomes the likely mode of HIV transmission (MoHCW, 2005; NAC, 2005; UNAIDS, 2010). Perinatal transmission accounts for 7% of all infections and the remaining 1% constitutes other modes of transmission.

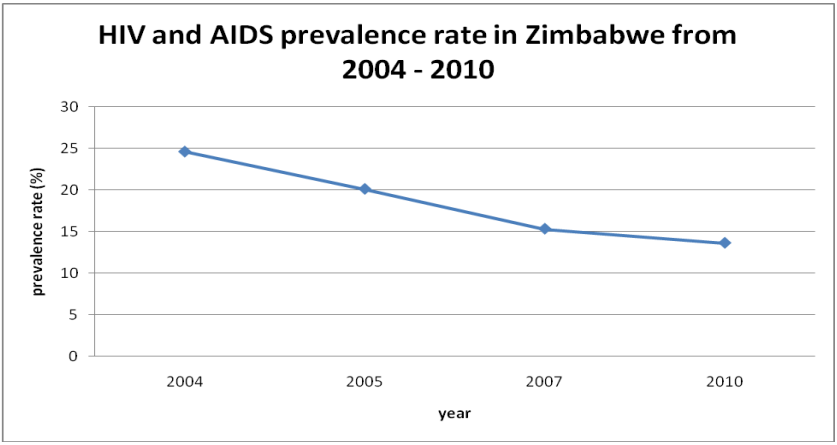


Figure 2.1: The Decline in HIV&AIDS Prevalence in Zimbabwe (*USAID 2010)*

WHO (2005), NAC (2005), FCTZ (2005) and IOM (2010) assert that the most severely affected areas (with average HIV prevalence of about 35%) are large-scale commercial farms and mines. The HIV prevalence rate (35%) shows that levels of HIV infection is very high in farms and mines compared to 28.1% and 20.9% of people living in towns and rural areas respectively (FCTZ, 2005). Research by IOM carried out in 2010 at Hippo Valley Estates revealed a prevalence rate of 35% among Hippo Valley Estate farm workers. Conversely, NAC (2005) carried out a National HIV survey among Antenatal Clinic attendees aged 15-24 and found out that HIV prevalence varies geographically (Figure 2. 2). The survey showed that the prevalence was high (50.5%) in commercial farms and mining, followed by border post (45.7%), growth points (38.7%), urban (27%) and rural areas (26.1%). The prevalence in commercial farms of female ANC attendees aged 15-24 declined, from a highest level of 50.5% in 2000 to 22% in 2007 (Ministry of Health and Child Welfare Zimbabwe, 2007). WHO (2005) asserts that, the high prevalence rate among farm workers was mainly because these are the areas that best illustrate development vulnerabilities in the population. Compared to cities and other urban centres, these areas do not receive adequate financial attention from the government hence they are always lagging recreationally, economically and industrially.

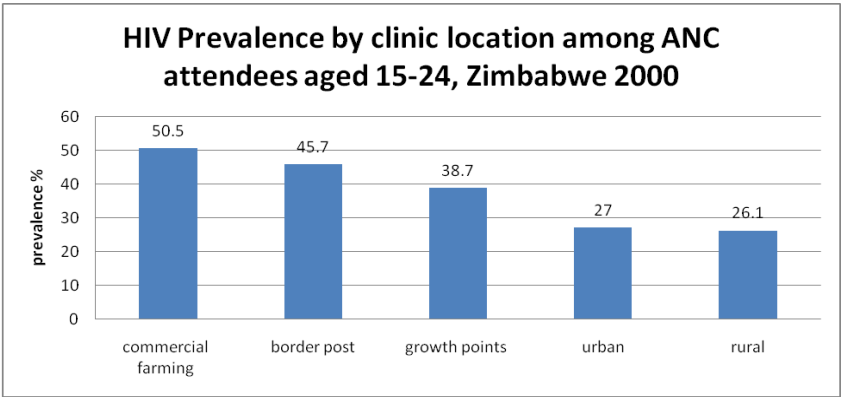


Figure 2.2: HIV Prevalence by clinic location among attendees aged 15-24 *(NAC Report, 2005)*

Knowledge about HIV&AIDS is universal. Globally, about 60% of both young men and women have comprehensive and correct knowledge about HIV&AIDS (UNAIDS, 2010). Although HIV prevention programmes have improved HIV knowledge and awareness around the globe, many new infections occur daily (UNAIDS, 2006; 2007; 2008; 2010). Globally, approximately 2.6 million people were newly infected in 2009 (UNAIDS, 2010).

As part of the effort to assess HIV&AIDS knowledge in Zimbabwe, ZDHS (2005/6) found out that knowledge levels of HIV&AIDS were very high (98%) for women and 99% for men. Mhloyi & Mhloyi (1996) carried out a baseline survey on KABP among Triangle Limited workers in Zimbabwe and found out that knowledge of HIV&AIDS was very high (85%).

The association between perception of risk of HIV infection and sexual behaviour remains poorly understood, even though perception of risk is the first stage towards behavioural change. A study by NCFH in Washington in 2003, revealed a negative attitude and perceptions towards HIV&AIDS among farm workers. Approximately 32% of respondents believed AIDS can be spread through kissing. About 15% of respondents reported that HIV&AIDS can be transmitted through bathing in the same shower while about 22% reported using the same eating utensils with someone with AIDS. Again, 11% reported that HIV can be transmitted through mosquito bites. About 28% of respondents reported that sharing of toothbrushes transmits HIV&AIDS while 9% reported having poor hygiene (NCFH, 2009).

A study by Mhloyi & Mhloyi (1996) among Triangle Limited workers in Zimbabwe revealed that risk perception was somewhat low. Approximately 40% of adults, 32% of youth and 76% of commercial sex workers perceived themselves at risk of HIV infection. Thus, these beliefs exacerbate the spread of HIV&AIDS because people may see the use of condoms as futile. Condom use is seen by men as rather disruptive to the natural flow of events in sex and intimacy (Chiororo *et al.*, 2002; SARD, 2006; Gunda, 2008 and IOM, 2010).

Research by NCFH (2009) in South Florida with regards to attitudes toward control measures against HIV&AIDS infection revealed that men have got a negative attitude towards condom use. Approximately, 85% reported that condom use diminishes sexual sensation, hence, the reason for not using them. Research by Chiororo *et al.* (2002) in Zimbabwe revealed that men do not perceive sex as an expression of love and intimacy between equal partners in a relationship but as an activity that should result in optimal sexual satisfaction for the man. As such, they engage in having unprotected sex. Therefore, according to Chiororo *et al.* (2002), there was a negative attitude towards condom use among men and male youths in Zimbabwe. Approximately, 90% of men and male youths reported that condoms are infected with diseases including HIV virus while 75% of men in rural areas believe that they can tell whether a woman they are about to sleep with is HIV positive or not, just by looking at her. If they conclude that she is healthy, most men and male youths would not use a condom because it diminishes sexual sensation and deprives men of sexual satisfaction, therefore, they are not comfortable in using them. Research by

Gunda (2008) revealed that, men need to enjoy unprotected sex with their wives and decent partners, hence, rejection of condom use in marriages.

Misconceptions were also noted during the study that condoms are only used with mistrusted new partners. Research by NBCSP (2006) revealed that condom use with casual partners in Zimbabwe is relatively high, but it is partially inconsistent. Condom use in longer-term and marital relationships remains low even though most couples do not know their HIV status, and unfaithfulness within marriages was reportedly high. Studies by Chikovore & Mbizvo (1997) revealed that 62% of commercial farm residents in Zimbabwe viewed condom use in marriage as totally unacceptable because it is associated with infidelity. Thus, women reportedly said "am I a prostitute?"

Culturally, women are unable to negotiate safer sexual relations, including condom use as well as refuse male demands for sexual intercourse. Barnet & White (2006) found out that women find it difficult for them to initiate or introduce contraception in their relationships as it was bound to raise a lot of questions including mistrust and one's morale standing in society. Research by Gunda (2008) revealed that 85% of women in farms were finding it difficult to refuse sex without protection in their sexual relations as they fear risk of losing their partners. Again, ZDHS (2005/6) reported that the extent women have over when and with whom they have sex has important implications on HIV&AIDS transmission.

The period between age at first sex and age at marriage are often of experimentation. ZDHS (2006) revealed that 4.9% and 5.2% young female and young male, respectively, had sex before age 15. According to the Global Health Council (2010), the early age at first sexual intercourse is associated with high propensity to HIV infection because their reproductive canal is not fully developed. This period is also associated with a higher propensity to contract HIV&AIDS infection and early pregnancies.

Meier& Allen (2008) defines premarital sex as any sexual activity practiced by persons prior to marrying each other. SARD (2006) and Farm Worker Justice (2009) assert that premarital sex is common among farm workers due to poverty which increases their vulnerability to HIV&AIDS infection. Barnet & White (2006) and Global Health Council (2010) propounded that premarital sex among girls predisposes the girl child to reproductive health problems such as birth complications.

SARD (2006) defines transactional sex as sex that involves non-marital sexual relationship in which a man provides cash, gifts or favours in exchange for sex.

For women such relationships are ways to survive in difficult circumstances. Farm workers, both males and females, engage in transactional sex (IOM, 2010; JICA, 2004). From the study that was carried out by IOM in 2010, 52% of women reported exchanging goods for sex with sugar daddies while being in a steadily relationship with a boyfriend. A total of 13% of male workers reported having offered gifts in exchange for sex with women. Farm girls and women gave themselves for simple things such as chicken feet and offals due to poverty (Ziningi, 2009). The transactional nature of the sexual relationships that often seem to develop in the farm setting reveals high dependency among female workers. Thus, they use transactional sex for their subsistence and that of their children, a structural powerlessness which makes female workers more vulnerable to HIV infection.

Poverty contributes to epidemic disease and epidemic disease contributes to poverty. According to Global Health (2010) the causation is bi-directional and occurs through many different pathways. According to ARASA (2008), poverty increases the risk vulnerability of HIV infection in farming communities as girls and women will be looking for survival. This leads women into transactional and intergenerational sex (Barnett, 2006; SARD, 2006). This further broadens sexual networks in farms and inter-infections are easily spread due to poverty (Ziningi, 2009).

FAO (2006) and ZHDR (2003) asserts that intergenerational sexual relations are common among young women than they are among young men. Young women argue that 'sugar daddies' provide material needs whilst young men are potential husbands in marriage. ZDHS (2005/6) further propounded that if a younger uninfected partner has sex with an older, infected partner, this means that the virus is introduced into a younger uninfected cohort. The young cohort cannot negotiate for safer sex.

MoHCW (2004, 2007) asserts that multiple sexual partnerships, especially those that occur concurrently in a person's life, contribute greatly to the spread of HIV&AIDS. An increase in the number of sexual partners greatly increases the probability that one will become infected by sexually transmitted diseases and HIV infection. According to MoHCW (2004; 2007), people with multiple sexual partners have a high risk of HIV infection. Ziningi (2009) asserts that, in farms, sexual networks which promote inter-infections are very broad. In most societies, sexual masculinity is expressed in virility. Thus, the virility of a man is proved by having many sexual partners. This however increases the vulnerability of both men and women to HIV infection (Farm Worker Justice, 2009). The ideologies of masculinity and femininity may help to shape an individual's sexual behaviour.

Polygamous behaviour has been considered one of the major factors promoting the spread of HIV in Africa, where the highest rates of HIV infection often are found in areas with high rates of polygamy Reniers & Watkins (2010). ZDHS (2006) states that 11% percent of women in Zimbabwe are in polygamous unions. According to ZDHS (2006), the proportion of women in polygamous unions increases with age, and rural women are almost three times as likely as urban women to be in a polygamous relationship (15% compared with 5%, respectively).

Condom use is one of the main strategies for combating the spread of HIV. Low condom use has huge implications for the prevention of HIV among farm workers and the use differs basing on whether the person is the primary or occasional sex partner (SARD, 2006). With occasional sex partners, male farm workers use condoms slightly over half of the time, and it is also linked to whether they have a condom with them and how confident they feel in negotiating the use of protection. When it comes to primary sex partners, the situation is different because approximately about 20% of farm workers use condoms with their primary sex partners and usage is dictated by social norms (SARD, 2006). Lack of condom use therefore increases rates of HIV infection among farm workers. Gunda (2008) asserts that, farm workers have a very inconsistent condom use especially with regular partner. Furthermore, condom use among farm workers was affected by myths and misconceptions. According to Gunda (2008), men reportedly said that "condoms were too small as African men are known to have big sexual organs that cannot fit in the condoms."

Even if farm workers can recognise their health problems, make decisions to seek care, but still some obstacles remain to obtaining good quality health care. These obstacles relate to availability, accessibility and affordability of HIV&AIDS services. SARPN (2008) asserts that access to health and care facilities in commercial farming areas is very poor and becoming more difficult for farm workers and their children. USAID (2010) asserts that Health institutions in most developing countries have deteriorated because of economic meltdown. This has resulted in health services crumbling down. Zimbabwe's public health system has been declining since 2000 (USAID, 2010). SARPN (2008) found out that farm clinics provide primary care which only attends to minor ailments. More complicated cases that need further management are referred to general or mission hospitals which are far away from the farms *(ibid)*. According to Heidman (2010) the transport service between the health centres from a clinic to general hospital in the farming community is very poor.

Correct information on HIV testing procedures, availability of ARVs for HIV positive farm workers are vital for farm workers to make informed decisions.

However, these services are not readily available in farms. Where available, the health centre will be manned by staff who are pressurised and demotivated (USAID, 2010). The geographic location of farm communities hinders availability and accessibility of HIV&AIDS services. Thus, NAC (2005) stated that the nature of farm communities makes it difficult for NAC to effectively plan and implement its programmes in large-scale commercial farms. According to NAC (2005), there has been a rise in the number of terminally ill people in farms who need services and facilities. Furthermore, 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 in urban areas of in communal areas. According to SARD (2006), the farm dichotomy typical of southern African countries impacts negatively on accessibility of services which is generally biased towards urban areas. USAID (2010) propounded that economic problems and political instability that occurred since 2000 in Zimbabwe have incapacitated the health sector to provide quality services.

The commercial agriculture sector is highly dependent on human labour that is undermined by morbidity and mortality associated with HIV infection (FAO, 2006). Morbidity and mortality effects of HIV infection are not systematically documented on many commercial farms. Therefore, many myths about the disease go unchallenged (Gunda, 2008; IOM, 2010). Although farm labourers are easy to replace, HIV&AIDS affect production as well as the balance of labour available. AIDS-related morbidity and mortality affect productivity in the commercial agriculture due to absenteesim, loss of skills and decline in available labour (Figure 2.7.1) Barnet & White (2006) stated that some people might not be absent but they are unproductive while they are at work due to morbidity. In a study that was carried out in Kenya, one of the farm owners attributed failure to meet production targets due to AIDS morbidity and 75% of lost labour was due to illness attributed to AIDS (FAO, 2006). Rugalema *et al.* (1999) asserts that frequent illness and deaths due to HIV&AIDS creates adverse financial and psychological effects on the workforce. This negatively affects motivation and labour productivity. Furthermore, among the 25 farms that were surveyed in Swaziland, more than half reported that AIDS was the leading factor that was affecting production (FAO, 2006). Therefore, the impact of the pandemic on agriculture compromises the quantity and quality of labour through incapacitation and deaths.

Productivity in the agricultural sector is undermined by lost labour and time due to HIV&AIDS morbidity and mortality. Illness compromises productivity by reducing on-the-job performance because of physical, physiological and phsychological factors associated with HIV (Figure 2.7.1). The Centre for International Health and Development (2006), carried out a study in Zambia and

found out that the average reduction in on the job performance was associated with HIV, with 27% of workers being infected. Apart from affecting on the job performance, HIV infection impacts negatively on the quality of the labour force resulting in low production (see Figure 2.7.1). Conversely, employees may force themselves to come to work because they fear loosing their job but due to ill-health, their performance is reduced. This results in low production and further leads to loss of revenue (Figure 2.7.1). Consistently, employees who retire on medical grounds or who die must be replaced and their replacements may be less skilled and experienced, therefore require training. According to Barnet & White (2006) recruitment and training of workers incur extra cost for an organisation which might also lead to potential collapse of the entire business (Figure 2.7.1). Again, as skilled workers become scarcer, wage rates may increase, as a result, the business environment may change with investors being reluctant to commit funds if they suspect that AIDS will compromise their investments and returns (Figure 2.7.1).

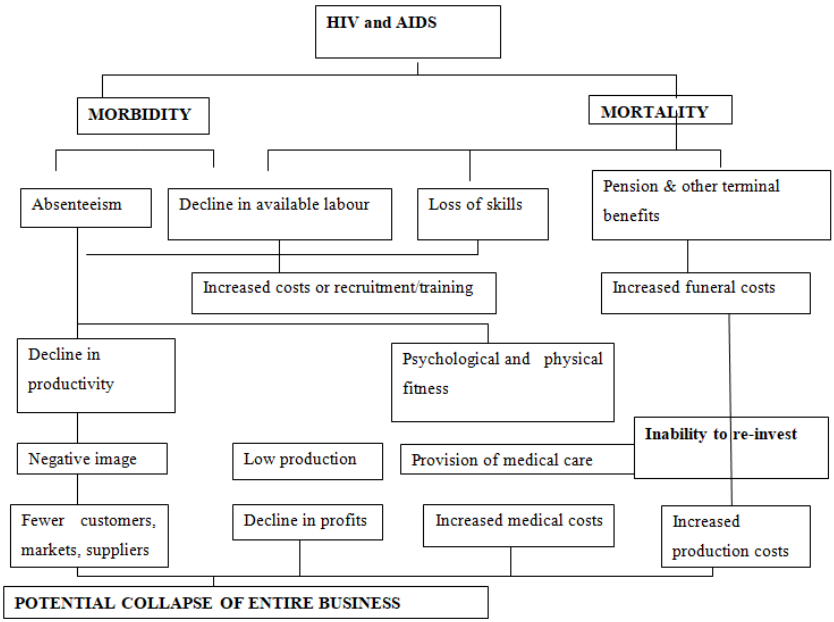


Figure 2.7.1: Overview of the main aspects of HIV&AIDS on commercial agriculture *((*Rugalema *et al., 1999) in FAO, 2006)*

FAO noted that the number of hours per week in agriculture fell from 33.6 hours in non-afflicted households to between 11 and 16 hours in afflicted households. According to Barnet & White (2006), a study of African enterprises found out

that HIV-related absenteeism accounted for 37% of increased labour cost and AIDS absenteeism accounted for a further 15% while funeral attendance and burial accounted for 6% and 16%, respectively (Figure 2.7.2 below). The reduction in labour supply due to funeral attendance and burial at crucial periods of planting and harvesting could significantly reduce the size of the harvest, therefore, affecting food production.

Rugalema *et al.* (1999); FAO, (1999); FAO, (2004); FAO, (2006), studies that were carried out in Kenya, revealed that prolonged AIDS-related morbidity and mortality in the workforce was forcing commercial farms to allocate additional resources for medical care and funerals. Farms in Swaziland attributed increased costs of production to rising healthcare costs largely associated with HIV, in addition to funeral costs and early retirement on medical grounds (Muwanga, 2002; FAO, 2006).

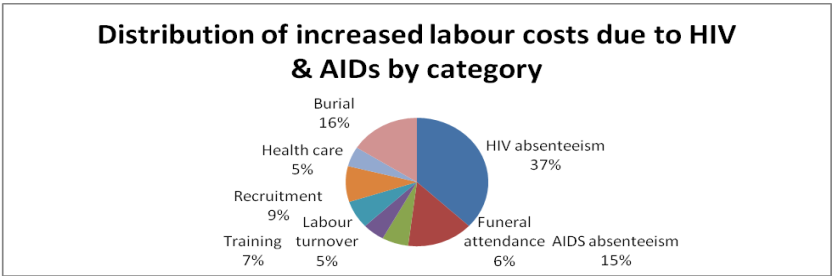


Figure 2.7.2: Percentage Distribution of increased labour costs due to HIV&AIDS *(Barnett & White, 2006)*

The most disastrous effect of HIV&AIDS on the agricultural community is a direct attack on food production as the infected and affected will completely abandon agricultural life (Goma, 1998; Neema, 1998; FAO, 2005). As a result, agricultural production would suffer losses because the infected and affected will be searching for treatment of opportunistic infections. For example, a survey that was carried out by Kwaramba (1997) in Zimbabwe revealed that agricultural output declined by nearly 50% in the households affected by AIDS. FAO (2006) asserts that in Sub-Saharan Africa, crop yields have declined significantly, partly due to AIDS. Although Zimbabwe is yet to conduct a comprehensive study on the impact of HIV&AIDS on the agricultural sector, findings from Gunda (2008)'s case studies on farms show that the pandemic remains an enormous challenge particularly on commercial farms. Kwaramba (1998), Neema (1998), Goma (1998), and SARD (2006) further propounded that the deterioration of agricultural output due to AIDS implies serious deterioration of household food security. Therefore, people may suffer from food deficiency, leading to malnutrition on both the affected and infected.

Basset & Mhloyi (1991), FAO (1995), Ncube (1998), and FAO (2006), highlighted their concerns about HIV&AIDS and women in Zimbabwe, as the epidemic is reportedly taking a heavier toll on women who are involved in care-giving, production of food and general household decision making and planning. According to Ncube (1998) and FAO (2006), women are the most affected because of the triple role they play in society which includes looking after the sick, dead before they are buried and caring for the family.

HIV&AIDS also have a negative impact on farm children especially when their parents die due to HIV&AIDS for they are left vulnerable to the pandemic. They may be forced to leave the farms and either re-join the ranks of destitute rural poor or live on the streets in urban areas. On the other hand, if they are allowed to remain on the farm, they may be at risk of exploitation as cheap farm labourers. Furthermore, the children may face sexual abuse and exploitation by other families within the farm compound (Barnet & White, 2006). A study by Gunda (2008) concluded that there are a lot of girls and women in farm operations who are being abused by the systems.

The conceptual framework shows factors underlying HIV infection among farm workers. It is important to understand the context of risk perception in relation to sexual behaviour because it is the first stage towards behavioural change from risk-taking to safer sex. It is assumed that people will respond to risk in a way that reflects their HIV&AIDS awareness levels. Thus, this assumption relies heavily on the Health Belief Model (HBM). To better understand the factors underlying HIV infection among farm workers, the HBM was adapted. This model was first postulated by Rosenstock in 1974.

Health Belief Model is a model for individual health that attempts to explain the thought processes behind individuals' decisions related to health behaviour change and maintenance. It also acts as a guiding framework for health behaviour interventions. The model suggests that individuals determine the feasibility benefits and costs related to an intervention or behaviour change based on the six constructs. These constructs are perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self-efficacy (Figure 3.1).

Perceived susceptibility are beliefs about the likelihood of getting a disease or a condition. It is assumed that women believe they are at low risk of acquiring HIV because they are in a monogamous relationship, therefore, they neglect condom use with their partners. This means that women will not change their health behaviour unless they believe that they are at risk.

Perceived severity is one's opinion of how serious a condition and its consequences are. For example, young girls can engage in unprotected sex with

their boyfriends because of trust thinking that having unprotected sex has no problem. This means that young girls will not realize the consequence or seriousness of having unprotected sex because they trust their boyfriends.

Perceived benefits are beliefs that a certain action will reduce risk or seriousness of impact. Thus, men who have HIV infection may be sceptical that Antiretroviral (ART) treatment and behaviour change will actually have any long-term impact on their health. This belief can affect behaviour change. Perceived benefits play an important role in the adoption of secondary prevention behaviours, such as HIV testing and counselling.

Since change is not something that comes easily to most people, the HBM addresses the issue of perceived barriers to change. This is an individual's own evaluation of the obstacles in the way of him or her adopting a new behaviour. Janz & Becker (1984) assert that perceived barriers are the most significant in determining behaviour change. For a new behaviour to be adopted, a person needs to believe the benefits of the new behaviour outweigh the consequences of continuing the old behaviour. This enables barriers to be overcome and the new behaviour to be adopted. For example, a commercial sex worker would like to remain HIV negative by having protected sex but thinks that she will lose out business when she initiates condom use. In this scenario, fear of losing out business is the barrier to condom use.

The HBM also suggests that behaviour is also influenced by cues. Cues to action are events, people or things that move people to change their behaviour. For example, media reports, campaigns and advice from other people or peer educators. Hearing TV or radio news stories about HIV&AIDS are cues to action associated with safer sexual practices. Self-efficacy are beliefs in one's ability to take action to produce desired outcomes. People generally do not try to do something new unless they think they can do it. For example, if someone believes that a new behaviour is useful (perceived benefit), but does not think he or she is capable of doing it (perceived barrier), chances are that it will not be tried. For example, women may want to have sex but due to poverty, they may lack skills to negotiate for condom use. According to the HBM, modifying variables, cues to action and self-efficacy affect our perception of susceptibility, seriousness, benefits and barriers and therefore our behaviour (Figure 3.1).

The HBM framework assumes that the background variables operate through a range of proximate variables to influence perception of risk and sexual behaviour. These factors may be socio-demographic, for example, marital status, levels of education, religion, ethnicity and gender. The proximate variables may be access to information, early sexual debut, multiple concurrent sexual partners,

transactional sex and intergenerational sex. However, these two variables (background and proximate/intermediate) are discussed below.

The age of a person is another factor that may influence sexual behaviour and the level of perceived risk to HIV infection. Young girls and boys (adolescents) are at an increased risk of HIV infection because they often engage in unprotected sexual intercourse because they do not perceive their risk to be high. It is assumed that sexual intercourse at an early age is associated with a long period of exposure to sexual activity.

Marital status influences perception of the risk of HIV infection and sexual behaviour. Non-married women may have the ability to negotiate safer sex, but married women face extra challenges because of fear of being suspected of promiscuity by their spouses. This may lead to unwanted consequences such as separation or divorce. Often, married women acquiesce on unsafe sexual practices, even if they suspect or know of their partner's extramarital relations. Although HIV cannot be spread through sexual intercourse in stable monogamous relationships between uninfected partners, among married women the presence and nature of their partners' casual or extramarital sexual practices largely determine the risk of HIV transmission.

Educational level may influence perception of HIV risk and sexual behaviour. It is assumed that a higher level of education increases contraceptive use. It is hypothesized that education equips one with knowledge on HIV due to exposure to AIDS information through mass media. Furthermore, education breaks down cultural practices that perpetuate HIV infection, such as polygamy. Polygamy promotes multiple concurrent partnering which increases one's chances of contracting HIV&AIDS.

Religion perpetuates HIV&AIDS because it can influence intermediate variables such as the age at first sexual encounter, marital status and access to information and services. It is assumed that some churches which encourage polygamy approves multiple partnering which result in exposure to HIV. Religion can also influence people's attitudes and perception of risk to HIV infection. It is assumed that some religions believe that AIDS is a disease that affects those who transgress against God. Consequently, those who are religious perceived their risk of HIV infection to be low. Religion can also work to influence community practices and national policies. It is hypothesized that AIDS programmes might face opposition or resistance from religious leaders at the onset particularly on the issue of introducing sex education in schools and condom use. This can be mistaken as encouraging promiscuity among school children.

Ethnicity may influence sexual behaviour through cultural beliefs and practices. It is assumed that the practice of levirate, where a dead man's widow is remarried to one of his brothers, is still practiced in some areas in Zimbabwe despite the high prevalence of HIV. Thus, the pressure to conform to cultural beliefs and practices may override concerns about HIV infection. Another risky sexual practice is that of wife sharing among farm workers. FOST (2005) asserts that, farm women move from farm to farm in search of men.

The impact of HIV&AIDS differs markedly along gender lines. Women's and men's roles put women at greater risk of HIV infection. Gender roles place women in subordinate positions. It is assumed that men have stronger sexual drives than women, and men cannot survive without sex. These assumptions exacerbate the spread of sexually transmitted diseases, including HIV. Furthermore, women are 2-4 times more likely than men to become infected with HIV after having intercourse with an infected partner due to physio-biological differences and their low socio-economic position. Due to economic power, men can have many wives. As a result, women are easily infected with HIV because they do not have the power to negotiate for safer sex. It is assumed that, culturally, women have no right to initiate condom use because condomised sex is associated with prostitutes. However, lack of power to negotiate safer sex among women is assumed to be perceived susceptibility.

There is also culture of silence on sexual matters among women. This assumption contributes significantly to women's inability to negotiate when, where and how sexual intercourse takes place. Figure 3.1, captures in a schematic diagram the Health Belief Model.

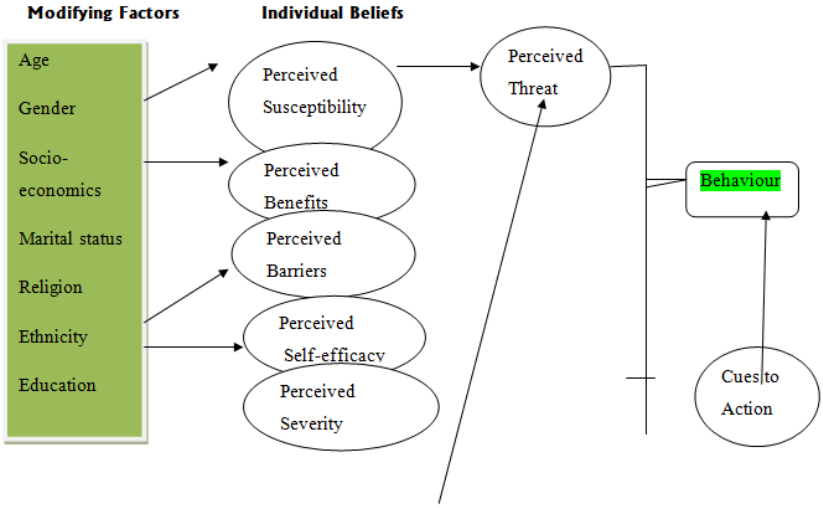


Figure 3.1: The Health Belief Model (*Champion & Skinner, in Glanz et al., 2008).*

HIV&AIDS remains a major health issue, especially among sexually active and productive individuals such as farm workers. Factors like limited access to healthcare, education, and awareness contribute to their heightened risk. The impact of HIV&AIDS extends to reduced productivity and economic stability within the agricultural sector. Using the adapted Health Belief Model (HBM) helps understand and address this risk by focusing on perceptions and attitudes towards sexual behaviour. The HBM's constructs, perceived susceptibility, severity, benefits, barriers, cues to action, and self-efficacy, can guide targeted interventions to improve awareness, reduce barriers, and promote safer sex practices among farm workers, ultimately enhancing their health outcomes and productivity.

CHAPTER 3:
Study Design and Methodology

The methodology section outlines a description of how the research was conducted. The important components of the research methodology included in this study are research design, study population, sampling procedures, data collection procedure and analysis.

The survey was carried out at Rattray Arnold Research Farm, situated in Goromonzi District, about (35) kilometres east of Harare. The study area was purposively selected because there are poor housing conditions at the farm, for instance, a 3 roomed house is normally occupied by two families, each with an average of four children. The farm is densely populated, and the nearest clinic is 22km away from the farm. However, it is hypothesized that region of residence determines the level of access to information and reproductive health services that can influence sexual behaviour and perception of risk. The nearest shops are 7km away from the farm while the nearest secondary school is 15km away. There were several bar outlets surrounding the farm which was the only source of entertainment. Residents are of low income. Furthermore, the farm employees consist of permanent, seasonal and casual workers.

The study targeted farm workers aged 15-49 years because they are the most sexually active group and are the most group affected by HIV infection. The study employed a mixed-methods approach, integrating both quantitative and qualitative data collection methods to ensure the validity and reliability of the data collected. The quantitative data were collected using a survey method. A questionnaire-based survey was conducted with 200 farm workers aged 15-49 years. This approach was chosen to quantify the knowledge, attitudes, behaviours, and practices (KABP) related to HIV and AIDS among the farm workers. Qualitative data were collected through focus group discussions, in-depth interviews and key informant interviews (KII).

Six FGDs were conducted, three with male participants and three with female participants. These discussions aimed to gain community definitions and deep insights into the knowledge, attitudes, perceptions, opinions, and practices towards HIV infection. The FGDs also sought to understand the underlying factors contributing to HIV infection among farm workers. Twenty in-depth interviews were conducted with farm workers living with HIV. These interviews aimed to understand the personal impact of the infection and the underlying factors contributing to HIV transmission. Five key informant interviews were conducted with individuals directly involved in health and HIV management at

the farm, including the Home-Based Care Officer, two Peer Educators, the Farm Manager, and the Foreman. These interviews provided insights into the factors underlying HIV infection at the farm and offered confidential information on the levels of HIV infection among farm workers.

The sample size was calculated using this formula.

$$n = \frac{Z^2pq}{e^2}$$

n = desired sample size

Z^2 = standard normal deviance set at 1.96 confidence interval corresponding to 95% confidence interval.

p = the proportion of the target population to the entire population

q = 1.0-p (proportion of the entire population excluding the target population)

e = the maximum allowable error which is set at 0.005.

Given that the total population of Rattray Arnold Research Farm workers is 211 (Farm Register, 2011) and the desired population characteristics of farm workers in the 15-49 age group was 180 (Farm Register, 2011). The sample size was calculated as shown below:

$$\text{Sample size (n)} = \frac{1.96^2(180/211)\ x\ (1.0 - p)}{0.05^2}$$

$$= \frac{1.96^2(0.85)(0.0.15)}{0.05^2}$$

$$= \frac{0.4896}{0.0025}$$

$$= 195.84$$

$$= 200 \text{ (rounded off)}$$

This study used stratified sampling to select research participants. The targeted age groups were grouped into stratum according to age groups and gender. This was done using probability proportionate to size sampling. Thus, the proportionate allocation was used to calculate the number of male and female respondents using the following formula:

n = n/N*nh

n = number of the total sample size to be distributed (200 farm workers)

N= the total target population

nh = desired sample size

The total number of female farm workers selected

= (103/211)*200

= 97.6

= 98

The total number of male farm workers selected

= (108/211)*200

=102.3

=102

To ensure representativeness, the probability proportional to size was used to determine the number of respondents per age-group by gender (Table 3.1).

Table 3.1: Number of respondents at Rattray Arnold Research Farm per age group by gender

Age-group (years)	Male sample size	Female sample size	Total
15-19	7	23	30
20-24	15	28	43
25-29	28	17	45
30-34	20	9	29
35-39	14	9	23
40-44	8	9	17
45-49	10	3	13
Total	**102**	**98**	**200**

The Rattray Arnold Research Farm workforce is gender balanced with approximately 51% males and 49% females (Table 4.1.1). The age distribution shows that the farm has young workforce because most of the workers, 85%, were less than 40 years old. The dominating age groups were 20-24 and 25-29 comprising 20% and 24%, respectively. Workers aged 40-44 and 45-49 were 9% and 7%, respectively. Most of farm workers, 68%, were either married or cohabiting. About 18% reported that they had never married while about 11% and 4% were either divorced or separated and widowed, respectively (Table 4.1.1). Generally, farm workers at Rattrary Arnold Research Farm are quite educated. Most of the workers, 44%, reported that they had 'O' level education and approximately 3% and 6% had 'A' level and tertiary education, respectively. About 35% had primary education and 14% had never attended school (Table 4.1.1). The majority (52%) of farm workers were Christians. This was reported by 24% Apostolic and 14% Catholic and Pentecostal, respectively. Approximately 49% were non-Christians. About 32% reported that they were traditional believers while 12% and 5% were non-believers and other religions, respectively (Table 4.1.1). Most of respondents, 86%, were farm labourers. About 12% were supervisors, 1% were managers and 2% were foremen (Table 4.1.1). Rattray Arnold Research Farm was dominated by part-time workers (52%). Another 48% reported that they were permanent workers (Table 4.1.1).

Table 4.1.1: Percentage distribution of respondents' demographic and socio-economic characteristics.

Sex	**Percentage (%)**
Male	51.0
Female	49.0
Total	**100.0**
AGE GROUP	
15-19	15.5
20-24	19.5
25-29	24.0
30-34	15.0
35-39	10.5
40-44	8.5
45-49	7.0
Total	**100.0**
Marital Status	
Never Married	17.5
Married or Cohabiting	68.0
Divorced or Separated	10.5
Widowed	4.0
Total	**100.0**
EDUCATION	
Never been to school	13.5
Primary school	35.0
"O" Level	43.5
"A" Level	2.5
Tertiary	5.5
Total	**100.0**
RELIGION	
Catholic	14.0
Pentecostal	13.5
Apostolic	24.0
Traditional	31.5
None	12.0
Other	5.0
Total	**100.0**
POSITION	
Supervisor	12.0
Manager	1.0
Foremen	1.5
Labourer	85.5
Total	**100.0**
EMPLOYMENT STATUS	
Permanent	48.0
Casual	24.0
Seasonal	28.0
Total	**100.0**

N = 200

Prior to research, four research assistants drawn from the University of Zimbabwe were selected for training. Those selected had a vast social science research experience. The training was carried out for two days. This was meant to orient the research assistants with the research objectives, research tools and to judge their comprehension of the questionnaire. The research methodology was also explained to the research assistants to familiarize them on how the research was to be conducted. After training, the research assistants participated in the pilot study.

Questionnaires were administered to twenty (20) farm workers drawn from the Mukwene, a nearby farm. The farm setting was similar in nature to Rattray Arnold Research Farm. This was done to verify the validity, reliability, appropriateness and necessity of questions. The researcher also wanted to measure how much time respondents took to complete each questionnaire. Information obtained during pretesting was analysed to check on question wording and response categories. This allowed the researcher to discard questions that failed to provide useful data. After the end of the session, debriefing session was held with the research assistants to correct any issues that were noted during the pre-testing period.

A total of five (5) Key Informant Interviews (using key informant interview guide) were undertaken. Key informants included the Home-Based Care Officer, two Peer Educators, Farm Manager and the Foreman. These were purposively selected because they were the custodians of health issues at the farm. Key informants provided data on the factors underlying HIV infection at the farm. They also provided confidential information, statistics pertaining to levels of HIV infection among farm workers at the farm.

In-depth interviews were undertaken with a total of twenty participants aged 15 - 49 years who were selected from farm workers. The major reason for carrying out in-depth interviews was that, the selected twenty participants are surviving with HIV infection. Therefore, the researcher wanted to get an in-depth insight on the impact of HIV infection among farm workers' lives. These were interviewed on availability basis. In-depth interviews used the same principle as focus group discussions, but subjects were interviewed individually. This enabled participants to freely express their views on knowledge, attitudes, perceptions and practices on HIV&AIDS. In-depth interviews were also carried out to understand the factors underlying HIV infection among farm workers. At least 1-2 participants were selected from each age group. As a result, 10 males and 10 females were randomly selected.

A total of six FGDs (using and FGD guide) were done with farm workers in age group 15-49 years. Three FGDs were done with males and the other three with females. These were carried out to get community definitions and deep insight about knowledge, attitudes, perceptions, opinions and practices towards HIV infection. FGDs were also done to get an in-depth insight into the underlying factors to HIV infection among farm workers.

Selection of respondents for each FGD was based on age cohorts and availability of participants. At least 1-2 participants were selected from each age cohort to ensure full representation. Age cohorts of 15-24, 25-34, 35-49 years were used for the selection of respondents to participate in FGDs.

FGDs were done in a hall at Rattray Arnold Research Farm, where the setting was more neutral, and privacy assured.

Participants' consent was sought from participants. The objectives of the study were explained to participants. Participants who were within the required ages (15-49) were randomly invited to participate in Focus Group Discussions. Pseudo names were assigned to participants, and these were maintained till the end of the discussion. This was done to make the citation of responses easier and to reinforce the issue of confidentiality among farm workers. The researcher was the moderator of the FGDs while research assistants recorded on paper the issues brought up in the discussions.

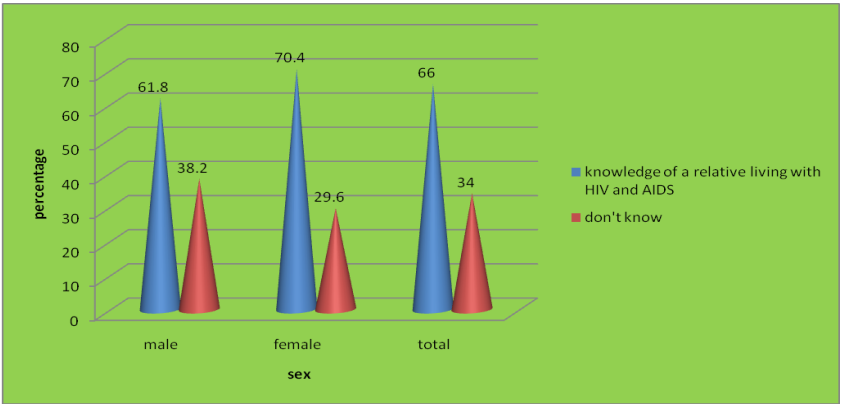
After the data were collected, the questionnaires were given code numbers that were used for tracking errors during data entry. SPSS (IBM Statistical Package for Social Scientists, Version 20) was used to analyse quantitative data. To avoid data entry errors, double entry and data cleaning was done. Again, inconsistencies between answers were verified with the raw data on the respective questionnaires. However, mistakes on the questionnaires were edited accordingly without changing the respondents' responses. Descriptive statistics were computed, and data was analysed by calculating percentages and frequencies. Cross-tabulations were used to analyse relationships between variables where necessary. Extensive note taking and tape recording was done during FGDs, In-depth-interviews and Key informant interviews. In the analysis of data, themes pertaining to the factors underlying HIV infection were identified. These were then used to explain and expand findings from the quantitative data.

CHAPTER 4:

Evidence on HIV Prevalence among Farm Workers at Rattray Arnold Research Farm, Goromonzi District, Peri-urban Harare

The Chapter presents the research findings in frequency distributions and cross tabulations. The findings triangulate data from the survey, FGDs, In-depth interviews and Key informant interviews.

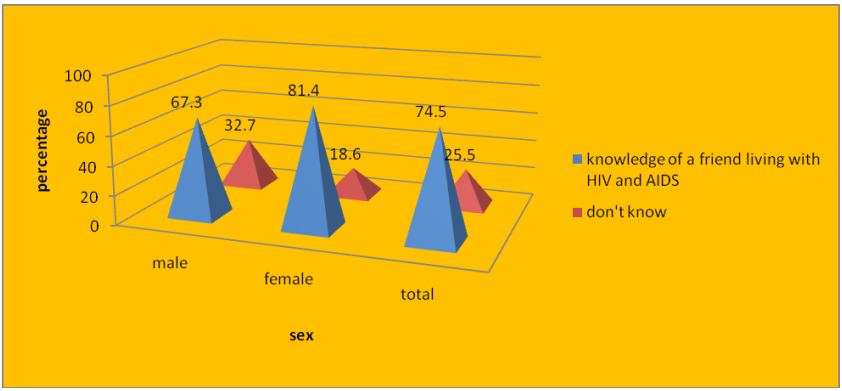
Respondents were asked whether or not they knew of a relative who is living with HIV&AIDS at the farm. A fair proportion, 66%, reported that they were aware of a relative who is living with HIV&AIDS (Figure 4.2.1). However, women are more likely to report knowledge about a relative who is living with HIV&AIDS than their male counterparts. This was reported by 70% females and 62% males. This could be attributed to the fact that women are care givers in society.



N = 200

Figure 4.2.1: Percentage distribution of respondents' knowledge of a relative living with HIV&AIDS by sex (*Field Survey, 2012 by Researcher)*

When further asked whether they knew of a friend who is living with HIV&AIDS at the farm, a moderately high proportion, 75%, reported that they were aware of a friend who is living with HIV&AIDS at the farm. Women were also more (81%) likely to report knowledge about a friend who is living with HIV&AIDS at the farm than their male counterparts (67%) (Figure 4.2.2).



N = 200

Figure 4.2.2: Percentage distribution of respondents' knowledge of a friend living with HIV&AIDS by sex *(Field Survey, 2012 by Researcher)*

Farm workers were also asked on whether or not they had been tested for HIV. A fair proportion, 52%, reported that they had been tested for HIV. Females were more likely, 61%, to report having been tested than their male counterparts, 44% (Table 4.2.1). About 48% reported that they were willing to know their status. Consistently, females were more likely, 56% to report willingness to know their status than their male counterparts, 39%.

During FGDs, it was noted that farm workers were afraid of knowing their status. Thus, a 33 year old man remarked;

> *"I have several sexual partners whom I had sex with without protection. I am afraid that if I am found HIV positive, it means the end of my life, therefore, it is better for me to remain ignorant about my status."*

Farm workers who were tested were asked if they disclosed their status to their partners. A large proportion, 76%, reported that they did not disclose their results to their partner. Males were more likely, 83%, to report that they did not disclose their results to their partner than their female counterparts, 66% (Table 4.2.1).

When interviewed during FGDs, a 38 year man echoed;

> *"When found HIV positive, revealing my status means that I will be exposing my infidelity to my wife, therefore I would rather keep quiet till I got sick or die."*

During in-depth interviews, a 29-year-old man echoed;

> *"It is not necessary to reveal my HIV status to my wife because 'machine wacho unombopotsa' (meaning that the machine is not accurate). I might tell my wife that I*

have tested HIV positive, yet I am negative due to inaccuracy of the machine which might cause some conflicts in marriage."

Table 4.2.1: Percentage distribution of respondents on VCT by sex *(Field Survey, 2012 by Researcher)*

Voluntary Counselling and Testing (VCT)	Male (%)	Female (%)	Total (%)
Ever been tested for HIV&AIDS			
Tested	44.1	61.2	52.5
Not tested	55.9	38.8	47.5
Total	**100**	**100**	**100**
Willing to know status			
Willing	39.0	56.0	48.0
Not willing	61.0	44.1	52.5
Total	**100**	**100**	**100**
Disclosure of results			
Disclosed	15.7	33.7	24.5
Never disclosed	84.3	66.3	75.5
Total	**100**	**100**	**100**

N = 200

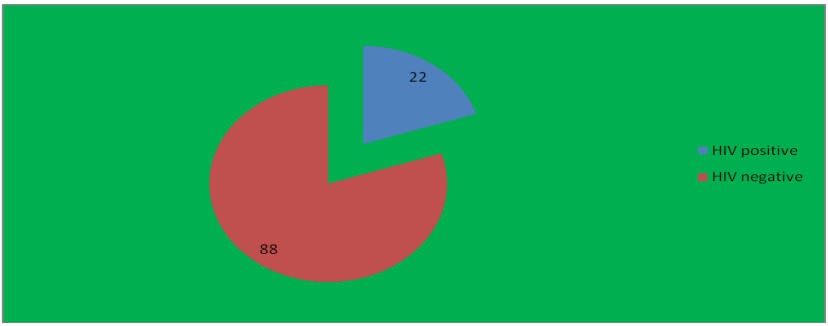
When further asked about farm workers' status, data obtained show that people do not open up about their HIV&AIDS status. There seems to be underreporting of HIV&AIDS seropositive status by farm workers. Only 22% reported that they were HIV positive (Figure 4.2.3).

While 22% reported HIV positive status, farm workers were perceived to be at high-risk of HIV infection and the death rate was high. The Home-Based Care Officer reported that;

"About 158 people (70 males and 88 females) (42%) out of a farm population of 380 were sick. Only 44 people (19 males and 25 females) were registered to be on ART. Approximately 35 children were also sick and were registered to be on ART."

During Key Informant Interview, The HBCO was further asked on the number of deaths due to HIV&AIDS at the farm. The HBCO noted that;

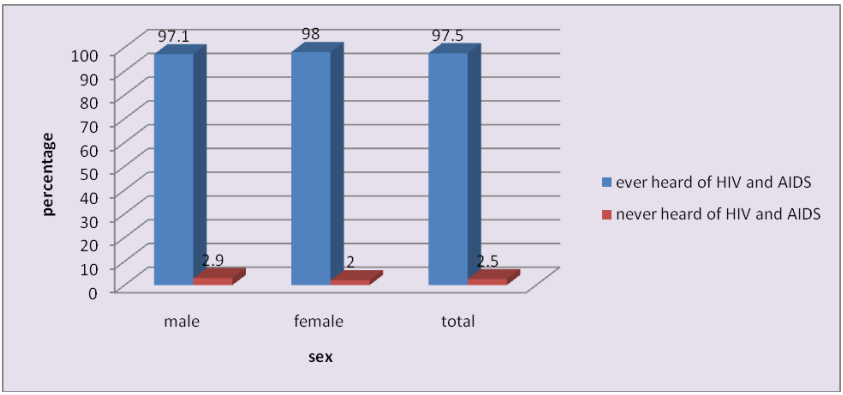
"For the past year, about 25% of farm workers were reported to have died of HIV&AIDS."



N = 200

Figure4.2.3: Percentage distribution of respondents' HIV status *(Field Survey, 2012 by Researcher)*

Knowledge about HIV&AIDS is universal in this study. Approximately 98% reported that they had heard of HIV&AIDS (Figure 4.3.1). There was no significant difference between males and females on the knowledge about HIV&AIDS, 98% of females and 97% of males reported that they ever heard of HIV&AIDS (Figure 4.3.1)

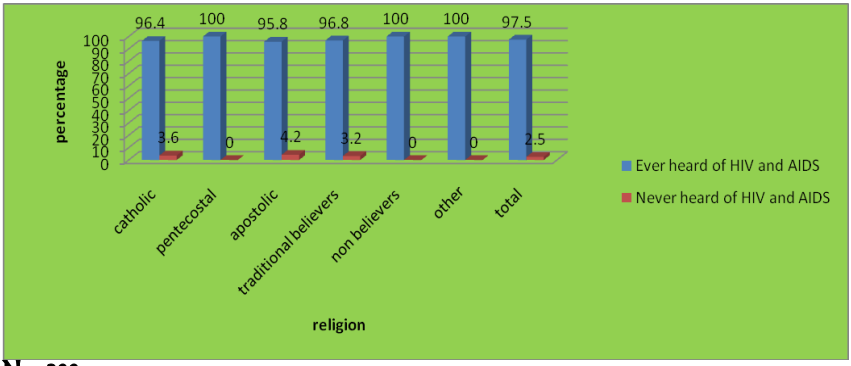


N = 200

Figure 4.3.1: Percentage distribution of ever heard of HIV&AIDS by sex *(Field Survey, 2012 by Researcher)*

There was no variation on the knowledge about HIV&AIDS by religion. About 100% Pentecostal and none believers reported that they ever heard of HIV&AIDS, respectively. Another 96% Catholics and Apostolic believers,

respectively, reported that they ever heard of HIV&AIDS while 97% traditional believers also reported ever heard of HIV&AIDS (Figure 4.3.2).



N= 200

Figure 4.3.2: Percentage distribution of ever heard of HIV & AIDS by religion *(Field Survey, 2012 by Research)*

Knowledge about modes of HIV transmission is high among farm workers though misconceptions about modes of HIV transmission also still exist. The most reported mode of transmission was unprotected sex which was reported by about 99% of respondents. Both males and females at Rattray Arnold Research Farm were highly knowledgeable that having unprotected sex with an infected partner transmits HIV. This was reported by 100% females and 97% males (Table 4.3.1). Sharing of sharp objects as a mode of HIV transmission was reported by about 75% of the respondents. More males (81%) than females (67%) reported sharing of sharp objects as a transmission mode to HIV&AIDS. Mother to child transmission (MTCT) as mode of HIV transmission was reported by about 73% of respondents (Table 4.3.1). Males were more knowledgeable (82%) than their female counterparts (62%). Only 45% reported blood transfusion as a mode of transmission. Again, males were more knowledgeable (46%) that blood transfusion transmits HIV than their female counterparts (44%) (Table 4.3.1).

During in-depth interviews and focus group discussions, people highlighted unprotected sexual intercourse as the major transmission mode to HIV infection while mother to child transmission and sharing infected sharp objects were also mentioned by farm workers at Rattray Arnold Research Farm.

However, misconceptions still exist among farm workers regarding modes of HIV&AIDS transmission. Approximately 16% and 9% of respondents reported kissing and mosquito bites as modes of HIV transmission, respectively (Table 4.3.1).

During FGDs with men, it was however noted that misconception about HIV&AIDS transmission modes exists among farm workers when a 25-year-old man remarked;

"Kissing tongue to tongue transmits HIV&AIDS."

Another man further echoed;

"Exchanging shooters (football boots for soccer players) *also transmit HIV&AIDS."*

During FGDs with women, it was also noted that misconception about HIV&AIDS transmission modes exists among farm workers when a 35-year-old woman remarked;

"Using utensils used by an infected person also transmit HIV&AIDS".

Table 4.3.1: Percentage distribution of respondents' knowledge on mode of HIV&AIDS transmission by sex *(Field Survey, 2012 by Researcher)*

Modes of Transmission	Male (%)	Female (%)	Total (%)
Unprotect sex			
Knowledgeable	97.1	100.0	98.5
Not knowledgeable	2.9	0.0	1.5
Total	**100**	**100**	**100**
Sharing Objects			
Knowledgeable	81.4	67.3	74.5
Not knowledgeable	18.6	32.7	25.5
Total	**100**	**100**	**100**
MTCT			
Knowledgeable	82.4	62.2	72.5
Not knowledgeable	17.6	37.8	27.5
Total	**100**	**100**	**100**
Blood transfusion			
Knowledgeable	46.1	43.9	45.0
Not knowledgeable	53.9	56.1	55.0
Total	**100**	**100**	**100**
Kissing			
Knowledgeable	18.6	13.4	16.1
Not knowledgeable	81.4	86.6	83.9
Total	**100**	**100**	**100**
Mosquito bites			
Knowledgeable	10.8	6.1	8.5
Not knowledgeable	89.2	93.9	91.5
Total	**100**	**100**	**100**

N = 200

When asked about their knowledge regarding preventive strategies, such knowledge was found to be moderate and abound with misconceptions. Males

were more likely to be knowledgeable about preventive strategies as compared to their female counterparts. The most commonly reported preventive strategy (73%) was condom use (Table 4.3.2). This was reported by 85% males and 59% females. Approximately, 60% of respondents reported abstinence. More males (73%) than females (48%) reported abstinence as a preventive measure to HIV&AIDS infection. About 57% reported treatment of STIs while 51% and 48% reported reduction of sexual partners and use of sterilized instruments, respectively. Approximately 61% reported male circumcision as a way of reducing HIV infection (Table 4.3.2).

FGDs highlighted that condom use reduce the spread of HIV&AIDS. However, it was gathered during key informant interviews with the HBCO that condom supply was very low at Rattray Arnold Research Farm because there are no health centres near the farm. This was exacerbating the spread of HIV&AIDS. Again, peer educators were not playing their role of educating people about HIV&AIDS.

The HBCO remarked;

> *"We do not have a nearest health centre that distribute or sell condoms here. The nearest health centres I usually visit to collect condoms to distribute to farm workers are St Joseph, Nyaure and Domboshava clinics. These three (3) clinics are too far (22 km) away from the farm and there is no transport that can take me there. Normally I use my bicycle which is not in good condition. When I manage to get to these centres, I will be given two (2) small boxes per month which are not even enough to distribute among farm workers."*

However, misconceptions still exist among farm workers regarding preventive measures. Approximately 8% and 7% reported prayer and sleeping with a virgin respectively as preventive measures against HIV infection (Table 4.3.2).

Table 4.3.2: Percentage distribution of respondents by preventive measures to HIV&AIDS *(Field Survey, 2012 by Researcher)*

Preventive Strategy	Male (%)	Female (%)	Total (%)
Using a condom			
Knowledgeable	85.3	59.2	72.5
Not knowledgeable	14.7	40.8	27.5
Total	**100**	**100**	**100**
Abstinence			
Knowledgeable	72.5	48.0	60.5
Not knowledgeable	27.5	52.0	39.5
Total	**100**	**100**	**100**
Treatment of STIs			
Knowledgeable	57.8	55.1	56.5
Not knowledgeable	42.2	44.9	43.5
Total	**100**	**100**	**100**

Male circumcision			
Knowledgeable	71.6	49.0	60.5
Not knowledgeable	28.4	51.0	39.5
Total	**100**	**100**	**100**
Prayer			
Knowledgeable	10.8	5.1	8.0
Not knowledgeable	89.2	94.9	92.0
Total	**100**	**100**	**100**
Sleeping with a virgin			
Knowledgeable	7.8	5.1	6.5
Not knowledgeable	92.2	94.9	93.5
Total	**100**	**100**	**100**

N=200

Generally, HIV&AIDS awareness and symptoms were very high among farm workers. The majority, 66%, reported that when a person is infected with HIV, it does not mean that he or she has AIDS. About 62% reported that an HIV person can stay healthy for a long time without showing any symptoms of HIV. 58% of respondents reported that an HIV positive person may pass HIV to other people and that HIV&AIDS can be treated with ART (Table 4.3.3). Again, misconceptions about an HIV infected person also exist among farm workers. Approximately, 12% of farm workers reported that when a person is infected with HIV, it means that he or she has AIDS while 14% of farm workers reported that he or she can pass HIV to other people only when he or she is sick (Table 4.3.3). This belief can lead to exposure to HIV infection since people are unlikely to take precautions when having sexual intercourse with healthy-looking persons, as they believe that HIV can be transmitted by a sick person only.

Table 4.3.3: Percentage distribution of respondents who agree with respective statements *(Field Survey, 2012 by Researcher)*

True Statement of an HIV Infected person	Percentage
He/she has AIDS	12.0
He/she may not have AIDS yet, but will almost develop AIDS.	65.5
He/she could pass HIV to other people only when he/she is sick.	13.5
He/she could pass HIV to other people.	57.5
He/she stay healthy for a long time.	62.0
He can be treated with ARVs.	57.5
He can be treated or cured.	12.5
All HIV positive mothers can transmit HIV to all their children.	11.5

N = 200

The majority, 99%, of farm workers were aware that unprotected sexual intercourse is the major route for HIV transmission. About 91% of respondents reported that getting tested allows a person to know his or her status. About 88%

of respondents reported that a person with HIV virus can look healthy for more than 10 years. Approximately, 75% of respondents reported that STIs also increase the chances of getting HIV (Table 4.3.4). However, misconceptions about HIV&AIDS cure still exist among farm workers. Approximately, 3% reported that traditional healers can cure HIV&AIDS (Table 4.3.4).

Table 4.3.4: Percentage distribution of respondents regarding True or False statements about HIV&AIDS *(Field Survey, 2012 by Researcher)*

True /False statements about HIV&AIDS	Percentage
You can get HIV&AIDS virus the first time you have unprotected sex.	99.0
The only way to know whether you have HIV or not is to get yourself tested.	91.0
People with HIV can look healthy for more than 10 years	88.0
STIs increase the chances of getting HIV.	75.0
Traditional healers can cure HIV&AIDS.	3.0

N = 200

Respondents were also asked about the stage when HIV is transmitted from mother to child (MTCT). Moderate knowledge exists. The largest proportion of respondents, 65%, reported that HIV is transmitted from mother to child during labour and delivery (Table 4.3.5). About 16% reported that HIV is transmitted from mother to child during breastfeeding while 13% of respondents reported that HIV can be transmitted from mother to child during pregnancy. Approximately, 7% of respondents reported complete lack of knowledge on how MTCT occurs (Table 4.3.5).

Table 4.3.5: Percentage distribution of respondents' knowledge about the stage of MTCT *(Field Survey, 2012 by Researcher)*

Period	Percentage
During pregnancy	13.0
During labour and delivery	64.5
During breastfeeding	16.0
Do not know	6.5
Total	**100.0**

N = 200

Respondents were asked about strategies for preventing the transmission of HIV from mother to child. Such knowledge about MTCT prevention was extremely low. The most reported strategy was exclusive breastfeeding for six months which was reported by approximately 31% of respondents. Another 21% of respondents reported protected sex during pregnancy while 15% of respondents reported not breastfeeding at all as a measure to prevent MTCT. About 11% of

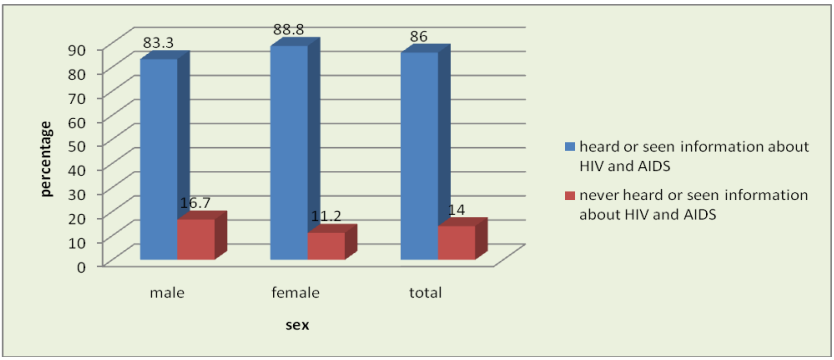
respondents reported the use of ARVs while 10% of respondents reported caesarean birth as preventive strategies against MTCT. Among respondents, 11% reported complete lack of knowledge on how MTCT can be prevented. It was also noted that misconceptions exist among farm workers on MTCT preventive measures. Approximately 2% of respondents reported that boiling of baby milk prevent MTCT (Table 4.3.6).

Table 4.3.6: Percentage distribution of respondents' knowledge on preventive measures against MTCT *(Field Survey, 2012 by Researcher)*

MTCT Preventive Strategies	Percentage (%)
Use of ARVs.	11.0
Exclusive breastfeeding for six months.	31.0
Caesarean birth.	10.0
Protected sex practices during pregnancy and breastfeeding.	20.5
Not breastfeeding at all.	15.0
Boiling of baby milk.	2.0
Do not know	10.5
Total	**100.0**

N = 200

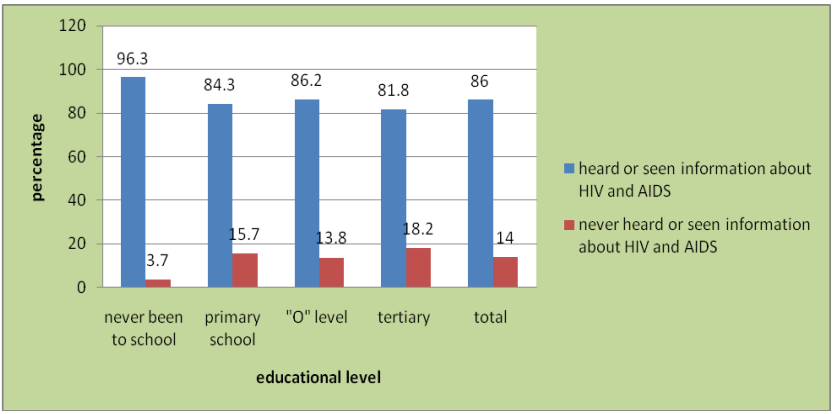
The findings from the study show that HIV&AIDS information was effectively disseminated. When asked on whether they have ever heard or seen any information about HIV&AIDS in the past three months, the majority (86%) reported that they had seen or heard HIV&AIDS information (Figure 4.3.3). Both females 89% and males 83% have ever heard or seen information about HIV&AIDS in the past three months.



N = 200

Figure 4.3.3: Percentage distribution of respondents who have heard or seen information about HIV&AIDS by sex *(Field Survey, 2012 by Researcher)*

There was no much variation by level of education on ever heard or seen HIV&AIDS information among farm workers. About 96% of never been to school respondents reported that they had heard or seen information about HIV&AIDS. Approximately, 86% of respondents who attained 'O' level, reported to have heard or seen HIV&AIDS information while 84% of respondents who attained primary school level reported to have heard or seen HIV&AIDS information. Another 82% of respondents who attained tertiary level also reported to have heard or seen HIV&AIDS information (Figure 4.3.4)



N = 200

Figure 4.3.4: Percentage distribution of respondents on heard or seen information about HIV&AIDS for the past 3 months by educational level *(Field Survey, 2012 by Researcher)*

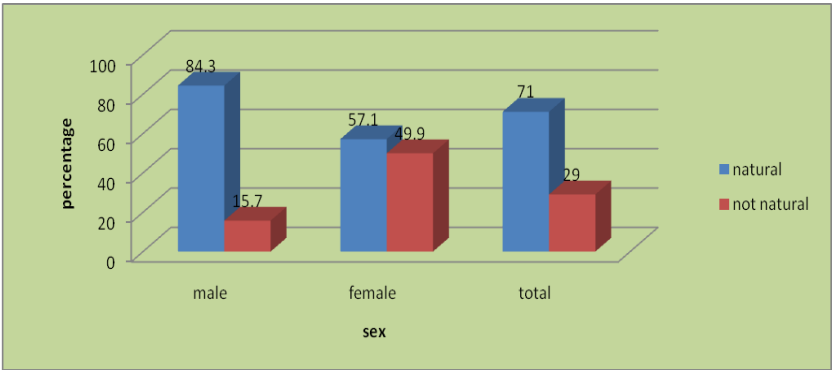
National media campaign was reminding farm workers on behaviour change at the farm. When asked about their sources of information about HIV&AIDS, sources of information that were reported by respondents were fairly comparable between males and females. For instance, the largest proportion of respondents, 82%, reported television as their major source of information. This was reported by about 83% of the males and 81% of the females. The second source of information reported by 79% of respondents was radio. Again, this was reported by 82% males and 76% females. Another 74% of respondents reported partner while peer educators, friends, relatives, parents, health providers and religious leaders were reported by 67%, 67%, 68%, 66%, 68% and 70%, respectively. Only 48% reported newspaper as their source of information (Table 4.3.7).

Table 4.3.7: Percentage distribution of respondents' sources of information by sex *(Field Survey, 2012 by Researcher)*

Sources of information	Male (%)	Female (%)	Total (%)
Television	83.3	80.6	82.0
Radio	82.4	75.5	79.0
Partner	72.5	74.5	73.5
Religious leaders	69.6	69.4	69.5
Health Providers	67.6	67.3	67.5
Relatives	66.7	68.4	67.5
Peer educators	64.7	69.4	67.0
Parents	64.7	67.3	66.0
Friends	63.7	69.4	66.5
Newspaper	47.1	48.0	47.5

N = 200

It was noted that the majority (71%) of respondents were of the view that it is natural for a man to have multiple sexual partners (Figure 4.4.1). It was interesting to note that more males (84%) than females (57%) reported that man should have multiple sexual partners.



N = 200

Figure 4.4.1: Percentage distribution of respondents' attitudes on male sexuality by sex *(Field Survey, 2012 by Researcher)*

In-depth interviews also highlighted the cultural perception that it is natural for a man to have multiple sexual partners. Thus, a 28-year-old man remarked;

> *"Why can I have one girlfriend or wife? Is it a calendar? To show manhood, a man should have as many sexual partners as he can because it bores to have sex with one woman all the time. It will be like eating sadza with rape (a vegetable) every day; therefore, one must look for meat."*

Data show that stigma regarding HIV&AIDS was moderately low. The findings show that males attach less stigma to PLWHA than females. When asked whether farm workers can shake hands with an HIV positive person, most of respondents, 81%, reported that they can shake hands with such people (Table 4.4.1). This was reported by 94% of males and 66% of females. Consistently, the majority (79%) of respondents reported that they are comfortable sharing food with an HIV positive person (Table 4.4.1). This was reported by 94% of males and 62% of females. Again, another 76% of respondents reported that they were also comfortable sharing a bed with an HIV positive person. This was reported by 84% males and 66% females.

Respondents also reported feeling less comfortable kissing and sharing utensils with PLWHA, with high stigma noted among females than males. The majority (60%) of respondents reported that they cannot kiss an HIV positive person. This was reported by 79% females and 42% males. Consistently, approximately 53% of respondents reported that they were not comfortable sharing utensils with an HIV positive person (Table 4.4.1). This was reported by 56% of females and 49% of males.

The issue of stigma was also noted among women during FGDs. The issue of not being able to share utensils was echoed by a 41-year-old woman;

> *"My brother died from AIDS three months ago. During the time of his sickness, I could not even allow my four-year-old daughter to use a cup or plate that was used by him."*

During FGDs, participants echoed almost similar views on sharing utensils with infected persons and supported that utensils should not be shared with HIV positive people. Furthermore, a 29-year-old woman remarked;

> *"I once took care of my uncle who was sick from AIDS. I kept his plate and cup separately from other utensils that we normally use. This is because I did not want to share my utensils with an HIV infected person."*

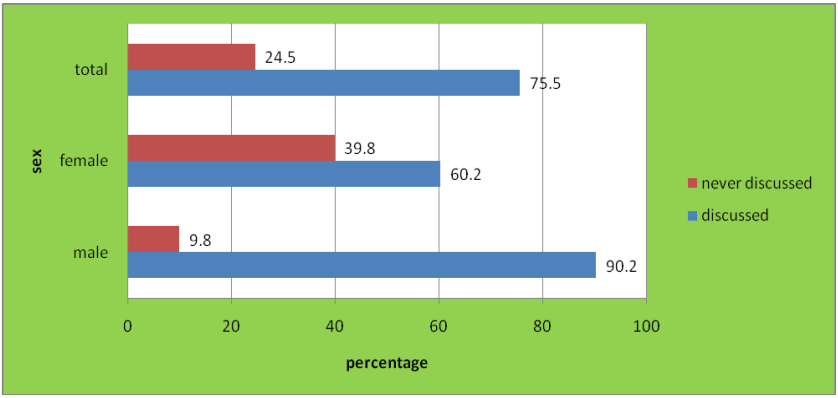
Table 4.4.1: Percentage distribution of stigma against people living with HIV and AIDS by sex *(Field Survey, 2012 by Researcher)*

Are you comfortable in shaking hands with PLWHA	**Male (%)**	**Female (%)**	**Total (%)**
Feel comfortable	94.1	66.3	80.5
Do not feel comfortable	5.9	33.7	19.5
Total	**100**	**100**	**100**
Are you comfortable in sharing food with PLWHA			
Feel comfortable	94.1	62.2	78.5
Do not feel comfortable	5.9	37.8	21.5
Total	**100**	**100**	**100**
Are you comfortable in Sharing bed with			

PLWHA			
Feel comfortable	84.3	66.3	75.5
Do not feel comfortable	15.7	33.7	24.5
Total	**100**	**100**	**100**
Are you comfortable in Sharing utensils with PLWHA			
Feel comfortable	51.0	43.9	47.5
Do not feel comfortable	49.0	56.1	52.5
Total	**100**	**100**	**100**
Are you comfortable in kissing PLWHA			
Feel comfortable	57.8	21.4	40.0
Do not feel comfortable	42.2	78.6	60.0
Total	**100**	**100**	**100**

N = 200

Respondents were asked about discussing some aspects of HIV&AIDS with their peers. The findings show that there are some discussions about HIV&AIDS between peers and males tend to discuss HIV&AIDS aspects more than their female counterparts. The majority (76%) reported that they had discussed some aspects of HIV&AIDS with their peers (Figure 4.4.2). This was reported by 90% of males and 60% of females.



N = 200

Figure 4.4.2: Percentage distribution of respondents who discussed HIV&AIDS with Peers by sex *(Field Survey, 2012 by Researcher)*

Farm workers perceived transactional sex as acceptable in society and women were more likely to accept transactional sex. When asked whether women and girls should exchange sex for goods and services, it was noted that women at the farm were of the view that transactional sex should be done. About 43%

reported that women should exchange sex for goods and services. This was reported by 51% of females and 35% of males (Table 4.4.2).

Data gathered during FGDs with men shows that women were exchanging sex for goods and services. A 30-year-old man remarked;

> *"Sister, it is difficult for our women not to exchange sex for either goods or services because men in our community do not look after their women. Therefore, our women are forced to exchange sex for goods or service."*

Table 4.4.2: Percentage distribution of respondents' perceptions about transactional sex *(Field Survey, 2012 by Researcher)*

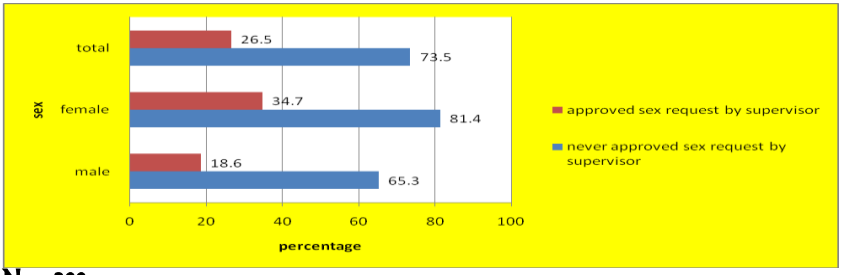
Perceptions on transactional sex	Male (%)	Female (%)	Total (%)
Strongly agree	29.4	50.0	39.5
Agree	5.9	1.0	3.5
Not sure	13.7	1.0	7.5
Disagree	3.9	4.1	4.0
Strongly disagree	47.1	43.9	45.5
Total	**100**	**100**	**100**

N = 200

Respondents were also asked about their perception regarding sex advances by a supervisor. Approximately 27% of respondents reported that there is nothing wrong by having sex with a supervisor. This was also reported by 35% female respondents and 19% male respondents (Figure 4.4.3).

There was a significant difference between males and females. Females seem to have approved sex advances by a supervisor than their male counterparts. FGDs also highlighted that some women cannot resist sex when asked by their supervisors. A 28 year old woman remarked;

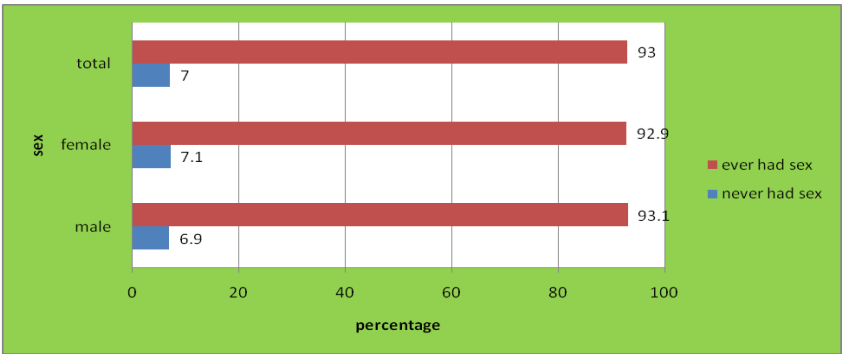
> *"My husband does not bring his salary home. I always use my salary to feed the children which is not enough, therefore, when asked for sexual favours by the supervisor, I will not be able to refuse because I need money to look after the kids."*



N = 200

Figure 4.4.3: Percentage distribution of respondents' views towards sexual advances by Supervisors *(Field Survey, 2012 by Researcher)*

The majority (93%) of farm workers ever had sex. There was no gender variation in sexual experience. This was reported by 93% males and females, respectively (Figure 4.5.1).



N = 200

Figure 4.5.1: Percentage distribution of respondents by ever had sex by sex *(Field Survey, 2012 by Researcher)*

Early sexual practices were common among farm workers. When asked about their age at first sexual encounter, 8% of respondents reported having had sex before age 15. However, more females (11%) than males (4%) ever had sex before age 15. About 55% of respondents reported that they had their first sexual encounter before age 20. Again, more females (64%) than males (45%) ever had sex before age 20. Another 26% of respondents reported that they started having sex before they reached 25 years. This was also reported by 33% males and 19% females. About 36% reported that they had their first sex before they reached 30 years (Table 4.5.1). More females (48%) than males (14%) reported having sex before they reached 30 years. Approximately, 2% reported that they had their first sex before they reached 35 years (Table 4.5.1). More males (4%) than females (1%) reported first sexual intercourse before they reached 35 years. The mean age at first sexual encounter was 12 years.

Table 4.5.1: Percentage distribution of respondents' age at first sexual encounter by sex *(Field Survey, 2012 by Researcher)*

Age at first sexual encounter	Male (%)	Female (%)	Total (%)
12-14	3.6	10.7	8.4
15-19	45.2	64.3	54.9
20-24	33.3	19.0	1.8
25-29	14.3	48.0	35.7
30-34	3.6	1.2	1.8
Total	**100**	**100**	**100**

N = 186

Rattray Arnold Research Farm workers ever had sex with either their boyfriend or girlfriend. The majority, 54%, had their first sexual encounter with either their boyfriend or girlfriend (Table 4.5.2). 34% had their first sexual encounter with either a husband or wife. Only, 6% of respondents reported that they had their first sexual encounter with a casual partner while 3% of respondents reported that had their first sexual encounter with a family member. One percent of respondents reported ever had their first sexual encounter with a commercial sex worker and someone who forced himself on (Table 4.5.2).

Table 4.5.2: Percentage distribution of respondents' first sexual encounter with partner *(Field Survey, 2012 by Researcher)*

Relationship with partner	Percentage
Husband	34.4
Family member	3.2
Boyfriend/girlfriend	53.8
Casual partner	6.4
Commercial sex worker	1.1
Someone who forced himself on	1.1
Total	**100.0**

N = 186

Farm workers who were below 20 years dominated in having sex early at Rattray Arnold Research Farm. When asked about the age of the partner at first sexual encounter, about 49% of respondents reported that the age of partner was below 20 years. More males (78%) than females (19%) had sex with a partner less than 19 years. Another 36% of respondents reported that their partners at first sexual encounter were aged between 20-24 years while 15% of respondents were aged between 25-31 years (Table 4.5.3).

Table 4.5.3: Percentage distribution of respondents' age of partner at first sexual encounter *(Field Survey, 2012 by Researcher)*

Age of partner	Male (%)	Female (%)	Total (%)
12-19	77.6	18.8	49.0
20-24	17.0	56.1	35.9
25-31	5.4	25.1	15.1
Total	**100**	**100**	**100**

N = 186

When asked reason why they engaged in sexual intercourse for the first time, more than half, 55%, of the farm workers reported that it was due to natural feelings. Approximately 18% reported that it was an expression of love for partner while 10% reported that their first sexual encounter was due to expectation of gifts or money. Another 5% reported that they felt like it and 4% reported that they were drunk. Consistently, 4%, reported that they were influenced by peers for them to have sex while 3% reported that it was due to other reasons (Table 4.5.4).

Table 4.5.4: Percentage distribution of respondents' reason for engaging in first sexual encounter *(Field Survey, 2012 by Researcher)*

Reason for engaging in sex	Percentage
Natural feelings/sex urge	54.8
Felt like it	5.4
Expression of love for partner	18.3
Influence from peers	4.3
Expectations of gifts/money	10.2
Was drunk	3.8
Other reasons	3.2
Total	**100.0**

N = 186

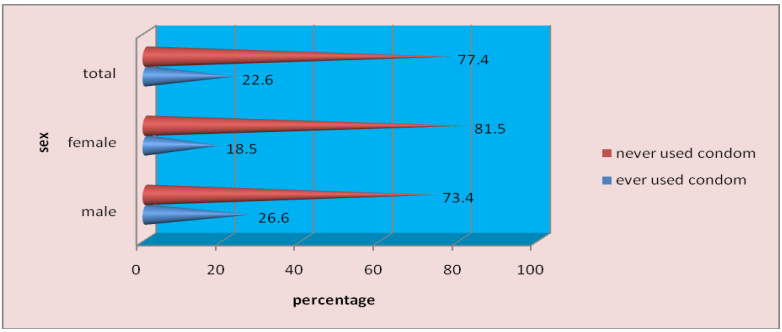
Condom use at first sexual encounter was extremely low. Respondents were asked whether or not they used a condom at their first sexual encounter, the majority (77%), reported that they never used condoms (Figure 4.5.2). More females (82%) than males (73%) did not use condoms.

It was also gathered during FGDs that condom use at first sexual encounter was extremely difficult at Rattray Arnold Research Farm, a 28 year old man remarked;

> "*It is difficult to get condoms here. Most of the time we depend on lending each other as men when we want to have sex privately. Therefore we are forced at times to have sex without condoms.*"

Limited condom use at first sexual encounter was also echoed in Key Informant Interview. One HBCO stipulated that;

> *"I receive two (2) small boxes with 100 condoms per box per month from Nyaure clinic which are not even enough to distribute among farm workers. Farm workers alone are 211 and the total adult population at this farm is 380."*



N = 186

Figure 4.5.2: Percentage distribution of respondents' condom use at first sexual encounter by sex *(Field Survey, 2012 by Researcher)*

A false sense of trust hampered condom use among farm workers during their first sexual encounter. When asked why they did not use condoms the first time they had sex, the most commonly reported reason was trust of partner that was reported by the majority (76%) of respondents. More females (86%) than males (66%) trusted their partners at their first sexual encounter. About 14% reported that they did not think of using one. While 4% reported that they felt embarrassed to ask partner to use a condom. Approximately 1% reported that they have limited access to condoms and that condoms reduce sexual pleasure, respectively. Another 2% reported that they did not feel that they need one. Only 1% reported that their partner disliked condoms break, respectively. About 1% reported that and they did not like them (Table 4.5.5).

Table 4.5.5: Percentage distribution of respondents' reasons for not using a condom at first sexual encounter by sex *(Field Survey, 2012 by Researcher)*

Reason for not using condom	Male (%)	Female (%)	Total (%)
I trust my partner	66.3	86.2	76.3
I do not feel I need one	2.2	1.1	1.6
I do not like them	1.1	1.1	1.1
My partner dislikes them	1.1	0.0	0.5
Condoms break	1.1	0.0	0.5
Condoms reduce pleasure	2.2	0.0	1.1
Limited access to condoms	2.2	0.0	1.1
Feel embarrassed to ask partner	4.3	3.2	3.8
I have not thought of using one	19.6	8.5	14.0
Total	**100**	**100**	**100**

N = 186

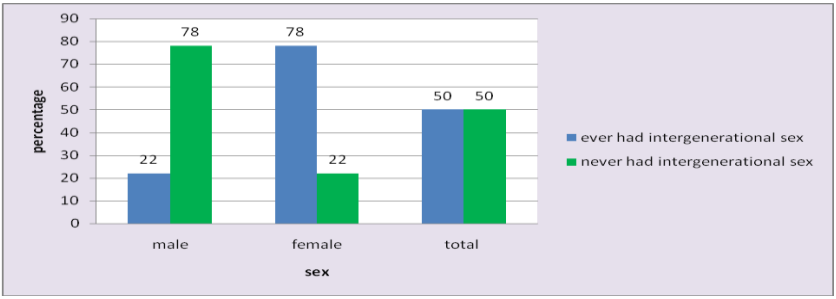
Farm girls at Rattray Arnold Research Farm were having sex before marriage. When asked whether most girls at the farm were having sex before marriage; the majority, 72%, reported that they strongly agree that girls at the farm were having sex before marriage (Table 4.5.6).

Table 4.5.6: Percentage distribution of respondents about sex before marriage *(Field Survey, 2012 by Researcher)*

Sex before marriage	Percentage
Strongly agree	71.5
Not sure	5.5
Disagree	8.0
Strongly disagree	7.0
Do not Know	8.0
Total	**100.0**

N = 200

Farm girls and young women were engaging in intergenerational sex at Rattray Arnold Research Farm. When asked whether farm girls and young women were engaging in intergenerational sex at the farm, a fair proportion (50%) of respondents reported that they ever had intergenerational sex. However, more women (78%) than males (22%) reported that they ever had intergenerational sex (figure 4.5.3).



N = 200

Figure 4.5.3: Percentage distribution of respondents who ever had intergenerational sex by sex *(Field Survey, 2012 by Researcher)*

It was also established during FGDs with women and men that some women were engaging themselves in intergenerational sex at the farm. A 48-year-old man remarked;

> *"I have two regular partners who are 18 years and 20 years respectively. When I want to have sex with them, I normally buy them some pants as gifts, and I am also responsible for their hair do."*

Another 49-year-old man remarked;

> *"My wife at home is now old and cannot satisfy me sexually. For sexual gratification, I have a regular partner who is 17 years old. I take care of her financially and I always buy her some groceries."*

An 18-year-old woman remarked;

> *"My boyfriend is 22 years old. He is not responsible enough because he does not buy me bathing soap, perfume and some lotions. My sugar daddy who is 42 years old and is a father of five children and does everything for me."*

Farm workers at Rattray Arnold Research Farm were having casual partners and females are more likely to report many causal partners that their male counterparts. Most of the respondents, 84%, reported that they had one casual partner in the last 6 months (Table 4.5.8). This was reported by (94%) females and (76%) males. Approximately, 7% of the respondents reported that they had two

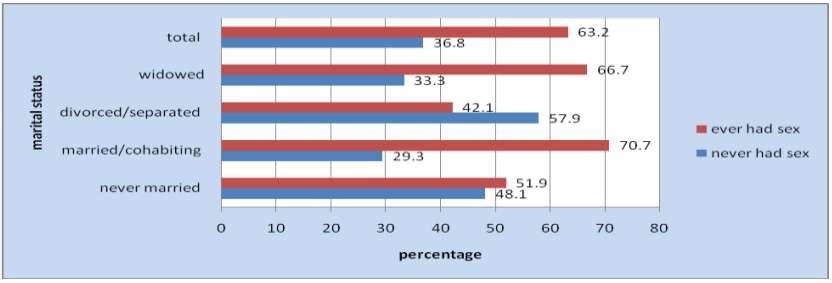
casual partners. It was noted that more males (10%) than females (3%) ever had two casual partners. About 4% of respondents reported that they had three casual partners. It was further noted that only (7%) males ever had three casual partners in the past six months. Another 6% reported that they had several casual partners for the past six months (Table 4.5.8). This was also reported by more males (7%) than females (3%).

Table 4.5.7: Percentage distribution of respondents' number of casual partners within the past six months by sex *(Field Survey, 2012 by Researcher)*

Number of Casual Partners	Male (%)	Female (%)	Total (%)
One	76.2	93.3	83.5
Two	9.5	3.3	6.9
Three	7.1	0.0	4.2
Several	7.2	3.4	5.4
Total	**100**	**100**	**100**

N = 144

Findings show that married or cohabiting respondents were dominating (71%) in having extra marital affairs. About 67% of widowed respondents and 52% of never married respondents reported having sex with casual partners. Another 42% of divorced or separated respondents also reported having sex with casual partners (figure 4.5.5).



N=144

Figure 4.5.4: Percentage distribution of ever had sex with casual partner for the past six months by marital status *(Field Survey, 2012 by Researcher)*

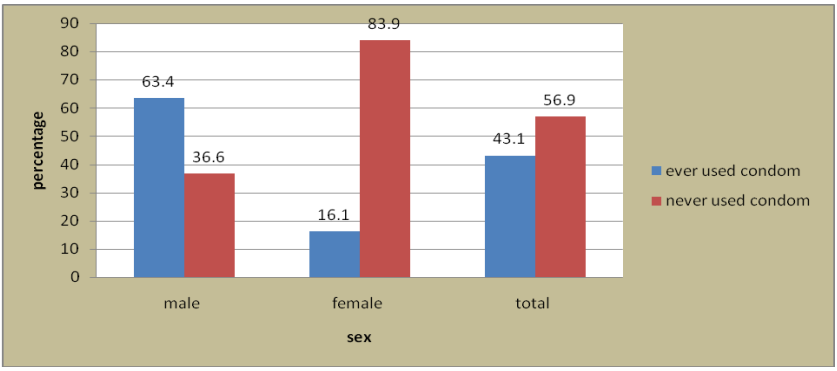
Condom use among farm workers with casual partners was extremely low. Most of respondents (57%) reported that they did not use a condom with a casual partner. More women (84%) than males (37%) reported that they did not use a condom with a casual partner (Figure 4.5.6).

It was also gathered during FGDs with women that condom use with casual partner was extremely low. Thus, a 35-year-old woman remarked;

> *"I engage a casual partner for sex in return for food to feed my children. How can I ask him to use a condom "ini ndichida sugar"? I will better cross red robot for the survival of my children. It's better to be infected with HIV virus to get sugar."*

In FGDs, a 26-year-old man remarked;

> *"Having sex putting on a condom is like eating a sweet with its paper, you will not feel the actual taste of the sweet (kudyira siwiti mupepa haizonake)."*



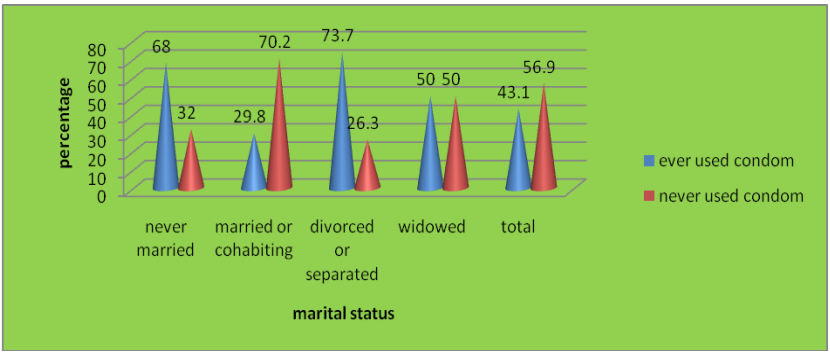
N= 144

Figure 4.5.5: Percentage distribution of respondents' condom use with casual partner for the past 6 months by sex *(Field Survey, 2012 by Researcher)*

There was variation in condom use with casual partner by marital status. Married or cohabiting respondents were less likely to report condom use with casual partner. The majority, 70% of married or cohabiting respondents reported that they did not use a condom with casual partner within the past six months. About 50% of widowed respondents also reported that they did not use a condom within the past six months while 32% of never married respondents reported again never use of condoms. Another 26% of divorced or separated respondents also reported never use of condoms (Figure 4.5.7).

During FGDS with men, it was also noted that married or cohabiting farm workers were not using condoms with a casual partner. A 40-year-old man remarked;

> *"Sister, sex with a casual partner is not for free. I pay money whenever I want to have sex with a casual partner. So, if I pay money, why do I need a condom for? Paying money means that I should enjoy sex as much as I can nekuti zvinonaka zvinodhura" (sweet things are expensive)."*



N = 144

Figure 4.5.6: Percentage distribution of respondents' condom use with casual partner by marital status *(Field Survey, 2012 by Researcher)*

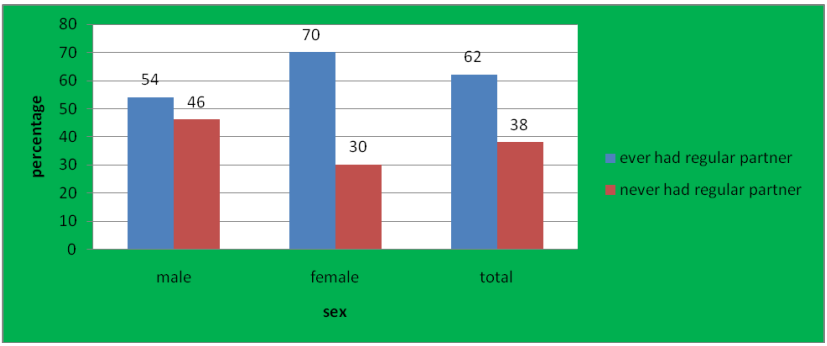
Those who used condoms were asked how often they used condoms with casual partners, a fair proportion, 50%, reported using condoms always whenever they had sex with a casual partner (Table 4.5.8). However, condom use pattern is high (72%) among males as compared to their female counterparts (20%). About 6% reported that they sometimes used condoms while 1% reported that they used condoms most of the times they have sex.

Table 4.5.8: Percentage distribution of respondents' frequency of condom use with casual partner for the past six months by sex

Frequency of condom use with a casual partner	Male (%)	Female (%)	Total (%)
Always	71.5	20.0	50.0
Sometimes	8.3	3.3	6.3
Most often	1.2	0.0	0.7
Never	19.0	76.7	43.0
Total	**100**	**100**	**100**

N = 82

Respondents were asked whether they had had a regular partner other than wife or husband in the last six months. Most respondents, 62%, reported that they had a regular partner in the past six months (figure 4.5.8). More females (70%) than males (54%) reported that they had a regular partner other than wife or husband.



N = 200

Figure 4.5.7: Percentage distribution of respondents who ever had a regular partner by sex *(Field Survey, 2012 by Researcher)*

Respondents were asked on how many regular partners they had for the past six months. The findings show that there was no significant difference between males and females in number of regular partners. Approximately 92% of respondents reported that they had one regular partner for the past six months. This was reported by 93% females and 91% males. About 6% reported to have had two regular partners for the past six months while 2% had three. Another 1% reported that they had several (Table 4.5.9).

Table 4.5.9: Percentage distribution on number of regular partners for the past six months by sex *(Field Survey, 2012 by Researcher)*

Number of Regular Partners	Male (%)	Female (%)	Total (%)
One	91.3	92.9	92.0
Two	4.3	7.1	5.6
Three	3.0	0	1.6
Several	1.4	0	0.8
Total	100	100	**100.0**

N = 125

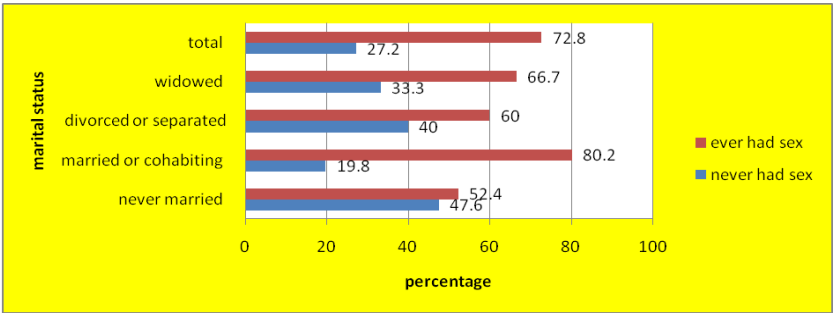
The findings show that there was not much variation in the number of regular partners by employment status. About 91% of permanent respondents reported that they had one regular partner.94% of casual respondents reported that they also had one regular partner. About 93% of seasonal respondents reported that they had one regular. Only 6% of permanent respondents, 3.2% of casual respondents and 7.4% of seasonal respondents had two regular partners while 2% of permanent respondents had three regular partners (Table 4.5.10).

Table 4.5.10: Percentage distribution of respondents' number of regular partners for the past six months by employment status *(Field Survey, 2012 by Researcher)*

Number of regular partner	Permanent (%)	Casual (%)	Seasonal (%)	Total (%)
One	91.0	93.6	92.6	92.0
Two	6.0	3.2	7.4	5.6
Three	1.5	3.2	0	1.6
Several	1.5	0	0	0.8
Total	**100**	**100**	**100**	**100**

N = 125

Married or cohabiting respondents dominated in having sex with a regular partner. About 73% reported having sex with regular partner. This was reported by 80% married or cohabiting, 68% widowed, 60% divorced or separated and 52% never married respondents (figure 4.5.9).



N=200

Figure 4.5.8: Percentage distribution of ever had sex with regular partner within the past six months against marital status *(Field Study, 2012)*

During FGDs with men, participants were asked the reasons why they engaged in multiple sexual partners, a 38-year-old married or cohabiting man had this to say;

> *"It is a way of giving a rest to our wives at home, because having sex with housewives everyday will make our wives grow older quickly."*

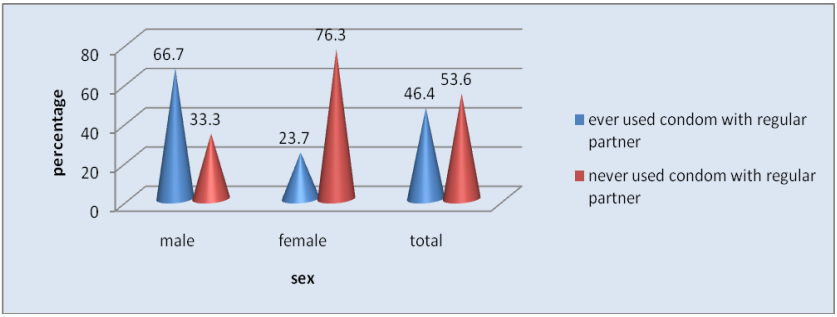
Another 27-year-old married or cohabiting man in FGDs had this to say;

> *"It bores to have sex with wives at home every day. Furthermore, our women at home are 'slim' and when we come across a 'big' woman you enjoy better. In addition, we will be eager to feel the difference between 'slim' and 'big' women."*

Another 48-year-old man in FGDS had this to say;

> *"Some of our partners are life-time girl friends who are single mothers (widowed or separated). We feel that we should help them by sleeping with them (having sex) so that they will be able to look after their children."*

Condom use with regular partner was extremely low among farm workers. When asked on whether they used condoms or not with regular partner, the majority (54%) reported that they did not use condoms with regular partner (figure 4.5.10). Note that, more women (76%) than males (33%) reported that they did not use condoms.



N = 125

Figure 4.5.9: Percentage distribution on condom use with regular partner by sex *(Field Survey, 2012 by Researcher)*

During FGDs, it was also gathered that condom use with regular partner was extremely low among farm workers. Thus, a 24-year-old man remarked;

> *"I have got one regular partner whom I have been in love with for 3 years now. To me she is like a handbag and the wife at home is like a suitcase. I treat them the same both my wife (suitcase) and my regular partner (handbag) but as usual, the handbag is daddy's favourite therefore I cannot use a condom with her because I trust her."*

Another 20-year-old man in FGDs remarked;

> *"For me to be satisfied sexually, I make sure that I do not put on a condom to ensure skin to skin contact."*

When asked on how often they used condoms with regular partner, a moderately low proportion, 47%, reported using condoms always whenever they had sex with a regular partner (Table 4.5.11). About 9% of respondents reported that they sometimes used condoms while 1% reported that they used the condom most of the times. Note that condom use pattern is high (74%) among male respondents and extremely low (16%) among female respondents.

Table 4.5.11: Percentage distribution of respondents' frequency of condom use with regular partner by sex *(Field Survey, 2012 by Researcher)*

Frequency of condom use with a regular partner	Male (%)	Female (%)	Total (%)
Always	73.5	15.8	47.2
Sometimes	8.8	8.8	8.8
Most often	1.5	0.0	0.8
Never	16.2	75.4	43.2
Total	**100**	**100**	**100.0**

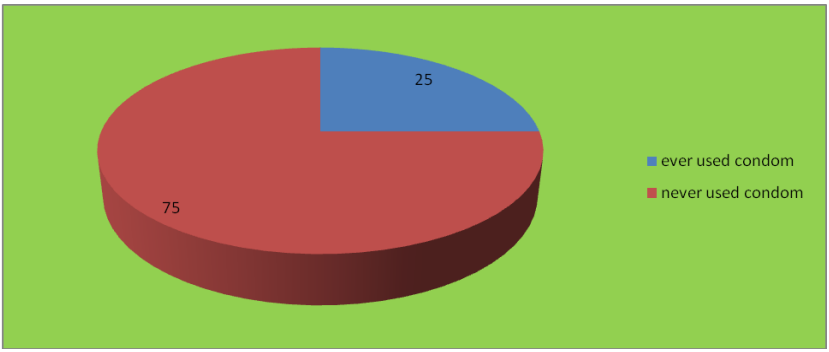
N = 71

When asked on the number of wives or husbands they had for the past 6 months, the majority, 92%, reported that they had one wife or husband. This was reported by 94% females and 87% males. However, some farm workers ever had polygamous marriages for the past six months. About 9% of respondents ever had polygamous marriages. More males (13%) than females (6%) had been involved in polygamy (Table 4.5.12).

Table 4.5.12: Percentage distribution on number of spouses for the past six months *(Field Survey, 2012 by Researcher)*

Number of wives or husbands	Male (%)	Female (%)	Total (%)
One	87.0	94.0	91.6
Two	5.2	0.0	2.5
Three	5.2	1.2	3.1
Several	2.6	4.8	3.8
Total	**100**	**100**	**100**

Condom use was noted to be unacceptable in marriages. When asked on condom use with spouse, the majority, 75%, reported that they never used a condom with spouse (Figure4.5.12).



N = 160

Figure 4.5.10: Percentage distribution of condom use with spouse *(Field Survey, 2012 by Researcher)*

It was also established during FGDs with men that condom use was totally unacceptable in marriage. A 28-year man remarked;

"Sister how can I use a condom with my wife whom I paid lobola for. Payment of lobola means that I should enjoy sex from my wife without a condom."

During FGDs, another 42-year-old man remarked;

"Condoms are only used with mistrusted partners."

It was also noted during FGDs with women that condom use was unacceptable in marriages. A 35-year-old woman remarked;

"It is difficult to initiate condom use to a husband. Inotoita hondo chaiyo mumba (conflicts will arise if you ask a husband to put on a condom). Usually my husband would say, 'did I give your parents a cow putting on a condom on its leg as a symbol that I am going to use a condom if I marry?'"

Another 25-year-old woman in FGDS remarked

"Kana yamira zvayo yemurume wangu muri vaviri kubedroom handimugone. Kunyangwe ndichiziva zvangu kuti anechirwere asi handingamuudze kuti ngatishandise kondomu nekuti ndakaroorwa. Kana ndikaramba kukwirwa wangu anotobvarurura bhurugwa racho akatoisa". (It is difficult to tell my husband to put on a condom even though I know that he is HIV positive because I am married to him. If I refuse to have sex with him, he will tear off my pants and force himself in).

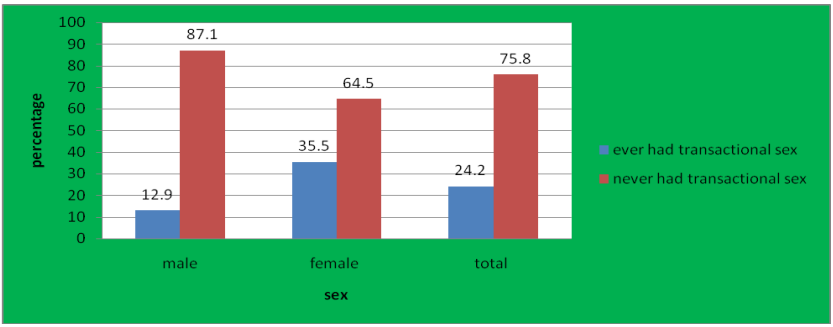
During FGDs, a 30 year old woman remarked;

"Makondomu anemafuta anoita kuti nhengo yababa ingeichingobuda buda saka zvinoita kuti baba vasanakidzwe zvakakwana. (Condoms have some oil which forces the penis to pull out easily which disturbs sexual pleasure)."

Another 42-year-old woman in FGDs further remarked;

"Nhai mwanangu ndikati baba vapfeke kondomu vanozondinzwa sei kuti ndinonaka. Ini ndinenge ndichitoda kuti baba vanzwe kutapira kwese kuti vasaende nemagora saka kondomu handidi kuriona mumba mangu. (My daughter how can I ask my husband to put on a condom while I want him to have a taste of me. My wish is to satisfy him sexually so that he will not be forced to engage into prostitution, therefore, I do not want to see a condom in my house."

Farm workers were engaging in transactional sex either for favours at work or for agricultural outputs such as maize, wheat and money. Respondents were asked if they received anything in exchange for sex, either cash or in kind. Approximately, 24% of respondents reported that they received cash, goods or services in exchange for sex. It was interesting to note that more women (36%) than men (13%) have received either goods or services in exchange for sex (Figure 4.5.13).



N = 186

Figure 4.5.11: Percentage distribution of respondents by whether they paid someone or got paid in cash or in kind by sex *(Field Survey, 2012 by Researcher)*

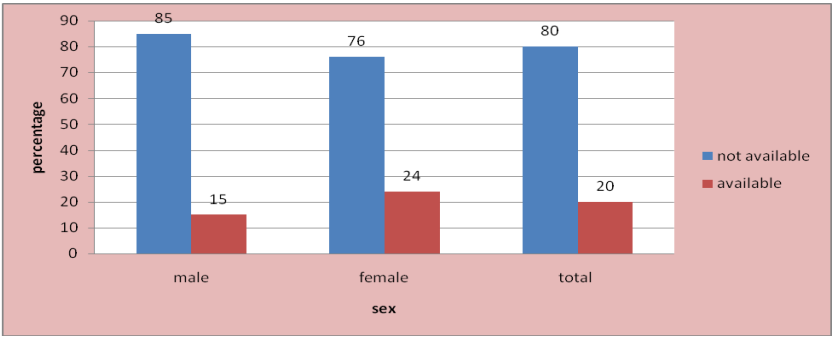
Transactional sex was also highlighted during key informant interview with HBCO. She remarked;

> *"Most women do not have enough food for the upkeep of their children. Therefore, they exchange sex for a 50kg bag of maize or wheat to feed their families."*

During FGDs with men, it was also highlighted that women were involved in transactional sex at the farm. A 31-year-old man remarked;

> *"Some women approach us demanding bathing soap insisting to pay the soap by providing sex."*

Condoms were scarce at Rattray Arnold Research Farm. Respondents were asked on whether condoms were readily available at the farm, the majority, 80%, of respondents reported that condoms were not readily available at Rattray Arnold Research Farm. More males (85%) than females (76%) reported that condoms were not readily available at the farm (Figure 4.6.1).



N = 200

Figure 4.6.1: Percentage distribution of respondents' knowledge on condom availability at the farm *(Field Survey, 2012 by Researcher)*

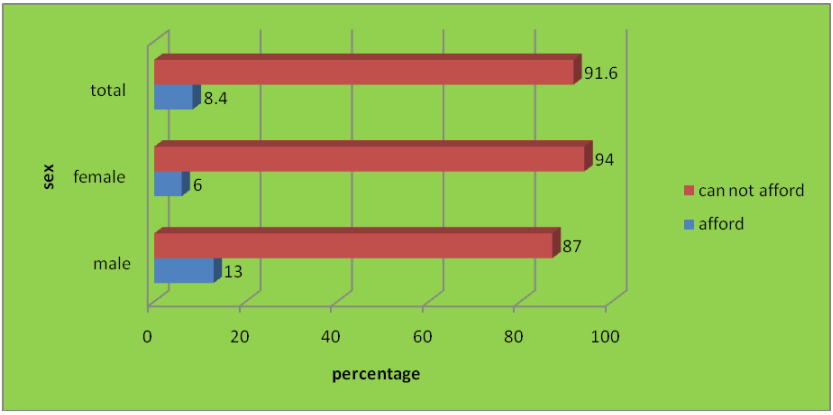
It was also established during FGDs with men that condoms were scarce at the farm. A 20 year old man remarked that;

> *"Our tuckshop here does not sell condoms. If I need to have a short one, I usually borrow condoms from friends who might have them but most of the time tinongorova waya (we normally have sex without protection when having sex with casual partner)."*

A 45 year old woman in FGDs remarked;

> *"My daughter makondomu hatiazive kuno. Tinongonzwa kuti kune redu rechikadzi asi ini handisati ndamboriona zvangu uye kuti rinoshandiswa sei. (We do not know condoms here. We just hear that there is a female condom, but I don't even know it)."*

Most farm workers lack financial resources to buy contraceptives. Respondents were asked whether or not they can afford to buy contraceptives. The majority (92%) of respondents reported that they do not have enough money to buy contraception. Note that more women (94%) than males (87%) reported that they cannot afford to buy contraceptives (Figure 4.6.2).



N = 200

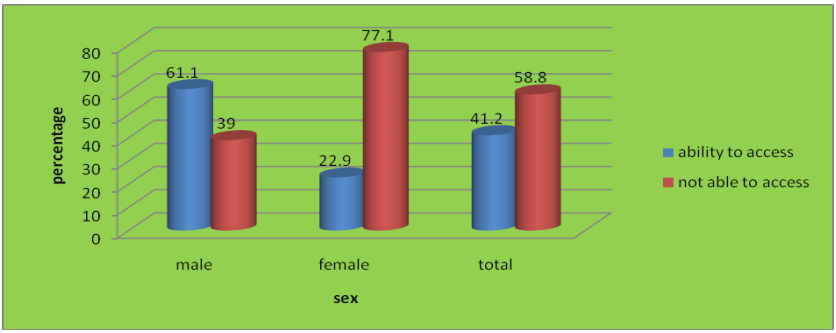
Figure 4.6.2: Percentage distribution of respondents who can afford to buy contraceptives *(Field Survey, 2012 by Researcher)*

It was also established during FGDs with men and women that farm workers were failing to buy contraception due to lack of financial resources. One condom was being sold at $1. Participants further reported that the HBCO is biased when selling condoms. Most of the time she tells us that she does not have condoms. Only her close relatives and friends have access to the condoms at 50 cents per condom. A 28-year-old man remarked;

> *"I earn $60.00 per month. From that salary, as a father of two children, I am expected to buy food for the family, clothing and pay school fees for my grade one daughter.*

The money is not even enough to cover all the family expenses. With all these, how can I buy condoms, yet I am failing to feed my family. To me buying condoms is a luxury because I need quite a few condoms per month which I cannot afford. When I have sex with a casual partner, I will quickly take a bath so that all dirt or viruses are washed away."

The geographic location of farm communities hinders accessibility of condoms at the farm. When asked on whether or not farm workers can access contraception at the farm, the majority (59%) of respondents reported that they do not have access to condoms. This was reported by more females (77%) than males (39%) (Figure 4.6.3).



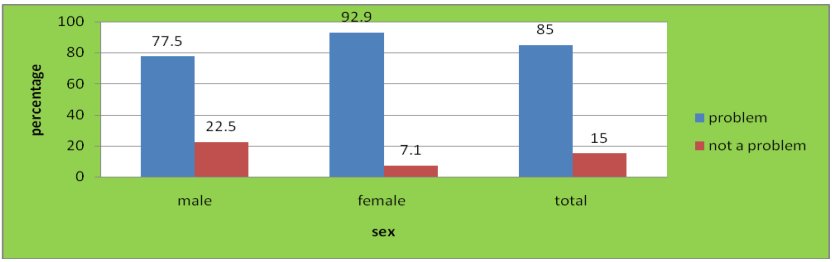
N = 200

Figure 4.6.3: Percentage distribution of respondents' ability to access contraception at the farm *(Field Survey, 2012 by Researcher)*

It was also established during key informant interview with HBCO that farm workers were finding it difficult to access condoms at the farm. One HBCO remarked;

"Condoms here can only be obtained from Nyaure, St Joseph and Domboshava clinics. All these clinics are roughly 20 km away from the farm. Farm workers need transport to get there and they do not have enough money to visit these centres."

HIV&AIDS was perceived to be a serious problem at Rattray Arnold Research Farm and the degree of seriousness was very high. The majority (85%) perceived HIV&AIDS as a problem (Figure 4.7.1). More females (93%) than males (78%) perceived HIV&AIDS as a problem.



N = 200

Figure 4.7.1: Percentage distribution of respondents' perception on the seriousness of HIV and AIDS at the farm by sex *(Field Survey, 2012 by Researcher)*

The seriousness of HIV&AIDS was also echoed in key informant interviews. One Home Based Care Officer (KII) noted;

> *" The level of seriousness is very high. At this farm because we have 158 adults and 35 children out of 380 people at the farm who are currently ill because of HIV&AIDS infection. Thirty deaths have occurred at the farm due to AIDS in the past one year."*

The Farm Manager (KII) also echoed;

> *"HIV&AIDS is a serious problem at the farm because 15 workers who occupied critical positions have died due to AIDS related sickness in the past one year."*

Respondents were asked if they had ever been absent from work due to illness in the past one year. Approximately 37% reported that they were absent for 1 to 9 days in the past year (Table 4.7.1). More females (45%) than males (29%) reported that they were absent in the past one year at the farm.

Respondents were also asked about absenteeism within the past six months due to illness. About 39% of respondents reported that they were absent for approximately 1-9 days in the past six months. This was reported by 49% of females and 29% of males (Table 4.7.1).

Absenteeism was less within short periods. Thus, farm workers were less likely to be absent from work due illness within a period of one month. Approximately 20% of respondents reported that they were absent from work within the past one month. This was reported by 24% males and 15% females (Table 4.7.1).

During key informant interviews with the Farm Manager, it was also gathered that illness compromises productivity by reducing on-the-job performance. Thus, the Farm Manager remarked that;

> *"Some employees who are ill force themselves to come to work because they fear losing their job. However, these employees are not effective as they are not able to*

carry out more demanding duties such as weeding, planting and spraying herbicides on crops. During this period, employees are required to carry a 20liter spray on their back. As a result, productivity is reduced because we do not have enough manpower to carry out weeding, planting and spraying of crops".

Table 4.7.1: Percentage distribution of respondents' absenteeism due to illness by sex *(Field Survey, 2012 by Researcher)*

Past one month	Male (%)	Female (%)	Total (%)
Never been absent	76.2	84.7	80.4
Absent	23.8	15.3	19.6
Total	**100.0**	**100.0**	**100.0**
Past 6 months			
Never been absent	70.6	51.0	61.0
Absent (1-9 days)	29.4	49.0	39.0
Total	**100.0**	**100.0**	**100.0**
Past one year			
Never been absent	70.6	55.1	63.0
Absent (1-9 days)	29.4	44.9	37.0
Total	**100.0**	**100.0**	**100.0**

N = 200

Farm workers can also be absent from work due to compassion. When asked if they had been absent from work due to compassion (funeral, care) for the past one month, approximately 36% reported that they had been absent due to compassion for approximately 1-9 days in the past one month. This was reported by 37% males and 34% females (Table 4.7.2).

When asked if they had been absent from work due to compassion in the past one year. Another 51% reported that they had been absent due to compassion for the past one year (Table 4.7.2). This was reported by 54% females and 49% males.

The Farm Manager also remarked;

" The major aim of this farm is to produce seed locally and regionally. However, as a farm, we are failing to meet targets due to HIV&AIDS. We do not have enough flow of production due to HIV&AIDS. For example, when a worker dies, almost half of the workers will not come for work because they will be attending a funeral of their colleague as most of them are related. By so doing, our day-to-day activities are disturbed and at times, we even fail to plant on time, as a result it affects our seed quality and yields."

Table 4.7.2: Percentage distribution of absenteeism due to compassion by sex *(Field Survey, 2012 by Researcher)*

Past one month	Male (%)	Female (%)	Total (%)
Never been absent	62.7	66.3	64.5
Absent	37.3	33.7	35.5
Total	**100.0**	**100.0**	**100.0**
Past one year			
Never been absent	51.5	45.9	48.7
Absent	48.5	54.1	51.3
Total	**100.0**	**100.0**	**100.0**

N= 200

Morbidity and mortality due to HIV&AIDS has negatively impacted on production at Rattray Arnold Research Farm. When asked about how illness or death due to HIV&AIDS has impacted on production at the farm, a significant proportion, 60%, reported that it reduced productivity. About 21% reported that there was increased workload because of co-workers' illness while 19% reported that there was no impact on productivity (Table 4.7. 3).

The Farm Manager, during key informant interview, also highlighted that HIV&AIDS has hampered productivity at the farm. He remarked;

> *" The farm had lost many skilled workers due to HIV&AIDS. In the past one year, the farm lost a Technician who died after a long illness, a Tractor driver, a Supervisor from maize section and a senior farm labourer. Since the technician from maize section died, it took time for us to complete packaging of maize seed for research because we had to train another person. However, the farm cannot easily replace the guy because he was the only person who knew randomization of plots to be planted."*

Another man echoed;

> *"HIV&AIDS is giving us pressure of work because the Farm Manager is taking long to replace the dead, therefore, we must cover his or her duties."*

Table 4.7.3: Percentage distribution on impacts of illness or death on productivity by sex *(Field Survey, 2012 by Researcher)*

Impact of illness or death on productivity	Male (%)	Female (%)	Total (%)
Increased workload	25.5	15.3	20.5
Reduced production	53.9	66.3	60.0
No impact	19.6	18.4	19.0
Other	1.0	0.0	0.5
Total	**100.0**	**100.0**	**100.0**

N = 200

CHAPTER 5:
Decoding the Meaning and the Way Forward

This chapter discusses findings presented in Chapter four. It also provides recommendations on addressing challenges that undermine the reduction of HIV&AIDS among farm workers that were explored in this study.

The findings revealed that the level of HIV infection among farm workers at Rattray Arnold Research Farm was very high. Data from KII revealed that (42%) adults of the farm population of 380, were living with HIV&AIDS, yet there was underreporting (22%) by farm workers at the farm on their HIV&AIDS status. These findings are higher than the 35% HIV prevalence among farm workers and mine workers reported by WHO (2005), FCTZ (2005), NAC (2005), MoHCW (2007), and IOM (2010). Among the infected, it was worrisome to note that only a paltry (12%) were on ART. This was exacerbated by long distances (20km) which farm workers had to travel to health centres to receive ARVs. Ziningi (2009) also noted that ART is expensive and difficult to get in farms because farm workers' income tended to be low and therefore could not afford the cost of the drugs. The findings revealed that 76% of respondents after being tested did not disclose their HIV status to their partners. However, non-disclosure of HIV status affects access to treatment, hence, more HIV infections to the farm community.

Knowledge about HIV&AIDS was universal in this study. The majority, 98%, had heard of HIV&AIDS. These findings are congruent with those from earlier, national surveys in Zimbabwe as shown in ZDHS (2005/6). While there was widespread knowledge about HIV&AIDS, misconceptions still exist among farm workers regarding modes of HIV&AIDS transmission. About 16% and 9% of respondents reported that kissing and mosquito bites transmit HIV&AIDS, respectively. During FGDs participants also echoed similar sentiments that using the same utensils with an HIV infected person and kissing, transmits HIV&AIDS. However, previous studies by NCFH (2009) had noted relatively lower percentages (32%) of misconceptions. Thus, it should be argued that such misconceptions can disturb contraception because if HIV&AIDS can be transmitted through kissing, mosquito bites and sharing utensils, then people might view contraception as futile.

Although perception of risk is considered to be the first stage towards behavioural change, the association between perception of risk of HIV infection and sexual behaviour remains poorly understood. The findings revealed that 71% of farm workers believed that men should have multiple sexual partners, even when married. It should be argued that farm workers' attitude of having multiple

sexual partners expose them at high risk of HIV infection. It was also interesting to note that more males (84%) than females (57%) perceived having multiple sexual partners as a sign of virility among men. These findings are congruent with those obtained by Farm Worker Justice (2009) that also revealed that sexual masculinity is expressed in virility that is proved by having many sexual partners. Chiororo *et al.* (2002) and Gunda (2008) in their studies established that men perceive sex as an activity that should result in optimal sexual satisfaction for the man. As such, they engage in having multiple sexual partners.

Findings show that stigma regarding HIV&AIDS was moderately low with males attaching less stigma to PLWHA than females. Since at the farm, women attach more stigma than men to PLWHA, men will face a dilemma in disclosing their HIV status to their partners because it may lead to discrimination and exclusion.

The findings revealed that the mean age at first sexual intercourse was 15 years. However, more females (11%) than males (4%) had sex by age 15. This corroborates findings by ZDHS (2005/6) which established that youth initiate sexual activity before age 15. However, Global Health Council (2010) asserts that early sexual practice is associated with a higher propensity to accumulate sexual partners, therefore, increases chances of contracting sexually transmitted diseases such as HIV&AIDS. It was also worrisome to note that girls were having sex before marriage. The majority (72%) of respondents had sex before marriage. The findings revealed that respondents wanted to explore the 'sexuality' while some had sex out of 'curiosity'. Such findings are similar to (Farm Worker Justice, 2009; SARD, 2006).

The results from this study revealed that farm workers at Rattray Arnold Research Farm were having intergenerational sex. A fair proportion (50%) of respondents ever had intergenerational sex with more women (78%) than males (22%) responding in the affirmative. Their argument was that 'sugar daddies' provide material needs while young men are potential husbands in marriages. Similar findings were also noted by FAO (2006), ZHDR (2003), and ZDHS (2005/6). This practice puts young women at high risk of HIV infection as they engage in unprotected sex to gain material things. It was also worrisome to note that some farm workers had engaged in transactional sex. Married women were reportedly engaging in transactional sex for the upkeep of their children. It was also established during FGDs that women were exchanging sex for a 50kg bag of maize, wheat and diesel for the upkeep of their families. It was noted that 24% of respondents had exchanged sex for either cash or kind, a figure which is lower than the 33% that was reported by IOM in 2010. FAO (2006) and Barnet & White (2006) propounded that, transactional sex is common on and near commercial farms, partly due to unequal income earning opportunities for men and women.

The results from this study revealed that farm workers at Rattray Arnold Research Farm had polygamous relationships. About 9% of respondents had polygamous marriages. The percentage of women in polygamous unions in this study is less than the 11% reported by ZDHS (2005/6). However, polygamous unions are also one of the major factors promoting the spread of HIV&AIDS in Africa (ZDHS, 2005/6).

While farm workers were having multiple sexual partners and polygamous relationships, it was surprising to note that condoms use was extremely low. The majority, 77% of respondents, reported having unprotected sex. Females were more likely (82%) than males (73%) to have unprotected sex. This figure is higher than the 30% (9% females and 51% males) reported in ZDHS (2005/6). Previous studies have also noted relatively lower prevalence of contraceptive use among both married and unmarried respondents (Chiororo *et al.*, 2002; MoHCW, 2007; Gunda, 2008). It was also noted that low condom was also exacerbated by a 'false sense of trust' of their regular partners, a situation which exposes both men and women to HIV&AIDS. While condoms offer dual protection, the issue of acceptability and accessibility at the farm hindered their use. The majority (80%) of respondents reported scarcity of condoms at the farm. Results from the study revealed that condoms were obtained from Nyaure, Domboshawa and St Joseph clinics. All these clinics are roughly 20 km away from the farm. Conversely, male respondents argued that they did not use condoms in marital unions because condoms are associated with infidelity and lack of trust.

The findings revealed that HIV&AIDS was a serious problem. Key informant interviews revealed that 158 adults and 35 children out of 380 people at the farm were living with HIV&AIDS. Furthermore, 30 deaths have occurred at the farm due to AIDS in the past one year and the farm had lost 15 workers who occupied critical positions due to AIDS related sickness in the past one year. Results also revealed that that the farm had lost productivity because of workers' absenteeism due to illness. The Farm Manager remarked that some employees' who were ill forced themselves to come to work due to fear of losing their job. However, these employees' performance was poor because they were not able to carry out more demanding farm duties such as weeding. Rugalema *et al.* (1999) cited in FAO (2006) states that AIDS related morbidity affect productivity in the commercial agriculture due to absenteeism, loss of skills and decline in available labour. Findings from the study revealed that more women had been absent from work caring for the sick or attending funerals. According to Basset & Mhloyi (1991), FAO (1995), Ncube (1998), and FAO (2006) HIV&AIDS epidemic was reported to be a heavier toll on women because they are care givers and are also involved in general household decision making and planning.

The study noted that the level of HIV infection among farm workers at Rattray Arnold Research farm was very high (42%). High levels of HIV&AIDS were exacerbated by different factors such as early sexual practices, premarital sex, intergenerational and transactional sex, having multiple sexual partners, polygamy and low condom use. Knowledge about HIV&AIDS was almost universal in both male and female respondents. The association between perception of risk of HIV infection and sexual behaviour remains poorly understood at the farm. The findings revealed that contraceptive use was very low at the farm. A false sense of trust affected the use of contraceptives in extramarital affairs. Availability, accessibility and affordability negatively impacted on contraceptive use. It was also noted that Rattray Arnold Research Farm was heavily affected by HIV&AIDS. Skills were lost due to HIV&AIDS morbidity and mortality at the farm.

The findings from the study support the need for a multi-sectorial approach to HIV&AIDS infection among farm workers. Given that Zimbabweans back borne is agriculture, it is necessary to implement a full range of interventions. The following are recommendations provided based on findings from the study:

The government through NGOs should avail free condoms to farm workers and make sure that farm workers are educated on correct and consistent use of condoms.

The government through NGOs should establish HIV support services such as treatment and care in farming communities. These established support services will ensure that health issues pertaining to HIV&AIDS are adequately addressed in the farming community.

The government and NGOs through Home Based Health Care Officers and Peer Educators should ensure that risk sexual practices are highlighted to farm workers. This can be done by engaging both married and unmarried farm workers in programmes that highlight the benefits of adopting safe sexual practices and behaviour to both men and women.

Promote delays in the onset of sexual activity among adolescents. The government and NGOs should carry out campaign programmes in farming communities that educate adolescents on the negative impacts of early sexual debut and premarital marriages.

The government should implement effective HIV&AIDS programmes in farming communities that provides farm workers with accurate information. It should also

establish a vibrant policy that addresses the plight of the farming community on issues pertaining to HIV&AIDS.

The study highlights a critical public health issue at the Rattray Arnold Research Farm, where the HIV infection rate among farm workers is alarmingly high at 42%. This prevalence significantly surpasses previous regional reports and underscores the urgent need for targeted interventions. Despite universal knowledge of HIV&AIDS among the workforce, misconceptions about transmission and a range of high-risk behaviours, including early sexual initiation, multiple sexual partners, intergenerational and transactional sex, and low condom use, contribute to the ongoing epidemic. While HIV & AIDS awareness is widespread, practical measures to prevent and manage the infection remain insufficient. The low uptake of antiretroviral therapy (ART), combined with barriers such as long distances to health facilities and high costs, exacerbates the situation. Additionally, the practice of non-disclosure of HIV status among partners and the stigmatization of people living with HIV&AIDS further hinder effective intervention and treatment. Systemic issues such as inadequate access to contraceptives, low condom use, and the economic and social challenges faced by farm workers, which compound their vulnerability to HIV&AIDS were identified. The high level of absenteeism and loss of productivity due to HIV&AIDS-related illnesses further impacts the farm's operations, highlighting the broader economic consequences of the epidemic.

To address these challenges, a multi-sectoral approach is essential. Recommendations include the provision of free condoms and education on their correct use, the establishment of accessible HIV support services, and comprehensive educational programs targeting safe sexual practices and risk reduction. Additionally, promoting delays in sexual activity among adolescents and implementing robust HIV&AIDS policies tailored to the farming community are crucial steps toward mitigating the epidemic's impact. By adopting these recommendations, stakeholders can help improve the health and economic well-being of farm workers, ultimately contributing to a more resilient and productive agricultural sector in Zimbabwe.

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Synopsis

HIV&AIDS remains one of the most pressing global health challenges, significantly affecting the lives of millions worldwide. The epidemic's complex interplay with socio-economic factors, such as poverty, education, and access to healthcare, continues to shape its trajectory. The note reflects on the progress made, the ongoing challenges, and the future directions in the fight against HIV&AIDS, particularly among marginalised communities such as farm workers in Zimbabwe.

Globally, 2023 marked a critical year in the epidemiology of HIV&AIDS. An estimated 39.9 million people were living with HIV, a figure that underscores the persistent burden of the disease. In the same year, 1.3 million individuals became newly infected, highlighting the ongoing need for robust prevention strategies. The death toll from AIDS-related illnesses reached 630,000, a stark reminder of the fatal consequences of the disease when untreated. However, there were significant advancements in treatment, with 30.7 million people accessing antiretroviral therapy (ART), a lifesaving intervention that has transformed HIV from a fatal diagnosis to a manageable chronic condition.

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